ABNORMAL PSYCHOLOGY



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Book: Abnormal Psychology (Lumen)

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This text was compiled on 04/14/2026

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Detailed Licensing

Detailed Licensing

Licensing

*A detailed breakdown of this resource's licensing can be found in **Back Matter/Detailed Licensing**.*

Hints on how to succeed in this course!

The grades you earn on each assignment are up to you. The documents below spell out in detail the requirements you must meet in order to earn an “A” grade. These “hints” give you a preview of those requirements:

- The course includes 5 **learning modules**.
  - Be aware of the start and end date of each discussion forum and the due date for each assignment.
  - Submit your initial forum posts and resource reports within the first 3 days that the module starts.
  - Participate in each of the discussion forums on at least 10 different days during the module
  - Submit your blog on the first day the blog assignment is active.
- Discussion posts that are submitted after the module ends are not graded.
- You will get no credit for a discussion post that violates either of the Two Cardinal Rules.

Frequently asked Questions:

Question 1: How will I be graded?

Answer: I use a grading rubric to provide feedback on every assignment. These rubrics are presented in the documents below, and are accessible in the My Grades section. I suggest that as the course proceeds you review each of your scored rubrics so that you are aware of any problems and do not make the same mistakes again.

Question 2: Why is there a “post on 10 different days” requirement for full credit on the discussion forums?

Answer: I have learned over my 20 years of teaching online that the discussion forum is the primary learning activity. To make an online discussion as meaningful as a face-to-face discussion, it is necessary to have the same back-and-forth interaction. This can only be done if you give the other participants a chance to respond before you get back to them with your reply.

Keep this in mind as you participate in the discussion forums, write your Internet Resource Reviews, Blogs and your Self-Analysis: **You are posting your work for the benefit of the other students – not for the benefit of the instructor!**

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Instructions for the Research and Discuss Assignments

Overview of the Research and Discuss assignments:

The purpose of this assignment is for each student to locate Internet resources that contain valid information relevant to the issues we will be discussing, write original and thoughtful analysis reviews about the content of the resources, and then lead class discussions on the issues.

Submit one Internet Resource review for each dropbox and discussion forum. You will receive 2 grades for each forum: the written review (50%) and your participation in the discussion forum (50%).

1. Using the Internet search engine of your choice (for example, Google or GoogleScholar), locate a Internet resource on your topic. Internet resources include articles, YouTube videos, Ted Talks, etc. Once a topic has been selected by another student you may not select it for yourself.
2. Write a review of your topic following the guidelines below. Include an overview of the main point(s) and your thoughts on the information.
3. Include a link to the resource at the bottom of your review.
4. Submit your review to the appropriate SafeAssign drop box for an Originality Analysis and for my evaluation.
5. Revise and resubmit your review if needed.
6. Your website review is graded within the SafeAssign drop box using the rubric below. Once graded, you can see my feedback by accessing the rubric via the "My Grades" link.
7. Paste your review into the Discussion Forum for class discussion. To receive full credit, you must submit your review within the first 3 days that the module is active.
8. In the discussion forum, discuss your review – and at least 2 others – with your classmates.
9. Your grade on the discussion forum will depend on the quantity, spacing, and quality of your posts.
10. Study the grading rubric carefully so that you are aware of how your work will be graded.
11. I grade your work – and update your discussion forum rubric – every day.

Begin this assignment by selecting a topic for the discussion forum. Then use the Internet search engine of your choice to a "good" resource dealing with the topic. Then, for each issue, write a review of the resource and submit it for grading (to the SafeAssign drop box) and discussion (to the discussion forum. By "good resource" I mean a resource that seems to you to provide accurate, relevant and unbiased information on the topic.

Detailed Instructions for each review:

Step 1 – Write an original review of the Internet resource – minimum 500 original* words. See the definition of "original words" below. Include a working link to the resource at the end of your review, and put the original word count (as determined following the instructions below) at the very bottom of your review. (e.g. "673 original words")

Step 2 – Submit your review to the SafeAssign dropbox. If there are plagiarism issues, correct them by either re-wording the passage or putting it in quotes and citing the source. I will evaluate your review in the dropbox using the rubric below.

***Definition of "Original Words":**

This assignment has a "minimum of 500 original words" requirement for an "A", but if you want to earn an "A+" then the minimum is 750 original words. See row 3 of the rubric for word-count details. . The SafeAssign dropbox analyzes your assignment and highlights plagiarized or "essentially the same" passages that already exists on the Internet. This "similar content" – EVEN IF YOU DID NOT COPY IT FROM THE WEB / EVEN IF YOU MADE IT UP YOURSELF – does not count as your "original words." All "siimilar" passages should be enclosed in quotes and the source cited.

Correct all of these issues before you submit your review to the class for discussion.

Step 3 – submit your review to the discussion forum. The discussion of the Internet resources will continue until the module ends. Review the grading rubric carefully so you can earn the forum grade you want.

Step 4 – Discuss your topic and at least 2 others which you select from reviews submitted by your classmates

1. Use the Create Thread button to submit your review for class discussion.

2. Facilitate the discussion of your review. When other students respond to your posting, respond back to them. Your job is to facilitate a discussion which explores the issues you have presented in your review.You are the “teacher.”
3. Read and discuss the reviews submitted by at least *2* other classmates. Be an active participant in these threads. (An “active participant” does more than reply once and not continue in the conversation.) You may participate in as many review discussions as you want to – but the minimum is 2.
4. I will evaluate a maximum of 3 discussion posts submitted to the same discussion forum during any 24 hour period. For example, if you submit 3 discussion posts to the same forum between noon and 1:00 pm, you should wait until 1:00 pm the following day to submit your next post. This rule is designed to give other students a chance to respond to your posts, so that you can then reply back to them. This also means that if you wait until the last day or 2 to submit lots of posts, I will only evaluate the first 3 each day.

You will earn a high grade on the discussion forum if you:

- Submit an acceptable review which satisfies all of the guidelines above to the SafeAssign dropbox **and** to the Discussion Forum during the first 3 days that the module is active.
- Submit 10 acceptable reply posts (Posts that comply with both of the Cardinal Rules.)
- Participate in the forum on 10 different days while the module is active.
- Remember that you won’t get credit for more than 3 posts submitted during any 24 hour period.

The Internet Resource Review Grading Rubric:



The Internet Resource Review Discussion Forum Grading Rubric:



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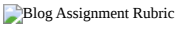
Instructions for the Reflective Blogs

The Reflective Blog assignment is treated as an exam. You will recieve 2 grades: The blog itself (50%) and the blog discussion forum (50%).

The purpose of the blog is for you to reflect about – write about – and discuss the new knowledge you and your fellow students actually learned in the module readings and discussions, and how your thoughts, feelings, and actions will be impacted by this new learning.

- Reflect upon the issues that you read about in the discussion forums.
- Select the 4 topics you feel were the most valuable to you in the module.
- List these topics, numbered from 1 (most valuable) to 4 (least valuable).
- For each topic:
  - provide an overview of the topic and what you learned about it, and
  - describe how what you learned will impact the way you think, feel, and behave in the future.
- The minimum blog requirement is 1000 original words: about 250 words per topic.
- Submit your blog in two places: the SafeAssign drop box for my evaluation, and the Blog Discussion Forum for classmate reactions.
- To earn full credit submit your Reflective Blog on the first day of the Knowledge Audit window – after the discussions have all ended. This is important so that other students will have sufficient time to respond.
- After you post your blog, reply to 5 other blogs during the 3-day Knowledge Audit window. Note – you must submit your blog before you can see the blogs posted by other students.
- To earn full credit, you need to submit six acceptable posts:
  - Submit your blog as a New Post
  - Reply to 5 other blogs – the minimum acceptable length of each reply is 200 words.
  - There is no requirement that you reply to those who comment on your blog – but you may if you wish. However, your blog discussion grade is based only on the 6 required posts.

Reflective Blog Grading Rubric:



Reflective Blog Discussion Forum Grading Rubric:



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CHAPTER OVERVIEW

1: Abnormal Psychology- History, Theories, and Research Methods

1.1: Abnormality- Read and Study Assignment
1.2: Why Science
1.3: Research Designs
1.4: History of Mental Illness
1.5: Module 1 Exam
1.6: Abnormality- Research and Discuss Assignment
1.7: Reflective Blog and Discussion
1.8: Exam 4

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1.1: Abnormality- Read and Study Assignment

Read and study the 3 articles below and then take the Module 1 exam. This is a self-paced assignment which must be completed prior to the end of Module 1. You may take the exam up to 5 times, and only your best score will be recorded in the grade book.

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1.2: Why Science

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1.5: Module 1 Exam

This is a 10 question exam with a 30 minute time limit. You may take this exam up to 5 times. Each exam will contain a random selection of items from the large test item pool. Only your highest exam score will be recorded in the grade book.

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1.6: Abnormality- Research and Discuss Assignment

Instructions:

- Click the “Reserve Your Theory” link below to select the theory you want to discuss with the class.
- Follow the instructions to review the discussion forum before you select so that you do not choose a theory that has already been selected by another student.
- Locate an Internet Resource (NOT Wikipedia) about the theory you have selected,
  - review the resource and submit your review to the SafeAssign drop box for my evaluation
    - The evaluation of your review will be based upon the Internet Resource Review rubric.
  - and to the discussion forum for class discussion.
- Reply to at least 2 other student reviews and discuss them until the module has ended.
    - This forum is graded using the standard discussion forum rubric.

(Note: Students reserve a theory from this list)

Theories for discussion:

Biological / Genetic

Biological / Brain Structures

Biological / Neurotransmitters

Biological / Hormones

Psychological / Psychodynamic

Psychological / Behavioral

Psychological / Cognitive

Psychological / Humanistic-Existential

Sociocultural

Diathesis-Stress

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1.7: Reflective Blog and Discussion

Modules 1 through 4 end with a reflective blog assignment. See the detailed instructions in the Course Information folder.

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1.8: Exam 4

This is a 10 question exam with a 30 minute time limit. You may take this exam up to 5 times. Each exam will contain a random selection of items from the large test item pool. Only your highest exam score will be recorded in the grade book

(Note: All exam items are from the Noba Project test item pool, which are licensed under Creative Commons Attribution-NonCommercial-Share Alike 4.0 International License)

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CHAPTER OVERVIEW

2: Assessment and Classification of Psychological Disorders

2.1: Assessing and Classifying Abnormal Behavior
2.2: Learning activities for Module 2

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2.1: Assessing and Classifying Abnormal Behavior

For this module, your assignment is to locate, review and discuss two online articles on the topic of assessing and classifying abnormal behavior.

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2.2: Learning activities for Module 2

This module required 2 drop boces and 2 discussion forums. Each student is responsible for locating, reviewing, and leading the discussion on two Internet resources related to assessment and classification of abnormal behavior.

The evaluation of learning is via a reflective blog and discussion.

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CHAPTER OVERVIEW

3: Psychological DIsorders

3.1: Psychological Disorders- Read and Study Assignment
3.2: ADHD and Behavioral Disorders in Children
3.3: Autism- Insights from the Study of the Social Brain
3.4: Anxiety and Related Disorders
3.5: Social Anxiety
3.6: Dissociative Disorders
3.7: Mood Disorders
3.8: Personality Disorders
3.9: Psychopathy
3.10: Schizophrenia Spectrum Disorders
3.11: Module 3 exam
3.12: Psychological Disorders- Research and Discuss Assignment
3.13: Reflective Blog

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3.1: Psychological Disorders- Read and Study Assignment

Read and study the 9 articles below and then take the Module 3 exam. This is a self-paced assignment which must be completed prior to the end of Module 3. You may take the exam up to 5 times, and only your best score will be recorded in the grade book.

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- Psychological Disorders: Read and Study Assignment. **Authored by**: WIlliam Pelz. **Provided by**: Herkimer College. **Located at**: https://herkimer.open.suny.edu/webapps/blackboard/execute/manageCourseItem?content_id=_24927_1&course_id=_794_1&dispatch=edit. **Project**: Abnormal Psychology - Achieving the Dream course. **License**: *CC BY: Attribution*

This page titled 3.1: Psychological Disorders- Read and Study Assignment is shared under a not declared license and was authored, remixed, and/or curated by Lumen Learning.

3.2: ADHD and Behavioral Disorders in Children

Milich, R. & Roberts, W. (2017). Adhd and behavior disorders in children. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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- ADHD and Behavioral Disorders in Children. **Authored by**: Milch and Roberts. **Provided by**: Noba Project. **Located at**: http://nobaproject.com/modules/adhd-and-behavior-disorders-in-children. **Project**: Abnormal Psychology - Achieving the Dream course. **License**: *CC BY-NC-SA: Attribution-NonCommercial-ShareAlike*

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3.3: Autism- Insights from the Study of the Social Brain

Pelphrey, K. A. (2017). Autism: insights from the study of the social brain. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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- Autism: Insights from the Study of the Social Brain. **Authored by**: Pelphrey. **Provided by**: Noba Project. **Located at**: http://nobaproject.com/modules/autism-insights-from-the-study-of-the-social-brain. **Project**: Abnormal Psychology - Achieving the Dream course. **License**: *CC BY-NC-SA: Attribution-NonCommercial-ShareAlike*

This page titled 3.3: Autism- Insights from the Study of the Social Brain is shared under a not declared license and was authored, remixed, and/or curated by Lumen Learning.

3.4: Anxiety and Related Disorders

Barlow, D. H. & Ellard, K. K. (2017). Anxiety and related disorders. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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- Anxiety and Related Disorders. **Authored by**: By David H. Barlow and Kristen K. Ellard. **Provided by**: Noba Project. **Located at**: http://nobaproject.com/modules/anxiety-and-related-disorders. **Project**: AtD Course. **License**: *CC BY-SA: Attribution-ShareAlike*

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3.5: Social Anxiety

http://nobaproject.com/modules/social-anxiety

Kashdan, T. (2017). Social anxiety. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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3.6: Dissociative Disorders

http://nobaproject.com/modules/dissociative-disorders

van Heugten – van der Kloet, D. (2017). Dissociative disorders. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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3.7: Mood Disorders

http://nobaproject.com/modules/mood-disorders

Gershon, A. & Thompson, R. (2017). Mood disorders. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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3.8: Personality Disorders

http://nobaproject.com/modules/personality-disorders

Crego, C. & Widiger, T. (2017). Personality disorders. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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3.9: Psychopathy

http://nobaproject.com/modules/psychopathy

Patrick, C. (2017). Psychopathy. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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3.10: Schizophrenia Spectrum Disorders

http://nobaproject.com/modules/schizophrenia-spectrum-disorders

Barch, D. M. (2017). Schizophrenia spectrum disorders. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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3.11: Module 3 exam

This is a 25 question exam with a 60 minute time limit. You may take this exam up to 5 times. Each exam will contain a random selection of items from the large test item pool. Only your highest exam score will be recorded in the grade book

A random block of 25 items selected from the pool of items. **(Note: All exam items are from the Noba Project test item pool, which are licensed under Creative Commons Attribution-NonCommercial-Share Alike 4.0 International License)**

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- Module 3 exam instructions. **Authored by**: William Pelz. **Provided by**: Noba Project. **Located at**: https://herkimer.open.suny.edu/webapps/assessment/do/content/assessment?action=MODIFY&course_id=_794_1&content_id=_24930_1&assessmentType=Test&method=modifyOptions. **Project**: Abmormal Psychology course for Achieving the Dream. **License**: *CC BY: Attribution*

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3.12: Psychological Disorders- Research and Discuss Assignment

Instructions:

- Select a psychological disorder from the DSM-5 (see link below) that is NOT included in the listing above to discuss with the class.
- Review the discussion forum before you select so that you do not choose a disorder that has already been selected by another student.
- Locate an Internet Resource (NOT Wikipedia) about the disorder you have selected,
  - review the resource and submit your review to the SafeAssign drop box for my evaluation
    - Review evaluation is based upon the Internet Resource Review rubric.
  - and to the discussion forum for class discussion.
- Reply to at least 2 other student reviews and discuss them until the module has ended.
    - This forum is graded using the standard discussion forum rubric.

DSM-V Disorders: https://en.Wikipedia.org/wiki/DSM-5

(Note: this assignment requires a drop box and a discussion forum)

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3.13: Reflective Blog

(Note: This assignment required a drop box and a discussion forum.)

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CHAPTER OVERVIEW

4: Treatment of Psychological Disorders

4.1: Treatment of Psychological Disorders- Read and Study Assignment

4.2: Therapeutic Orientations

4.3: Psychopharmacology

4.4: Treatment of Psychological Disorders- Research and Discuss Assignment

4.5: Reflective Blog

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4.1: Treatment of Psychological Disorders- Read and Study Assignment

Read and study the 2 articles below and then take the Module 4 exam. This is a self-paced assignment which must be completed prior to the end of Module 4. You may take the exam up to 5 times, and only your best score will be recorded in the grade book.

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4.2: Therapeutic Orientations

http://nobaproject.com/modules/therapeutic-orientations

Boettcher, H., Hofmann, S. G., & Wu, Q. J. (2017). Therapeutic orientations. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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4.3: Psychopharmacology

http://nobaproject.com/modules/psychopharmacology

Barron, S. (2017). Psychopharmacology. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. DOI:nobaproject.com

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4.4: Treatment of Psychological Disorders- Research and Discuss Assignment

Instructions:

- Select a treatment from the link below to discuss with the class.
- Review the discussion forum before you select so that you do not choose a treatment that has already been selected by another student.
- Locate an Internet Resource (NOT Wikipedia) about the treatment you have selected,
  - review the resource and submit your review to the SafeAssign drop box for my evaluation
    - Review evaluation is based upon the Internet Resource Review rubric.
  - and to the discussion forum for class discussion.
- Reply to at least 2 other student reviews and discuss them until the module has ended.
    - This forum is graded using the standard discussion forum rubric.

DSM-V Disorders: https://en.Wikipedia.org/wiki/Treatment_of_mental_disorders

(Note: This assignment requires a drop box and a discussion forum.)

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- Treatment of Psychological Disorders: Research and Discuss Assignment. **Authored by**: William Pelz. **Provided by**: Herkimer College / SUNY. **Located at**: https://herkimer.open.suny.edu/webapps/blackboard/execute/toolLinkProperties?itemAction=edit&content_id=_24933_1&course_id=_794_1&type=forum. **Project**: Abmormal Psychology course for Achieving the Dream. **License**: *CC BY: Attribution*

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4.5: Reflective Blog

This is the SafeAssign drop box for your Reflective Blog 1. Wait until the module discussions have ended before you write your blog.

Submit your Reflective Blog after the module discussions have ended. See the Detailed Instructions in the Course Information section to review the requirements for this assignment.

(Note: This assignment required a drop box and a discussion forum.)

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CHAPTER OVERVIEW

5: Self Analysis (or pseudo self-analysis)

5.1: Instructions for your Clinical Case Study assignment

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5.1: Instructions for your Clinical Case Study assignment

The purpose of this assignment is for you to demonstrate your understanding of the concepts and issues presented in this course. Your case study should be based upon yourself, and may be factual, fictional, or some mix of the two. You are NOT required to disclose any personal or sensitive information.

A large collection of fictional case studies are available for your review as you prepare to write your personal clinical case study.

A case analysis consists of several components:

- background information
  - demographics
  - psycho-social factors
  - medical factors
  - education
  - family
  - etc
- assessment
  - methods
  - instruments
- diagnosis
  - using the multi-axial DSM-IV classification system
- etiology
  - predisposing factors
  - precipitating factors
- dynamics
  - diagnosis
  - presenting symptoms
  - course
- treatment recommendations
  - goals
  - methods
- prognosis

(Here is a link to a sample case history: https://www.fmhs.auckland.ac.nz/assets/fmhs/som/psychmed/docs/writing_a_psychiatry_case_study.pdf)

Your assignment:

Part 1: Write your self analysis

- minimum length: 2000 original words
- submit to the SafeAssign drop box on or before the final day of the Module 4 discussion forums
- This assignment is graded via the rubric below.

Part 2: Discuss the analyses

- Submit to the Self-analysis discussion forum on or before the start of Module 5
- Facilitate the discussion of your self-analysis
- Be an active participant in the discussion of at least 2 other students' self-analyses
- Self-analysis dIscussions continue until the Module 5 discussion forums end.
- This forum is graded via the same discussion forum rubric used for the issue/topic discussions.

((Note: This assignment required a drop box and a "symposium" discussion forum.)

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CHAPTER OVERVIEW

6: Case Studies of Fictional Characters

6.1: Trichotillomania (312.39)
6.2: Impulse-Control Disorder NOS (312.30)
6.3: Voyeurism (302.82)
6.4: Transvestic Fetishism (302.3)
6.5: Frotteurism (302.89)
6.6: Sexual Masochism (302.83)
6.7: Sexual Sadism (302.84)
6.8: Gender Identity Disorder in Adolescents or Adults (302.85)
6.9: Exhibitionism (302.4)
6.10: Generalized Anxiety Disorder
6.100: Pathological Gambling (312.21)
6.101: Pyromania (312.33)
6.102: Kleine Levin Syndrome (Sleeping Beauty Syndrome
6.103: Primary Hypersomnia (307.44)
6.104: Vascular Dementia (290.4x)
6.105: Dementia of the Alzheimer's Type (294.1x)
6.106: Body Dysmorphic Disorder (300.7)
6.107: Cyclothymic Disorder
6.108: Dyspareunia (302.76)
6.109: Conversion Disorder (300.11)
6.11: Specific Phobia (300.29)
6.110: Depersonalization Disorder (300.6)
6.111: Dissociative Fugue (300.13)
6.112: Undifferentiated Somatoform Disorder (300.82)
6.113: Primary Insomnia (307.42)
6.114: Factitious Disorders (300.19)
6.115: Intermittent Explosive Disorder (312.34)
6.116: Kleptomania (312.32)
6.117: Pathological Gambling (312.21)
6.118: Pyromania (312.33)
6.119: Vaginismus (306.51)
6.12: Obsessive-Compulsive Disorder (OCD)
6.120: Transvestic Fetishisim
6.121: Female Sexual Arousal Disorder (302.72)
6.122: Fetishism (302.81)
6.123: Generalized Anxiety Disorder
6.124: Dissociative Amnesia (300.12)
6.125: Depersonalization Disorder (300.6)
6.126: Dissociative Fugue (300.13)
6.127: Dissociative Identity Disorder (300.14)

6.128: Dissociative Disorder NOS (300.15)
6.129: Introduction to Somatoform Disorders
6.13: Post-Traumatic Stress Disorder (PTSD)
6.130: Body Dysmorphic Disorder (300.7)
6.131: Conversion Disorder (300.11)
6.132: Hypochondriasis (300.7)
6.133: Somatization Disorder (300.81)
6.134: Posttraumatic Stress Disorder
6.135: Undifferentiated Somatoform Disorder (300.82)
6.136: Somatoform Disorder Not Otherwise Specified (300.81)
6.137: Complex Somatic Symptom Disorder (CSSD)
6.138: Pain Disorder
6.139: Anorexia Nervosa (307.1)
6.14: Social Phobia
6.140: Bulimia Nervosa (307.51)
6.141: Eating Disorder Not Otherwise Specified (307.50)
6.142: Binge-Eating Disorder
6.143: Rumination Syndrome (307.53)
6.144: Hallucinogen Dependence (304.5) and Hallucinogen Abuse (305.3)
6.145: Schizophrenia
6.146: Hallucinogen Intoxication (292.89)
6.147: Hallucinogen Persisting Perception Disorder (Flashbacks) (292.89)
6.148: Opioid Abuse (305.52)
6.149: Sedative, Hypnotic, or Anxiolytic Related Abuse and Dependence (292.89)
6.15: Panic Disorder and Agoraphobia
6.150: Nicotine Dependence (305.1)
6.151: Alcohol Dependence (303.90)
6.152: Alcohol Abuse (305.00)
6.153: Alcohol Intoxication (303.00)
6.154: Alcohol Withdrawal(291.81)
6.155: Cocaine Abuse and Dependence (305.6)
6.156: Pathological Gambling
6.157: Cannabis Abuse and Dependence (305.20/304.3)
6.158: Phencyclidine Abuse and Dependence (305.9)
6.159: Inhalant Abuse and Dependence (305.9)
6.16: History of Abnormal Behavior
6.160: Amphetamine Intoxication (282.89)
6.161: Amphetamine Withdrawal (292.0)
6.162: Caffeine Intoxication (305.9)
6.163: Cannabis Intoxication (292.89)
6.164: Substances
6.165: Paranoid Personality Disorder
6.166: Schizoid Personality Disorder
6.167: Antisocial Personality Disorder
6.168: Narcissistic Personality Disorder

6.169: Schizotypal Personality Disorder
6.17: History of the DSM
6.170: Antisocial Personality Disorder
6.171: Borderline Personality Disorder
6.172: Histrionic Personality Disorder
6.173: Dependent Personality Disorder
6.174: Avoidant Personality Disorder
6.175: Obsessive-Compulsive Personality Disorder
6.176: Depressive Personality Disorder
6.177: Passive-Aggressive Personality Disorder (Negativistic Personality Disorder)
6.178: Social Phobia (Social Anxiety Disorder)
6.179: Schizophrenia, Paranoid Type (295.30)
6.18: References
6.180: Schizophrenia, Disorganized Type (295.10)
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6.1: Trichotillomania (312.39)



Trichotillomania, also known as trich, is a poorly understood disorder characterized by the recurrent pulling out of one's own hair that results in noticeable hair loss (Chamberlain, Menzies, Sahakian & Fineberg, 2007). A person with trichotillomania may pull out hair from any part of his or her body. The most common locations pulled are the scalp, eyebrows, and eyelashes. For people who suffer from this impulse-control disorder, pulling decreases stress and tension and causes pleasure (Bayer, 2000). The pulling may occur during periods of relaxation. However, stressful events tend to increase the amount of time a person may spend pulling his or her hair (Bayer, 2000). The act of pulling may take place in brief episodes throughout the day or during less-frequent periods that can last for hours (Bayer, 2000).

Trichotillomania causes considerable social and occupational problems. Sufferers do not typically pull their hair in front of others unless they are close family members, so they may tend to avoid social situations (Bayer, 2000). Some people with trichotillomania may deny the behavior and attempt to conceal bald spots (Bayer, 2000).

Some researchers suggest that trich is a compulsive behavior. Although people who seek treatment for trich may do so for reasons similar to people with OCD, trich is different from OCD in several ways. Unlike OCD, the behavior is not performed in response to an obsessional thought or to prevent some unwanted event or situation (Bayer, 2000). Furthermore, individuals with trich only pull hair, whereas people with OCD may perform multiple types of rituals (Bayer, 2000). Also, while OCD is equally evident in males and females, trich is a predominately a female disorder (Bayer, 2000).

Trichotillomania usually begins in childhood, but short term episodes of hair pulling in childhood may be a benign habit that does not persist later in life (Bayer, 2000). Some individuals experience continuous symptoms for several years while others can go into remission for weeks, months, or years (Bayer, 2000). High amounts stress may cause the behavior to reappear (Bayer, 2000). Those who suffer from trichotillomania are more likely than the general population to have mood, anxiety, and substance-related disorders (Bayer, 2000). According to DSM-IV, 1-2% of college students have a current or past history of the illness.

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. People with trich will examine the hair root, twirl it off, pull the strand of hair between their teeth, or may eat their hair. Hair eating is known as trichophagia. They usually do not pull their hair out in the presence of anyone except family members. Some individuals 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 other people's hair, but often can refrain. Dolls, pets, carpet, and sweaters are often pulled on like hair (Bayer, 2008). Nail biting, scratching, gnawing, and excoriation (tearing off skin or skin picking) are often associated with this disorder.
- Trichotillomania is linked to obsessive-compulsive disorder; often, both disorders are present in younger females. The pulling of the hair becomes a habit to obsess about. Many of the same attributes of OCD appear in patient with trichotillomania including the need for perfection and order. Hair pulling has appeared to be stress relief from the obsessions.

Child vs. Adult presentation

Trich usually begins in late childhood or early adolescence. The peak age of onset is 13 to 14 years old (Chamberlain et al., 2007). It is more common during the first 20 years of someone's life. There is not a difference in presentation between children and adults,

however. Children with trich may feel socially isolated because they often feel that no one else has this disorder (Anegundi, Shetty, Yavagal & Pandurangi, 2010)

Gender and cultural differences in presentation

- When presented in children, the rates between genders tend to be relatively equal. However, trichotillomania is more common in adult females than adult males. It has been found that approximately 70% of adults that have trich are female (Anegundi et al., 2010). 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 (Anegundi, Shetty, Yavagal & Pandurangi, 2010).
- Women tend to pull from limited locations while men pull from many locations on the body (Anegundi et al., 2010)

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%, but it is difficult to determine. This rate is based on the psychological affect- the release of tension after pulling the hair out. However, when including those individuals who subconsciously pull hair, the rate is approximately 1.5% for males and 3.4% of females. A study of 2,500 college students found similar lifetime prevalence rates when using strict DSM-III-R criteria (Chamberlain et al., 2007).
- Trich is often comorbid with with mood and anxiety disorders, such as major depression, generalized anxiety disorder, and simple phobias (Chamberlain et al., 2007).

Etiology

- There is evidence of a genetic predisposition. Hair pulling and similar grooming phenomena often occur in family members of people with trich (Chamberlain et al., 2007). Mutations in a gene called 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.
- Trich also shows high overlap with PTSD, which suggests affective contributions (Chamberlain et al., 2007).
- 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.
- There are two types of trichotillomania that have been described: focused pulling and non-focused pulling. The focused pulling is used to control negative emotions, such as anger. The non-focused pulling is a nonintentional type of pulling that occurs without the patients complete awareness.

Empirically supported treatments

- Treatment for trichotillomania may be through behavior therapy aimed at habit reversal (Chamberlain et al., 2007). Sufferers learn to identify when they have urges to pull out their hair and how to relax in order to reduce the tension caused by the urge. Therapy also helps them develop a competing response when their urge arises. For example, they may make a fist with their hands to stop from pulling out hair.
- Cognitive therapy may also be used to address distorted thinking.
- Medication such as an antidepressant called selective serotonin reuptake inhibitors (SSRIs) may be used as part of the treatment program as well.
- Given the limited amount of research available, no formal treatment algorithm can be created (Chamberlain et al., 2007)

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6.2: Impulse-Control Disorder NOS (312.30)

*Associated Features

***Individuals who fall under Impulse-Control Disorder NOS do not meet any of the criteria for the above disorders or any of the other impulse control disorders in the DSM-IV-TR. (eg. substance abuse, paraphilias). Some common impulse-control disorders in this category include impulsive sexual behaviors, pathological skin picking, self-mutilation, and compulsive shopping. Those with sexual impulses often are promiscuous, show compulsive masturbation, show a compulsive use phone sex lines and/or pornography, and often show pornography dependence. Compulsive shopping problems appear more in women than men. It is often associated with the individual's need to control his or her mood, which the person does by compulsively buying things and spending money. Pathological skin pickers may pick pimples and scabs on the face or anywhere else on the body (Spiegel & Finklea, 2009). Like trichotillomania, SSRIs are typically used as treatment for this disorder (Spiegel & Finklea, 2009).

Etiology

Impulsive behavior seems to have an underlying pre-disposition which may or may not be related to existing mental health or medical conditions, but research over the past decade has stressed the substantial co-morbidity of impulse control disorders with mood disorders, anxiety disorders, eating disorders, substance abuse, personality disorders, and with other specific impulse control disorders. In particular cases, it may be clinically difficult to disentangle from one another, with the result that the impulsivity at the core of the disorders is obscured.

Empirically supported Treatments

Although the specific category of impulse control disorders has become firmly entrenched in the DSM-IV-TR, strictly defined cases are nonetheless relatively uncommon with the result that there have not been many large scale studies of homogeneous populations. Clinicians widely appreciate, however, that these behavioral problems can cause significant stress for individuals and their families and justify further study and attempts at treatment. Findings in recent research have led some researchers to suggest that impulse control disorders form part of "the affective spectrum" linked by some common neurochemical abnormality involving low brain serotonin levels. This interest in a possible neurochemical basis for impulsive behaviors leads clinicians to hope that newer pharmacological therapies may be soon available. As well, advances in cognitive behavioral treatment suggest that a combination of pharmacotherapy and cognitive behavioral treatment may mutually enhance each other's benefits.

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6.3: Voyeurism (302.82)

DSM-IV-TR criteria

- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.
- The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
- These activities have caused distress, impaired work, social or personal functioning.

Associated features

- Voyeurism, a form of paraphilias, refers to the achievement of sexual gratification by observing or spying on unsuspecting people, especially while they dress, undress, or engage in sexual activity. The observers, often known as “Peeping Tom’s”, may not feel guilt or remorse when intruding upon other individuals’ privacy. Voyeuristic individuals may rationalize their behavior, claiming “no harm, no foul.” Voyeurism is considered a crime in several states, but the definition of voyeurism varies from state to state.
- This clip shows the story of when a person is caught acting on voyeurism.
- The voyeur may wait outside their victims window and masturbate to the subject undressing, taking a shower, or even a couple having sex. They also may wait until afterwards to masturbate while replaying the incident in their mind.
- The voyeur may risk injury by assuming precarious positions to catch a preferred view of their target.

Child vs. adult presentation

Lack of maturity and understanding prevents children from being diagnosed with Voyeurism.

Gender and cultural differences in presentation

- Men are much more likely to be diagnosed with Voyeurism than women. There does not seem to be any differences with cultural presentation of Voyeurism. However, with the social nature of the prohibited activity it appears to be an important facctor in the sexual arousal pertaining to Voyeurism.
- Voyeurs tend to harbor feelings of inadequacy and to lack social and sexual skills.

Epidemiology

- The onset for the disorder is normally before the age of 15 years.
- Some studies have shown that men express voyeuristic tendencies more often than women, but the disorder is not unique to males (American Psychiatric Association). The prevalence rate of this abnormality is not known. Some research suggests that people in the U.S. are showing more voyeuristic characteristics due to the increase in reality television shows being aired.

Etiology

There are some differing opinions on the origins of voyeuristic behavior. One opinion is derived from Freudian psychoanalytic studies; this theory places an emphasis on child abuse and the harboring of traumatic childhood memories. Voyeuristic tendencies may be rooted in childhood. (Lane, R.). A different approach to voyeurism is expressed in the cognitive-behavioral approach. An Orgasm is labeled as a reinforcer that can lead to voyeuristic or exhibitionistic behaviors. An orgasm is defined as “The peak of sexual excitement, characterized by strong feelings of pleasure and by a series of involuntary contractions of the muscles of the genitals, usually accompanied by the ejaculation of semen by the male.” The nature of the orgasm teaches, reinforces, and conditions some individuals to the point that they acquire a desire to engage in voyeuristic activities. (Schwartz, M.).

Empirically supported treatments

Successful treatment requires a desire from the individual to change his/her voyeuristic tendencies. Behavioral therapy is most commonly used for voyeurs. The person is instructed in ways to control the impulses that cause these actions (Schwartz, M.). The physician may suggest alternative means of sexual gratification to help change patterns of thinking that lead to voyeurism. Other treatment options would include psychoanalytic therapy (Lane, R.). The therapist would help to uncover the underlying thoughts that are causing the voyeuristic thoughts or tendencies. Support groups and the use of SSRIs and Antiandrogens are also a common treatment for individuals suffering from voyeurism.

Prognosis

- Once voyeurism behaviors take place, they typically do not stop. Over time, it may become the main form of sexual gratification for the voyeur. The course of voyeurism tends to be chronic.
- The prognosis for eliminating voyeurism tends to be poor because individuals with this disorder typically have no desire to change their patterns of behavior.
- Since voyeurism involves non-consenting partners and is against the law in many jurisdictions, the possibility of embarrassment may deter some individuals.

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6.4: Transvestic Fetishism (302.3)

DSM-IV-TR criteria

- Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.
- 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.
- Specify if :
  - With Gender Dysphoria: if the person has persistent discomfort with gender role or identity

Associated features

- Common symptoms associated with this psychological disorder do not seem to vary greatly, but these symptoms do vary in severity. Transvestic Festishism is defined as a paraphilia by the DSM and usually occurs in patients as one of several paraphilias. These disorders, known as paraphilias, are a group of mental disorders characterized by several types of obsessions involving sexual practices or activities that incorporate sexual practices involving non-consenting or inappropriate partners, or unusual means of arousal. The main feature of this disorder is recurrent sexual urges or sexual desires involving dressing in clothing normally worn by the opposite sex. This is often also referred to as cross-dressing. A diagnosis of this disorder is usually made only if an individual has acted out on these urges or if the urges seem to interfere with everyday activities for the individual. The frequency at which the urges occur is the deciding factor in the severity of cases. For some individuals, the urge occurs often and is necessary for sexual arousal, while in some individuals they may not be necessary or present unless triggered by outside influences (e.g. stress). When these outside influences are absent, individuals with less severe cases are typically able to function in a normal sexual manner. Participation in transvestism is usually gradual, over time the sufferer begins to assume the identity of a member of the opposite sex based on his or her perceptions of that sex. Transvestic behavior in patients is closely associated with achieving some sort of sexual gratification. A person that practices transvestic fetishism often finds it difficult to distinguish from the opposite gender. They have often adopted many qualities specific to that gender (e.g. mannerisms, clothing, materials, and other items associated with the opposite gender). In extreme cases some individuals undergo hormonal or surgical procedures to change their appearance to that of the opposite sex (gender reassignment surgery.) The DSM states that one should not be considered homosexual in nature just because of transvestism, although some do occasionally have homosexual encounters. Some individuals with transvestic behavior appear to be motivated by autogynephilia which is a condition in which the individual is sexually stimulated by fantasies that their own bodies are female.
- The ICD-10 adds the additional exclusion criteria that the disorder is not a symptom of another mental disorder such as schizophrenia. It also includes a separate diagnosis of Dual-role Transvestitism characterized by non-erotic cross-dressing and the absence of desire toward permanent sex reassignment.

Child vs. adult presentation

It is difficult to determine differences in the presentation of this disorder between children and adults because the disorder typically begins during childhood and progresses further into adulthood if untreated.

Gender and cultural differences in presentation

- Individuals diagnosed with this disorder are typically male; females are rarely diagnosed. A few cases have been reported, but virtually no information is available on female occurrences of the disorder. This may be due to the fact that, in Western cultures, women may dress in a number of socially accepted ways, while men are more limited in socially accepted attire. It should be noted, however, that in current times, there are fewer diagnoses of this disorder. Today there is a greater degree of acceptance regarding this condition and the disorder is generally seen as harmless to others.
- Some Dutch studies suggest adult transsexualism ratios of 1:11,900 in males and 1:30,400 in females. In adults transsexualism is difficult to estimate or diagnose. In children there have been reports of 10-16%.

Epidemiology

Estimation is difficult in adults but probably less than 2% to 5% in the general population, but is difficult to estimate or diagnose.Transvestic Fetishism is slightly more prevalent in the child population because that is where it usually begins.

Etiology

- Some individuals may be unaware of the root causes of the disorder in their cases. Possible causes of this disorder could be adolescent curiosity or factors stemming from encounters in childhood as simple as dressing up in the clothes of one's mothers or sister if the individual in question is male. In adults, many of these individuals will steal their relatives/or girlfriends undergarments and hide them when they are not around. They will wait for the opportune time to wear these things when alone for fear their "little secret" will come out. The activity is found enjoyable and therefore repeated, but the reasoning behind the enjoyment is unconscious. It has been suggested that the disorder can sometimes be caused by mothers creating gender confusion by dressing the boy as if he were a girl. This behavior is sometimes related to the mother's anger towards men or anger at the fact that she had a son rather than a daughter. Such occurrences are rare and support for this notion is lacking.
- Ray Blanchard has suggested an etiological association between transvestic fetishism and "non-homosexual gender identity disorders" (i.e., FTMs sexually attracted to men, both men and women, or neither, and MTFs attracted to women, both men and women, or neither). This is based on retrospective studies of transvestic male fetishists and MTFs where Blanchard has identified a common element of "autogynephilia"–which Blanchard defines as a man's eroticization of himself as being or dressing as a female.

Empirically supported treatments

- The most common diagnosing practice is taking a history or by engaging in direct observation. A diagnosis is only made if a patient is markedly distressed by an inability to dress as they desire or if the disorder interferes with normal activities in daily life. Known treatments for the disorder were developed when the disorder was less accepted. These treatments often utilized aversion therapy involving electrical shocks, but these treatments were largely unsuccessful.
- Another type of treatment referred to as orgasmic reorientation has also been tried with little success. The goal in this type of therapy was to attempt to help people learn to respond sexually to generally accepted stimuli. With the view of the disorder changing with the times there is less focus on treatment of the disorder and more encouragement for societal acceptance.

Prognosis

- The prognosis for treatment of transvestic fetishism is poor, as most persons with this disorder do not desire to change. Most cases in which treatment was demanded by a spouse as a condition of continuing in a marriage have not been successful.
- The video below is an interview with Eddie Izzard who is a stand-up comedian, but also has a fetish for cross-dressing. Most people with this disorder are able to lead normal lives and most of them "dress up" in their own privacy; however, it is clearly seen in this interview that Eddie Izzard mixes his fetish in with his every day life.



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6.5: Frotteurism (302.89)

DSM-IV-TR criteria:

- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person.
- The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
- Frotteurism is the paraphilic focus that involves touching and/or rubbing against a nonconsenting person. This particular behavior usually occurs in crowded places, such as public transportation facilitates and concerts, from which the individual can more easily escape arrest. The most common form of Frotteurism is when he or she rubs his or her genitals against the victim's thighs and buttocks or with women, fondles her genitalia or breasts with his hands. Individuals with Frotteurism will often fantasize that they have an exclusive and caring relationship with their victim at the moment of contact. While doing this when he or she usually recognizes what has happened and to avoid possible prosecution, he or she must escape detection after touching his victim.

Associated features

- A person who is suffering from Frotteurism usually experiences symptoms such as intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person for over a period of at least six months. These fantasies, urges, and behaviors can cause distress and problems associated with work, social atmospheres, and other important daily activities. Frotteurism is a derivative of the French word "frotter" meaning "to rub."
- Frotteurism is also known as "mashing". Mashing has been reported exclusively among males (DSM, 2000). Mashing usually takes place in crowded places, such as buses, elevators, or subway cars. The man usually incorporates images of his mashing within his masturbation fantasies. Mashing is related to "toucherism", which is the fondling of nonconsenting strangers. Mashing can be so furtive and fleeting that the victim may not realize what has happened.

Child vs. adult presentation

Typically, children under the age of 12 do not have Frotteurism due to lack of understanding and maturity. Most individuals who participate in frotteurism are between the ages of 15 and 25.Tendencies typically increase the age of 15 and decrease after the age of 25.

Gender and cultural differences in presentation

- Activities related to this disorder have been well-documented, particularly during historic periods in which they were considered more appropriate in certain less-established areas.
- Men are more likely to engage in frotteurism than women. Women are most likely to be the victims of the acts of frotteurism.

Epidemiology

Currently, there is no information on the epidemiology of Frotteurism available. Frotteurism is associated with paraphilic fantasies, but it occurs most commonly in adolescents. This disorder is not associated with traumatic experiences in either adolescent or adult life.

Etiology

Research has been unable to uncover a direct cause for Frotteurism; however, some possible causes have been suggested. One theory that experts agree on is that there are underlying issues related to one's childhood that plays a major role. Other experts say that when a person accidentally and randomly touches or rubs on another person's genitals or other body parts in public and finds sexual arousal from that contact, the person's feelings act as a reinforcer that perpetuates the behavior. Sometimes the sexual arousal and excitement become too much for one to bear and the person succumbs to these urges.

Empirically supported treatments

- To treat paraphilias, one generally uses either medication and/or behavioral therapy. This behavioral therapy or psychotherapy is focused on uncovering and establishing the cause and reason for taking part in frotteurism. The most successful treatment is Cognitive-behavioral therapy (CBT). Other therapies include biofeedback therapy, and covert sensitization. In biofeedback

therapy, an individual is connected to a machine that displays light and/or sound. The individual must attempt to keep the light or sound within a certain range while he or she is exposed to sexually-enticing objects or material. Covert sensitization is a therapy in which an individual is relaxed and then asked to picture things in her or his mind that excite them. The individual is then instructed to picture something negative. The goal behind this therapy is to link the sexually pleasing cognitions to negative cognitions in order to suppress them. In order for treatment to be successful, the individual must learn how to control the temptations and impulses to touch other non-consenting individuals for sexual gratification. An example of a medication that can be given to help females who suffer from Frotteurism is Medroxyprogesterone, which is a female hormone that is credited to decrease sexual desire. Antiandrogens are a type of medication given to males suffering from Frotteurism. The medicine fluoxetine, or Prozac, is commonly given to people who suffer from Frotteurism to increase the chemical serotonin in the brain, which would reduce obsessive thoughts and behaviors that are compulsive.

Prognosis

The prognosis for eliminating frotteurism is poor as most “frotteurs” have no desire to change their behavior. Since frotteurism involves nonconsenting partners and is against the law in many jurisdictions, the possibility of embarrassment may deter some individuals.



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6.6: Sexual Masochism (302.83)

DSM-IV-TR criteria

- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.
- The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Associated features

- Sexually masochistic behaviors are usually evident by early adulthood and often begin with masochistic or sadistic play during childhood. The masochist experiences sexual excitement from physically or psychologically receiving pain, suffering, and/or humiliation. Fantasies, sexual urges, or behaviors through which the individual is beaten, bound, humiliated, or subjected to pain in some ways characterize this disorder. Some that suffer from sexual masochism may be uncomfortable with or bothered by these fantasies and sexual urges, so they may not act on them when engaged in sexual activity with other people but may carry them out in private. There is a dangerous and potentially fatal form of masochism called hypoxyphilia, in which individuals experience sexual pleasure or arousal by way of oxygen deprivation, such as choking with hands or other materials. Hypoxyphilia is a dangerous act, where the victim achieves sexual arousal and attempts to enhance his or her experience of an orgasm by oxygen deprivation; to this occurs via strangulation, using a plastic bag or a mask. Mistakes while engaging in hypoxyphilia can result in serious injury, brain damage, or death. Paraphilic Infantilism, another form of Sexual Masochism involves the victim's desire to be treated as an infant. Such individuals often wear diapers in these situations. The majority of Infantilists are heterosexual males. This may be due to the feeling of freedom and loss of responsibility some attempt to achieve through Infantilism.
- Sexual masochism is a paraphilia, where a sexual sadist will have a partner who willingly acts with him or her. Sexual masochists have a desire or need for pain or humiliation to enhance sexual arousal so that gratification may be attained. During sexual excitation or sexual contact, the individual is humiliated, beaten, or receives some type of pain or suffering. For the masochist, she or he is typically bound to increase the feeling of helplessness. Like sexual sadism, some masochists are bothered by their fantasies, and they may appear, but not acted on, during sexual activity. This situation usually involves a fantasy rape without any possibility of escape. Some act on fantasies in private; usually these would include self-mutilation, sticking themselves with pins, or giving themselves electric shocks. If the partner is involved, the acts might include blindfolding, restraint, spanking, whipping, cutting, and some form or humiliation.
- Sexual masochism is very different from Sexual Sadism, yet oftentimes the two are linked. Sexual masochism tends to be chronic once it appears, and the acts may increase in severity, eventually leading to serious injury or to death. Sexual Sadism is also chronic and the behaviors can increase in severity. Also, there is a term known as sadomasochism which is used to illustrate the occasion where sadism and masochism are both present in one person but portrayed as different disorders, or according to which theory is used, it can also be used as a replacement for both terms.However, Masochism, like Sadism, is formed from a proper name. The term is derived from an Australian novelist, Leopold von Sacher-Masoch, who explains this disorder in his novels.

Hitler as a Masochist

Otto Strasser told the OSS officials during interviews on May 13, 1943 that Hitler's niece, Geli Raubal, had confided in him a story about Hitler's perversion. She had told him that "Hitler made her undress… He would lie down on the floor. Then she would have to squat over his face where he could examine her at close range and this made him very excited. When the excitement reached it's peak, he demanded that she urinate on him and that gave him his sexual pleasure. Geli said the whole performance was extremely disgusting to her and … it gave her no gratification." This leads many to believe that Hitler may have been a masochist. A personal friend to Hitler, Father Bernard Stempfle, supported this claim along with the claim of Geli Raubal. He said that there was a compromising letter written to Geli from Hitler that fortunately for Hitler Geli never received. The letter was said to contain Hitler's mention of his masochistic and coprophilic inclinations. Another accusation of his masochism came from the German film star, Renaté Mueller. She had been invited to join Hitler for the night in his Chanceller, where after they had reached the undressing point Hitler "lay on the floor… condemned himself as unworthy, heaped all kinds of accusations on his own head, and just

groveled around in an agonizing manner. The scene became intolerable to her, and she finally acceded to his wishes to kick him. This excited him greatly; He became more and more excited"

(Waite, R. G. L. (1977). The Psychopathic God Adolf Hitler. New York: Basic Books, Inc., Publishers.).

Child vs. adult presentation

Masochistic sexual fantasies often begin in childhood, but children are not diagnosed with this disorder. Sexual masochism is generally diagnosed by early adulthood. This disorder takes on a chronic course which can vary by person in severity and in dangerousness. For some, the dangerousness will rise to a level and plateau, for others it could become so severe or dangerous it could lead to permanent damage or even death. Private acts may include: self mutilation, sticking with pins, electric shocks, cutting, burning, and choking. Partnered acts may include: spanking, whipping, handcuffing, chaining, blindfolding, and humiliation in the form of defecation, urination, cross dressing, and mocking animal behavior (such as dogs or cats).

Gender and cultural differences in presentation

Males are more commonly diagnosed with sexual masochism than females. Cultures may differ on how the individuals satisfy their sexual urges toward this disorder, but all cultures that have been examined are similar in presentation.

Epidemiology

Approximately thirty percent of masochists also participate in sadistic behaviors (sadism). There are less than 2 people per million in the U.S. and other countries that die from hypoxyphilia, oxygen deprivation. There is no significant difference between the prevalence of Sexual Masochism in heterosexuals and homosexuals.

Etiology

The causes of sexual masochism are unclear; however, there a handful of theories that attempt to shed some light on the etiology of SM. Some theories attempt to explain the presence of sexual paraphilias in a general sense. Paraphilias involve sexual sadism and masochism with unusual masturbatory behaviors and with the use of special sexual devices and props. Most urges are acted upon alone and, though they may seem highly unusual to the average person, they usually cause no harm to the primary individual or to others. In some cases, such behaviors can indeed cause harm and can be serious in some cases. Unusual sexual practices stem from boredom of traditional sex or out of curiosity. This theory uses learning theory to back up its assertion that paraphilias develop because inappropriate sexual fantasies are suppressed and become stronger when forbidden. When the individual can finally act on them, they are in distress or arousal and so the paraphilia becomes associated with the arousal. Another theory explains this behavior as a form of escape (from old routine). Theories that stem from the psychoanalytic camp suggest that childhood trauma plays a role in the development of sexual masochism or sadism. This disorder is incompletely understood, and the etiology remains unclear.

Empirically supported treatments

Behavioral treatment is used to treat paraphilias and focuses on correcting and maintaining healthy arousal patterns and masturbation. Other behavioral therapies may include social skills training and cognitive restructuring. Medications can also be used treatment to reduce fantasies and behaviors relating to paraphilias. The goal of medication treatment is to reduce the sex drive so the number of sexual fantasies, erections, and sexual behaviors such as masturbation and sexual intercourse, diminishes.

Prognosis

- Because of the chronic course of sexual masochism and the uncertainty of its causes, treatment is often difficult. The fact that many masochistic fantasies are socially unacceptable or unusual leads some people who may have the disorder not to seek or continue treatment.
- Treating a paraphilia is often a sensitive subject for many mental health professionals. Severe or difficult cases of sexual masochism should be referred to professionals who have experience treating such cases.

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6.7: Sexual Sadism (302.84)

DSM-IV-TR criteria

- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.
- The person has acted on these sexual urges with non consenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
- Sexual Sadism is severe and is associated with Antisocial Personality Disorder. The sexually sadistic individual may either seriously injure or kill the victim or partner.

Associated features

- The paraphilic focus of Sexual Sadism involves acts in which the individual derives sexual excitement from psychological or physical suffering (including humiliation) of the non-consenting victim. It is the suffering of the victim that is sexually arousing. Sadistic fantasies or acts may involve activities that indicate the dominance of the person, such as forcing the victim to crawl or keeping the victim confined. Such fantasies may also involve restraint, blindfolding, paddling, spanking, whipping, pinching, beating, burning, electrical shocks, rape, cutting, stabbing, strangulation, torture, mutilation, or killing. Some individuals with this Paraphilia feel empowered by their sadistic fantasies; this feeling may be invoked during sexual activity but not otherwise acted upon. Some individuals with SS may engage in sexual acts for many years without the need to increase the potential for inflicting serious physical damage; however, usually the severity of their sadistic acts increases over time. When SS is severe, or when it is associated with Antisocial Personality Disorder, the individual with SS may seriously injure or kill the victim.
- The urges must have been recurrent for at least six months for a diagnosis to be made or attempted. Achieving sexual excitation or orgasm is dependent on the other individual's being humiliated or receiving pain. Some individuals are bothered by these fantasies, which may occur during the sexual excitation and activity but are otherwise not carried out; thus, they remain fantasies. The partner (victim) may very well be terrified of the anticipated act, especially if the behavior involves total control or domination. In other instances, the sexual sadist will have a partner who willingly acts with him or her; she or he may suffer from sexual masochism. Some individuals with SS may act out their fantasies on unwilling partners or victims. Typical sadistic fantasies involve dominance over the partner/victim, and the fantasies were most likely present during the individual's childhood.
- Sexual Sadism is often linked with Sexual Masochism.

Child vs. adult presentation

Sadistic sexual fantasies are likely to have been present during childhood and it is likely that individuals with SS were abused as children, both sexually and physically. Adult presentation is usually expressed in early adulthood about the time that the sexually sadistic activities appear, and the disorder is usually chronic in its course. Generally the sadistic acts increase in severity over the sufferer's lifespan.

Gender and cultural differences in presentation

Sexual Sadism presents itself in males in over 95% of known cases researched worldwide. Sexual Sadism will present itself in much the same manner throughout different cultures. Although this disorder can be obtained by males or females, it is more common for males to behave with more non-consenting partners even if it is considered rare.

Epidemiology

- Sexual Sadism is found in only 1 to 2% of the population in the United States.
- Age of onset varies greatly, but it typically has developed by early adulthood.

Etiology

There is no universally accepted cause or theory explaining the origin of Sexual Sadism. Some researchers explain it as the result of biological factors. Evidence for this theory comes from abnormal findings from neuropsychological and neurological tests from

offenders. Others believe it is caused from brain injury or mental disorders such as Schizophrenia.

Empirically supported treatments

- Behavior therapy is often used to treat Sexual Sadism. This psychological treatment includes management and conditioning of arousal patterns and masturbation as well as cognitive restructuring and social skills training.
- Medication is especially recommended for individuals with SS who exhibit behaviors dangerous to others. The medications that are used are female hormones, which speed up the clearance of testosterone from the bloodstream, and Antiandrogen medications, which block the body's uptake of testosterone. SSRIs may also be used.

Prognosis

Because of the chronic course of sexual sadism and the uncertainty of its causes, treatment is often difficult. The fact that many sadistic fantasies are socially unacceptable or unusual leads many people who may have the disorder to avoid or drop out of treatment. Treating a paraphilia is often a sensitive subject for many mental health professionals. Severe or difficult cases of sexual sadism should be referred to a specialized clinic for the treatment of sexual disorders or to professionals with experience in treating such cases.

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6.8: Gender Identity Disorder in Adolescents or Adults (302.85)

DSM-IV-TR criteria

- 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.
- 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.
- The disturbance is not concurrent with a physical intersex condition.
- 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

Associated features

- Differentiation of sex vs. gender – The terms sex and gender are commonly, mistakenly, considered interchangeable. Stoller (1968) defines sex as the sum of overt anatomical and physiological differences between male and female. Gender, separate from sex, refers to the sum of behavioral or psychological differences between the sexes.
- General descriptive features – Individuals with GID experience strong, persistent desires to live as the opposite sex. These desires lead to pervasive distress over their assigned sex. Adults, often independent of immediate familial pressures, may seek hormonal treatment or gender reassignment surgery in order to pass as the opposite sex. This appearance is further enhanced by cross-dressing. Tension may exist between individuals with GID and their families; tension is typically greater when the subject is male, though generally neither males nor females are supported by their families in matters relating to their dissatisfaction with their assigned sex. In extreme cases, individuals with GID may resort to mutilation of, or self-removal of, their genitalia.
- Physical examination findings – individuals with GID generally have normal, rather than ambiguous, genitalia, which debunks the notion that GID onset may be related to ambiguous genitalia. Hormonal treatments may result in noticeable increases in breast size in males. Individuals with GID may also resort to plastic surgery or surgical reduction of the Adam's apple in order to complete their desired appearances.

Adolescent vs adult presentation

- Adolescent presentation – Adolescents with GID are at a greater risk for depression, thoughts relating to suicide, and suicide attempts. In adolescents, GID presentation may resemble child or adult presentation depending on the level of development. Criteria are applied accordingly, but assessment of developmental levels may take considerable time in order to assure the valid application of said criteria. Younger adolescents may be difficult to diagnose because lack of cooperation from the child to discuss their feelings, particularly if they are concerned with how their families may react. Subjects may be referred to a clinic for issues concerning poor social integration with peers.
- Adult presentation – Adults with GID commonly experience anxiety and depressive symptoms. Adult individuals with GID experience frustrations with their biological sex and frequently cross-dress in the privacy of their homes. Through hormonal treatment and skillful cross-dressing techniques, many adults can convincingly pass for members of the opposite sex. Unless gender reassignment surgery has been performed, sexual activity is typically limited by individuals' insistence that partners abstain from touching or seeing their genitalia.

Gender and cultural differences in presentation

- Gender – Typically, females with GID are more accepted than males with GID, this is because men are often ostracized (with considerable severity). Females generally experience less peer rejection and ridicule. In clinical settings, males outnumber females at a ratio as high as 3:1, and males are at a higher risk for associated Personality Disorders.
- Culture – GID seems to be more present in males than females across cultures, but cultural acceptance is highly varied. In Western culture, GID is pathologized and individuals with the disorder, particularly males, are heavily stigmatized. In Native

American cultures, such individuals are received differently; individuals who assume the roles of the opposite sex are known as the Two-Spirit. As the name suggests, the two-spirited are those who have both male and female spirits. Two-Spirits perform the work of the opposite sex and don garments appropriate for their new roles. This concept appears to be consistent across contemporary Native American cultures.

Epidemiology

- Prevalence – Due to the stigma associated with GID, epidemiologists have encountered great difficulties in determining its prevalence; it is considered relatively rare even when accounting for underreporting due to the fear of stigmatization. The Meyer-Bahlburg (1985) study suggests a 1 in 30,000 occurrence in men and a 1 in 100,000 occurrence in women. Another study (Bakker, van Kesteren, Gooren, & Bezemer, 1993) suggests higher rates based on the prevalence of hormonal treatments for persons suffering from gender-identity-related problems in the Netherlands.
- Course – Typically, gender dysphoria in childhood subsides before adulthood is reached, but some studies suggest that its previous presence may influence sexual orientation. Individuals with gender dysphoria in childhood sometimes reconcile their issues by identifying themselves as homosexual during adolescence. GID can follow two courses in adulthood. The first course is a continuation of GID that has persisted through childhood. The second course is characterized by a gradual onset beginning in early to mid-adulthood that follows, or is comorbid with, Transvestic Fetishism. Both forms of GID present in adulthood are persistent, but spontaneous remissions have been noted.

Etiology

- Biological factors – A great deal of research has been dedicated to assessing the effects of biological factors in determining risk for GID. Current research is inconsistent and exiguous, and much of it concerns the sensitive topic of homosexuality rather than GID directly. Some studies attempt to link GID with prenatal hormone environments; it has been posited that DES (diethylstilbesterol), a drug thought to prevent miscarriages that has the side effect of exposing the fetus to abnormally high levels of testosterone, results in masculine behavioral patterns in females. This hypothesis is not well supported, due to there being few differences between subjects exposed to this drug and control subjects. Other studies suggest physical attractiveness as a factor in GID. Typically, males with GID are rated as more physically attractive, while females with GID are rated as less physically attractive. It has been hypothesized that parental behavior may influence notions of gender identity in children. For example, a boy with a feminine appearance may be dressed in non-masculine accoutrement; the imaged imposed upon him by his parents may influence his notions of appropriate masculine behavior in later life. Limited research studying GID and twins has shown that if one twin has GID, the other is more likely to have it as well. This would provide good support for biological theories, but very small sample sizes have made it difficult to examine this hypothesis thoroughly.
- Psychosocial factors – Sex assignment at birth has been hypothesized as a determining factor of GID. Infants born with ambiguous genitalia who are assigned sex roles typically develop gender identities consistent with their assigned roles; however, supporters of said hypothesis maintain that if these roles are not decisively reinforced, subjects may develop GID. Social reinforcement is also considered a deciding factor in the development of GID. A lack of corrective measures taken when observing play patterns inconsistent with that of an individual's sex has been associated with the development of GID. The quality of parenting as a factor has been examined; Zucker & Bradley (1995) suggested that mothers diagnosed with mental illnesses may be less capable in their parenting, which may increase the likelihood of GID onset. Similarly, Coates (1985) and Green (1987) suggested that distant or absent fathering may be linked to GID onset.

Empirically supported treatments

- Psychotherapy – Psychotherapy has proven useful in interventions, though its effectiveness is dependent upon how early it is administered. The purpose of this treatment is to help individuals cope with their biologically determined sex and reinforce the behavioral patterns associated with those roles. This method may reduce transsexual behavior in later life.
- Hormonal treatment and surgery – Adults with GID may request surgical reassignment of sex. Individuals who desire this treatment have typically experienced hormonal therapy to reduce undesired secondary sex characteristics and to develop those present in the opposite sex. Hormonal treatment causes breast growth and reductions of facial hair in males and cessation of menstruation, increases in body hair, and voice deepening effects in females. Subjects are typically required to live as the opposite sex with hormonal treatment for a year or more before surgery is considered an option.
- Past treatments have included various behavioral therapies targeted toward changing the individual's social and sexual behaviors to be more stereotypically masculine or feminine, including behavioral modification of vocal characteristics, sexual

fantasies, patterns of sexual arousal, even movements and posture.

- In contrast, current treatment, as outlined by the Standards of Care, includes three principal elements comprising a ” triadic therapy.” These elements include living as the desired gender, hormone therapy, and sex reassignment surgery- although not all individuals will desire, or complete, all three steps.

Prognosis

If gender identity disorder persists into adolescence, it tends to be chronic in nature. There may be periods of remission. However, adoption of characteristics and activities appropriate for one’s birth sex is unlikely to occur.

Link:

- A touching story featuring two 8 year-old transgender girls. The story begins at 29 minutes 35 seconds.
- Two Transgender Girls Story



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=330

Two Spirits clip from Frameline on Vimeo.

Journal article: Is the gap more than gender?

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6.9: Exhibitionism (302.4)

DSM-IV-TR criteria

- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, urges, or behaviors involving the exposure of one's genitals to unsuspecting strangers
- The person has acted on said urges, or the urges or fantasies cause marked distress or interpersonal difficulty

Associated features

Exhibitionists in some cases masturbate while exposing themselves (or while fantasizing that he/she is exposing himself/herself) to another person. There is a pattern in which males exhibit themselves and there are three characteristic features of the exhibition: 1) It is performed for unknown women. 2) It takes place where sexual intercourse is impossible (e.g. a crowded shopping center). 3) It seems designed to surprise and shock the woman. The male exhibitionist usually exposes his erect penis, but it is not necessarily essential for the activity. Ejaculation may occur at the moment of exposure or develop later with masturbatory stimulation. Some exhibitionists are aware of a conscious desire to shock or upset their target; while others fantasize that the target will become sexually aroused by their display.

Child vs. adult presentation

Generally, society accepts exhibitionism in children as a natural curiosity, not a disorder, however if the behaviors continue a paraphilia is probable. Disorder appears to develop before the age of 18, and rarely is found in people over the age of 50.

Gender and cultural differences in presentation

Most reported cases of exhibitionism involve males. Some scientists argue that women who undress in front of windows (as to invite a person to watch), or who wear low cut gowns are exhibitionists in a sense. Exhibitionism generally appears in Western society and is believed to be almost absent in such countries as Japan, Burma, and India. Additionally, in the American society it can be a crime when committed by a male, but when women expose themselves, excluding total nudity, they are often seen as victims of male voyeurism.

Epidemiology

Prevalence and incidence are not easily defined because people with this disorder usually do not seek treatment voluntarily. Exhibitionism is one of the three most common sexual offenses, the other two being voyeurism and pedophilia. It is rarely diagnosed in general mental health clinics, but most professionals believe that it is probably underdiagnosed and under-reported.

Etiology

- People with these types of paraphilia tend to have personalities accompanied by social isolation, low self-esteem, and, usually, feelings of sexual inadequacy. They are not generally comfortable with normal heterosexual relationships and they are not willing to risk the rejection of their attempts to create willing sexual relationships, so they resort to abnormal sexual activity. They suggest that sexual abuse as children or other traumatic childhood situations may be the cause. According to Freudian theory, during the phases of psychosexual development, fixations rooted at one level of sexual adjustment prevent normal progress to the next stage of development. Some behavioral theories state that sexual arousal has been linked with the activity of exposure through either a Pavlovian-type conditioning process or operant conditioning. Some documented cases have shown that some men become exhibitionists after traumatic brain injuries (TBIs).
- Several theories have attempted to explain the etiology of exhibitionism.
- Biological theories – these theories hold that testosterone increases the susceptibility of males to develop deviant sexual behaviors.
- Learning theories – these theories assert that emotional abuse in childhood and family history are both risk factors.
- Psychoanalytical theories – these theories posit that male gender identity requires separation from his mother psychologically so that he does not identify with her as a member of the same sex.

Empirically supported treatments

- Cognitive-behavioral therapy is the most effective form of treatment for exhibitionism. Under C-B treatments, patients are encouraged to recognize and address the irrational justifications and possible punishments for their behaviors and thinking patterns.
- Psychotherapy is typically aimed at finding the hidden or underlying cause of such behavior.
- Group Couples Therapy is usually helpful for those who are married and whose family ties have been strained by exhibitionism. Orgasmic reconditioning has the patient replace the exhibitionist fantasies with more socially acceptable sexual behaviors while masturbating.
- Group Therapy- is typically used to get people past the ” denial” stage that is frequently associated with paraphilias, and acts a form of relapse prevention.
- Twelve-Step programs for sexual addicts. Exhibitionists who feel guilty and anxious about their behavior are often helped by social support and emphasis on a healthy spirituality found in these groups, as well as cognitive restructuring that is built into the twelve steps.

Prognosis

The prognosis for people with exhibition disorder depends on a number of factors, including the age of onset, the reasons for the patient’s referral to psychiatric care, degree of his cooperation with the therapist, and comorbidity with other paraphilias or other mental disorders. For some patients, exhibitionism is a temporary disorder related to sexual experimentation during their adolescence. For others, however, it is a lifelong problem with potentially serious legal, interpersonal, financial, educational, and occupational consequences. People with exhibition disorder have the highest recidivism rate of all the paraphilias; between 20% and 50% of men arrested for exhibitionism are rearrested within two years.

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6.10: Generalized Anxiety Disorder

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 comorbids include the other anxiety disorders, sleep disorders, and chronic pain. These high rates of comorbidity have lead 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 norephinephrine 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.



Sleep disturbances (difficulty falling or staying asleep) are common with general anxiety disorder.

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6.100: Pathological Gambling (312.21)

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

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6.101: Pyromania (312.33)

DSM-IV-TR criteria

A. Deliberate and purposeful fire setting on more than one occasion.

B. Tension or affection arousal before the act.

C. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences).

D. The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, in response to a delusion or a hallucination, or as a result of impaired judgment (e.g., in dementia, Mental Retardation, Substance Intoxication).

E. The fire setting is not motivated by monetary gain, sociopolitical ideology, anger or revenge, psychotic thinking (delusions or hallucinations), or to conceal criminal activity.

The fire setting is not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.

Associated features

- Individuals with pyromania often have a difficult time controlling themselves, specifically in situations that are harmful to themselves and others. Those with head injuries or epilepsy are at an increased risk of developing and impulse control disorder. Researchers have noticed an increase in impulse control disorders in older patients with Parkinson's disease due to the effect of the dopaminergic drugs. There has also been a correlation with pyromania to learning disabilities, as well as cruelty to animals; these problems could suggest a higher risk of violence in the future. There is also high comorbidity with disorders, such as: substance abuse disorders, obsessive compulsive disorder, anxiety disorders, and mood disorders.
- In one study, arsonists have more often received psychiatric treatment, prior to committing their index offence, and had a history of severe alcohol abuse more often in comparison to the controls. The arsonists turned out to be less likely to suffer from a major psychotic disorder.

Child vs. adult presentation(Labree, Nijman, van Marie, & Rassin, 2010).

- The age of onset for pyromania is approximately 18 years. It is extremely rare for a child younger than adolescence to develop Pyromania. It is also rare for older adults to develop pyromania.
- Fire setting in children may be a way of relieving tension or stress. This outward expression of tension/stress may be associated with depression, suicidal thoughts, poor coping abilities, and repeated interpersonal conflicts.
- It is rare for children to have it, but it can occur in children as young as three. Most of the time, parents recognize the behaviors and get it treated before it becomes a problem.
- Features such as temperament, parental psychopathology, social and environmental factors and possible neurochemical predispositions have been hypothesized to cause childhood pyromania.

Gender and cultural differences in presentation

- Males have a much higher risk for developing pyromania. Approximately 90% of those diagnosed with Pyromania are male. There are no cultural differences in presentation of this disorder. People from many different cultures will show the same symptoms.
- Pyromania in childhood appears to be rare. Juvenile fire setting is usually associated with Conduct Disorder, Attention-Deficit/Hyperactivity Disorder, or Adjustment Disorder.
- Pyromania occurs much more often in males, especially those with poorer social skills and learning difficulties.

Epidemiology

- It is a very rare disorder, about less than 1% of the populations has it.
- Most of the research done on Pyromania has not focused on the epidemiology. It is only known that there is a higher prevalence of Pyromania in men than women.
- It is known that about 9% of the population has impulse control problems which include pyromania.

- Only 14% of fires are started by people with pyromania and other mental disorders.
- The majority of epidemiological studies have focused on pyromania in childhood and adolescence, and have reported prevalence rates to be between 2.4% and 3.5% (Dell'Osso, Altamaura, Allen, Marazziti and Hollander 2006).

Etiology

Although little research has been done on the etiology of Pyromania, it is believed that the cause can be targeted during childhood. Many researchers say that possible causes can be an abusive family environment or mild brain trauma. Other factors of pyromania are: antisocial behaviors and attitudes, people seeking sensation and adventure, people seeking attention, a lack of social skills with others, and a lack of fire-safety knowledge and/or ignorance of the dangers involved. Environmental factors include things such as: poor supervision from parents, peer pressure, and stressful life events.

Empirically supported treatments

- Counseling and medication are both preferred for treating pyromania. Behavior modification is the best treatment found so far for treating this disorder in hopes of getting a response to social limits.
- Treatment of adults and children with pyromania is often individualized based on the patient's presenting problems and history. Treatment of children with this disorder often begins with an assessment of the child's life and includes the evaluation of such factors as stressors on the child, home discipline, and supervision of the child. This assessment is generally followed by a case-management approach, rather than a medicinal approach, where the treatment is tailored to the child and involves a variety of approaches, such as anger management and communication skills.
- Treatment of adults with pyromania is often approached differently. Because adult patients with this disorder tend to be uncooperative, they are generally treated with a combination of medication and psychotherapy. Usually the patient is treated with a selective serotonin reuptake inhibitor, but there have also been multiple case reports of tricyclic antidepressants and mon-amine oxidase inhibitors being useful in impulse control disorders. There haven't been very many carefully controlled studies that use strict diagnostic criteria on adult patients diagnosed with pyromania or other impulse-control disorders.
- Treatments work in 95% of children that exhibit signs and symptoms of pyromania.

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6.102: Kleine Levin Syndrome (Sleeping Beauty Syndrome

Proposed addition to DSM-V.

Criteria

A. The patient experiences recurrent episodes of excessive sleep (>11 hours/day).

B. Episodes occur at least once a year, and are generally 2 days to 4 weeks in duration.

C. During episodes, when awake, cognition is abnormal with feeling of unreality or confusion. Behavioral abnormalities such as megaphagia or hypersexuality may occur in some episodes.

D. The patient has normal alertness, cognitive functioning, and behavior between the episodes.

E. The condition is not better accounted for by another mental disorder (e.g, mood disturbance), and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another general medical condition (e.g. a metabolic disorder).

Treatment:

Treatment for KLS has not been established, although lithium has been used in limited cases with insignificant efficacy. Gabapentin has shown some promise in being effective for the prevention of hypersomnia attacks. There is considerable speculation that the recurrent hypersomnia and behavior disturbance are related to epilepsy-like neuronal discharge from the thalamus due to dysfunction in GABAnergic receptors (Itokawa et al., 2009).
For more information, check out the KLS Foundation: http://www.kleinelevin.com/

- Segment about Kleine Levin Syndrome http://klsfoundation.org/kleine/levin/video_article/strange_brain/

Dsm5 proposed changes (dsm5.org)

A. The patient experiences recurrent episodes of excessive sleep (>11 hours/day).

B. Episodes occur at least once a year, and are generally 2 days to 4 weeks in duration.

C. During episodes, when awake, cognition is abnormal with feeling of unreality or confusion. Behavioral abnormalities such as megaphagia or hypersexuality may occur in some episodes.

D. The patient has normal alertness, cognitive functioning, and behavior between the episodes.

E. The condition is not better accounted for by another mental disorder (e.g, mood disturbance), and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another general medical condition (e.g. a metabolic disorder).

Rationale for change

- There is increasing evidence that the disorder is a genuine disease entity based on its consistent description in term of clinical presentation, demographics (70% male, adolescent), evolution (eventually disappears), and therapeutic response (almost nothing is effective). It may be misdiagnosed as depression or other psychiatric consequences, with devastating consequences.
- Relationship to International Classification of Diseases- 10
- Other Sleep Disorders: Kleine-Levin Syndrome G47.8
- Relationship to International Classification of Sleep Disorders 2nd Edition
- **Recurrent Hypersomnia 327.13**

Severity

Recommendations for severity criteria for this disorder are forthcoming.

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6.103: Primary Hypersomnia (307.44)

DSM-IV-TR criteria

- The patient experiences excessive sleepiness for at least one month. This can include prolonged sleep at night or additional sleep in the daytime.
- The patient experiences significant distress or functional impairment due to excessive sleepiness.
- The excessive sleepiness is not better accounted for by insomniaand does not occur exclusively during the course of another Sleep Disorder (e.g. Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder, or a Parasomnia) and cannot be accounted for by an inadequate amount of sleep.
- The disturbance does not occur exclusively during the courseof another mental disorder.
- The condition cannot occur exclusively with any other mental disorder, physical medical condition, or substance use.

Proposed DSM 5 changes (DSM5.org)

A. The predominant complaint is unexplained hypersomnia (excessive sleep) or/and hypersomnolence (sleepiness in spite of sufficient nocturnal sleep), for at least 3 months, occurring 3 or more times per week.1. Hypersomnia (excessive sleep) is defined by a prolonged nocturnal sleep episode or daily sleep amounts (>9 hours/day).2. Hypersomnolence is defined by excessive daytime sleepiness with recurrent daytime naps or lapses into sleep that occurs daily or almost daily over at least the last 3 months (when the patient is untreated) and daily sleep amounts > 6 hours. To document hypersomnolence, the Multiple Sleep Latency Test must show a mean sleep latency below 8 minutes, with or without Sleep Onset REM Periods (SOREMPs). If the patient has more than 2 SOREMPs, the condition may be called “narcolepsy without cataplexy”. B. The sleep periods are non-restorative (unrefreshing) or so prolonged in length that this causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.C. The hypersomnia is not better accounted for by insomnia and does not occur exclusively during the course of another Sleep Disorder (e.g., Narcolepsy with Cataplexy, Sleep-Related Breathing Disorder, Circadian Rhythm Sleep Disorder, or a Parasomnia) and cannot be accounted for by an inadequate amount of sleep. D. The disturbance does not occur exclusively during the course of another mental or medical disorder but may occur simultaneously with these disorders.E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication).

Clinically Comorbid Conditions:

1. Mental/Psychiatric Disorder (specify)
2. Medical Disorder (specify)

Rationale:

- Narcolepsy without cataplexy is defined based on a positive Multiple Sleep Latency Test but no cataplexy. Its symptoms are identical to hypersomnia without long sleep time. Most of these cases are not caused by hypocretin deficiency. The treatment of narcolepsy without cataplexy is similar to that of primary hypersomnia. There is no proof that narcolepsy without cataplexy and primary hypersomnia are distinct disease entities. Advantage: Simplifies the classification. Disadvantage: Some patients with “narcolepsy” but without cataplexy/hypocretin deficiency (generally narcolepsy without cataplexy) would now go into the category 307.44 “primary hypersomnia/narcolepsy without cataplexy”. As the cause of 307.44 is unknown, this is a “softer” diagnosis.

Criterion A:

Rationale, advantage and disadvantage: It is not a major change, but rather a clarification. The term “Hypersomnia” originally meant “increased sleep amounts”; it is distinct from “hypersomnolence (daytime sleepiness). The The two interacts, and both may be present. There are no disadvantages. The three month criteria is more standard.

Criterion B:

- Rationale, advantage and disadvantage: It is not a major change, but rather a clarification. By definition, sleep must be non-restorative or unrefreshing and cause distress. If the subjects sleeps a lot but feels fine, he/she would be characterized as a long sleeper. It would really become pathological only if extremely long and unmanageable socially.

Criterion C, D, & E: are primarily in the wording.

Relationship to International Classification of Diseases -10:
Nonorganic hypersomnia F51.1, Disorders of Excessive Somnolence (hypersomnias) G47.1

Relationship to International Classification of Sleep Disorders 2nd edition: The revised classification will remain similar to that of the ICSD-2, except that two instead of 4 categories are included. Primary hypersomnia/narcolepsy without cataplexy will be a category merging ICSD-2 narcolepsy without cataplexy, hypersomnia with long time sleep, and narcolepsy without long time sleep. As these three entities are not known to be pathophysiologically distinct, and are treated and evaluated similarly. Narcolespy withou cataplexy 347.00

Severity:

1. Epworth sleepiness Scale

2. Multiple Sleep Latency Test
3. Maintenance of Wakefulness test

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6.104: Vascular Dementia (290.4x)

A video documentary of a man caring for his father who has Vascular Dementia can be found at http://current.com/groups/culture/85771461_julius-and-dementia.htm.

DSM-IV-TR criteria

A. 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:

- aphasia (language disturbances)
- apraxia (impaired ability to carry out motor activities despite intact motor function)
- agnosia (failure to recognize or identify object despite intact sensory function)
- disturbances in executive functioning (i.e. planning, organizing, sequencing, abstracting)

B. 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.

C. Focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity) or laboratory evidence indicative of cerebrovascular disease (e.g., multiple infarctions involving cortex and underlying white matter) that are judged to be etiologically related to the disturbance.

D. The deficits do not occur exclusively during the course of a delirium.

Code based on predominant features:

- **290.41 With Delirium:** if delirium is superimposed on the dementia
- **290.42 With Delusions:** if delusions are the predominant feature
- **290.43 With Depressed Mood:** if depressed mood (including presentations that meet full symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.
- **290.40 Uncomplicated:** if none of the above predominates in the current clinical presentation

Specify if:

- **With Behavioral Disturbance**

Coding note: Also code cerebrovascular condition on Axis III.

Associated features

Individuals with Dementia may become spatially disoriented and have difficulty with spatial tasks. Poor judgment and poor insight is also fairly common in Dementia. Sometimes individuals with this disorder may display no awareness of the loss of their cognitive abilities. Suicidal tendencies have also been seen in individuals with Dementia. Disinhibited behavior, slurred speech, motor disturbances, and delusions have also been associated with Dementia.

Child vs. adult presentation

The age of onset of Vascular Dementia is typically earlier than that of Dementia of Alzheimer's Type.

Gender and cultural presentation

This disorder seems to be more common in males than in females.

Epidemiology

Vascular Dementia is much less common than Dementia of Alzheimer's Type

DSM 5 Changes: (DSM5.org)

Proposed Revision:The work group is recommending that this disorder be subsumed into a new disorder: Major Neurocognitive Disorder. Work on a subtype for vascular etiology is currently in progress.

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6.105: Dementia of the Alzheimer's Type (294.1x)

Diagnostic criteria

A. 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:

- aphasia (language disturbance)
- apraxia (impaired ability to carry out motor activities despite intact motor function)
- agnosia (failure to recognize or identify objects despite intact sensory function)
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting)

B. 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.

C. The course is characterized by gradual onset and continuing cognitive decline.

D. 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 deficeincy, hypercalcemia, ceurosyphilis, HIV infection)

(3) substance-induced conditions

E. The deficits do not occur exclusively during the course of a delirium.

F. The disturbance is not better accounted for by another Axis I disorder (e.g. Major Depressive Disorder, Schizophrenia).

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).

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).

Associated Features

- Dementia of Alzheimer's Type is increasingly diagnosed in individuals with Down Syndrome and those with a history of head trauma. Brain atrophy is present in the majority of individuals diagnosed with Dementia of Alzheimer's Type, and they generally have wider cortical sulci and larger cerebral ventricles than would be expected given the normal aging process.
- Few motor and sensory signs are seen in the first years of illness. Also, myoclonus and gait disorder may appear as the illness progresses. 10% of individuals with Dementia of the Alzheimer's Type begin having seizures.

Child vs. Adult presentation

This disorder is not seen in children, it is present in adults only. Very few cases are seen before age 50. Late onset of Dementia of Alzheimer's Type is more typical than early onset, meaning that the age of onset is typically after age 65 years.

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.

DSM-5 proposed changes (DSM5.org)

1. Removing the term "Dementia" and adding "Major Neurocognitive Disorders"
2. Adding a category of "Minor Cognitive Disorders"
3. Categorizing behavioral disturbances, particularly the syndromes of psychosis and depression, associated Neurocognitive Disorders
4. Selecting specific domains as well as measures of severity of cognitive functional impairment

Major Neurocognitive Disorder (DSM-5)

Disorders subsumed under this overarching category would include, but not limited to, the following: Dementia Due to a General Medical Condition, Dementia Not Otherwise Specified, Dementia of the Alzheimer's Type, Vascular Dementia, Dementia Due to Multiple Etiologies, Amnestic Disorder Due to a General Medical Condition, and Amnestic Disorder Not Otherwise Specified. Some individuals meeting criteria for Cognitive Disorder Not Otherwise Specified may also meet criteria for this disorder. Certain specific etiologies would be coded as subtypes, such as the Alzheimer's Disease Subtype of Major and Minor Neurocognitive Disorders.

Major Neurocognitive Disorder

A. Evidence of significant cognitive *decline from a previous level of performance* in one or more of the domains outlined above based on:

1. Reports by the patient or a knowledgeable informant, or observation by the clinician, of clear decline in specific abilities as outlined for the specific table above.

AND

2. Clear deficits in objective assessment of the relevant domain (typically > 2.0 SD below the mean [or below the 2.5th percentile] of an appropriate reference population [i.e., age, gender, education, premorbid intellect, and culturally adjusted])

B. The cognitive deficits are sufficient to interfere with independence (e.g., at a minimum requiring assistance with instrumental activities of daily living, i.e., more complex tasks such as finances or managing medications)

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not wholly or primarily attributable to another Axis I disorder (e.g., Major Depressive Disorder, Schizophrenia)

Rationale for Change

Major Neurocognitive Disorder (including what was formerly known as Dementia) is a disorder with greater cognitive deficits in at least one (typically two or more) of the following domains:

Complex attention (planning, decision-making, working memory, responding to feedback/error correction, over-riding habits, mental flexibility),

Executive ability (planning, decision-making, working memory, responding to feedback/error correction, overriding habits, mental flexibility),

Learning and memory(immediate memory, recent memory [including free recall, cued recall, and recognition memory])

Language(expressive language [including naming, fluency, grammar and syntax] and receptive language),

Visuoconstructional-perceptual ability (construction and visual perception),and

Social cognition (recognition of emotions, theory of mind, behavioral regulation).

The cognitive deficits must be sufficient to interfere with functional independence. Important changes from the DSM-IV criteria include: change in nomenclature (MNCD or Dementia), not necessarily requiring memory to be one of the impaired domains, allowing cognitive deficit limited to one domain. In the introductory text, we offer a table that offers more details about the

assessment of each domain in the form of specific symptoms of decline that can be elicited or observed, and assessment procedures that can be used to document the cognitive impairment and quantify its severity.

- The term “dementia” is replaced by Major Neurocognitive Disorder, which is conceptualized as including what was formerly known as dementia as well as entities like amnestic disorder. “Dementia” is an accepted term for older adults (e.g., with Alzheimer’s disease)—although even in this setting it has acquired a pejorative or stigmatizing connotation, it is less well accepted among younger adults with deficits related to e.g., HIV or head injury.
- This rewording focuses on decline (rather than deficit—consistent with the requirement in the basic definition of an acquired disorder) from a previous level of performance.
- The previous criteria for dementia used Alzheimer’s disease as their prototype and thus required memory impairment as a criterion for all dementias. There is growing recognition that, in other neurocognitive disorders (e.g., HIV-related cognitive decline, cerebrovascular disease, frontotemporal degeneration, traumatic brain injury, etc.), other domains such as language or executive functions may be impaired first, or exclusively, depending on the part of the brain affected and the natural history of the disease.
- The terminology for the cognitive domains has been updated to reflect current usage in neuropsychology and neurology.
- The new definition, consistent with DSM-wide changes, focuses first on performance rather than disability. In the introductory table, we provide for each domain examples of specific symptoms or observations consistent with the Major level of decline and objective assessments. This encourages the use of objective measures, including formal neuropsychological testing where feasible with lesser exclusive reliance on individual judgment.
- The presence of both symptoms/observations and objective assessment is included to ensure specificity. This is a larger issue for Minor Neurocognitive Disorder but included here for parallel structure of the criteria.

NOTE: The committee is in the process of refining criteria A1 and A2 to achieve a balance between preferred formal neuropsychological assessment and what may feasible in some clinical settings. They welcome input on this issue.

- The new language preserves the traditional function-based threshold for dementia but tries to operationalize it more clearly as a loss of independence.

NOTE: The committee is still refining criterion D and discussing to what extent Major Neurocognitive Disorder should be diagnosed in the setting of disorders like schizophrenia and depression (although this concern applies primarily to Minor Neurocognitive Disorder). They also realize that issues of this nature are being addressed at the DSM-wide level, and are awaiting input of these larger discussions, as well as public input on this issue.

Minor Neurocognitive Disorder(DSM-5)

A. Evidence of minor cognitive decline from a previous level of performance in one or more of the domains outlined above based on:
1. Reports by the patient or a knowledgeable informant, or observation by the clinician, of minor levels of decline in specific abilities as outlined for the specific domains above. Typically these will involve greater difficulty performing these tasks, or the use of compensatory strategies.
AND
2. Mild deficits on objective cognitive assessment (typically 1 to 2.0 SD below the mean [or in the 2.5th to 16th percentile] of an appropriate reference population (i.e., age, gender, education, premorbid intellect, and culturally adjusted). When serial measurements are available, a significant (e.g., 0.5 SD) decline from the patient’s own baseline would serve as more definitive evidence of decline.
B. The cognitive deficits are not sufficient to interfere with independence (Instrumental Activities of Daily Living are preserved), but greater effort and compensatory strategies may be required to maintain independence.
C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not wholly or primarily attributable to another Axis I disorder (e.g., Major Depressive Disorder, Schizophrenia).
Rationale for Change

Minor Neurocognitive Disorder has been added to recognize the substantial clinical needs of individuals who have mild cognitive deficits in one or more of the same domains but can function independently (i.e., have intact instrumental activities of daily living),

often through increased effort or compensatory strategies. This syndrome, known in many settings as Mild Cognitive Impairment may be particularly critical, as it may be a focus of early intervention. Early intervention efforts may enable the use of treatments that are not effective at more severe levels of impairment and/or neuronal damage, and, in the case of neurodegenerative disease, may enable a clinical trial to prevent or slow progression.

- Minor Neurocognitive Disorder is added to account for individuals with minor levels of cognitive impairment who may require assessment and treatment, but are not sufficiently impaired the Major diagnosis. To some extent, this entity will take care of individuals currently coded as Cognitive Disorder NOS without specific criteria. This change is driven by the need of such individuals for care, and by clinical; epidemiological; and radiological, pathological and biomarker research data suggesting that such a syndrome is a valid clinical entity with prognostic and potentially therapeutic implications. Prime examples are the prevalent neurocognitive disorders associated with various neuromedical conditions such as traumatic brain injury, HIV, substance-use-related brain disorders, diabetes, and early/mild stages of neurodegenerative disorders like Alzheimer's disease and of cerebrovascular disease. As these conditions are increasingly seen in clinical practice, clinicians have a pressing need for reliable and valid diagnostic criteria in order to assess them and provide services including treatment of associated mood symptoms, further investigation of brain function, identification of treatable causes, and, for progressive disorders, appropriate early interventions.
- The Neurocognitive Disorders Work Group is aware that the specific term "minor" can be challenged on the grounds that it implies lack of need for services and are open to alternative suggestions. They chose "minor" rather than "mild" to be parallel with "major" and to be able to maintain the mild, moderate, and severe distinction within Major NCD.
- The combination of symptoms/observations and objective assessment is critical in Minor Neurocognitive Disorder to maintain specificity: a report of a *change* in abilities protects against overcalling the disorder in those with lifelong poor performance (since*decline* can only be *inferred* from a single observation), and objective assessment protects against overcalling the disorder in "the worried well."
- The Neurocognitive Disorders Work Group is in the process of refining these criteria to achieve a balance between preferred formal neuropsychological assessment and what may be feasible in some clinical settings. The issue is particularly difficult for Minor Neurocognitive Disorder because at lesser levels of cognitive impairment symptom reports may be unavailable or unreliable, observation may be less informative, the interpretation of objective assessments is complicated by variable premorbid abilities, and simpler assessments are likely to be insensitive. They welcome input on this issue.
- The Neurocognitive Disorders Work Group is still refining criterion D and discussing to what extent Minor Neurocognitive Disorder should be diagnosed in the setting of disorders like schizophrenia and depression. They also realize that issues of this nature are being addressed at the DSM-wide level and are awaiting input of these larger discussions, as well as public input on this issue.

Alzheimer's Disease Subtype of Major or Minor Neurocognitive Disorders (DSM-5)

A. Major: Meets criteria for Major Neurocognitive Disorder, with memory being one of the impaired domains.
Minor: Meets criteria for Minor Neurognitive Disorder with memory impairment AND there is clear supporting evidence for the Alzheimer etiology (e.g. a positive test for a known mutation in an Alzheimer's disease associated gene), or with evolving research, documentation based on biomarkers or imaging.
B. Early and prominent impairment in the Memory domain (rarely, other domains such as visuoconstructive perceptual domain may be prominently affected, but Alzheimer's disease would not be diagnosed without clear supporting imaging, biomarker or genetic evidence).
Major: Deficits are observed in at least one other domain, often Executive Ability, and as the disease progresses, in additional domains.
Minor: Only Memory may be affected, but deficits in Executive Abilities are common.
C. The course is characterized by gradual onset and continuing cognitive decline
D. Evidence from history, examination, and investigations that deficits are not wholly or primarily attributable to other disorders. However, other such disorders may coexist.
RATIONALE FOR CHANGE

Alzheimer's disease is a neurodegenerative disorder, typically seen in late life, but can occur earlier. It is marked by insidious onset, gradual decline, and typically an early prominent memory loss. For Major Neurocognitive Disorder this typical clinical picture has

excellent predictive value for the Alzheimer subtype and is all that is required for a diagnosis of the Alzheimer subtype, although additional evidence adds to the certainty of diagnosis. For less typical clinical profiles such as posterior coritical atrophy or visual variant of AD, additional supportive evidence such as typical neuroimaging patterns of atrophy is required. For Minor Neurocognitive Disorder, because of the modest predictive value of the clinical picture alone and the significant social consequences of an Alzheimer diagnosis, the Alzheimer's disease subtype is not commonly diagnosed. However, such a diagnosis is possible if there is sufficient information available (e.g., a positive genetic test for dominantly inherited AD, or as the field develops, evidence that certain imaging markers, atrophy of medial temporal lobe structures on MRI, temporoparietal hypometabolism on FDG PET, amyloid deposition on PET scanning or markers for tau and abeta in the CSF are sufficiently predictive of an underlying AD pathology).

While patients in memory disorders clinics who meet current research criteria for Mild Cognitive Impairment (similar to Minor Neurocognitive Disorder with impaired memory) progress to dementia of the Alzheimer type at the rate of 12-15% per year and have neuropathological evidence of both neurodegeneration and cerebrovascular disease, population-based studies show a much lower rate of progression with some individuals improving. Research is ongoing into what specific features of MCI might reliably indicate the presence of prodromal Alzheimer's disease. Until those features can be identified, the Neurocognitive Disorders Work Group does not feel that the predictive value of Minor Neurocognitive Disorder (minor NCD) with memory impairment is sufficient for a diagnosis of Alzheimer's disease. However, such a diagnosis might be made in an individual with an autosomal dominant family history or positive test for a mutation in an autosomal dominant "AD gene", or, after further research, with clearly predictive biomarkers or imaging studies.

- This is an area in which knowledge is evolving rapidly; the procedures described above are increasingly used in clinical practice at tertiary care centers and outside the US. It is possible some of them will enter standard use in the near future.
- Previous terminology was revised to recognize the clinical and pathological evidence that comorbidity is the norm in the population at large, that having cerebrovascular disease does not preclude also having Alzheimer's disease and vice versa, and in the presence of both, it is not useful to arbitrarily assign causality to one or the other.
- There is little scientific rationale for retaining the distinction between early and late onset, as the underlying pathology is the same, and the threshold of age 65 is arbitrary at best.

Criteria for Psychosis of AD:

A. Characteristics symptoms: Delusions or auditory or visual hallucinations

B. Primary diagnosis: AD: Chronology of onset of symptoms of dementia prior to onset of psychotic symptoms

C. Duration: >1 month, although the delusions and hallucinations may be intermittent; symptoms cause clinically significant distress or functional disruption

D. Symptoms not exclusively during delirium

E. Symptoms not due to direct physiological effects of a substance and cannot be better accounted for schizophrenia or other psychotic disorder

Rationale

(1) Public health importance: High prevalence & incidence

(2) Associated with: More agitation, aggression, More rapid cognitive decline, Greater caregiver distress, earlier institutionalization, and higher cost of care

(3) Persistence or recurrence common

(4) Aggregates in families

(5) Clinical differences between AD + Psychosis and both AD without psychosis and Psychosis without AD

(6) Specific treatment considerations

Criteria for Depression of AD:

A. 3 (or more) of 10 listed symptoms under Major Depressive Disorder

B. Primary diagnosis: AD

C. Duration: > 2 weeks; Symptoms cause clinically significant distress or functional disruption

D. Symptoms not exclusively during delirium

E. Symptoms not due to direct physiological effects of a substance and cannot be better accounted for by another disorder

Rationale

(1) Public health importance: High prevalence and incidence

(2) Associated with: Higher mortality and Higher cost of care

(3) Persistence or recurrence common

(4) Clinical differences between AD + depression and both AD without depression and Depression without AD

(5) Specific treatment considerations

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6.106: Body Dysmorphic Disorder (300.7)

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)

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6.107: Cyclothymic Disorder

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 conditioned (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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=132

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6.108: Dyspareunia (302.76)

DSM-IV-TR criteria

- A. Recurrent or persistent genital pain associated with sexual intercourse in either a male or female
- B. The disturbance causes marked distress or interpersonal difficulty.
- C. The disturbance is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except another Sexual Dysfunction), and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- Specify type:
  - Lifelong Type
  - Acquired Type
- Specify type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

Associated Features

- A person with dyspareunia experiences pain in the genital area before, during or after sexual intercourse. The nature, duration, and intensity of the pain may vary across individuals, but is most often experienced during sexual intercourse.
- The most reported type of pain is superficial pain which occurs upon penetration.

Child vs. adult presentation

This occurs in sexually active individuals and is not normally seen in children.

Gender and cultural differences in presentation

- Men can have this disorder, however, it is very rare. When men do have it, it is almost always due to a medical condition.
- Estimates of the prevalence of male dyspareunia are sparse but appear to affect 3% to 5% of men in Western countries and 10% to 12% of men in the Middle East and Southeast Asia.
- A study of 404 gay men reported a prevalence rate of approximately 14% anodyspareunia from receptive anal sex, with the majority experiencing it lifelong. A significant proportion of men found it highly distressing, and, as a result, it led to avoidance of sexual activity or restricting activity to insertive anal sex.

Epidemiology

- In a survey of 329 women in 1993 at a gynecological clinic it was found that 7.7% of women experienced painful intercourse on most or all occasions. There is very little data on the prevalence of this disorder in men. However, studies have shown that when this disorder exists in men, it is usually caused by a medical problem.
- 60% of women experience genital pain before, during, or after intercourse at some point. However, the location and frequency varies among women.

Etiology

There are several causes of dyspareunia. There are entry pain causes. These would include inadequate lubrication, injury, trauma, or irritation. This could be due to a pelvic surgery or a female circumcision. Another cause could be inflammation, infection, or skin disorder, such as eczema. Also, allergic reactions to birth control products, such as latex could be the cause. Also, an improper fit of a diaphragm can cause pain. Vaginismus can also be a cause, which is involuntary muscle spasms of the vagina. Finally, vestibulitis is unexplained stinging or burning around opening of vagina can cause entry pains associated with dyspareunia. There are also deep pains that are caused by illnesses, infections and surgeries or medical treatments. These could include pelvic inflammatory disease, uterine prolapse, infections in the uterus or Fallopian tubes, and complications from hysterectomies. There are also emotional

causes that could include psychological factors, stress, and history of sexual abuse. Specifically, these could include fear of intimacy and depression. Also, pelvic floor muscles are very sensitive to stress, so this could be a factor. This being caused by a history of sexual abuse is not very common although it can be a factor.

Empirically supported treatments

- Carefully examining the pelvis to duplicate as closely as possible the discomfort and to identify a site or source of the pelvic pain.
- Clearly explaining to the patient what has happened, including identifying the sites and causes of pain. Making clear that the pain will, in almost all cases, disappear over the time or at least will be greatly reduced. If there is a partner, explaining him also the causes and treatment and encouraging him to be supportive.
- Encouraging the couple to add pleasant, sexually exciting experiences to their regular interactions, such as bathing together (in which the primary goal is not cleanliness), mutual caressing without intercourse, and using sexual books and pictures.
- Prescribing very large amounts of water-soluble sexual or surgical lubricant during intercourse.
- A manual physical therapy (Wurn Technique) which treats pelvic and vaginal adhesions and micro adhesions may decrease or eliminate intercourse pain.
- Reducing use of scented bath products can help, because they can irritate the genital area.
- Kegal exercises for relaxation of the vaginal muscles also can help.
- Instructing the receiving partner to take the phallus of the penetrating partner in their hand and control insertion themselves, so that they are in control.

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6.109: Conversion Disorder (300.11)

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 indifference. 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 100,00 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, quilt, 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)

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6.11: Specific Phobia (300.29)

DSM-IV-TR Criteria

- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., heights, blood, injections, animals). Specific anxiety and fear elicited by an object or situation and resulting in avoidance behaviors.
- 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.
- C. The person recognizes that the fear is excessive or unreasonable. NOTE: In children, this feature may be absent.
- D. The phobic situation(s) is(are) avoided, or else endured with intense anxiety or distress.
- 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.
- F. In individuals under age 18 years, the duration is at least 6 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.

The DSM-IV-TR categorizes five general types of SP:

1. Animal Type: These include fears of animals such as dogs, snakes, cats, bears, etc.
2. Natural Environment Type: These include fears of heights, storms, and being near a water source such as a river or lake.
3. Blood-Injection-Injury (B-I-I) Type: These include fears of seeing blood; receiving a blood test or injection; for the more serious types of this phobia, seeing an injection on television or talking about the act.
4. Situational Type: These include fears of situations such as driving, flying, elevators, and enclosed places.
5. Other Type: These include other specific fears, including fear of choking or vomiting after eating certain foods, fear of balloons breaking or guns going off, fear of clowns or midgets.

There is controversy over these divisions, however. Some research has shown that SP instead may be better divided into three primary clusters of animal, B-I-I, and a combined situational/natural environment type, while other analyses have found only two clusters: B-I-I and all others. Still other researchers contend that dividing the categories based on the type of emotion elicited by the phobic object, fear or disgust, is most accurate and clinically useful. Much more research is needed in this area to clarify this issue.

Associated Features

People with SP will often remember fearful experiences they encountered in a drastically exaggerated manner. For example, a person with a fear of dogs may remember a dog they once encountered as being larger and faster than it actually was, or baring its teeth viciously when it was only panting with an open mouth. They will often go to great lengths to avoid an encounter with the phobic object, affecting one's work, family, and social life. For instance, a job may require a person to fly for a business meeting, but a fear of flying could keep them from completing this job task and result in the loss of that job. Exposure to feared stimuli often causes significant physiological responses, such as dizziness, shortness of breath, increased heart rate, and even fainting.

Over 75% of individuals who are diagnosed with SP actually have multiple phobias, with over 50% reporting three or more. In animal and height phobias, there is a substantial comorbidity with major depressive disorder, but this relationship is not seen across the other types. Across all types, though, comorbid anxiety disorders are highly common, but not as high as in other types of anxiety disorders.

With the B-I-I type, a strong vasovagal fainting response is common, characterized by an acceleration of heart rate and elevation in blood pressure followed by rapid deceleration of heart rate and drop in blood pressure and not infrequent fainting. This is in direct contrast to the acceleration in heart rate and elevation in blood pressure seen in the other specific phobias. It has been hypothesized

that these differences are a biological protection mechanism, as one would want the sympathetic nervous system to be highly activated for most phobic objects, in order to enable "fight or flight." In B-I-I, for instance if you were seriously injured and bleeding, sympathetic nervous system activation would cause the heart to beat furiously, pumping blood out of the wound and putting one at greater risk of death.

As illustrated in some of the examples above, SP can have quite a negative impact on a person's functioning. Both adults and youth with clinical-level phobias shower a lower overall quality of life (QoL) than those without SP. In adults, functional impairment in education and employment has been observed, as well as more work loss days and poorer physical and mental QoL.

Child vs. Adult Presentation

Children will often express anxiety associated with this phobias by freezing, crying, throwing tantrums, or by refusing to let go of a person they trust to protect them. Children seem to display a higher degree of response to perceived threats of their phobias than adults. However, the physical anticipatory response is higher in adults. Adults and teenagers are usually aware that their phobia is unreasonable, although younger children often will not be. Children with SP are more likely to show distorted thoughts and memories concerning past experiences with the feared stimuli than are adults, but whether this is a result of the fear or caused the fear in the first place is unknown.

Gender and Cultural Differences in Presentation

Females in general have about a 2:1 ratio to males for having SP, with between 21.2-26.5% of women and 10.9-12.4% of men meeting criteria. Animal, situational, and storm or water phobias are overwhelmingly female, while heights (60% female) and B-I-I (35-65% female) more evenly distributed. There appear to be few differences in type prevalence across SES, family structure, or age, though.

There is some research on cultural differences, but not much. For example, here in the U.S., African-Americans endorse SP at three times the Caucasian rate, as well as endorsing more animal phobias but fewer B-I-I phobias. Interestingly, persons of Asian and Hispanic heritage show lower rates than Caucasians. Around the world, the overall reported prevalence rates in Puerto Rico, Germany, Switzerland and New Zealand are extremely low. One thing to note is that a fear that is commonly present in a culture, such as a fear of magic or spirits, should not be considered a SP unless it is in excess for that particular culture.

Epidemiology

Rates of SP in the general population are very high, with a lifetime prevalence rate of 12.5% and 12-month rate of 9.1%. A natural decline in SP rates across the lifespan is seen, with rates in 18-29 year olds almost double that of persons over 60 (10.3% vs. 5.6% over a 12-month period). The rates for types of phobias vary dramatically, with natural environment the most occurring (8.9-11.6%), followed by situational (5.2-8.4%), animal (3.3-7%), and B-I-I (3-4.5%).

The onset age depends upon the type of phobia. Generally, animal (6.3-9.2 years), natural environment (6.5-13.6 years), and B-I-I (5.5-9.4 years) types develop in early childhood. Fear of heights and situational specific phobias (such as claustrophobia) typically develop during the late teenage years and early third decade of life (13.4-21.8 years).

Given these high rates, and the fact that treatment for SP works remarkably well (see below), it is surprising how few persons actually present to treatment for phobias. For example, in a college sample, 34% of students reported being "significantly" or "severely" afraid of spiders, but less than 1 in 5 of them was interested in seeking treatment. This is particularly sad given the average age of onset for most phobias is prior to adolescence, which means people are spending decades of their life being terrified by something that could be resolved in a short time.

Etiology

There are two possible frameworks to view the development of SP: associative and nonassociative. The associative model of SP developed from animal models of fear, with some of the earliest work being done by John B. Watson using only classical conditioning (the famous – or infamous – "Little Albert" studies). As knowledge about operant conditioning grew, however, Mowrer's two-factor theory of avoidance learning became highly influential. In this theory, fears develop initially via classical conditioning and are then maintained via the operant conditioning process of negative reinforcement. For example, a girl gets attacked by a dog, classically associating the dog with fear; she then goes out of her way to avoid dogs, such as crossing the street to avoid encounter one, not going into pet stores, or declining invitations to parties where the host has a dog, negatively reinforcing

that avoidance. Vicarious conditioning can also play an important role in associative learning, via modeling (a child sees a parent display fear or disgust to stimuli, and then patterns his behavior after that), information transmission (hearing about how dangerous it is to fly due to terrorists), and visual observation of fear (watching someone else encounter a stimuli and display phobic reactions). The impact of these types of associative learning, however, appear to be strongly mediated by nonassociative factors, such as preparedness and innate fears.

Evolutionary preparedness is a nonassociative theory that we as a species may be genetically primed to fear certain stimuli, thanks to our evolutionary history. This would include commonly phobic objects such as snakes and reptiles, spiders, the dark, heights, and closed spaces. The theory is that, due to the inherent dangerousness of such things throughout the history of our species, those individuals with a natural tendency to avoid such things were more likely to survive and reproduce, passing on the genes related to such a behavioral expression. It would also help to explain why things that are actually more dangerous, such as guns and cars, but have been around a relatively short period of time are not seen in phobic individuals nearly as often. This is not to say, though, that people are born afraid of certain stimuli. Instead, we slowly acquire the competencies needed to deal with both fear predispositions and actual fears, with phobias being those predispositions or fears that are a) resistant to extinction or habituation and b) acquired through associative processes. As such, one's environment can work toward eliminating biologically relevant fears via the same processes that are at work in building them. As such, the reality seems to be that it is not whether a given fear is associative or nonassociative, but instead how much learning is needed to evoke that particular fear.

Empirically Supported Treatments

Unlike the other anxiety disorders, where there are both supported psychological and pharmacological therapies, the treatment of specific phobias is done only with psychotherapy. The gold-standard treatment for phobias is exposure with response prevention, specifically using Öst's "One Session Treatment" protocol. There are two phases in this therapy: assessment and treatment. First, the clinician conducts a diagnostic assessment using an evidence-based, multi-method and multi-informant approach. This would include a structured or semi-structured interview such as the Anxiety Disorder Interview Schedule (ADIS-IV), self-report, and behavioral avoidance tasks. Afterwards, a functional assessment follows to accomplish several goals. First, to determine any maintaining variables of the phobia that would impede treatment. Second, a fear hierarchy, which is a rank ordering of feared stimuli or situations from most to least fearful, is generated. Next, the hierarchy is used to catalog most severe and catastrophic cognitions associated with each stimuli or situation. The clinician also attempts, if possible, to determine the onset and course of the phobia. Finally, the assessment allows the clinician to build rapport and present the rationale for treatment.

During the treatment phase, the clinician primarily makes use of exposure with response prevention techniques, but also incorporates cognitive challenges, modeling, reinforcement, education, and skills training into therapy. Exposures are seen as a series of negotiated behavioral experiments based on the fear hierarchy constructed during the assessment phase. Starting near the bottom of the hierarchy, the patient gradually confronts more and more fear-provoking stimuli, guided by the therapist. Patients must show at least a 50% decrease in distress to each stimuli before moving on to the next one. Generally, the treatment phase will last around three hours, allowing for massed exposure to the fear stimuli. This is then followed by self- or parent-guided exposures for homework, which allows overlearning to occur and a complete extinction of the fear to happen. Success rates with this time of treatment are astounding, with effect sizes well over 1.0 and treatment gains maintained for years afterward.

Proposed DSM-5 Revisions

The proposed changes for SP are primarily wording changes, rather than substantive diagnostic changes. For example, the DSM-IV wording of "marked and persistent fear" is changed to "marked fear or anxiety."

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6.110: Depersonalization Disorder (300.6)

This is a video of a woman who was diagnosed with depersonalization disorder. In the video she gives a good description of what it feels like when a person is experiencing an episode caused by depersonalization disorder.

DSM-IV-TR criteria

A. Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).

B. During the depersonalization experience, reality testing remains intact.

C. The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The depersonalization experience does not occur exclusively during the course of another mental disorder, such as Schizophrenia, Panic Disorder, Acute Stress Disorder, or another Dissociative 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)

Associated features

- Associated features may include anxiety or depression. Sometimes, individuals have a hard time with sense of time and may have somatic manifestations. Comorbidity can include Panic Disorder, Borderline Personality Disorder, Post-Traumatic Stress Disorder, Obsessive-compulsive Disorder, Dysthymic Disorder, Acute Disorder, or Major Depressive disorders. Individuals with Depersonalization disorder may have personality disorders as well.
- Individuals with Depersonalization have difficulty describing their symptoms and may fear that these experiences signify that they are "crazy." Derealization may also be present and is experienced as the sense that the external world is strange or unreal. The individual may perceive an uncanny alteration in the size or shape of objects, and people may seem unfamiliar or mechanical.

Child vs. adult presentation

The disorder is more likely to occur in late adolescence to adulthood.

Gender and cultural differences in presentation

- From various studies, equal numbers of men and women are diagnosed. Individuals from individualistic societies are more likely to suffer from the disorder (see Etiology).
- In clinical samples, this disorder is diagnosed at least twice as often in women than in men.

Epidemiology

- Although much of the general population experiences a depersonalization experience (whether caused by a traumatic experience or danger, or a drug induced experience), only about 2.4% of the population has been diagnosed with depersonalization disorder.
- A transient experience of depersonalization develops in nearly one-third of individuals exposed to life-threatening danger and in close to 40% of patients hospitalized for mental disorders.

Etiology

Similar to the other dissociative disorders, scientists link severe childhood abuse to depersonalization disorders. Brain imaging including pet scans show sensory cortex abnormalities. Positron emission tomography scans used to assess brain glucose metabolism show abnormalities in the sensory cortex including the temporal, occipital, and parietal lobes. The sensory cortex controls the senses and perception of an individual's body in space. Lower levels of nerve cell responses in the area of the brain that controls emotion may correlate to the emotional detachment that individual's feel during an episode of depersonalization. Western cultures where individuals live in a more individualistic society may be more likely to suffer from a depersonalization disorder. Individualism is stressed in most Western cultures and may have an effect on an individual's sense of self. Also, it is thought that trauma and childhood abuse (physical, emotional, and/or sexual) could be a factor to depersonalization disorder.

Empirically supported treatments

- There are currently no empirically supported treatments for this condition. For the most part, DPD remains resistant to traditional treatment measures. Psychotherapeutic techniques like cognitive behavioral therapy have been used to treat this disorder, but none of them have an established effectiveness. Pharmacological options continue to be researched. Some possible options that could be used to treat this condition include selective serotonin reuptake inhibitors, anticonvulsants, and opioid antagonists.
- Also some medications like benzodiazepine tranquilizers (lorazepam and clorazepate) and tricyclic antidepressants (amitriptyline and doxepin) can be helpful in treatment for Desensitization Disorder.
- Despite anecdotal reports that serotonin reuptake inhibitors may improve depersonalisation, there is no proven efficacious treatment for depersonalisation disorder (Simeon, Guralnik, Schmeidler, & Knutelska, 2004).

Proposed Changes in DSM-5 (dsm5.org)

Either (1), (2), or both:

A1. *Depersonalization:* Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling as though one is in a dream; sense of unreality of self or body; or time moving slowly)

A2. *Derealization:* Persistent or recurrent experiences of unreality of surroundings (e.g., world around the person is experienced as unreal, dreamlike, distant, or distorted)

B. During the depersonalization or derealization experience, reality testing remains intact
C. The depersonalization or derealization symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The depersonalization or derealization 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., complex partial seizures).
E. The depersonalization or derealization symptoms are not restricted to the symptoms of another mental disorder (e.g.,schizophrenia, panic disorder, acute stress disorder, posttraumatic stress disorder, major depressive disorder, or another dissociative disorder).

Specify if:

a) Depersonalization only

b) Derealization only

Rationale for Change

D and E: Changes allow comorbid diagnoses to be made when warranted.

Severity

Brief Dissociation Scale (Carlson E & Dahlenberg C, 2009)

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6.111: Dissociative Fugue (300.13)

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 Maclean's 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.

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6.112: Undifferentiated Somatoform Disorder (300.82)

DSM criteria

A. one or more physical complaints (e.g. fatigue, loss of appetite, gastrointestinal or urinary complaints).

B. Either 1 or 2:after appropriate investigation, the symptoms 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)

when there is a related general medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important area of functioning.

D. the duration of the disturbance is at least 6 months.

E. The disturbance is not better accounted for another mental disorder (e.g. another Somatoform Disorder, Sexual Dysfunction, Mood Disorder, Anxiety Disorder, Sleep Disorder, or Psychotic Disorder).

F. The symptom is not intentionally produced or feigned (as in Fictitious Disorder or Malingering).

Associated Features

The symptoms of this disorder vary from person to person. The most common symptoms associated with this disorder are mostly physical complaints. These include:

- pain
- fatigue
- appetite loss
- various gastrointestinal problems

The characteristic that defines this disorder is that although the person complains, no evidence can be found that these physical symptoms actually exist. Even with lab test and exams by doctors, no physical signs can be supported to prove that the person actually has these symptoms.

Child vs. adult presentation

Undifferentiated somatoform disorder is more common in adults than children.

Gender and cultural differences

The highest frequency of unexplained physical complaints occurs in young women of low socioeconomic status, but such symptoms are not limited to any gender, age, or sociocultural group.

Epidemiology

Undifferentiated Somatoform Disorder is relatively common. About four to eleven percent of the population will experience this disorder at some point in their life. This disorder is also comorbid with anxiety and depression. About fifty percent of people also suffer with these comorbid disorders.

Etiology

Some people believe that in the development of Undifferentiated Somatoform Disorder, causes could include problems in the family when the person was a child. Other explanations are that the person experiences stress or depression. A final possible cause is the patient worrying about every little change or sensation their body has.

Empirically Supported Treatments

Most treatments are done via psychotherapy. These treatments focus on the stressors that cause the patient to think something is happening to their body. If the patient already suffers from depression or stress, treating this problem can help lead to making the symptoms of the disorder go away or at least subside for a while. Most treatments will try to help the person manage stress, as well as differentiate between psychological stressors and physiological pain.

Dsm5 Proposed Changes (Dsm5.org)

The work group is recommending that this disorder be subsumed into a new disorder: Complex Somatic Symptom Disorder

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, hypochondiasis, undiffereniated 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.

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6.113: Primary Insomnia (307.42)

Diagnostic Criteria

A. The predominant complaint is difficulty initiating or maintaining sleep, or nonrestorative sleep, for at least one month.

B. The sleep disturbance (or associated daytime fatigue) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The sleep disturbance does not occur exclusively during the course of Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder, or a Parasomnia.

D. The disturbance does not occur exclusively during the course of another mental disorder (e.g., Major Depressive Disorder, Generalized Anxiety Disorder, a delirium).

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.

Associated features

- Many individuals with Primary Insomnia have a history of light sleep prior to the development of this disorder. Anxious over concern with general health and increased sensitivity to the daytime effects of mild sleep loss have been noticed within Primary Insomnia. Also, interpersonal, social, and occupational problems may develop as a result of over concern with sleep, increased daytime irritability, and poor concentration.
- Individuals with severe Primary Insomnia may have concentration problems and greater functional impairment, lower productivity, and increased health care utilization.
- Individuals with this disorder may have a history of mental disorder, particularly Mood and Anxiety Disorders.

Child vs. adult presentation

Complaints of Insomnia are more prevalent with increasing age. Young adults more often complain of difficulty falling asleep, whereas midlife and elderly adults are more likely to have difficulty with maintaining sleep and early morning awakening.

Gender and cultural differences

Primary Insomnia is more prevalent in females than in males.

Epidemiology

- One-year prevalence rates are as high as 30%-45% in adults. The prevalence rates for the general adult population is approximately 1%-10% and up to 25% in the elderly.
- Primary Insomnia typically begins in young adulthood or middle age and is very rare in children or adolescents.

Etiology

Most cases of Primary Insomnia develop after a sudden onset of psychological, social, or medical stress, and typically persist long after the original causal factors resolve, due to the development of heightened arousal and negative conditioning.

Treatment

Orexin-A and -B (also known as hypocretin-1 and -2) are neuropeptides produced in the lateral hypothalamus that promote many aspects of arousal through the OX1 and OX2 receptors. In fact, they are necessary for normal wakefulness, as loss of the orexin-producing neurons causes narcolepsy in humans and rodents. This has generated considerable interest in developing small-molecule orexin receptor antagonists as a novel therapy for the treatment of insomnia. Orexin antagonists, especially those that block OX2 or both OX1 and OX2 receptors, clearly promote sleep in animals, and clinical results are encouraging: Several compounds are in Phase III trials. As the orexin system mainly promotes arousal, these new compounds will likely improve insomnia without incurring many of the side effects encountered with current medications (Scammel & Winrow, 2010). Acupuncture and cupping have shown significant effects in treating insomnia in college students (Zhang, Ren, & Zhang, 2010).

PROPOSED CHANGES IN DSM-5 (DSM5.org)

Insomnia Disorder

A. The predominant complaint is dissatisfaction with sleep quantity or quality made by the patient (or by a caregiver or family in the case of children or elderly).

B. Report of one or more of the following symptoms:

- Difficulty initiating sleep; in children this may be manifested as difficulty initiating sleep without caregiver intervention
- Difficulty maintaining sleep characterized by frequent awakenings or problems returning to sleep after awakenings (in children this may be manifested as difficulty returning to sleep without caregiver intervention)
- Early morning awakening with inability to return to sleep
- Non restorative sleep
- Prolonged resistance to going to bed and/or bedtime struggles (children)

C. The sleep complaint is accompanied by significant distress or impairment in daytime functioning as indicated by the report of at least one of the following:

- Fatigue or low energy
- Daytime sleepiness
- Cognitive impairments (e.g., attention, concentration, memory)
- Mood disturbance (e.g., irritability, dysphoria)
- Behavioral problems (e.g., hyperactivity, impulsivity, aggression)
- Impaired occupational or academic function
- Impaired interpersonal/social function
- Negative impact on caregiver or family functioning (e.g., fatigue, sleepiness

D. The sleep difficulty occurs at least three nights per week.

E. The sleep difficulty is present for at least three months.

F. The sleep difficulty occurs despite adequate age-appropriate circumstances and opportunity for sleep.

Duration:

1. Acute insomnia (<1 month)
2. Sub acute insomnia (1-3 months)
3. Persistent insomnia (> 3 months)

Clinically Comorbid Conditions:

- Psychiatric disorder (specify)
- Medical disorder (specify)
- Another disorder (specify)

Rationale For Changes

This new terminology reflects a change in paradigm, recommended by NIH (2005), and widely adopted in the sleep community. Making a reliable differential diagnosis between "Primary Insomnia" and "Insomnia related to another disorder" implies that a clinician can identify the cause and the consequence of the main condition, a determination that is often difficult, if not impossible to make. We recommend using "Insomnia Disorder" whenever diagnostic criteria are met, whether or not there is a co-existing psychiatric, medical, or another sleep disorders. The presence of any of these disorders can still be coded separately. Adopting this new paradigm/terminology would preclude using criteria C, D, E from DSM-IV.

CRITERION A

The addition of dissatisfaction to the insomnia definition may improve detection of clinically significant insomnia relative to a single focus on insomnia symptoms. Also, dissatisfaction is more strongly related to daytime impairments compare to insomnia symptoms alone.

References:

- Ohayon, M. M. (2002). “Epidemiology of insomnia: What we know and what we still need to learn.” Sleep Medicine Reviews 6(2): 97-111.
- Ohayon, 2009. Secondary analyses.
- Early morning awakening can be the only presenting insomnia symptom and this does not necessarily have the same presentation or significance as nocturnal awakenings with difficulty returning to sleep. This addition may enhance specificity of symptoms/diagnosis and, potentially, treatment.
- References:
- Hohagen, F., C. Kappler, et al. (1994). “Sleep onset insomnia, sleep maintaining insomnia and insomnia with early morning awakening–temporal stability of subtypes in a longitudinal study on general practice attenders.” Sleep17(6): 551-554.
- Morin, C. M., M. LeBlanc, et al. (2006). “Epidemiology of insomnia: prevalence, self-help treatments, consultations, and determinants of help-seeking behaviors.” Sleep Medicine 7(2):
- CRITERION B
- The examples of impairments may facilitate assessment of the impact of insomnia on daytime functioning.
- References:
- Buysse, D. J., W. Thompson, et al. (2007). “Daytime symptoms in primary insomnia: a prospective analysis using ecological momentary assessment.” Sleep Medicine 8(3): 198-208.
- Edinger, J. D., M. H. Bonnet, et al. (2004). “Derivation of research diagnostic criteria for insomnia: report of an American Academy of Sleep Medicine Work Group.” Sleep 27(8): 1567-96.

CRITERION C

The frequency of occurrence of insomnia symptoms is an important determinant of morbidity/impairment. Although arbitrary, the proposed cut-point is consistent with ICD-10 and with those typically used in clinical research. This change would contribute to harmonizing criteria across diagnostic nosologies.

References:

- Ohayon (2009). Secondary analysis

CRITERION D

The 1-month threshold is a very short period of time to define insomnia as chronic and persistent. Insomnia lasting only 1 month might be better conceptualized as an episode of insomnia rather than an insomnia disorder. Morbidity may also increase with insomnia duration longer than one month.

References:

- Ohayon (2009). Secondary analyses.
- Morin, C. M., Belanger, L. et al. (2009). “The natural history of insomnia: a population-based 3-year longitudinal study.”Arch Intern Med 169(5): 447-53.

CRITERION E

Consistent with the Research Diagnostic Criteria, this specification can be helpful to distinguish clinical insomnia from volitional sleep deprivation.

References

- Edinger, J. D., M. H. Bonnet, et al. (2004). “Derivation of research diagnostic criteria for insomnia: report of an American Academy of Sleep Medicine Work Group.” Sleep 27(8): 1567-96.

COMORBID CONDITIONS

Although we wish to move away from the previous conceptualization of insomnia as primary or secondary, it would be helpful to still code the presence of any comorbid psychiatric, medical, or other sleep disorders.

Relationship to International Classification of Diseases 10

Nonorganic Insomnia F 51.0, Disorders of initiating and maintaining sleep (insomnias) G 47.0

Relationship to International Classification of Sleep Disorders 2nd Edition

Psychophysiological, paradoxical and idiopathic insomnia 307.42

Severity

1. Insomnia Severity Index

2. PROMIS Sleep-Wake Disurbance Self-Report (preliminary in development now)

3. Women's Health Initiative Insomnia Rating Scale

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6.114: Factitious Disorders (300.19)

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

Gasner 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.

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6.115: Intermittent Explosive Disorder (312.34)

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-injurous 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-injurous behavior (McCloskey, Ben-Zeev, Lee & Coccaro, 2008).
- It was also found that women were at an increased risk for self-injurous 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 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.

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6.116: Kleptomania (312.32)

A kleptomaniac is not someone who shoplifts on occasion or who steals because they are in need. Kleptomania is defined as the repeated failure to resist the impulse to steal, even when the item is not taken for personal use or for its monetary value (Bayer, 2000). It involves the desire to steal more than the need for the item (Bayer, 2000). A person with kleptomania feels gratification and relief while he or she steals. After stealing, the person is likely to give away, throw away, hoard, or return the items he or she took (Bayer, 2000). People with this impulse-control disorder realize that stealing is wrong and may feel guilty about their behavior, but they are unable to stop themselves from performing the act.

Kleptomania is not an expression of an emotion, an act of rebellion, or an antisocial gesture (Bayer, 2000). Furthermore, it is not a part of a delusional or hallucinogenic experience (Bayer, 2000). Kleptomaniacs do not usually plan the theft ahead of time, and they rarely steal with help from other people (Bayer, 2000). Comorbid disorders may include mood disorders, eating disorders, and anxiety disorders (Bayer, 2000). Getting caught in the act can cause serious legal, social, and occupational problems for people with this disorder. However, kleptomania may persist for years, regardless of apprehension and conviction (Bayer, 2000).

Unlike ordinary stealing, kleptomania is quite rare. According to the DSM-IV, only about 5% of shoplifters are kleptomaniacs. This disorder afflicts more women than men, unlike intermittent explosive disorder, pathological gambling, and pyromania.

Because it is rare and not well-studied, researchers have not yet agreed upon the most effective treatment for kleptomania (Bayer, 2000). Most people with the disorder are likely to keep it a secret and not seek treatment unless they are caught, due to the shame that they feel (Bayer, 2000). It seems that the most effective treatment usually involves a combination of therapies, including medication, psychotherapy, and behavior modification (Bayer, 2000).

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 an emotional disturbance rather than economic need. It is frequently observed in patients who are “chemically dependent” or who 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. They often feel guilty after committing theft and surreptitiously return the stolen items. If the items, usually of lesser importance, are not 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 or for social acceptance; this should not be diagnosed as kleptomania.

Child vs. adult presentation

It is difficult to assess the differences in presentation of kleptomania among children and adults. This is because it is virtually impossible to distinguish if children are stealing because of a disorder or if it is because they do not know any better. 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.

Gender and cultural differences in presentation

Kleptomania occurs slightly more often in males than in females. No information is available regarding cultural differences in the presentation of kleptomania.

Epidemiology

Studies suggest that approximately 0.6% of the general population that may have this disorder. Studies also suggest that it is more prominent in females. Other studies, interestingly, have found high comorbidity rates (65%) of kleptomania in patients with bulimia. Also, approximately 0.7% of patients also have a history of obsessive-compulsive disorder.

Course

The DSM-IV-TR identifies three courses of kleptomania:

1. sporadic stealing with brief episodes and long periods of remission
2. episodic stealing with protracted periods of stealing and periods of remission
3. chronic stealing, in which the individual steals constantly, with some degree of fluctuation

The disorder may continue for years, despite convictions for shoplifting.

Etiology

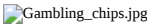
- One theory suggests that receiving the thrill of stealing can aid in alleviating symptoms in people who are clinically depressed. Individuals with kleptomania never seek aid in the act of theft and never plan to steal with others present. There may be favored objects or environments where thefts occur, but detection of kleptomania, even by family, is difficult. Consequently, 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 an 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 during initial psychological assessments. It is most commonly addressed when one comes in for other reasons such as depression, bulimia, or emotional instability. 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.
- Treatments will vary concerning this disorder. It begins with an extensive psychological assessment. The patient then undergoes 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, are included in the treatment.
- Several medications have been shown to work, but effectiveness depends on other mental disabilities the individual may have. Antidepressants, such as Prozac, are the most commonly used medications to treat kleptomania. These are serotonin re-uptake inhibitors. Side-effects often occur, so patients should consult doctor if any occur. Mood stabilizers can also be used to stabilize the individual's mood. These are meant to keep the patient from having rapid or uneven mood changes that may trigger them to steal. An example of this includes lithium, which is shown to be somewhat helpful. Benzodiazepines can also be used, but the effectiveness often varies from person to person. Individuals may eaisily 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 such as Revia, an opioid antagonist that is most commonly prescribed for kleptomania. This drug blocks the part of the brain that feels pleasure during certain addictive behaviors, reducing the patient's urge to steal.

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6.117: Pathological Gambling (312.21)


Gambling_chips.jpg

Pathological gambling (PG) involves being unable to resist the impulse to gamble. The transition from recreational gambling to pathological gambling may occur gradually, or it may transition suddenly in response to a stressful event such as job loss (Bayer, 2000).

Some features associated with pathological gamblers include denial, overconfidence, delusions of grandeur, development of superstitions, highly competitive, and overly concerned with approval from others (Bayer, 2000). In order to be diagnosed as a pathological gambler, the individuals symptoms must be persistent and recurrent, and the individual must be preoccupied with reliving past gambling experiences or planning future gambling excursions (Bayer, 2000). After some time, the individual may feel compelled to take higher risks to produce the desired level of excitement. This disorder can result in a host of occupational, social, and legal problems. Compulsive gamblers often find themselves lying to their family members and friends to hide the severity of their problem. They may even resort to illegal, but typically nonviolent, means of acquiring money to gamble (Bayer, 2000).

Compulsive gamblers are more prone to medical conditions that are brought about by stress such as hypertension, peptic ulcers, and migraine headaches (Bayer, 2000). They may also have comorbid mood disorders, substance-related disorders, antisocial behavior, attention-deficit disorder, or hyperactivity (Bayer, 2000). Compulsive gambling can be confused with bipolar disorder, which sometimes accompanies compulsive gambling (Bayer, 2000).

This impulse-control disorder is more common among men than women. Women who do have this disorder are often hesitant to seek treatment; this may be because society tends to view gambling as less acceptable for women than men.

Pathological gambling typically begins in adolescence for boys and later in life for girls (Bayer, 2000). It may be regular or episodic, but it is often chronic (Bayer, 2000). Environmental stressors or depression may increase the frequency of gambling (Bayer, 2000).

Treatment for compulsive gambling includes inpatient & outpatient programs, residential care, halfway houses, behavior modification, individual and group therapy, and traditional psychoanalysis (Bayer, 2000). Relapses are common.

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 gambling despite compounding severe negative consequences. Individuals with PG may present distortions in thinking and may believe that money is both the cause and solution to all of their problems. Individuals with PG tend to be highly competitive, energetic, and easily bored. They may be overly concerned with others’ approval and may be extravagantly generous. When they are not gambling, they may considered to be workaholics or “binge” workers. They may be at risk for medical

conditions associated with stress, and those seeking treatment have high rates of suicidal ideation and attempts. Individuals who suffer from PG often have problematic interpersonal relationships. These relationships become increasingly strained during the progression of the disorder. Some individuals with PG may try to legally finance gambling and living expenses through loans. Others 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 with alcohol abuse and depression. A 1992 study showed that 12.9% of heavy drinkers had a gambling problem, 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. 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 by Timothy W. Fong, gambling is a media-driven, socially acceptable form of behavior. Fong also noted that 86% to 93% of all adolescents have gambled for money at least once (2006). Seventy-five percent of those did it within the confines of their home, while 85% of parents did not care (Fong, 2006). Fong stated that adolescent gambling is the most popular risk-taking behavior seen in adolescents, trumping cigarettes, alcohol, drugs, and sex (2006). The reasons why adolescents start gambling in comparison to the reasons why adults start gambling are very different. Adolescents use gambling as a form of excitement, a relief of boredom, and a coping mechanism or relief from daily stress. Adolescents have a need to keep playing for spectator success, and gambling is a social acceptable form of competition.

Gender and cultural differences in presentation

More men than women are diagnosed with pathological gambling, with a 2:1 ratio, and men have a higher tendency to start at a younger age. Gambling usually begins in early adolescence in men and from ages 20-40 in women. Culturally, pathological gambling is more prevalent in minority groups. Socioeconomic status also strongly correlates; it is more common in poor individuals who cannot afford to gamble and who inevitably feel as though they cannot afford not to gamble.

Epidemiology

- As gambling facilities become more prevalent, so do PG 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. Prevalence rates in other countries vary. Worldwide rates range from 2% to 6%.
- Pathological gambling usually begins in early adolescence in males and later in life in females. A few individuals are “hooked” with their first bet, but for most the course is more insidious. Years of social gambling may be followed by an abrupt onset that may be precipitated by greater exposure to gambling or to some stressor. The pattern may be regular or episodic, and the course of the disorder is often chronic.

Etiology

The causes do not seem to be biological as there is no evidence to support it. A psychological cause 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.

Empirically supported treatments

- Treatment for PG includes therapy and possibly medication. Before treatment can begin, the individual 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 several of the people who stay in treatment, it is successful. On average, however, 50% drop out of the therapy.
- Aversion therapy is one option available to pathological gamblers. During aversion therapy, 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 are also available.
- It is often recommended that the individual never return to gambling. It is also recommended that the individual never return to the places that he or she gambled, because returning causes the patient to be at high risk for a relapse.
- Medications such as antidepressants and opioid antagonists (naltrexone) may help, also.
- Follow this link to see more stats on gambling and to see what some of the signs are to help spot someone with a gambling problem: http://www.overcominggambling.com/facts.html

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6.118: Pyromania (312.33)



Pyromania is characterized by multiple deliberate attempts at fire setting that can provide the individual with psychological gratification and relief (Bayer, 2000). The diagnosis of pyromania does not apply if a person sets fire because he or she is mentally retarded, intoxicated, or has impaired judgment due to a medical condition (Bayer, 2000). An individual is not diagnosed with pyromania if he or she sets fire because of some other psychological disorder (Bayer, 2000). People with pyromania do not set fires to express their emotions, to make money, or to support a political ideology (Bayer, 2000). Their intention is not to destroy evidence of criminal activity or to improve their living situation (Bayer, 2000). Additionally, their fire setting is not a response to a delusion or hallucination (Bayer, 2000).

People with pyromania are fascinated by fire and may be attracted to fire-related equipment such as fire trucks, hoses, and hydrants (Bayer, 2000). They may deliberately seek to observe fires, set false alarms, or associate with fire departments or firefighters (Bayer, 2000). They may spend a great deal of time preparing to set fires (Bayer, 2000). They may be indifferent to the loss of life and property that the fires cause (Bayer, 2000). They may even derive pleasure from thinking about the destruction, danger, and consequences of the fires (Bayer, 2000). Since the individual often derives pleasure from being near fires and the results, he or she often stays in the vicinity of the scene after a fire has been set (Bayer, 2000).

This impulse-control disorder is somewhat rare. Pyromania typically begins in childhood. Males are diagnosed more often than females, particularly males with poor social skills and learning difficulties (Bayer, 2000). The course of the disorder may wax and wane (Bayer, 2000). The disorder often lasts only a few years or during a specific period of an individual's life (Bayer, 2000). Often, it initially appears during a crisis and disappears after the crisis has dissolved (Bayer, 2000).

Fire Play Versus Fire Setting:

Fire Play (childhood experimentation)	Fire setting (pyromaniac behavior)
1. The incident occurred only once.	1. The behavior has recurred.
2. The action was unplanned.	2. The action was planned.
3. The individual burned paper, trash, or leaves.	3. The individual used flammable or combustible material to ignite property of some value.
4. The individual burned garbage or his or her own property.	4. The individual burned someone else's property, an animal, or a person.
5. The individual went for help or called the fire department.	5. The individual ran away.
(Bayer, 2000)	

DSM-IV-TR criteria

- A. Deliberate and purposeful fire setting on more than one occasion.
- B. Tension or affection arousal before the act.
- C. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences).
- D. The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, in response to a delusion or a hallucination, or as a result of impaired judgment (e.g., in dementia, mental retardation, substance intoxication).
- E. The fire setting is not motivated by monetary gain, sociopolitical ideology, anger or revenge, psychotic thinking (delusions or hallucinations), or to conceal criminal activity.
- The fire setting is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder.

Associated features

Individuals with pyromania often have a difficult time controlling themselves, specifically in situations that are harmful to themselves and others. They may make considerable advance preparation for starting a fire, and may be indifferent to the consequences of their actions. They may derive pleasure from the resulting destruction. Those with head injuries or epilepsy are at an increased risk of developing and impulse control disorder. Researchers have noticed an increase in impulse-control disorders in older patients with Parkinson's disease due to the effect of the dopaminergic drugs. There has also been a correlation with pyromania and learning disabilities and cruelty to animals.

Child vs. adult presentation

- The age of onset for pyromania is approximately 18 years of age. It is extremely rare for a child younger than adolescence to develop pyromania. It is also rare for an older adult to develop the disorder. Those older than adolescence tend to develop primarily pathological gambling.
- It is rare for children to have it, but it can occur in children as young as three years old. Most of the time, parents recognize the behaviors and get it treated before it becomes a problem.

Gender and cultural differences in presentation

Males have a much higher risk for developing pyromania than females. Approximately 90% of those diagnosed with pyromania are male. There are no cultural differences in the presentation of this disorder. People from many different cultures show the same symptoms.

Epidemiology

- It is a very rare disorder, with less than 1% of the population meeting the diagnostic criteria.
- Most of the research done on pyromania has not focused on the epidemiology. It is only known that there is a higher prevalence of pyromania in men than women.
- It is known that about 9% of the population have impulse-control problems that include pyromania.
- Only 14% of fires are started by people with pyromania and other mental disorders.

Etiology

- Although little research has been done on the etiology of pyromania, it is believed that the cause can be targeted during childhood. Many researchers say that possible causes can be an abusive family environment or mild brain trauma.
- Some suggest that pyromania may be a form of communication from those that have few social skills.

Empirically supported treatments

- Counseling and medication are both preferred for treating pyromania. So far, behavior modification has been found to be the best treatment this disorder.
- Treatment of adults and children with pyromania is often individualized based on the patient's presenting problems and history. Treatment of children with this disorder often begins with an assessment of the child's life and includes the evaluation of such factors as stressors on the child, home discipline, and supervision of the child. This assessment is generally followed by a case-management approach, rather than a medicinal approach, where the treatment is tailored to the child and involves a variety of approaches, such as anger management and communication skills.
- Treatment of adults with pyromania is often approached differently. Because adult patients with this disorder tend to be uncooperative, they are generally treated with a combination of medication and psychotherapy. Usually the patient is treated with a selective serotonin reuptake inhibitor (SSRI), but there have also been multiple case reports of tricyclic antidepressants and monamine oxidase inhibitors (MAIOs) being useful in impulse control disorders.
- Treatments work in 95% of children that exhibit signs of pyromania.

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6.119: Vaginismus (306.51)

DSM-IV-TR criteria

- A. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.
- B. The disturbance causes marked distress or interpersonal difficulty.
- C. The disturbance is not better accounted for by another Axis I disorder (e.g., Somatization Disorder) and is not due exclusively to the direct physiological effects of a general medical condition.
- Specify type:
  - Lifelong Type
  - Acquired Type
- Specify type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

Associated Features

- Vaginismus, or spasm of the muscle surrounding the vagina often occurs in response to attempted intercourse, but can also occur in response to penetration by a finger, tampon, or speculum. Although this disorder is listed as a pain disorder, pain is not a necessary condition for the diagnosis. Vaginismus may be best defined as a phobic/aversive response to vaginal penetration.
- There are two types of vaginismus: Primary and Secondary. Primary vaginismus occurs in women who have never been able to have pain-free intercourse. Secondary vaginismus is due to a medical condition, surgery, traumatic event, childbirth, or menopause.
- Individuals suffering from Vaginismus disorder display symptoms such as trouble or impossibilities with sexual penetration and pelvic examination.

Child vs. adult presentation

Vaginismus is a disorder that occurs in women. Children do not have to worry about it, although, Vaginismus could be linked to sexual trauma as a child, or teen.

Gender and cultural differences in presentation

- Vaginismus is only present in females.
- Research shows that 0.17% of women in the United Kingdom have this disorder. Also, 5 out of 1000 marriages in Ireland reported having this problem.
- The problem occurs in 1% to 6% of women and is highly comorbid with dyspareunia.

Epidemiology

- A study in 1993 by Rosen and colleagues estimate that the rates of vaginismus range from 5% to 17%.
- 2 out of 1000 women have this. However, it could be higher, because women are embarrassed and it is not commonly known about and often misdiagnosed.
- In the United States, 47% of women with this disorder are single or dating, while 53% are married.
- The majority (53%) are ages 26 to 35. Next, women aged 36-50 make up 26% of those with the disorder. 18% are 25 or younger and 9% are 51 or older.

Etiology

- Non-physical causes are fears, anxiety, stress, traumatic event, childhood experiences, and partner issues. Sometimes, there is no known cause at all. Physical causes are medical conditions, childbirth, abuse, menopause, pelvic trauma, and temporary discomfort.

- Most common causes are fears and anxiety about intercourse and pain. Anxiety due to performance pressures and negativity towards sex can also cause a woman to experience this. Partner issues such as abuse, distrust, and fear of commitment are causes as well. Childhood experiences like overly rigid parenting, inadequate sex education, and exposure to shocking sexual imagery can lead to vaginismus.

Empirically supported treatments

- It is very treatable and most cases do not require medications. It includes a combination of pelvic floor control exercises, training for insertion or dilation, and learning techniques for pain elimination. These treatments can be done from home, however, it is helpful to have the support of a partner in a therapy-like setting.
- Vaginismus is generally treated with behavioral exercises in which plastic vaginal dilators of increasing size are inserted to help relax the vaginal musculature. A gynecologist usually demonstrates by inserting the narrowest dilator. The woman then increases the size of dilator as she becomes capable of tolerating insertion and containment (for 10 or 15 minutes) without pain or discomfort. Psychological treatment may also be necessary if the woman has a history of sexual trauma.
- According to the behavioral view, treatment of vaginismus involves a reconditioning of the bodies response to feared objects such as the penis, a speculum, or a tampon, much like the treatment approach for other specific phobias. Using a systhematic desensitization approach, the woman is asked to create a hierarchy of feared objects that she will then progressively work through to insert vaginally over the course of treatment.

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6.12: Obsessive-Compulsive Disorder (OCD)

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 or 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 comorbids 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 Christina 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 mediated 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 a 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 specifer 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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6.120: Transvestic Fetishisim

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 heath, 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 healthly 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 Fetishisim. 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 Fetishisim. 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 Fetishisim 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 Fetishisim.

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.

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6.121: Female Sexual Arousal Disorder (302.72)

DSM-IV-TR criteria

- A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.
- B. The disturbance causes marked distress or interpersonal difficulty.
- C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- Specify type:
  - Lifelong Type
  - Acquired Type
- Specify Type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors
- Limited evidence suggests that Female Sexual Arousal Disorder is often accompanied by Sexual Desire Disorders and Female Orgasmic Disorder. The individual with Female Sexual Arousal Disorder may have little or no subjective sense of sexual arousal. The disorder may result in painful intercourse, sexual avoidance, and the disturbance of marital or sexual relationships.

Associated Features

- Personal relationship problems
- Inability to attain or maintain adequate physical response to sexual excitement. It is considered a disorder when it causes distress or interpersonal conflict

Child vs. adult presentation

Gender and cultural differences in presentation

Epidemiology

Inhibited female orgasm ranged from 18% to 76% in clinics, but only 5% to 20% in community samples. Similarly up to 62% of females seeking sex therapy experience arousal disorder, while community estimates are closer to 11%.

Etiology

May be associated with specific settings, situations and relationships or generally present in all sexual settings. It may be due to psychological factors or a combination of psychological and physical factors.

Empirically supported treatments

- Relaxation techniques and various creams and jellys are suitable lubricants and may help to alleviate the discomfort
- There is a clitoral device called Eros that was approved y the Food ad Drug Administration in 2000 and is available by prescription. The clitoris swells during sexual arousal because of vasocongestion, and vasocongestion increases clitoral sexual sensations, thus moving somewhat in step with sexual interest and lubrication. This device creates a gentle suction over the clitoris, increasing vasocongestion and sexual sensations (Leland, 2000).
- The psychological portion of treatment is directed at teaching how to focus on pleasurable thoughts and feelings about sex
- It is recommended that the sufferer discuss this matter with her gynecologist.

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6.122: Fetishism (302.81)

DSM-IV-TR criteria

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).

Associated Features

- May be employed or undertake volunteer work to enable behavior to be practiced. For example, taking a job in a shoe shop in the case of a shoe fetish.
- Early symptoms for a fetish involve excessive touching of the object of desire. The amount of time spent thinking about the fetish object may increase. Over time, the importance of the fetish object expands. In the extreme, it becomes a requirement for achieving sexual pleasure and gratification.
- The word fetish comes from the French fe'tiche, which is thought to derive from the Portuguese feitico, meaning "magic charm."
- Fetishism is related to the paraphilia, partialism, which is where people are excessively aroused by a particular body part, such as the feet, breasts, or buttocks.

Gender and cultural differences in presentation

Child vs. adult presentation

Fetishism typically begins by adolescents, although the fetish may have been endowed with special significance earlier in childhood, therefore, children and adults present with this Paraphilia.

Epidemiology

Etiology

The association between an object and sexual arousal may be adolescent curiosity or a random association between the object and feelings of sexual pleasure. A random association may be innocent or unappreciated for its sexual content when it initially occurs. For example, a male may enjoy the texture or tactile sensation of female undergarments or stockings. At first, the pleasurable sensation occurs randomly, and then, in time and with experience, the behavior of using female undergarments or stockings as part of sexual activity is reinforced, and the association between the garments and the sexual arousal is made. A person with a fetish may not be able to pinpoint exactly when his or her fetish began. A fetish may be related to activities associated with sexual abuse.

Empirically supported treatments

Most persons who have a fetish never seek treatment from professionals. Most are capable of achieving sexual gratification in culturally appropriate situations. As of 2002, American society seems to have developed more tolerance for persons with fetishes than in the past, thus further reducing the already minimal demand for professional treatment.

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6.123: Generalized Anxiety Disorder

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 woozles (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.

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6.124: Dissociative Amnesia (300.12)

Dissociative Amnesia could be brought on by a Traumatic Event.

It used to be known as Psychogenic Amnesia. The crucial feature of this type of dissociative disorder is the failure to recall important personal information more extensive than explained by an individual's normal forgetfulness. The nature of the information is usually traumatic or stressful. (American Psychiatric Association, 2000)

Mental illness

- Patient is alert or oriented.
- Patient is subadequately related with limited eye contact.
- Speech is slow and logical.
- Attention and concentration are limited.
- Energy level is not characterized by hyperactivity or slowing.
- Recent memory may be slightly impaired.
- Remote memory is intact.
- Mood is anxious or dysphoric.
- Affect is constricted.
- A negligible degree of conceptual disorganization is present.
- Reasoning and judgment are limited, and insight is lacking.
- An increased likelihood of passive suicidal ideation as well as violent ideation, sometimes even homicidal, is present, most likely due to severe frustration of the dissociation.

The DSM-IV-TR criteria according to the American Psychiatric Association (2000) includes the following:

- A. "The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness" (p. 523).
- B. "The disturbance does not occur exclusively during the course of Dissociative Identity Disorder, Dissociative Fugue, Posttraumatic Stress Disorder, Acute Stress Disorder, or Somatization Disorder and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a neurological or other general medical condition (e.g., Amnestic Disorder due to head trauma)" (p. 523).
- C. "The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 523).

Associated features for dissociative amnesia according to the American Psychiatric Association (2000) are:

- Dissociative amnesia occurs when a person blocks out certain information, usually associated with a stressful or traumatic event.
- With this disorder, the degree of memory loss goes beyond normal forgetfulness and includes gaps in memory for long periods of time or of memories involving the traumatic event.
- Some individuals with this disorder report trance states, spontaneous age regression, anxiety, depersonalization, analgesia, depressive symptoms, and they may provide approximate, though incorrect, answers to questions.
- This disorder may be accompanied by sexual dysfunction, self-mutilation, suicidal impulses and acts, and impairment in social functioning, and they may meet criteria for Conversion Disorder, Mood Disorders, Substance-Related Disorders, or Personality Disorders. There is a lack of damage to the brain, but brain images do show abnormal activity. Results of FMRI's suggest that, during an amnesiac episode, patients are unable to retrieve emotional memories normally, suggesting possible changes in the limbic system.

Child vs. Adult presentation

- Dissociative Amnesia is more common among young adults than in older adults but can occur at any age past infancy. It is difficult to assess in preadolescent children, as it may be confused with inattention, anxiety, psychosis, oppositional behavior, or developmentally appropriate childhood amnesia.
- Gender and cultural differences in presentation.

- Dissociative Amnesia is more common among women than men.

Epidemiology

- “There has been an increase in reported cases of Dissociative Amnesia that involves previously forgotten early childhood traumas. This increase has been subject to very different interpretations. Some believe that the greater awareness of the diagnosis among mental health professionals has resulted in the identification of cases that were previously undiagnosed. In contrast, others believe that the syndrome has been over-diagnosed in individuals who are highly suggestible.” (American Psychiatric Association, 2000)
- “Dissociative Amnesia can be present in any age group. The main symptom is a retrospective gap in memory. The reported duration of the forgotten events varies. Only a single episode may be reported, although there are commonly two or more episodes described. Individuals who have had one episode may be predisposed to develop amnesia for subsequent traumas. Acute Amnesia may resolve spontaneously after the individual is removed from the circumstances with which it is associated. Some may begin to recall distant memories, while others may develop a chronic form of amnesia.” (American Psychiatric Association, 2000)

Etiology

Dissociative amnesia has been linked to overwhelming stress, which might be the result of traumatic events—such as war, abuse, accidents or disasters—that the person has experienced or witnessed. There also might be a genetic link to the development of dissociative disorders, including dissociative amnesia, people with these disorders usually have close relatives who have had similar conditions. (American Psychiatric Association, 2000)

Differential diagnosis

- The differential diagnosis of DA are any organic metal disorders, dementia, delirium, transient global amnesia, Korsakoff’s disease, post-concussion amnesia, substance abuse, other dissociative disorders, and malingering, factitious disorders.
- Memory loss in organic metal disorders is typically gradual and incomplete. Clinicians may encounter difficulty in differentiating between substance abuse and DA because many patients minimize their abuse and also misattribute their amnesia to alcohol or drugs because of their of a diagnosis of dissociation. Obtaining a careful history from multiple informants is often necessary to clarify the situation. However, unlike DA, memory loss due to substance abuse is seldom reversible.
- Korsakoff disease may also be confused with DA. This disease, also known as alcohol amnestic disorder, is associated with heavy and prolonged alcohol abuse and is not associated with psychological stress. However, unlike DA, patients with Korsakoff disease are not able to learn new information and they often experience significant deterioration in personal functioning.
- Amnesia from brain injury or head trauma can be differentiated from DA based on a history of trauma; patients usually have retrograde amnesia before the trauma, unlike patients with DA, who have anterograde amnesia. In addition, patients with brain injury do not show the susceptibility or response to hypnosis so frequently observed in patients with dissociative disorders. Because dissociative disorders are associated with some evidence of biology causality, not every case of trauma results in symptoms that produce the disorder, nor does every person with the disorder have a history of childhood or adult trauma. (American Psychiatric Association, 2000)

Indications for hospitalization

In most instances in which patients present a clear and present danger to themselves or others, when medication effects must be evaluated, and in instances in which a diagnosis has not been determined, hospitalization is often necessary. Hospitalization allows patients to separate themselves from the environmental stimuli, sexual and physical abuses, and stresses that may be contributing to their reactions and episodes of amnesia, compulsive behaviors, and recklessness. It also protects them during a perplexing period of their lives when they honestly d not know who they are. Other indications are suicidal behavior or gesturing. Patients may experience problems with concentration and feelings of rejection, re-occurrence of preexisting psychiatric conditions, intrusive re-experiencing of trauma or negative thinking, feelings of emotional overwhelm, paranoia or general distrust, and episodes of schizophrenia and fear.

Empirically supported treatments

- Like most other disorders, Dissociative amnesia uses a combination of psychotherapy, cognitive therapy, medicine, family and creative therapy and a new approach- clinical hypnosis.
- Psychotherapy
  - In psychotherapy, the first phase of the treatment is to provide support to the patient. This involves creating a comfortable and supportive atmosphere in the treatment room. Generally the therapist will be there helping the patient to regain their memory, but one study reports that patients regain their memories while at home or surrounded by close friends and family. The patients denied that their memory was regained due to the therapist, but that the therapy did help.
  - The second phase of treatment occurs once the patient has recovered enough of their memories and has had a strong sense of self. The second phase involves helping the patient cope with the traumatic effects as well as the aftereffects.
- Cognitive Therapy
  - Therapy that focuses on changing the thinking pattern and the resulting behaviors.
- Family Therapy
  - Therapy for the family to help teach them about the causes of the disorder. This therapy can also help the family recognize the recurrence of symptoms.
- Creative Therapy
  - Forms of therapy that helps the patient express and explore their thoughts and feelings in a creative and safe manner.
- Medications
  - There is no medicinal cure for amnesia. However, patients may be given antidepressants to help with the anxiety, depression, insomnia, or other symptoms that are associated with dissociative amnesia.
- Clinical Hypnosis
  - Clinical hypnosis is a new approach to amnesia that is used if memories do not return spontaneously. In this treatment, hypnosis or the drug sodium amytal, which puts the patient in a hypnotic state, is used to try to make the memories emerge. Use of intense relaxation and concentrations. This approach allows the patient to explore feelings, thoughts, and memories that may be hidden from their conscious minds.
- “More controversy surrounds the use of hypnotically facilitated techniques to explore areas of amnesia, or to further explore fragmentary images or recollections. Some authorities who support hypnosis for these indications point to the recovery of material that has been confirmed at a later date or to the therapeutic progress often achieved irrespective of the veracity of what is found. Others believe that use of these methods carries the risk that hypnotically facilitated memory processing will increase the patient’s chances of mislabeling fantasy as real memory. They believe that these are strong disincentives to this use of hypnotic exploration.” (Chu, 2005)
- Dissociative amnesia

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- A. Inability to recall important personal information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.
  - Note: There are two primary forms of Dissociative Amnesia: (1) localized amnesia for a specific event or events, and (2) Dissociative Fugue: generalized amnesia for identity and life history. Fugue may be accompanied by either purposeful travel or bewildered wandering.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The memory loss is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a neurological or other general medical condition (e.g., Amnestic Disorder Due to Head Trauma).
- D. The memory loss is not restricted to the symptoms of another mental disorder (e.g., inability to remember an important aspect of the traumatic event in Posttraumatic Stress Disorder or Acute Stress Disorder, or amnesia occuring as a symptom of Dissociative Identity Disorder or Somatization Disorder).

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6.125: Depersonalization Disorder (300.6)

Derealization or depersonalization is characterized by feelings that the objects of the external environment are changing shape and size, or that people are automated and inhuman, and each of them features detachment as a major defense. Depersonalization disorder usually begins in adolescence; typically, patients have continuous symptoms. Onset can be sudden or gradual. There is an estimated 2.4% of the general population that meets the diagnostic criteria for this disorder. However, the prevalence rate is questioned by many clinicians may be lower. This disorder is frequently coexists with mood, anxiety, and psychotic disorders. (American Psychiatric Association, 2000)

Mental Status

- Patients present alert and disoriented in some spheres.
- Both relatedness and eye contact are limited.
- Patient may appear preoccupied and irritable.
- A distressed facial expression with constricted affect is characteristic.
- Reasoning, judgment, and insight are fair to limited.

The DSM-IV-TR criteria according to the American Psychiatric Association (2000) includes the following:

- A. “Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one’s mental processes or body (e.g., feeling like one is in a dream)” (p. 532).
- B. “During the depersonalization experience, reality testing remains intact” (p. 532).
- C. “The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (p. 532).
- D. “The depersonalization experience does not occur exclusively during the course of another mental disorder, such as Schizophrenia, Panic Disorder, Acute Stress Disorder, or another Dissociative 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)” (p. 532).

Associated features

Associated features may include anxiety or depression. Sometimes, individuals have a hard time with sense of time and may have somatic manifestations. Comorbidity can include Obsessive-compulsive, Dysthymic, or Major Depressive disorders. Individuals with Depersonalization disorder may have personality disorders as well. Individuals with Depersonalization Disorder often have difficulty describing their symptoms and may fear that they will be seen as “crazy.” They may also experience derealization in the sense that the external world is unreal, and they may perceive an alteration in the size or shape of objects. People may seem unfamiliar or mechanical. Other features could include obsessive rumination, somatic concerns, a disturbance in the sense of time, and Hypochondriasis. (American Psychiatric Association, 2000)

Child vs. Adult presentation

The disorder is more likely to occur in late adolescence to adulthood.

Gender and cultural differences in presentation

From various studies, equal numbers of men and women are diagnosed. Individuals from individualistic societies are more likely to suffer from the disorder (see Etiology). Some cultures make use of meditative and trance practices which result in experiences of depersonalization and derealization.

Epidemiology

“Although much of the general population experiences a depersonalization experience (whether caused by a traumatic experience or danger, or a drug induced experience), only about 2.4% of the population has been diagnosed with depersonalization disorder. Onset is typical during the teenage years and early 20s, though some report earlier or later onset (the mean age is around 16 years). There can be an acute or insidious onset. When acute, some individuals will remember the time and place of their first depersonalization experience. Insidious onset may reach as far back as one remembers, or it may begin with smaller episodes that increase in severity over time. Duration of episodes may be very brief or persistent. Depersonalization following a life-threatening

situation usually develops suddenly upon exposure to teh trauma. The course is usually chronic and may fluctuate in intensity, but it is sometimes episodic. Actual or perceived stressful events most often exacerbate the symptoms." (American Psychiatric Association, 2000)

Etiology

Similar to the other dissociative disorders, scientists link severe childhood abuse to depersonalization disorders. Brain imaging, including pet scans, show sensory cortex abnormalities. Positron emission tomography scans used to assess brain glucose metabolism show abnormalities in the sensory cortex including the temporal, occipital, and parietal lobes. The sensory cortex controls the senses and perception of an individual's body in space. Lower levels of nerve cell responses in the area of the brain that controls emotion may correlate to the emotional detachment that individual's feel during an episode of depersonalization. Western cultures where individuals live in a more individualistic society, may be more likely to suffer from a depersonalization disorder. Individualism is stressed in most Western cultures and may have an effect on an individual's sense of self. (American Psychiatric Association, 2000)

Empirically supported treatments

- "Treatment recommendations and guidelines for depersonalisation disorder have not been established. There are few studies assessing the use of pharmacotherapy in this disorder. Medication options that have been reported include clomipramine, fluoxetine, lamotrigine and opioid antagonists. However, it does not appear that any of these agents have a potent anti-dissociative effect. A variety of psychotherapeutic techniques has been used to treat depersonalisation disorder (including trauma-focused therapy and cognitive-behavioural techniques), although again none of these have established efficacy to date. Overall, novel therapeutic approaches are clearly needed to help individuals experiencing this refractory disorder." (Simeon, 2004)
- Treatment for this disorder is more about treating the symptoms of the disorder or stresses associated disorder, more than the disorder itself. Treatments for the stresses include Psychotherapy, Cognitive Therapy, medications, Family therapy, Creative Therapies, and Clinical hypnosis.
- Psychotherapy
  - A type of counseling and is the primary treatment for dissociative disorders.
- Cognitive Therapy
  - Therapy that focuses on changing the thinking pattern and the resulting behaviors.
- Family Therapy
  - Therapy for the family to help teach them about the causes of the disorder. This therapy can also help the family recognize and recurrence of symptoms.
- Creative Therapy
  - Forms of therapy that helps the patient express and explore their thoughts and feelings in a creative and safe manner.
- Medications
  - Antidepressants and anti-anxiety medications are used for the depression and the anxiety often felt by people with this disorder.

A film based on a person suffering from depersonalization disorder:



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6.126: Dissociative Fugue (300.13)

Dissociative Fugue is characterized by sudden, unplanned trips from the home or workplace without the ability to remember some or all of the individual's past. Some of these patients take on new characteristics or aspects not related to their original identity. They tend to be running away from something of which they are unaware. After a fugue episode resolves, patients are unable to remember the events of the state. Although moving occurs in other disorders, in fugue it is purposeful and it is not enacted in a confused or dazed state. In a typical case, the fugue is brief, with purposeful travel, and limited contact with others. About 0.2% of the general population is afflicted with this type of dissociative disorder. (American Psychiatric Association, 2000).

Mental Status

- The mental status exam varies widely.
- Patient may present alert and oriented only to oneself.
- Eye contact and relatedness are limited to fair at best.
- Psychomotor activity is characterized by normal activity.
- Thought processes are intact, although thought content may vary widely from preoccupations to preservations to obsessive fixations to none.
- Reasoning and judgment are lacking, and insight is poor.
- An increased finding of violent or homocidal ideation is present, but suicidal ideation is lacking.

The DSM-IV-TR criteria according to the American Psychiatric Association (2000) includes the following:

- 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" (p. 526).
- B. "Confusion about personal identity or assumption of a new identity (partial or complete)" (p. 526).
- 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)" (p. 526).
- D. "The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 526).

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, guilt, dysphoria, psychological stress, conflict, and suicidal and aggressive impulses, and he may give approximate, though inaccurate, answers to questions. (American Psychiatric Association, 2000)

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. (American Psychiatric Association, 2000)
- Single episodes are most commonly reported and vary in duration. Recovery is usually rapid, but Dissociative Amnesia may sometimes be present. (American Psychiatric Association, 2000)

Etiology

Episodes of Dissociative Fugue are usually triggered by traumatic, overwhelming, 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. (American Psychiatric Association, 2000)

Differential diagnosis

Dissociative fugue includes other dissociative disorders, seizure disorder, amnestic disorder, schizophrenia, mania, dementia (often of the Alzheimer type), malingering, frontal lobe disorders, head trauma and injury, and factitious disorder. Fugue differs from other mental disorders in that the flight behavior is organized and purposeful. Patients with seizure disorder do not assume a new identity and usually have an altered state of conscious with abnormal findings on electroencephalogram testing. (American Psychiatric Association, 2000)

Indications for hospitalization

In making a primary diagnosis, observing the patient in a controlled setting is often necessary. Patients reveal their level of need through interactions with others, inappropriate behavior without remorse, or by verbalizing their symptoms when they are aware of their suffering. In general, hospitalization is indicated when medical or surgical treatment is required, when the diagnosis is unclear, when no safe alternative exist for housing the patient, or as a means of stopping the ongoing abuse. Additionally, any time a patient experiences severe confusion regarding his or her identity or chronic amnesia regarding the total fugue episode, hospitalization if indicated. Hospitalization is also a tool for assessing and administering social services and medication, developing behavior, and ensuring that a patient will respond to medication under the safety and care of medical professionals. And, hospitalization provides containment. Most patients with dissociative fugue symptoms receive acute treatment in general hospital settings and psychiatric departments because they have a tendency to be brought in during an episode. In this way, the hospital provides the safety and treatment mechanism needed for a disorder that, without intervention, remains undiagnosed. Hospitalization most often occurs in order to provide emergency crisis treatment that is best provided in an acute are setting.

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 Maclean's 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). Here is a news video clip on this case.

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Dissociative Fugue subtype:

- 1. Amnesia includes lack of control over how much of a person's past they can recall, confusion about their individual identity, or assumption of a new identity (partial or complete)
- 2. Sudden, unplanned journey away from home or a job.

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6.127: Dissociative Identity Disorder (300.14)



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The above video about Sybil contains content licensed by Warner Bros. Entertainment

DID, formerly refer to as multiple personality disorder, is characterized by the existence of two or more identities or personality traits within a single individual. Patient with this disorders demonstrate transfer of behavioral control among alter identities either by state transitions or by interference and overlap of alters who manifest themselves simultaneously. It is observed in 1-3% of the general population. (American Psychiatric Association, 2000)

Mental Status

- Patient is alert and oriented in all spheres.
- Affect may be labile or irritable.
- Mood is euthymic or anxious.
- Relatedness is very limited, and eye contact is very frequently minimal.
- Thought content may be characterized significant hypervigilance, preoccupations, or hallucinations.
- Patient appears fixed on extraneous or internal stimuli.
- Reasoning and judgment are diminished and insight is poor.
- An overall increase incidence of both suicidal and homocidal ideation in these patients is present.
- Orientation is frequently off.
- Long-term memory is poor.

The DSM-IV-TR criteria according to the American Psychiatric Association (2000) includes the following:

- 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)” (p. 529).
- B. “At least two of these identities or personality states recurrently take control of the person’s behavior” (p. 529).
- C. “Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness” (p. 529).
- 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” (p. 529).

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 or derealization occurs when a person feels unattached to him or herself. During this phenomenon, it is almost as if one can see themselves from another view point. Derealization is when one experiences 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, each child's mind 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, while 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.

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 alternate personality states so they can create a fantasy world in order to escape real life. The average age of onset is in early childhood, generally by the age of four. The average time period for the first symptom to occur to diagnose is 6-7 years. The disorder may go dormant after 40 years of age but may reappear during episodes of stress,trauma or with substance abuse.

Gender and cultural differences in presentation

- Dissociative Identity Disorder has been found in individuals from 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.
- Some researchers report that dissociative symptoms were more common among minorities, but when socioeconomic statues was controlled, that difference disappeared.

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. About 7% of the population may have undiagnosed dissociative disorder. 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%." (American Psychiatric Association, 2000)
- 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. (American Psychiatric Association, 2000)
- Dissociative Identity Disorder has a course that is chronic and recurrent. On average, the time between the appearance of the first symptoms and diagnosis is six to seven years. There have been reports of episodic and continuous courses. The disorder becomes less noticeable beyond age 40, but it may reemerge during episodes of stress or trauma or with Substance Abuse. (American Psychiatric Association, 2000)
- Figures from psychiatric populations (inpatients and outpatients) show a wide diversity from different countries.

Etiology

- The causes are not yet confirmed, but there are some theoretical predictions of what causes DID. They are overwhelming stress, inadequate childhood nurturing, and the inability 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 the “happy place” and reality. (American Psychiatric Association, 2000)

- Research also shows that a mixture of environmental and biological factors may cause DID. (American Psychiatric Association, 2000)

Etiology Different Diagnosis

It is indicated when diagnosing DID, clinicians should consider other disorders such as dissociative disorder, mood disorder, personality disorder, schizophrenia, seizure disorder, eating disorder, malingering, and factitious disorders. A critical important difference between DID and Schizophrenia is that in schizophrenic people they hear voices within their heads, not from the outside. In addition, clinicians must be must be careful relying on historical references to recognize chronic amnesia, symptoms of PTST, a history of maltreatment, and the presence of alter identities that may allow them to make a diagnosis of DID even if other comorbid disorders are observed. (American Psychiatric Association, 2000)

Indications for hospitalization

The treatment of dissociative disorders is difficult and time-consuming and is mostly enacted via behavioral modifications through outpatient therapy. However, in extreme cases or when physical or emotional harm is imminent, hospitalization may be a required intervention. Some of the indications for inpatient assessment or hospitalization include severe depression over a long period, anxiety and delusion disorders that lead to compulsive acting out of behaviors, cognitive reactions (eg, nightmares, flashbacks), physical reactions, fatigue, and interpersonal reactions (eg, conflict, problems with mood regulation, antisocial behavior, physical aggressiveness, suicidal behavior, traumatic and schizophrenic episodes). The ultimate goal for hospitalization of a patient is to ensure immediacy in restoring safey and stability. The patient remains at risk as long as no change in behavior or in approach for generating behavior modifications to improve response to stress and quality of life occurs.

Empirically supported treatments

- Treatment is done to try to reconnect the different personalities to one functional identity. Sometimes, if that does not work, a clinician may try other treatments to help with the symptoms. Some of the possible treatments are psychotherapy or medications for comorbid disorders such as anxiety and depression. They may benefit from medication that is prescribed for the comorbid disorders such as antidepressants or anti-anxiety medication. They may also do 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.
- People with DID may also form mutual self-help support groups within larger communities and online communities.



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The show, The United States of Tara on Showtime is a show that depicts a woman that deals with Dissociative Identity Disorder.



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Tony, in this video, has 53 personalities.



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In this video, a therapist talks about a client whose symptoms often caused others to misdiagnose her.

- Each of the videos contains a person with more than one personality, but all of them including Sybil have a personality that knows about all the others and what is going on.

Dissociative Disorders

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6.128: Dissociative Disorder NOS (300.15)

Associated Features

- Dissociative Disorder NOS includes dissociative symptoms, such as disruption of the usually integrated functions of consciousness, memory, identity, or perception of the environment, but does not meet the criteria for a specific dissociative disorder.

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6.129: Introduction to Somatoform Disorders

Somatoform disorders encompass many mental health disorders. People with these disorders believe that they are sick so they are not “faking” the illness. There is no general medical condition present rather psychological problems are being translated into physical complaints. The people that have this disorder have many symptoms that last for a long time due to the specific cause not being found.

Somatization, the physical expression of emotional distress, is a process and not a disorder unless it interferes with comfort, work and quality of life to the degree that it leads to consultation with physicians, use of medication, and adoption of the sick role (Lipsitt, & Starcevic, 2006).

These disorders cause stress on all of the patient’s relationships as the patient is the only one who is able to “see/feel” the afflicting illness. Diagnosis is difficult because the doctors must be completely sure that a real illness is indeed affecting the patient. Those who suffer from these disorders will often never see just one doctor. This distrust may leak into other relationships as well.

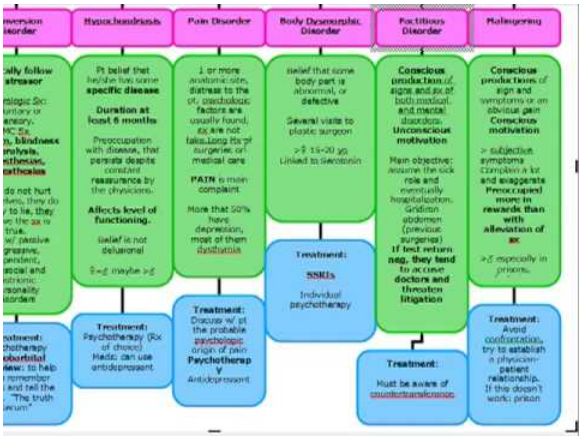
Somatization gained widespread currency when it was introduced as a psychiatric diagnostic term by the authors of the DSM-III in 1980 (Mai, 2004).

It has been proposed that this group of disorders will be renamed Somatic Symptoms Disorder in the DSM-V. These disorders share a common feature in that they all involve both somatic symptoms and psychological concerns for medical condition. Thus, a more appropriate label is proposed.

Quick Facts

- 1 in every 500 adults report having a Somatoform Disorder.
- Roughly 544,00 people in the United States.
- Comorbidty with Substance use/abuse, anxiety disorder, and mood disorders.
- May also be known as also known as Briquet’s syndrome

USMLE – Somatoform Disorder Video



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6.13: Post-Traumatic Stress Disorder (PTSD)

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: E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.
  1. Difficulty falling or staying asleep
  2. Irritability or outbursts of anger
  3. Difficulty concentrating
  4. Hypervigilance
  5. Exaggerated startle response
- 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 comorbids. 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 is 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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6.130: Body Dysmorphic Disorder (300.7)

CNN Report With Behavioral Therapist Arie Winnograd



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DSM-IV-TR criteria

A. Preoccupation with an imagined defect in appearance. If slight physical anomaly 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).

- BDD has a delusional form that is classified in the psychosis section of DSM-IV (Didie, Kelly, & Phillips, 2010).

Barlow and Durand (2009) give an example of BDD:

In his mid-20s, Jim was diagnosed with suspected social phobia; he was referred to our clinic by another professional. Jim had just finished rabbinical school and had been offered a position at a synagogue in a nearby city. However, he found himself unable to accept because of marked social difficulties. Lately he had given up leaving his small apartment for fear of running into people he knew and being forced to stop and interact with them.

Jim was a good-looking young man of about average height, with dark hair and eyes. Although he was somewhat depressed, a mental status exam and a brief interview focusing on current functioning and past history did not reveal any remarkable problems. There was no sign of a psychotic process (he was not out of touch with reality). We then focused on Jim's social difficulties. We expected the usual kinds of anxiety about interacting with people or "doing something" (performing) in front of them. But this was not JIm's concern. Rather, he was convinced that everyone, even his good friends, were staring at a part of his body that he found grotesque. He reported that strangers would never mention his deformity and his friends felt too sorry for him to mention it. Jim thought his head was square! Like the Beast in Beauty and the Beast who could not imagine people reacting to him with anything less than revulsion, Jim could not imagine people getting past his square head. To hide his condition as well as he could, Jim wore soft floppy hats and was most comfortable in winter, when he could all but completely cover his head with a large stocking cap. To us, Jim looked normal.

Associated features

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. Many patients with BDD believe that their deformities make them unacceptable as a person (Didie et al., 2010). Suicide idealization, 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. Suicide attempts are as high as 24%-28% with ideation as high as 78%-81% (Didie et al., 2010). BDD lifetime rate of suicide attempts is an estimated 5.2 times higher than in the general U.S. adolescent population (Phillips, Didie, Menard, Pagano, Fay, & Weisberg, 2006).
- BDD preoccupations are time-consuming, occurring on average 3 to 8 hours per day (Didie et al., 2010).

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).

In general adolescents and adults do not differ significantly on most characteristics (Phillips et al., 2006).

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 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 suggest prevalence rate to be very similar.

Epidemiology

- BDD is relatively common with prevalence rates from 0.7% to 2.4% in the general population (Didie et al., 2010).
- Prevalence rates tend to increase in clinical settings. Prevalence rates in the medical population of dermatology increase to 9%-12%, and in the cosmetic surgery population, an increase of 3%-53% (Didie et al., 2010).
- BDD is relatively common in outpatients with OCD (8% to 37%); social phobia (11% to 13%); trichotillomania (26%); and atypical major depressive disorder (14% to 42%) (Didie et al., 2010).

Etiology

Body Dysmorphic Disorder usually begins during adolescence but can begin during childhood. About 70% of patient's experience onset of BDD before 18 years (Didie et al., 2010). The disorder is more commonly chronic and unremitting than it is not. Suicidal have higher rates for this disorder than other mental disorders.

The disorder may not be diagnosed for many years, often because Individuals with the disorder are reluctant to reveal their symptoms. The onset may be gradual or abrupt, and the disorder has a continuous course, with few intervals that are symptom-free, although the intensity of the symptoms may fluctuate over time.

Treatments

People suffering with BDD typically present to cosmetic surgeons for correction of perceived bodily flaw, and inevitably receive no satisfaction or relief from disorder.

Serotonin deregulation seems to be common among patients with BDD. Selective serotonin reuptake inhibitor (SSRI) (i.e., fluoxetine hydrochloride, otherwise known as Prozac) 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.

The key to successful CBT for BDD is engagement of the patient (Veale, 2010).

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.

It is recommended that individuals with mild BDD are offered CBT that is specific for BDD or guided self-help based on CBT (Veale, 2010).

Individuals with BDD with sever functional impairment should be offered combined treatment with an SRI and CBT (Veale, 2010).

Another treatment that is sort of under the radar is the idea of plastic surgery. Almost 50% of people with BDD go "under the knife" to correct what they have a problem with on their body too.

Comorbidity

- Major depressive disorder is the most common comorbid disorder in patients with BDD, with social phobia and OCD the next common (Didie et al., 2010).
- Lifetime rates of substance abuse disorders are 36% to 48%, with 30% of individuals with BDD having comorbid lifetime substance abuse and 36% having comorbid lifetime substance dependence (Didie et al., 2010).

DSM-V recommended revisions www.dsm5.org

Major Changes:

#1: Clarify the criterion's meaning and aim to make it more acceptable to patients.

#2: Add examples to increase awareness of some of the common types of distress or impairment in functioning.

#3: Limit criterion to eating disorders.

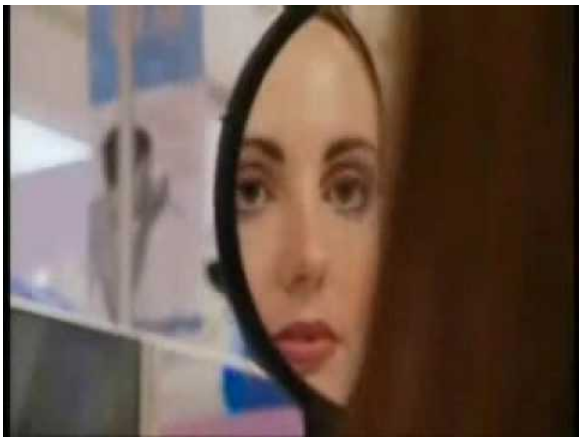
The work group is recommending that this disorder be reclassified from Somatoform Disorders to Anxiety and Obsessive-Compulsive Spectrum Disorders

- 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

60 Minutes Report – Mirror Mirror (part1)



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=368

60 Minutes Report – Mirror Mirror (part 2)



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=368

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6.131: Conversion Disorder (300.11)

- A conversion disorder is a psychiatric disorder with a physical manifestation (Deaton, 1998).
- It is a specific form of somatization in which the patient presents with symptoms and signs that are confined to the voluntary central nervous system (Hurtwitz, 2004).
- The disorder's basis is believed to be the substitution of a physical symptom for an emotional conflict that cannot be expressed openly (Deaton, 1998).

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.

Barlow and Durand (2009) give an example of conversion disorder:

Eloise sat on a chair with her legs under her, refusing to put her feet on the floor. Her mother sat close by, ready to assist her if she needed to move or get up. Her mother had made the appointment and, with the help of a friend, had all but carried Eloise into the office. Eloise was a 20-year-old of borderline intelligence who was friendly and personable during the initial interview and who readily answered all questions with a big smile. She obviously enjoyed the social interaction.

Eloise's difficulty walking developed over 5 years. Her right leg had given way and she began falling. Gradually, the condition worsened to the point that 6 months before her admission to the hospital Eloise could move around only by crawling on the floor.

Physical examinations revealed no physical problems. Eloise presented with a classic case of conversion disorder. Although she was not paralyzed, her specific symptoms included weakness in her legs and difficulty keeping her balance, with the result that she fell often. This particular type of conversion symptom is called astasia-abasia.

Eloise lived with her mother, who ran a gift shop in the front of her house in a small rural town. Eloise had been schooled through exceptional education programs until she was about 15; after this, no further programs were available. When Eloise began staying home, her walking began to deteriorate.

Associated features

- Some people with Conversion Disorder may display la belle indifference. This is a relative lack of worry about their condition or its implications. Other people may act in a dramatic or histrionic manner.
- These individuals, often being suggestible, may show symptoms that are modified or resolved by external cues. These symptoms are, however, not specific to this disorder and may also occur with a general medical condition.
- Symptoms may more commonly follow extreme psychosocial stress.
- 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. They may, however, develop symptoms that resemble those observed in others or themselves. Individual symptoms generally do not lead to physical changes, but when they do, changes such as atrophy and contractures may occur.

- Laboratory analysis of the condition typically do not yield any findings either. 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.

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 disorders are more common in adolescents than either children or adults (Deaton, 1998).

Gender and cultural differences in presentation

Conversion disorder is diagnosed more frequently in women than in men (Deaton, 1998). 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.

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.

Onset is usually from late childhood to early adulthood, usually between the ages of 10 and 35, but onset as late as the ninth decade has been reported. When the disorder first develops in middle or old age, an occult neurological or other general medical condition is highly probable. The onset is usually acute, but the symptoms may also sometimes appear gradually. Individual symptoms are usually short in duration. Recurrence is common, and a single recurrence predicts future episodes. An acute onset, presence of clearly identifiable stress at the time of onset, a short interval between onset and treatment, and above-average intelligence are factors associated with a good prognosis. Symptoms of aphonia, blindness, and paralysis are also associated with a good prognosis, whereas tremors and seizures are not.

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.

Research shows that Conversion Disorder is triggered by a significant stressor such as, difficulty with peer relationships, family discord or marital problems, difficulties with academics or economic hardship within the family.

Studies have also shown that children whose family members have a chronic illness are more likely to model their symptoms. Also, between 10% and 60% of children with Conversion Disorder had previous illness.

Empirically supported treatments

Patients referred for the treatment of conversion disorder must first be medically cleared for any neurological condition (Hurtwitz, 2004).

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. Some research has recommended an anxiolytic or antidepressant agent (Tocchio, 2009). 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. Physiotherapy is also a technique used to treat Conversion disorder. This therapy involves maintaining and restoring maximum movement and ability throughout life.

CBTs have been shown to improve patient functioning and reduce the cost of care (Tocchio, 2009).

Outpatient treatment of patients with conversion symptoms can be attempted using some of the strategies used in the inpatient setting (Hurtwitz, 2004).

Patients with chronic and entrenched conversion symptoms usually require admission to an inpatient psychiatric unit that has experience with conversion disorders (Hurtwitz, 2004).

DSM-V recommended revisions www.dsm5.org

Major changes:

#1: Rename Somatoform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders.

#2: De-emphasize medically unexplained symptoms.

#3: Modify criteria for conversion disorder.

- Patients with conversion disorder typically present with neurological symptoms that are found, after appropriate medical assessment, to be incompatible with a general medical condition. These presentations may be acute or chronic. Typical symptoms include weakness, events resembling epilepsy or syncope, abnormal movements, sensory symptoms, dizziness, speech and swallowing difficulties. In addition, the diagnosis will usually be supported by confirmatory physical signs or diagnostic investigations consistent with the diagnosis (such as, Hoover's sign). Psychological factors may be associated with the onset of symptoms, but are not essential for the diagnosis. If there is evidence that the symptoms are intentionally feigned, the condition is not conversion disorder but rather either factitious disorder or malingering. When the symptom is limited to pain or to a disturbance in sexual functioning, it is typically coded elsewhere in the DSM (a different Somatic Symptom Disorder diagnosis or in the Sexual Disorders Section).

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.

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6.132: Hypochondriasis (300.7)

DSM -IV-TR criteria

A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms

B. The preoccupation persists despite appropriate medical evaluation and reassurance.

C. The belief in Criteria A is not a delusional intensity (as in Delusional Disorder, Somatic Type) and is not restricted to a circumscribed concern about appearance (as in Body Dysmorphic Disorder).

D. The preoccupation cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. Duration of disturbance at least six months.

F The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive episode, Separation Anxiety or other Somatoform Disorder.

Specify if: With Poor Insight: if for most of the time during the current episode, the person does not recognize that the concern about having a serious illness is excessive or unreasonable.

Barlow and Durand (2009) give an example of hypochondriasis:

Gail was married at 21 and looked forward to a new life. As one of many children in a lower-middle-class household, she felt weak and somewhat neglected and suffered from low self-esteem. An older stepbrother berated and belittled her when he was drunk. Her mother and stepfather refused to listen to her or believe her complaints. But she believed that marriage would solve everything; she was finally someone special. Unfortunately, it didn't work out that way. She soon discovered her husband was continuing an affair with an old girlfriend.

Three years after her wedding, Gail came to our clinic complaining of anxiety and stress. She was working part-time as a waitress and found her job extremely stressful Although to the best of her knowledge her husband had stopped seeing his former girlfriend, she had trouble getting the affair out of her mind.

Although Gail complained initially of anxiety and stress, it soon became clear that her major concerns were about her health. Any time she experienced minor physical symptoms such as breathlessness or a headache, she was afraid she had a serious illness. A headache indicated a brain tumor. Breathlessness was an impending heart attack. Other sensations were quickly elaborated into the possibility of AIDS or cancer. Gail was afraid to go to sleep at night for fear that she would stop breathing. She avoided exercise, drinking, and even laughing because the resulting sensations upset her. Public restrooms and, on occasion, public telephones were feared as sources of infection.

The major trigger of uncontrollable anxiety and fear was in the new in the newspaper and on television. Each time an article or show appeared on the "disease of the month," Gail found herself irresistibly drawn into it, intentionally noting symptoms that were part of the disease. For days afterwards she was vigilant, looking got the symptoms in herself and others. She even watched her dog closely to see whether he was coming down with the dreaded disease. Only with great effort could she dismiss these thoughts after several days. Real illness in a friend or relative would incapacitate her for days at a time.

Gail's fears developed during the first year of her marriage, around the time she learned of her husband's affair. At first, she spent a great deal of time and more money than they could afford going to doctors. Over the years, she heard the same thing during each visit: "There's nothing wrong with you; you're perfectly healthy." Finally, she stopped going, as she became convinced her concerns were excessive, but her fears did not go away and she was chronically miserable.

Associated Features

- Hypochondriasis is characterized by a preoccupation with physical symptoms; however, a key feature is that it combines the fear with the conviction that one has an organic disease (Mai, 2004).
- Fear of aging and death. They place a greater importance on physical health, but do not have better health habits than someone who does not have a disorder. "Doctor shopping", as well as deterioration with Doctor relationships with frustration and anger

towards each other are common. This deterioration could be due to the fact that even when a medical examination proves that there is nothing wrong, the patient continues to believe he or she is sick. The patient may also believe he or she is not getting proper care, and they may resist referral to mental health professionals. Social relationships become strained.

- One interprets physical symptoms and feelings as signs of a serious medical illness in spite of medical assurance that they are not.
- May be especially concerned about a particular organ system (such as the cardiac or digestive system).
- They usually present their medical record in great detail.
- Individuals suffering from Hypochondriasis generally need to be under constant reassurance from family, friends, and doctors. Certain individuals suffering from this disorder rarely speak about their anxieties whereas other individuals constantly talk about their anxieties.
- Anxiety, clinical depression, phobias, somatization disorder and obsessive-compulsive personality traits are frequently observed.

Child vs. Adult Presentation

- This can occur at any age; however it is usually seen in early adulthood.

Gender and Cultural Differences in Presentation

- Males and Females show the same rates through most of the studies.
- Culturally, some may have a fear of illness that resembles Hypochondriasis, but it is not the same and they are influenced by cultural beliefs and practices.

Epidemiology

- The prevalence of Hypochondriasis in the general population is 1%-5% (community), 2-7% (primary care outpatients).
- The disorder can begin at any age, but the most common age at onset is early adulthood. The course is typically chronic, and the symptoms fluctuate, but there are some complete recoveries. Acute onset, mild duration, mild symptoms, general medical comorbidity, and the absence of a comorbid mental disorder, and the absence of secondary gain indicate a favorable prognosis. Some view this disorder as having certain “trait like” characteristics.

Etiology

Serious illnesses, particularly in childhood, and past experience with disease in a family member are associated with the occurrence of Hypochondriasis. Psychosocial stressors, in particular the death of someone close to the individual, are thought to precipitate the disorder in some cases.

The etiology of this disorder has no exact cause; it is unknown. There are some things that can bring about this disorder such as past abuse, problems expressing emotions, or an inherited susceptibility.

One theory as to the cause of this is that people with this are highly sensitive to physical pain. They pay attention more closely to changes in their body. They tend to freak out when something had changed and often make a bigger deal out of it than it really is. Situational factors can play a role in this.

Another theory suggests that people with this disorder misinterpret their symptoms. Most people think they are healthy until they have symptoms of a disease. However, this theory suggest that people with Hypochondriasis think they are ill or something is wrong with them, until they have proof that there is not.

Empirically supported treatments

The physician and his or her team’s attention, concern, interest, careful listening, and nonjudgmental stance, can potentially break a pathological cycle of maladaptive interactions between the patient and movement from physician to physician. Cognitive behavioral therapy (CBT) and selective serotonin re uptake inhibitors (SSRIs such as fluoxetine and paroxetine) are also treatments that have proven to be useful in treating Hypochondriasis. SSRIs generally diminish the anxiety through changing the neurotransmitter levels to a more compatible level.

Comorbidity

Patients with hypochondriasis have high levels of psychiatric distress including anxiety, depressive and somatoform symptoms (Magarnos, Zafar, Nissenson, & Blanco, 2002).

DSM-V recommended revisions www.dsm5.org

Major changes:

#1: Rename Somatoform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders.

#2: Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD).

The work group is recommending that this disorder be subsumed into a new disorder: Complex Somatic Symptom Disorder.

The following optional specifiers may be applied to a diagnosis of CSSD where one of the following dominates the clinical presentation:

High health anxiety (previously, hypochondriasis) {If patients present solely with health-related anxiety in the absence of somatic symptoms, they may be more appropriately diagnosed as having an anxiety disorder.} *

*Note: Both the Somatic Symptom Disorders Work Group and the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group are considering the possibility that what was described as Hypochondriasis in DSM-IV may represent a heterogeneous disorder in which some individuals may be better considered to have CSSD and some may be better considered to have an anxiety disorder. There will be ongoing discussion of this issue.

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6.133: Somatization Disorder (300.81)

DSM-IV-TR criteria

A. 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.

B. 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 pseudoneurological 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 lump in throat, aphonia, urinary retention, halluciantions, 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 e expected from the history, physical examination or laboratory findings

- D. The symptoms are not intentionally produced or feigned (as in Factitous Disorder or Malingering).

Barlow and Durand (2009) give an example of somatization disorder:

Linda, an intelligent woman in her 30s, came to our clinic looking distressed and pained. As she sat down she noted that coming into the office was difficult for her because she had trouble breathing and considerable swelling in the joints of her legs and arms. She was also in some pain from chronic urinary tract infections and might have to leave at any moment to go to the restroom, but she was extremely happy she had kept the appointment. At least she was seeing someone who could help alleviate her considerable suffering. She said she knew we would have to go through a detailed initial interview, but she had something that might save time. At this point, she pulled out several sheets of paper and handed them over. One section, some five pages long, described her contacts with the health-care system for major difficulties only. Times, dates, potential diagnosis, and days hospitalized were noted. The second section, one-and-a-half single-spaced pages, consisted of a list of all medications she had taken for various complaints.

Linda felt she had any one of a number of chronic infections that nobody could properly diagnose. She had begun to have these problems in her teenage years. She often discussed her symptoms and fears with doctors and clergy. Drawn to hospitals and medical clinics, she had entered nursing school after high school. However, during hospital training, she noticed her physical condition deteriorating rapidly: She seemed to pick up the diseases she was learning about. A series of stressful emotional events resulted in her leaving nursing school.

After developing unexplained paralysis in her legs, Linda was admitted to a psychiatric hospital, and after a yea,r she regained her ability to walk. On discharge, she obtained disability status, which freed her from having to work full time, and she volunteered at the local hospital. With her chronic but fluctuating incapacitation, on some days she could go in and on some days she could not. She was currently seeing a family practitioner and six specialists, who monitored various aspects of her physical condition. She was also seeing two ministers for pastoral counseling.

Associated features:

Patients possessing Somatization Disorder (SD) typically complain of physical symptoms that seem to have no physical origins. They describe their symptoms in colorful, exaggerated terms, but do not give specific information. They are often inconsistent as

historians, so a thorough review of medical treatments and hospitalization may be necessary. They often seek treatment from several physicians at the same time, so there is a risk of complicated and dangerous combination of treatments. Experts believe that unconscious physical symptoms arise due to internal psychological conflicts. Patients will visit numerous doctors and never figure out their problems. As a result, their symptoms worsen and cause social dysfunction. In other words, SD causes it's inhabitant to become very antisocial. They commonly have prominent anxiety symptoms and depressed mood, which symptoms may be the cause of being in a mental health setting. They may exhibit impulsive and antisocial behavior, suicide threats and attempts, and marital discord. Their lives are often chaotic and complicate. Their frequent use of medications may lead to Substance-Related Disorders. They undergo frequent examinations, procedures, surgeries, and hospitalizations. Comorbidity can occur with Major Depressive Disorder, Panic Disorder, and Substance-Related Disorder, as well as some Personality Disorders, most commonly Histrionic, Borderline, and Antisocial Personality Disorders.

Child vs. Adult Presentation:

Despite the fact that children commonly respond to psychosocial stressors with reported physical and somatic complaints, a diagnosis of Somatization Disorder in children is rare.

Gender and Cultural Differences in Presentation:

Somatization Disorder occurs in 0.2 % to 2% of females and 0.2% of males. Although the disorder occurs most often in women, the male relatives of affected women have an increased risk of substance-related disorders and antisocial personality disorders. Cross-culturally, certain symptoms of Somatization Disorder present themselves differently. For example, people in African and South Asian countries are more prone to have the symptom of worms or ants crawling in their head than those in North American countries. In addition, boys are prone to report more headaches at a younger age whereas girls are reported to have more headaches with the disorder during their teens.

Epidemiology:

- In the general population, Somatization Disorder is not common. Somatization Disorder is prevalent in 0.02% of the population. Mood and anxiety disorders are typically co-morbid with this disorder.
- Individuals typical meet diagnostic criteria before 25 years of age. The disorder is chronic and fluctuating, and it rarely remits completely. A year seldom passes without the individual seeking medical attention for some unexplained somatic complaint.

Etiology

Studies have investigated that several risk are associated with Somatization Disorder. There is evidence that parental divorce is implicated in the risk for Somatization Disorder. Also, research has proven that higher risk for Somatization Disorder occurred in families with Antisocial Personality Disorder.

Empirically Supported Treatments

Treatments for Somatization are cognitive behavioral therapy and medications. (CBT) consists of focusing on negative thoughts, behaviors, and feelings that contribute to somatic symptoms. This treatment helps patients identify the more dysfunctional thinking. Overall, they will develop a better idea to positive thinking and rational explanations. It also helps them along with being more socially active, because people who suffer from somatization usually avoid social activities. (CBT) also teaches relaxation techniques.

Anti-depression medications will sometimes be prescribed in order to help alleviate symptoms.

Comorbidity

- Somatization disorder co-occurs with the majority of Axis II PDs (Bornstein, & Gold, 2008).
- Clinicians have discussed the connections between SD and at least six Axis II PDs: antisocial, avoidant, borderline, dependent, histionic, and obsessive-compulsive (Bornstein, & Gold, 2008).
- Effect sizes linking SD with paranoid PD and obsessive-compulsive PD were small, effect sizes for antisocial, borderline, narcissistic, histionic, avoidant and dependent PD yielded effect sizes about or above 0.02 (Bornstein, & Gold, 2008).
- The co-existence of somatization and abnormal illness behaviour is well known (Chaturvedi,Desai, & Shaligram, 2006). Abnormal illness behaviour is defined as: persistence of an inappropriate or maladaptive pattern of behaviour (Chaturvedi et al., 2006).

DSM-V recommended revisions www.dsm5.org

Major changes:

#1: Rename Somatoform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders.

#2: Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD).

The work group is recommending that this disorder be subsumed into a new disorder: Complex Somatic Symptom Disorder.

The following optional specifiers may be applied to a diagnosis of CSSD where one of the following dominates the clinical presentation:

1. Multiplicity of somatic complaints (previously, somatization disorder)

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6.134: Posttraumatic Stress Disorder

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 accidently 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.

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6.135: Undifferentiated Somatoform Disorder (300.82)

DSM-IV-TR Criteria

A. One or more physical complaints (e.g., fatigue, loss of appetite, gastrointestinal or urinary complaints).

B. Either (1) or (2):

1. after appropriate investigation, the symptoms 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 is in excess of what would be expected from the history, physical examination, or laboratory findings.

- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The duration of the disturbance is at least 6 months.
- The disturbance is not better accounted for by another mental disorder.
- The symptom is not intentionally produced or feigned.

Associated Features

The most common symptoms are fatigue, loss of appetite, pain, and gastrointestinal problems. There seems to be many different physical symptoms for people with this disorder. No physical or medical causes for the pain is the main characteristic of this disorder. The pain or physical symptoms continue even after the person is told there is no medical cause.

Child vs. Adult Presentation

Adults are more likely than children to develop undifferentiated somatoform disorder. The elderly are also a common group to develop this disorder.

Gender and Cultural Differences in Presentation

Women are more likely to have undifferentiated somatoform disorder than men. Those with low socioeconomic status are more likely to develop this disorder than those with high SES. The most common group to develop this disorder are young women who have a low SES status. If symptoms persist for longer than six months, the disordered is classified as “Neurasthenia.” In some cultures, medically unexplained symptoms and worry about physical illness do not indicate psychopathology. This disorder is not prone to a certain type of cultural rather than the position that an individual holds in a culture.

Epidemiology

Approximately four to eleven percent of the population will experience this disorder at some point in their life. About fifty percent of people with this disorder are co-morbid with other disorders such as anxiety or depression.

The course is unpredictable.

Etiology

There is no for sure cause of the disorder. Some studies suggest that it can be genetic. If it runs in a family, then those in that family are more likely to develop it. Other studies suggest that depression and anxiety can play a role. Also, people who give obsessive attention to minor changes or sensations in their body are also said to be likely to develop this disorder.

Empirically Supported Treatments

- Treatments should focus on finding the underlying cause of the psychological or stress problems.
- Also, if it is co-morbid with some other disorder, treating that first often helps lessen the symptoms.
- Teaching people how to manage stress effectively has also been shown to help. These kinds of programs teach patients how to cope with criticism, as well as how to stop negative behavior patterns.

DSM-V recommended revisions www.dsm5.org

Major changes:

#1: Rename Somatoform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders.

#2: Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD).

The work group is recommending that this disorder be subsumed into a new disorder: Complex Somatic Symptom Disorder.

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6.136: Somatoform Disorder Not Otherwise Specified (300.81)

DSM-IV-TR Criteria

This category includes disorders with somatoform symptoms that do not meet the criteria for any specific Somatoform Disorder. Examples include:

- Pseudocyesis: a false belief of being pregnant that is associated with objective signs of pregnancy, which may include abdominal enlargement (although the umbilicus does not become everted), reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery. Endocrine changes may be present, but the syndrome cannot be explained by a general medical condition that causes endocrine changes (e.g., a hormone-secreting tumor)
- A disorder involving nonpsychotic hypochondriacal symptoms of less than 6 months' duration.
- A disorder involving unexplained physical complaints (e.g., fatigue or body weakness) of less than 6 months' duration that are not due to another mental disorder.

DSM-V recommended revisions www.dsm5.org

Major changes:

#1: Name change of disorder to Somatic Symptom Disorder Not Elsewhere Classified.

#2: Adding Simple Somatic Symptom Disorder.

#3: Changing qualifications in Pseudocyesis category.

#4: Adding Isolated Health Anxiety category.

The group is recommending changing the disorder name to Somatic Symptom Disorder Not Elsewhere Classified.

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6.137: Complex Somatic Symptom Disorder (CSSD)

(Not currently located in the DSM-IV-TR)

Proposed changes in the DSM-V include grouping the following disorders into a single category: 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. This new category would focus on both the physical symptoms and the psychological dysfunctions, with more emphasis on cognitive distortions than previous diagnostic categories.

CSSD is characterized by a disproportionate or maladaptive reaction to somatic symptoms or concerns. The disorder can occur in conjunction with a general medical or psychiatric disorders or it can occur alone. Treatment of the symptoms is usually unsuccessful; in fact, treatment may exacerbate symptoms.

Symptoms may be either specific, such as localized pain, or more general, such as fatigue or multiple symptoms. Anxiety-causing symptoms are usually ordinary bodily sensations, or discomfort not associated with a known serious medical condition.

Interestingly, patients diagnosed with CSSD typically have a poor health-related quality of life as compared to patients diagnosed with other medical conditions or those with similar symptoms.

DSM-V Criteria

Symptom clusters A, B, and C must be met for a diagnosis of Complex Somatic Symptom Disorder

- 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:
  - High level of health-related anxiety.
  - Disproportionate and persistent concerns about the medical seriousness of one's symptoms.
  - Excessive time and energy devoted to the 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 on 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)

*Criteria B is still under active discussion

See here for the DSM-V proposed changes to this category: DSM-V

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6.138: Pain Disorder

DSM-IV-TR criteria

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

E. The pain is not better accounted for by a Mood, Anxiety or Psychotic Disorder and does not meet criteria for Dyspareunia.

Specify if:

Acute: duration of less than 6 months

Chronic: duration of 6 months or longer

Specify if:

Acute: duration of less than 6 months

Chronic: duration of 6 months or longer

Note: The following is not considered to be a mental disorder is included her to facilitate differential diagnosis.

Major changes:

#1: Rename Somatoform disorders to Somatic Symptom Disorders and combine with PFAMC and Factitious Disorders.

#2: Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled “Complex Somatic Symptom Disorder” (CSSD).

The work group is recommending that this disorder be subsumed into a new disorder: Complex Somatic Symptom Disorder.

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6.139: Anorexia Nervosa (307.1)

DSM-IV-TR criteria

A. 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).

B. Intense fear of gaining weight or becoming fat, even though underweight.

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.

D. 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).

Specify type:

- Restricting Type: The person describes presentations in which weight loss is accomplished by dieting, fasting, or excessive exercise and has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or misuse of laxatives, diuretics, or enemas).
- Binge-Eating/Purging Type: During the current of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).(The binge-eating/purging type used to be called bulimiarexia. That term is now archaic.). Some in this subtype do not binge, but do purge after consuming small amounts of food.

Associated features

People that suffer from Anorexia Nervosa typically view themselves as overweight. The term anorexia means "loss of appetite"; however, individuals that have anorexia constantly feel hungry since they constantly deprive their body of adequate nutrition. Often time's individuals with anorexia refuse to eat in order to lose weight. If they feel they have gained weight, they may use extreme measurements to become thin, such as using laxatives, induce vomiting, excessive exercise, consuming diet or diuretic pills, and obsessing all caloric intake of everything they eat.

Some anorexic women consider amenorrhea as a milestone in weight loss; if they are menstruating they often think they are too fat.

Many people that have anorexia often deny how severely underweight they are; they think they are still too fat and need to continuously lose weight. In young girls, obsession with weight typically begins at the onset of puberty. Girls who mature early are at a greater risk of developing an eating disorder than girls that mature at a normal rate. Other people are worried about their health but not in such an extensive way as anorexic people. However, anorexic individuals rarely believe that their current weight is acceptable and do not seem to find a point at which it is unhealthy to lose additional weight. Therefore, they end up losing more weight than necessary which can cause serious health problems.

The signs and symptoms of anorexia can include: low body temperature, coldness in the extremities, and constipation for some time. The individuals with anorexia nervosa are unable to tolerate cold temperatures; they also often report fatigue or tiredness, episodes of dizziness, constipation, periodic vomiting, and shortness of breath. Individuals also tend to develop irregular menstrual cycles or actually lose their periods for long stages of time due to malnutrition and being underweight. Anorexia can also affect a woman's fertility. In females, there are low levels of serum estrogen, and there are low levels of serum testosterone in men. Thinning of the hair, sunken eyes like low in eyelids, and puffy cheeks are some of the most observable signs that one may be anorexic. The individuals, however, are unable to tell that these characteristics are seen as abnormal towards others. Anorexia nervosa is commonly co-morbid with mood disorders. Many individuals with the eating disorder also report anxiety disorders such as obsessive-compulsive disorder (OCD) and social phobia disorders. People who suffer from anorexia also tend to have a harder time with concentration due to the fact that they are constantly reminded by their body of its nutritional needs.

The behaviors expressed tend to be more introverted like social withdrawal in particular situations and decreased interest in sex over time. An individual who views themselves as excessively thin may feel sexually undesirable resulting in a reduction of sexual interest. Recovery rates are low for anorexia nervosa. Although 50% achieve partial recovery, only 10% fully recover from the

disorder. Within the first five years of the diagnosis, many individuals with the restricting subtype of anorexia nervosa will develop an eating pattern that is more typical of the binge-eating/purging subtypes. If unchecked, chronic starvation and weight loss can result in severe dehydration and electrolyte imbalance that may require hospitalization if not cared for or attended to soon.

These individuals put extreme amounts of emphasis on their weight that they may actually measure everything that comes in and out by the ounce.

Child vs. adult presentation

Anorexia nervosa normally begins in mid to late adolescence (age 14-18 years). It is not likely to see children under the age of 13 with anorexia because of their lack of concern with social acceptance and appearance. Seventeen is the average age of onset of anorexia nervosa. Rare cases of older adults being diagnosed with the disorder do exist, however, it is highly unlikely that an individual over 40 years of age will be diagnosed. Most individuals in the age group of 14-18 are very social, seek relationships and social acceptance much of the time. These individuals may become very self-conscious about their physical appearance, predisposing them to the development of anorexia nervosa.

Gender and cultural differences in presentation

Anorexia nervosa is more common in females than in males. This may be the result females being more concerned about their appearance than males. It is a common stereotype that many females are more willing to go to extremes to look better. Among the amount of people with the disorder, about 95% are female compared to 5% of whom are male. Most of these come from high-achieving families and believe they have to be presentable, which is viewed as thin and beautiful opposed to big and bulky. There has also been an associated link found between Anorexia and authoritarian parenting styles, many say the child can feel too much pressure from their parents, and thus develop disorders such as anorexia. Anorexia nervosa is most prevalent in the U.S. and other countries with high economic status. It is estimated that about one out of every 100 adolescent girls has the disorder. Caucasians are more often affected than people of other racial backgrounds, but currently there has been an increase in the number of African American females who are being diagnosed with this disorder. Anorexia is also more common in middle and upper socioeconomic groups. According to the U.S. National Institute of Mental Health (NIMH), an estimated 0.5% to 3.7% of women will suffer from this disorder at some point in their lives.Approximately half of anorexic females are predicted to develop bulimia, which is also considered a psychological eating disorder, and is defined as excessively overeating and then different improper methods are used to get rid of the food just ingested, such as throwing up.

Epidemiology

In women, anorexia nervosa can occur between a percentage rate of 0.5% to 3%. The lifetime prevalence rate of this disorder is around 0.5%. Approximately 1% of the population will be diagnosed with anorexia nervosa in a lifetime, and there is some concern that this rate is increasing. Since the 1930s, there has been an increasing number of anorexia nervosa cases. This may be due to the increase in the prevalence of industrialized societies, as well as the constant pressure to be thin as implicated by the mass media (characteristics of personality and the cultural approval of thinness). Television shows constantly portray favorable bias toward thin, better looking people as opposed to those who are considered to be overweight individuals.

Anorexia Nervosa usually begins in mid to late adolescence. The rarely occurs in females over 40 years of age. The onset may be associated with a strssful life event. The course and outcome are highly variable. Some never fully recover after a single episode; some exhibit a pattern of weight gain and loss, and others experience a chronic course over many years. With time, a significant of the Restricting Type develop binge eating, changing to the Binge Eating/Purging Subtype. The long term mortality is over 10%, most commonly from starvation, suicide, or electrolyte imbalance.

Etiology

Socio-cultural factors: Industrialized societies place great value on women who are thin. Evidence of this can be seen in the entertainment industry, (such as movies, TV shows, advertising and catalogs), where nearly all of the women featured are thin. Being thin is considered better than being bigger. Through this media, young women are conditioned to believe that only “thin” is beautiful, and they may become obsessed with attaining this image, such as an hour glass figure (big in the hips and thin in the waist). Inner beauty is not a factor in the real-world which helps one achieve success; it is physical appearance and social capital. Furthermore, being thin in these industrialized societies is culturally reinforced by what the favorable definitions are for popularity. Since men are also conditioned to believe that “thin” is beautiful, the attention that petite women receive from the opposite sex acts

to reinforce women's attitudes that they look good being thin and that is the body image men desire. Anorexia Nervosa is far more prevalent in industrial societies such as the United States, Canada, Europe, Australia, Japan, New Zealand, and South Africa. Moreover, eating disorders are less prevalent in societies where women have fewer decision-making responsibilities.

Psychological Factors: Individuals with anorexia nervosa tend to be perfectionists, a person who places very high standards on everything and is displeased with things if they fall short of the expected standard, which affects the way they look at their body. They become so obsessed with achieving the image of the "ideal woman" that they will push themselves to dangerous extremes and begin possessing obsessive or narcissistic qualities. They also engage in compulsive behavior, which includes frequently checking their appearance and weight, like combing their hair, shaving, brushing teeth, or even repetitive flossing. These individuals crave control, especially over their eating habits, by engaging in restrictive diets and always eating the same thing because nothing else is satisfying. They in return learn to ignore the resulting internal cues of hunger. Psychological symptoms of anorexia consist of those characteristics that are related to the development of the disorder and those that are secondary to the disorder.

Biological factors: Twin studies in anorexia have found concordance rates for mono-zygotic (identical) twins to be significantly higher than concordance rates for dy-zygotic (nonidentical or fraternal) twins. This finding suggests that there may be genetic factors involved in predisposing individuals to anorexia nervosa, such as gene combination with parental sequences, passed down. There is also an increased risk of anorexia nervosa developing in the first-degree biological relatives of anorexic individuals. They have a greater chance of acquiring the odd sequences that cause these problems in anatomy and dietary functions. There also can be a weak genetic component more developmental than mental so other factors should be considered like family history of eating, perfectionist and their personality.

Empirically supported treatments

Anorexia nervosa is difficult to treat and relapse is common among the patients with the disorder. Most anorexic individuals do not see a problem with themselves and, consequently, are not admitted to treatment by their own accord. Often, a friend of the troubled individual has to intervene and recommend that he or she seek help to further their daily functioning. Help may be gained either through medication or behavioral therapies. Denial, coupled with an individual's unwillingness to participate in treatment, can make changing a patient's attitude very challenging.

There are two major goals for treating patients with this disorder:

1. Getting the patient to gain weight is not an easy task. It is important that the patient gradually begins to eat more during each meal time and not forcibly trying to eat larger amounts of food at one time. If adequate nutrients are not obtained in food, normal functioning is inhibited. It is crucial for underweight individuals to gain more weight, at least to the point where health and nutritional concerns are no longer a factor. Underweight individuals possess less ability to fight off pathogenic diseases because their immune systems are not prepared to provide proper circulation to crucial areas of the muscles, glands, and other areas due to a lack of nutrition. Also, the body needs the right amount of nutrition to be able to function to its normal capacity. However, the patient needs to be aware of the importance of gaining weight gradually because the body will encounter problems attempting to adjust to rapid increases in weight. If this occurs, it can cause complications in the individual's digestive system and a person may become overstuffed and burst.
2. Addressing other psychological, social, and environmental issues is a vital part of one's treatment. During treatment, clinicians try to change the way the patient views his or her self. Clinicians goals are to address the issues that potentially caused the disorder, change the patient's perspectives on body image, maintain a healthy diet, and help the patient classify a healthy weight. The clinicians let the patients know what is socially acceptable or popular and emphasize the vitality of maintaining healthy food choices. The clinicians also inform the patient of a respectable weight he or she should maintain.

When treating the young women and men who are suffering from anorexia nervosa, the most common technique is through family therapy. In family therapy, the clinician usually tries to change the patient's attitude about their body image. They also try to increase the patient's self-esteem by teaching him or her to accept the way his or her body looks and becoming satisfied with it. The family attends these counseling sessions with the patient and will gain control over the patient's eating habits until the patient can maintain healthy habits oneself. They also reinforce what the clinician says. For example, the family members may stress that the patient's body is fine and satisfying to the public eye. Families may also be asked to monitor exercise habits. If the patient exercises excessively, they will need to improve the workout by designating only a certain amount of time a day for exercise. However, this

technique usually only lasts for a short period of time and the patient becomes bored with the activities. This is due to the fact that many patients are in denial and tend to get into a relapse or think that they are really fine, that everyone is jealous around them because they are better.

Another technique for treating people diagnosed with anorexia nervosa is attending self-help groups. The American Anorexia Bulimia Association is one organization that provides support groups for those who are suffering from eating disorders that need to talk it out with others experiencing the same problems. The more "experienced," affected individuals with anorexia nervosa are very good when telling the "newbies" how to deal with certain problems they already have experienced. The same techniques do not work for everyone but can help ignorant patients that do not know where to turn for help. People can gather and give each other support to help them recover from this disorder and prevent them from going into denial or put in a relapse.

Medication is not recommended for treating people with anorexia nervosa. The main reason is because these individuals are often very thin. Because they are thin, their bodies have a harder time with the chemicals found in the drugs. Those with low body weight can overdose much quicker than others, and their immune system is very weak. They could become dependent on drugs such as Xanax or Valium, both are CNS depressants, which could cause a number of health, and maybe even legal problems that need to be avoided if at all possible. Psychotropic drugs can decrease the patient's suffering, but also allow a degree of stabilization in the patient's chaotic life. Some psychiatrists prefer to use SSRIs because of their efficacy. This could cause negative side effects and complications, sometimes even death. Estrogen may also be prescribed as part of treatment. Women with anorexia are at risk of fractures as a result of osteoporosis, which usually occurs during menopause; however, the lack of menstruation due to their low body weight puts them in a state like early menopause. There is some suggestion that taking estrogen can help some women have the ability to regain some of their bone functioning and stability that has been lost and prevent other fractures from possibly happening.

Parenting classes have been a new and upcoming technique that helps parents learn how to build self-esteem in their kids. This treatment helps the teen to value themselves as a person and learn to trust their abilities and feelings while working toward their goals.

- Individuals who suffer from Anorexia Nervosa believe that they are improving their appearance while often harming themselves by abstaining from food. See video https://youtu.be/8XVkPpDJfYE

https://youtu.be/8XVkPpDJfYE

- A girl discusses her life with Anorexia. Note: Some of the images in this video may be disturbing. See Video https://youtu.be/ZmzJt5G9ud8



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=384

- The following link is from Morning Edition on NPR. It is a short recount of a young girl's experience with anorexia.
- The following link is from New and Notes on NPR. Farai Chideya interviews different people on eating disorders and anorexia specifically for African-Americans.

To view images of anorexia visit: Anorexia in Males and Anorexia in Females

Explanation of Anorexia Nervosa Impact of Eating Disorder

Story of 12yr old Bryony above: http://www.dailymail.co.uk/femail/article-432132/My-little-girl-anorexic-12.html

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6.14: Social Phobia

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 comorbids 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 it's 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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6.140: Bulimia Nervosa (307.51)

DSM-IV-TR criteria

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- 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
- 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)
- eating is usually done in secret

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.

C. The binge eating and inappropriate compensatory behaviors both occur on average at least twice a week for three months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

- Purging Type: during a current episode of Bulimia Nervosa, the person regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, enemas or ipecac, as means of rapidly extricating the contents consumed.
- Non-purging Type: during a current episode of Bulimia Nervosa, the person uses other inappropriate compensatory behaviors, such as fasting or excessive exercise, but does not regularly engage in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.
- The following six criteria should be met for a patient to be diagnosed with bulimia
  - 1.The patient feels incapable of controlling the urge to binge, even during the binge itself, and consumes a larger amount of food than an average healthy person would normally consume at one sitting.
  - 2.The patient purges him or herself of the recent intake, resorting to vomiting, laxatives, diuretics, exercising, etc.
  - 3. The patient engages in such secretive behavior at least twice per week for three months.
  - 4. The patient is focused upon body image and possesses a desperate desire to appear thin.
  - 5. The patient does not meet the diagnostic criteria for anorexia nervosa
  - 6.The patient is of normal weight or overweight, contrasting with characteristics of anorexia nervosa.

Associated features/ effects

A person with Bulimia Nervosa suffers from “body image disturbance”, which makes them unable to perceive their body size accurately. By having these distorted thoughts about their body, they avoid looking into a mirror. People suffering from bulimia nervosa are usually not noticed right away. They seem normal in appearance and are not noticed as easily as anorexics are in public settings. This is because they engage in binge eating activities privately as a solitary activity. People with bulimia nervosa consume their food at a rapid pace, and this may be present along with depression feelings, environmental influential factors, irritability, and tension in some parts of their life. After a binge episode, feelings of guilt and depression follow, forcing the bulimic into purging behaviors which allows them to regain control of the situation. The actual word, bulimia, is translated as “hunger like an ox.”

They experience fluctuating weight loss, but unlike anorexia nervosa, people with bulimia nervosa are still able to maintain the average weight with respect to their height, so they appear relatively normal. Bulimia nervosa is more of a mental aspect than a physical one such as private eating activities. Compared to the rest of the population or those with regular eating habits, people with bulimia nervosa are still considered to be the thinner individuals. Them also wear loose-fitting clothes in order to hide their bodies.

Research has shown that, if caught in early stages enough and treated in the right way, 80% of people with bulimia nervosa can fully recover. This is because the habits are not formed completely in the mind’s everyday activities schedule. If it is not so branded into the behaviors, one can change the eating habits to normal functioning abilities. Most patients can control the behavior with

psychotherapy, counseling, biofeedback training and individual or group psychotherapy. Without treatment complications can be fatal.

These individuals may have scabs or nicks on their knuckles from constantly trying to make themselves vomit. Their teeth and esophagus suffer from the constant presence of acid. The recurrent vomiting can lead to loss of dental enamel, and their teeth may appear chipped and ragged. Excessive vomiting also leads to scratched and discolored fingernails due to the patient sticking them down the throat. Sometimes, the salivary glands become permanently enlarged. Also, a person suffering from bulimia will usually display the often recognized “chipmunk cheeks” because they are inflamed due to repeated vomiting. Amenorrhea and chronic bowel problems are also associated with this eating disorder.

Although it is stereotyped that individuals suffering from anorexia nervosa fear the scale, it is actually bulimics that seem to show the most fear of stepping onto a scale. Because bulimia nervosa sufferers have an exaggerated fear of gaining weight, they tend to avoid weighing themselves.

New findings of associated features

Professors and researchers at the University of Pittsburg Medical Center have found evidence supporting that Nervosa Bulimia may be linked by a biological factor. The researchers suggest that an alteration of brain chemistry contributes to a persons development of bulimia nervosa. Dr. Walter H. Kaye, a professor of psychiatry, states in his journal article that, “Women with bulimia nervosa, when bingeing and purging, are known to have alterations of brain serotonin activity and mood as well as obsessions with perfectionism” (Kaye, et al., 1998). An alteration in serotonin levels could cause one to portray anxious and obsessive behaviors.

Symptoms

1. The patient’s laboratory blood studies, including measurement of electrolyte levels are abnormal
2. Patient suffers from recurrent mood swings or depression.
3. Problems with stomach, esophagus, colon and throat.
4. Patient has no satisfaction with their body shape and is preoccupied with becoming thin.
5. Excessive exercising to control weight gain.
6. Unable to stop binge/purge cycle without intervention.
7. Dental problems
8. Frequent weight fluctuation
9. Fear of weight gain
10. Build up of fluid with swelling of the parotid glands.

Child vs. adult presentation

Onset is later in both children and adults for anorexia nervosa, and bulimia usually begins in late adolescence or early adulthood. It is usually 15 to 21 years of age that onset is diagnosed or becomes possible to diagnose. It is vital that a clinician has time to evaluate the behaviors of the individuals and the environments they inhabit.

The age of onset for children has recently lowered to 9-12 years. This could be related to the pressures from the media and television. Television shows for kids show the same favorable societal definitions that adult shows provide. The decrease in the age of onset could also be related to the onset of puberty decreasing as well. Because children are beginning to experience puberty sooner, their bodies are also developing at a earlier age. For girls, this means more fat tissue is formed which may possibly cause unhealthy self images to exist at earlier ages. Because these children are so young, the abnormal diet and lack of nutrition can lead to the absence of nutritional essentials for their development.

Gender and cultural differences in presentation

Females are much more likely to suffer from Bulimia Nervosa than males. About 1 male for every 10 females suffers from Bulimia Nervosa. This is because women tend to care more about their appearance than males. There are no cultural differences among patients with Bulimia Nervosa regarding their symptoms.

Cultural differences: In Eastern Asian countries, weight is considered to be an indifferent topic; however, their body structure and diet may reduce the chances of staying thin.

Epidemiology

About 1% to 3% of people have reported or been diagnosed with Bulimia Nervosa during their lifetime, and most are female. The male to female ratio is 1 male to 10 females.

There are also new studies being conducted that compare the environmental factors of binging and purging habits on the individuals who have Bulimia Nervosa. One of the studies show that there is a 46% binging variance and a 72% vomiting variance. Showing that because of environmental factors, binging can only occur during certain periods while vomiting can happen more frequently. Also, another study in the UK has shown that Bulimia Nervosa is increasing at high rates, almost doubling in occurrence every year, with a lower frequency of occurrence for Anorexia Nervosa.

Bulimia Nervosa usually begins in late adolescence or early adult life. The binge eating often begins during or after a dieting episode. Disturbed eating behavior lasts for at least several years in clinical samples. The course may be chronic or intermittent, with remission altering with relapses into binge eating. over long term, the symptoms of many seem to diminish. Remission longer than one year is associated with better long-term outcome.

Studies show that only 6% of people suffering from Bulimia Nervosa receive mental health care. Statistics show that there has been a dramatic increase of Bulimia in recent years among women between the ages of 15 and 24.

Etiology

The cause for this disorder is believed to be less from the desire for food, and more from an interaction between biological, environmental, and psychological factors. Common personality characteristics found in people with this disorder are that they are outgoing, sociable, impulsive, and more sexually active. However, a decrease in sex drive or a person's libido is also reported along with an increase in suicidal behavior.

There is strong evidence of genetic heritability for people with Bulimia Nervosa. A person is six times more likely to develop the disorder if they have a relative with the disorder. Low levels of serotonin have also been found to have a connection with development of Bulimia Nervosa. There is more familial prevalence of obesity in Bulimia Nervosa, compared to that of Anorexia Nervosa.

Psychological Factors: Bulimia includes an obsession with thinness, a diminished perception of self-worth, and an impaired sense of self-confidence. People with bulimia also associate thinness with success, attractiveness, and happiness.

Comorbid Conditions

Depression, anxiety, phobias or intense fears, and personality disorders such as Histrionic Personality Disorder, Borderline Personality Disorder, and Obsessive Compulsive Personality Disorder, are often associated with Bulimia Nervosa along with other types of eating disorders. Also, insomnia is sometimes coexistent with Bulimia Nervosa due to malnutrition. It is not uncommon for people with Bulimia Nervosa to develop certain addictions like gambling, shoplifting, or alcohol and drug usage. In fact, research shows 9% of the general population use alcohol and drugs, whereas 30-50% of people with eating disorders use them.

Empirically supported treatments

- Some medications, such as fluoxetine (Prozac) are used to treat mood symptoms (depressive symptoms, mood elevations, binge eating desires) for people who are suffering from Bulimia Nervosa. The most common medications are Tricyclic antidepressants such as Selective Serotonin Re-Uptake Inhibitors (SSRI's). Medication to treat acid reflux caused by bulimia may also be prescribed. Vitamin and mineral supplements are necessary until signs of deficiency disappear and normal eating patterns are established.
- Cognitive Behavioral Therapy methods are also conducted to change the mindset of people with Bulimia Nervosa. This method focuses on changing the way patients think about their body image, and can sometimes be done in groups. In addition, restriction to binge-type foods is also used to control people who engage in binge-eating.
- Family therapy involving communication exercises, conflict resolution, and re-establishing boundaries is used more often than other treatments of Bulimia Nervosa.
- Individual psychotherapy helps the patient develop self-esteem and assertiveness. This therapy also teaches the patient streamlining social skills and pressure-coping strategies.

- Hospitalization is helpful for bulimia patients who have extreme eating binges which have caused severe medical problems and health hazards. Patients may also have to be hospitalized if they show signs of being suicidal.

Links

- Video about male bulimia: http://www.youtube.com/watch?v=HqpVc39ZSzg

http://www.youtube.com/watch?v=HqpVc39ZSzg

- http://www.bulimiaguide.org/
- What is Bulimia Nervosa?: http://www.5min.com/Video/What-is-Bulimia-Nervosa-231371849

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6.141: Eating Disorder Not Otherwise Specified (307.50)

DSM-IV-TR Criteria

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced committing after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.

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6.142: Binge-Eating Disorder

DSM-IV-TR criteria

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- (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 in a similar period of time under similar circumstances
- (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge-eating episodes are associated with three (or more) of the following:

- (1) eating much more rapidly than normal
- (2) eating until feeling uncomfortably full
- (3) eating large amounts of food when not feeling physically hungry
- (4) eating alone because of being embarrassed by how much one is eating
- (5) feeling disgusted with oneself, depressed, or very guilty after overeating
- C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least 2 days a week for 6 months.

- Note: The method of determining frequency differs from that used for Bulimia Nervosa; future research should address whether the preferred method of setting a frequency threshold is counting the number of days on which binge eating occur or counting the number of episodes of binge eating.

E. The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa.

F. About 2 percent of all adults in the United States (as many as 4 million Americans) have binge eating disorder. About 10 to 15 percent of people who are mildly obese and who try to lose weight on their own or through commercial weight-loss programs have binge eating disorder. The disorder is even more common in people who are severely obese.

Associated Feature

Some individuals report that binge eating is triggered by dysphoric moods, such as depression and anxiety. Others are unable to identify specific precipitants but may report a nonspecific feeling of tension that is relieved by the binge eating. Some individuals describe a dissociative quality to the binge episodes (feeling “numb” or “spaced out”). Many individuals eat throughout the day with no planned meal times.

These individuals are seen in clinical setting have varying degrees of obesity. Most have a long history of repeated efforts to diet and feel desperate about their difficulty in controlling food intake. Some continue to make attempts to restrict caloric intake, whereas others have given up on all efforts to diet because of repeated failures. In weight-control clinics, individuals with this eating pattern are, on average, more obese and have a history of more marked weight fluctuations than individuals without this pattern. In non-patient community samples, most individuals without this eating pattern are overweight (although some have never been overweight).

These Individuals may report that their eating or weight interferes with their relationships with other people, with their work, and with their self-esteem. In comparison with individuals of equal weight without this pattern of eating, they report higher rates of self-loathing, disgust about body size, depression, anxiety, somatic concern, and interpersonal sensitivity. There may be higher lifetime prevalence of Major Depressive Disorder, Substance-Related Disorders, and Personality Disorders. Individuals suffering from this disorder also report a lower sexual drive and level of self-satisfaction and higher levels of embarrassment and guilt.

Individuals who develop BED often come from families who put an unnatural emphasis on the importance of food. For example, these families may use food as a source of comfort in times of emotional distress. As children, BED patients may have been taught to clean their plates regardless of their appetite, or to be a good girl or boy and finish all of the meal. Cultural attitudes towards beauty and thinness may also be a factor in BED.

Etiology

The causes of binge eating disorder is still unknown. BED patients are also more likely to have an additional diagnosis of impulsive behaviors (for example, compulsive shopping), post-traumatic stress disorder (PTSD), panic disorder, or personality disorders. Due to the high rates of depression seen in patients who compulsively eat, the two disorders are suspected to be linked. Whether binge eating disorder causes depression or if depression causes the disorder is still unknown. Risk increases with depression, anorexia nervosa, stress caused by lifestyle changes, such as moving or starting a new job, or a neurotic preoccupation with being physically attractive.

Epidemiology

In samples drawn from weight-control programs, the overall prevalence varies from approximately 15% to 50% (with a mean of 30%), with females approximately 1.5 times more likely to have this eating pattern than males. In non-patient community samples, a prevalence rate of 0.7% – 4% has been reported.

Empirically supported treatment

The onset of binge eating is in the late adolescence or in the early 20's, often coming soon after significant weight loss from dieting. Among individuals presenting for treatment, the course appears to be chronic.

- Psychotherapy
  - Cognitive behavioral therapy: Some studies show that cognitive behavioral therapy may help you cope better with issues that may trigger binge-eating episodes, such as negative feelings about your body or a depressed mood. It may also give you a better sense of control over your behavior and eating patterns. However, cognitive behavioral therapy hasn't been shown helpful in reducing weight. So if you're overweight, you may need additional treatment.
  - Interpersonal therapy: Interpersonal therapy focuses on your current relationships with other people. This may help reduce binge eating that's triggered by poor relationships and unhealthy communication skills. The goal is to improve your interpersonal skills — how patients relate to others, including family, friends, and colleagues. The patients learn how to evaluate the way they interact with others and develop strategies for dealing with relationship and communication problems.
  - Dialectical behavior therapy: This form of therapy can help patients learn behavioral skills to help their tolerate stress, regulate their emotions and improve their relationships with others, all of which can reduce the desire to binge eat.
  - Allopathic Treatment: Antidepressants may be prescribed for BED patients. SSRI's, such as Prozac, are usually preferred because they offer fewer side effects. However, clinical studies don't show much effectiveness for use of antidepressants in treating BED. Psychotherapy have produced better results. Once the binge eating behavior is curbed and depressive symptoms are controlled, the physical symptoms of the disorder can be addressed.
- Medications
  - Antidepressants: Antidepressants, known as selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) may be helpful for binge eating. It's not clear how these can reduce binge eating, but it may be related to how they affect certain brain chemicals associated with mood.
  - The anticonvulsant topiramate (Topamax): Normally used to control seizures, topiramate has also been found in some studies to reduce binge-eating episodes. However, it can cause serious side effects, including blurred vision, double vision, clumsiness or unsteadiness, dizziness, drowsiness, and trouble in thinking.
  - The anti-obesity medication sibutramine (Meridia): Officially included in the group of antidepressants known as serotonin and norepinephrine reuptake inhibitors (SNRIs), sibutramine has been FDA approved for long-term obesity treatment. Sibutramine may be most helpful if you have binge-eating disorder and are obese. It's been found to suppress hunger and make you feel full, leading to weight loss. However, it can cause dangerous changes in your blood pressure and other side effects.

Links

- Distinguishing Binge Eating Disorder from Bulimia Nervosa
- The following link features two individuals providing their own personal story with Binge Eating
  - This link continues the conversation with the two individuals from the above vidoe on Binge Eating
- The following link connects to an article on APA's website titled Binge-Eating Disorder: What's the Best Treatment?

- The following link connects to an audio interview on NPR with Neal Conan and Ron Saxen, author of the book “The Good Eater: The True Story of One Man’s Struggle With Binge Eating Disorder”.
- Video: http://www.encyclopedia.com/video/jphOUvVt7KA-binge-eating-disorder-my-secret.aspx

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6.143: Rumination Syndrome (307.53)

DSM-IV-TR criteria

A. Repeated regurgitation and re-chewing of food for a period of at least 1 month that follows a normal functioning period

B. 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 sufficient to warrant independent attention.

C. The behavior is not due to an associated gastrointestinal or other general medical condition.

- Esophogeal reflux, GI tract problems, etc.

Associated Features

- Rumination Syndrome may be diagnosed when a person deliberately brings food back into the mouth after being swallowed, and either re-chews and re-swallows it or removes it from the mouth.
- Rumination Syndrome is also referred to as Merycism.
- This disorder is most commonly found in cases of Mental Retardation and is usually found in infants.
- The regurgitation is not caused by a medical condition.

Etiology

- Rumination Syndrome is most common in infants and mentally handicapped persons, but also occurs in children, adolescents and adults of normal intelligence. In infants, it is thought to be caused by a lack of physical contact or nurturing. It also might be done in an effort to self-soothe.
- Studies show there is a correlation to heredity, in most cases the parents of the patient had this disorder.
- It can be brought on by a previous serious illness or through the transition of drugs.
- In adults and adolescents the disorder can be split into two categories, habit-induced or trauma-induced.
    - Habit-induced usually stems when a person has a history of regurgitation, such as Bulimia Nervosa or Professional Regurgitation. The act can manifest itself to a state beyond the person's realm of control.
    - Trauma-induced might stem from emotional or physical injury, usually one that involves excessive vomiting.

Epidemiology

- This disorder has a low prevalence and is often misdiagnosed as Bulimia Nervosa, Anorexia Nervosa, or Gastroesophageal Reflux disease (GERD).
- It is more predominantly female
- It is found more quickly in males than in females, the average for males is 11 whereas in females it's 13.8 making the average age 12.9.
- In infants the prevalence rate is 6-10% of the population and 8-10% of institutionalized adults.
- It's been shown that up to 20% of people with Bulimia Nervosa ruminate.

Treatments

Treatment for infants with Rumination Syndrome may be as simple as being fed by someone other than the primary caregiver; this is most effective if the parent is the cause of the disorder, for example, if they aren't caring or nurturing as they should be. Counseling for parents is also strongly recommended. Therapy to increase the parent-child bond can be done to deplete rumination.

In adults, often giving gum to appease an oral fixation may be helpful. Some of the same treatments for Anorexia Nervosa and Bulimia Nervosa have been shown to be helpful. Behavior Modification has also been successful in treating this disorder. Treatment also depends on the age and cognitive ability of the patient.

Diaphragmatic breathing has shown good results, by teaching to breathe with the diaphragm the muscles used to ruminate are occupied by breathing.

Children that are in serious life-threatening danger due to rumination may need to be hospitalized until their condition can be stabilized.

The Mayo Clinic has been one of the leaders in treating Rumination Syndrome and they have a high success rate. For the most successful outcome, the Mayo Clinic uses a collaboration of pediatricians, psychologists and gastroenterologists.

Medical treatment such as proton pump inhibitors or H2 receptor antagonists may be offered to help the patient protect the lining of the esophagus due to severe regurgitation.

Additional links:

- http://www.pbs.org/wgbh/nova/thin/program.html
- http://www.videomd.com/AneorexiaNervosa-fv-659.aspx
- http://www.disordered-eating.co.uk/index.html
- Girl discusses Rumination Disorder

https://www.youtube.com/watch?v=w2zpD3ncI5U

- http://recoveryforsuccess.com/rumination-syndrome.html

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6.144: Hallucinogen Dependence (304.5) and Hallucinogen Abuse (305.3)

Hallucinogen Dependence – DSM-IV-TR criteria

One of the generic Dependence criteria (i.e., withdrawal) does not apply to hallucinogens, and others require further explanation. Tolerance has been reported to develop rapidly to the euphoric and psychedelic effects of hallucinogens but not to the autonomic effects such as pupillary dilation, hyperreflexia, increased blood pressure, increased body temperature, piloerection, and tachycardia.

Specify if:

- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission
- In a Controlled Environment

Hallucinogen Abuse – DSM-IV-TR criteria

Individuals may use hallucinogens in situations that are physically hazardous (e.g., while driving a motorcycle or a car) and/or repeatedly fail to fulfill obligations at school, home, or work due to behavioral impairments caused by Hallucinogen Intoxication. There may be recurrent social or interpersonal problems due to the individual's behavior while intoxicated, isolated lifestyle, or arguments with significant others.

Associated features

- Individuals with hallucinogen dependency continue to use hallucinogens even when they are aware of the adverse effects of the drug as well as the impact on his/her life. They report "craving" hallucinogens after not using them for a period of time (It should be noted that these are psychological addictions, as hallucinogens do not create a physiological dependency). So the individual just wants the substance really bad, but is not dependent on it physically. Individuals with hallucinogen abuse continue to use hallucinogens in spite of certain cases of impairment that disable them from fulfilling obligations in their work, home, etc. This is when you know that it has a major effect on the individual when they are inhibited in most daily activities and obligations such as school duties, work, home chores, and even routine stuff such as hygiene and other motor activities. Hallucinogen use by "abusers" is generally less frequent than those with dependency. Abusers just use when a particular substance is readily available and easy to obtain, for example, if a friend is in possession of that substance. Dependent individuals need that certain substance to get a "fix" on themselves to assure themselves that they are normal. This helps the person in stressful situations in which they feel uncomfortable and think they have to do these behaviors to be or act normal.
- In Hallucinogen Dependence, withdrawal does not apply, but the person may have mental cravings for a substance. With Hallucinogen Abuse, one is likely to use less often; however, they may have a tendency to fail to fulfill certain obligations, and have legal, social and interpersonal problems that have to do with societal functions. Individuals with hallucinogen dependence tend to have a blurring of the senses, a loss of appetite, distortions, tachycardia, dilated pupils, and nausea.

Child vs. adult presentation

- There is no differentiation between child and adult presentation because it is dependent upon consumption of the substance and not from psycho developmental causes. The amount of substance consumed is generally more for the adults than the children with a particular substance mainly because of low body weight and a low tolerance level.

Gender and cultural differences in presentation

- While there are no significant differences between gender and use, it has been found that these disorders are much more prevalent in cultures where there are "raves," dance clubs, and other similar social settings where hallucinogens are common. There is move from recreational use to disorder is determined by cultural and social contexts; what is acceptable depends on what society it occurs in. Norms are defined by how a society defines addiction. Majority of research is on males because they are overall more likely to use and abuse psychoactive substances. Women use more in response to current stressful situations and are more likely to have used a substance preceded by another mental disorder. Women users are seen as more promiscuous

and more likely to be a victim of a violent crime. There is a stigma attached to women who use because people view it as socially unacceptable. They generally do not reveal their problems on their own, an intervention is likely to help recover. Female users appear not to respond as well to treatments, family support and other numerous factors.

Epidemiology

- Hallucinogen dependency is considered more rare than abuse. Only 2-3% of people who recurrently use hallucinogens become dependent upon them. Abuse is not as rare and a little more common because the amount of time required to abuse rather than depend on a substance is less. To abuse a substance, a person just uses it and eventually will want to do it again, and it is usually followed by some form of dependence. This would involve wanting the substance on a regular basis, and if not in possession of said substance, some aggressive, stress reaction would follow; it could also be in the form of violent behaviors that would end up hurting others close to you.

Etiology

- The causes of hallucinogen dependency and abuse are difficult to pinpoint, as they are purely psychological addictions. Self-esteem, self-worth, and history with other substance use are the best indicators of one's susceptibility to hallucinogen dependence and/or abuse. When a person uses drugs it makes it more likely that they will try other drugs. There is a 40% to 60% risk of alcoholism that is explained by genetic influences. Alcohol dependence is 3-4 times higher in close relatives of people with alcohol dependence. There is reinforcement of substance use because of how it reduces anxiety and tension.

Empirically supported treatments

- In the treatment of one under the influence, Lorexone has been used to mitigate the anxiety attack resulting from a "bad trip." The treatment of dependency involves extended sessions of psychotherapy. Any underlying physiologic disorders connected to addictive personality, if present, should be addressed and resolved. Pharmacotherapy treatments that have little effect if discontinued are Antabuse, which is naltrexone for alcohol, and Methadone or LAAM for opiates. Co-occurring disorders may be treated medically with antidepressants and SSRI's, or selective serotonin re-uptake inhibitors. Antipsychotic medicines can also be prescribed to help with the dependency; haloperidol and risperidone are examples of these. Also, certain treatments require the use of self-help groups, such as Narcotics or Alcoholics Anonymous, in order to provide a secure and encouraging environment for the individual.

Links:

- Ecstasy Destroys: Documentary Education Video/MDMA Ecstasy Destroys

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6.145: Schizophrenia

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.

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6.146: Hallucinogen Intoxication (292.89)

DSM-IV-TR criteria

A. Recent use of a Hallucinogen.

B. Clinically Significant maladaptive behavioral or psychological changes (e.g., marked anxiety or depression, ideas of reference, fear of losing one's mind, paranoid ideation, impaired judgment, or impaired social or occupational functioning) that developed during, or shortly after, hallucinogen use.

C. Perceptual changes occurring in a state of full wakefulness and alertness (e.g., subjective intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias) that developed during, or shortly after, hallucinogen use.

D. Two (or more) of the following signs, developing during, or shortly after, hallucinogen use:

- pupillary dilation
- tachycardia
- sweating
- palpitations
- blurring of vision
- tremors
- incoordination

E. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Associated features

- Hallucinogen Intoxication usually begins with some stimulant effects such as restlessness and autonomic activation. Nausea may occur. A sequence of experiences then follows, with higher doses producing more intense symptoms. Feelings of euphoria may alternate rapidly with depression or anxiety. Initial visual illusions or enhanced sensory experience may give way to hallucinations. At low doses, perceptual changes frequently do not include hallucinations. Synesthesias (a blending of senses) may result, for example, in sounds being "seen." The hallucinations are usually visual, often of geometric forms or figures, sometimes of persons and objects. More rarely, auditory or tactile hallucinations are experienced. In most cases, reality testing is preserved (i.e., the individual knows that the effects are substance induced).
- Symptoms include distortion of sight, sound, and touch, disorientation, paranoia, anxiety attacks, blissful calm or state of being mellow, increased empathy, long-term memory loss, and impaired concentration and motivation.
- Physical symptoms include increased blood pressure, increased heart rate, vomiting, blurred vision, enlarged pupils, sweating, diarrhea, restlessness, muscle cramping, dehydration, and increase in body temperature that may lead to seizures.

Child vs. adult presentation

Gender and cultural differences in presentation

Epidemiology

Etiology

Empirically supported treatments

While someone is suffering from Hallucinogen Intoxication it is best to have physical contact with the person, although sometimes adverse reactions do occur to physical touch sometimes it helps to keep the person intact with reality. Helping the intoxicated person to breath slowly and keep them away from large groups of people helps.

Links:

- ONF NFB: Hoffman's Potion

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6.147: Hallucinogen Persisting Perception Disorder (Flashbacks) (292.89)

DSM-IV-TR criteria

A. The re-experiencing, following cessation of use of a hallucinogen, of one or more of the perceptual symptoms that were experienced while intoxicated with the hallucinogen (e.g., geometric hallucinations, false perceptions of movement in the peripheral visual fields, flashes of color, intensified colors, trails of images of moving objects, positive afterimages, halos around objects, macropsia, and micropsia).

B. The symptoms in Criterion A cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The symptoms are not due to a general medical condition (e.g., anatomical lesions and infections of the brain, visual epilepsies) and are not better accounted for by another mental disorder (e.g., delirium, dementia, Schizophrenia) or hypnopompic hallucinations.

Associated features

Major depression and panic disorders and frequented associated features of HPPD.

Child vs. adult presentation

Gender and cultural differences in presentation

Epidemiology

- Episodes of self induced abnormal perceptions are associated with HPPD. These episodes can occur simply by thinking about them or can be triggered by stressors such as entry into a dark environment, various drugs, and anxiety or fatigue. These episodes will usually stop or be less frequently occurring after several months. The individual must be able to recognize that the perception is a drug effect and does not represent external reality. A diagnosis of Psychotic Disorder Not Otherwise Specified would be needed if the individual has a delusional interpretation concerning the etiology of the perceptual disturbance.
- Uncommon, although prevalence rates are higher in larger populations, the amount of people who take hallucinogens and those who suffer from HPPD have no correlation.

Etiology

No one is completely sure what causes HPPD, although there have been many theories. Many believe that the excessive use of hallucinogen causing drugs do not develop HPPD.

Empirically supported treatment

HPPD can often times mimic side affects of a stroke, brain tumor, or any other neurological disorder. Antidepressant drugs can sometimes help but there is no certain cure or treatment for HPPD. Psychotherapy helps to reduce anxiety or to help one cope with the hallucinations, but unfortunately there is nothing to take away the actual hallucinations. Benzodiazepines such as Valium or Xanax can help to reduce haullucinations as well as the anticonvulsant drug Clonazepam/Klonopin.

DSM-V Proposed Changes: Adding “Hallucinogen-Use Disorder”

DSM-V Criteria for Hallucinogen-Use Disorder:

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, ant-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

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

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6.148: Opioid Abuse (305.52)

DSM-IV-TR criteria

A maladaptive pattern of substance 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 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. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

4. 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)

Or that symptoms have never met the criteria for Substance Dependence for this class of substance.

Associated features

Opioids are drugs that include both natural and synthetic substances. The mental effects of an opioid abuser include depression with few or all of its diagnostics, such as selflessness, problems sleeping, lack of interest, faulty coping skills, and even suicidal thought. The effects of opioid abuse are not easily noticeable. The only recognizable observation that could be made is the result of small-sized pupils, or inflamed nasal mucosa if snorted. Although opioid abuse is not as severe as being dependent of opioids, it does however continuously result in negative consequences of using the drug recurrently.

Child vs. adult presentation

Opioid abuse can arise in both children and adults at any age, yet is most common among young adults roughly starting at about sixteen and older. The age of first use opioid abuse is typically about sixteen years of age, though this age has been dropping over the years. From 2002 to 2007 opioid abuse among young adults (18 & older) rose by more than twelve percent. Although opioid abuse is harmful to the abuser, it can also result in mental injury or death of young children, most often between the ages of three and six.

Gender and cultural differences in presentation

Opioid abuse among men increased two percent in 2002 to 2.6 percent in 2007 but did not change significantly for females. Men are twice as likely to overdose on pain relievers than women. Males are more likely to abuse opioids than females, with the male-to-female ratio being approximately 1.5:1 for prescription opioids. There is a much higher incidence of opioid-related deaths in rural areas than urban areas.

Epidemiology

Opioids that are most commonly abused are oxycodone (79%), hydrocodone (67%), methadone (40%), morphine (29%), heroin (13%), hydromorphone (16%), fentanyl (9%) and buprenorphine(1%). Regular opium is also abused but is in some form listed previously.

Etiology

There are no definite causes of opioid abuse other than initial choice to use the drug, though this choice can be highly influenced by peer pressure. Most opioid abusers typically experience early health problems in life, behavioral problems in early childhood, low self-esteem, and lack of respect for authority figures.

Empirically supported treatments

- There are roughly eight ways to go about treating opioid abuse. These treatments include counseling, medications to reverse the effects of opioids, supportive-expressive psychotherapy sessions, and self-help groups. Opioid abuse treatment is influenced by

managed care and is changing rapidly.

- The psychotherapy sessions try to focus on relapse prevention and cognitive therapy.
- There are two major types of maintenance therapy. They are methadone and buprenorphine. Methadone has been in use for over 30 years. It acts as an antagonist and replaces the need to daily dose of different types of opioids. It reduces criminal acts and promiscuous behaviors. It is only available at specialty clinics. Buprenorphine is like methadone in reducing cravings. It is safer at higher levels which produce no side effects. It is becoming more popular for this reason. It is also more accessible because it can be used in a doctor's office.
- Opioid abuse relapse rates vary from 25%-97%, being higher for those who smoke cigarettes than those who do not. Successful treatments are determined by improvements in social functions, reduction of illicit drug use, and performance at work and school. The success of treatment often varies according to the type of opioid abused and other factors such as medical care, employment, legal situation, family, and psychological difficulties. The chances of a successful recovery from opioid abuse are much higher in those with profession degrees than those with a poor education level and lower income jobs.

Links:

- HBO: Treating Opiate Addiction With Replacement Therapy Treating Opiate Addiction
- HBO: Opiates and Your Brain Opiates and Your Brains
- An individual's personal story about Opioid Addiction. (uploaded by newsinfusion)
- A continunation of Mike's Story and the medication he used for treatment. Other possible treatments for opioid abuse are listed above. (uploaded by newsinfusion)
- The following video discusses pharmacological treatments for opioid abuse. Additional treatments are listed above. (uploaded by RickChavezMD)

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6.149: Sedative, Hypnotic, or Anxiolytic Related Abuse and Dependence (292.89)

DSM-IV-TR criteria

A) A Cessation of (or reduction in) sedative, hypnotic, or anxiolytic use that has been heavy and prolonged.

B) Two (or more) of the following, developing within several hours to a few days after Criterion A:

- autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
- increased hand tremor
- insomnia
- nausea or vomiting
- transient visual, tactile, or auditory hallucinations or illusions
- psycho-motor agitation
- anxiety
- grand or Gran Mal seizures

C) The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D) The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Specify if:

With Perceptual Disturbances

Associated features

- Slurred speech or memory loss is very common. If in a working situation, the chances of the abuser missing work or have inconsistent work effort is high. People that abuse alcohol will often have the constant smell of alcohol on their breath. Sedative, hypnotic, or anxiolytic substances can also affect ones family life, bring up more conflicts and arguments, and sometimes even split up a family.
- Other features include paranoia, trouble sleeping, and putting oneself in hazardous situations, such as driving while intoxicated or high. A result of abuse of drugs can also be coma or some times even death

Child vs. adult presentation

- Although abuse/dependency occurs more in adults than in children, the population of children consuming sedative, hypnotic or anxiolytic substances increases daily. Though children are not addicted to said substances it increases their chances of being dependent on them later on in life
- Seizures can be seen with the abuse of sedative, hypnotic, or anxiolytic substances. Grand Mal seizures or Gran Mal is a seizure type that is most commonly associated with epilepsy. There are other types that are less known and can occur.

Gender and cultural differences in presentation

Sedative, hypnotic, or anxiolytic abuse not only appears in the United States, but throughout the world. When it comes to prescription, women have higher chances of becoming addicted than men do. Also, the older the woman is, it increases her chances of substance abuse/dependency.

Epidemiology

Up to 90% of people in the United States have received some type of sedative, hypnotic, or anxiolytic drug while hospitalized. Over 15% of adult Americans take one or more of these drugs as prescribed medicine. These types of drugs could be benzodiazepines(used for may things such as insomnia, seizures, epilpsy, sedation for surgical procedures, etc., barbiturates (used for epilepsy management, contributes to withdrawal symptoms),other sleeping pills, as well as alcohol.

Etiology

- There are several causation's for sedative, hypnotic, or anxiolytic abuse/dependency. Some of those reasons include stress or depression. Many times users create an addiction to these drugs because they started abusing them at an early age. Another

causation for abuse could be that one was prescribed medicine because of injury, leading to a dependence on said medication.
- People who are addicted to said drugs have a higher chance of fighting people around them to continue taking the drugs. They will make up excuses as to why they need to take the drug, such as they cannot sleep at night without it, etc.

Empirically supported treatments

The best form of treatment for sedative, hypnotic, or anxiolytic abuse/dependency would be complete independence from all drugs. This causes users to experience withdrawal that consists of lack of sleep, breaking into sweats, anxiety, vomiting, and sometime even seizures. If the drug is one that takes longer to take effect then its withdrawal takes longer. If it is a drug that may work quickly then withdrawal symptoms with be visual sooner. In March 2007, the United States Food and Drug Administration encouraged the pharmaceutical companies producing sedative-hypnotic drugs to increase their labeling that such abuse of drugs could cause allergic reaction or sleep related behaviors.

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6.15: Panic Disorder and Agoraphobia

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 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 derealizational
    9. Flushes, 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 meditated 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 periaqeductal 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. Benzodiazipines (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 sensivity, 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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6.150: Nicotine Dependence (305.1)

DSM-IV-TR criteria

Specifiers:

- With Physiological Dependence
- Without Physiological Dependence
- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission

- Nicotine dependence is both a psychological and physical reliance on the drug nicotine that can be found in a variety of tobacco products. Throughout the world, tobacco is one of the most widely used legal substances. Nicotine research indicates that the use of even a small amount can lead to dependency. Even though nicotine has been linked to cancer-related deaths and a myriad of health related issues, an individual who is dependent upon nicotine has difficulty in cessation due to continued compulsions to use the substance. Nicotine, like many of the other substances that are grouped into substance use disorders, can produce a euphoric feeling that alters the mood of the user. These effects can be seen in the individual brain patterns of the user. Regular and normal functioning of a person with nicotine dependency often relies on this substance to complete everyday activities. At the same time, quitting tobacco use causes withdrawal symptoms, including but not limited to irritability and anxiety.

Associated features

Nicotine comes from the tobacco plant which is dried and used in cigarettes, chewing tobacco, cigars, and pipes. The use of nicotine can generate a feeling of increased alertness or relaxation in the individual. This may also depend on how much a person smokes, the strength of inhalation, and how often the person uses nicotine. The psychological aspects connected with nicotine can be triggered by normal everyday events such as waking up, getting into a car, or finishing a meal. Psychological triggers can occur when an individual is faced with particular situations or issues that make them angry, stressed, anxious, or bored. The physical reliance is related to the functioning of the brain and how nicotine affects it. Certain receptors in the brain cells come to rely on nicotine molecules to enable the normal functioning of an individual on a daily basis.

Child vs. adult presentation

- Children and adolescents often exhibit nicotine dependence symptoms even if they have never smoked. These symptoms are often a result of living with parents or guardians that smoke in the home or in the car or if they smoked while in the room. There is also an increased risk in children for developing asthma, ear infections, and colds. Infants of smokers are often more prone to sudden infant death syndrome (SIDS). Adolescents are often affected by peers that smoke in their presence; it happens all the time because not all people smoke and it is a social gathering activity to talk and smoke. Second-hand smoke can cause withdrawal symptoms in children that can be expressed as depression, irritability, problems sleeping, increased appetite, and anxiety. Nicotine dependence in children can often be seen to impair concentration and results in poor school performance. They may also experience cravings for nicotine and increased temptation to smoke when they are around others that smoke.Children that have parents that smoke are more likely to engage in the act than those who have parents that are non-smokers. It has been estimated that around 20% of teen smokers exhibit substantial nicotine dependence. Recent research suggests that some adolescents may begin to experience a loss of control over their smoking within weeks of smoking the first cigarette. In both adults and children, using any amount of tobacco can quickly lead to nicotene dependence.
- Adults, as well as children, that are exposed to nicotine may experience both short-term and long-term effects. Short-term effects include an increase in heart rate, blood pressure, and metabolism. The “fight-or-flight” response may also be experienced as a result of increased adrenaline production that causes rapid heartbeat, increased blood pressure, and rapid, shallow breathing. It takes an average of seven seconds for the effects of nicotine to reach the brain. Research indicates that there may be a drop in skin temperature, decreased appetite, diarrhea, and saliva excretion. The physical appearance of a smoker may also be altered. Smoking can change the structure of the skin, causing premature aging and wrinkles, as well as causing yellowing of teeth, fingers, and fingernails. Long-term effects include re-occurring problems with blood pressure, coronary heart disease, emphysema, shortness of breath, reduced fertility, and abnormal sperm forms. Individuals with HIV or

other immuno-deficiency diseases are more apt to contract life-threatening illnesses due to the effects of a weakened immune system that are caused by nicotine. In addition, the nicotine in tobacco can damage cell structure, causing increased cell proliferation, which may cause several types of carcinomas. Nicotine has also been known to block the release of insulin into the blood stream, leading to hyperglycemia.The blockage of insulin also increases the smoker's risk of developing type 2 diabetes and, those who already have diabetes, are at an increased risk for complications including kidney disease. Nicotine can also cause complications in pregnancy such as miscarriage, preterm delivery, and SIDS as well as low birth-weight in newborns. Newborns with low birth-weight are more likely to die or have learning or physical problems.

Gender and cultural differences in presentation

- Many of the cultural and gender differences can be seen in the history of nicotine itself. Mayan cultures indicated use of tobacco in their stone carvings as far back as 900 A.D. The Native American cultures used tobacco ceremonially and the men of the tribe would often use it as a sign of wealth and friendship. Tobacco was brought to Europe in the 1500's where it became popular via pipes, cigars, and snuff. Tobacco, however, was often punishable in some European and Asian cultures by mutilation and/or death. In the United States, tobacco still maintains its popularity and its respectability as a valuable cash crop.
- Historically, more men than women use nicotine, especially in the form of chewing tobacco. It is often used to fit in socially and to project a certain image while at the same time give sensory rewards and emotional relief to the individual using it. Smoking, at one time, projected the appearance of wealth and prestige in Rome and France where it was socially acceptable for women to smoke as well. In the United States, smoking has begun to take on a negative connotation. New laws forbidding the act of smoking in public places and in vehicles around children have emerged. In addition, pregnant women who smoke are looked down upon as it goes against the new social norms. In one city in Arizona, it is not only illegal to smoke in public places or in the presence of children, but it is also illegal to smoke in vehicles with the windows rolled down.
- Besides the traditional cigarettes and smokeless tobacco, there are several other types cigarettes that must be considered. Bidis are handmade cigarettes composed of tobacco hand-wrapped in a dried tendu or temburni leaf and tied with a string. Bidis comes in many flavors, including chocolate, wild cherry, and cinnamon. These types of cigarettes are relatively cheap and have a harmless appearance; however, because the the wrappers have a low combustibility the user has to smoke more. This is a problem because bidis produces more carbon monoxide and tar than conventional cigarettes. Bidis are popular in South Asian countries such as India, Sri Lanka, Bangladesh, Pakistan, Afghanistan, Cambodia, and Nepal. In these countries, poverty, low education, scheduled castes, and scheduled tribes are found to be associated with higher prevalence of tobacco use. Clove cigarettes called Kreteks contain a mixture of Indonesian tobacco and shredded clove spice wrapped in either an ironed corn husk or a slip of paper. Many smokers who use Kreteks inhale the chemicals much deeper because of their anesthetizing effects.
- Although 60-70% similar to conventional cigarettes, they produce twice as much tar, nicotine, and carbon monoxide. The active ingredient in cloves known as Eugenol is the anesthetic and it is known to contribute to the development of respiratory tract infections. These infections are due to the numbing effect the ingredient has on the back of the throat and trachea which hides the harshness of the cigarette. This numbing effect contributes greatly to an increase in nicotine dependence. This type of tobacco product is mainly used in Indonesia; however, internet sales have increased its popularity to all other parts of the world. Another type of tobacco product is known as a hookah, or its alternate name "hubble bubble". A hookah is a long-necked water pipe in which the smoke passes through a long tube and through an urn of water that makes a bubbling noise. In India and Persia, the bulb used to hold the water is made of coconut shells although in many cases they are made of glass, porcelain, silver, or crystal embedded with gold and silver. There has been little research done to support the claim that hookah smoking delivers less harmful substances to the smoker than do conventional cigarettes; however, hookah smoke contains significant amounts of carbon monoxide and nicotine. Hookah smoking has gained popularity in not only India and Persi, but also many of the Arab countries, London, England, and Paris, France have caused a regained interest due to the proliferation of Hookah cafes.

- Smokeless tobacco is used as a broad term that refers to more than thirty types of products. These products are used around the world but are most common in northern Africa, Southeast Asia, and the Mediterranean region. These products are consumed without burning the product and can are used orally or nasally. Most of these products are placed in the mouth, cheek, or lip and are sucked (dipped) or chewed. Fine tobacco powder may be inhaled and absorbed through the nasal passages. Southeast Asia is a major producer and exporter of smokeless tobacco. In countries such as India and Bangladesh, smokeless tobacco is often associated with areas of low education and low income. Despite the harmful effects, smokeless tobacoo may be used to treat

toothaches, headaches, and stomachaches. Harmful effects include an increase in the risk of oral cancers, oral submucous fibrosis, hypertension, and reproductive health problems.

- In some cultures, such as First Nations People, tobacco is used as a medicine in ceremonial practices. For the purposes of honoring and including cultural traditions and healing practices in relation to new laws being written regarding the use of tobacco, the difference between tobacco use and dependence, ceremonial tobacco, and recreational use must be clearly defined.
- The 1998 Surgeon General's report, Tobacco Use Among U.S. Racial/Ethnic Minority Groups, addressed diverse tobacco-control needs of the four primary U.S. racial/ethnic minority populations: non-Hispanic blacks, American Indians/Alaska Natives (AI/ANs), Asians/Pacific Islanders, and Hispanics. The report results indicated that the prevalence of cigarette smoking among adults age 18 and older ranged from 40.4% for AI/ANs to 12.3% for the Chinese population. The prevalence amoung youths aged 12-17 years ranged from 27.9% for AI/ANs to 5.2% for the Japanese population.

Epidemiology

It has been found that 55%-90% of those that are diagnosed with mental disorders also use nicotine on a regular basis. In the general population, 30% of individuals were found to be users of tobacco that were absent mental illness. It has also been indicated that 25% of the population of the United States has been diagnosed with nicotine dependence. Of those that use tobacco on a regular basis, 45% can stop using nicotine eventually; however, it has been estimated that only 5% will be successful without help. People who have depression, schizophrenia, and other forms of mental illness are more likely to be smokers simply because it may be a form of self-medication for these disorders. People who abuse alcohol and illicit drugs are also more likely to be smokers. Diagnosis of substance dependence, including nicotine dependence as well as others, is based upon the 'Four Cs' Test. This test is conducted by psychiatrists, psychotherapists, social workers, and addiction counselors. This test focuses on four areas: compulsion, control, cutting down, and consequences. Compulsion is the intensity with which the desire to use a chemical, such as tobacco, overwhelms the patient's thoughts, feelings, and judgements. Control focuses on the degree to which patients can (or cannot) control their chemical use once they have started using. Cutting down refers to the analysis of the withdrawal symptoms experienced by an individual. This aspect focuses on the effects of reducing chemical intake. The final factor deals with the consequences associated with the chemical dependence. This area deals with the denial or acceptance of the damage caused by the chemical. The 'Four Cs' Test is the DSM-IV based diagnosis of nicotine dependence.

Etiology

Nicotine dependence is caused by the reliance of receptors in the brain that deal with mood-altering and physical effects on the body. The nicotine binds to nicotine receptors that then stimulate such neurotransmitters including dopamine. These neurotransmitters become dependent on the chemical in order to regulate normal body functioning. Nicotene is responsible for a host of health problems; however, the physical and mood-altering effects in the brain are temporarily pleasing. It is these effects that spur continued use of tobacco products and this is ultimately what leads to dependence. Adolescents that smoke may be more prone to being diagnosed with nicotine dependency because their brains are not fully developed. The genes that are inherited play a role in some aspects of nicotine dependence. This is based on more than just the immediate environment (i.e. having parents that smoke). For example, the likelihood that an individual will start smoking and keep smoking may be partly inherited. Some people experiment with smoking and don't experience the pleasure, so they never become smokers. Other people develop dependence very quickly such as the dependence seen in adolescents. Some "social smokers" can smoke just once in a while, and yet another group of smokers can stop smoking with no withdrawal symptoms. These differences can be explained by genetic factors that influence how receptors on the surface of the brain's nerve cells respond to nicotine.

Empirically supported treatments

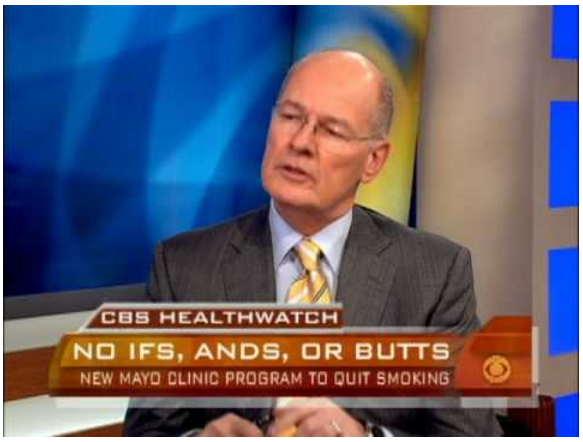
- Medications, which include nicotine replacement therapy, can be effective treatments for nicotine dependency. Nicotine replacement therapy includes products that include nicotine at lower doses, without the appearance of the over 3,000 chemicals that are in tobacco products. These products include nicotine patches, gums, and lozenges. Prescription products, such as nicotine nasal spray (Nicotrol NS) and nicotine inhalers are also available on the market to help combat nicotine dependence. Many medications used to help curb the cravings of nicotine dependency do not include nicotine. Certain antidepressants, such as Zyban or Wellbutrin, can help increase the levels of norepinephrine and dopamine in the brain to reduce the need for nicotine. Varenicline, which targets nicotine receptors in the brain, and high blood pressure medication such as Clonidine are examples of other non-nicotine medications that are in use to help individuals reduce and/or stop the use of nicotine. Research

shows that amalgamating medications and behavioral counseling is an effective way for long-term success in being sober from tobacco. The counseling helps develop the skills needed to stay away from the substance. In addition, the development of vaccines are being investigated which will prevent nicotine users from relapse. There are no physical tests top determine the exact degree to which an individual is dependent upon nicotine. A physician may assess the degree of an individual's dependence by asking questions or having a questionnaire completed. The more cigarettes a person smokes each day and the earlier in the day a person smokes after awakening, the more dependent the individual is.

- Most of the nicotine replacement products are available over-the-counter. The nicotine patch, which includes NicoDerm CQand Habitrol, delivers nicotine through the skin and directly into the bloodstream. A new patch is placed on the skin each day and the treatment period usually lasts for eight weeks or longer. The patch dosage may be adjusted or an additional medication may be needed in order to stop smoking if this has not occurred after two weeks. Nicotrol inhaler is a nicotine inhaler that is shaped like a cigarette. This allows the smoker to satisfy the urge as well as the physical act of smoking. This inhaler delivers nicotine vapors into the mouth where it is absorbed in the lining of the mouth directly into the bloodstream. However, the inhaler may cause side effects such as mouth and/or throat irritation and occasional coughing.
- Current funding is being used to create opportunities for development and implementation of youth tobacco-control programs. Research shows that combining medicine with behavioral counseling provides the best chance for long-term success in abstaining from alcohol. Medication is used to lessen the withdrawal symptoms in an individual that has nicotine dependence while the behavioral treatments focus on helping the individual develop the skills needed to stay away from tobacco over the long run.

Links:

- Nicotine in the brain Nicotine in the Brain
- What's Inside a US Blended Cigarette? Inside a Cigarette
- Effects of Nicotine on the Brain. Effects of Nicotine on the Brain
- What happens when you quit smoking: Smoking Withdrawals
- Dr. Richard Hurt from the Mayo Clinic discusses possible ways to quit smoking (uploaded by CBSNewsOnline, direct link https://youtu.be/_9DurNWR-hQ)



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=404

- An individual's personal story on quitting smoking (uploaded by livestrong)
- Methods to help smokers quit (uploaded by TheIowaClinic)

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6.151: Alcohol Dependence (303.90)

DSM-IV-TR criteria

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) 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

(2) 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

(3) The substance is often taken in larger amounts or over a longer period than was intended

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) Important social, occupational, or recreational activities are given up or reduced because of substance use

(7) 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)

Specify if:

- With Physiological Dependence
- Without Physiological Dependence
- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission
- In a Controlled Environment

Associated features

- Statistics show that: in the United States about one out of ten people are alcohol dependent; there is either an intoxicated driver or pedestrian involved in approximately one half of all highway fatalities; and among individuals with alcohol dependence, approximately ten percent commit suicide (this is shown to be related to Substance Induced Mood Disorders) . Other studies show a connection between long term heavy alcohol use and the development of Dementia and Wernicke's disease. In pregnant women alcohol dependence can also cause different birth defects such as Fetal Alcohol Effects (FAE) and Fetal Alcohol Syndrome (FAS).Fetal Alcohol Syndrome is more severe and usually causes some form of mild Mental Retardation and physical defects leading to intellectual deficiencies and learning disabilities. The statistics concerning FAS are staggering. It is estimated that out of every 1000 infants born alive, approximately 1.5 has FAS. Not only is Fetal Alcohol Syndrome the primary preventable cause of Mental Retardation in the United States, it is also the third leading cause of birth defects.
- Regarding tolerance, it is a sign that the liver has been damaged when reverse tolerance, that is, the need of less alcohol to produce the desired effect, appears.

Child vs. Adult presentation

Having hyperactive ADHD increases teenagers' chances of using alcohol. Children who come from families that sanction drinking have a higher risk of becoming alcohol users. Adolescents and teenagers who first use alcohol are starting the experimentation

process. Adults who first use alcohol are doing so because of some positive or negative influence in their lives.

Gender and Cultural differences in presentation

- Religion is a large factor in the rates of alcohol abuse and dependence in different cultures. Part of that influence is the context in which the alcohol is being used. There tends to be lower rates of Alcohol Dependence in cultures that use alcohol in religious ceremonies. Rates of Alcohol Dependence are higher in cultures where religion uses alcohol as a social lubricant.
- Alcohol dependence is more prominent among Native Americans and Irish or Irish Americans. For Native Americans this stems from the history of being deprived of their lands and denied the stability of economic success. Because their homes are usually too small and crowded to get together with friends and family, the pub is usually the social center of the Irish way of life.
- Men represent a larger population of alcohol dependent's than do women. Numerous studies have shown that men will be less likely to abstain from using alcohol, and hence more often become dependent on the substance. Men generally consume more alcohol and abuse alcohol more frequently than women (Homila 2004). From culture to culture the size of this discrepancy varies, and more research is needed to explain why these cultural differences exist.

Epidemiology

Ninety percent of the population has used alcohol at some point in their lives. Alcohol has the effects of positive reinforcement by changing brain and body chemistry. Alcohol also has a negative reinforcement effect of removing inhibitions and anxiety. It is at least three times as likely for a primary biological relative to have Alcohol Dependence if a first degree biological relative has the same disorder. The environment of where individuals live and their Socio Economic Status also play a role in developing Alcohol Dependence. There is also a new theory being studied that connects Alcohol Dependence to abnormally low serotonin levels.

Etiology

- There are many various factors that influence whether or not an individual develops alcohol dependence. From a psychoanalyst perspective, Alcohol Dependence would be seen as a result of anxiety, repressed emotions, or neurotic conflict, and could also be used as a way to boost self esteem. Having an oral fixation has also been connected to Alcohol Dependence. There can also be a genetic connection. A key factor is that the individual must hold a positive attitude towards alcohol. Peer pressure during adolescence and the media portrayal of alcohol (having sex appeal) throughout life are also strong influential factors. Once an individual gives into the pressure he will start to experiment with alcohol. These experiments may have positive or negative effects. If the individual has a positive opinion about alcohol and enjoys drinking then he will continue to drink. If he steadily increases the amount of alcohol he drinks it could eventually lead to complications of his everyday life. Ads for alcoholic beverages are increasigly targeted at the youth, especially young men, sending the message that drinking beer may, for example, cause scandalously clad women to flock to one's location. The individual then begins to experiment with alcohol, usually with a peer group, and continues use through school. Problems occur and worsen the heavier the alcohol use becomes.
- Two key etiological factors are generally agreed upon. First, the individual must have a positive attitude toward alcohol.

Empirically supported treatments

- It is much easier to treat and stop the alcohol abuse before it becomes dependence. There are many proposed treatments for an individual with Alcohol Dependence. Psychotherapy, ketamine-enhanced psychotherapy (Kolp, Friedman, Young & Krupitsky, 2006), medications such as Disulfiram (Mustard, May & Phillips,2006; Obholzer, 1974), 12-step programs (Gomes & Hart, 2009), and religious programs are all empirically supported treatments for individuals with Alcohol Dependence. It is not uncommon for two or more of these methods to be used in treating individuals with Alcohol Dependence. Spirituality is suggested to be inversely related to alcohol use, therefore, increasing one's spirituality is an approach taken by many substance-abuse professionals in an attempt at treatment of the Substance-Related Disorders (Johnson, Sheets & Kristeller, 2008). Twelve-step programs such as Alcoholics Anonymous or Narcotics Anonymous are examples of commonly used spirituality-based treatments for Substance-Related Disorders. It is suggested that use of a 12-step program in combination with psychotherapy is quite effective (Knack, 2009). Groh, Jason, Ferarri, & Davis (2009) examined the effectiveness of 12-step involvement in combination with the use of an Oxford House (group recovery living) in 150 substance-dependent individuals. Groh (2009) and his colleagues found that in the 12-step/Oxford house combination condition, 87.5% of individuals with "high 12-step involvement" were abstinent at 24 months. Abstinence rates at 24 months for individuals with "low 12-step involvement" were fairly similar across both conditions; 12-step/Oxford combination = 31.4%, 12-step alone = 21.2% (Groh, Jason, Ferarri, & Davis, 2009)

- The Disease Model sees Alcohol dependence as a medical condition. This model ties into the genetic factor. If Alcohol Dependence is seen as a biological condition then the only successful way to treat it, is to completely abstain from drinking alcohol. The self help group Alcoholics Anonymous (AA) recognizes the disease model. It is unsafe for an individual that is dependent on alcohol to stop “cold turkey”. The alcohol must be removed from the system in a slow process of detoxification. To prevent sever withdrawal complications, the individual will be given some form of anti-anxiety medications. Medications such as Antabuse may also be used in an attempt to maintain abstinence. Severe Alcohol Dependence can have a spontaneous remission with about twenty percent never experience drinking problems again.

Links:

- CBT Role Play – Alcohol Dependence Alcohol Dependence
- Alcohol and Drug Dependence Dependence
- Alcohol Addiction and Abuse Addiction and Abuse

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6.152: Alcohol Abuse (305.00)

DSM-IV-TR criteria

A maladaptive pattern of substance 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 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) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) 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)

Or the symptoms have never met the criteria for Substance Dependence for this class of substance.

Associated features

- Alcohol abuse has a high co-morbidity rate with the abuse of other substances. When substances that are normally abused are not available, alcohol may be used as an alternative. Alcohol abuse can also be associated with other psychological disorders such as conduct disorder and antisocial behavior in adolescents. Alcohol has the psychological effect of inhibition reduction making it seem as if it is a stimulant. Alcohol is in fact a depressant of the central nervous system (CNS). It is estimated that forty percent of all people in the United States will be involved in an accident related to alcohol at some point during their lives and that fifty five percent of all fatal driving accidents are in some way due to alcohol. A diagnosis of Alcohol Abuse can be applied when alcohol is causing problems in the individual's life activities. Binge drinking is a serious problem and also a form of abuse that occurs in about fifty-percent of college men. The average age that one peaks at consumption and abuse is twenty one. Individuals who qualify for Alcohol Abuse typically consume alcohol in situations that are hazardous to one's health. The most common of which is driving while intoxicated (DWI) from alcohol and is the number one cause of all automobile accidents in the United States.
- Alcohol withdrawal occurs when one stops or reduces heavy or prolonged use. Some withdrawal symptoms are autonomic hyperactivity, increased hand tremor, psycho-motor agitation, insomnia, nausea or vomiting, and transient visual, auditory or tactile hallucinations or delusions. Also anxiety and grand Mal seizures may be present.

Child vs. adult presentation

According to recent studies, the prevalence of alcohol abuse among adolescents ranges between four and percent in males. This percentage has been found to increase with age. Children who start to use alcohol at an earlier age (before fifteen) have a higher tendency to abuse alcohol later on. The age at which adults abuse alcohol varies widely. Males tend to present with alcohol abuse at a younger age than females.

Gender and cultural differences in presentation

- Men are diagnosed with alcohol abuse more often than women. The ratio has been as high as 5:1 with a variance between age groups. Men start drinking at a younger age than women, however, once alcohol use becomes abusive, the disorder progresses faster in females than in males. The rate is highest among men aged 18 to 25, most of which are in college. Throughout different cultures, the amount of alcohol abuse varies widely. There are many possible reasons for this variance; alcohol is more readily available in some cultures than in others and each culture has its own social beliefs and regulations about drinking. What is socially acceptable in one culture is not necessarily the same in others. Cultural attitudes about alcohol consumption are also affected by the religious beliefs of each culture. Alcohol abuse also has different physiological effects on people of different cultures because of the religious beliefs and what is expected when alcohol is consumed, such as hallucinations or delusions as a possibility.

- Prevalence is high in western countries; Asian cultures have a low prevalence but male to female ratio is high. Caucasian males generally reach a peak, in terms of alcohol use, during early adulthood from ages 18-30. After age 30 alcohol use in this group tends to wane throughout the rest of life. African American males often display drinking patterns completely different from those of Caucasion males. African American males generally have low instances of alcohol abuse during their 20's, and rising use during their 30's and 40's (Homila, 2004).
- Women are affected differently than men. When consuming alcohol women become more impaired even when taking weight into account. The reason is that alcohol mixes with the water in your body and that dilutes it. Men generally have more water in their bodies than women, so alcohol is diluted more when men drink it versus women. A binge drinker is classified as a person that consumes 5 or more drinks in a one week period more than once a week in men, and only 4 or so for women in the same classification.

Epidemiology

It is estimated that between sixty-six and ninety percent of all adults have at some time in their lives consumed alcohol. Although alcohol abuse is not as severe as alcohol dependence, it is more common and can be seen a precursor to dependence. Alcohol is the second most used psychoactive substance, next to caffeine. Lifetime prevalence is 13.3% to 15% in the general population. The highest prevalence is in ages 26-34 with 77% prevalence. Alcohol abuse and dependence are co-morbid with Axis I and II, mood disorders, anxiety, Schizophrenia and Anti-Social Personality disorder. Depression may result from effects of intoxication or withdrawal. Concurrent and sequential treatments are questionable for other problems.

Etiology

Individuals who have a positive attitude about alcohol consumption tend to be more likely to abuse alcohol. There are many different types of and reasons for alcohol abuse. These reasons range from psychosocial to physiological and cultural. One type of alcohol abuse is getting drunk or binge drinking (which has a high prevalence in college men) at social events. Alcohol abuse can also be attributed to other substance abuse disorders and psychological disorders. Alcohol abuse can be used to deal with physiological problems or pain. There is also a possible genetic factor involved in alcohol abuse and dependence.

Empirically supported treatments

The first and most important step in treatment of alcohol abuse is to make the individual realize and admit that he abuses alcohol. The most effective way to prevent alcohol abuse is abstaining from its use. Clinical therapy can also be used to help the person learn to control the amount of alcohol consumption. Prescription medications can also be used to reduce the desire to consume alcohol. Alcoholics Anonymous is a self-help group that has been around for over seventy years. This program is structured around alcohol dependence but can be used by alcohol abusers that realize they may be on the road to dependence. Its method is called the "Twelve Step Program." Members introduce themselves anonymously and progress through the twelve steps. Some studies show a greater recovery in those individuals who participate in non-emotion centered therapy. Other individuals involved in therapy centered on depression or other emotional problems have a tendancy to show lower recovery rates (Raitasalo, 2005).

Links:

- Health: Defining Alcoholism What is Alcoholism?
- Alcoholism Alcoholism
- Health: Alcoholism Diagnosis and Treatment Treatment of Alcohol
- End Result of Alcoholism (College Health Guru) Results of Alcoholism
- Alcohol: A Women's Health IssueAlcohol and Women
- Alcohol Abuse in College WomenAlcohol Abuse and Women
- What is Alcohol Poisoning? (College Health Guru) Alcohol Poisoning
- Alcohol Abuse Alcohol Abuse
- Abuse of Alcohol Abusing Alcohol
- History of AA Alcohol Awareness
- Alcohol Abuse vs Dependence Some signs of each (uploaded by :, direct link http://www.youtube.com/watch?v=FdAu5HcMuBs)

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6.153: Alcohol Intoxication (303.00)

DSM-IV-TR criteria

A. Recent ingestion of alcohol

B. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment, impaired social or occupational functioning) that developed during, or shortly after, alcohol ingestion.

C. One (or more) of the following signs, developing during, or shortly after, alcohol use:

1. Slurred speech
2. Incoordination
3. Unsteady gait
4. Nystagmus (involuntary eye movement)
5. Impairment in attention or memory
6. Stupor or coma

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

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6.154: Alcohol Withdrawal(291.81)

DSM-IV-TR criteria

A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.

B. Two (or more) of the following, developing within several hours to a few days after Criterion A:

1. Automatic hyperactivity (e.g., sweating or pulse rate greater than 100)
2. Increased hand tremor
3. Insomnia
4. Nausea or vomiting
5. Transient visual, tactile, or auditory hallucinations or illusions
6. Psychomotor agitation
7. Anxiety
8. Grand mal seizures

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Specify if:

With Perceptual Disturbances

Emperically supported treatment

- Many treatment with alcohol withdrawal syndroms can be managed with various pharmaceutical medications including barbituates, benzodiazepines, and clonidine, certain vitamins are also an important part of the management of alcohol withdrawal syndrome.
- Barbituates are superiors to diazepam in the treatment of severe alcohol withdrawal syndromes such as delirium tremens but equally effective in mildr cases of alcohol withdrawal.
- Clonidine has demonstrated superior clinical effects in the suppression of alcohol withdrawal symtpoms in a head to head comparison study with the benzodiazepine drug.
- Benzodiazepines are the most commonly used drug for the treatment of alcohol withdrawal and are generally safe and effective in suppressing alcohol withdrawal signs. Chlordiazepoxide and diazepam are the benzodiazepines most commonly used in alcohol detoxification. Benzodiazepines can be life saving, particularly if delerium tremens appears during alcohol withdrawal. Benzodiazepines should only be used short term in alcoholics who aren't already dependent on benzodiazepines as benzodiazepines share cross tolerance with ethanol and there is a risk of replacing the addiction with a benzodiazepine dependence or worse still adding an additional addiction. Furthermore disrupted GABA benzodiazepine receptor function is part of alcohol dependence and chronic benzodiazepines may prevent full recovery from alcohol induced mental effects. Benzodiazepines have the problem of increasing cravings for alcohol in problem alcohol consumers and they also increase the volume of alcohol consumed by problem drinkers. The combination of benzodiazepines and alcohol can amplify the adverse psychological effects of each other causing enhanced depressive effects on mood and increase suicidal actions and are generally contraindicated except for alcohol withdrawal.
- Vitamins
- Alcoholics are often deficient in various nutrients which can cause severe complications during alcohol withdrawal such as the development of wernicke syndrome. The vitamins of most importance in alcohol withdrawal are thiamine and folic acid. To help to prevent wernicke syndrome alcoholics should be administered a multivitamin preparation with sufficient quantities of thiamine and folic acid. Vitamins should always be administered before any glucose is administered otherwise wernicke syndrome can be precipitaed.

Links:

- How long does withdrawal last? A discussion of the time course and symptoms associated with withdrawal at different stages in alcohol abuse and dependence (uploaded by ehowhealth, direct link http://www.youtube.com/watch?v=CWrp3YXMohQ)

DSM-V Proposed Changes: adding “Alcohol-Use Disorder”

DSM-V Alcohol-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.

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

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6.155: Cocaine Abuse and Dependence (305.6)

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 it 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, psycho motor 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 Healthreported 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. Benzodiapines have shown to help people with intoxication symptoms that do not go away. Benzodiapines 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 ChemistryDrugs 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, ant-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

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6.156: Pathological Gambling

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 is 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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6.157: Cannabis Abuse and Dependence (305.20/304.3)

DSM-IV-TR criteria

A. Cannabis is a generic term used to denote the several psychoactive preparations of the plant Cannabis sativa. The major psychoactive constituent in cannabis is Δ-9 tetrahydrocannabinol (THC). Cannabis impairs cognitive development (capabilities of learning), including associative processes; free recall of previously learned items is often impaired when cannabis is used both during learning and recall periods

B. Cannabis impairs psycho-motor performance in a wide variety of tasks, such as motor coordination, divided attention, and operative tasks of many types; human performance on complex machinery can be impaired for as long as 24 hours after smoking as little as 20 mg of THC in cannabis; there is an increased risk of motor vehicle accidents among persons who drive when intoxicated by cannabis.

C. Some difficulties when cannabis is used may interfere with academic or occupational achievement or with social communication. Coding should be in AXIS I: CLINICAL DISORDERS/OTHER DISORDERS THAT MAY BE A FOCUS OF CLINICAL ATTENTION Under Substance-related disorders.

Associated features

- Cannabis used during pregnancy is associated with impairment in fetal development leading to a reduction in birth weight; it also may lead to postnatal risk of rare forms of cancer although more research is needed in this area. Marijuana is the most used illicit drug in the United States. According to the 1994 National Household Survey on Drug Abuse, averages of 10 million Americans use marijuana each month. Within a few minutes of inhaling marijuana smoke, users likely experience dry mouth, rapid heartbeat, some loss of coordination and poor sense of balance, and slower reaction times, along with intoxication. Blood vessels in the eye expand. For some people, marijuana raises blood pressure slightly and can double the normal heart rate. This effect can be greater when other drugs are mixed with marijuana.
- Cannabis has been proven to cause damage with short term memory. This is caused by the THCs effect on the hippocampus, the area of the brain responsible for memory formation
- Cannabis smoke contains 50 – 70 percent more carcinogenic hydrocarbons than tobacco smoke. This has been suspected to be more likely to cause lung cancer. People inhaling the smoke also tend to hold the smoke in their lungs longer than cigarette smoke.THC has also been proven to inhibit a persons immune system, making them much more vulnerable to infectious diseases.

Child vs. adult presentation

NIDA's 1995 Monitoring the Future study found that from 1991 to 1995, marijuana use in the 12 months before the surveys rose from 23.9 to 34.7 percent among the Nation's 12th graders, from 16.5 to 28.7 percent among 10th graders, and from 6.2 to 15.8 percent among 8th graders. Children often present about the same effects as adults on the substance directly after inhalation (see associated features). Peer pressure is a factor for children if other delinquents their age are engaged in use or around somebody who is. It is continuously becoming more and more popular among a variety of ages. Adult use is very likely to have risen as well or just continued their use through high school and college because of their liking of the substance and the good times associated with it.

Gender and cultural differences in presentation

The Drug Abuse Warning Network (DAWN), a system for monitoring the health impact of drugs, estimated that, in 2001, marijuana was a contributing factor in more than 110,000 emergency department (ED) visits in the United States, with about 15 percent of the patients between the ages of 12 and 17, and almost two-thirds were male. On average, 53 percent of juvenile male and 38 percent of juvenile females arrested and tested positive for marijuana; males are more likely to be associated with such deviant behavior but females are not restricted from use; there is just a difference in amount use and the frequency of occurrence. Cultures in America are more likely to run across this cannabis substance because of the diversity and the many people in the United States.

Epidemiology

Cannabis is by far the most common and widely cultivated, trafficked, and abused illicit drug. Half of all drug seizures worldwide are related to cannabis. The geographical spread of those seizures is also global, covering practically every country of the world. About 147 million people, 2.5% of the world population, consume cannabis (annual prevalence) compared with 0.2% consuming cocaine and 0.2% consuming opiates.

Etiology

Cannabis is often blamed as the "gateway" drug but no evidence seems to be able to support this claim. There is a correlation between association of "having a good time" and reuse. If the user learns to associate enjoyment with the activity then he/she will be much more likely to use it again. People can build up a tolerance to cannabis so they tend to use and abuse more the longer they use the substance. Although the causes of use vary from person to person, some use it for "medicinal uses." Cannabis, and the THC that is in it, is often used to treat nausea, pain, and even glaucoma. Also, it has been used in cancer patients to get them to eat. This is still, however, considered illegal in most states.

Empirically supported treatments

Treatment programs directed at marijuana abuse are rare, partly because many who use marijuana do so in combination with other drugs such as cocaine and alcohol. Therapy may be individual treatment that includes motivational interviewing and advice on ways to reduce marijuana use. By increasing patients' awareness of what triggers their marijuana use, they may be able to better manage their addiction. Four of the most commonly used treatments are: Basic principles, Psychotherapy, Behavioral Therapy, and 12-step programs. Basic Principles treatment includes: education, urine tests, and communication. Psychotherapy focuses on the reasons why the patient is using, and often encorporates other users of the substance who are currently battling with the same issues. Behavioral Therapy teaches users of the substance to focus on other ways to reduce anxiety with special emphasis is on relaxation techniques, self-control skills, and assertiveness training. Twelve-Step programs, such as Narcotics Anonymous (NA), focus on building a support group that is battling with similiar issues, relying on a higher power to remove the obsession to use the substance, and helping others in their battle with the substance.

Links:

- Chris Rock's take on illegal drugs Vs. legal drugs
- Cannabis Addiction Addiction to Cannabis
- How Cannabis Works Cannabis

DSM-V Proposed Changes: adding "Cannabis-Use Disorder" and "Cannabis Withdrawal"

DSM-V Cannabis-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, ant-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

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

DSM-V Cannabis Withdrawal Criteria:

A. Cessation of cannabis use that has been heavy and prolonged

B. 3 or more of the following develop within several days after Criterion A:

1. Irritability, anger or aggression
2. Nervousness or anxiety
3. Sleep difficulty (insomnia)
4. Decreased appetite or weight loss
5. Restlessness
6. Depressed mood
7. Physical symptoms causing significant discomfort: must report at least one of the following: stomach pain, shakiness/tremors, sweating, fever, chills, headache

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

D. The symptoms are not due to a general medical condition and are not better accounted for by another disorder

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6.158: Phencyclidine Abuse and Dependence (305.9)

DSM-IV-TR criteria

1. See above for specific abuse and dependence criteria.

Associated features

1. Phencyclidine can be sold as a crystalline powder, paste, liquid, or a drug soaked paper. Common street drug names for Phencyclidine are: PCP, angel dust, boat, tic tac, zoom, hog, ozone, rocket fuel, wack, and shermans. It can be smoked, injected or snorted; smoking being the most common way it is used. It is sometimes used as an additive to marjuanna, and in this case the street names could include but are not limited to: super grass, lovelies, wet, fry, killer joints, and waters.
2. Depending on the route in which the drug is used, as well as the dosage, the effects and severity of the effects will vary. It is often known as the “dissociative anesthetic” because of its distortment in sights and sounds. PCP can give an individual the feeling of detachment from his or her environment and self and have psychological and physiological effects such as: sedation, immobility, amnesia, numbness, slurred speech, rapid and involuntary eye movements, increased blood pressure, elevated tempature and heart rate, analgesia, and (with a high enough dosage) illusions and hallucinations.
3. Chronic use of the drug can result in several impairments; speech, memory, and thinking. Long-term effects can include suicidal ideation, depression, anxiety, and social isolation. There have also been drowning deaths, violent and accidental deaths, and suicide linked to the usage of PCP.

Child vs. adult presentation

PCP abuse occurs more in high school students and young adults, rather than in children. Studies have shown that the usage has varied among ages and has been seen prevalent in anywhere from 12 to 34; 26 to 34 being the highest range where users typically fall under. However, children may be exposed to it due to parental use and neglect.

Gender and cultural differences in presentation

It is not very common but more PCP use is among males than females because of association with delinquent peers is most likely male involvement.

Epidemiology

- PCP is associated with 10% of substance abuse deaths and 32% of related emergency room visits. Most users are between 18-25 years of age, and account for more than 50% of cases. Most patients are more likely to be white males. Mostly used in the United States.
- Phencyclidine was once marketed as an anesthetic in United States for medical purposes under the trade names of Sernyl and Sernylan, but is no longer produced or used in the U.S. It was used on patients before surgery to calm them down, and used during and after surgery to ease pain, but after many reports of troubled speech, hallucinations, disoriented behavior, and other disturbing effects, it was withdrawn from the market in 1979.

Etiology

Phencyclidine (PCP) is a hallucinogenic drug that can mimic several aspects of the schizophrenic symptomatology in healthy volunteers. In a series of studies PCP was administered to rats to determine whether it was possible to develop an animal model of the positive and negative symptoms of schizophrenia. The rats were tested in the social interaction test and it was found that PCP dose-dependently induces stereotyped behavior and social withdrawal, which may correspond to certain aspects of the positive and negative symptoms, respectively. The effects of PCP could be reduced selectively by anti-psychotic drug treatment, whereas drugs lacking anti-psychotic effects did not alleviate the PCP-induced behaviors. Together these findings indicate that PCP effects in the rat social interaction test may be a model of the positive and negative symptoms of schizophrenia with face and predictive validity and that it may be useful for the evaluation of novel anti-psychotic compounds.

Empirically supported treatments

Hospitalization is recommended when acute PCP intoxication occurs because hyperpyrexia and other autonomic instabilities can lead to death; Benzodiazepines, like Lorazepam, are good for these patients and serve well for controlling agitation and seizures.

Typical anti-psychotics, such as, Phenothiazines and haloperidol help to control psychotic symptoms. In order to help eliminate Phencyclidine dependence, ammonium chloride should be given to help extract it from the body. As far as psychological treatment goes, out-patient treatment or follow-ups, along with utilizing the communities resources are essential in staying clean from the drug. Life style changes, such as staying away from places, people, and things are encouraged. Psychotherapy is often beneficial to users as well as attending Narcotics Anonymous as a support program.

DSM-V Proposed Changes: adding “Phencyclidine-Use Disorder”

DSM-V Phencyclidine-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:

- 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

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 Environmen

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6.159: Inhalant Abuse and Dependence (305.9)

DSM-IV-TR criteria

INHALANT DEPENDENCE. The DSM-IV-TR specifies that three or more of the following symptoms must occur at any time during a 12-month period (and cause significant impairment or distress) in order to meet diagnostic criteria for inhalant dependence:

- Tolerance. The individual either has to use increasingly higher amounts of the drug over time in order to achieve the same effect, or finds that the same amount of the drug has much less of an effect over time than before. After using inhalants regularly for a while, people may find that they need to use at least 50% more than the amount they started with in order to get the same effect.
- Loss of control. The person either repeatedly uses a larger quantity of inhalant than planned, or uses the inhalant over a longer period of time than planned. For instance, someone may begin using inhalants on school days, after initially limiting their use to weekends.
- Inability to stop using. The person has either unsuccessfully attempted to cut down or stop using the inhalants, or has a persistent desire to stop using. Users may find that despite efforts to stop using inhalants on school days, they cannot stop.
- Time. The affected person spends large amounts of time obtaining inhalants, using them, being under the influence of inhalants, and recovering from their effects. Obtaining the inhalants might not take up much time because they are readily available for little money, but the person may use them repeatedly for hours each day.
- Interference with activities. The affected person either gives up or reduces the amount of time involved in recreational activities, social activities, and/or occupational activities because of the use of inhalants. The person may use inhalants instead of playing sports, spending time with friends, or going to work.
- Harm to self. The person continues to use inhalants in spite of developing either a physical (liver damage or heart problems, for example) or psychological problem (such as depression or memory problems) that is caused by or made worse by the use of inhalants

INHALANT ABUSE. The DSM-IV-TR specifies that one or more of the following symptoms must occur at any time during a 12-month period (and cause significant impairment or distress) in order to meet diagnostic criteria for inhalant abuse:

1. Interference with role fulfillment. The person's use of inhalants frequently interferes with his or her ability to fulfill obligations at work, home, or school. People may find they are unable to do chores or pay attention in school because they are under the influence of inhalants.
2. Danger to self. The person repeatedly uses inhalants in situations in which their influence may be physically hazardous (while driving a car, for example).
3. Legal problems. The person has recurrent legal problems related to using inhalants (such as arrests for assaults while under the influence of inhalants).
4. Social problems. The person continues to use inhalants despite repeated interpersonal or relationship problems caused by or made worse by the use of inhalants. For example, the affected person may get into arguments related to inhalant use

DSM-V Proposed Changes: adding "Inhalant-Use Disorder"

DSM-V Inhalant-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

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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

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
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6.16: History of Abnormal Behavior

500 B.C. – Ancient Times

- Mental illness was thought to be caused by demons or animal spirits taking over the body.
  - This was also true of prehistoric man – a bronze statue formerly displayed in the Fort Worth Museum of Science and History depicted two men holding down another while using rudimentary tools to puncture his skull. The display placard read that ancient man believed that mental illness was caused by supernatural factors that may be released from the ill person's skull (description recalled from contributor's personal experience) (Buchanan, 2009).
  - Other cultures used early forms of brain surgery to cure or alleviate any number of misunderstood maladies (O'Donnell, 2010).
- The treatment for mental illness was exorcism or torture.
  - While more cautiously approached, exorcism is still used as a means of treating misdiagnosed mental illnesses today (National Catholic Reporter, 2000).
- Trepanning, which consisted of a small instrument being used to bore holes in the skull, would allow the evil spirits to leave the possessed person.
- Abuse the body badly enough, and the spirit will want to leave it.

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'A Hole In The Head' documentary DVD trailer

Uploaded by aholeinthehead. – Check out other Film & TV videos.

450 B.C. – Golden Age of Greece

Hippocrates (Greek physician, father of modern medicine)

- Denied that deities/demons caused mental illness.
- Viewed abnormal behavior and illness in general as having internal causes, and thus having biological natures or etiologies.
- Has a key belief that if you took care of your body, your mind would also stay well (Hippocrates, 2010).
- Treatment was to modify the environment (tranquil life, sobriety, exercise, and abstinence from excess).
- Believed patients needed to choose health over mental illness.
- Was the basis for the Hippocratic Oath
  - Physicians or healers will not deliberately harm an individual who seeks their help; they will treat anyone who comes seeking their aid; they will not give a deadly drug if the patient requests it; and they keep all information about doctor-patient professional relationships confidential (Hippocratic oath, 2010).
  - Such harms still later included:
    - Terrible conditions (patients shackled to walls or dark cells).
    - Treatment (electric shock, bleeding, spinning, restraints) used to intimidate patients into choosing health over illness.

1800s – Reforms in Mental Health Treatment

Benjamin Rush (Leitch, 1978).

- Published the first American textbook on psychiatry, Mental Inquiries and Observations upon the Diseases of the Mind.
- Believed the cause of mental illness was exposure to severe psychological and social stressors.
- Treatment was "moral management", which focused on the patient's social, individual, and occupational needs (manual labor, spiritual discussion, humane treatment).

Philippe Pinel (Enersen, 2010).

- Frenchman and early reformer in the proper treatment of mentally ill individuals.
- Like Rush, also believed mental illness were caused by excessive psychological and social stresses.
- Advocated that the mentally ill be treated with sympathy, compassion, and empathy.
- One of the founders of psychiatry.

Dorothea Dix ("Dorothea Lynde Dix", 2010).

- Helped establish 32 mental hospitals throughout the United States.
- 1845 – first public mental hospital in Pennsylvania Harrisburg State Hospital.
- 1847 – first state mental institution in Illinois established.
- 1856 – first state mental institution in North Carlina opened and named in her honor.
- Authored bills that were intended to protect, and reform treatment for, mentally ill patients.

1900s – Modern Era

- Major breakthrough: Discovery of biological cause of general paresis (syphilis of the brain) (Jasmin, 2008).
- Symptoms of syphilis are paralysis, insanity, and death.
- Treatment was to infect sufferer with malaria (high fever would kill the syphilis organism).
- Led to increased focus on diseased bodily organs as underlying cause of mental illness.
- Accompanied by tremendous advances in anatomy, physiology, neurology, chemistry.

Emil Kraepelin (Emil Kraepelin, n.d.)

- Developed a classification system of mental disorders (precursor to The DSM).
- Classified psychosis into two forms, manic depression and dementia praecox.
- Recognized that different types of disorders had different outcomes.
- Emphasized importance of underlying brain pathology.

Richard Freiherr von Krafft-Ebing(Kiff, n.d.)

- Performed extensive work and research in human sexual behavior
- Wrote Psychopathia Sexualis, the first major study of sexual perversity. This coined many terms associated with sexuality today (i.e, sadism, masochism, etc.)
- Served as authoritative influential study of human sexual behavior until Freud.

Advances in psychological understanding of mental disorders:

Sigmund Freud (Thornton, 2005)

- Developed psychoanalytic theory – the theory of psychological development in terms of stages throughout life.
- Believed unconscious processes, motives, and urges are at the core of many of our behaviors and difficulties.
- Developed the doctor-patient paradigm.
- The doctor was viewed as being in a power position, and the patient was a sick individual who would take the doctor's words as an unquestionable fact.

B.F. Skinner (Vargas, 2005)

- Father of radical behaviorism.
- Believed that any behavior that was reinforced or rewarded would be more likely to increase or recur; any behavior that was either not reinforced or was punished would be more likely to decrease or be extinguished.

- Created experiments which demonstrated operant conditioning. Most well known for creating the Skinner Box, a devise demonstrating conditioning of rats pressing a lever to receive food. http://www.youtube.com/watch?v=PQtDTdDr8vs.

Albert Bandura (Pajares, 2004)

- Teaches at Stanford University.
- Developed Social Learning Theory(Modeling).
- Suggested that we could learn based upon what we observed in a model.
- Bobo Doll Experiment.

Albert Ellis (Ellis et al, 2005)

- Believes that we get depressed and develop other mental illnesses because of faulty thinking.
- Rational Emotive Behavior Therapy(REBT).
- REBT works well with Anxiety Disorder and Mood Disorders.

Carl Rogers

- Humanist who believed in the innate goodness of all people and in the ability of all people to grow and lead constructive lives.
- Developed the client- or person-centered therapy.
- The psychologist is seen as someone who is a skilled listener, not judgmental, and certainly not powerful nor omniscient.
- Theorized that dysfunction begins in infancy.



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Henri Laborit

- Introduced Thorazin.
- Used for the treatment of Schizophrenic Disorders by calming patients without putting them to sleep.
- Led to widespread use of the treatment for Schizophrenic Disorder and the field of psychopharmacology.



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6.160: Amphetamine Intoxication (282.89)

DSM-IV-TR criteria

A. Recent use of amohetamine or a related substance (e.g. methylphenidate).

B. Clinically significant maladaptive behavior or psychological changes (e.g. euporia or affective blunting; changes is sociability; hypervigilance;interpersonal sensitivity; anxiety; tension, or anger; stereotyped behaviors; impaired social or occupational functioning) that developed during, or shortly after, use of amphetamine or a related substance.

C. Two or more of the following, developing during, or shortly after, use of amphetamine or a related substance:

- tachycardia or bradycardia
- pupillary dilation
- elevated or lowered blood pressure
- perspiration or chills
- nausea or vomiting
- evidence of weight loss
- psychomotor agitation or retardation
- muscle weakness, respiratory depression, chest pain, or cardiac arrhythmias
- confusion, seizures, dykinesias, dystonias, or coma

D. The symptoms are not due to a general medical condition and are not better accounted for by another disorder

Specify if:

- With Perceptual Disturbances
- This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. Intact reality testing means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered

Associated Features

After being intoxicated by recent use, there will be psychological and behavioral changes that will be significantly noticeable. Psychologically there may be some impairments of sociability and judgement There may be hostile or aggressive behavior depending on how much amphetamines were ingested. Hallucinations that are auditory or visual may occur and paranoia is also a possibility. It is actually fairly similar to schizophrenia . Hyperactivity and hypersexuality is also a common feature. The patient may have delusions such as feeling like there are insects crawling under their skin. The person may have issues with the law naturally due to the illegal nature of amphetamines. Their family and work life may suffer as well. There may be a presentation of very dull feelings along with sadness and social withdrawal. Fatigue, cardiac arrythmia, elevated or lowered blood pressure, dialation of the pupils, nausea or vomiting, or sweating and chills are some of the other issues that will probably show in the individuals during, or shortly after, they are intoxicated. Since amphetamines are highly addicting, it is very common for individuals to become addicted in a fairly short amount of time. This, of course, will ultimately lead to amphetamine dependence.

Child vs. adult presentation

Typically, it is rare for children to abuse amphetamines. It is much more common for children to accidentally ingest it than abuse it. For those rare cases of child amphetamine abuse, they will show similar symptoms. Adolescents and young adults, however, are among the highest users today.

Gender and cultural differences in presentation

Men are much more likely to abuse amphetamines than women. There is information that supports men enjoy amphetamines more than women due to the male body releasing 3 times as much dopamine. Different cultures that abuse amphetamines will show the same symptoms as Americans.

Epidemiology

Amphetamine intoxication can happen in any level of society and usually are used by individuals between the ages of 18 to 30 years old. It's reported that about 8.8 million Americans alone will be intoxicated by some form of amphetamine in some point during their lifetimes. One of the most common, heavily abused amphetamine is methamphetamine. Reports have shown that a 30% increase in emergency room cases involving the use of methamphetamine from 1999 to 2000 alone, and the rates continue to climb.

Etiology

There is more supported evidence that this is environmentally influenced as opposed to biologically. Reseach has found that most use and abuse of amphetamines was started with the intent to aid them with weight loss. Others have been introduced through illegal drug experimentation. Low SES shows a high correlation with more intravenous use, which causes a quicker dependence on the amphetamine.

Empirically supported treatment

- There is currently not a widely supported treatment for amphetamine abuse. One thing that is agreed upon is that it is not a good idea to treat amphetamine abuse with different medications. Since a prescribed medication may have caused the problem in the first place, it is easy to see prescribing more is not a smart idea. There is a little evidence that supports the drugs fluoxentine and imipramine as helpful alternatives, but more research is needed.
- — Amphetamines cause a lack of saliva that causes teeth to decay as a consiquence. See video http://www.youtube.com/watch?v=j5SXjgrJITY



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6.161: Amphetamine Withdrawal (292.0)

DSM-IV-TR criteria

A. Cessation of (or reduction in) amphetamine (or related substance) that has been heavy and prolonged.

B. Sysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion

- fatigue
- vivid, unpleasant dreams
- insomnia or hypersomnia
- increased appetite
- psychomotor retardation or agitation

C. The symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Associated features

This happens when an individual who has reduced or discontinued the use of amphetamines that was originally used for a long time or in heavy amounts. The symptoms may vary depending on the level of dependence. Dysphoric mood and psychological changes such as fatigue, unpleasant dreams, trouble sleeping, and an increase in appetite will be noticeable. Depression or anxiety can be a very common part in withdrawal symptoms. Withdrawal can last from 3 days to 2 weeks depending on the severity.

Child vs. adult presentation

Children have been prescribed amphetamines for many different reasons throughout the years, but prodominately it was prescribed to them for the treatment of ADHD. Withdrawl symptoms in children have been known to be very slight because this prescribing for hyperactivity has been relatively stopped or regulated. More of the cases of amphetamine withdrawal is seen in adults because of the heavy recreational use of amphetamines such as ecstasy and methamphetamines. Adults have also been seen with more withdrawal symptoms because they use amphetamines for their success in helping drop the pounds.

Gender and cultural differences in presentation

There are no significant differences in males and females when it comes to withdrawal because it will be present in most cases, no matter how severe the symptoms are, if the individual has been using the drug heavily or for a prolonged amount of time. Culturally there are also no differences in the symptoms of amphetamine withdrawal throughout the world.

Epidemiology

Withdrawal can happen at any age or severity depending on how long and how much of the amphetamine has been used. It is only present when the individual reduces or stops the use, and it will continue to show its effects for as long as 2 weeks. Because of this, there are low success rates of overcoming the withdrawal symptoms since most choose to continue to use amphetamines in order to reverse the effects.

Etiology

This is only caused by environmental factors. It is specifically brought on by the lowered levels of amphetamines in the body once there has been a regulated tolerance for the substance in order to function. Environmental factors such as family or legal intervention might also play a role in developing the reason for the reduction or elimination of the use, which will spark the presentation of the withdrawal symptoms.

Empirically supported treatment

- There are no specific medications that are used in effectively treating all of the withdrawal symptoms. Amphetamines have been studied as being a very good treatment, but there are conflicting reports as to how effective it is on reducing or eliminating the symptoms in order to let the individual overcome the addiction. Hospital detoxification is primarily the safest way to get

through the symptoms and be closely evaluated especially for the chronic users, who may show significantly severe withdrawal symptoms.

- Below is a video from the reality show Intervention, where families come together to help their loved ones with addiction. This video shows two females, the focus for this section is Amy, who is addicted to methamphetamine.

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6.162: Caffeine Intoxication (305.9)

DSM-IV-TR criteria

A. Recent consumption of caffeine, usually in excess of 250mg (e.g. more than 2-3 cups of brewed coffee).

B. Five or more of the following signs, developing during, or shortly after, caffeine use:

1. restlessness
2. nervousness
3. excitement
4. insomnia
5. flushed face
6. diuresis
7. gastrointestinal disturbance
8. muscle twitching
9. rambling flow of thought and speech
10. tachycardia or cardiac arrhythmia
11. periods of inexhaustibility
12. psychomotor agitation

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. (e.g. Anxiety Disorder)

- Tolerance to caffeine may be developed, so Caffeine Intoxication may not occur in certain individuals.

DSM-IV-TR criteria for caffeine-induced anxiety disorder

- Prominent anxiety predominates in the clinical picture.
- There is evidence from the history, physical examination, or laboratory finding suggesting that the anxiety developed within 1 month of caffeine intoxication or withdrawal or that medications containing caffeine are etiologically related to the disturbance.
- The disturbance is not bettr accounted for by an anxiety disorder that is not substance-induced.
- The disturbance does not occur exclusively during the course of a dlirium.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functiong.

DSM-IV-TR criteria for caffeine-induced sleep disorder

- A prominent disturbance in sleep occurs that is sufficiently severe to warrant independent clinical attention.
- There is evidence from the history, physical examination, or laboratory findings that the sleep disturbance is the direct physiological consequence of caffeine consumption.
- The disturbance is not better accounted for by another mental disorder.
- The disturbance does not occur exclusively during the course of a delirium.
- The disturbance does not meet the criteria for breathing-related sleep disorder or narcolepsy.
- The sleep disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-IV-TR criteria for caffeine-related disorder NOS

- This includes any caffeine disorder other than those previously listed.
- Symptoms of caffeine withdrawal that are not currently an officially recognized diagnosis are present.

Mental Status Examination

- Many of the effects of caffeine consumption are expressed in behavioral manifestations. The most common is anxiety, with its associated fidgetiness, distractibility, poor eye contact, hesitating speech, and prolonged bursts of energy.
- Caffeine's effecton mood is complicated and not fully understood. Although initially it may promote some improvement in mood, notably identified by some slight euphoria or focused attention, this pattern may give way to a chronic dysphoria. This mildly depressed state may be a consequence of withidrawal.
- Any complaint of sleep difficulty should include a careful assessment of beverage consumption.
- Caffeine would not produce perceptual problems such as hallucinations.
- Caffeine consumption does not produce alterations in thinking, such as delusions.
- Caffeine consumption does not cause disorientation, memory problems, mental confusion, impairment in judgment, or problems with abstract thinking.

Causes

- The means by which caffeine exerts its pharmacologic effects remains a subject of active research.
- A leading theory suggests that caffeine is an adenosine receptor antagonist that blocks two major types of adenosine receptors, A1AR and A2AAR.
- Adenosine is an inhibitory neuromodulator affecting norepinephrine, dopamine, and serotonin activity.
- Caffeine's putative antagonism of adenosine would increase those neurotransmitters promotting psychostimulation.
- The same neurotransmitter systems are implicated in the pathophysiology of several psychiatric.

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6.163: Cannabis Intoxication (292.89)

DSM-IV-TR criteria

A. Recent use of cannabis.

B. Clinically significant maladaptive behavioral or psychological changes (e.g. impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during, or shortly after, cannabis use.

C. Two or more of the following signs, developing 2 hours of cannabis use:

- conjuctival injection
- increased appetite
- dry mouth
- tachycardia

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Specify if:

- With Perceptual Disturbances
- This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. Intact reality testing means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered
- When cannabis is smoked, intoxication develops within minutes; however, if cannabis is ingested orally, intoxication may take a few hours to develop.
- Effects of cannabis intoxication usually last 3-4 hours. The effects may last longer if the cannabis was ingested orally.
- The behavioral and psychological changes that occur depend of the dose, the administration, and the individual. For example, a person’s tolerance, rate of absorption and sensitivity will differ greatly 23. Other (or Unknown) Substance-Related Disorders

A list of the Other (or Unknown) Substance-Use Disorders and the Other (or Unknown) Substance-Induced Disorders

Definition

- This is a category of classification when the substances associated with the disorder are not covered by the 11 categories the DSM-IV-TR uses to classify Substance-Related Disorders. Substances that may relate to the disorder but are not covered include anabolic steroids, nitrite inhalants, nitrous oxide, catnip, betel nut, and kava. The disorders are generally described with the disorder that they share phenomenology with.

Other (or Unknown) Substance-Use Disorders

- Other (or Unknown) Substance Dependence 304.9
- Other (or Unknown) Substance Abuse 305.9

Other (or Unknown) Substance-Induced Disorders

- Other (or Unknown) Substance Intoxication 292.89 Specify if: With Perceptual Disturbances
- Other (or Unknown) Substance Withdrawal 292.0 Specify if: With Perceptual Disturbances
- Other (or Unknown) Substance-Induced Delirium 292.81
- Other (or Unknown) Substance-Induced Persisting Dementia 292.82
- Other (or Unknown) Substance-Induced Persisting Amnestic Disorder 292.83
- Other (or Unknown) Substance-Induced Psychotic Disorder, with Delusions 292.11 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Induced Psychotic Disorder, with Hallucinations 292.12 Specify if: With Onset During Intoxication/With Onset During Withdrawal

- Other (or Unknown) Substance-Induced Mood Disorder 292.84 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Induced Anxiety Disorder 292.89 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Induced Sexual Dysfunction 292.89 Specify if: With Onset During Intoxication
- Other (or Unknown) Substance-Induced Sleep Disorder 292.85 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Related Disorder Not Otherwise Specified 292.9

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6.164: Substances

Substance-Related Disorders

1. Introduction to the Substance-Related Disorders

- The Substance-Related Disorders include disorders brought about by taking the drug of abuse (including alcohol), the side effects of a medication, or by the exposure of toxins. In the DSM-IV, the word substance can refer to a drug of abuse, a medication, or a toxin one is exposed to (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000).
- Substance-Related Disorders involve various forms of indulgence of drugs or chemicals that could lead to the demise of an individual's physical or mental health status. A substance use disorder can affect anyone; rather they be rich or poor, male or female, employed or unemployed, young or old, and any race or ethnicity. The etiology is unknown, however; the chance of developing a substance use disorder depends partly on genetics, which are biological traits passed down through families. Although person's environment, psychological traits, and stress level can also play a significant role in the use of alcohol or drugs. These substances can include nicotine in the form of tobacco, alcohol, hallucinogens, steroids, inhalants as well as opioids. The use of these substances can affect cognitive, behavioral, and psychological symptoms that occur due to repetitive use and abuse of the substance that can often lead to tolerance, withdrawal, and dependency. An individual's need to continue to use the substances despite their awareness of negative side affects is a key factor in determining dependency. They feel like they have to use the substance to function day to day in society. There are many documentaries that have been made revealing the seriousness of substance use, case in point the new MTV documentary "Steve-O Demise and Rise".

2. Substance Abuse vs. Substance Dependence

- DSM-IV-TR Substance Dependence Criteria
- A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by either of the following:

- (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- (b) markedly diminished effect with continued use of the same amount of the substance

2. withdrawal, as manifested by either of the following:

- (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. 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)

- Specify if:

1. With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either item 1 or 2 is present)
2. Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither 1 nor 2 is present)

- Course specifiers:

1. Early Full Remission
2. Early Partial Remission

3. Sustained Full Remission
4. Sustained Partial Remission
5. On Agonist Therapy
6. In a Controlled Environment

- DSM-IV-TR Substance Abuse Criteria:
- A. A maladaptive pattern of substance use leading to clinically significant impairment of distress, as manifested by one (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. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. continued 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)

- B. The symptoms have never met the criteria for Substance Dependence for this class of substance.
- Epidemiology
- Alcohol use reportedly has been on the decline in recent years. Reports indicate that roughly two thirds of all adults drink alcohol occassionally. Approximately 13% of people in the US are alcoholics, and 1 person in 5 who uses alchol for recreational purposes becomes dependent for some period of time. Studies perfomed in urban EDs indicate that up to 20% of patients may have problems with alcohol, with the highest rate in patients who present late at night. In contrast to alcohol use, heroin use is rising. Estimates place the number of heroin users in the US at 750, 000. Heavy cocaine use has remained fairly steady since its peak in the late 1980s and early 1990s, with an estimated 600,000-700,000 regular users. On the rise in rural communities is use of methamphetamine, also known as crystal meth. It is easily manifactured as the base ingredient is over-the-counter cold medication. It is found to be abused most often in the 15-to-25-year-old age bracket. Abuse of prescription and over-the-counter drugs is rapidly increasing, especially in teenagers.
- LINKS:
- Drug Abuse, Mental Illness and Co-Occurring Disorders VideoDrug Abuse and Co-Occurring Disorders
- Addicted Brain ChangesAddicted Brain Changes
- Addicted Brain Addicted Brain
- HBO: Addiction Addiction
- Addiction: HBO Video about Medication Assisted Treatment Medicated Assisted Treatment
- What is Drug Dependency? (uploaded by ehowhealth)
- A discussion about drug abuse with high school students by Dr. Volkow. (uploaded by NIDANIH)

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3. Substance intoxication

- DSM-IV-TR Substance Intoxication Criteria
- A. The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. NOTE: different substances may produce similar or identical syndromes.
- B. Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood liability, cognitive impairment, impaired judgment, impaired social or occupational functioning) and development during or shortly after use of the substance.
- C. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

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4. Substance Withdrawal

- DSM-IV-TR Substance Withdrawal criteria
- A. The development of a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and
- prolonged.
- B. The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of
- functioning.
- C. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
- Links
- Alcohol & Substance Abuse : How Long Do Alcohol Withdrawl Symptoms Last? Alcohol and Substance Abuse
- Alcohol & Substance Abuse : Withdrawal Symptoms of Alcohol Symptoms from Alcohol Withdrawals
- Alcohol Withdrawal Seizure, Delirium Tremens Alcohol Withdrawal Seizures
- — There is no way to avoid withdrawal symptoms, physicians are trying to develop methods to help cope with it. See video http://www.youtube.com/watch?v=Gng8lM8gMGA
-
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- DSM-V Proposed Changes:
- Adding “Substance-Use Disorder”
- DSM-V Criteria for Substance-Use Disorder
- A. 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. a need for markedly increased amounts of the substance to achieve intoxication or desired effect

- b. 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, ant-anxiety medications or beta-blockers.)

1. withdrawal, as manifested by either of the following:

a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)

- b. 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.)

1. the substance is often taken in larger amounts or over a longer period than was intended
2. there is a persistent desire or unsuccessful efforts to cut down or control substance use
3. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. important social, occupational, or recreational activities are given up or reduced because of substance use

5. 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
6. 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

5.Hallucinogen Dependence (304.5) and Hallucinogen Abuse (305.3).

- Hallucinogen Dependence – DSM-IV-TR criteria
- One of the generic Dependence criteria (i.e., withdrawal) does not apply to hallucinogens, and others require further explanation. Tolerance has been reported to develop rapidly to the euphoric and psychedelic effects of hallucinogens but not to the autonomic effects such as pupillary dilation, hyperreflexia, increased blood pressure, increased body temperature, piloerection, and tachycardia.
- Specify if:
- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission
- In a Controlled Environment
- Hallucinogen Abuse – DSM-IV-TR criteria
- Individuals may use hallucinogens in situations that are physically hazardous (e.g., while driving a motorcycle or a car) and/or repeatedly fail to fulfill obligations at school, home, or work due to behavioral impairments caused by Hallucinogen Intoxication. There may be recurrent social or interpersonal problems due to the individual's behavior while intoxicated, isolated lifestyle, or arguments with significant others.
- Associated features
- Individuals with hallucinogen dependency continue to use hallucinogens even when they are aware of the adverse effects of the drug as well as the impact on his/her life. They report "craving" hallucinogens after not using them for a period of time (It should be noted that these are psychological addictions, as hallucinogens do not create a physiological dependency). So the individual just wants the substance really bad, but is not dependent on it physically. Individuals with hallucinogen abuse continue to use hallucinogens in spite of certain cases of impairment that disable them from fulfilling obligations in their work, home, etc. This is when you know that it has a major effect on the individual when they are inhibited in most daily activities and obligations such as school duties, work, home chores, and even routine stuff such as hygiene and other motor activities. Hallucinogen use by "abusers" is generally less frequent than those with dependency. Abusers just use when a particular substance is readily available and easy to obtain, for example, if a friend is in possession of that substance. Dependent individuals need that certain substance to get a "fix" on themselves to assure themselves that they are normal. This helps the person in stressful situations in which they feel uncomfortable and think they have to do these behaviors to be or act normal.

- In Hallucinogen Dependence, withdrawal does not apply, but the person may have mental cravings for a substance. With Hallucinogen Abuse, one is likely to use less often; however, they may have a tendency to fail to fulfill certain obligations, and have legal, social and interpersonal problems that have to do with societal functions. Individuals with hallucinogen dependence tend to have a blurring of the senses, a loss of appetite, distortions, tachycardia, dilated pupils, and nausea.
- Child vs. adult presentation
- There is no differentiation between child and adult presentation because it is dependent upon consumption of the substance and not from psycho developmental causes. The amount of substance consumed is generally more for the adults than the children with a particular substance mainly because of low body weight and a low tolerance level.
- Gender and cultural differences in presentation
- While there are no significant differences between gender and use, it has been found that these disorders are much more prevalent in cultures where there are "raves," dance clubs, and other similar social settings where hallucinogens are common. There is move from recreational use to disorder is determined by cultural and social contexts; what is acceptable depends on what society it occurs in. Norms are defined by how a society defines addiction. Majority of research is on males because they are overall more likely to use and abuse psychoactive substances. Women use more in response to current stressful situations and are more likely to have used a substance preceded by another mental disorder. Women users are seen as more promiscuous and more likely to be a victim of a violent crime. There is a stigma attached to women who use because people view it as socially unacceptable. They generally do not reveal their problems on their own, an intervention is likely to help recover. Female users appear not to respond as well to treatments, family support and other numerous factors.
- Epidemiology
- Hallucinogen dependency is considered more rare than abuse. Only 2-3% of people who recurrently use hallucinogens become dependent upon them. Abuse is not as rare and a little more common because the amount of time required to abuse rather than depend on a substance is less. To abuse a substance, a person just uses it and eventually will want to do it again, and it is usually followed by some form of dependence. This would involve wanting the substance on a regular basis, and if not in possession of said substance, some aggressive, stress reaction would follow; it could also be in the form of violent behaviors that would end up hurting others close to you.
- Etiology
- The causes of hallucinogen dependency and abuse are difficult to pinpoint, as they are purely psychological addictions. Self-esteem, self-worth, and history with other substance use are the best indicators of one's susceptibility to hallucinogen dependence and/or abuse. When a person uses drugs it makes it more likely that they will try other drugs. There is a 40% to 60% risk of alcoholism that is explained by genetic influences. Alcohol dependence is 3-4 times higher in close relatives of people with alcohol dependence. There is reinforcement of substance use because of how it reduces anxiety and tension.
- Empirically supported treatments
- In the treatment of one under the influence, Lorexone has been used to mitigate the anxiety attack resulting from a "bad trip." The treatment of dependency involves extended sessions of psychotherapy. Any underlying physiologic disorders connected to addictive personality, if present, should be addressed and resolved. Pharmacotherapy treatments that have little effect if discontinued are Antabuse, which is naltrexone for alcohol, and Methadone or LAAM for opiates. Co-occurring disorders may be treated medically with antidepressants and SSRI's, or selective serotonin re-uptake inhibitors. Antipsychotic medicines can also be prescribed to help with the dependency; haloperidol and risperidone are examples of these. Also, certain treatments require the use of self-help groups, such as Narcotics or Alcoholics Anonymous, in order to provide a secure and encouraging environment for the individual.
- LINKS:
- Ecstasy Destroys: Documentary Education Video/MDMA Ecstasy Destroys

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6. Hallucinogen Intoxication (292.89)

- DSM-IV-TR criteria
- A. Recent use of a Hallucinogen.
- B. Clinically Significant maladaptive behavioral or psychological changes (e.g., marked anxiety or depression, ideas of reference, fear of losing one's mind, paranoid ideation, impaired judgment, or impaired social or occupational functioning) that developed during, or shortly after, hallucinogen use.
- C. Perceptual changes occurring in a state of full wakefulness and alertness (e.g., subjective intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias) that developed during, or shortly after, hallucinogen use.
- D. Two (or more) of the following signs, developing during, or shortly after, hallucinogen use:

1. pupillary dilation
2. tachycardia
3. sweating
4. palpitations
5. blurring of vision
6. tremors
7. incoordination

- E. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
- Associated features
- Hallucinogen Intoxication usually begins with some stimulant effects such as restlessness and autonomic activation. Nausea may occur. A sequence of experiences then follows, with higher doses producing more intense symptoms. Feelings of euphoria may alternate rapidly with depression or anxiety. Initial visual illusions or enhanced sensory experience may give way to hallucinations. At low doses, perceptual changes frequently do not include hallucinations. Synesthesias (a blending of senses) may result, for example, in sounds being "seen." The hallucinations are usually visual, often of geometric forms or figures, sometimes of persons and objects. More rarely, auditory or tactile hallucinations are experienced. In most cases, reality testing is preserved (i.e., the individual knows that the effects are substance induced).
- Symptoms include distortion of sight, sound, and touch, disorientation, paranoia, anxiety attacks, blissful calm or state of being mellow, increased empathy, long-term memory loss, and impaired concentration and motivation.
- Physical symptoms include increased blood pressure, increased heart rate, vomiting, blurred vision, enlarged pupils, sweating, diarrhea, restlessness, muscle cramping, dehydration, and increase in body temperature that may lead to seizures.
- Child vs. adult presentation
- Gender and cultural differences in presentation
- Epidemiology
- Etiology
- Empirically supported treatments
- While someone is suffering from Hallucinogen Intoxication it is best to have physical contact with the person, although sometimes adverse reactions do occur to physical touch sometimes it helps to keep the person intact with reality. Helping the intoxicated person to breath slowly and keep them away from large groups of people helps.
- Links:
- ONF NFB: Hoffman's Potion

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7. Hallucinogen Persisting Perception Disorder (Flashbacks) (292.89)

- DSM-IV-TR criteria
- A. The re-experiencing, following cessation of use of a hallucinogen, of one or more of the perceptual symptoms that were experienced while intoxicated with the hallucinogen (e.g., geometric hallucinations, false perceptions of movement in the

peripheral visual fields, flashes of color, intensified colors, trails of images of moving objects, positive afterimages, halos around objects, macropsia, and micropsia).

- B. The symptoms in Criterion A cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The symptoms are not due to a general medical condition (e.g., anatomical lesions and infections of the brain, visual epilepsies) and are not better accounted for by another mental disorder (e.g., delirium, dementia, Schizophrenia) or hypnopompic hallucinations.
- Associated features
- Major depression and panic disorders and frequented associated features of HPPD.
- Child vs. adult presentation
- Gender and cultural differences in presentation
- Epidemiology
- Episodes of self induced abnormal perceptions are associated with HPPD. These episodes can occur simply by thinking about them or can be triggered by stressors such as entry into a dark environment, various drugs, and anxiety or fatigue. These episodes will usually stop or be less frequently occurring after several months. The individual must be able to recognize that the perception is a drug effect and does not represent external reality. A diagnosis of Psychotic Disorder Not Otherwise Specified would be needed if the individual has a delusional interpretation concerning the etiology of the perceptual disturbance.
- Uncommon, although prevalence rates are higher in larger populations, the amount of people who take hallucinogens and those who suffer from HPPD have no correlation.
- Etiology
- No one is completely sure what causes HPPD, although there have been many theories. Many believe that the excessive use of hallucinogen causing drugs do not develop HPPD.
- Empirically supported treatment
- HPPD can often times mimic side affects of a stroke, brain tumor, or any other neurological disorder. Antidepressant drugs can sometimes help but there is no certain cure or treatment for HPPD. Psychotherapy helps to reduce anxiety or to help one cope with the hallucinations, but unfortunately there is nothing to take away the actual hallucinations. Benzodiazepines such as Valium or Xanaxcan help to reduce haullucinations as well as the anticonvulsant drug Clonazepam/Klonopin.
- DSM-V Proposed Changes: Adding “Hallucinogen-Use Disorder”
- DSM-V Criteria for Hallucinogen-Use Disorder:
- A. 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. a need for markedly increased amounts of the substance to achieve intoxication or desired effect

- b. 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, ant-anxiety medications or beta-blockers.)

1. withdrawal, as manifested by either of the following:

a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)

- b. 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.)

1. the substance is often taken in larger amounts or over a longer period than was intended
2. there is a persistent desire or unsuccessful efforts to cut down or control substance use
3. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. important social, occupational, or recreational activities are given up or reduced because of substance use
5. 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
6. 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

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8. Opioid abuse (305.52)

- DSM-IV-TR criteria
- A. A maladaptive pattern of substance 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 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) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct) (4) 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)
- B. The symptoms have never met the criteria for Substance Dependence for this class of substance.
- Associated features
- Opioids are drugs that include both natural and synthetic substances. The mental effects of an opioid abuser include depression with few or all of its diagnostics, such as selflessness, problems sleeping, lack of interest, faulty coping skills, and even suicidal thought. The effects of opioid abuse are not easily noticeable. The only recognizable observation that could be made is the result of small-sized pupils, or inflamed nasal mucosa if snorted. Although opioid abuse is not as severe as being dependent of opioids, it does however continuously result in negative consequences of using the drug recurrently.
- Child vs. adult presentation

- Opioid abuse can arise in both children and adults at any age, yet is most common among young adults roughly starting at about sixteen and older. The age of first use opioid abuse is typically about sixteen years of age, though this age has been dropping over the years. From 2002 to 2007 opioid abuse among young adults (18 & older) rose by more than twelve percent. Although opioid abuse is harmful to the abuser, it can also result in mental injury or death of young children, most often between the ages of three and six.
- Gender and cultural differences in presentation
- Opioid abuse among men increased two percent in 2002 to 2.6 percent in 2007 but did not change significantly for females. Men are twice as likely to overdose on pain relievers than women. Males are more likely to abuse opioids than females, with the male-to-female ratio being approximately 1.5:1 for prescription opioids. There is a much higher incidence of opioid-related deaths in rural areas than urban areas.
- Epidemiology
- Opioids that are most commonly abused are oxycodone (79%), hydrocodone (67%), methadone (40%), morphine (29%), heroin (13%), hydromorphone (16%), fentanyl (9%) and buprenorphine(1%). Regular opium is also abused but is in some form listed previously.
- Etiology
- There are no definite causes of opioid abuse other than initial choice to use the drug, though this choice can be highly influenced by peer pressure. Most opioid abusers typically experience early health problems in life, behavioral problems in early childhood, low self-esteem, and lack of respect for authority figures.
- Empirically supported treatments
- There are roughly eight ways to go about treating opioid abuse. These treatments include counseling, medications to reverse the effects of opioids, supportive-expressive psychotherapy sessions, and self-help groups. Opioid abuse treatment is influenced by managed care and is changing rapidly.
- The psychotherapy sessions try to focus on relapse prevention and cognitive therapy.
- There are two major types of maintenance therapy. They are methadone and buprenorphine. Methadone has been in use for over 30 years. It acts as an antagonist and replaces the need to daily dose of different types of opioids. It reduces criminal acts and promiscuous behaviors. It is only available at specialty clinics. Buprenorphine is like methadone in reducing cravings. It is safer at higher levels which produce no side effects. It is becoming more popular for this reason. It is also more accessible because it can be used in a doctor's office.
- Opioid abuse relapse rates vary from 25%-97%, being higher for those who smoke cigarettes than those who do not. Successful treatments are determined by improvements in social functions, reduction of illicit drug use, and performance at work and school. The success of treatment often varies according to the type of opioid abused and other factors such as medical care, employment, legal situation, family, and psychological difficulties. The chances of a successful recovery from opioid abuse are much higher in those with profession degrees than those with a poor education level and lower income jobs.
- LINKS:
- HBO: Treating Opiate Addiction With Replacement Therapy Treating Opiate Addiction
- HBO: Opiates and Your Brain Opiates and Your Brains
- An individual's personal story about Opioid Addiction. (uploaded by newsinfusion)
- A continunation of Mike's Story and the medication he used for treatment. Other possible treatments for opioid abuse are listed above. (uploaded by newsinfusion)
- The following video discusses pharmacological treatments for opioid abuse. Additional treatments are listed above. (uploaded by RickChavezMD)
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9. Sedative, hypnotic, or anxiolytic related abuse and dependence(292.89)

- DSM-IV-TR criteria
- A) A Cessation of (or reduction in) sedative, hypnotic, or anxiolytic use that has been heavy and prolonged.
- B) Two (or more) of the following, developing within several hours to a few days after Criterion A:
- autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
- increased hand tremor
- insomnia
- nausea or vomiting
- transient visual, tactile, or auditory hallucinations or illusions
- psycho-motor agitation
- anxiety
- grand or Gran Mal seizures
- C) The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D) The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
- Specify if:
- With Perceptual Disturbances
- Associated features
- Slurred speech or memory loss is very common. If in a working situation, the chances of the abuser missing work or have inconsistent work effort is high. People that abuse alcohol will often have the constant smell of alcohol on their breath. Sedative, hypnotic, or anxiolytic substances can also affect ones family life, bring up more conflicts and arguments, and sometimes even split up a family.
- Other features include paranoia, trouble sleeping, and putting oneself in hazardous situations, such as driving while intoxicated or high. A result of abuse of drugs can also be coma or some times even death
- Child vs. adult presentation
- Although abuse/dependency occurs more in adults than in children, the population of children consuming sedative, hypnotic or anxiolytic substances increases daily. Though children are not addicted to said substances it increases their chances of being dependent on them later on in life
- Seizures can be seen with the abuse of sedative, hypnotic, or anxiolytic substances. Grand Mal seizures or Gran Mal is a seizure type that is most commonly associated with epilepsy. There are other types that are less known and can occur.
- Gender and cultural differences in presentation
- Sedative, hypnotic, or anxiolytic abuse not only appears in the United States, but throughout the world. When it comes to prescription, women have higher chances of becoming addicted than men do. Also, the older the woman is, it increases her chances of substance abuse/dependency.
- Epidemiology
- Up to 90% of people in the United States have received some type of sedative, hypnotic, or anxiolytic drug while hospitalized. Over 15% of adult Americans take one or more of these drugs as prescribed medicine. These types of drugs could be benzodiazepines(used for may things such as insomnia, seizures, epilpsy, sedation for surgical procedures, etc., barbiturates (used for epilepsy management, contributes to withdrawal symptoms),other sleeping pills, as well as alcohol.
- Etiology
- There are several causation’s for sedative, hypnotic, or anxiolytic abuse/dependency. Some of those reasons include stress or depression. Many times users create an addiction to these drugs because they started abusing them at an early age. Another causation for abuse could be that one was prescribed medicine because of injury, leading to a dependence on said medication.

- People who are addicted to said drugs have a higher chance of fighting people around them to continue taking the drugs. They will make up excuses as to why they need to take the drug, such as they cannot sleep at night without it, etc.
- Empirically supported treatments
- The best form of treatment for sedative, hypnotic, or anxiolytic abuse/dependency would be complete independence from all drugs. This causes users to experience withdrawal that consists of lack of sleep, breaking into sweats, anxiety, vomiting, and sometime even seizures. If the drug is one that takes longer to take effect then its withdrawal takes longer. If it is a drug that may work quickly then withdrawal symptoms with be visual sooner. In March 2007, the United States Food and Drug Administration encouraged the pharmaceutical companies producing sedative-hypnotic drugs to increase their labeling that such abuse of drugs could cause allergic reaction or sleep related behaviors.

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10. Nicotine dependence (305.1)

- DSM-IV-TR criteria
- Specifiers:
- With Physiological Dependence
- Without Physiological Dependence
- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission
- Nicotine dependence is both a psychological and physical reliance on the drug nicotine that can be found in a variety of tobacco products. Throughout the world, tobacco is one of the most widely used legal substances. Nicotine research indicates that the use of even a small amount can lead to dependency. Even though nicotine has been linked to cancer-related deaths and a myriad of health related issues, an individual who is dependent upon nicotine has difficulty in cessation due to continued compulsions to use the substance. Nicotine, like many of the other substances that are grouped into substance use disorders, can produce a euphoric feeling that alters the mood of the user. These effects can be seen in the individual brain patterns of the user. Regular and normal functioning of a person with nicotine dependency often relies on this substance to complete everyday activities. At the same time, quitting tobacco use causes withdrawal symptoms, including but not limited to irritability and anxiety.
- Associated features
- Nicotine comes from the tobacco plant which is dried and used in cigarettes, chewing tobacco, cigars, and pipes. The use of nicotine can generate a feeling of increased alertness or relaxation in the individual. This may also depend on how much a person smokes, the strength of inhalation, and how often the person uses nicotine. The psychological aspects connected with nicotine can be triggered by normal everyday events such as waking up, getting into a car, or finishing a meal. Psychological triggers can occur when an individual is faced with particular situations or issues that make them angry, stressed, anxious, or bored. The physical reliance is related to the functioning of the brain and how nicotine affects it. Certain receptors in the brain cells come to rely on nicotine molecules to enable the normal functioning of an individual on a daily basis.
- Child vs. adult presentation
- Children and adolescents often exhibit nicotine dependence symptoms even if they have never smoked. These symptoms are often a result of living with parents or guardians that smoke in the home or in the car or if they smoked while in the room. There is also an increased risk in children for developing asthma, ear infections, and colds. Infants of smokers are often more prone to sudden infant death syndrome (SIDS). Adolescents are often affected by peers that smoke in their presence; it happens all the time because not all people smoke and it is a social gathering activity to talk and smoke. Second-hand smoke can cause withdrawal symptoms in children that can be expressed as depression, irritability, problems sleeping, increased appetite, and anxiety. Nicotine dependence in children can often be seen to impair concentration and results in poor school performance. They may also experience cravings for nicotine and increased temptation to smoke when they are around others that smoke.Children that have parents that smoke are more likely to engage in the act than those who have parents that are non-

smokers. It has been estimated that around 20% of teen smokers exhibit substantial nicotine dependence. Recent research suggests that some adolescents may begin to experience a loss of control over their smoking within weeks of smoking the first cigarette. In both adults and children, using any amount of tobacco can quickly lead to nicotene dependence.

- Adults, as well as children, that are exposed to nicotine may experience both short-term and long-term effects. Short-term effects include an increase in heart rate, blood pressure, and metabolism. The “fight-or-flight” response may also be experienced as a result of increased adrenaline production that causes rapid heartbeat, increased blood pressure, and rapid, shallow breathing. It takes an average of seven seconds for the effects of nicotine to reach the brain. Research indicates that there may be a drop in skin temperature, decreased appetite, diarrhea, and saliva excretion. The physical appearance of a smoker may also be altered. Smoking can change the structure of the skin, causing premature aging and wrinkles, as well as causing yellowing of teeth, fingers, and fingernails. Long-term effects include re-occurring problems with blood pressure, coronary heart disease, emphysema, shortness of breath, reduced fertility, and abnormal sperm forms. Individuals with HIV or other immuno-deficiency diseases are more apt to contract life-threatening illnesses due to the effects of a weakened immune system that are caused by nicotine. In addition, the nicotine in tobacco can damage cell structure, causing increased cell proliferation, which may cause several types of carcinomas. Nicotine has also been known to block the release of insulin into the blood stream, leading to hyperglycemia.The blockage of insulin also increases the smoker’s risk of developing type 2 diabetes and, those who already have diabetes, are at an increased risk for complications including kidney disease. Nicotine can also cause complications in pregnancy such as miscarriage, preterm delivery, and SIDS as well as low birth-weight in newborns. Newborns with low birth-weight are more likely to die or have learning or physical problems.
- Gender and cultural differences in presentation
- Many of the cultural and gender differences can be seen in the history of nicotine itself. Mayan cultures indicated use of tobacco in their stone carvings as far back as 900 A.D. The Native American cultures used tobacco ceremonially and the men of the tribe would often use it as a sign of wealth and friendship. Tobacco was brought to Europe in the 1500’s where it became popular via pipes, cigars, and snuff. Tobacco, however, was often punishable in some European and Asian cultures by mutilation and/or death. In the United States, tobacco still maintains its popularity and its respectability as a valuable cash crop.
- Historically, more men than women use nicotine, especially in the form of chewing tobacco. It is often used to fit in socially and to project a certain image while at the same time give sensory rewards and emotional relief to the individual using it. Smoking, at one time, projected the appearance of wealth and prestige in Rome and France where it was socially acceptable for women to smoke as well. In the United States, smoking has begun to take on a negative connotation. New laws forbidding the act of smoking in public places and in vehicles around children have emerged. In addition, pregnant women who smoke are looked down upon as it goes against the new social norms. In one city in Arizona, it is not only illegal to smoke in public places or in the presence of children, but it is also illegal to smoke in vehicles with the windows rolled down.
- Besides the traditional cigarettes and smokeless tobacco, there are several other types cigarettes that must be considered. Bidis are handmade cigarettes composed of tobacco hand-wrapped in a dried tendu or temburni leaf and tied with a string. Bidis comes in many flavors, including chocolate, wild cherry, and cinnamon. These types of cigarettes are relatively cheap and have a harmless appearance; however, because the the wrappers have a low combustibility the user has to smoke more. This is a problem because bidis produces more carbon monoxide and tar than conventional cigarettes. Bidis are popular in South Asian countries such as India, Sri Lanka, Bangladesh, Pakistan, Afghanistan, Cambodia, and Nepal. In these countries, poverty, low education, scheduled castes, and scheduled tribes are found to be associated with higher prevalence of tobacco use. Clove cigarettes called Kreteks contain a mixture of Indonesian tobacco and shredded clove spice wrapped in either an ironed corn husk or a slip of paper. Many smokers who use Kreteks inhale the chemicals much deeper because of their anesthetizing effects.
- Although 60-70% similar to conventional cigarettes, they produce twice as much tar, nicotine, and carbon monoxide. The active ingredient in cloves known as Eugenol is the anesthetic and it is known to contribute to the development of respiratory tract infections. These infections are due to the numbing effect the ingredient has on the back of the throat and trachea which hides the harshness of the cigarette. This numbing effect contributes greatly to an increase in nicotine dependence. This type of tobacco product is mainly used in Indonesia; however, internet sales have increased its popularity to all other parts of the world. Another type of tobacco product is known as a hookah, or its alternate name “hubble bubble”. A hookah is a long-necked water pipe in which the smoke passes through a long tube and through an urn of water that makes a bubbling noise. In India and Persia, the bulb used to hold the water is made of coconut shells although in many cases they are made of glass, porcelain, silver, or crystal embedded with gold and silver. There has been little research done to support the claim that hookah smoking

delivers less harmful substances to the smoker than do conventional cigarettes; however, hookah smoke contains significant amounts of carbon monoxide and nicotine. Hookah smoking has gained popularity in not only India and Persi, but also many of the Arab countries, London, England, and Paris, France have caused a regained interest due to the proliferation of Hookah cafes.

- Smokeless tobacco is used as a broad term that refers to more than thirty types of products. These products are used around the world but are most common in northern Africa, Southeast Asia, and the Mediterranean region. These products are consumed without burning the product and can are used orally or nasally. Most of these products are placed in the mouth, cheek, or lip and are sucked (dipped) or chewed. Fine tobacco powder may be inhaled and absorbed through the nasal passages. Southeast Asia is a major producer and exporter of smokeless tobacco. In countries such as India and Bangladesh, smokeless tobacco is often associated with areas of low education and low income. Despite the harmful effects, smokeless tobacoo may be used to treat toothaches, headaches, and stomachaches. Harmful effects include an increase in the risk of oral cancers, oral submucous fibrosis, hypertension, and reproductive health problems.
- In some cultures, such as First Nations People, tobacco is used as a medicine in ceremonial practices. For the purposes of honoring and including cultural traditions and healing practices in relation to new laws being written regarding the use of tobacco, the difference between tobacco use and dependence, ceremonial tobacco, and recreational use must be clearly defined.
- The 1998 Surgeon General's report, Tobacco Use Among U.S. Racial/Ethnic Minority Groups, addressed diverse tobacco-control needs of the four primary U.S. racial/ethnic minority populations: non-Hispanic blacks, American Indians/Alaska Natives (AI/ANs), Asians/Pacific Islanders, and Hispanics. The report results indicated that the prevalence of cigarette smoking among adults age 18 and older ranged from 40.4% for AI/ANs to 12.3% for the Chinese population. The prevalence amoung youths aged 12-17 years ranged from 27.9% for AI/ANs to 5.2% for the Japanese population.

Epidemiology

- It has been found that 55%-90% of those that are diagnosed with mental disorders also use nicotine on a regular basis. In the general population, 30% of individuals were found to be users of tobacco that were absent mental illness. It has also been indicated that 25% of the population of the United States has been diagnosed with nicotine dependence. Of those that use tobacco on a regular basis, 45% can stop using nicotine eventually; however, it has been estimated that only 5% will be successful without help. People who have depression, schizophrenia, and other forms of mental illness are more likely to be smokers simply because it may be a form of self-medication for these disorders. People who abuse alcohol and illicit drugs are also more likely to be smokers. Diagnosis of substance dependence, including nicotine dependence as well as others, is based upon the 'Four Cs' Test. This test is conducted by psychiatrists, psychotherapists, social workers, and addiction counselors. This test focuses on four areas: compulsion, control, cutting down, and consequences. Compulsion is the intensity with which the desire to use a chemical, such as tobacco, overwhelms the patient's thoughts, feelings, and judgements. Control focuses on the degree to which patients can (or cannot) control their chemical use once they have started using. Cutting down refers to the analysis of the withdrawal symptoms experienced by an individual. This aspect focuses on the effects of reducing chemical intake. The final factor deals with the consequences associated with the chemical dependence. This area deals with the denial or acceptance of the damage caused by the chemical. The 'Four Cs' Test is the DSM-IV based diagnosis of nicotine dependence.
- Etiology
- Nicotine dependence is caused by the reliance of receptors in the brain that deal with mood-altering and physical effects on the body. The nicotine binds to nicotine receptors that then stimulate such neurotransmitters including dopamine. These neurotransmitters become dependent on the chemical in order to regulate normal body functioning. Nicotene is responsible for a host of health problems; however, the physical and mood-altering effects in the brain are temporarily pleasing. It is these effects that spur continued use of tobacco products and this is ultimately what leads to dependence. Adolescents that smoke may be more prone to being diagnosed with nicotine dependency because their brains are not fully developed. The genes that are inherited play a role in some aspects of nicotine dependence. This is based on more than just the immediate environment (i.e. having parents that smoke). For example, the likelihood that an individual will start smoking and keep smoking may be partly inherited. Some people experiment with smoking and don't experience the pleasure, so they never become smokers. Other people develop dependence very quickly such as the dependence seen in adolescents. Some "social smokers" can smoke just once in a while, and yet another group of smokers can stop smoking with no withdrawal symptoms. These differences can be explained by genetic factors that influence how receptors on the surface of the brain's nerve cells respond to nicotine.

- Empirically supported treatments
- Medications, which include nicotine replacement therapy, can be effective treatments for nicotine dependency. Nicotine replacement therapy includes products that include nicotine at lower doses, without the appearance of the over 3,000 chemicals that are in tobacco products. These products include nicotine patches, gums, and lozenges. Prescription products, such as nicotine nasal spray (Nicotrol NS) and nicotine inhalers are also available on the market to help combat nicotine dependence. Many medications used to help curb the cravings of nicotine dependency do not include nicotine. Certain antidepressants, such as Zyban or Wellbutrin, can help increase the levels of norepinephrine and dopamine in the brain to reduce the need for nicotine. Varenicline, which targets nicotine receptors in the brain, and high blood pressure medication such as Clonidine are examples of other non-nicotine medications that are in use to help individuals reduce and/or stop the use of nicotine. Research shows that amalgamating medications and behavioral counseling is an effective way for long-term success in being sober from tobacco. The counseling helps develop the skills needed to stay away from the substance. In addition, the development of vaccines are being investigated which will prevent nicotine users from relapse. There are no physical tests top determine the exact degree to which an individual is dependent upon nicotine. A physician may assess the degree of an individual's dependence by asking questions or having a questionnaire completed. The more cigarettes a person smokes each day and the earlier in the day a person smokes after awakening, the more dependent the individual is.
- Most of the nicotine replacement products are available over-the-counter. The nicotine patch, which includes NicoDerm CQand Habitrol, delivers nicotine through the skin and directly into the bloodstream. A new patch is placed on the skin each day and the treatment period usually lasts for eight weeks or longer. The patch dosage may be adjusted or an additional medication may be needed in order to stop smoking if this has not occurred after two weeks. Nicotrol inhaler is a nicotine inhaler that is shaped like a cigarette. This allows the smoker to satisfy the urge as well as the physical act of smoking. This inhaler delivers nicotine vapors into the mouth where it is absorbed in the lining of the mouth directly into the bloodstream. However, the inhaler may cause side effects such as mouth and/or throat irritation and occasional coughing.
- Current funding is being used to create opportunities for development and implementation of youth tobacco-control programs. Research shows that combining medicine with behavioral counseling provides the best chance for long-term success in abstaining from alcohol. Medication is used to lessen the withdrawal symptoms in an individual that has nicotine dependence while the behavioral treatments focus on helping the individual develop the skills needed to stay away from tobacco over the long run.
- LINKS:
- Nicotine in the brain Nicotine in the Brain
- What's Inside a US Blended Cigarette? Inside a Cigarette
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- Effects of Nicotine on the Brain. Effects of Nicotine on the Brain
- What happens when you quit smoking: Smoking Withdrawals
- Dr. Richard Hurt from the Mayo Clinic discusses possible ways to quit smoking (uploaded by CBSNewsOnline, direct link http://www.youtube.com/watch?v=_9DurNWR-hQ)
- An individual's personal story on quitting smoking (uploaded by livestrong)
- Methods to help smokers quit (uploaded by TheIowaClinic)
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11. Alcohol Dependence (303.90)

- DSM-IV-TR criteria·
- A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
- (1) Tolerance, as defined by either of the following:
- (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect
- (b) Markedly diminished effect with continued use of the same amount of the substance
- (2) Withdrawal, as manifested by either of the following:

- (a) The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for Withdrawal from the specific substances)
- (b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- (3) The substance is often taken in larger amounts or over a longer period than was intended
- (4) There is a persistent desire or unsuccessful efforts to cut down or control substance use
- (5) A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
- (6) Important social, occupational, or recreational activities are given up or reduced because of substance use
- (7) 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)
- Specify if:
- With Physiological Dependence
- Without Physiological Dependence
- Early Full Remission
- Early Partial Remission
- Sustained Full Remission
- Sustained Partial Remission
- In a Controlled Environment
- Associated features
- Statistics show that: in the United States about one out of ten people are alcohol dependent; there is either an intoxicated driver or pedestrian involved in approximately one half of all highway fatalities; and among individuals with alcohol dependence, approximately ten percent commit suicide (this is shown to be related to Substance Induced Mood Disorders) . Other studies show a connection between long term heavy alcohol use and the development of Dementia and Wernicke's disease. In pregnant women alcohol dependence can also cause different birth defects such as Fetal Alcohol Effects (FAE) and Fetal Alcohol Syndrome (FAS).Fetal Alcohol Syndrome is more severe and usually causes some form of mild Mental Retardation and physical defects leading to intellectual deficiencies and learning disabilities. The statistics concerning FAS are staggering. It is estimated that out of every 1000 infants born alive, approximately 1.5 has FAS. Not only is Fetal Alcohol Syndrome the primary preventable cause of Mental Retardation in the United States, it is also the third leading cause of birth defects.
- Regarding tolerance, it is a sign that the liver has been damaged when reverse tolerance, that is, the need of less alcohol to produce the desired effect, appears.
- Child vs. Adult presentation
- Having hyperactive ADHD increases teenagers' chances of using alcohol. Children who come from families that sanction drinking have a higher risk of becoming alcohol users. Adolescents and teenagers who first use alcohol are starting the experimentation process. Adults who first use alcohol are doing so because of some positive or negative influence in their lives.
- Gender and Cultural differences in presentation
- Religion is a large factor in the rates of alcohol abuse and dependence in different cultures. Part of that influence is the context in which the alcohol is being used. There tends to be lower rates of Alcohol Dependence in cultures that use alcohol in religious ceremonies. Rates of Alcohol Dependence are higher in cultures where religion uses alcohol as a social lubricant.
- Alcohol dependence is more prominent among Native Americans and Irish or Irish Americans. For Native Americans this stems from the history of being deprived of their lands and denied the stability of economic success. Because their homes are usually too small and crowded to get together with friends and family, the pub is usually the social center of the Irish way of life.
- Men represent a larger population of alcohol dependent's than do women. Numerous studies have shown that men will be less likely to abstain from using alcohol, and hence more often become dependent on the substance. Men generally consume more alcohol and abuse alcohol more frequently than women (Homila 2004). From culture to culture the size of this discrepancy varies, and more research is needed to explain why these cultural differences exist.

- Epidemiology
- Ninety percent of the population has used alcohol at some point in their lives. Alcohol has the effects of positive reinforcement by changing brain and body chemistry. Alcohol also has a negative reinforcement effect of removing inhibitions and anxiety. It is at least three times as likely for a primary biological relative to have Alcohol Dependence if a first degree biological relative has the same disorder. The environment of where individuals live and their Socio Economic Status also play a role in developing Alcohol Dependence. There is also a new theory being studied that connects Alcohol Dependence to abnormally low serotonin levels.
- Etiology
- There are many various factors that influence whether or not an individual develops alcohol dependence. From a psychoanalyst perspective, Alcohol Dependence would be seen as a result of anxiety, repressed emotions, or neurotic conflict, and could also be used as a way to boost self esteem. Having an oral fixation has also been connected to Alcohol Dependence. There can also be a genetic connection. A key factor is that the individual must hold a positive attitude towards alcohol. Peer pressure during adolescence and the media portrayal of alcohol (having sex appeal) throughout life are also strong influential factors. Once an individual gives into the pressure he will start to experiment with alcohol. These experiments may have positive or negative effects. If the individual has a positive opinion about alcohol and enjoys drinking then he will continue to drink. If he steadily increases the amount of alcohol he drinks it could eventually lead to complications of his everyday life. Ads for alcoholic beverages are increasigly targeted at the youth, especially young men, sending the message that drinking beer may, for example, cause scandalously clad women to flock to one's location. The individual then begins to experiment with alcohol, usually with a peer group, and continues use through school. Problems occur and worsen the heavier the alcohol use becomes.
- Two key etiological factors are generally agreed upon. First, the individual must have a positive attitude toward alcohol.
- Empirically supported treatments
- It is much easier to treat and stop the alcohol abuse before it becomes dependence. There are many proposed treatments for an individual with Alcohol Dependence. Psychotherapy, ketamine-enhanced psychotherapy (Kolp, Friedman, Young & Krupitsky, 2006), medications such as Disulfiram (Mustard, May & Phillips,2006; Obholzer, 1974), 12-step programs (Gomes & Hart, 2009), and religious programs are all empirically supported treatments for individuals with Alcohol Dependence. It is not uncommon for two or more of these methods to be used in treating individuals with Alcohol Dependence. Spirituality is suggested to be inversely related to alcohol use, therefore, increasing one's spirituality is an approach taken by many substance-abuse professionals in an attempt at treatment of the Substance-Related Disorders (Johnson, Sheets & Kristeller, 2008). Twelve-step programs such as Alcoholics Anonymous or Narcotics Anonymous are examples of commonly used spirituality-based treatments for Substance-Related Disorders. It is suggested that use of a 12-step program in combination with psychotherapy is quite effective (Knack, 2009). Groh, Jason, Ferarri, & Davis (2009) examined the effectiveness of 12-step involvement in combination with the use of an Oxford House (group recovery living) in 150 substance-dependent individuals. Groh (2009) and his colleagues found that in the 12-step/Oxford house combination condition, 87.5% of individuals with "high 12-step involvement" were abstinent at 24 months. Abstinence rates at 24 months for individuals with "low 12-step involvement" were fairly similar across both conditions; 12-step/Oxford combination = 31.4%, 12-step alone = 21.2% (Groh, Jason, Ferarri, & Davis, 2009)
- The Disease Model sees Alcohol dependence as a medical condition. This model ties into the genetic factor. If Alcohol Dependence is seen as a biological condition then the only successful way to treat it, is to completely abstain from drinking alcohol. The self help group Alcoholics Anonymous (AA) recognizes the disease model. It is unsafe for an individual that is dependent on alcohol to stop "cold turkey". The alcohol must be removed from the system in a slow process of detoxification. To prevent sever withdrawal complications, the individual will be given some form of anti-anxiety medications. Medications such as Antabuse may also be used in an attempt to maintain abstinence. Severe Alcohol Dependence can have a spontaneous remission with about twenty percent never experience drinking problems again.
- LINKS:
- CBT Role Play – Alcohol Dependence 1Alcohol Dependence
- Alcohol and Drug Dependence Dependence
- Alcohol Addiction and Abuse Addiction and Abuse]]

12. Alcohol abuse (305.00)

- DSM-IV-TR criteria
- A) A maladaptive pattern of substance 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 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) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
- (4) 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)
- B) The systems have never met the criteria for Substance Dependence for this class of substance.
- Associated features
- Alcohol abuse has a high co-morbidity rate with the abuse of other substances. When substances that are normally abused are not available, alcohol may be used as an alternative. Alcohol abuse can also be associated with other psychological disorders such as conduct disorder and antisocial behavior in adolescents. Alcohol has the psychological effect of inhibition reduction making it seem as if it is a stimulant. Alcohol is in fact a depressant of the central nervous system (CNS). It is estimated that forty percent of all people in the United States will be involved in an accident related to alcohol at some point during their lives and that fifty five percent of all fatal driving accidents are in some way due to alcohol. A diagnosis of Alcohol Abuse can be applied when alcohol is causing problems in the individual's life activities. Binge drinking is a serious problem and also a form of abuse that occurs in about fifty-percent of college men. The average age that one peaks at consumption and abuse is twenty one. Individuals who qualify for Alcohol Abuse typically consume alcohol in situations that are hazardous to one's health. The most common of which is driving while intoxicated (DWI) from alcohol and is the number one cause of all automobile accidents in the United States.
- Alcohol withdrawal occurs when one stops or reduces heavy or prolonged use. Some withdrawal symptoms are autonomic hyperactivity, increased hand tremor, psycho-motor agitation, insomnia, nausea or vomiting, and transient visual, auditory or tactile hallucinations or delusions. Also anxiety and grand Mal seizures may be present.
- Child vs. adult presentation
- According to recent studies, the prevalence of alcohol abuse among adolescents ranges between four and percent in males. This percentage has been found to increase with age. Children who start to use alcohol at an earlier age (before fifteen) have a higher tendency to abuse alcohol later on. The age at which adults abuse alcohol varies widely. Males tend to present with alcohol abuse at a younger age than females.
- Gender and cultural differences in presentation
- Men are diagnosed with alcohol abuse more often than women. The ratio has been as high as 5:1 with a variance between age groups. Men start drinking at a younger age than women, however, once alcohol use becomes abusive, the disorder progresses faster in females than in males. The rate is highest among men aged 18 to 25, most of which are in college. Throughout different cultures, the amount of alcohol abuse varies widely. There are many possible reasons for this variance; alcohol is more readily available in some cultures than in others and each culture has its own social beliefs and regulations about drinking. What is socially acceptable in one culture is not necessarily the same in others. Cultural attitudes about alcohol consumption are also affected by the religious beliefs of each culture. Alcohol abuse also has different physiological effects on people of different cultures because of the religious beliefs and what is expected when alcohol is consumed, such as hallucinations or delusions as a possibility.
- Prevalence is high in western countries; Asian cultures have a low prevalence but male to female ratio is high. Caucasian males generally reach a peak, in terms of alcohol use, during early adulthood from ages 18-30. After age 30 alcohol use in this group

tends to wane throughout the rest of life. African American males often display drinking patterns completely different from those of Caucasion males. African American males generally have low instances of alcohol abuse during their 20's, and rising use during their 30's and 40's (Homila, 2004).

- Women are affected differently than men. When consuming alcohol women become more impaired even when taking weight into account. The reason is that alcohol mixes with the water in your body and that dilutes it. Men generally have more water in their bodies than women, so alcohol is diluted more when men drink it versus women. A binge drinker is classified as a person that consumes 5 or more drinks in a one week period more than once a week in men, and only 4 or so for women in the same classification.
- Epidemiology
- It is estimated that between sixty-six and ninety percent of all adults have at some time in their lives consumed alcohol. Although alcohol abuse is not as severe as alcohol dependence, it is more common and can be seen a precursor to dependence. Alcohol is the second most used psychoactive substance, next to caffeine. Lifetime prevalence is 13.3% to 15% in the general population. The highest prevalence is in ages 26-34 with 77% prevalence. Alcohol abuse and dependence are co-morbid with Axis I and II, mood disorders, anxiety, Schizophrenia and Anti-Social Personality disorder. Depression may result from effects of intoxication or withdrawal. Concurrent and sequential treatments are questionable for other problems.
- Etiology
- Individuals who have a positive attitude about alcohol consumption tend to be more likely to abuse alcohol. There are many different types of and reasons for alcohol abuse. These reasons range from psychosocial to physiological and cultural. One type of alcohol abuse is getting drunk or binge drinking (which has a high prevalence in college men) at social events. Alcohol abuse can also be attributed to other substance abuse disorders and psychological disorders. Alcohol abuse can be used to deal with physiological problems or pain. There is also a possible genetic factor involved in alcohol abuse and dependence.
- Empirically supported treatments
- The first and most important step in treatment of alcohol abuse is to make the individual realize and admit that he abuses alcohol. The most effective way to prevent alcohol abuse is abstaining from its use. Clinical therapy can also be used to help the person learn to control the amount of alcohol consumption. Prescription medications can also be used to reduce the desire to consume alcohol. Alcoholics Anonymous is a self-help group that has been around for over seventy years. This program is structured around alcohol dependence but can be used by alcohol abusers that realize they may be on the road to dependence. Its method is called the "Twelve Step Program." Members introduce themselves anonymously and progress through the twelve steps. Some studies show a greater recovery in those individuals who participate in non-emotion centered therapy. Other individuals involved in therapy centered on depression or other emotional problems have a tendancy to show lower recovery rates (Raitasalo, 2005).
- Links
- Health: Defining Alcoholism What is Alcoholism?
- Alcoholism Alcoholism
- Health: Alcoholism Diagnosis and Treatment Treatment of Alcohol
- End Result of Alcoholism (College Health Guru) Results of Alcoholism
- Alcohol: A Women's Health IssueAlcohol and Women
- Alcohol Abuse in College WomenAlcohol Abuse and Women
- What is Alcohol Poisoning? (College Health Guru) Alcohol Poisoning
- Alcohol Abuse Alcohol Abuse
- Abuse of Alcohol Abusing Alcohol
- History of AA Alcohol Awareness
- Alcohol Abuse vs Dependence Some signs of each (uploaded by illumistream, direct link http://www.youtube.com/watch?v=FdAu5HcMuBs)

13. Alcohol Intoxication (303.00)

- DSM-IV-TR criteria
- A. Recent ingestion of alcohol
- B. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment, impaired social or occupational functioning) that developed during, or shortly after, alcohol ingestion.
- C. One (or more) of the following signs, developing during, or shortly after, alcohol use:
- (1) Slurred speech
- (2) Incoordination
- (3) Unsteady gait
- (4) Nystagmus (involuntary eye movement)
- (5) Impairment in attention or memory
- (6) Stupor or coma
- D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

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14. Alcohol Withdrawal(291.81)

- DSM-IV-TR criteria
- A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
- B. Two (or more) of the following, developing within several hours to a few days after Criterion A:
- (1) Automatic hyperactivity (e.g., sweating or pulse rate greater than 100)
- (2) Increased hand tremor
- (3) Insomnia
- (4) Nausea or vomiting
- (5) Transient visual, tactile, or auditory hallucinations or illusions
- (6) Psychomotor agitation
- (7) Anxiety
- (8) Grand mal seizures
- C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
- Specify if:
- With Perceptual Disturbances
- Emperically supported treatment
- Many treatment with alcohol withdrawal syndroms can be managed with various pharmaceutical medications including barbituates, benzodiazepines, and clonidine, certain vitamins are also an important part of the management of alcohol withdrawal syndrome.
- Barbituates are superiors to diazepam in the treatment of severe alcohol withdrawal syndromes such as delirium tremens but equally effective in mildr cases of alcohol withdrawal.
- Clonidine has demonstrated superior clinical effects in the suppression of alcohol withdrawal symtpoms in a head to head comparison study with the benzodiazepine drug.
- Benzodiazepines are the most commonly used drug for the treatment of alcohol withdrawal and are generally safe and effective in suppressing alcohol withdrawal signs. Chlordiazepoxide and diazepam are the benzodiazepines most commonly used in alcohol detoxification. Benzodiazepines can be life saving, particularly if delerium tremens appears during alcohol withdrawal. Benzodiazepines should only be used short term in alcoholics who aren't already dependent on benzodiazepines as benzodiazepines share cross tolerance with ethanol and there is a risk of replacing the addiction with a benzodiazepine dependence or worse still adding an additional addiction. Furthermore disrupted GABA benzodiazepine receptor function is

part of alcohol dependence and chronic benzodiazepines may prevent full recovery from alcohol induced mental effects. Benzodiazepines have the problem of increasing cravings for alcohol in problem alcohol consumers and they also increase the volume of alcohol consumed by problem drinkers. The combination of benzodiazepines and alcohol can amplify the adverse psychological effects of each other causing enhanced depressive effects on mood and increase suicidal actions and are generally contraindicated except for alcohol withdrawal.

- Vitamins
- Alcoholics are often deficient in various nutrients which can cause severe complications during alcohol withdrawal such as the development of wernicke syndrome. The vitamins of most importance in alcohol withdrawal are thiamine and folic acid. To help to prevent wernicke syndrome alcoholics should be administered a multivitamin preparation with sufficient quantities of thiamine and folic acid. Vitamins should always be administered before any glucose is administered otherwise wernicke syndrome can be precipitaed.
- Links
- How long does withdrawal last? A discussion of the time course and symptoms associated with withdrawal at different stages in alcohol abuse and dependence (uploaded by ehowhealth, direct link http://www.youtube.com/watch?v=CWrp3YXMohQ)
- DSM-V Proposed Changes: adding “Alcohol-Use Disorder”
- DSM-V Alcohol-Use Disorder Criteria:

A. 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:

1. a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
2. b. markedly diminished effect with continued use of the same amount of the substance
3. (Note: Tolerance is not counted for those taking medications under medical supervision such as analgesics, antidepressants, ant-anxiety medications or beta-blockers.)

1. withdrawal, as manifested by either of the following:

4. a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)

1. b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
2. (Note: Withdrawal is not counted for those taking medications under medical supervision such as analgesics, antidepressants, anti-anxiety medications or beta-blockers.)

1. the substance is often taken in larger amounts or over a longer period than was intended
2. there is a persistent desire or unsuccessful efforts to cut down or control substance use
3. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. important social, occupational, or recreational activities are given up or reduced because of substance use
5. 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.
6. Craving or a strong desire or urge to use a specific substance.

5. Severity specifiers:

1. Moderate: 2-3 criteria positive

2. Severe: 4 or more criteria positive
3. Specify if:
4. With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 4 or 5 is present)
5. Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 4 nor 5 is present)
6. Course specifiers (see text for definitions):
7. Early Full Remission
8. Early Partial Remission
9. Sustained Full Remission
10. Sustained Partial Remission
11. On Agonist Therapy
12. In a Controlled Environment

5. 15. Cocaine Abuse and Dependence (305.6)

1. DSM-IV-TR criteria

1. A. 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. 1. Recurrent cocaine use resulting in a failure to fulfill major role obligations at work, school or home.
2. 2. Recurrent cocaine use in situations in which it is physically hazardous
3. 3. Recurrent cocaine-related legal problems
4. 4. Continued cocaine use despite having a persistent or recurrent social or interpersonal problem caused or exacerbated by it use.

2. B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

2. Associated features

1. 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.
2. Withdrawal symptoms can include a dysphoric or unpleasant mood, fatigue, unpleasant dreams, insomnia, psycho motor 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.
3. 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.
4. 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.

3. Child vs. adult presentation

1. 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.

4. Gender and cultural differences in presentation

1. 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.
2. 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.

5. Epidemiology

1. In 2007, the National Survey on Drug Use and Healthreported 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.

6. Etiology

1. 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.

7. Empirically supported treatments

1. 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. Benzodiapines have shown to help people with intoxication symptoms that do not go away. Benzodiapines 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.

8. Links

1. Cocaine, Marijuana, Crack, Meth, Heroin Changes Brain ChemistryDrugs Damaging the Brain

1. DSM-V Proposed Changes: adding “Cocaine-Use Disorder”
2. DSM-V Cocaine-Use Disorder Criteria:
3. A. 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:
4. 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)
5. 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)
6. 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)
7. tolerance, as defined by either of the following:

7. a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
8. b. markedly diminished effect with continued use of the same amount of the substance
9. (Note: Tolerance is not counted for those taking medications under medical supervision such as analgesics, antidepressants, ant-anxiety medications or beta-blockers.)

1. withdrawal, as manifested by either of the following:

10. a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
11. b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
12. (Note: Withdrawal is not counted for those taking medications under medical supervision such as analgesics, antidepressants, anti-anxiety medications or beta-blockers.)

1. the substance is often taken in larger amounts or over a longer period than was intended
2. there is a persistent desire or unsuccessful efforts to cut down or control substance use
3. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. important social, occupational, or recreational activities are given up or reduced because of substance use
5. 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)

6. Craving or a strong desire or urge to use a specific substance.

13. Severity specifiers:
14. Moderate: 2-3 criteria positive
15. Severe: 4 or more criteria positive
16. Specify if:
17. With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 4 or 5 is present)
18. Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 4 nor 5 is present)
19. Course specifiers (see text for definitions):
20. Early Full Remission
21. Early Partial Remission
22. Sustained Full Remission
23. Sustained Partial Remission
24. On Agonist Therapy
25. In a Controlled Environment
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16. Cannabis Abuse and Dependence (305.20/304.3)

- DSM-IV-TR criteria
- A. Cannabis is a generic term used to denote the several psychoactive preparations of the plant Cannabis sativa. The major psychoactive constituent in cannabis is Δ-9 tetrahydrocannabinol (THC). Cannabis impairs cognitive development (capabilities of learning), including associative processes; free recall of previously learned items is often impaired when cannabis is used both during learning and recall periods
- B. Cannabis impairs psycho-motor performance in a wide variety of tasks, such as motor coordination, divided attention, and operative tasks of many types; human performance on complex machinery can be impaired for as long as 24 hours after smoking as little as 20 mg of THC in cannabis; there is an increased risk of motor vehicle accidents among persons who drive when intoxicated by cannabis.
- C. Some difficulties when cannabis is used may interfere with academic or occupational achievement or with social communication. Coding should be in AXIS I: CLINICAL DISORDERS/OTHER DISORDERS THAT MAY BE A FOCUS OF CLINICAL ATTENTION Under Substance-related disorders.
- Associated features
- Cannabis used during pregnancy is associated with impairment in fetal development leading to a reduction in birth weight; it also may lead to postnatal risk of rare forms of cancer although more research is needed in this area. Marijuana is the most used illicit drug in the United States. According to the 1994 National Household Survey on Drug Abuse, averages of 10 million Americans use marijuana each month. Within a few minutes of inhaling marijuana smoke, users likely experience dry mouth, rapid heartbeat, some loss of coordination and poor sense of balance, and slower reaction times, along with intoxication. Blood vessels in the eye expand. For some people, marijuana raises blood pressure slightly and can double the normal heart rate. This effect can be greater when other drugs are mixed with marijuana.
- Cannabis has been proven to cause damage with short term memory. This is caused by the THCs effect on the hippocampus, the area of the brain responsible for memory formation
- Cannabis smoke contains 50 – 70 percent more carcinogenic hydrocarbons than tobacco smoke. This has been suspected to be more likely to cause lung cancer. People inhaling the smoke also tend to hold the smoke in their lungs longer than cigarette smoke.THC has also been proven to inhibit a persons immune system, making them much more vulnerable to infectious diseases.
- Child vs. adult presentation
- NIDA's 1995 Monitoring the Future study found that from 1991 to 1995, marijuana use in the 12 months before the surveys rose from 23.9 to 34.7 percent among the Nation's 12th graders, from 16.5 to 28.7 percent among 10th graders, and from 6.2 to 15.8 percent among 8th graders. Children often present about the same effects as adults on the substance directly after

inhalation (see associated features). Peer pressure is a factor for children if other delinquents their age are engaged in use or around somebody who is. It is continuously becoming more and more popular among a variety of ages. Adult use is very likely to have risen as well or just continued their use through high school and college because of their liking of the substance and the good times associated with it.

- Gender and cultural differences in presentation
- The Drug Abuse Warning Network (DAWN), a system for monitoring the health impact of drugs, estimated that, in 2001, marijuana was a contributing factor in more than 110,000 emergency department (ED) visits in the United States, with about 15 percent of the patients between the ages of 12 and 17, and almost two-thirds were male. On average, 53 percent of juvenile male and 38 percent of juvenile females arrested and tested positive for marijuana; males are more likely to be associated with such deviant behavior but females are not restricted from use; there is just a difference in amount use and the frequency of occurrence. Cultures in America are more likely to run across this cannabis substance because of the diversity and the many people in the United States.
- Epidemiology
- Cannabis is by far the most common and widely cultivated, trafficked, and abused illicit drug. Half of all drug seizures worldwide are related to cannabis. The geographical spread of those seizures is also global, covering practically every country of the world. About 147 million people, 2.5% of the world population, consume cannabis (annual prevalence) compared with 0.2% consuming cocaine and 0.2% consuming opiates.
- Etiology
- Cannabis is often blamed as the “gateway” drug but no evidence seems to be able to support this claim. There is a correlation between association of “having a good time” and reuse. If the user learns to associate enjoyment with the activity then he/she will be much more likely to use it again. People can build up a tolerance to cannabis so they tend to use and abuse more the longer they use the substance. Although the causes of use vary from person to person, some use it for “medicinal uses.” Cannabis, and the THC that is in it, is often used to treat nausea, pain, and even glaucoma. Also, it has been used in cancer patients to get them to eat. This is still, however, considered illegal in most states.
- Empirically supported treatments
- Treatment programs directed at marijuana abuse are rare, partly because many who use marijuana do so in combination with other drugs such as cocaine and alcohol. Therapy may be individual treatment that includes motivational interviewing and advice on ways to reduce marijuana use. By increasing patients’ awareness of what triggers their marijuana use, they may be able to better manage their addiction. Four of the most commonly used treatments are: Basic principles, Psychotherapy, Behavioral Therapy, and 12-step programs. Basic Principles treatment includes: education, urine tests, and communication. Psychotherapy focuses on the reasons why the patient is using, and often encorporates other users of the substance who are currently battling with the same issues. Behavioral Therapy teaches users of the substance to focus on other ways to reduce anxiety with special emphasis is on relaxation techniques, self-control skills, and assertiveness training. Twelve-Step programs, such as Narcotics Anonymous (NA), focus on building a support group that is battling with similiar issues, relying on a higher power to remove the obsession to use the substance, and helping others in their battle with the substance.
- Links
- Chris Rock’s take on illegal drugs Vs. legal drugs
- Cannabis Addiction Addiction to Cannabis
- How Cannabis WorksCannabis
- DSM-V Proposed Changes: adding “Cannabis-Use Disorder” and “Cannabis Withdrawal”
- DSM-V Cannabis-Use Disorder Criteria:
- A. 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:
- 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)

- 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)
- 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)
- tolerance, as defined by either of the following:
- a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- b. 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, ant-anxiety medications or beta-blockers.)
- withdrawal, as manifested by either of the following:
- a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- b. 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.)
- the substance is often taken in larger amounts or over a longer period than was intended
- there is a persistent desire or unsuccessful efforts to cut down or control substance use
- a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
- important social, occupational, or recreational activities are given up or reduced because of substance use
- 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
- 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
- DSM-V Cannabis Withdrawal Criteria:
- A. Cessation of cannabis use that has been heavy and prolonged
- B. 3 or more of the following develop within several days after Criterion A
- 1. Irritability, anger or aggression
- 2. Nervousness or anxiety
- 3. Sleep difficulty (insomnia)
- 4. Decreased appetite or weight loss
- 5. Restlessness
- 6. Depressed mood

- 7. Physical symptoms causing significant discomfort: must report at least one of the following: stomach pain, shakiness/tremors, sweating, fever, chills, headache
- C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- D. The symptoms are not due to a general medical condition and are not better accounted for by another disorder
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17. Phencyclidine Abuse and Dependence (305.9)

- DSM-IV-TR criteria

1. See above for specific abuse and dependence criteria.

- Associated features

1. Phencyclidine can be sold as a crystalline powder, paste, liquid, or a drug soaked paper. Common street drug names for Phencyclidine are: PCP, angel dust, boat, tic tac, zoom, hog, ozone, rocket fuel, wack, and shermans. It can be smoked, injected or snorted; smoking being the most common way it is used. It is sometimes used as an additive to marjuanna, and in this case the street names could include but are not limited to: super grass, lovelies, wet, fry, killer joints, and waters.
2. Depending on the route in which the drug is used, as well as the dosage, the effects and severity of the effects will vary. It is often known as the “dissociative anesthetic” because of its distortment in sights and sounds. PCP can give an individual the feeling of detachment from his or her environment and self and have psychological and physiological effects such as: sedation, immobility, amnesia, numbness, slurred speech, rapid and involuntary eye movements, increased blood pressure, elevated tempature and heart rate, analgesia, and (with a high enough dosage) illusions and hallucinations.
3. Chronic use of the drug can result in several impairments; speech, memory, and thinking. Long-term effects can include suicidal ideation, depression, anxiety, and social isolation. There have also been drowning deaths, violent and accidental deaths, and suicide linked to the usage of PCP.

- Child vs. adult presentation

1. PCP abuse occurs more in high school students and young adults, rather than in children. Studies have shown that the usage has varied among ages and has been seen prevalent in anywhere from 12 to 34; 26 to 34 being the highest range where users typically fall under. However, children may be exposed to it due to parental use and neglect.

- Gender and cultural differences in presentation

1. It is not very common but more PCP use is among males than females because of association with delinquent peers is most likely male involvement.

- Epidemiology

1. PCP is associated with 10% of substance abuse deaths and 32% of related emergency room visits. Most users are between 18-25 years of age, and account for more than 50% of cases. Most patients are more likely to be white males. Mostly used in the United States.
2. Phencyclidine was once marketed as an anesthetic in United States for medical purposes under the trade names of Sernyl and Sernylan, but is no longer produced or used in the U.S. It was used on patients before surgery to calm them down, and used during and after surgery to ease pain, but after many reports of troubled speech, hallucinations, disoriented behavior, and other disturbing effects, it was withdrawn from the market in 1979.

- Etiology

1. Phencyclidine (PCP) is a hallucinogenic drug that can mimic several aspects of the schizophrenic symptomatology in healthy volunteers. In a series of studies PCP was administered to rats to determine whether it was possible to develop an animal model of the positive and negative symptoms of schizophrenia. The rats were tested in the social interaction test and it was found that PCP dose-dependently induces stereotyped behavior and social withdrawal, which may correspond to certain aspects of the positive and negative symptoms, respectively. The effects of PCP could be reduced selectively by anti-psychotic drug treatment, whereas drugs lacking anti-psychotic effects did not alleviate the PCP-induced behaviors. Together these findings indicate that

PCP effects in the rat social interaction test may be a model of the positive and negative symptoms of schizophrenia with face and predictive validity and that it may be useful for the evaluation of novel anti-psychotic compounds.

- Empirically supported treatments

1. Hospitalization is recommended when acute PCP intoxication occurs because hyperpyrexia and other autonomic instabilities can lead to death; Benzodiazepines, like Lorazepam, are good for these patients and serve well for controlling agitation and seizures. Typical anti-psychotics, such as, Phenothiazines and haloperidol help to control psychotic symptoms. In order to help eliminate Phencyclidine dependence, ammonium chloride should be given to help extract it from the body. As far as psychological treatment goes, out-patient treatment or follow-ups, along with utilizing the communities resources are essential in staying clean from the drug. Life style changes, such as staying away from places, people, and things are encouraged. Psychotherapy is often beneficial to users as well as attending Narcotics Anonymous as a support program.

- DSM-V Proposed Changes: adding “Phencyclidine-Use Disorder”
- DSM-V Phencyclidine-Use Disorder Criteria:
- A. 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. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- b. 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, ant-anxiety medications or beta-blockers.)

1. withdrawal, as manifested by either of the following:

- a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- b. 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.)

1. the substance is often taken in larger amounts or over a longer period than was intended
2. there is a persistent desire or unsuccessful efforts to cut down or control substance use
3. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. important social, occupational, or recreational activities are given up or reduced because of substance use
5. 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
6. 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

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18. Inhalant Abuse and Dependence (305.9)

- DSM-IV-TR criteria

1. INHALANT DEPENDENCE. The DSM-IV-TR specifies that three or more of the following symptoms must occur at any time during a 12-month period (and cause significant impairment or distress) in order to meet diagnostic criteria for inhalant dependence:

- Tolerance. The individual either has to use increasingly higher amounts of the drug over time in order to achieve the same effect, or finds that the same amount of the drug has much less of an effect over time than before. After using inhalants regularly for a while, people may find that they need to use at least 50% more than the amount they started with in order to get the same effect.
- Loss of control. The person either repeatedly uses a larger quantity of inhalant than planned, or uses the inhalant over a longer period of time than planned. For instance, someone may begin using inhalants on school days, after initially limiting their use to weekends.
- Inability to stop using. The person has either unsuccessfully attempted to cut down or stop using the inhalants, or has a persistent desire to stop using. Users may find that despite efforts to stop using inhalants on school days, they cannot stop.
- Time. The affected person spends large amounts of time obtaining inhalants, using them, being under the influence of inhalants, and recovering from their effects. Obtaining the inhalants might not take up much time because they are readily available for little money, but the person may use them repeatedly for hours each day.
- Interference with activities. The affected person either gives up or reduces the amount of time involved in recreational activities, social activities, and/or occupational activities because of the use of inhalants. The person may use inhalants instead of playing sports, spending time with friends, or going to work.
- Harm to self. The person continues to use inhalants in spite of developing either a physical (liver damage or heart problems, for example) or psychological problem (such as depression or memory problems) that is caused by or made worse by the use of inhalants

- INHALANT ABUSE. The DSM-IV-TR specifies that one or more of the following symptoms must occur at any time during a 12-month period (and cause significant impairment or distress) in order to meet diagnostic criteria for inhalant abuse:

1. Interference with role fulfillment. The person's use of inhalants frequently interferes with his or her ability to fulfill obligations at work, home, or school. People may find they are unable to do chores or pay attention in school because they are under the influence of inhalants.
2. Danger to self. The person repeatedly uses inhalants in situations in which their influence may be physically hazardous (while driving a car, for example).
3. Legal problems. The person has recurrent legal problems related to using inhalants (such as arrests for assaults while under the influence of inhalants).
4. Social problems. The person continues to use inhalants despite repeated interpersonal or relationship problems caused by or made worse by the use of inhalants. For example, the affected person may get into arguments related to inhalant use

- DSM-V Proposed Changes: adding "Inhalant-Use Disorder"
- DSM-V Inhalant-Use Disorder Criteria:
- A. 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. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- b. 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, ant-anxiety medications or beta-blockers.)

1. withdrawal, as manifested by either of the following:

- a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- b. 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.)

1. the substance is often taken in larger amounts or over a longer period than was intended
2. there is a persistent desire or unsuccessful efforts to cut down or control substance use
3. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. important social, occupational, or recreational activities are given up or reduced because of substance use
5. 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
6. 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
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19. Amphetamine Intoxication (282.89)

- DSM-IV-TR criteria
- A. Recent use of amohetamine or a related substance (e.g. methylphenidate).
- B. Clinically significant maladaptive behavior or psychological changes (e.g. euporia or affective blunting; changes is sociability; hypervigilance;interpersonal sensitivity; anxiety; tension, or anger; stereotyped behaviors; impaired social or occupational functioning) that developed during, or shortly after, use of amphetamine or a related substance.

- C. Two or more of the following, developing during, or shortly after, use of amphetamine or a related substance:
- 1 tachycardia or bradycardia
- 2 pupillary dilation
- 3 elevated or lowered blood pressure
- 4 perspiration or chills
- 5 nausea or vomiting
- 6 evidence of weight loss
- 7 psychomotor agitation or retardation
- 8 muscle weakness, respiratory depression, chest pain, or cardiac arrhythmias
- 9 confusion, seizures, dykinesias, dystonias, or coma
- D. The symptoms are not due to a general medical condition and are not better accounted for by another disorder
- Specify if:
- With Perceptual Disturbances
- This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. Intact reality testing means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered
- Associated Features
- After being intoxicated by recent use, there will be psychological and behavioral changes that will be significantly noticeable. Psychologically there may be some impairments of sociability and judgement There may be hostile or aggressive behavior depending on how much amphetamines were ingested. Hallucinations that are auditory or visual may occur and paranoia is also a possibility. It is actually fairly similar to schizophrenia . Hyperactivity and hypersexuality is also a common feature. The patient may have delusions such as feeling like there are insects crawling under their skin. The person may have issues with the law naturally due to the illegal nature of amphetamines. Their family and work life may suffer as well. There may be a presentation of very dull feelings along with sadness and social withdrawal. Fatigue, cardiac arrythmia, elevated or lowered blood pressure, dialation of the pupils, nausea or vomiting, or sweating and chills are some of the other issues that will probably show in the individuals during, or shortly after, they are intoxicated. Since amphetamines are highly addicting, it is very common for individuals to become addicted in a fairly short amount of time. This, of course, will ultimately lead to amphetamine dependence.
- Child vs. adult presentation
- Typically, it is rare for children to abuse amphetamines. It is much more common for children to accidentally ingest it than abuse it. For those rare cases of child amphetamine abuse, they will show similar symptoms. Adolescents and young adults, however, are among the highest users today.
- Gender and cultural differences in presentation
- Men are much more likely to abuse amphetamines than women. There is information that supports men enjoy amphetamines more than women due to the male body releasing 3 times as much dopamine. Different cultures that abuse amphetamines will show the same symptoms as Americans.
- Epidemiology
- Amphetamine intoxication can happen in any level of society and usually are used by individuals between the ages of 18 to 30 years old. It’s reported that about 8.8 million Americans alone will be intoxicated by some form of amphetamine in some point during their lifetimes. One of the most common, heavily abused amphetamine is methamphetamine. Reports have shown that a 30% increase in emergency room cases involving the use of methamphetamine from 1999 to 2000 alone, and the rates continue to climb.
- Etiology

- There is more supported evidence that this is environmentally influenced as opposed to biologically. Reseach has found that most use and abuse of amphetamines was started with the intent to aid them with weight loss. Others have been introduced through illegal drug experimentation. Low SES shows a high correlation with more intravenous use, which causes a quicker dependence on the amphetamine.
- Empirically supported treatment
- There is currently not a widely supported treatment for amphetamine abuse. One thing that is agreed upon is that it is not a good idea to treat amphetamine abuse with different medications. Since a prescribed medication may have caused the problem in the first place, it is easy to see prescribing more is not a smart idea. There is a little evidence that supports the drugs fluoxentine and imipramine as helpful alternatives, but more research is needed.
- — Amphetamines cause a lack of saliva that causes teeth to decay as a consiquence. See video http://www.youtube.com/watch?v=j5SXjgrJITY
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20. Amphetamine Withdrawal (292.0)

- DSM-IV-TR criteria
- A. Cessation of (or reduction in) amphetamine (or related substance) that has been heavy and prolonged.
- B. Sysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion
- 1 fatigue
- 2 vivid, unpleasant dreams
- 3 insomnia or hypersomnia
- 4 increased appetite
- 5 psychomotor retardation or agitation
- C. The symptoms in Criteria B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
- Associated features
- This happens when an individual who has reduced or discontinued the use of amphetamines that was originally used for a long time or in heavy amounts. The symptoms may vary depending on the level of dependence. Dysphoric mood and psychological changes such as fatigue, unpleasant dreams, trouble sleeping, and an increase in appetite will be noticeable. Depression or anxiety can be a very common part in withdrawal symptoms. Withdrawal can last from 3 days to 2 weeks depending on the severity.
- Child vs. adult presentation
- Children have been prescribed amphetamines for many different reasons throughout the years, but prodominately it was prescribed to them for the treatment of ADHD. Withdrawl symptoms in children have been known to be very slight because this prescribing for hyperactivity has been relatively stopped or regulated. More of the cases of amphetamine withdrawal is seen in adults because of the heavy recreational use of amphetamines such as ecstasy and methamphetamines. Adults have also been seen with more withdrawal symptoms because they use amphetamines for their success in helping drop the pounds.
- Gender and cultural differences in presentation
- There are no significant differences in males and females when it comes to withdrawal because it will be present in most cases, no matter how severe the symptoms are, if the individual has been using the drug heavily or for a prolonged amount of time. Culturally there are also no differences in the symptoms of amphetamine withdrawal throughout the world.

- Epidemiology
- Withdrawal can happen at any age or severity depending on how long and how much of the amphetamine has been used. It is only present when the individual reduces or stops the use, and it will continue to show its effects for as long as 2 weeks. Because of this, there are low success rates of overcoming the withdrawal symptoms since most choose to continue to use amphetamines in order to reverse the effects.
- Etiology
- This is only caused by environmental factors. It is specifically brought on by the lowered levels of amphetamines in the body once there has been a regulated tolerance for the substance in order to function. Environmental factors such as family or legal intervention might also play a role in developing the reason for the reduction or elimination of the use, which will spark the presentation of the withdrawal symptoms.
- Empirically supported treatment
- There are no specific medications that are used in effectively treating all of the withdrawal symptoms. Amphetamines have been studied as being a very good treatment, but there are conflicting reports as to how effective it is on reducing or eliminating the symptoms in order to let the individual overcome the addiction. Hospital detoxification is primarily the safest way to get through the symptoms and be closely evaluated especially for the chronic users, who may show significantly severe withdrawal symptoms.
- Below is a video from the reality show Intervention, where families come together to help their loved ones with addiction. This video shows two females, the focus for this section is Amy, who is addicted to methamphetamine.
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21. Caffeine Intoxication (305.9)

1. DSM-IV-TR criteria

- A Recent consumption of caffeine, usually in excess of 250mg (e.g. more than 2-3 cups of brewed coffee).
- B Five or more of the following signs, developing during, or shortly after, caffeine use:

1. restlessness
2. nervousness
3. excitement
4. insomnia
5. flushed face
6. diuresis
7. gastrointestinal disturbance
8. muscle twitching
9. rambling flow of thought and speech
10. tachycardia or cardiac arrhythmia
11. periods of inexhaustibility
12. psychomotor agitation

2. C The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- D The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. (e.g. Anxiety Disorder)
- Tolerance to caffeine may be developed, so Caffeine Intoxication may not occur in certain individuals.

3. DSM-IV-TR criteria for caffeine-induced anxiety disorder

- Prominent anxiety predominates in the clinical picture.
- There is evidence from the history, physical examination, or laboratory finding suggesting that the anxiety developed within 1 month of caffeine intoxication or withdrawal or that medications containing caffeine are etiologically related to the disturbance.

- The disturbance is not bettr accounted for by an anxiety disorder that is not substance-induced.
- The disturbance does not occur exclusively during the course of a dlirium.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functiong.

4. DSM-IV-TR criteria for caffeine-induced sleep disorder

- A prominent disturbance in sleep occurs that is sufficiently severe to warrant independent clinical attention.
- There is evidence from the history, physical examination, or laboratory findings that the sleep disturbance is the direct physiological consequence of caffeine consumption.
- The disturbance is not better accounted for by another mental disorder.
- The disturbance does not occur exclusively during the course of a delirium.
- The disturbance does not meet the criteria for breathing-related sleep disorder or narcolepsy.
- The sleep disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5. DSM-IV-TR criteria for caffeine-related disorder NOS

- This includes any caffeine disorder other than those previously listed.
- Symptoms of caffeine withdrawal that are not currently an officially recognized diagnosis are present.

6. Mental Status Examination

- Many of the effects of caffeine consumption are expressed in behavioral manifestations. The most common is anxiety, with its associated fidgetiness, distractibility, poor eye contact, hesitating speech, and prolonged bursts of energy.
- Caffeine's effecton mood is complicated and not fully understood. Although initially it may promote some improvement in mood, notably identified by some slight euphoria or focused attention, this pattern may give way to a chronic dysphoria. This mildly depressed state may be a consequence of withidrawal.
- Any complaint of sleep difficulty should include a careful assessment of beverage consumption.
- Caffeine would not produce perceptual problems such as hallucinations.
- Caffeine consumption does not produce alterations in thinking, such as delusions.
- Caffeine consumption does not cause disorientation, memory problems, mental confusion, impairment in judgment, or problems with abstract thinking.

7. Causes

- The means by which caffeine exerts its pharmacologic effects remains a subject of active research.
- A leading theory suggests that caffeine is an adenosine receptor antagonist that blocks two major types of adenosine receptors, A1AR and A2AAR.
- Adenosine is an inhibitory neuromodulator affecting norepinephrine, dopamine, and serotonin activity.
- Caffeine's putative antagonism of adenosine would increase those neurotransmitters promotting psychostimulation.
- The same neurotransmitter systems are implicated in the pathophysiology of several psychiatric.
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22. Cannabis Intoxication (292.89)

- DSM-IV-TR criteria

- A. Recent use of cannabis.
- B. Clinically significant maladaptive behavioral or psychological changes (e.g. impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during, or shortly after, cannabis use.
- C. Two or more of the following signs, developing 2 hours of cannabis use:

- conjuctival injection
- increased appetite
- dry mouth

- tachycardia
- D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
- Specify if:
- With Perceptual Disturbances
- This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. Intact reality testing means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered
- When cannabis is smoked, intoxication develops within minutes; however, if cannabis is ingested orally, intoxication may take a few hours to develop.
- Effects of cannabis intoxication usually last 3-4 hours. The effects may last longer if the cannabis was ingested orally.
- The behavioral and psychological changes that occur depend of the dose, the administration, and the individual. For example, a person's tolerance, rate of absorption and sensitivity will differ greatly 23. Other (or Unknown) Substance-Related Disorders
- A list of the Other (or Unknown) Substance-Use Disorders and the Other (or Unknown) Substance-Induced Disorders
- Definition
- This is a category of classification when the substances associated with the disorder are not covered by the 11 categories the DSM-IV-TR uses to classify Substance-Related Disorders. Substances that may relate to the disorder but are not covered include anabolic steroids, nitrite inhalants, nitrous oxide, catnip, betel nut, and kava. The disorders are generally described with the disorder that they share phenomenology with.
- Other (or Unknown) Substance-Use Disorders
- Other (or Unknown) Substance Dependence 304.9
- Other (or Unknown) Substance Abuse 305.9
- Other (or Unknown) Substance-Induced Disorders
- Other (or Unknown) Substance Intoxication 292.89 Specify if: With Perceptual Disturbances
- Other (or Unknown) Substance Withdrawal 292.0 Specify if: With Perceptual Disturbances
- Other (or Unknown) Substance-Induced Delirium 292.81
- Other (or Unknown) Substance-Induced Persisting Dementia 292.82
- Other (or Unknown) Substance-Induced Persisting Amnestic Disorder 292.83
- Other (or Unknown) Substance-Induced Psychotic Disorder, with Delusions 292.11 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Induced Psychotic Disorder, with Hallucinations 292.12 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Induced Mood Disorder 292.84 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Induced Anxiety Disorder 292.89 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Induced Sexual Dysfunction 292.89 Specify if: With Onset During Intoxication
- Other (or Unknown) Substance-Induced Sleep Disorder 292.85 Specify if: With Onset During Intoxication/With Onset During Withdrawal
- Other (or Unknown) Substance-Related Disorder Not Otherwise Specified 292.9

SOCIAL ISSUES RELATED TO SUBSTANCE USE AND ABUSE

- Pregnancy and Substance Abuse
- Rates of women who abuse substances are increasing. Most of the women who abuse substances are of child bearing ages. This presents a number of unique, complex and socially relevant issues. Including

- • Effects on children of substances used during the pregnancy.
- • Effects of attachment and mothering- state issues related to child-rearing
- • Effects of possible HIV infection due to contaminated needle usage during and after pregnancy
- Treating professionals must also be aware of ethical issues related to suspicions of substance use on the part of a mother. These ethical concerns center around whether the mother is doing harm to an unborn child and whether the professional has a duty to warn social services agencies. Further, in terms of physical health physicians also must weigh to whom they have a duty to treat in the best interest of the mother or the unborn child.
- Maternal consumption of alcohol and other drugs during any time of pregnancy can cause birth defects or neurological deficits.
- Alcohol
- Alcohol use by a woman who is pregnant is said to affect the fetus in a dose dependent manner. With “very high repetitive doses” there is a 6-10% chance of the fetus developing the fetal alcoholic syndrome manifested by prenatal and postnatal growth deficiency, specific craniofacial dysmorphic features, mental retardation, behavioral changes and a variety of major anomalies (Ornoy & Ergaz, 2010).
- Cognitive performance is less affected by alcohol exposure in infants and children whose mothers stopped drinking in early pregnancy, despite the mothers’ resumption of alcohol use after giving birth.
- Prenatal alcohol effects have been detected at moderate levels of alcohol consumption in nonalcoholic women. Even though a mother may not regularly abuse alcohol, her child may not be spared the effects of prenatal alcohol exposure
- Offspring of mothers using ethanol during pregnancy can suffer from developmental delays and/or behavioral difficulties. High repetitive doses of alcohol 6-10% chance of fetus developing the fetal alcoholic syndrome manifested by prenatal and post natal growth deficiency, specific craniofacial dysmorphic features, mental retardation, and other major anomalies. Even with lower repetitive doses risk of slight intellectual impairment, growth disturbances and behavioral changes. Binge drinking imposes danger of slight intellectual deficiency. (Ornoy A, Ergaz Z.)
- Studies were done on 12 year olds exposed to tobacco versus to 12 year olds unexposed to compare brain function. Researchers found that children who were prenatally exposed to tobacco show increased rates of behavior problems related to response inhibition deficits.
- Methamphetamines
- Children that are born to women who use methamphetamines are more likely to experience preterm delivers, have lower Apgar scores, increase rates of cesarean delivery and increased neonatal mortality (Good MM, et., al, 2010)
- Cocaine
- • Studies have shown that exposure to cocaine during fetal development may lead to subtle but significant deficits later on, especially with behaviors that are crucial to success in the classroom, such as blocking out distractions and concentrating for long periods.Children ages four to nine whose parents had used cocaine were studied to measure their cognitive abilities. The study showed that gender effected the outcome because boys whose mothers who used cocaine had lower IQ scores, and placed boys at risk for problems of inhibitory control, emotional regulation, and antisocial behavior (Bennett, D., et., al, 2008).
- It was also found that children exposed to cocaine during the first trimester were smaller on all growth parameters than the children who were not exposed to cocaine during the first trimester.
- The results of these studies also indicate cocaine associated deficits in attention processing through the age 7.
- It was also found that boys who were prenatally exposed to cocaine reported engaging in more high-risk behaviors
- Tobacco
- Smoking during pregnancy most prevalent risk factor (Burstyn I, Kapur N Cherry NM.
- Attachment difficulties appear if mother is incarcerated secondary to drug usage. (Cassidy J, Ziv Y, Stupica B, Sherman LJ, Butler H, Karfgin A, Cooper G, Hoffman KT, Powell B.
- HIV
- For women who have drug-usage related HIV treatment for drug abuse during pregnancy which can include methadone and buprenorphine may have drug interactions withHIV medicaltions, and HIV medicatins. (mcCance-Katz EF)
- Treatment include several integrated programs that have been specifically developed to meet the needs of pregnant and parenting women with substance abuse issues. These programs are aimed more specifically at the needs of the children and to educate them about the damages to the children caused by the substance. Evidence shows that these programs are indeed effective but no more effective than regular treatment programs for women who abuse substance (Milligan, K., et., al, 2010).

- http://www.drugabuse.gov/consequences/prenatal/
-
-
- http://www.youtube.com/watch?v=DMlRa2JDbwc&feature=related
-
- .
- **23. CHILDREN OF ADDICTED PARENTS:Video Link: Children of Methamphetamine Addiction** http://www.cbsnews.com/video/watch/?id=1690339n&tag=related;photovideo

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6.165: Paranoid Personality Disorder

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.



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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 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 personality functioning and specific pathological personality traits, rather than as a specific type.

(APA, 2010)

Links

- The Encyclopedia of Mental Disorders

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6.166: Schizoid Personality Disorder

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 conserved 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

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6.167: Antisocial Personality Disorder

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 evolution, 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 socials 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 sucide. 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 to 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

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6.168: Narcissistic Personality Disorder

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I ndividual 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 the 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 in1914. 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 rationalemotive 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

Links

- www.minddisorders.com
- Narcissistic Personality Disorder video:



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6.169: 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 grammer. 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 prevelant 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)

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6.17: History of the DSM

- In 1918, the American Medico-Psychological Association (presently the American Psychological Association, or APA) issued the Statistical Manual for Use of Institutions for the Insane. It did not catch on.
- In 1928, the American Psychiatric Association issued another edition but it was too narrowly focused. It looked primarily at neuroses and psychoses.
- By World War II, the military had its own nomenclature system.
- The World Health Organization (WHO) issued the International Classification of Diseases-6 (ICD-6); it contained a section on mental disorders but it needed modification for use in the United States.

DSM-I

- The APA published the Diagnostic and Statistical Manual of Mental Disorders in 1952; it was based off of the ICD-6 and the military system.
- The first DSM contained about 60 disorders and was based on theories of abnormal psychology and psychopathology.
- Problems: DSM was criticized for its reliability and validity. The major limitation of the DSM was that the concept had not been scientifically tested. Also, all of the disorders listed were considered to be reactions to events occurring in an individual's environment. Another problem was that there really was no distinction between abnormal and normal behavior. Despite this, it gained acceptance.

DSM-II

- The DSM-II was published in 1968 but still had criticism over its validity and reliability. Changes in the DSM-II included eleven major diagnostic categories, with 185 total diagnoses for mental disorders. Additionally, increased attention was given to children and adolescents in the DSM-II. For example the diagnostic category of Behavior Disorders of Childhood-Adolescence was presented for the first time.
- In 1974, the seventh printing of the DSM-II no longer listed homosexuality as a disorder.

DSM-III

- The DSM-III was published in 1980. This dramatically changed the field of psychology.
- The five part multiaxial diagnostic system, still used today, first appeared in DSM-III.
- DSM-III provided specific diagnostic criteria for 265 diagnoses.
- Dr. Robert L. Spitzer was appointed to lead the changes to the DSM in 1974. He was largely involved in creating the discrete diagnostic categories of the DSM-III, as opposed to a dimensional model of diagnosis.
- As with the DSM-II, many significant changes were made in the third edition of the DSM. For example, previously many of the anxiety disorders were lumped together as one diagnosis of Anxiety Neurosis. The DSM-III broke that broad diagnosis down to include many different anxiety disorders such as generalized anxiety disorder (GAD), panic disorder, agoraphobia, and social phobia. In fact, the term "neurosis" was removed from the DSM-III altogether. Furthermore, social issues came into play with the development of the DSM-III. Racism was considered as a mental disorder to be added, but after much deliberation and research was not included. Post-traumatic stress disorder was added to the DSM at this time. Also, the DSM-II category of "sexual orientation disturbance" was changed to "ego-dystonic homosexuality."

DSM-III-R

- The revision for DSM-III was published in 1987.
- 297 diagnoses

DSM-IV

- The DSM-IV was published in 1994.
- This edition was more research based as far as criteria and diagnoses are concerned.
- 365 diagnoses.

DSM-IV-TR

- The newest revision of the DSM was published in 2000.
- This volume is heavily research based and includes information about the etiologies of the disorder.

DSM-V

- The newest revision, DSM-V, will be available in 2012, with final approved edition expected May 2013.
- Join effort between the American Psychiatric Association, the National Institute of Mental Health, the World Health Organization, and the World Psychiatric Association.
- Efforts began in 2000, and have involved 13 conferences with international involvement.
- Some of the proposed changes include:
  - Modifications of various disorder spectrums, such as including Asberger's disorder within the autism spectrum;
  - Modiciations of terminology, such as replacing use of "mental retardation" with "intellectual disability";
  - Improved methods of assessment.
  - Large scale inclusion of new criteria to all aspects, with some proposed removals and integrations.
- To learn more about many of the changes being proposed, click here.

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6.170: Antisocial Personality Disorder



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=440

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 earning, 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:	• Coordinate treatment • Communicate with other providers • Make contracts with clients
Confront:	• Be direct and firm • Identify antisocial thinking • Conduct random substance testing
Consequences:	• 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 reacitivity
- 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, Bihrle, 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 the brain of a psycopathic person.

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6.171: 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”)
FEELING: Poorly regulated, highly changeable emotions	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
ACTING: Impulsive behaviors	Imulsiveness in at least 2 areas that are potentially self-damagine (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

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 conlusions 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 unconcious 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.
- A 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 vulnerabilties
- 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 anexthetize 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, manipulativeness, 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 patients 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 patients well-being that may or many 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:
- congitive 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) haloperidol (Haldol) trifluoperazine (Stelazine) flupenthixol	anxiety, obsessive-compulsivity, depression, suicide attempts, hostility, impulsivity, self-injury/assaultive-ness, illusions, paranoid thinking, psychoticism, poor general functioning
Atypical	olanzapine (Zyprexa) aripiprazole (Abilify) risperidone (Risperdal) clozapine (Clozaril) quetiapine (Seroquel)	anxiety, anger/hostility, paranoid thinking, self-injury, impulsive aggression, interpersonal sensitivity, low mood, aggressions

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 emplyability, 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

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6.172: Histrionic Personality Disorder



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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 interpersonal 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 is 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
- Blance DuBois from A Streetcar Named Desire
- The Penguin from Batman
- He constantly compensates fro his short stance and horrible appearance with an active sense of panache
- Constantly seeking attention to his small self
- Bellatrix Lestrange from Harry Potter
- The theatrical right-had 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

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6.173: Dependent Personality Disorder

DSM-IV-TR criteria

- A pervasive and excessive need to be taken are of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. needs others to assume responsibility for most major areas of his or her life
3. has difficulty expressing disagreement with others because of fear of loss of support or approval NOTE: Do not include realistic fears of retribution.
4. has difficulty initiating projects or doing things on his or her own (because of lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
5. goes to excessive lengths to obtain nurture and support from others, to the point of volunteering to do things that are unpleasant
6. feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7. urgently seeks another relationship as a source of care and support when a close relationship ends
8. is unrealistically preoccupied with fears of being left to take care of himself or herself



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Associated features

- Dependent individuals are often very pessimistic, self-defeating, and exhibit low self-esteem. They tend to belittle their assets and to refer to themselves as “stupid.” They take criticism very personally, seeing it as “proof” of their worthlessness. Their tendency is to seek out over protection and dominance from others. These individuals become very anxious when faced with a decision and may avoid positions of responsibility. Chronic physical illness or Separation Anxiety Disorder in childhood may predispose an individual to developing Dependent Personality Disorder.
- There may be an increased risk of Mood Disorders, Adjustment Disorder, and Anxiety Disorders.
- These individuals lack self confidence and lack a sense of autonomy. They see themselves as extremely weak and others very powerful. They are extremely dependent on others and have a great need to be taken care of, which makes these individuals cling to others and to be submissive to others’ wishes and demands. When one relationship ends, they become desperate and have to form another relationship to replace the broken one. Some individuals panic if they have to be alone or separated from depended-upon people.
- They do not demonstrate appropriate anger with other people because they are terrified of losing their support. As a result, they remain in psychologically and physically damaging and abusive relationships. They, in effect, lose their individuality because they let others make the decisions, both large and small in their lives.

Child vs. Adult Presentation

- This diagnosis is only cautiously given to children and adolescents, as some dependent behavior may be developmentally appropriate at this time.
- Symptoms in adults are very similar to Separation Anxiety in children.

Gender and Cultural Differences in Presentation

- Prevalence rates are significantly higher in India and Japan, possible because dependent behaviors is expected and encouraged, especially for women.
- Dependent Personality Disorder occurs more frequently in women, and is co-morbid with Borderline, Schizoid, Histrionic, Schizotypal, and Avoidant Personality disorders. There is also co-morbidity within the Axis I disorders of Bipolar Disorder, unipolar depression (or major depressive episode), anxiety disorders, and Bulimia Nervosa.

Epidemiology

- Dependent PD is one of the most reported Personality Disorders in mental health clinics and they do not give a percentage of prevalence. But a reasonable estimate is from 0.5% to 1.5% of people in the general population have this type of PD. There is around 1.4% in outpatient psychiatric settings; there are no significant familial problems.
- It is reported that about 10% of outpatients seen in mental health clinics also have Dependent PD (SAMHSA, 2009).

Etiology

- Parents who are more authoritative (holds very high standard for achievement and low in giving love and attention to the child) can cause person to develop Dependent PD because the person is not used to making their own choices and decisions. Parenting styles are authoritative, meaning many rules and chores.
- People with Dependent PD have very low sense of self-efficacy. There is restricted development of self-efficacy. They often don't believe that they are able to do some things by themselves.
- Females diagnosed with Dependent PD generally have a history of depression or depressive symptoms in early adolescent girls.
- Peers may have responded to these individuals with rejection, teasing, and other remarks on their dependence and incompetence, thereby reinforcing the views conveyed by caregivers that the person with DPD is in dire need of constant care.
- Infantile temperament may be an additional variable that interacts with parenting style to further elicit overprotective and authoritarian responses to the individual child.

Empirically Supported Treatments

Psychotherapy

- Used as treatment for people with dependent personality disorder. Cognitive-behavioral therapy focuses on patterns of maladaptive thinking and seeks to eliminate them. Often people in cognitive-behavioral therapy set goals that they eventually try to achieve without relying on others. Interpersonal therapy is also a useful approach. Often the patient is receptive to the treatment and seeks help with their personal relationships. With this particular kind of therapy, the therapist will help the patient understand how they interact with others and how this contributes to their dependency issues. This particular therapies purpose is to show the patient that their dependency comes with a high price and that they do have alternatives. Another type of therapy used to treat dependent personality disorder is group therapy. Often people taking part in group therapy must be highly motivated to see improvement. Studies show that time-limited assertiveness-training groups with very clear goals are successful. It has also been said that family or martial therapy can improve a person's independence by working on the families relationship as a whole.

Cognitive-behavioral therapy

- Cognitive-behavioral approaches attempt to increase the affected person's ability to act independently of others, improve their self-esteem, and enhance the quality of their interpersonal relationships. Often, patients will play an active role in setting goals. Methods often used in cognitive-behavioral therapy (CBT) include assertiveness and social skills training to help reduce reliance on others, including the therapist.

Interpersonal therapy

- Treatment using an interpersonal approach can be useful because the individual is usually receptive to treatment and seeks help with interpersonal relationships. The therapist would help the patient explore their long-standing patterns of interacting with others, and understand how these have contributed to dependency issues. The goal is to show the patient the high price they pay for this dependency, and to help them develop healthier alternatives. Assertiveness training and learning to identify feelings is often used to improve interpersonal behavior

Group therapy

- When a person is highly motivated to see growth, a more interactive therapeutic group can be successful in helping him/her to explore passive-dependent behavior. If the individual is socially reluctant or impaired in his/her assertiveness, decision-making, or negotiation, a supportive decision-making group would be more appropriate. Time-limited assertiveness-training groups with clearly defined goals have been proven to be effective

Family and marital therapy

- Individuals with dependent personality disorder are usually brought to therapy by their parents. They are often young adults who are struggling with neurotic or psychotic symptoms. The goal of family therapy is often to untangle the enmeshed family relationships, which usually elicits considerable resistance by most family members unless all are in therapy. Marital therapy can be productive in helping couples reduce the anxiety of both partners who seek and meet dependency needs that arise in the relationship.

Medications

- According to the encyclopedia of mental disorders, Individuals with dependent personality disorder can experience anxiety and depressive disorders as well. In these cases, it may occasionally prove useful to use antidepressants or anti-anxiety agents. Unless the anxiety or depression is considered worthy of a primary diagnosis, medications are generally not recommended for treatment of the dependency issues or the anxiety or depressive responses. Persons with dependent personality disorder may become overly dependent on any medication used
- Antidepressants, anti-anxiety agents, sedatives, and tranquilizers.
- Dependency can eventually become an issue for someone using one of these medications, therefore most often they are not prescribed.

Prevention

- Since dependent personality disorder originates in the patient's family, the only known preventive measure is a nurturing, emotionally stimulating, and expressive care giving environment

Portrayed in Popular Culture

- Bella/Edward relationship from Twilight
- They are completely dependent on each other to the point of being suicidal without the other
- Peter Pettigrew from Harry Potter
- The once friend of James Potter shifts the target of his submissive behavior from James and his friends to Voldemort and the Death Eaters.
- In The Prisoner of Azkaban, when his transgressions are revealed, Peter soon tries to gain anybody's approval by groveling and pleading

DSM-V Changes

- Dependent 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
- Submissiveness, Anxiousness, Separation Insecurity (APA, 2010)



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6.174: Avoidant Personality Disorder

DSM-IV-TR criteria

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety o contexts, as indicated by four (or more) of the following:

1. avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
2. is unwilling to get involved with people unless certain of being liked
3. shows restraint within intimate relationships because of the fear of being shamed or ridiculed
4. is preoccupied with being criticized or rejected in social situations
5. is inhibited in new interpersonal situations because of feelings of inadequacy
6. views self as socially inept, personally unappealing, or inferior to others
7. is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Associated features

- People with Avoidant Personality Disorder often appraise every movement and expression of those whom they are around. They can be fearful and tense which can elicit the ridicule of others which confirm preconceived self-doubts. They tend to be very anxious thinking that they will react to criticism with crying or blushing. Others describe them as “shy,” “lonely,” “timid,” and “isolated.” Their major problems are in social and occupational functioning. Their low self-esteem and hypersensitivity to rejection can restrict interpersonal contacts. Individuals may become isolated and do not usually have a large social support network to help them. They want affection and acceptance and fantasize over idealized relationships. The avoidance behaviors also adversely affect occupational functioning because of the fear the individuals have of social situations. They may try to avoid situations that are important for jobs and advancements.
- These individuals are fearful of the possibility of criticism, rejection, or disapproval and therefore, will usually not engage in social relationships unless they are assured of being liked. However, these individuals desire affection and thus are often lonely and bored. They may even go to the extreme where they avoid work situations that involve a lot of interpersonal situations and contacts. Being alone is not enjoyed and is caused by their inability to relate to others, which causes extreme anxiety and often leads to low self-esteem and being excessively self-conscious. Ridicule and rejection are seen when in fact none exists. Also, they also tend to say or do little when they have to be involved in social situations because they are fearful that they will say something silly or foolish. They see themselves as being incompetent, inferior to other people, and are not risk takers. They generally do not get involved in or with new activities.
- Co-morbidity is often displayed with Dependent Personality Disorder. This occurs because when a friend or friends are made, they become extremely attached to and dependent on that individual. Avoidant personality disorder is also co-morbid with Borderline PD and the Cluster A disorders, Paranoid, Schizoid, and Schizotypal. It is often diagnosed with Mood and Anxiety Disorders, especially generalized Social Phobia and unipolar depression.

Child vs. Adult Presentation

- Avoidant Personality Disorder does not typically become a diagnosis of children. The normal guideline is that usually no one under the age of 18 are diagnosed with this disorder. Most patients, however, report that their symptoms were present during childhood or adolescents.

Gender and Cultural Differences in Presentation

- There may be variations in the prevalence of diagnosed individuals across cultures as the degree of appropriate diffidence and avoidance differs between societies. Avoidant behavior may also be influenced by problems in acculturation following immigration (“culture shock”). Avoidant Personality Disorder seems to occur equally between males and females.

Epidemiology

- Prevalence rates of Avoidant Personality Disorder for the general population are between 0.5% and 1%. There is a prevalence rate between 2% and 5% in the general population, and around 15% in psychiatric outpatient settings. It is reported that about 10% of outpatients seen in mental health clinics also have Avoidant Personality Disorder.

- Avoidant behavior often starts in infancy. Shyness is normal in children, but tends to dissipate with age. Those who develop Avoidant Personality Disorder may become increasingly shy over time. Some evidence suggests that APD tends to lesson or remit with age.

Etiology

- There is evidence to suggest that genetic factors play a role in the development of Avoidant PD. Shyness is also believed to be genetically inherited or linked to a person. There is a link to bio-genetic tendencies toward a lowered autonomic arousal threshold.
- Environmental factors also play a role in a person with Avoidant PD. A history of being ridiculed or rejection may cause the person to later develop this disorder.
- May have parental or peer rejection and/or ridicule.
- Recent studies show evidence of shyness in post birth temperaments (compared to children the same age).

Empirically Supported Treatments

- A mixture of medication to reduce sensitivity when being rejected and cognitive therapy seems to work best for people with Avoidant PD compared to medication alone or therapy alone.
- Treatment can be vital to living anything close to a “normal” life. Without treatment, those who suffer from APD make retreat completely to their homes. They will begin to avoid every and any social event instead of just most. They might also develop a second disorder along with their APD that could have been completely avoided altogether.

Psychodynamically oriented therapies

- According to the Encyclopedia of Mental Disorders these approaches are usually supportive; the therapist empathizes with the patient’s strong sense of shame and inadequacy in order to create a relationship of trust. Therapy usually moves slowly at first because persons with avoidant personality disorder are mistrustful of others; treatment that probes into their emotional state too quickly may result in a more protective withdrawal by the patient. As trust is established and the patient feels safer discussing details of his or her situations, he or she may be able to draw important connections between their deeply felt sense of shame and their behavior in social situations.

Cognitive-behavioral therapy (CBT)

- may be helpful in treating individuals with avoidant personality disorder. This approach assumes that faulty thinking patterns underlie the personality disorder, and therefore focuses on changing distorted cognitive patterns by examining the validity of the assumptions behind them. If a patient feels he is inferior to his peers, unlikable, and socially unacceptable, a cognitive therapist would test the reality of these assumptions by asking the patient to name friends and family who enjoy his company, or to describe past social encounters that were fulfilling to him. By showing the patient that others value his company and that social situations can be enjoyable, the irrationality of his social fears and insecurities are exposed. This process is known as “cognitive restructuring.”

Group therapy

- May provide patients with avoidant personality disorder with social experiences that expose them to feedback from others in a safe, controlled environment. They may, however, be reluctant to enter group therapy due to their fear of social rejection. An empathetic environment in the group setting can help each member overcome his or her social anxieties. Social skills training can also be incorporated into group therapy to enhance social awareness and feedback.

Family and marital therapy:

- Family or couple therapy can be helpful for a patient who wants to break out of a family pattern that reinforces the avoidant behavior. The focus of marital therapy would include attempting to break the cycle of rejection, criticism or ridicule that typically characterizes most avoidant marriages. Other strategies include helping the couple to develop constructive ways of relating to one another without shame.

Medications

- The use of monoamine oxidase inhibitors (MAOIs) has proven useful in helping patients with avoidant personality disorder to control symptoms of social unease and experience initial success. The major drawback of these medications is limitations on the

patient's diet. People taking MAOIs must avoid foods containing a substance known as tyramine, which is found in most cheeses, liver, red wines, sherry, vermouth, beans with broad pods, soy sauce, sauerkraut, and meat extracts.

Prevention

- Since avoidant personality disorder usually originates in the patient's family of origin, the only known preventive measure is a nurturing, emotionally stimulating and expressive family environment.
- Read more: www.encyclopediaofmentaldisorders.com

Avoidant PD versus Social Phobia

- Avoidant PDs were less socially skilled than those with social phobia
- There were differences on behavioral skill factors, molecular behaviors such as eye contact, and on overall skill
- Looking at psychophysiological and cognitive variables, there are no differences between the two
- APD reported:
  - more social avoidance and subjective distress
  - significantly higher score on the SCL-90-R Interpersonal Sensitivity scale as well as on the SCL-90-R Anxiety, Depression, and Obsessive-Compulsive subscales. (Turner, Beidel, Dancu, & Keys, 1986)

Portrayed in Popular Culture

- Rubeus Hagrid from Harry Potter
  - Although he develops strong relationships with several characters in the series, his half-giant background and shameful exits from Hogwarts make him very sensitive to the opinions of others

DSM-V Changes

- Reformulated as the Avoidant Type
- Individuals who match this personality disorder type have a negative sense of self, associated with a profound sense of inadequacy, and inhibition in establishing intimate interpersonal relationships.
- More specifically, they feel anxious, inadequate, inferior, socially inept, and personally unappealing; are easily ashamed or embarrassed; and are self-critical, often setting unrealistically high standards for themselves.
- At the same time, they may have a desire to be recognized by others as special and unique.
- Avoidant individuals are shy or reserved in social situations, avoid social and occupational situations because of fear of embarrassment or humiliation, and seek out situations that do not include other people.
- They are preoccupied with and very sensitive to being criticized or rejected by others and are reluctant to disclose personal information for fear of disapproval or rejection.
- They appear to lack basic interpersonal skills, resulting in few close friendships. Intimate relationships are avoided because of a general fear of attachments and intimacy, including sexual intimacy.
- Individuals resembling this type tend to blame themselves or feel responsible for bad things that happen, and to find little or no pleasure, satisfaction, or enjoyment in life's activities.
- They also tend to be emotionally inhibited or constricted and have difficulty allowing themselves to acknowledge or express their wishes, emotions – both positive and negative – and impulses.
- Despite high standards, affected individuals may be passive and unassertive about pursuing personal goals or achieving successes, sometimes leading to aspirations or achievements below their potential.
- They are often risk averse in new situations

(APA, 2010)



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6.175: Obsessive-Compulsive Personality Disorder

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 posses 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 per forming 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 adu VEPhuiw">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)



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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.

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6.176: Depressive Personality Disorder

DSM-IV-TR Criteria

A pervasive pattern of depressive cognitions and behaviors beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, unhappiness
2. self-concept centers around beliefs of inadequacy, worthlessness, and low self-esteem
3. is critical, blaming, and derogatory toward self
4. is brooding and given to worry
5. is negativistic, critical, and judgmental toward others
6. is pessimistic
7. is prone to feeling guilty or remorseful

- Does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder.

Associated Features

- These individuals may be quiet, introverted, passive, and unassertive, preferring to follow others rather than taking the lead.
- This pattern may occur with approximately equal frequency in females and males.
- Individuals with this presentation may be predisposed to developing Dysthymic Disorder and possibly Major Depressive Disorder.
    - These conditions may exist on a spectrum, with depressive personality disorder being the early-onset, persistent, trait like variant of the Depressive Disorders.
    - Preliminary evidence suggests that depressive personality disorder may have an increased prevalence in family members of probands with Major Depressive Disorder.
    - Conversely, Major Depressive Disorder may occur with increased frequency in family members of probands with depressive personality disorder who do not themselves have Major Depressive Disorder.

Typical Beliefs

- I am always disappointed with myself and cynical about others and the future.
- I do not consider the spreading of good cheer to be among my responsibilities.
- I am not eager for authority.
- I expect those under me to take on a great deal of work.
- When I am in charge, the work atmosphere need not be upbeat, personally encouraging, or even supportive.
- I can be quite critical of those who work under me.
- I never expect things to go right.
- I don’t get much pleasure from anything outside of work.
- I What’s the use of looking at life from the bright side.
- Life is just work, pain, and loss.
- I’ll believe it when I see it.
- Life is depressing; I have a right to always be pessimistic.
- I believe that my dark views of things is just being realistic.
- Bad news is interesting and reassuring because it represents reality.
- A person should remain faithful to their spouse, even if their spouse does not.
- I expect worse from others.
- I am very critical of my mate.
- Other people expect too much of me.
- Parents should teach their children not to expect too much from life.
- Parents should inculcate the value of work; activities outside of homework and chores should be restricted.
- I am severely limited as a person; if only I’d been born with a different temperament.
- My life has been a series of failures and I am helpless in the face of forces beyond my control.

- I should continually prepare for the worst.
- I must keep my nose to the grindstone, adhere to routine, and remain un-distracted by impulses and passion.
- I should always think everything through before acting, not take risks or challenge fate, and never try to escape into pleasure.
- There is no hope, now or ever.

(Beck & Freeman, 1990)

In Terms of the 5-Factor Model of Personality

- They Experience:
  - High neuroticism
  - Low extroversion
  - Low openness
  - Low agreeableness
  - High conscientiousness

(McCrae, 1994)

DSM-V Changes

- Depressive 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
- Pessimism, Anxiousness, Depressivity, Low self-esteem, Guilt/shame, Anhedonia

(APA, 2010)

For More Information, Please Read:

- Finnerty, T. (2009). Depressive personality disorder: Understanding current trends in research and practice. Columbus, OH: WorldWideMentalHealth.com
- Phillips, K.A., Gunderson, J.D., Triebwasser, J., Kimble, C.R., Faedda, G., Lyoo, I.K., & Renn, J. (1998). Reliability and validity of depressive personality disorder. American Journal of Psychiatry, 155, 1044-1048.

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6.177: Passive-Aggressive Personality Disorder (Negativistic Personality Disorder)

DSM-IV-TR Criteria

- Passive-aggressive behavior is a pattern of expressing your negative feelings in an indirect way.
- A pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following (Rotenstein):
  - Passively resists fulfillment
  - Routine social and occupational tasks
  - Complains of being misunderstood and unappreciated by others
  - Sullen and argumentative
  - Unreasonably criticizes and scorns authority
  - Expresses envy and resentment
  - Toward those apparently more fortunate
  - Voices exaggerated and persistent complaints of personal misfortune
  - Alternates between hostile defiance and contrition
  - Does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder
  - Different from previous formulations, the DSM-IV description of the disorder places emphasis on the pattern of sullen and irritable moods and negativistic attitudes (DSM-IV, APA, 1994).

Associated Features

- It is a long-term (chronic) condition in which a person seems to actively comply with the desires and needs of others, but actually passively resists them. In the process, the person becomes increasingly hostile and angry (Moore & Jefferson, 2004).
- These individuals are often overtly ambivalent, wavering indecisively from one course of action to its opposite.
- They may follow an erratic path the causes endless tension with others and disappointments for themselves.
- An intense conflict between dependence on others and the desire for self-assertion are characteristics of these individuals.
- Their self-confidence is often poor despite a superficial boldness.
- They foresee the worst possible outcome for most situations, even those that are going well.
- They have an outlook of always being defeated, which can evoke hostile and negative responses from others who are subjected to the complaints of these individuals.
- They will typically not confront others directly about problems, but will instead attempt to undermine their confidence or their success through comments and actions that can be explained away easily so as not to place any blame on themselves.
- This pattern of behavior often occurs in individuals with Borderline, Histrionic, Paranoid, Dependent, Antisocial, and Avoidant Personality Disorders.
- Manifest itself as: resentment, stubbornness, procrastination, sullenness, dawdling, deliberate inefficiency, pretended forgetfulness, unreasonable criticism of people in authority, or intentional failure at doing requested tasks.
  - For example: They might take so long to get ready for a party that they don't want to go to, that by the time they are ready, the party is nearly over.
- It is often seen in people who view themselves as peaceful.
  - Expressing their anger this way is morally favorable to direct confrontation.
- Symptoms often include:
  - putting things off
  - "forgetting" to do things others ask
  - being stubborn
  - disliking people who are in charge, or having a bad attitude about them
  - complaining frequently
  - purposely working poorly or slowly
  - feeling unappreciated
  - blaming problems on others

- being irritable
- disliking the ideas of other people, even if they are useful
- arguing frequently
- (McCrae, 1994)

Gender and Cultural Differences in Presentation

- Although little research has dealt with gender differences regarding PAPD, Mair and colleagues(1992) have noted that PAPD tends to be more frequently diagnosed in females.
- The passive-aggressive style may be a way for women to avoid the social stigma and rejection that are often associated with women who are seen as challenging or aggressive in advocating for their own need and wants.

Epidemiology

- The prevalence rate for Passive-Aggressive Personality Disorder is 3.3%

Etiology

- The exact cause is still unknown due to a lack of research in this area however some have suggested that this disorder, like most personality disorders, hails from a combination of genetic and environmental factors.
  - May also be a result of society's conditioning of individuals.
  - Society teaches that direct confrontation can lead to harmful consequences.
- Childhood abuse and/or neglect as well as sexual abuse has appeared to contribute to this disorder.

Empirically Supported Treatments

- The most common, is psychological treatment for those individuals who do not see themselves as having a problem. They are usually forced into treatment, e.g., family, employers, or the legal system. These clients with PAPD have minimal insight; they fail to admit that they are a major factor in the problems they have.
- Counseling is useful in helping the person identify and change the behavior.
- Cognitive therapy and antidepressant drugs are very effective to control negative attitude (McCrae, 1994).

Typical beliefs

- I am self-sufficient, but I do need others to help me reach my goals.
- The only way I can preserve my self-respect is by asserting myself indirectly, for example, by not carrying out instructions exactly.
- I like to be attached to people but I am unwilling to pay the price of being dominated.
- Authority figures tend to be intrusive, demanding, interfering, and controlling.
- I have to resist the domination of authorities but at the same ti me maintain their approval and acceptance.
- Being controlled or dominated by others is intolerable.
- Making deadlines, complying with demands, and conforming are direct blows to my pride and self-sufficiency.
- If I follow the rules the way people expect, it will inhibit my freedom of action.
- It is best not to express my anger directly but to show my displeasure by not conforming.
- I know what's best for me and other people shouldn't tell me what to do.
- Rules are arbitrary and stifle me.
- Other people are often too demanding.
- If I regard people as too bossy, I have a right to disregard their demands.

(Beck & Freeman, 1990)

In Terms of the 5-Factor Model of Personality

- They have:
  - High neuroticism
  - High extroversion
  - Low openness
  - Low Agreeableness

- High conscientiousness

(McCrae, 1994)

Fun Fact

The term “passive-aggressive” arose in the U.S. military during World War II, when officers noted that some soldiers shirked their duties by adopting these types of behaviors.

DSM-V Changes

- Passive-Aggressive (Negativistic) 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.
- Personality Traits
- Oppositionality, Hostility, Guilt/shame

(APA, 2010)

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6.178: Social Phobia (Social Anxiety Disorder)

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.

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6.179: Schizophrenia, Paranoid Type (295.30)

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 indiviual 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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=456

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6.180: Schizophrenia, Disorganized Type (295.10)

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 clincal 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.

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6.181: Schizophrenia, Catatonic Type (295.20)

DSM-IV-TR criteria

- A type of Schizophrenia where the clinical picture is dominated by two of the following:

1. Motor immobility as evidenced by catalepsy (including waxy flexibility) or stupor.
2. Excessive motor activity that is purposeless and not influenced by external stimuli.
3. Extreme negativism or mutism.
4. Peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms, or prominent grimacing.
5. Echolalia or echopraxia

Associated features

- Those diagnosed with the Catatonic subtype of schizophrenia are characterized by extreme psychomotor dysfunctions. They experience physical immobility; this occurs when they are completely unable to move or speak.
- They also may go into a catatonic stupor, which includes a form of waxy flexibility. Waxy flexibility occurs when a patients arm is moved into a position and remains in that position for hours.
- A catatonic Schizophrenic may also experience fits of excessive movement or mobility. These movements seem to have no purpose; it could include pacing, turning in circles, flailing of the arms, or making loud noises.
- Another feature of catatonic Schizophrenia is extreme negativism or mutism. This is when the person exhibits extreme resistance to instructions or help. They will resist any attempt to be moved and may refuse to speak.
- Peculiar postures or movements are also common with Catatonic Schizophrenia. This includes things such as posturing, which is sitting odd or bizarre postures for long periods of time. This could also include grimacing or the adoption of odd mannerisms.
- Along with fore mentioned symptoms, stereotyped behaviors are common, such as repeating words, following a routine obsessively, or constantly arranging objects the same way.
- Catatonic Schizophrenics will often suffer from echolalia, which causes them to involuntarily repeat things that they hear. They also suffer from echopraxia, which is the involuntary copy of movements or gestures made by someone else.
- Some other symptoms along with the catatonic behaviors could include delusions, hallucinations, incoherent speech, angry outbursts, neglect of personal hygiene, social isolation, and clumsy, uncoordinated movements.
- Other associated symptoms would include cognitive deficits, such as difficulty with the processing of visual stimuli because they can only focus on one object, poor verbal and spatial memory, abstract reasoning, poor psycho motor speed, and very poor planning ability.
- Social and emotional deficits are also seen. There is an impaired ability to solve or understand social problems and issues. They have an impaired ability to recognize emotion expressed in others and also have an abnormal expression of emotions. For example, they do not always respond with the correct emotion, such as being happy when they should be sad.
- There are high rates of substance abuse seen. Around 80-90% use nicotine heavily and many use more than one substance, such as alcohol and nicotine.
- There are also high rates of attempted suicide. About 50-70% of schizophrenics attempt suicide and 10% succeed.

Child vs. adult presentation

- A very small number of Schizophrenics experience childhood onset. The DSM IV-TR uses the same criteria to diagnose children as it does adults. The treatments for children are very similar to the ones that are used on adults, but in children one must be very careful with the drug treatments because there is little data on the long-term outcomes of anti-psychotics on children. Children who have a schizophrenic onset will most likely have schizophrenia their entire life.
- Gender and cultural differences in presentation
- There does not seem to be much difference in schizophrenia across cultures. There is a slight difference between genders though, as slightly more males seem to have this disorder than females.

Epidemiology

- The prevalence rate for catatonic schizophrenia is about 3% of those that are diagnosed with schizophrenia.
- The prevalence rate for schizophrenia is about 1% of the general population.
- Some psychologists would like to consider Catatonic Schizophrenia to be very rare now compared to what it was in the past. A Study done in Monroe County in New York from 1960 to 1967 proved otherwise. The researchers concluded, “The seven-year prevalence of catatonic schizophrenia, based on the span of this study, is close to one per 1,000 county inhabitants. Far from being a vanishing entity, the catatonic type of schizophrenia now represents five percent of all first diagnosis of schizophrenia.”

Etiology

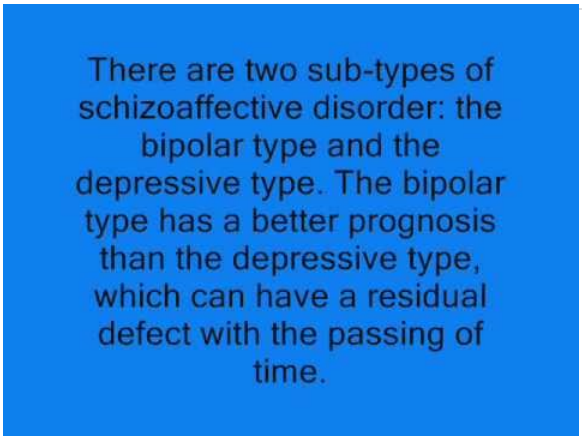
- Although no one is exactly sure what causes schizophrenia it definitely has something to do with genes, but not entirely. Many theorize that certain genes give someone a predisposition to schizophrenia, but a mixture of genes and environmental factors play a role.
- There is also the dopamine hypothesis. This theory suggests that a schizophrenic’s brain is producing too much dopamine at certain receptors, or that their receptors have become hypersensitive causing the dopamine neurons to fire off when they should not.

Empirically supported treatments

- The main treatments used for catatonic schizophrenia include medications, electro-convulsive therapy, hospitalization, psychotherapy, or vocational skills training.
- One medication available is Benzodiazepine. This sedative is usually the medication of choice for catatonic schizophrenia. It is usually injected into a vein, which is helpful if the patient is in a catatonic stupor, it is fast acting, and it helps to relieve the catatonic symptoms quickly. However, it may cause dependency over time.
- There are also Barbiturates. These are also sedatives that have a similar effect. They work quickly and relieve the catatonic symptoms, but they are not often used to treat catatonic schizophrenia.
- Antipsychotic medications, which are generally used with normal schizophrenia, are not recommended for those with catatonic type because they have a habit of make the catatonic symptoms worse.
- Electroconvulsive therapy is when they shoot electric currents through a patient’s brain. This is only used when symptoms are extreme and medications are not effective.

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6.182: Schizoaffective Disorder (295.70)



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DSM-IV-TR criteria

- A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.
- B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.
- C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., drug abuse, medication) or a general medical condition.
    - The bipolar type is diagnosed if the disturbance includes a manic or a mixed episode (or a manic or a mixed episode and major depressive episodes).
    - The depressive type is diagnosed if the disturbance includes only major depressive episodes.

Subtypes

- Bipolar Type (Schizomanic): if the disturbance includes a Manic or a Mixed Episode (or a Manic or a Mixed Episode and Major Depressive Episodes). Many but not all studies find that Schizomania is closer to Bipolar Disorder than to classic Schizophrenia. The family histories of Schizomanic patients are generally loaded with mood disorders and not with Schizophrenia. They frequently respond to mood stabilizers. Their prognosis is reasonably good—similar to that of Bipolar Disorder and not to Schizophrenia.
- Depressive Type (Schizodepressive): if the disturbance only includes Major Depressive Episodes. Schizodepression is probably closer to classic Schizophrenia. Families of patients with Schizodepression show significant genetic loading for Schizophrenia and not as much for Bipolar Disorder; generally, these patients respond better to anti-psychotics than to mood stabilizers. Their prognosis is not as good as that of mood disordered patients and is much closer to that of Schizophrenic patients.
- Chronic and Nonchronic forms: For Schizomania and Schizodepression, patients whose symptoms are more chronic and less episodic have worse prognoses.

Associated features

- There may be poor occupational functioning, a restricted range of social contact, difficulties with self-care, and increased risk of suicide associated with Schizoaffective Disorder. Anosognosia (i.e., poor insight) is also common in Schizoaffective Disorder, and individuals with Schizoaffective Disorder may be at increased risk for later developing episodes of pure Mood Disorder, Schizophrenia, or Schizophreniform Disorder. There may be associated Alcohol and other Substance-Related Disorders.
- Elevated risk for suicidal behavior among individuals with Schizoaffective Disorder is associated with history of suicidal behavior, severity of suicide ideation and fewer reasons for living, presence and severity of depression, long duration of

untreated psychosis, number of hospitalizations in the prior 36 months, more frequent prescription of typical (vs. atypical) antipsychotic agents, and history of abuse or dependence on nicotine or other substances.

Child vs. adult presentation

- Schizoaffective Disorder, Bipolar Type, may be more common in young adults, whereas Schizoaffective Disorder, Depressive Type, may be more common in older adults.
- Schizoaffective Disorder usually starts in early adulthood.
- Rarely is it diagnosed before age 13.

Gender and cultural differences in presentation

The incidence of Schizoaffective Disorder is higher in women than in men, which is mostly accounted for by an increased incidence among women of the Depressive Type.

Schizophrenic Disorders are more prevalent among individuals with lower Social Economic Status. The lower the SES, the more prevalent the Schizophrenic Disorders appear to be.

Little research has occurred examining which cultural factors, if any, both increase and decrease the risk of developing a Schizophrenic Disorder. Although, Schizophrenic Disorders appear to occur less often in what we consider to be third-world, or less industrially developed, countries.

Epidemiology

The prevalence rate for Schizoaffective disorder widely varies. Studies do show that Schizoaffective Manic patients appear to comprise 3-5% of psychiatric admissions to typical clinical centers.

Etiology

There is no single causal factor, a certain causal sequence of events, or one entity (genetic or otherwise) in the etiology of Schizoaffective Disorder. Although the exact etiology of Schizoaffective disorder is unknown, it may involve the balance of dopamine and serotonin in the brain. Others believe that it may be due to in-utero exposure to viruses, malnutrition, or even birth complications.

There is substantial evidence that there is an increased risk for Schizophrenia in first-degree biological relatives of individuals with Schizoaffective Disorder. Most studies show that relatives of individuals with Schizoaffective Disorder are at increased risk for Mood Disorders. As a group, Schizoaffective patients have family histories with increased genetic loading for both Schizophrenia and Mood Disorders.

The prognosis for Schizoaffective Disorder tends to be better than that for Schizophrenia and worse than that for Mood Disorders. The presence of precipitating events or stressors is associated with a better prognosis.

Differential Diagnosis

Substance-Induced Psychotic Disorder and Substance-Induced Delirium are distinguished from Schizoaffective Disorder by the fact that a substance is judged to be etiologically related to the symptoms.

Distinguishing Schizoaffective Disorder from Schizophrenia: In Schizoaffective Disorder, there must be a mood episode that is concurrent with the active-phase symptoms of Schizophrenia, mood symptoms must be present for a substantial portion of the total duration of the disturbance, and delusions or hallucinations must be present for at least 2 weeks in the absence of prominent mood symptoms. In contrast, mood symptoms in Schizophrenia have a duration that is brief, occur only during the prodromal or residual phases, or do not meet full criteria for a mood episode.

Distinguishing Schizoaffective Disorder from Mood Disorder with Psychotic Features: If psychotic symptoms occur exclusively during periods of mood disturbance, the diagnosis is Mood Disorder with Psychotic Features. In Schizoaffective Disorder, symptoms should not be counted toward a mood episode if they are clearly the result of symptoms of Schizophrenia. Criterion A for Schizoaffective Disorder, the Major Depressive Episode must include pervasive depressed mood.

Mood disturbances, especially depression, commonly develop during the course of Delusional Disorder. However, such presentations do not meet criteria for Schizoaffective Disorder because the psychotic symptoms in Delusional Disorder are

restricted to non-bizarre delusions and therefore do not meet Criterion A for Schizoaffective Disorder.

Schizoaffective Disorder and Schizophrenia: because the relative proportion of mood to psychotic symptoms may change over the course of the disturbance, the appropriate diagnosis for an individual episode of illness may change from Schizoaffective Disorder to Schizophrenia. The diagnosis may also change for different episodes of illness separated by a period of recovery. If psychotic symptoms and affective symptoms always overlap, the person is diagnosed with an affective disorder, whereas if psychotic symptoms are present some of the time, in the absence of an affective syndrome, the person meets criteria for either Schizoaffective Disorder or Schizophrenia. Schizoaffective Disorder is diagnosed if the mood symptoms are prolonged

Empirically supported treatments

Schizoaffective patients respond better to lithium than do schizophrenics, but not as well as Bipolar patients.

Electroconvulsive therapy (ECT) is indicated for Schizoaffective disorder that has an acute onset, presence of hallucinations or delusions, and acute and severe mania, and that has been found to be non-responsive to psychotropic medications. However, some studies find that ECT is not productive in reducing hallucinations or delusions.

There is no cure for Schizoaffective Disorder. However, the most effective approach toward treating the Schizophrenic Disorders seems to be a combination of pharmaceutical, behavioral, cognitive, and family therapy, with the use of anti-psychotic medications seen as the primary treatment modality.

Pharmacotherapy with an antidepressant, an antipsychotic, and/or mood stabilizer is also a mainstream treatment. In quite a few instances, effective treatment modalities will work on attempting to rid the individual of hallucinations, delusions, and disorganized aspects of behavior, or at the very least, attempt to lessen these symptoms.

Even so, many individuals will relapse, even if their treatment is maintained.

Common medicines for neuroleptic symptoms are Olanzapine, Risperidone, Quetiapine, Aripiprazole, and Ziprasidone. Mood stabilizer medications examples are Lithium salt, Valproate semisodium, and Carbamazepine.

Links

- Living with Schizoeffective disorder

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6.183: Brief Psychotic Disorder (298.8)

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.

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6.184: Delusional Disorder (297.1)

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. Erotomanic 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 to 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?

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6.185: Shared Psychotic Disorder (273.5)

DSM-IV-TR criteria

- A delusion develops in an individual in the context of a close relationship with another person or persons, who have an already established delusion.
- The delusion is similar in content to that of the person who already has an established delusion.
- The disturbance is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (e.g., drug abuse, medication) or a general medical condition.

Associated features

Shared Psychotic Disorder is a rare condition where a healthy person, also known as secondary in this situation, shares the delusions and false beliefs that the other person refuses to give up.

Also, this usually occurs in the face of contradictory facts of a more superior person, also known as primary in this situation that has the psychotic disorder. Delusions may occur and may be similar to the ones experienced by someone close who has a psychotic disorder.

However, the primary individual with this disorder generally will have delusions less bizarre than an individual with schizophrenia and the delusions are much more believable, making it easier for the secondary individual to believe the delusion.

Individuals with Shared Psychotic Disorder do not usually have unusual or odd behavioral issues. Secondary hallucinatory experiences occur less frequently and are less intense than primary hallucinatory experiences.

In two reported cases, the secondary experienced hallucinations while the primary did not.

Child vs. adult presentation

Other than the fact that Shared Psychotic Disorder tends to occur in relationships that are time-honored and resistant to change, which could include children and adults, there is little information regarding child vs. adult presentation or onset.

Gender and cultural differences in presentation

Since the 1650s, Shared Psychotic Disorder has been identified more frequently in women, reflecting the traditional submissive role of females in the family. Nevertheless, no confirmation of increased susceptibility of females exists today.

Both female and male secondaries are equally affected by female primaries.

Epidemiology

Rarely seen in clinical settings, it is argued that some cases of Shared Psychotic Disorder go without ever being diagnosed. If it is brought to clinical attention, it is the result of the primary person receiving treatment. The person with Shared Psychotic Disorder does not walk into a clinic alone.

Etiology

The cause of Shared Psychotic Disorder is unknown. However, several possible factors are believed to play roles in the development of Shared Psychotic Disorder. Some researchers believe that the disorder comes from a psychosocial perspective, as most of the individuals with the disorder have immediate relatives with psychiatric disorders. Additionally, family isolation and the presence of a dominant-submissive factor within a relationship affect the presence of this disorder.

Empirically supported treatments

Effective treatment of the secondary requires neuroleptics and separation from the primary.

There are three possible treatments for Shared Psychotic Disorder: psychotherapy, family therapy, and medication.

Psychotherapy can help the person with Shared Psychotic Disorder recognize the delusion and correct the underlying thinking that has become distorted. It also can address relationship issues and any emotional effects of a short-term separation from the person with a psychotic disorder.

Family therapy might focus on increasing exposure to outside activities and interests, as well as the development of social supports to decrease isolation and help prevent relapse. Family therapy also might help to improve communication and family dynamics.

Short-term treatment with anti-psychotic medication might be used if the delusions do not resolve after separation from the primary case. In addition, tranquilizers or sedative agents such as lorazepam or diazepam (Valium) can help alleviate intense symptoms, such as anxiety, agitation, and insomnia, which might be associated with the disorder.

Individuals with this disorder rarely seek treatment, though, and are usually only brought to clinical attention when the primary case receives treatment.

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6.186: Schizophreniform Disorder (295.40)

DSM-IV-TR criteria

- A. Criteria A, D, and E of Schizophrenia are met.
- B. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months. (When the diagnosis must be made without waiting for recovery, it should be qualified as “Provisional.”)
- Specify if:
  - Without Good Prognostic Features – this is used if two of more of the features below have not been present.
  - With Good Prognostic Features: as evidenced by two (or more) of the following:
    - (1) onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning.
    - (2) confusion or perplexity at the height of the psychotic episode
    - (3) good premorbid social and occupational functioning
    - (4) absence of blunted or flat affect

Associated Features

Also see the discussion in the Associated Features and Disorders section for Schizophrenia, p.304. Unlike Schizophrenia, impairment in social or occupational functioning is not required for a diagnosis of Schizophreniform Disorder.

However, most individuals do experience dysfunction in various areas of daily functioning such as: learning problems, hypoactivity, euphoric mood, guilt or obsession, sexually deviant behavior, or even Dependent and Antisocial Personality Disorders.

Child vs Adult Presentation

Criteria of Schizophreniform Disorder in DSM is listed as “referrence to Schizophrenia”.

Typically it is seen that this develops between the late teens and mid 30’s.

It is very rare to see these disorders develop or be diagnosed in children; however there have been cases reported with the onset of 5 and 6.

It is also rare to see this develop in a later stage in life, but again there have been cases reported with the onset of 60 years. It is still unclear if identifiable brain pathology defines late-onset illness.

Gender and culture differences in presentation

For additional discussion of cultural, age, and gender factors relevant to the diagnosis of Schizophreniform Disorder, see the Specific Culture, Age, and Gender Features section for Schizophrenia (p306).

There are suggestions that in developing countries, recovery from Psychotic Disorders may be more rapid, which would result in higher rates of Schizophreniform Disorder than of Schizophrenia

Epidemiology

Available evidence suggests variations in incidence across sociocultural settings.

In the United States and other developed countries, the incidence is low, possibly fivefold less than that of Schizophrenia. In developing countries, the incidence is substantially higher, especially for the subtype “With Good Prognostic Features”; in some of these settings Schizophreniform Disorder may be as common as Schizophrenia.

There have been few studies of families where the focus has been Schizophreniform Disorder; however, there is available evidence that suggests that relatives of Schizophreniform Disorder have an increased risk for Schizophrenia.

Etiology

Approximately one-third of individuals with an initial diagnosis of Schizophreniform Disorder (Provisional) recover within the 6-month period and receive Schizophreniform Disorder as their final diagnosis of Schizophrenia or Schizoaffective Disorder.

The cause of it appears to be related to abnormalities in the structure and chemistry of the brain, and appears to have strong genetic links; but its course and severity can be altered by social factors such as stress or a lack of support within the family. It is less clear cut, but biological factors are also suspected

Empirically supported treatment

Treatment aims to protect and steady the patient, to minimize the psychosocial consequences, and to resolve the target symptoms with minimal adverse effects. The patient who may be at risk of harming himself, herself, or others requires hospitalization. This allows for complete diagnostic evaluation and helps to ensure the safety of the patient and others. A supportive environment with minimal stimulation is also helpful.

As improvement progresses, help with coping skills, problem-solving techniques, and psycho educational approaches may be added for patients and their families.

Patients may benefit from a structured intermediate environment, such as a day hospital, during the initial phases of returning to the community.

Pharmacotherapy for schizophreniform disorder is similar to that for schizophrenia. At this time, atypical antipsychotics, such as risperidone, olanzapine, quetiapine, and ziprasidone, are commonly used. In November 2003, a new atypical antipsychotic drug, aripiprazole (Abilify), was approved by the US Food and Drug Administration. Aripiprazole has a novel mechanism of action because it is a partial agonist at the dopamine receptors, unlike its predecessors.

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6.187: Dementia of the Alzheimer's Type (294.1x)

DSM-IV-TR criteria

- A. The development of multiple cognitive deficits manifested by both
  - 1) memory impairment (impaired ability to learn new information or to recall previously learned information) and
  - 2) one (or more) of the following cognitive disturbances:
    - a) aphasia (language disturbance)
    - b) apraxia (impaired ability to carry out motor activities despite intact motor function)
    - c) agnosia (failure to recognize or identify objects despite intact sensory function)
    - d) disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting)
- B. The cognitive deficits in Criterion A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.
- C. The course if characterized by gradual onset and continuing cognitive decline.
- D. 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 dydrocephalus, 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
- E. The deficits do not occur exclusively during the course of a delirium
- F. The disturbance is not better accounted for by another Axis I disorder (e.g., Major Depressive Disorder, Schizophrenia
- *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.

Associated Features

- Individuals at risk and initial stages – Individuals with Down Syndrome and individuals with past head trauma are at a greater risk for developing Dementia of the Alzheimer's Type.
- Physiological precursors of Alzheimer's may be seen as early as the 40s, though recognizable symptoms do not present until later in life.
- Associated laboratory findings – Not widely accepted, sensitive, and specific biological marker is currently available that is universally accepted as diagnostic of Dementia of the Alzheimer's Type in a living individual. In the majority of cases, brain atrophy in Dementia of the Alzheimer's Type, with wider corticalsulci and larger cerebral ventricles than would be expected given the normal aging process. This may be demonstrated by computed tomography (CT) or magnetic resonance imaging (MRI). Microscopic examination usually reveals histopathological changes, including senile plaques, neurofibrillary tangles, granulovascular degeneration, neuronal loss, astrocytic gliosis, and amyloid angiopathy. Lewy bodies are sometimes seen in the cortical neurons.
- Associated physical examination findings and general medical conditions – In the first years of illness, few motor and sensory signs are associated with Dementia of the Alzheimer's Type. Later in the course, myoclonus and gait disorder may appear.
- Seizures occur in approximately 10% of individuals with the disorder

Gender and cultural differences in presentation

Alzheimer's is seen more in female patients than in males.

The onset of Alzheimer's before age 50 is rare in both sexes.

Epidemiology

The prevalence of Dementia of the Alzheimer's Type increases dramatically with increasing age, rising from 0.6% in males and 0.8% in females at age 65 (all levels of severity) to 11% in males and 14% in females at age 85.

At age 90 the prevalence rises to 21% in males and 25% in females, and by age 95 the prevalence is 36% in males and 41% in females.

Moderate to severe cases make up about 40%-60% of these estimated prevalence rates.

Etiology

Dementia of the Alzheimer's Type is chronic and degenerative.

In many cases, initial deficits in working memory are followed by aphasia, apraxia, and agnosia. Coinciding with these physiological changes are behavioral changes; individuals may become increasingly more irritable and, in some cases, territorial. Familiar surroundings will become unfamiliar; if home remodeling has been done in the past several years, individuals with Dementia of the Alzheimer's Type may begin to perceive their homes as more and more foreign.

In the more advanced stages, individuals will develop motor disturbances and will eventually may become fully incapacitated.

Average life expectancy from the onset of Dementia of the Alzheimer's Type to its conclusion in death is approximately 8-10 years.

Link to Diabetes – While research has failed to demonstrate conclusively any causal relationship between Dementia of the Alzheimer's Type and Diabetes, it is been established that Diabetes and Alzheimer's are highly correlated. Individuals with Diabetes are at a severe risk when comorbid Alzheimer's is present. Individuals with Diabetes often must have extremities amputated due to infection, and if said individuals have Alzheimer's and cannot remember that these extremities have been lost, there can be dire consequences (e.g. serious falls).

Empirically supported treatments

Supported treatments include caregiving and pharmacotherapy.

Links

- There are many challenges for family members of Alzheimer's patients. Click here for one family's story: Challenges of Alzheimer's
- Journal articles:
  - Do neuropsychological tests detect preclinical Alzheimer's Disease?
  - Relearning face-name associations in early Alzheimer's Disease

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6.188: Vascular Dementia (formerly Multi-Infarct Dementia) (290.4x)

DSM-IV-TR criteria

- A. The development of multi cognitive deficits manifested by both:
  - 1) memory impairment (impaired ability to learn new information or to recall previously learned information) and
  - 2) one (or more) of the following cognitive disturbances:
    - (a) Aphasia (language disturbance)
    - (b) Apraxia (impaired ability to carry out motor activities despite intact motor function)
    - (c) Agnosia (failure to recognize or identify objects despite intact sensory function)
    - (d) disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)
- B. 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.
- C. Focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity) or laboratory evidence indicative of cerebrovascular disease (e.g., multiple infarctions involving cortex and underlying white matter) that are judged to be etiologically related to the disturbance.
- D. The deficits do not occur exclusively during the course of a delirium
- Code based on predominant features:
  - 290.41 With Delirium: if delirium is superimposed on the dementia
  - 290.42 With Delusions: if delusions are the predominant feature
  - 290.43 With Depressed Mood: if depressed mood (including presentations that meet full symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.
  - 290.40 Uncomplicated: if none of the above predominates in the current clinical presentation
- Specify if:
  - With Behavioral Disturbance
  - *Coding note: Also cerebrovascular condition on Axis III**

Associated Features

- Associated descriptive features and mental disorders.
- Associated laboratory findings. The extent of central nervous system lesions detected by CT and MRI in Vascular Dementia typically exceeds in the extent of changes detected in the brains of healthy elderly persons (e.g., periventricular and white matter hyperintensities noted on MRI scans). Lesions often appear in both white matter and gray matter structures, including subcortical regions and nuclei. Evidence of old infarctions (e.g., focal atrophy) may be detected, as well as findings of more recent laboratory evidence of associated cardiac and systemic vascular conditions (e.g., ECG abnormalities, laboratory evidence of renal failure).
- Associated physical examination findings and general medical conditions. Common neurological signs (e.g., abnormal reflexes, weakness of an extremity, gait disturbance) are discussed in the “Diagnostic Features” section. There is often evidence of long-standing arterial hypertension (e.g., funduscopic abnormalities, enlarged heart), valvular heart disease (e.g., abnormal heart sounds), or extracranial vascular disease that may be sources of cerebral emboli. A single stroke may cause a relatively circumscribed change in mental state (e.g., an aphasia following damage to the left hemisphere, or an amnestic disorder from infarction in the distribution of the posterior cerebral arteries), but generally does not cause Vascular Dementia, which typically results from the occurrence of multiple strokes, usually in different times

Gender and cultural differences in presentation

In most countries, vascular dementia is a much less common form of dementia than AD.

This is true in North America and Europe, but is not so in Japan, where it is more common than AD. Overall, vascular dementia is the second most common form of dementia, after AD.

About 10–20% of patients who experience dementia have the vascular form of the disorder.

The difference in prevalence in different countries may result from different lifestyle factors rooted in the culture.

Vascular dementia is more common in men than in women, which may be because men are more likely than women to suffer from strokes.

Vascular dementia becomes increasingly prevalent as people grow older.

The number of people affected by vascular dementia rises dramatically during and after the sixth decade. Vascular dementia usually occurs at a younger age than AD.

The onset of Vascular Dementia is typically earlier than that of Dementia of the Alzheimer's Type.

Epidemiology

Vascular Dementia is reportedly much less common than Dementia of the Alzheimer's Type

Etiology

See p. 152 for a general discussion of the course of dementia.

The onset of Vascular Dementia of typically abrupt, followed by a stepwise and fluctuating course that is characterized by rapid changes in functioning rather than slow progression.

The course, however, may be highly variable, and an insidious onset with gradual decline is also encountered. Usually the pattern if deficits is "patchy," depending on which regions of the brain have been destroyed.

Certain cognitive functions may be affected early, whereas others remain relatively unimpaired.

Early treatment of hypertension and vascular disease may prevent further progression.

*Vascular dementia is thought to be caused by strokes that interfere with blood flow to the brain and is sometimes called multi-infarct dementia.

Links

- Journal article: Cognitive functioning in Alzheimer's and Vascular Dementia

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6.189: Borderline Personality Disorder

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 complexation 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 *veryvery* 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 stubble 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 his 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, it he decides to throw the Queen of Hearts a unbirthday 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.

In the 2010 film

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 Heart 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 easy 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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=150

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.

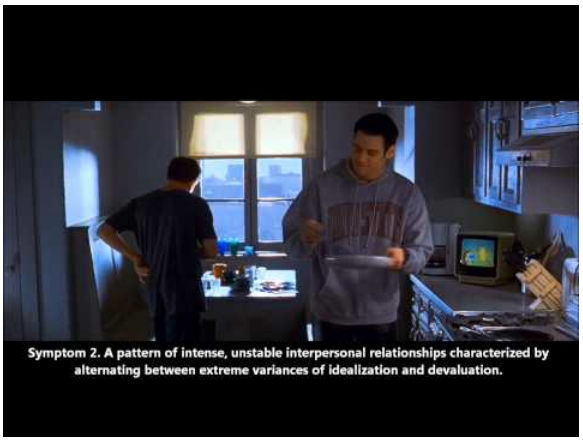
7. Chronic feelings of emptiness
    - Chip appears to feel empty from an early age as he lives in a neglectful home. There is no father present and a mother who goes out to happy hour in search of a man. In his adult age, Chip feels empty because no one takes the time to ask for his name let alone befriend 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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6.19: The Nature of Mental Disorders

The terms “mental disorder,” “mental illness,” and “psychopathology” are often used interchangeably by those in psychology and related fields; all refer to the study of unusual or abnormal behaviors. Unlike terms and concepts in many of the physical sciences, however, there is not a single, agreed-upon by all operational definition for these terms. The primary definitional conflict hinges on this question: Can mental disorders be defined as a scientific term, or are they instead socially constructed?

This lack of a single definition can lead to confusion and communication problems both when mental health professionals, such as psychologists, psychiatrists, counselors, or social workers, attempt to talk to each other and to the general public. As a result, mental disorders are used and defined in a variety of ways. Before beginning our examination of anxiety disorders, we must discuss these definitions and decide which one (or ones) will guide this book. Below are descriptions of the most common perspectives.

Mental Disorders as Statistical Deviance

The statistical deviance perspective has enormous common sense appeal, as it involves defining abnormal behavior by comparing an individual’s behavior to the frequency of occurrence of the same behavior in the general population. A behavior is considered abnormal if it occurs rarely or infrequently in the general population. This definition lends itself very well to measurement, as researchers and clinicians can administer objective assessments to clients and get accurate measurements of just how far their depression, anxiety, hyperactivity, and so on are from the norm. As such, this definition is often seen as highly scientific.

Unfortunately, several problems are apparent when this model is examined closely. First, who determines how far from the norm is too far from the norm? It is not as if there is a stone tablet handed down from the psychopathology gods that has “Behaviors that are two or more standard deviations from the norm shall be considered abnormal” written on it. Instead, researchers and clinicians make that decision. Often, behaviors are considered “abnormal” if they occur in less than 5% of the population (1.645 standard deviations from the mean), but this is an entirely arbitrary cutoff. Another concern is that the tests that measure one’s deviation are developed from within a particular cultural framework. In other words, there is not an objective, scientific definition of “obsessive-compulsive disorder,” there is only the definition that the researchers developing the measure have (and someone else may not agree with it).

It is also worth noting that when viewing behavior, both sides of the normal curve would be considered “abnormal.” So, according to this model, both someone with very high and very low general anxiety would be considered abnormal. In the real world, though, it is usually only one tail of the curve that is viewed as problematic or abnormal. For illustrative purposes, picture someone with an IQ of 70 and another person with an IQ of 130. On a scale where 100 is the average, with a standard deviation of 15, both are equally deviant from “normal” intelligence. Most people, however, would only consider the person with extremely low IQ to have a mental disorder, another problem with this conception.

Mental Disorders as Social Deviance

In the social deviance perspective, behavior is deemed abnormal if it deviates greatly from the accepted social standards, values, and norms of an individual’s culture. This is different from the statistical perspective described above, as this method is uninterested in the actual norms of the population. This is because a population may have accepted standards that the majority of the culture do not actually meet. An example of this would be using alcohol and tobacco prior to the legal age of use, which would be considered unlawful and socially unacceptable, yet major surveys show that over 75% of high school seniors have consumed alcohol.

The problems with the social norms perspective are fairly obvious. First, there is little to no objective validity, due to individuals and groups even within the same culture having different ideas of what is socially acceptable. Second, what is acceptable at one point in time can become unacceptable with the passage of time, or vice versa. Until 1973, for example, homosexuality was classified as a diagnosable mental disorder by the American Psychiatric Association, rather than being recognized as a normal variation of sexual orientation. Finally, the different morals and standards of disparate cultural groups would mean that what was normal in one country or region would be considered abnormal in another.

Mental Disorders as Maladaptive Behavior

The maladaptive behavior perspective attempts to classify as mental disorders those behaviors that are dysfunctional. This refers to the effectiveness or ineffectiveness of a behavior in dealing with challenges or accomplishing goals. Typically discussed maladaptive behaviors include physically harmful behaviors, behaviors that prevent the person from taking care of themselves, those that prevent communication with others, and those that interfere with social bonding and relationships. As with our other perspectives, there are major concerns with this one.

First, how adaptive a behavior is hard to objectively quantify. This is due to the fact that the adaptive level of any particular behavior is based on both the situation and one's subjective judgment. If a person is engaging in coercive behaviors, stealing, and lying to others, most people would say those are maladaptive behaviors (and depending on his age, qualify you for a diagnosis of Conduct Disorder or Antisocial Personality Disorder). But what if you learn that he was doing this to obtain food or medicine for his family? Would that still be maladaptive? One's culture also plays a large role in determining the adaptiveness of a behavior.

For instance, in many Native American tribes, it is considered disrespectful to look an elder directly in the eye when talking to them. In other cultures, though, it would be considered disrespectful to not look them in the eye. Finally, this perspective clashes mightily with the statistical deviance perspective, in that statistically deviant behaviors (e.g., an IQ higher than 99% of the population) can be highly adaptive, and that numerous maladaptive behaviors (such as fear of public speaking) are quite common in the population as a whole.

Dimensional vs. Categorical Models of Mental Disorders

Another, different way to think about mental disorders is captured in the concept of categories versus dimensions. In a categorical model, psychopathology is dichotomous, either being present or not being present. In other words, you either have a mental disorder, or you don't, there is no in-between. Dimensional models, on the other hand, acknowledge the fact that the vast majority of human behavior exists on a continuum, rather than the polarized view of the categorical model. What tends to be labeled as abnormal and unusual are merely the far ends of this normal curve of behavior. In this model, then, mental disorders are just extreme variations of normal psychological phenomena or problems that many or most of us experience.

The dimensional model has a very large amount of scientific support, particularly in the area of personality disorders. Support has been found for dimensional models of many other disorders, though, including anxiety, depressive episodes, and even psychotic disorders. Unfortunately, however, the real-world often requires caseness or non-caseness. In many instances one must be diagnosed with a particular mental disorder to obtain certain things, such as insurance reimbursement, special services at school, or disability benefits. This, subsequently, creates a tension between the need for categories and the lack of scientific support for them.

DSM Definitions of Mental Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association, and is the most widely used classification system of mental disorders in the United States (outside of the U.S., both the DSM and the International Classifications of Disease, or ICD, are used). It provides diagnostic criteria for almost 300 mental disorders. But how exactly does it define mental disorder? In the most recent edition, published in 1994, the following features are considered descriptive of a mental disorder:

- A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual
- Is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom
- Must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one
- A manifestation of a behavioral, psychological, or biological dysfunction in the individual
- Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual

The DSM-IV goes on to state, though, that "no definition adequately specifies precise boundaries for the concept of "mental disorder" and that "the concept of mental disorder (like many other concepts in medicine and science) lacks a consistent operational definition that covers all situations." Even with those caveats, this definition has considerable concerns: What exactly

does “clinically significant” mean? How much distress is enough distress and who determines that? Who says what is or is not “culturally sanctioned”? And last, but perhaps most important, what defines a “behavioral or psychological syndrome or pattern”?

The categorical nature of the DSM-IV is also of concern, and the authors even state that they recognize the actual, dimensional nature of mental disorders, but due to the need for caseness (as described above) must operate in a categorical nature. This, in turn, contributes to the high amount of diagnostic overlap, or comorbidity, present in clinical populations. In one of the most well-conducted studies to examine this issue, Ronald Kessler and his research team (2005) found that 26.2% of Americans met criteria for a mental disorder; of these, 45% met criteria for two or more disorders.

These concerns and questions are certainly on the minds of many researchers and clinicians, and in fact a special group was assembled to rework the definition of a mental disorder for the upcoming revision of the DSM, the DSM-5, which is scheduled to be published in May 2013. The proposed revision, which was made available both online at DSM5.org and in an article by D.J. Stein and colleagues (2010), is as follows.

- A behavioral or psychological syndrome or pattern that occurs in an individual
- That reflects an underlying psychobiological dysfunction
- The consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)
- Must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals)
- That is not primarily a result of social deviance or conflicts with society

As in the DSM-IV definition, there are other proposed caveats or considerations. A mental disorder should, by this definition, have diagnostic validity, clinical utility, and be differentiated from other, similar disorders. In addition, it is again acknowledged that there is no precise boundary between normality and mental disorders, and that the addition or deletion of a condition from the DSM should have substantial potential benefits which outweigh potential harms. While this proposed definition, and the revisions to many disorders that actually specify measures to determine severity and symptom level, are certainly an improvement over the DSM-IV (which was, in turn an improvement over earlier versions), there are still concerns over this definition. Specifically, will such severity indicators be used in real-world practice, and how will the introduction of such dimensionality impact treatment, reimbursement, and diagnostic practices? Will the improved diagnostic categories decrease the amount of overlap and comorbidity seen in mental health settings?

What to Do?

Given the problems with all of the preceding definitions of a mental disorder, one might begin to question the need for such a term or concept. After all, if it cannot be easily and accurately defined, what use is it? If the DSM categories are problematic, then why diagnose using them? The simple answer is “We use them because we need them.”

Humans are natural categorizers, with a need to group and order things that we encounter. Our diagnostic typologies reflect this underlying need. It is much easier to understand and communicate to someone that a client is diagnosed with obsessive-compulsive disorder and generalized anxiety than to say something like “Their general anxiety level is at the 87th percentile, while they also have more obsessive, intrusive thoughts than 94% of the population and a subsequent rate of compulsive, anxiety reducing behaviors greater than all but 16% of their peers.” In many cases, dimensional models of psychopathology, although perhaps more accurate, may simply be too confusing and/or complex to be useful in the real world.

Doing diagnostic work, and giving a patient a diagnosis based on presenting symptoms and lab findings, is an enormous part of all health professions. This is true even though dimensional models actually make more sense for almost all of what are called diseases (e.g., “Your blood pressure is higher than 95% of males your age, weight, and fitness level” rather than “You have high blood pressure.”) Given clinical psychology’s development and outgrowth from medicine, it makes sense that diagnosis would be part of our heritage. In many ways, it also establishes the credibility of psychiatry and clinical psychology by allowing these professions to stake out their “territory.” Having something like the DSM essentially says “These problems and dysfunctions are the domain of psychiatry, so you other types of health providers back off.” Losing diagnoses as part of the profession would mean that, in essence, we were losing our domain of health care. These reasons are, of course, in addition to the facts discussed previously about how real-life requires caseness or non-caseness in many occasions.

So, we as a profession and a society need definitions of mental disorders, and yet there does not appear to be a scientific consensus or definition on what a mental disorder actually is. So if there can be no truly scientific definition, what are we left with?

Mental Disorders as Social Constructions

Mental disorders, mental illness, and psychopathology are best understood as products of our history and culture, and should try to be defined as some sort of universal, scientific construct. Mental disorders are, in a very real sense, invented. This does not, however, mean that they are not real. Instead, our conception of what is and is not normal behavior is influenced by everything from social and cultural forces, to politics and economics, to which professional groups have the most influence and clout at the time new definitions are being written. Mental disorders, then, are social constructs, a concept that is constructed by a particular group (in this case, the committee members of the DSM Work Groups, who are in turn influenced by researchers, clinicians, politicians, lay people, industry, religious beliefs, and more).

Accepting that mental disorders are a social construct, for some, implies that they are somehow fake or unimportant. Nothing, in fact, could be further from the truth. To put this in perspective, consider a number of other social constructs: love, beauty, race, poverty, wealth, physical disease. Each of those is constructed, and you will see different definitions of each when moving across time and between cultures.1 This does not rob any of them of their importance, or make any of them less real. The same is true of mental disorders.

Conclusions

Mental disorders are hard to define, even by those who make it their life's work to study and treat them. Although there are certainly faults and flaws with the most widely used and social constructed definition, that of the DSM, the drawn boundary between normal and abnormal are essential to clinical psychology as a profession, persons with mental illness, and society as a whole.

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6.190: Schizophrenia Residual Type

Residual-type schizophrenia is characterized by a past history of a least one episode of schizophrenia, but the person will currently have no positive symptoms (delusions, hallucinations, disorganized speech or behavior). Symptoms may represent a transition between a full-blown episode and complete remission, or it may continue for years without any further psychotic episodes.

DSM criteria

- A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.
- B. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- Residual schizophrenia is typically by diagnosed by the following symptoms:
  - a. Prominent “negative” schizophrenic symptoms, such as psychomotor slowing, underactivity, blunting of affect, passivity and lack of initiative, poverty of quantity or content of speech, poor nonverbal communication by facial expression, eye contact, voice modulation, and posture, poor self-care and social performance
  - b. Evidence in the past of at least one psychotic episode meeting the diagnostic criteria for schizophrenia;
  - c. A period of at least 1 year during which the intensity and frequency of florid symptoms such as delusions and hallucinations have been minimal or substantially reduced and the “negative” schizophrenic syndrome has been present;
  - d. Absence of dementia or other organic brain disease or disorder, and of chronic depression or institutionalism sufficient to explain the negative impairments.

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6.191: Schizophrenia Undifferentiated Type

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.

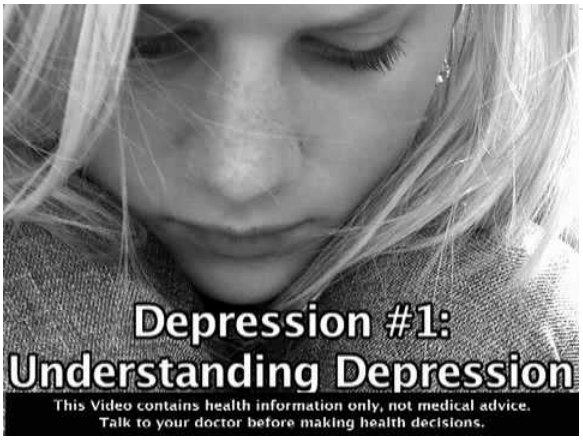
- Criterion A
  - delusions
  - hallucinations
  - disorganized speech (e.g., frequent derailment or incoherence)
  - grossly disorganized or catatonic behavior
  - negative symptoms (e.g., affective flattening, alogia, or avolition)
- * Note: Only one Criterion A symptom is required if delusions are 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.

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6.192: 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:
  - 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 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 a 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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=480

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6.193: Dysthymic Disorder (300.4)

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 then 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).

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6.194: Depressive Disorder Not Otherwise Specified (311)

DSM-IV-TR criteria

The Depressive Disorder Not Otherwise Specified category includes disorders with depressive features that do not meet the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder With Depressed Mood, or Adjustment Disorder with Mixed Anxiety and Depressed Mood. Sometimes depressive symptoms can present as part of an Anxiety Disorder Not Otherwise Specified. Examples of Depressive Disorder Not Otherwise Specified include:

1. Premenstrual dysphoric disorder: in most menstrual cycles during the past year, symptoms (e.g., markedly depressed mood, marked anxiety, marked affective liability, decreased interest in activities) regularly occurred during the last week of the luteal phase (and remitted within a few days of the onset of menses). These symptoms must be severe enough to markedly interfere with work, school, or unusual activities and be entirely absent for at least 1 week postmenses.
2. Minor Depressive Disorder: episodes of at least 2 weeks of depressive symptoms but with fewer than the five items required for Major Depressive Disorder.
3. Recurrent brief depressive disorder: depressive episodes lasting from 2 days up to 2 weeks, occurring at least once a month for 12 months (not associated with the menstrual cycle)
4. Postpsychotic depressive disorder of Schizophrenia: a Major Depressive Episode Disorder that occurs during the residual phase of Schizophrenia.
5. A Major Depressive Episode superimposed on Delusional Disorder, Psychotic Disorder Not Otherwise Specified, or the active phase of Schizophrenia.
6. Situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.
7. Seasonal Affective Disorder: seasonal regularity. Symptoms include: intense hunger, weight gain in winter, sleep more than usual, depressed more in the evening than the morning.

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6.195: Bipolar I Disorder (296.xx)



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 then 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).

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6.196: Bipolar II Disorder (296.89)

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 that 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 Disorderand 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).

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6.197: Cyclothymic Disorder (301.13)

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 then 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 medicaations 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.

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6.198: Mood Disorder Due to a General Medical Condition (293.83)

DSM-IV-TR criteria — Mood Disorder Due to …[Indicate the General Medical Condition]

- 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 that the disturbance is the direct physiological consequence of a general medical condition.
- C.The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder with Depressed Mood in response to the stress of having a general medical condition)
- 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.
- Specify type
  - With Depressed Features: if the predominant mood is depressed but the full criteria are not met for a Major Depressive Episode
  - With Major Depressive-Like Episodes: if the full criteria are met (except Criterion D) for a Major Depressive Episode
  - With Manic Features: if the predominant mood is elevated, euphoric, or irritable
  - With Mixed Features: if the symptoms of both mania and depression are present but neither predominates
  - Coding Note: Include the name of the general medical condition on Axis I; also code the general medical condition on Axis III
  - Coding Note: If depressive symptoms occur as part of a preexisting Vascular Dementia, indicate the depressive symptoms by coding the appropriate subtype.

Associated features

An individual may have different conditions. A person may have degenerative neurological conditions such as Parkinson's or Huntington's disease, or they may have cerebrovascular, metabolic conditions, autoimmune conditions, endocrine conditions, cancer, viral or other infections.

Differential Diagnosis:

A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given if the mood disturbance occurs exclusively during the course of a delirium. In contrast, a diagnosis of Mood Disorder Due to a General Medical Condition may be given in addition to a diagnosis of dementia if the mood symptoms are a direct etiological consequence of the pathological process causing the dementia and if the mood symptoms are a prominent part of the clinical presentation (e.g., Mood Disorder Due to Alzheimer's Disease). An exception to this occurs when depressive symptoms occur exclusively during the course of Vascular Dementia.

If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin, a Substance-Induced Mood Disorder should be considered.

Mood Disorder Due to a General Medical Condition must be distinguished from Major Depressive Disorder, the Bipolar disorders, and Adjustment Disorder with Depressed Mood. In these Disorders, no specific and direct causative physiological mechanisms associated with a general medical condition can be demonstrated.

Child vs. adult presentation

Gender and cultural differences in presentation

Epidemiology

Prevalence estimates for Mood Disorder Due to a General Medical Condition are confined to those presentations with depressive features. Between 25% and 40% of individuals with certain neurological conditions (including Parkinson's disease, Huntington's

disease, multiple sclerosis, stroke, and Alzheimer's disease) will develop a marked depressive disturbance at some point during the course of the illness. For general medical conditions without direct central nervous system involvement, rates are far more variable, ranging from more than 60% in Cushing's syndrome to less than 8% in end-stage renal disease.

Etiology

Empirically supported treatments

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6.199: Substance-Induced Mood Disorder

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 syndrom
  - 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 withdrawl. 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 the 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 inceidence 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

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6.20: Sexual Aversion Disorder (302.79)

DSM-IV-TR criteria

- Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.
- The disturbance causes marked distress or interpersonal difficulty.
- The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction).
- Subtypes: To indicate onset (Lifelong versus Acquired) and Context (Generalized versus Situational)

Associated features

Some individuals faced with severe sexual aversion disorder may experience panic attacks with extreme anxiety, dizziness, nausea, faintness, heart palpitations, and breathing difficulties. There may be noticeable changes in interpersonal relations (such as marriage). Individuals with sexual aversion disorder (SAD) may avoid sexual situations or potential sexual partners by subtle diversion strategies like falling asleep early, traveling, neglecting their appearance, substance abuse, or burying themselves in work, school, or other activities.Sexual aversion disorder is characterized not only by a lack of desire, but also by fear, revulsion, disgust, or similar emotions when the person with the disorder engages in genital contact with a partner. The aversions may take several different forms, it may be related to specific aspects of sexual intercourse, such as the sight of the partner's genitals, or the smell of his or her body secretions, but it may also include kissing, hugging, and petting as well as intercourse itself.

Child vs. adult presentation

This disorder manifests itself in early adulthood, so there is no information regarding symptom presentation in children.

Gender and cultural differences in presentation

There are few statistics on the number of people with SAD because it is often confused with other disorders. Many people find sex a hard subject to talk about even with a doctor; consequently, the number of people with SAD is greater than the number of people who seek treatment.

Epidemiology

Because SAD is a subcategory of the Hypoactive Sexual Desire Disorders, the prevalence of SAD is currently unknown. The prevalence is higher in women than in men.

Etiology

In women Sexual aversion disorder is normally caused by a traumatic experience of the past, such as rape, incest, molestation, and other forms of sexual abuse. In men the disorder is associated with performance anxiety. Evidence suggests that past sexual trauma and/or relationship issues may be an underlying cause in the development of SAD.

Empirically supported treatments

Sexual aversion disorder is treated most often with the help of a psychiatrist and psychotherapy. If the disorder also concerns a partner or a spouse, marriage counseling is often used. Pharmacotherapy is typically used for patients with sexual aversion disorder only if they are experiencing panic attacks severe enough to cause additional distress not normally for the disorder itself. Behavioral counseling would be of use in finding out and resolving the underlying issue of this conflict.

Prognosis

- When sexual aversion disorder is addressed as a psychological disorder, treatment can be very successful. Psychotherapy to treat the underlying psychological problems can be successful as long as the patient is willing to attend counseling sessions regularly. For sexual aversion disorder that is situational or acquired, psychotherapy for both the patient and his or her partner may help to resolve interpersonal conflicts that may be contributing to the disorder. Panic attacks caused by or associated with the disorder can be treated successfully by medication if the doctor considers this form of treatment necessary.
- If sexual aversion disorder is not diagnosed, discussed, or treated, the result may be infidelity, divorce, or chronic unhappiness in the relationship or marriage.

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6.200: Intermittent Explosive Disorder

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 (Conon 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, α(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 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.

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6.21: Narcissistic Personality Disorder

Name: Jenna Maroney

Source: 30 Rock (Television series, mid 2000s)

Background Information

Jenna Marony 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
  - 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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6.22: Major Depressive Disorder

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

296.2x Major Depressive Disorder, Single Episode

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 without psychotic features. Further diagnosis will be needed to determine catatonic, melancholic, or atypical 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 though 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), 296.3x. According to the DSM-IV-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.

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6.24: Anorexia Nervosa

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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6.25: Alcohol Abuse

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.

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6.26: Panic Disorder without Agoraphobia

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 paint 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 medicationdue to his co-occuring 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.

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6.27: Panic Disorder with Agoraphobia

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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=162

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6.28: Obsessive-Compulsive Disorder

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 s 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 fuional. 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

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6.29: Bipolar II Disorder

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.

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6.30: Oppositional Defiant Disorder

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 resentfulness 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 episodes 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 confliction 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.
Stewies 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 viscious 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 greatly increases awareness in the child as to what is expected of them as well as what will happen if they misbehave.

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6.31: Gender Identity Disorder

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 dyshoria 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 differ 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, the 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 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.

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6.32: Autistic Disorder

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

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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
                    - 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:
    - 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
- **3. Symbolic or imaginative play**
- **C. The disturbance is not better accounted for by Rhett'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.

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6.33: Dysthymic Disorder

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.



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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 fallowing 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.

<h3**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.

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6.34: Bulimia Nervosa

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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=174

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 binging 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 binging and purging.

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6.35: Alzheimer's Dementia

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 deficeincy, hypercalcemia, ceurosyphilis, 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, ceurosyphilis, 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 mematine. 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.

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6.36: Histrionic Personality Disorder

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. distain) 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.

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 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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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 consorted 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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6.37: Attention-Deficit/Hyperactivity Disorder

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 co-morbid 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 Destroamphetamine 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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6.38: Anorexia Nervosa

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

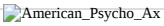
Nervosa. The self-help group meetings would enlighten Trevor about Anorexia Nervosa tremendously. In order for self-help treatments to be successful Trevor must attend the meetings regularly and change his behavior through the acquisition of new knowledge. The self-help groups may be the social support 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.



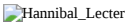
A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=180

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6.39: Psychopathy



Christian Bale in American Psycho



Anthony Hopkins in The Silence of the Lambs

Dictionary.com Definition of Psychopath: “a mental disorder in which an individual manifests amoral and antisocial behavior, lack of ability to love or establish meaningful personal relationships, extreme egocentricity, failure to learn from experience, etc.”

Introduction to Psychopaths

Psychopaths are utterly fascinating to both scientists and non-scientists alike. The discovery of the existence of psychopaths has led to the creation of a vast number of books, TV shows, and movies. Some examples of these are the book and TV series *Dexter*, and the book and film *The Silence of the Lambs*. The more accurate versions of these entertainment sources (e.g., the novel and film *American Psycho*) depict psychopaths for what they really are: individuals that never feel genuine guilt or concern for others; cold, inhuman beings that lack the ability to empathize and whose main focus is always on themselves.

Psychopathy is a term that was created by Hervey Cleckley in 1941. This word was initially used to discuss individuals that possessed artificial charisma and intellect, and that were non-empathetic, deceitful in nature, careless, incapable of guilt or real concern for people, and fearless (Larsen & Buss, 2010). Psychopaths feel no compassion for other humans, which is why they frequently abuse (emotionally and/or physically), murder, manipulate, deceive, con, and abandon other people. They are able to do this because they are often masterful manipulators and actors, often times being able to keep up the appearance of being completely normal. Many of them are observant, charming, human chameleons that can easily blend in with their social environment (Hare, 1993). From an evolutionary standpoint, this makes plenty of sense. Humans that blatantly show zero concern for fellow humans, through such actions as murder and abandonment, are going to stick out in a negative manner. Of course, not all psychopaths avoid behaving in violent or conning ways that can get them put into prison. Certain serial killers that are currently incarcerated or were incarcerated prior to their death are prime examples of this. Prison is where many people assume that most psychopaths are located, but this is an inaccurate and dangerous belie (Hare, 1993).

The incarcerated psychopaths, however, are what a great deal of the available research on psychopathy has been conducted on. It can be very difficult to successfully identify psychopaths, even the ones that are in prison for violent crimes. This is so because the majority of them are exquisite liars, and a lot of them are smart enough to know what researchers are looking for on psychological tests and in one-on-one interviews. In fact, there are inmates that obtain books dealing with psychological testing and various other areas in the field of psychology. These inmates study the material and then, in return for payment, instruct fellow inmates how to answer psychological tests in a manner that will make them look good and possibly get them an early release from jail (Hare, 1993). So, this means that psychopaths can learn how to efficiently trick psychometric tests while they are in prison. Psychopaths have much better access to information about psychological testing and psychology in general when they are not imprisoned, obviously including research regarding psychopathy. It is possible that some of them receive actual training or college degrees in

psychology, making them that much more adept at avoiding detection. In summary, it is not as simple to correctly recognize a psychopath as the media and Hollywood make it appear to be. Someone is not automatically a psychopath because they committed murder, rape, torture, etc. There are certain personality traits *and* socially undesirable behaviors that must be present before someone can be diagnosed as a psychopath (Hare, 1993).

Terminology

Psychopath, Sociopath, or Antisocial Personality Disorder: Which is the correct term?

It is quite common for the terms *psychopath* and *sociopath* to be used synonymously by scientists and non-scientists alike. Reading articles and other research writings in the areas of psychopathy and sociopathy can easily be confusing because different terms are preferred by different researchers. Adding to the confusion is the fact that *antisocial personality disorder* is frequently used as an equivalent of psychopath and sociopath (Hare, 1993). Sociopath is sometimes preferred by some individuals because, unlike psychopath, it does not indicate that someone is psychotic or insane. Some common misconceptions are that psychopaths are completely insane and unaware of what they are doing and why they are doing it. Psychopaths are actually fully aware of their behaviors and the motivations behind them; they are logical and live in reality. Psychopaths know what they are doing, and they make decisions out of their own free will. Unfortunately for those around them, these individuals are not acting in socially deviant or harmful ways because they are delusional or suffering from hallucinations. (Hare, 1993). Psychopaths choose to act in certain socially unacceptable ways, all the while cognizant of how they are acting; they know what they are doing and they do not care if it negatively affects the people around them.

Robert Hare (1993) believes that the preference for *psychopath* or *sociopath* is a clear indication of what that person's causal theories are. Many different social scientists (e.g., psychologists, criminologists, and sociologists) like to use *sociopathy* because they think that this disorder is directly a result of social factors and experiences that an individual underwent while growing up. On the other hand, *psychopathy* is more preferable to scientists that believe that the disorder is caused by a mix of cognitive, physiological, social, and genetic elements. Hare (1993) goes on to say that *antisocial personality disorder* is a phrase that was intended to be almost synonymous with psychopath and sociopath, but that this was not quite accurate due to a difference in diagnostic requirements. The symptoms that are required in order for one to receive a diagnosis of antisocial personality disorder are numerous antisocial and illegal actions. As a result, most criminals meet the necessary qualifications for diagnosis of antisocial personality disorder (Hare, 1993). Psychopaths, however, are described as performing various antisocial and unlawful behaviors *in addition to* having a certain set of personality characteristics. It can easily be seen that the symptoms of antisocial personality disorder are quite similar to those of psychopathy (Lack, 2010), but symptoms are not present in the extreme form like they are in psychopathy.

David Lykken (1995) uses the phrase *sociopath* when he is discussing people with antisocial personality disorders that demonstrate negative behaviors that are caused by unhealthy social or family-related experiences. He uses the phrase *psychopath* when he is talking about humans that express socially undesirable behaviors that are likely a result of a physiological anomaly and not because of their socialization. Lykken (1995) views psychopaths and sociopaths as two distinctly separate types of individuals, even though there are some similarities between the two. Even though he sees psychopathy and sociopathy as not being one and the same, he provides the same reasoning for the causes of psychopathy/sociopathy that Robert Hare, probably the leading specialist in the area of psychopathy, does (Lykken,1995).

Something else that further confuses the nomenclature of psychopathy is the absence of psychopathy or sociopathy as a diagnosis in the DSM-IV-TR (American Psychiatric Association, 2000). It is no wonder so many scientists cannot agree on one term or usage of both terms in regards to antisocial personality disorders, i.e., psychopathy or sociopathy, when the so-called Bible of mental disorders does not contain either of them. The DSM-IV-TR only has a section discussing antisocial personality disorder. At the beginning of the section, it briefly mentions that antisocial personality disorder has previously been mentioned as "psychopathy, sociopathy, or dyssocial personality disorder" (American Psychiatric Association, 2000). A big problem with this is that research shows that there is only a small overlap of calculations (i.e., psychological measurements) of psychopathy and antisocial personality disorder (Lilienfeld & Arkowitz, 2007). It appears that the DSM-V will include psychopathy in the antisocial personality disorder section. The proposed idea is for the Antisocial Personality Disorder section to be changed to Antisocial/Psychopathic Type.

In conclusion, psychopath is a term used to describe people that exhibit antisocial behaviors and that were born with physiological differences that cause them to behave in socially unacceptable and often hurtful ways towards others. Sociopath is a term used to describe individuals that perform antisocial behaviors as a result of various social and environmental factors that they experienced earlier in life; there is no inherited brain abnormality that causes the behavior. Antisocial personality disorder and sociopathy do not come across as very different from each other in the current literature; it can argued that they are the same thing. Psychopathy, however, is quite different from these two other terms because it has a genetic component, and should not be referred to as antisocial personality disorder or sociopathy, as a result. The focus of this chapter is on psychopathy, so the terms antisocial personality disorder and sociopathy will not be further examined outside of this area of the chapter.

In case you want to read more about antisocial personality disorder, see the antisocial personality disorder portion of this online text. ASPD is located in the Cluster B of personality disorders.

Etiology

The amount and quality of research is still fairly limited on psychopaths since they are fairly difficult to find and get useful and valid data from. There are still, however, theories as to the cause of psychopathy. It appears that a mix of both environmental and genetic effects are to be blamed for the cause of this syndrome.

Genetics

In regards to genetic causes, one belief is that there is an inherited abnormality that causes unhealthy and abnormal emotional thinking. What this denotes is that it is not that psychopaths inherit bad behaviors, but that their acquired genes cause them to develop unnatural emotional processing**,** as compared to the emotional processing in the brains of normal people. The development of anomalous emotional processing in the brains of psychopaths is responsible for their antisocial behaviors and non-human-like cognitions (Blair, Mitchell, & Blair, 2005). This would explain why psychopaths do not have the cognitive abilities to accurately interpret, recognize, and feel typical human emotions. This unusual brain functioning prevents them from being able to empathize and care about other people's feelings. A psychopath may be able to recognize what certain facial expressions represent (e.g., pain, sadness, anger)**,** but they cannot put themselves in the other person's shoes in order to determine what someone is feeling underneath a particular countenance. And since psychopaths primarily and often only worry about themselves, it is unlikely that they would even bother to take the time to try and figure out what someone else is feeling.

Socialization

The social upbringing is another area of focus for the causality of psychopathy. One causal theory is that psychopaths grow up in environments where their aggression and cruelty go unpunished and possibly even get reinforced by others. Parents may reinforce their child's aggressive and violent behavior by giving in to what the child wants. For example, a kid may start threatening to punch or actually punching a sibling as a means to receive some type of desired object/event (e.g., candy). If the parents give in to their child's demand(s), the violence/aggression is rewarded and the child learns that violence and aggressiveness are acceptable methods to get what they desire; the negative behavior is more likely to happen again in the future. This can easily lead to socially deviant and destructive actions, and may also prompt a person meeting the qualifications for other psychological disorders, such as conduct disorder or antisocial personality disorder (Hare, 1993).

It could also be possible that social environments that reinforce hostility and violence additionally involve modeling of said types of behavior by caretakers. A combination of positive reinforcement of a child's violent behaviors and displays of violent behaviors by caretakers would make it highly likely that a child becomes violent. The child learns through instrumental conditioning that hostility can be a means to receive things that they want (reinforcement). An unhealthy environment like this would probably put a child at a greater risk to develop psychological disorders, like conduct disorder and antisocial personality disorder. Robert Hare (1993) found that psychopathic adults often were diagnosed or met criteria for diagnosis of these disorders earlier in their lives. Not all people diagnosed with conduct disorder or antisocial personality disorder become psychopaths, but it is very likely that they will become psychopaths if they do not receive some sort of treatment. Because of this, it is imperative that children displaying antisocial behavior and affect undergo treatment as soon as possible, as long as their symptoms are above the normal level of antisocial behavior that can be expected from children (e.g., insulting, fighting, etc.). The longer the antisocial behavior persists without being treated, the more difficult it will be to successfully treat the individual, and the greater the possibility there will be that they develop into a psychopath (Hare, 1993).

Symptoms

As previously mentioned, it is very difficult to identify actual psychopaths. There is, however, one research scale that has a lot of empirical results to back up its effectiveness at correctly diagnosing psychopaths, Robert Hare's Psychopathy Checklist-Revised (PCL-R). The PLC-R is employed across the globe to help scientists attain accurate diagnoses of true psychopaths, differentiating them from people that are merely just somewhat socially deviant in their behavior (Hare, 1993). This method involves an in-person interview in addition to the researcher or clinician looking over the interviewee's personal records, such as crimes carried out in the past. The scale is comprised of three different-labeled, but alike personality trait labels: interpersonal deficiencies (e.g., manipulation), affective deficiencies (e.g., inability to empathize), and rash/illegal behaviors (e.g., arson) (Lilienfeld & Arkowitz, 2007).

The PCL-R enabled Robert Hare to come up with a set of symptoms that are frequently seen in psychopaths.

Table of Psychopath's Key Symptoms Taken From *Without Conscience* (Hare, 1993)

Emotional/Interpersonal	**Social Deviance**
Glib and superficial	Impulsive
Egocentric and grandiose	Poor behavior controls
Lack of remorse/guilt	Need for excitement
Lack of empathy	Lack of responsibility
Deceitful and manipulative	Early behavior problems
Shallow emotions	Adult antisocial behavior

- The traits listed above in the table are commonly mentioned by researchers in the field of psychopathy.
- Sexual promiscuity: psychopaths tend to be sexually promiscuous, especially psychopathic men.
    - Male psychopaths often have more female sex partners, act more sexually aggressive, have more children out of wedlock, and have a higher number of marriages ending in divorce than males that are not psychopaths (Larsen & Buss, 2010).
    - Female psychopaths may measure up equally to their male psychopathic counterparts in terms of sexual behavior. Females frequently physically abuse and emotionally starve their offspring, sometimes just flat out abandoning them and going on to their next sexual adventure.
        - On a side note, something lacking in the current literature is research on the prevalence rates of sexually transmitted diseases (STDs) in both psychopathic males and females. It could be entirely possible that psychopaths have a higher rate of STDs for numerous reasons.
            - Psychopaths are primarily concerned about themselves and often have a hedonistic approach to life. Condoms are not as sexually pleasurable as unprotected sex and psychopaths frequently move on to new lovers quickly, which may result in psychopathic individuals often engaging in risky sexual behaviors.
            - Large numbers of sexual partners makes knowledge about partners' sexual histories and diseases/infections close to or actually nonexistent. Even if psychopaths religiously use condoms, they are still probably more likely to get an STD than average individuals, due to their elevated number of sexual partners. Condoms break, get used improperly, and sometimes fail to prevent the transmission of sexual diseases even when used properly.
                - It is frightening to think about psychopaths having higher rates of STDs when one factors in their disregard for others and inability to empathize. They may be fully aware that they have a sexual disease but not have a care in the world about infecting their lovers.
                - One thing that would make it difficult to perform useful research in this area would be the issue of the prison population being the main focus of research on psychopathy. It is almost a sure thing to say that safe sex is never performed in prisons. Incarcerated psychopaths may have entered prison with no STDs, had sex with a fellow inmate and gotten a disease/virus from them, and then test positive during a study of STD prevalence rates amongst psychopaths. This is something to factor in on any future research done to link STD rates with psychopathy.

Treatments

Not Much Hope for Now

- The lack of agreement on terminology and etiology makes it difficult to formulate effective treatment programs. It could also be argued that therapists that only support social causes for psychopathy are wasting their time. As previously mentioned, it appears that psychopathy is caused by both genetic and environmental influences. Treatment of a biologically-caused disorder is unlikely to be very effective if the therapist is unaware of the biological component or just flat-out disagrees that it exists.
- Psychopaths usually do not try to get treatment even when they know they are not normal (Lilienfeld & Arkowitz, 2007).
- The intensity and rate of antisocial behavior typically decreases in people as they get older. Because of this, it has been suggested that the most effective treatment for psychopaths is to age while they are in jail. Older, imprisoned psychopaths still exhibit indifference about other people's emotions and other people in general, but they do not behave as antisocially or violently as they did when they were younger (Larsen & Buss, 2010).
- If treatment is to have any chance of preventing the development of a full psychopath, it must be performed in the early years of child; there is little hope of preventing the development of a full-fledged psychopath if treatment starts in adolescence or any time there after. The most treatment strategies can do, at best, is produce some short-lived behavioral improvements when they are used on people with firmly-ingrained antisocial tendencies and attitudes (Hare, 1993).
- Many therapists attempt to use strategies that target specific antisocial behavioral patterns, such as stealing, physical violence, and manipulation of others. This is ineffective because these therapists are failing to treat what is a personality disorder that has a biological component (Hare, 1993).
- Psychopaths are difficult to therapeutically alter because they tend to just go through the actions and not really try to get better. They may do or pretend to do what the clinician asks but they do not really care about changing or fixing their relationships. Also, a psychopath cannot be taught or conditioned to empathize; it simply is not a possibility with the way that their brains are wired (Hare, 1993).
- Treating psychopaths may actually make them worse than better, more dangerous to be specific (Hare, 1993). This unfortunate concept can be true for several reasons.
    - Teaching psychopaths which of their behaviors are socially unacceptable and which behaviors they should display instead gives new ideas to the antisocial patient of how to better disguise their true nature. Informing them about the social undesirability of certain cognitions that they share aloud can help with this too. They will continue to have the thoughts but be wiser and not tell them to other people.
    - Learning more about proper ways to act and what behaviors are approved by others can just provide psychopaths with better tools to manipulate and use people (Hare, 1993).
- The current outlook on treating psychopaths is not a very pleasant one, but much more research is needed in this relatively young field.

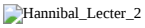
Prevalence

- It is difficult to come to an representative prevalence rate for a few reasons.
    - Psychopaths tend to avoid coming in for treatment (Lilienfeld & Arkowitz, 2007), preventing clinicians and researchers from being able to garner representative statistics of the psychopathic population.
        - Even if people with this disorder come in for or are forced to take therapy for some reason (other than them being a psychopath, e.g., a boss requiring an employee get treatment after the death of a spouse), most of them are charming and intelligent enough to keep their true nature hidden.
    - It is difficult for researchers and clinicians to get a gauge of how many psychopaths exist when there is not even a mostly-agreed-upon term for these antisocial types of people, and when there is debate over the causes of this disorder. Some people may give prevalence rates for antisocial personality disorder (when it is really psychopathy), and others may provide prevalence rates for psychopathy (when it is really ASPD, or something else like conduct disorder).
- Psychopaths are usually males, but it is unknown why this is the case (Lilienfeld & Arkowitz, 2007).
- The disorder is not isolated in Western cultures, and has even been found in cultures in very isolated parts of the world (e.g., Inuits that lived near the Bering Strait) (Lilienfeld & Arkowitz, 2007).
- Robert Hare (1993) gave a conservative estimate that 2 million psychopaths lived in the United States in 1993.

Examples of Psychopaths From Movies and Television

Hannibal Lecter

- Hannibal is one of the main characters in the movie, *The Silence of the Lambs*.


Hannibal_Lecter_2

- Commits violent murders, even killing people that have demonstrated kindness towards him during the film.
- Is imprisoned for murder, cannibalism, and serving cooked human body parts to unknowing dinner guests (the cannibalism and human entree part are only mentioned and not shown in the film).
- Highly intelligent and can be very charming and sophisticated when he wants to be. He managed to obtain a medical degree and work as a psychiatrist prior to his capture, so he was effective at blending in for a long while.
- Asks very personal questions, insults people, and makes vulgar remarks without any concern for the discomfort he causes others. In fact, it actually appears that he enjoys making people upset and uncomfortable.
    - This is visible in the following clip from *The Silence of the Lambs*. The clip shows an interaction between Hannibal and a senator that wants his help to save her kidnapped daughter from a vicious serial killer. Hannibal makes crude comments about the senator's anatomy and how she will feel when she sees her dead daughter's body. The comments seem to be made solely to upset the senator, and Hannibal appears to be pleased with how upset his comments make her. There is zero concern exhibited by Hannibal for how he affects another person.
        - Scene From The Silence of the Lambs

Patrick Bateman

- Patrick is the main character of the movie, *American Psycho*.


Patrick_Bateman_3

- Commits numerous, extremely violent murders, cannibalism, snorts cocaine, tortures people, and kills a dog for no reason.
- Repeatedly uses other people for his gain, without caring about inconveniencing them or repaying them in some way.
- Cruelly insults people, even those he knows well, for no reason except that it possibly entertains him.
- Very charming, intelligent, and well-spoken. Admits at one point during the movie that he only keeps his job in order to "fit in." This shows that he knows what he is doing; knows he is different from other people; and that he must hide his actions because society would not look kindly upon it.
    - In the following clip from *American Psycho*, Patrick is extremely upset because he thinks he is going to get caught for his violent crimes, not because of what he did to the victims. He also acknowledges that what he does is not normal human behavior by saying, "I mean I guess I'm a pretty sick guy."

Dexter Morgan

- Dexter is the main character from the Showtime TV series *Dexter.*


Dexter_Morgan

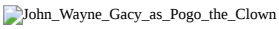
- Commits a massive number of murders that are almost always extremely bloody.
- Is very sarcastic (not that this alone is an indication of psychopathy) and often laughs at and mocks his victims right before he ends their lives.
- Exceptionally charming and fairly good at fitting into society, as shown by his ability to have a sister that loves him and also by him finding a person to love and marry him. Knows how to use his charm to get things he wants from people, even though he has no understanding of why people respond as they do to his faked charm.
- His inner monologue, that is heard by the viewing audience, is a frequent reminder that he is not entirely human. He often internally comments that he cannot fully understand the meaning of concepts like "love" and has difficulty understanding other people's emotions and behaviors. Admits that he is a monster and must follow a code of behavior so that his dark deeds are not discovered.
- Different from Hannibal and Patrick Bateman is that there are reasons and hints given as to why Dexter is a "monster" (psychopath). The show implies that the brutal death of his mother set in motion the monster that he would become, thus socialization played a part in his becoming a psychopathic serial killer. The show also repeatedly indicates that Dexter was born

the way he is. The death of his mother may have accelerated the process, but he was going to become what he is regardless of any socialization factors.

- Something that makes Dexter different from other psychopaths is that he has a moral code, albeit a very twisted one. He strives to only kill bad people (e.g., pedophiles or murderers). This makes one wonder, are there psychopathic serial killers at large, similar to the fictional Dexter, that believe they are making the world a better place by eliminating people that do bad things?
    - There is a quote at the end of the following clip that perfectly illustrates that Dexter has something physiologically different about him than most people: “I see their pain…I just can’t feel their pain.” He can recognize pain in others, but he cannot mentally experience what they are going through; he is unable to empathize. The video briefly shows and describes some of the things that exhibit that Dexter is a psychopath.
        - Dexter Trailer

Real-life Example of a Psychopath

John Wayne Gacy


John_Wayne_Gacy_as_Pogo_the_Clown

- Effectively charmed people in a superficial manner (Lilienfeld & Arkowitz, 2007). Gacy effectively blended in for awhile by serving as a chaplain, being helpful towards his neighbors, entertaining youths by dressing up as a clown named “Pogo,” and even managing to get married and have children (Chua-Eoan,1979).
- Extreme lack of remorse and presence of empathy (Lilienfeld & Arkowitz, 2007).
- Gacy took the lives of between 28-32 (28 confirmed) young males. Twenty-eight of them that he killed he buried in the crawl space beneath his home. Claimed to have tossed the four other bodies into a river (Chua-Eoan,1979).
- Enjoyed toying with his victims by teasing them by handcuffing them and not letting them get out of the cuffs (Chua-Eoan,1979).
- It is probably fair to assume that he had a high need for excitement since he killed such a large number of people.
    - In the following clip, Gacy discusses his knowledge of how to tie a tourniquet knot in a rope. He discusses this calmly and even jokes with the interviewer. Gacy appears to be a reasonably normal person in the video, seemingly just discussing his knowledge about tying a type of knot in a rope. As the video points out at the end, the knot type he discusses is the same type of knot found in ropes tied around his victims’ necks; he did not even bother to remove the ropes he used for strangulation before he buried the bodies. This video is a small sample of a psychopath speaking and behaving, but it shows that they can quite easily present as a normal human being.
        - John Wayne Gacy Interview

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6.40: Mood Disorders

Athletes, unlike nonathletes, do not show major changes in thier mood. Instead they are show signs in their preformance, such as decreased energy, poor performance, and dissatifaction with in their performance. It is very important for the sports medicial 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 arent many studies the show who, females or males, more more prone to the disorder. However, in a general population, woman are more likely then 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 conentration and a feeling of hopelessness.
- ***Bipolar Disorders:*** are characterized by manic and depressive episodes.
  - Althought 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. Howver, 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 mad 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



Pete Harnisch



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image

Ilie Nastase



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6.41: Anxiety Disorders

For most atheletes, performance comes easy on and off the field. However there are some athletes do well in practice and once a game day approahes 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 Generalixed Anxiety disorder(GAD), panic disorder, social anxiety disorder, post tramutic stress disorder (PTSD) or obession complusion 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,a nd half of them have reacurrent 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 he 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 wherther 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 ritals they go through. Those with a "pracitice makes perfect" attitude are twice as likley 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 then non-athletes because several things are happeing 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 athletes.
    - 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, AHDH 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 interfee 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.
    - Treatment includes stimulats 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.



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



David Beckham



These sports above, are consider good for an athlete with ADHD because it requries about of energy.

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6.42: Pedophilia (302.2)

DSM-IV-TR criteria

- The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.
- The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children (generally age 13 or younger)
- Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old
- The person must state whether they are:
  - Sexually attracted to males
  - Sexually attracted to females
  - Sexually attracted to both males and female
- Must specify if:
  - Limited to incest
- Must state whether:
  - Exclusive Type (aroused only by children)
  - Nonexclusive Type

Associated features

- Recurring sexual dreams, behaviors, or urges concerning children that are 13 years old or younger. These urges may be directed toward children of the same sex as the pedophiles, or the other sex. Some pedophiles are attracted to both boys and girls. Some are attracted to to only children, while others are attracted to children as well as adults. These issues must be persistent for at least 6 months and must cause impairment to everyday functioning to be considered symptoms. If an individuals is 16 years old and exhibits these behaviors with someone that is at least 5 years younger, he would be considered for this disorder.
- To be diagnosed as having Pedophilia, the individual must be at least 16 years of age. The disorder typically begins in adolescence, although some individuals with Pedophilia report that they did not become sexually aroused by children until middle adulthood.
- Pedophiles may limit their activity to exposing themselves to the child (sometimes known as flashing), touching and fondling the child gently, undressing the child and looking at him or her, or masturbating in front of the child.

Gender and cultural differences in presentation

- The word “Pedophilia” is derived from the Greek words “paidos” (child) and “philia” (love). Until recently, pedophilic individuals had found it relatively easy to gain access to unattended children. Awareness of Pedophilia has been raised in the past two decades, and it has become more difficult for these individuals to find children with whom to act out their fantasies. In response to the scarcity of vulnerable children, many pedophiles have turned to chatrooms and child pornography.
- Males are more often diagnosed with this disorder than women. Pedophilia is more prevalent among Caucasians than among other ethnicities. It is also known that if a male prefers males, it is more likely that he will repeat his pedophilic actions. This has led certain religious or otherwise radical activists to suggest that pedophilia and homosexuality are “one and the same,” resulting in further media attention to an already well-covered topic.
- One of the biggest issues in assessing behavior as pedophilic or normal is the criteria for Pedophilia; by Western standards, certain cultures (e.g. Islamic) would have higher prevalence of Pedophilia. Some cultures allow “child weddings,” or unions between mature males and prepubescent females. In some tribal societies in Africa, pedophilic behavior is considered perfectly normal; men often take “boy-wives” in addition to wives. The men engage in sexual activity with these boy-wives until it is deemed time for the young boy to choose a wife of his own. At this point, the boy’s “husband” will then aid him in choosing a wife, and the boy will be allowed to leave to start a family of his own. Clearly, it is important to note any religious or cultural backgrounds in individuals being examined as having Pedophilia. This is a very difficult situation, as some groups have voiced the concern that any pedophile can simply convert to a belief system that accommodates and excuses his behaviors
- Islamic Sharia law

Epidemiology

- There is very little known about the prevalence of Pedophilia at this time because, due to the severely negative stigma associated with having Pedophila, many people with Pedophilia rarely seek help from a mental health professional. The ratio of sex offenders against female children and sex offenders against male children is about 2:1. According to data in a (1987; 1988) study, sexual offenders against males have many more victims than those against females. Sexual offenses against female children have a rate of 19.8, while sexual offenses against male children are at a rate of 150.2. Since there is a higher rate of sexual offenders against male children, this may suggest that this group has a greater number of true pedophiles.
- Note: The large commercial market in pedophiliac pornography suggests a much higher prevalence than the limited medical data indicates

Etiology

Some researchers feel that it is due to biological factors, that one of the male sex hormones predisposes men to be more sexually deviant; however, according to a 2002 study there is no evidence of any link between genetics and Pedophilia. Others suggest that pedophilia results from certain psychosocial factors (e.g. being sexually abused as a child, or the nature of one's familial interactions). Still others invoke factors such as the following: anomalies in psychological development, the desire to overpower sexual partners, and the belief that sex is a necessary requisite for affection.

Empirically supported treatment

- There are multiple treatment options for those individuals that are considered to have Pedophilia. The first one is cognitive behavioral therapy. This is a relapse prevention program that has been shown to reduce recidivism.
- Another option is behavioral interventions. This helps suppress sexual arousal of children and turn it more toward adult arousal. However, it is currently not known if the method changes sexual interest or if it just changes the ability to control erections during testing.
- Medication is also used in some cases. The three classes of medications most often used to treat pedophilia (and other paraphilias) are: female hormones, particularly medroxyprogesterone acetate, or MPA; luteinizing hormone-releasing hormone (LHRH) agonists, which include such drugs as triptorelin (Trelstar), leuprolide acetate, and goserelin acetate; and anti-androgens, which block the uptake and metabolism of testosterone as well as reducing blood levels of this hormone. These hormones are sometimes prescribed to divert intrusive sexual thoughts, urges, or abnormally frequent sexual behavior. Although medication may seem like a good option, it almost always must be long term to be fully and completely effective.
- Relapse- Pedophilia is typically chronic in nature, but the fantasies and behaviors associated with Pedophilia tend to decrease with age (as is the case with any sexual activity).
- Surgical castration is sometimes offered as a treatment to pedophiles who are repeat offenders or who have pleaded guilty to violent rape.

Prognosis

- The prognosis of successfully ending pedophilic habits among people who practice pedophilia is not favorable. Pedophiles have a high rate of recidivism; that is, they tend to repeat their acts often over time.
- The rate of prosecution for pedophiles through the criminal justice system has increased in recent years. Pedophiles are at high risk of being beaten or killed by other prison inmates. For this reason, they must often be kept isolated from other members of a prison population. Knowledge of the likelihood of abuse by prison personnel and inmates is not, however, an effective deterrent for most pedophiles.

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6.43: Personality Disorders

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 insiststance on being the object of admiration and attention



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6.44: Eating and Body Dysmorphic Disorders

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 extermes 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.
    - Calucating 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 wheter 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 fluxuations 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 periodls of uncontrooled, impulsive or continuous eating beyond the poine of feeling comfortably fully. Althought 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 intead 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 Dysmorphis is common mainly amoug 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 percieved apperance 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 inperfections 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 piblic 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 mirroe, 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 Serotoin reuptake inhibitors or antidepressants that decrease the obsessive and compulsive behaviors.
    - Cognitive behavioral therapy**,** which is a three step process.

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6.45: Substance Abuse Disorders

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 femles include:
  - Acne, really bad acne, especially on face and back
  - Baldness
  - A slow down of growth in athletes who aren't done growing yet
  - 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?



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=192

https://youtu.be/fmu_h8HCiGo

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6.46: Expressive language disorder (315.31)

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.

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6.47: Mental Retardation

Name: Carla Tate
Source: *The Other Sister* (movie, 1999)

Background Information

Carla Tate is a Caucasian female around the age of 18-20 (her age was not specified.) She currently has no job, but is attending a vocational school called Bay Area Poly Technical school, and only took one class, Computer 101, which she passed. A lowered intellectual quotient (IQ) and slower processing overall characterize her mental health. No drug or alcohol usage has been reported or detected. Tate recently moved out of her parent's house and into her own apartment, although her parents pay for it. She seems to have a very healthy family structure overall. She comes from an upper socioeconomic status. She has two sisters, whom she frequently talks to, and a mother and father that are still married. Her father seems passive and very supportive to Tate. In contrast, Tate reports and it has been witnessed that Tate's mother is very controlling and overly protective. Tate complains that her mother inhibits her freedom and does not allow her to try new activities. Although this causes self-reported strain in their relationship, Tate still says she is close to her mother. Tate is very social and seems to have a positive base line of friends. Her goal is to become a veterinary assistant in the future and continue to gain freedom from her controlling mother. Her daily activities include going to her classes and spending time with her significant other and family.

Description of the Problem

Tate currently has a lowered IQ (probably around 70, although further testing would be necessary) and impaired cognitive processes. Her mother and father report that these symptoms were also present in early childhood. She also displays impaired social behaviors by violating social norms and over sharing. Tate's physical condition is very healthy. She is in her weight class for her height. She has not reported physical problems and none have been observed. Her mood is very positive and open. However, she sometimes displays rapid mood swings and quickly gets upset at what most view trivial things.

Diagnosis

Carla Tate appears to meet the criteria for mild mental retardation (317.0).
A. Significantly sub-average intellectual functioning: An IQ of approximately 70 or below on an individually administered IQ test. For infants, a clinical judgment for significantly sub-average intellectual functioning.
Although not specifically told, Tate has been diagnosed with a lowered IQ because she went to a certified school for individuals with lowered IQ.

2. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas:
1. Communication
2. Self-care
3. Home living
4. Social/interpersonal skills
5. Use of community resources
6. Self-discretion
7. Functional academic skills
8. Work
9. Leisure
10. Health
11. Safety

Tate displays a deficiency in communication when she is upset especially. Her words become slurred and rapid. She also qualifies for social and interpersonal skills impairment. Although she is an outgoing individual, she sometimes misinterprets situations. She also acts out and causes scenes in socially inappropriate places. Overall, she takes direction well, but she often misunderstands what the instructions are if they are not given to her very simplistically. Her functional academic skills are also impaired. Although Tate does attend Bay Area Poly Technical School, she struggles to keep up with the other students, and can only master basic concepts. Although no tests have been conducted, her IQ is estimated to be around 70. Tate also currently does not maintain

employment at any job. Although Tate is relatively safe, there have been past reported incidences by her mother and Tate herself, of inflicting harm on other children by accident and setting accidental fires, which falls under safety. Tate does meet the criteria for mild retardation, which she has been diagnosed with and treated for in a special school, but she is relatively normally functioning in day-to-day life.

B. Onset before the age of 18

Tate's parents were alerted of her learning difficulties and social impairments around the age of 8 or 9 (no specific age was given.) She was sent to a special school soon after
because her parents felt they could not help her adequately.

C. Stable IQs from early in life to adulthood

As reported by her mother, Tate has maintained a longitudinal average of a lowered IQ from her early childhood to present.

Accuracy of Portrayal

The average person watching this movie would automatically be able to diagnose Tate as someone who is mentally retarded. However, many individuals do not understand that different levels of mental retardation exist based on IQ scores. Although mild retardation is the most common level of retardation, accounting for 65-75% of all diagnoses of mental retardation, most of the population lump all forms of mental retardation together. Another fallacy which might be correct with an everyday person watching this movie is understanding that although mentally retarded individuals are limited in some of their functions, they can become with supportive help, a very productive member of society. One possible misconception the movie might give viewers is the idea that mentally retarded individuals normally come from a higher SES and often have people to take care of their needs. However, statistically most people with a mental handicap, especially people with mild retardation, come from a low SES neighborhood. They often become homeless or wards of the state because of lack of specialized training and education.

Treatment

There is no cure for mental retardation. The goal of treatment is to maximize her potential in every area of life despite her mental condition. Special teachers and programs intervention at the youngest age possible is recommended, which she received. Tate should be trained not only in life skills and academic areas at her level, but also in social skills and self-control. Family therapy should also be conducted to help the family better understand her condition and to help her family better know what are the most effective ways of dealing with her. They should also be informed of her abilities and limitations. Tate is a highly functioning female with mental retardation, and therefore, needs less care from her family. However, because her mother is slightly controlling, it limits Tate's autonomy, which is very essential for all humans, especially for someone with mental retardation. This situation should be addressed and healthy boundaries should be agreed upon among Tate, her mother and the therapist. Autonomy will allow Tate to develop to her full potential and has shown great success in the past with other similar patients.

Name: Charles Gordon
Source: *Flowers for Algernon* (movie, 2000)

Background Information

The main character of this movie is Charlie Gordon, a mentally challenged 32-year-old man, with an IQ of 68, who works at a bakery as a delivery boy and moonlights as a janitor. He also attends the adult school for the mentally retarded at night after work. Charlie is a simple man with simple goals. One of his goals in life is for people to like him. When Charlie was little, his mother and father abandoned him shortly after they discovered that he is mentally challenged. Charlie was put in a foster home when he was merely a child. When he is old enough to make a living, he moves out and lives by himself in a deteriorated apartment in the middle of a suburban area, a place that he could afford. Isolated and alone since childhood, Charlie yearns for close relationships; as a result, it is no surprise that he wants to be liked and wanted. For example, occasionally at the work place, he would act like a clown (e.g., pretend to slip and fall, put flour on his nose, make funny faces, etc.) in hope to make his coworkers laugh because he thinks that they like him and are his "friends" but, alas, little does he knows that they are not laughing with him but at him.

One day at the adult school, his special education teacher, Ms. Kinnian –who is very impressed with his free-spirit, friendliness, and curiosity to learn –tells him about the brain-operation experiment, an experiment that promises to make people like him smart. Charlie immediately signs up for the experiment because he feels that if he is smart then maybe people would like him more. After the controversial experimental brain surgery, Charlie's IQ increases at an exponential rate, tripling his original IQ at 185. With Ms.

Kinnian's guidance, Charlie also learned to read advanced level books, such as *Robinson Crusoe*, mathematical quadrants, etc., and write in comprehensive sentences, as demonstrated in his "progris riports."

Shortly after the brain-operation, Charlie explores his inner feelings and emotions, such as betrayal, jealousy, love, and pain that he never thought he had. He begins to understand the world around him. For example, after the brain surgery, he begins to understand that his coworkers aren't really his real friends after all because real "friends" would not invite you to bars and poke fun at you in front of everyone for good laughs. In addition, before the brain-surgery, he never knew he could fall in love and reciprocate his feelings. But as time goes by, his feelings for Ms. Kinnian develop. Alas, the ephemeral love between Ms. Kinnian and Charlie does not last. The movie ends with Charlie telling Ms. Kinnian goodbye the day he learns that the experiment would not work and that he would have to go back to being the mentally challenged man that he once was. Before the reversal of his intelligence, while he is still able to think and make decision, Charlie moves far away to another place to live, a place where Ms. Kinnian cannot find him.

As a man who is mentally challenged, Charlie has many difficulties and challenges in life. As you can see, his life difficulties involve deficits in intellectual abilities and functioning, such as the ability to read, write, and speak in coherence sentences. He may have learning disabilities, such as Written Expression (as demonstrated in his "progris riports"), Reading Disorder, and more. He also has difficulties in establishing interpersonal and social relationships because he does not have the ability to read facial cues and expressions. Little is known about his family mental health history. Charlie does not seem to have drug or alcohol problems. He also does not seem to have physical impairments, but mostly psychological and cognitive impairments.

Description of the Problem

Life is already hard, and life is even harder if you have Mental Retardation. As demonstrated in the movie *Flowers for Algernon*, Charlie shows significant limitations in intellectual functioning, such as not being able to read, write, and communicate coherently. He demonstrates maladaptive symptoms, such as emotional deficits and interpersonal problems. He does not seem to have sensory symptoms. His sensory modalities work fine. He can work and make a low profile and honest living as a delivery person and janitor at the bakery. He is not physically handicapped or in any way.

From the movie, Charlie is a mentally challenged man with an IQ of 68 and the symptoms that he shows qualify him for Mild Mental Retardation (MMR), which will be discussed in the diagnosis section. He is portrayed as a care-free and happy person, whose personality is almost childlike. He is not passive, placid, dependent, nor aggressive. He does not have severe nor profound mental retardation and he does not depend on anyone to dress for him or take care of him. But he does show signs of lack of communication skills, developmental delays, social and emotional deficits, impaired ability to solve or understand social problems and issues, and impaired ability in recognizing emotion in others. His academic performance is also affected by his mental delays; as a result, he goes to the adult school for the mental retarded instead of going to college. He can adapt easily at his working place, such as working as a delivery boy, janitor, and running errands, except that he does not have the capability to use a dough mixing machine, which requires the ability to follow instructions. The symptoms that Charlie has qualify him for MMR. He does not have self-injurious behaviors or stereotypical movements.

Overall, Charlie can function adequately at a slow pace environment, an environment that does not require higher order thinking and decision making abilities.

Diagnosis

Charlie Gordon meets the criteria for mild mental retardation (317.0) using the criteria from the DSM-IV-TR:

A) Significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test.

Gordon has an IQ level of 68 since childhood. This qualifies him as having significantly sub-average intellectual ability.

B) Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her culture group) in at least two of the following areas: (1) communication, (2) self-care, (3) home living, (4) social/interpersonal skills, (5) use of community resources, (6) self-direction, (7) functional academic skills, (8) work, (9) leisure, (10) health, and (11) safety.

Gordon meets more than two symptoms of the above areas. He has problems in (1) communication, (4) social/interpersonal skills, (6) self-direction, (7) functional academic skills, and (9) leisure. He does not have deficits in (3) home living, (5) use of community resources, (8) work, (10) health, and (11) safety.

C) The onset is prior to 18 years of age.

Gordon has shown signs of mental retardation since childhood. The onset must be before the age of 18; hence, he also meets this criterion.

Accuracy of Portrayal

The movie does a good job in describing someone with mental retardation, especially a man with mild mental retardation. This movie was adapted from the original novel, *Flowers for Algernon*, written by Daniel Keyes. Keyes knew what he was doing when he was writing this novel. He had worked at many mental retardation facilities and had worked as a special education teacher before he wrote this novel. With the skills and trainings that he developed, he was able to describe in details the behaviors that he had observed from his students with mental disabilities, such as how they talk, write, associate with others, and so on. A person watching this movie would not be misled but be persuaded by the information that this movie provides and how it accurately portrays someone with this mental disorder. A person watching this movie would also get to learn more about MMR and the symptoms that a person with this disorder has.

Treatment

Currently, there is no cure for mental retardation. Mental disorder are an enduring and pervasive disease (which is why it is listed on Axis II), but several empirical supported studies show that therapy, special education and training, and social skill training can help ease the symptoms of mental retardation. Mental Retardation is not an easy disorder to treat since it is related to genetic factors, such as irregular genes or genes that did not fuse together properly (i.e., Down syndrome), and environment factors (e.g., infections, chromosomal abnormalities, metabolic, and nutritional, especially for persons with low socioeconomic status [SES]). It is also important for a trained specialist to evaluate the person for co-morbidity with other disorders, such as Attention-Deficit/Hyperactivity Disorder, Mood Disorders, Pervasive Developmental Disorders, Stereotypical Movement Disorder, Down syndrome, Fragile X, and more since these disorders may also affect the diagnosis and outcomes. The prognosis depends on the severity of the disorder, such as mild, moderate, severe, and profound. The less severe the levels and the early the treatment, the better the outcomes. Many people may lead productive lives and function on their own; whereas, others need a structured environment to be most successful.

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6.48: Mixed Receptive-Expressive Language Disorder (315.32)

DSM-IV-TR criteria

- A. The scores are obtained from a battery of standardized, individually administered measures of both receptive and expressive language development which are substantially below those obtained from standardized measures of nonverbal intellectual capacity. Symptoms include those for Expressive Language Disorder as well as difficulty understanding words, sentences, or specific types of words, such as spatial terms.
- B. The difficulties with receptive and expressive language significantly interfere with academic or occupational achievement, or with social communication.
- C. Criteria are not met for a Pervasive Developmental Disorder.
- D. If Mental Retardation then a speech-motor, 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 or sensory deficit or a neurological condition is present, code the condition on Axis III.

Associated features

- The essential diagnostic feature of Mixed Receptive-Expressive Language Disorder is a disability found in the development of both the receptive and expressive language as demonstrated by standardized testing that is individually administered and measures both receptive and expressive language development. The scores are significantly below the standardized measures of the nonverbal intellectual capacity as in Criterion A. When unable to or inappropriate to do standardize testing, the diagnosis can be based on a methodical practical assessment of the person's language ability.
- The language difficulties in communication may involve verbal and sign language. The difficulties with the communication hinder the academic or occupational achievement and social communication in accordance with Criterion B, and the symptoms do not meet the criteria for Pervasive Developmental Disorder as with Criterion C. Criterion D gives one more feature which is that if Mental Retardation, a speech-motor or sensory deficit, or environmental deficiency are present, the language difficulties are in excess. If a speech-motor or sensory deficit or a neurological condition is present, the disorder is coded on Axis III.
- An individual diagnosed with Mixed Receptive-Expressive Language Disorder has the same difficulties as someone diagnosed with Expressive Language Disorder, but also has difficulties with understanding words, sentences, or specific types of words, which is receptive language development. There are milder cases where there are only difficulties with understanding particular types of words like spatial terms or with statements such as complex sentences. The more severe cases may have multiple disabilities.
- These disabilities include an inability to understand basic vocabulary and/or simple sentences, along with a deficiency in the discrimination of sounds, association of sounds and symbols, recollection, storage, and sequencing. The development of expressive language in children depends on the acquisition of receptive language skills, therefore it is hardly ever seen that a child will be diagnosed with a pure receptive language disorder.
- The linguistic features of Mixed Receptive-Expressive Language Disorder in the production impairment are quite similar to Expressive Language Disorder as previously stated. It is comprehension that distinguishes Mixed Receptive-Expressive Language Disorder from Expressive Language Disorder. The comprehensive distinguishing feature varies depending on the severity of the disorder and the age of the child. Difficulties with language comprehension are not as easily recognizable as language production difficulties. They may only appear under formal observation. The child will show poor or nonexistent conversational skills, may seem to follow directions incorrectly or not at all and give inappropriate answers to questions asked of them.

Child vs. adult presentation

Acquired Mixed Receptive-Expressive Language Disorder is seen at any age. Developmental Mixed Receptive-Expressive Language Disorder is seen in children with a normal onset at or around age 4. Severe forms of Mixed Receptive-Expressive Language Disorder can be detected by age 2. The milder forms may not be detected until the child reaches school where comprehension problems become more apparent.

Gender and cultural differences in presentation

The developmental type is more prevalent in males than in females. Prevalence estimates vary with age. When doing the assessment of the disorder, the cultural and language context must be taken into account. This is especially important in bilingual environments. The standardized measurements of the language development and nonverbal intellectual capacity have to be relevant for cultural and linguistic groups.

Epidemiology

- Other disorders that are associated with Mixed Receptive-Expressive Language Disorder include Phonological Disorder, Learning Disorders, and deficits in the perception of speech and impairment of memory. In addition, Attention-Deficit/Hyperactivity Disorder, Developmental Coordination Disorder, and Enuresis are sometimes present in the developmental type. Mixed Receptive-Expressive Language Disorder is occasionally accompanied by EEG abnormalities, and other neurological signs.
- Acquired Mixed Receptive-Expressive Language Disorder can happen at any age. A form of acquired Mixed Receptive-Expressive Language Disorder has an onset of 3-9 years of age. It is accompanied by seizures and referred to as Landau-Kleffner syndrome.
  The prognosis of acquired Mixed Receptive-Expressive Language Disorder depends on the severity of the brain damage and the location of the damage. It also depends on the extent of the language development when the disorder is acquired.
- The developmental Mixed Receptive-Expressive Language Disorder has its onset as previously stated beginning at or around the age of four. There is an estimate of the developmental type of Mixed Receptive-Expressive Language Disorder that occurs in up to 5% of preschool children and 3% of school-age children. It is essentially less common than Expressive Language Disorder, Landau-Kleffner syndrome and the other forms of acquired Mixed Receptive-Expressive Language Disorder.
- Severe forms of the developmental Mixed Receptive-Expressive Language Disorder have their onset by 2 years of age. The milder forms may not be detected until the child reaches elementary school. A child who has Mixed Receptive-Expressive Language Disorder will eventually acquire normal language skills, but the prognosis for those with Expressive Language Disorder is worse.
- Developmental Mixed Receptive-Expressive Language Disorder is more common with first-degree biological relatives with the disorder than the general population. The acquired Mixed Receptive-Expressive Language Disorder has no evidence of familial ties.

Etiology

- Mixed Receptive-Expressive Language Disorder can either be acquired or developed. Developmental Mixed Receptive-Expressive Language Disorder does not have a known cause. Research is being conducted to determine if the cause is biological, environmental, or both. Malnutrition during pregnancy probably plays a major role in developmental Mixed Receptive-Expressive Language Disorder.
- Acquired Mixed Receptive-Expressive Language Disorder is generally caused by an injury to the brain. The injury to the brain can be either direct trauma such as head injuries or indirect trauma such as strokes, or seizures. Acquired Mixed Receptive-Expressive Language Disorder is commonly misdiagnosed as a Developmental Disorder. Developmental Mixed Receptive-Expressive Language Disorder and other receptive language disorders start showing symptoms beginning around the age of four.
- The specific symptoms of acquired Mixed Receptive-Expressive Language Disorder depend on which area of the brain received damage, and also on how severe the damage is.
- The symptoms for developmental Mixed Receptive-Expressive Language Disorder are extremely similar to the symptoms of Expressive Language Disorder. The symptoms vary considerably from child to child. Generally speaking, Mixed Receptive-Expressive Language Disorder is characterized by a difficulty with spoken communication. The child can pronounce the words, unlike Phonological Disorders, but has problems with coherent syntax, the usage of proper grammar, and word recollection.
- A child who is diagnosed with Mixed Receptive-Expressive Language Disorder has trouble communicating his or her thoughts, needs, and what he or she wants at the same level or same complexity as other children the child's age. The child generally has a smaller vocabulary as well.

Empirically supported treatments

- There can be complete or nearly complete clinical improvement in language abilities. There are some instances that may have incomplete recovery or progressive insufficiency. Mixed Receptive-Expressive Language should be treated as soon as you reach a diagnosis. Clinical improvement is more likely with early intervention.
- Treatment involves anyone who interacts regularly with the child diagnosed with the disorder. One-on-one treatment regularly scheduled, that focuses on specific language abilities can be effective. Pair the one-on-one treatment with a more general approach with family and caregivers is more effective.
- Teaching the child specific communication skills for interaction with his/her peers is extremely important. This could avoid problems later in life like social isolation, depression, and/or behavioral problems. Teaching the child reading skills will benefit the child to avoid serious long-term academic problems.

Christian age four diagnosed with Mixed receptive-Expressive language disorder. See video:

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6.49: Stuttering (315.31)

DSM-IV-TR criteria

- A. Disturbance in the normal fluency and time patterning of speech (inappropriate for the individual's age), characterized by frequent occurrences of one or more of the following:
  1. Sound and syllable repetitions
  2. Sound prolongations
  3. Interjections
  4. Broken words (e.g., pauses within a word)
  5. Audible or silent blocking (filled or unfilled pauses in speech)
  6. Circumlocutions (word substitutions to avoid problematic words)
  7. Words produced with an excess of physical tension
  8. Monosyllabic whole word repetitions (e.g., "I-I-I-I see him")
- B. The disturbance in fluency interferes with academic or occupational achievement and with social communication.
- C. If a speech-motor or sensory deficit is present, the speech difficulties are in excess of those usually associated with these problems.

Associated features

- When stuttering first comes about, the affected individual may not realize there is a problem. After time goes on, most people with stuttering issues will realize there is a problem; some may begin to fear that they will stutter in front of others. To avoid embarrassment, a person with a stuttering problem may try to create ways to avoid stuttering. They might avoid speaking in front of a crowd where they know they would become more anxious and more likely to stutter. They could also change the way they speak. Slowing down the rate of speech would make pauses less noticeable and drawing out certain words wouldn't be as obvious either if all words were spoken at a slower pace.
- In extreme cases, a person may choose to avoid social contact entirely in order to prevent occurrences where they now some form of stuttering will occur regardless of what precautions they may take.
- Stress makes stuttering more likely to occur. The anxiety about stuttering can lead to several other issues with social functioning. Self-esteem in individuals with a stuttering problem is typically lower than the "normal" population who have less issues with social communication. Nervous twitches may arise in those who stutter such as eye blinks, tics, tremors, and other "twitches" non of which are uncommon.

– Other people may try to hide their unorthodox speech from others by rearranging the words in their sentence (***circumlocution***), pretending to forget what they wanted to say, or declining to speak.

Child vs. adult presentation

- The presentation of stuttering in children and adults is very similar; however, the manner in which it affects their lives can be quite different. In children and adults, stuttering can create a major impairment of social functioning.
- In adults, this impairment may also carry over into the work place. Stuttering can limit career options for adults, considering occupations dealing with frequent speaking in front of groups could cause considerable distress or anxiety to an individual who stutters. Stuttering could also limit opportunity for job advancement.
- In children, stuttering causes more of an issue in peer communication.

Gender and cultural differences in presentation

- Stuttering is much more frequently diagnosed in males than in females. According to the DSM, for every female diagnosed with stuttering, there are approximately 3 males diagnosed. Other sources indicate that this ratio may actually be 4:1 (Stuttering).
- While there are no known cultural differences in presentation, it may be possible to avoid being diagnosed with stuttering throughout different cultures due to different languages that may disguise the symptoms of stuttering,

Epidemiology

The prevalence of stuttering in children is approximately 1%. This falls to 0.8% in adolescence. 98% of cases of stuttering occur before age 10. The onset of stuttering typically occurs during the period of greatest language development in which individuals

move from simple words and phrases to more complex ones. Later acquisition of the condition may be caused by brain lesions via strokes or other injuries in the speech-governing areas of the brain.

Etiology

- Research has shown many individuals have a predisposition to stuttering. Research with twins have demonstrated that if one twin suffers from stuttering, the other is more likely to suffer from it.
- The exact cause of stuttering is not known, because there are many brain mechanisms that may be involved in the process. Congenital brain damage has been implicated as well. There are also external causes that can contribute to the onset of stuttering.
- Children who have negative experiences with stuttering may develop further problems with speech and communication. If stuttering doesn't create any social discomfort for the child, they may correct the behavior themselves. Different people have different degrees of stuttering that cause different problems in social situations.
- Some recent studies have shown that genetics play a role in stuttering. Some people inherit traits that put them at a higher risk level for developing a stutter.

Empirically supported treatments

Medicinal treatments for stuttering are not the usual route, since the exact cause of stuttering remains unknown. Instead, behavioral treatments are utilized to try and correct the patient's stuttering. In these treatments, patients are taught how to control the way, speed, and overall manner in which they communicate (Stuttering). Treatments in speech are limited but can be done if the patient is committed and willing to work with their impairment. A person may also be taught how to control or monitor their breathing as a way of helping as well.

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6.50: Selective Mutism (313.23)

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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6.51: Phonological Disorder (315.39)

DSM-IV-TR criteria

- A. Failure to use developmentally expected speech sounds that are appropriate for age and dialect (e.g., errors in sound production, use, representation, or organization such as, but not limited to, substitutions of one sound for another [use of /t/ for target /k/ sound] or omissions of sounds such as final consonants).
- B. The difficulties in speech sound production interfere with academic or occupational achievement or with social communication.
- C. If Mental Retardation, a speech-motor or sensory deficit, or environmental deprivation is present, the speech difficulties are in excess of those usually associated with these problems.

Coding Note: If a speech-motor or sensory deficit or a neurological condition is present, code the condition on Axis III.

Associated features

- Knowing and learning the various aspects of speech rather than being unable to physically pronounce words are the signs of a phonological disorder. For example, a child with a phonological disorder may not know a word whereas a child with an articulation disorder knows the word but is unable to get their articulators to shape the word so that they can say it.
- According to the American Speech-Language-Hearing Association, signs of a phonological disorder "involve patterns of sound errors. For example, substituting all sounds made in the back of the mouth like "k" and "g" for those in the front of the mouth like "t" and "d" (e.g., saying "tup" for "cup" or "das" for "gas")." (http://www.asha.org)
- Young children expectantly leave out sounds when they are learning to speak, especially when pronouncing words that begin with two consonants, such as the word spoon, but as the child gets older, these problems should dissipate. If they do not, the child could be showing signs of a phonological process disorder. Person's with phonological disorders are presumed to experience difficulty acquiring the rules that underlie speech. (Bleile, 2003)

Child vs. adult presentation

- Phonological disorder is most commonly a childhood disorder. If a child's speech is not easily understood by non-family members by the age of 4, a phonological disorder may be present. Most will grow out of the disorder by third grade, but spontaneous recovery becomes less likely after the fourth grade (around age 8).
- In severe cases, the disorder may be unremitting through adulthood. Children who misarticulate only a few phonemes are more prone to a spontaneous recovery. If articulation problems are still present after the age of 5, children are at higher risk for auditory problems.

Gender and cultural differences in presentation

- Taking dialect features into consideration is important so that the patient is not misdiagnosed. Bilingual phonology is a field that there is not enough knowledge in.
- Currently bilingual children are assessed using monolingual standards. According to the MIT encyclopedia of communication disorders,
- Nearly two-thirds of Children under the age of 18 who are diagnosed with speech-language disorders are male. Communication disorders are twice as likely to be diagnosed in males age 45 and younger than in females. African Americans younger than 45 and of the same age are one-third as likely to be diagnosed as Caucasians. (Bleile, 2003)

Epidemiology

Phonological and Articulation disorders compose nearly 32% of the communication disorders. Six million children under the age of 18 are estimated to have a language disorder. According to Arsano, et al. (2008), approximately 20% of pre-school aged children and 6% of school aged children are affected by phonological disorder. The prevalence rates decrease as age increases.

Etiology

- According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), "Phonological Disorder includes phonological production (i.e., articulation) errors that involve the failure to form speech sounds correctly and cognitively based forms of phonological problems that involve a deficit in linguistic categorization of

speech sounds (e.g., a difficulty in sorting out which sounds in the language make a difference in meaning).” (American Psychiatric Association, 2000).

- Some professionals prefer to distinguish between language knowledge (phonological) and speech-motor control (articulation). Phonological disorder can develop due an environment where the child is abused or neglected, placed in an environment with a bad teacher, or long term hospitalization. Direct physical damage to the brain or body can also be responsible for the development of the disorder.
- A child who presents with another disorder, such as attention deficit disorder (ADD), can suffer indirect physical damage due to the fact that they may not be able to concentrate long enough to acquire complex communication skills. While phonological disorder is usually an isolated problem, occasionally it occurs simultaneously with another medical condition such as cognitive limitations, neurological conditions, hearing impairments, orofacial anomalies, structural deficits of the oral peripheral speech mechanism, psychosocial problems, or respiratory problems.

Empirically supported treatments

- Children who present with moderate to severe disorders are usually recommended for treatment. The two most popular forms of treatment are the phonological approach and the traditional approach. According to Kaplan & Saddock, the phonological approach is for children with extensive patterns of multiple speech sound errors where treatment involves practice of specific sounds and is then extended into using the words in meaningful words and sentences.
- The traditional approach involves speech therapy by a speech-language pathologist (SLP). The American Speech-Language-Hearing Association defines speech-language pathologists as professionals who identify, assess, and provide treatment for individuals with speech, language, and swallowing problems. (http://www.asha.org) They are trained individuals who not only work with the individual experiencing phonological problems, but they also work with the family, teachers, and other professionals involved in the process of correction.
- According to the US Department of Education Institute of Education Sciences, “phonological awareness training is a general practice aimed at enhancing young children’s phonological awareness abilities. It can involve various training activities that focus on teaching children to identify, detect, delete, segment, or blend segments of spoken words (i.e., words, syllables, onsets and rimes, phonemes) or that focus on teaching children to detect, identify, or produce rhyme or alliteration.” (http://www.ed.gov)

Children with phonological disorder believe they are articulating the words they attempt to say although they are not. They often become frustrated when they are told they are not speaking correctly.

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6.52: Rumination Disorder (307.53)

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.

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6.53: Female Orgasmic Disorder (302.73)

DSM-IV-TR criteria

- Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.
- The disturbance causes marked distress or interpersonal difficulty.
- The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition.
- Specify type:
  - Lifelong Type
  - Acquired Type
- Specify type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

Associated Features

The disorder may affect body image, self-esteem, or her relationship satisfaction. Chronic general medical conditions such as diabetes or pelvic cancer have a more likely reason to impair the arousal phase of the sexual response.

Child vs Adult Presentation

There is little information on how this affects children since children are typically not sexually active or mature. It mostly begins in early adulthood. Younger women seem to have this disorder because the ability increases with age.

Gender and Cultural Differences in Presentation

This certain disorder only affects females, although there is a Male Orgasmic Disorder as well. Cultural presentation will be the same as western cultures.

Epidemiology

The epidemiology of Female Orgasmic Disorder varies extensively. Some examples are 10-15% of women had never had an orgasm, 10-15% hardly ever had experienced an orgasm, 50% of women had experienced an orgasm during intercourse, and 10-15% had experienced orgasm difficulty.

Etiology

There is evidence that a traumatic experience likely leads to this disorder. It can also be related to problems in a relationship. Another cause is a pelvic floor prolapse. This is the loosening of the muscles that support the organs. It can be caused by surgery or childbirth.

Empirically Supported Treatments

- Some treatments for Female Orgasmic Disorder are as follows: Developing proper communication skills, sexual aides, behavioral and cognitive therapy, directed masturbation training, and body awareness. These can be developed through sex counseling and therapy.
- There are substance-induced (drug related) sexual dysfunctions for which inhibited orgasm can be the result.

Prognosis

Many women with FOD can be helped to achieve orgasm through a combination of psychotherapy and guided sexual exercises. However, this does not mean that they will be able to achieve an orgasm all of the time or in every situation, or that they will always be satisfied with the strength or quality of the climax. Couples often need to work through relationship issues that have either caused or resulted from FOD before they can see improvement. Working through the problems take time, and commitment from both parties.

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6.54: Tourette's Disorder (307.23)

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-injurous 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 is 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 approprimately 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 McPeek Villatoro as he discusses his and his daughter’s Tourette’s Syndrome.

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6.55: Transient Tic Disorder (307.21)

DSM-IV-TR criteria

- A. Single or multiple motor and/or vocal tics (i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations).
- B. The tics occur many times a day, nearly every day for at least 4 weeks, but for no longer than 12 consecutive months.
- C. The onset is before age 18 years.
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).
- E. Criteria have never been met for Tourette's Disorder or Chronic Motor or Vocal Tic Disorder.
- Specify if: Single Episode or Recurrent.

Associated features

Transient Tic Disorder generally has the same characteristics as Tourette's Disorder, except the symptoms are not as severe. Common associated features with this disorder are depression (loss of pleasure in everyday activities), too much sleep or not enough, guilt (inappropriate feelings of worthlessness that could even be delusional), trouble concentrating, or having obsessions. Brief and jerky movements and sounds tend to be associated with Transient Tic Disorder also.

Child vs. adult presentation

Transient Tic Disorder is presented in children, before age 18 and is usually seen by the pre-school to early school-age, but has been seen as early as 2 years.

Gender and cultural differences in presentation

Transient Tic Disorder, much like the other Tic Disorders, is more common in males than females. The disorder is seen across the map in all ethnic and cultural groups but appears to be more prevalent in Caucasians than African Americans.

Epidemiology

Transient Tic Disorder may not be reported in all cases because the symptoms are short-lived; however, it appears to occur in 4 to 24% of all school-aged children.

Etiology

Although there has been no finding of a "tic gene", the disorder appears frequently within the same families. Genetic factors are definitely thought to be a cause, but environmental factors such as the stress level a child is exposed to as well as the parental method a child is under, could play a role in the cause too. Transient Tic Disorder may also be physical or mental.

Empirically supported treatments

Treatment for Transient Tic Disorder is much like the treatment for all of the Tic Disorders, but in this particular disorder, educating the family is one, if not the most, important thing to do. Physicians will tell the family to ignore the tics in the beginning because the unwanted notice of the tics could reinforce them, causing them to become more frequent. If the tics are bad enough that they are interfering with the child's lifestyle and functioning, behavioral treatments and possibly even pharmacotherapy are suggested.

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6.56: Chronic Motor and Vocal Tic Disorder (307.22)



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=210

DSM-IV-TR criteria

- A. Single or multiple motor or vocal tics (i.e., sudden, rapid, recurrent, non-rhythmic, stereotyped motor movements or vocalizations), but not both, have been present at some time during the illness.
- B. The tics occur many times a day nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months.
- C. The onset is before age 18 years.
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).
- E. Criteria have never been met for Tourette's Disorder.

Associated features

Chronic Motor and Vocal Tic Disorder is more common than Tourette's Disorder. Individuals with Chronic Motor and Vocal Tic Disorder have a very hard time suppressing the urges that a tic can bring. The tension, for most people, can be described as an occurrence that falls in between a voluntary motion and an involuntary motion; similar to the need to scratch an itch, it can be avoided but the tension isn't relieved until a tic takes place. Some common complex motor tics include Copropraxia, (making obscene and inappropriate gestures) and Echopraxia, (mimicking another person's movement). Some common complex vocal tics include Echolalia, (mocking a statement or phrase or noise that was heard most recently) and Coprolalia, (saying something that is vulgar or socially unacceptable).

Child vs. adult presentation

People most often present with Chronic Motor and Vocal Disorder before age 18 and it is rarely diagnosed after the age of 18. If the disorder develops between the ages of 6 and 8, the chances of the individual getting control of the tics and living a normal life are ideal; however, if it is diagnosed later on in life the individual will probably always have to deal with the disorder.

Gender and cultural differences in presentation

This disorder presents itself in all ethnic groups, but is three to four times more common in males than females, and is generally found in children rather than adults.

Epidemiology

Occurring more often than Tourette's syndrome, chronic Motor and Vocal Disorder is prevalent in 1 to 2% of our population. It is less common than transient tic disorder.

Etiology

Heredity plays a large role in the development of Chronic Motor and Vocal Tic Disorder. Tourette's Disorder may also be genetically shared with Chronic Motor and Vocal Tic Disorder because it is often seen in the same families.

Empirically supported treatments

Depending on how severe and how often the tics occur determines the treatment method used. Also, depending on how the tics affect the individual's daily life, such as the distress it causes because of work or school, will depend on the treatment method as well. Behavioral therapy is one approach; this is where things like relaxing techniques and habit-reversal training are taught. Pharmacologic therapy is another approach; here drugs are used to reduce the individuals tics and urges but does not ever completely eliminate them. One last approach is Psychological therapy; counseling is provided to the individual and sometimes even the family, in order to help deal with the social and emotional issues that an individual develops because of this disorder.

Links

The MayoClinic provides a video on Tics that discusses the different types of tic disorders and the characteristics of tics. See video: http://www.youtube.com/watch?v=4OM6pbzVnbQ

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6.57: Developmental Coordination Disorder (315.4)

DSM-IV-TR criteria

- A. Performance in daily activities that requires motor coordination is substantially below that expected given that person's chronological age and measured intelligence. This may manifested by marked delays in achieving motor milestones (e.g., walking, crawling, sitting), dropping things. "clumsiness," poor performance in sports or poor handwriting.
- B. The disturbance is Criterion A significantly interferes with academic achievements or activities of daily living.
- C. The disturbance is not due to a general medical condition (e.g., cerebral palsy, hemiplegia, or muscular dystrophy) and does not meet criteria for a Pervasive Developmental Disorder.
- D. If Mental Retardation is present, the motor difficulties are in excess of those usually associated with it.

Associated features

- Associated features for Developmental Coordination Disorder include clumsiness, awkwardness, speech delay and/or poor coordination skills. Developmental Coordination Disorder all so includes impairments in the development of motor coordination such as playing ball, handwriting, walking, and running. Others have problems with muscle skills such as fastening buttons or tying shoes. Speech- language disorders may be closely linked to Developmental Coordination Disorder, but the reason is unclear right now
- Children with developmental coordination disorder tend to suffer from depression, followed by poor self esteem, and are often disruptive in social and school situations. This is caused by the physical inability to socialize with peers (playing games or sports) and the frequent inability of writing letters, coloring, making sculptures, etc. The child may become so frustrated with the situation that they stop trying and just disrupt the class. Individualized therapy specializing in arts/crafts, writing, and playground skills can alleviate these problems.

Child vs. adult presentation

Children that exhibit Developmental Coordination Disorder has trouble with motor skills development that affects the whole child because some of the associated conditions may include sensory integration disorder, specific language impairment, and also mixed expressive-receptive language disorder. Developmental Coordination Disorder in adults is the same as with children where they have difficulty in motor skills such as hand-eye coordination.

Gender and cultural differences in presentation

There are no known cultural differences for patience that a diagnosis with Developmental Coordination Disorder. However, it is thought that males and females are equally likely to have this disorder, but might be diagnosed more often in males.

Epidemiology

It has been reported that 5-9% of children in the normal population is diagnosis with Developmental Coordination Disorder. Also about 6% between age 5 and 11 have have DCD.

Etiology

The etiology is unclear but it is believed that it is caused by neuronal damage at the cellular level in the receptor system and/or neurotransmitter.

Empirically supported treatments

- There is no known treatment for Developmental Coordination Disorder at this point. Experts would recommend the patient to continue working on there motor skills and motor control with peers, perhaps by going to an occupational therapist. Special education and physical education seem to be beneficial also.

There are different names used for Developmental Coordination Disorder. One of the most common names in the UK is Dyspraxia. This link will take you to a video of a very well-known researcher of this condition and give more information about it. http://www.youtube.com/watch?v=s832Yv-Dbwc

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6.58: Encopresis (307.7)

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.

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6.59: Tourette's Disorder

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 coproplalia, 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.

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6.60: Reactive Attachment Disorder of Infancy or Early Childhood (313.89)

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

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6.61: Pica (307.52)

DSM-IV-TR criteria

- A. Persistent eating of nonnutritive substances for a period of at least one month.
- B. The eating of nonnutritive substances is inappropriate to the developmental level.
- C. The eating behavior is not part of a culturally sanctioned practice.
- D. If the eating behavior occurs exclusively during the course of another mental disorder (e.g., Mental Retardation, Pervasive Developmental Disorder, Schizophrenia), it is sufficiently severe to warrant independent clinical attention.

Associated features

Pica is commonly Associated with Pervasive Developmental Disorders as well as Mental Retardation. Mineral and vitamin deficiencies have been reported in some cases though no specific biological abnormalities have been found. In some cases it is only after general medical complications that Pica comes into attention. Poverty, lack of parental supervision, developmental delay, and neglect can increase the risk for the condition. Pica is considered to be a serious eating disorder that could result in health problems such as lead poisoning, bowel problems, dental injury, and parasitic infections. In order for the action of ingesting these abnormal non-nutritive substances to be considered pica, the actions have to occur for more than one month at a cognitive level that recognizes the abnormality.

Child vs. adult presentation

Pica is more of a young child disorder and can occasionally be seen in pregnant females. This disorder is more commonly observed in children than adults. Pica in children occurs about the same in boys as in girls between the ages of 2 and 3. It can be found in ages younger, but eating items such as dirt, clay, paper, soap, mucus, cigarette butts, etc. are considered normal at a younger age. Pica is observed more in adults with mental retardation around the ages of 10-20 years. More common forms of Pica involve the ingestion of ice.

Gender and cultural differences in presentations

Although no specific data exist regarding racial predilection, the practice is reported to be more common among certain cultural and geographic populations. For example, geophagia (eating of soil) is accepted culturally among some families of African lineage and is reported to be problematic in 70% of the provinces in Turkey. People who live in the tropics, tribe-oriented societies, and in poverty are the places that geophagia is the most common form of pica. Pica is a widespread practice around different many places such as: western Kenya, southern Africa, India, Australia, Canada, Israel, Iran, Uganda, Wales, Turkey, and Jamaica. For instance, in Uganda, they purchase soil only for the purpose of ingestion. In the Unites States Pica is less common than international places; it is a disorder that is often unrecognized and not reported.

Epidemiology

It is estimated that Pica is seen in about 4-26% of institutionalized populations. The prevalence of Pica also increases with mental retardation, with it being high as15% for adults with severe mental retardation.

Etiology

The cause or etiology of Pica has been attributed to various cases, including nutritional, mental retardation or brain damage, cultural and economic, and emotional deprivation. Although specific causes of Pica are unknown, there are some certain conditions and situations that an increase a person's risk for Pica: nutritional deficiencies, dieting, cultural factors, parental neglect, lack of supervision, food deprivation, developmental problems, mental health problems (OCD and Schizophrenia), and pregnancy increase that risk. http://www.pregnancy-info.net/pica.html

Empirically supported treatments

- Sources such as the *Handbook for Clinical Child* Psychology support general behavioral strategies as being the most effective treatment for Pica. This involves specific training for the child on edible versus non-edible foods and positive reinforcement. The primary prevention of Pica is the efforts to remove or alter factors involved in its etiology. It must be directed toward improving the mental health of children in infancy and early childhood."

- The treatment of Pica can be very difficult to treat. Parents are told to encourage children to eat a healthy and balanced diet. Anything that is dangerous and can be ingested should be removed from your home, so they will be not be tempted to ingest those substances. Any nutritional deficiencies should be identified to help with the treatment. “Parents should consider consulting with a behaviorally-trained mental health clinician, as a comprehensive behavioral plan based squarely on principles of learning theory may be necessary to manage and ultimately eliminate Pica.”
- “Pica will unconsciously reappear in young children and pregnant women, but may never go away if it is left untreated.” Also, the doctor can educate the child on acceptable and unacceptable “food”. Child-safety locks and high shelving are also good options to get the items out of the child’s reach.
- Additional Information can be found at the KidsHealth website.
- The video below is a satirical view of Pica. It is *not* an actual portrayal of Pica

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6.62: Feeding Disorder of Infancy or Early Childhood (307.59)

DSM-IV-TR criteria

- A. Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least one month.
- B. The disturbance is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).
- C. The disturbance is not better accounted for by another mental disorder (e.g., Rumination Disorder) or by lack of available food.
- D. The onset is before the age of 6.

Associated features

Infants with feeding disorders can be more irritable and difficult to console when feeding then others of their age. They appear withdrawn and apathetic and may also show developmental delays. Sometimes parent-child interaction problems may add to or exacerbate the infant's feeding problems. Inadequate caloric intake can make associated features worse and further impact to feeding difficulties. Factors that may be associated with Feeding Disorder of Infancy or Early Childhood include temperamental characteristics or intrauterine growth retardation. Preexisting developmental impairments that make the child less responsive could also be factors. Some other associated factors include parental psychopathology and child abuse or neglect.

Child vs. adult presentation

- Due to the nature of the disorder, adults cannot present with feeding disorders. This disorder is primarily focused on the presentation in children from infants to early childhood.
- A later onset, during toddler years, is associated with developmental delay and malnutrition. Growth retardation may be observed.

Gender and cultural presentation

Feeding Disorder of Infancy or Early Childhood seems to be equally common in both males and females.

Epidemiology

Of all pediatric hospital admissions, 1%-5% are for failure to thrive, and up to one-half of these may reflect feeding disturbances without any apparent predisposing general medical condition. Data from community samples suggest a point prevalence of around 3% for failure to thrive.

Etiology

- Feeding problems often occur in infant and children who are tube fed for extended periods of time due to some other illness or disability. In premature infants, the underdeveloped sphincter muscle, between the stomach and esophagus, can cause the infant to spit up frequently during feedings. Because this is uncomfortable for the child, he or she may not want to eat.
- Disorders of the digestive system can also cause feeding problems, and include abnormalities of the throat and esophagus that cause pain during swallowing, inhaling food into the lungs, constipation, and celiac disease, a hereditary disorder in which a cereal protein called gluten, which is found in wheat, causes an allergic reaction that results in poor absorption of fats from the diet.
- Other digestive-type disorders that can cause feeding problems include necrotizing entercolitis, a condition seen mainly in premature newborns where the inner surface of the intestine becomes injured and inflamed; Hirschprung disease, in which a section of the large intestine is abnormally developed; short bowel syndrome; pyloric stenosis, caused by a narrowing or blockage at the stomach outlet; and gastroesophageal reflux (GER), which occurs when the acid contents of the stomach flow back, or reflux, into the esophagus.
- Feeding disorders can be caused by food allergies, by difficulty with the movement of the mouth or tongue (oromotor), or may be a cry for attention by a neglected child or a child with a behavioral disorder. Some other factors include poverty, dysfunctional caregiver child-caregiver interactions, and parental misinformation.

Empirically supported treatments

- Depending on the severity of the condition of the infant the amount of calories and intake of fluids should be increased. You should also correct any vitamin or mineral deficiencies that the child may have. It is also very important to identify any physical problem that may be causing the disorder.
- To be able to effectively accomplish these goals, a brief hospital stay may be necessary. Isolating the child in the constant care of the hospital for a short time will make sure all the proper procedures are taken. Also, gastroenterologists, behavioral psychologists, and occupational and/or speech therapists.

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6.63: Enuresis (307.6)

The term enuresis comes from the Greek word meaning “I make water” and refers to the involuntary voiding of urine, after an age at which toilet training is expected to have been completed.

DSM-IV-TR criteria

- A. Repeated voiding of urine into bed or clothes (whether involuntary or intentional).
- B. The behavior is clinically significant as manifested by either a frequency of twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- C. Chronological age is at least 5 years (or equivalent developmental level).
- D. The behavior is not due exclusively to the direct physiological effect of a substance (e.g., a diuretic) or a general medical condition (e.g., diabetics, spina bifida, a seizure disorder).
- Specify type:
  - **Nocturnal (Nighttime urination) Only**
  - **Diurnal (Daytime urination) Only**
  - **Nocturnal and Diurnal (a mixture of both)**

Associated features

An associated feature of Enuresis is a function of the limitation on the child’s social activities, it has effects on the child’s self-esteem, the degree of social ostracism by peers, and the anger, punishment, and rejection on the part of caregivers. Motor skills delays, language, speech delays, and learning delays are present in children with Enuresis. Along with having Enuresis, some children/adults may exhibit Sleepwalking Disorder and/or Sleep Terror Disorder. Urinary tract infections are more common in children with Enuresis, most common in the one’s with Diurnal Type than those who are continent.

Child vs. adult presentation

There are not many differences in the presentation among children and adults. Usually, adults that have this condition also had it when they were children and it carried on throughout their lives. Adults will usually have wetting during the day, as well as the night.

Gender and cultural differences in presentation

Studies have shown that enuresis tends to appear significantly greater in males than females. Enuresis can be found more among African American population than any other ethnicities studied. Reports show that boys aged 7 to 10 years old have about an 8% prevalence, while the average for girls is about 4.5%.

Epidemiology

The prevalence of Enuresis is around 5-10% among 5 years old, 3-5% among 10 years old, and around 1% among individuals of the age of 15 and older.

Etiology

- There can be an organic cause of Enuresis, however it is highly unlikely. Some examples of organic causes are a urinary tract infection, constipation, and food allergies. Most agree that there are a number of factors that contribute to Enuresis. One is genetic factors. If a parent had this, then it is very likely that their child will develop this as well. If both parents had Enuresis, there is about a 75% chance that their child will have it too. The rate significantly goes down if neither parents had it. Another factor is sleep patterns. There are differences between children with Enuresis and without in their sleeping patterns.
- One common belief is that Enuresis is caused by psychological factors. However, many studies show that children with this disorder behave in the same way as children without this disorder. For the most part, it has been found that because of the Enuresis, secondary psycho-social problems develop in children. Some researchers have found that low bladder capacity is related to nocturnal Enuresis. However, some question this because they feel that the child would have symptoms throughout the day if they had a low bladder capacity.

- Another common factor that many researchers have found is delayed development of the central nervous system. This causes the child not to realize that they need to empty their bladder during the night.

Empirically supported treatments

There are a number of behavioral treatments that can be used to help children with Enuresis. A few examples are a pad or a buzzer/alarm. Medication is also an option. One option is a nasal spray that is anti-diuretic. Also, an anti-depressant called imipramine is useful in treatment. If these do not work, the condition could be more serious and may result in the child and family needing to see a psychiatrist.

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6.64: Male Orgasmic Disorder (302.74)

DSM-IV-TR Criteria

- Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity, and duration.
- The disturbance causes marked distress or interpersonal difficulty.
- The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition.
- Specific type:
  - Lifelong Type
  - Acquired Type
- Specify type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

Associated Features

- Male orgasmic disorder refers to a delay in or absence of orgasm following a normal phase of excitement and an adequate degree of stimulation. Male orgasmic disorder is most often situational. The male may have an issue reaching orgasm with a certain partner, but not through masturbation.
- Male orgasmic disorder has also been termed delayed ejaculation, ejaculatory incompetence, and retarded ejaculation.

Child vs. Adult Presentation

This disorder occurs once the individual has become sexual active and is not seen in children.

Gender and Cultural Differences in Presentation

- Research shows that this occurs in every race and ethnic group. This disorder is more commonly found in women.
- In Lifelong Type manifestations will occur around the age of puberty
- In certain genetic hypogonadism disorders such as Klinefelter's syndrome, certain body signs and symptoms may alert the physician
- In acquired Type of Male orgasmic disorder, the patient will have had the previous experience of normal sexual function. In these cases, it is usually a situational factor that precipitates the disorder.

Epidemiology

It is rare for males to have a lifelong form of the disorder. Research shows that about 8% of males have experienced this at one time or another.

Etiology

- The causes are mostly psychological.
- The psychological causes can be intrinsic or extrinsic. Intrinsic factors include the fear of getting the partner pregnant, depression, low self-esteem, stress, bad relationships, and traumatic experiences with sex. The extrinsic factors may include the absence of a private location to perform, or perhaps, fatigue from other parts of life.
- Although male orgasmic disorders are generally psychological, there are cases where the causes are organic. The disorder could be caused by hypogonadism, in which enough testosterone is not produced. Pituitary conditions, thyroid disorders, and diseases of the body or penis may also cause orgasmic disorder. Additionally, medications such as as blood pressure medication or antidepressants or substance abuse- narcotic or alcohol- can cause this disorder.

- The most common causes of the male orgasmic syndrome are psychological in nature. The responsible psychological mechanisms may be “intrinsic” (due to basic internal factors), or “extrinsic” (due to external or environmental factors).
- The disorder can result from trauma but can also be acquired through problems within relationships.

Empirically Supported Treatments

- The most effective treatment is psychotherapy. This might require the partner to be actively involved with the therapy as well.
- Before the orgasmic disorder can be treated, the cause of the condition must be discovered, then the treatment will follow accordingly. If the condition is caused by a physical problem, treatment for the physical problem is sought. However, if the condition is caused by a psychological problem, psychotherapy and sex therapy are commonly used. In couples sex therapy, the couple is often taught to focus on relaxation, exploration, decreasing inhibitions, and improving sexual communication. Sex therapy focuses on increasing sexual stimulation and reducing performance anxiety.

Prognosis

The prognosis of a male with males orgasmic disorder is dependent on whether the condition is lifelong or acquired and the conditions causes.Prognosis is best when it can be demonstrated that the condition is related to some extrinsic or environmental factor that can be correlated. The prognosis is also favorable in those cases that are due to an organic disorder such as thyroid disorder or hypogonadism. The prognosis is a grimmer when the disorder is found to be a secondary to a deeper and chronic psychological or psychiatric problem that it in itself carries an unforgivable prognosis.

Additional Information

Male orgasmic disorder



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6.65: Separation Anxiety Disorder (309.21)



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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 or 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 my 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

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6.66: Stereotypic Movement Disorder (307.3)

DSM-IV-TR criteria

- A. Repetitive, seemingly driven, and nonfunctional motor behavior (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, hitting own body).
- B. The behavior markedly interferes with normal activities or results in self-inflicted bodily injury that requires medical treatment (or would result in an injury if preventive measures were not used).
- C. If Mental Retardation is present, the stereotypical or self-injurious behavior is often of sufficient severity to become a focus of treatment.
- D. The behavior is not better accounted for by a compulsion (as in Obsessive-Compulsive Disorder), a tic (as in Tic Disorder), a stereotype that is part of a Pervasive Developmental Disorder, or hair pulling (as in Trichotillomania).
- E. The behavior is not due to the direct physiological effects of a substance or a general medical condition.
- F. The behavior persists for 4 weeks or longer.
- Specify if:
  - With Self-Injurious Behavior

Epidemiology

- Approximately 2-3% of children with some form of mental retardation suffer from Stereotopic Movment Disorder in the community.
- 25% of all people institutionalized with mental retardation have Sterotypic Movement Disorder.
- Among those with severe or profound retardation, the rate is about 60%, with 15% showing behavior that causes self-injury (Steroetypic Movement Disorder).

Comorbidity

- Stereotypic Movement Disorder is extremely common in children who are considered severely retarded.
- Occurs most often in children with autism, childhood degenerative disorder, Asperger's disorder, and most other pervasive developmental disorders (Stereotypic Movement Disorder).

Etiology

- May be caused by major disorders such as Autism and/or mental retardation.
- Children with Anxiety disorders may be more likely to suffer from Stereotypic Movement Disorder.

Treatment

- Few treatments used specifically for this disorder are successful.
- Drugs that have been used with some success to treat stereotypic movement disorder include **clomipramine** (Anafranil), **desipramine** (Norpramin), **haloperidol**(Haldol) and **chlorpromazine** (Thorazine)(Stereotypic Movement Disorder).

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6.67: Reading Disorder (315)

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 rythm 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.

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6.68: Mathematics Disorder (315.1)

DSM-IV-TR criteria

- A. Considered a disorder in 1937. Formerly known as developmental arithmetic disorder, developmental acalculia, or dyscalculia. This is a learning disorder in which a person's mathematical ability is substantially lower than the expected base for age, intelligence levels, life experiences, educational background, and physical impairments.
- B. Mathematical ability, as measured by individually administered standardized tests, is substantially below that expected given the person's chronological age, measured intelligence, and age appropriate education.
- C. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living that require mathematical ability.
- D. If a sensory deficit is present, the difficulties in mathematical ability are in excess of those usually associated with it.

Coding Note: If a general medical (e.g., neurological) condition or sensory deficit is present, code the condition on Axis III.

Associated Features

- The person's mathematical ability must be substantially below the levels of peers with symptoms usually occurring simultaneously. Early difficulties with arithmetic are very noticeable through low scores in math. There are four types of symptom categories that people with Mathematics Disorder can be observed having: 1.) Language Symptoms:misunderstanding of greater than or less than or misunderstanding of word problems 2.) Recognition or Perceptual Symptoms: difficulty reading numbers, difficulty understanding plus or minus signs, or properly aligning numbers to perform calculations 3). Mathematical Symptoms: difficiencies in the ability to count, memorize basic arithmetic data as multiplication tables, or follow sequential steps in problem solving 4.) Attention Symptoms: inability to copy numbers or ignoring operational signs
- Other learning disabilities are common in comorbidity with mathematics disorders. Usually reading problems can be highly associated with mathematical disorders. For example, a child can experience difficulty when attempting to solve a math word problem if he/she cannot even understand the words he/she is reading

Child vs. Adult Presentation

This is primarily seen in children in elementary school more than in adults because of the amount of mathematical requirements that schools tend to impose on children to progress with their peers. It can also be seen in children as young as 6, but it is usually diagnosed when the child is 8 or in the third grade due to a foundation of basic math at that age. If proper diagnosis and treatment is not received early, studies show that there is higher risk of school drop out rates in children suffering from the disorder.

Gender and Cultural Differences in Presentation

Some studies have shown no significant gender difference, but it may occur with greater frequency in girls. Social constructs and state level administered tests tend to suggest that boys are better at math and girls are better at reading and writing. This way of thinking has been unconsciouly passed on to children and they test higher and perform academically superior in their gender specific areas. This has negatively impacted research as researchers must first eliminate that way of thinking before even beginning their research on gender differences in mathematics disorders. For the purpose of identifying cultural differences, a random sample of the population is tested, as well as the individualized testing that is performed to diagnose the disorder. Equally vital, is the inclusion of a similar socioeconomic and educational status for the participants that are being researched.

Epidemiology

- According to the Diagnostic and Statistical Manual of Mental disorders, which is the basic manual consulted by mental health professional to asses the presence of mental disorders, approximately 1% of school age children have a mathematical disorder. It is difficult to determine the actual prevalence rate for mathematics disorders because so many studies focus on the prevalence of learning disabilites as a whole rather than separating into the specific reading, mathematic, or written expression disorders.
- Mathematical disorders appear to be less prevalent than reading disorders. Approximately one in every five cases of learning disorders has a specific mathematics disorder.
- This disorder appears to run in families, similar to other learning disabilities. This suggests that there is a genetic component to this disorder.

Etiology

- The genetic components, which are thought to be a possible culprit for the disorder, are ones such as: Fragile X and Turner Syndrome. Fragile X is a genetic syndrome which results in a spectrum of characteristics: physical, intellectual retardation, emotional and behavioral features which range from severe to mild manifestation. It is the most common inherited cause of mental retardation and is associated with autism. It is a genetic disorder caused by a mutation of the FMR1 gene on the X chromosome. Mutation on that site is found in 1 out of every 4,000 males and in 1 out of every 6000 females. Turner Syndrome is a genetic disorder in which only an X chromosome is present, instead of an X and a Y chromosome. This disorder affects females and is associated with short stature, lack of sexual development, cardiac problems, kidney abnormalities, and possible mental retardation.
- It is also more commonly seen in familial instances, in which one or more parents show more difficulty with mathematical subjects. Also, it is commonly thought to be multifactorial. Children seem to show signs of other learning disorders in reading and language skills, but can experience it independently if their reading and language skills are average or above average.
- Injury to specific portions of the brain are also known to cause the inability to perform critical calculations thus leading to Mathematics disorder.

Twin Studies

Monozygotic twins have the same genotype, as opposed to dizygotic twins. In other words, monozygotic twins share the same environment and, therefore, share heritability. The results for a group of twins researched were shared genetic influences in mathematics disorders and language disorders.

Empirically Supported Treatments

- Children diagnosed with this disorder are eligible for an individual education plan that focuses on giving them specific details that include learning accommodations for the child and a unique plan to treat their disorder. Studies show that those children need to be introduced to more problem-solving skills and tactics to eliminate distraction and add to their understanding.
- Placement in special math classes with expert math teachers may be the most helpful to a child once he or she is diagnosed. Remedial education is shown to be effective for children because they need the specific help from teachers trained in learning disorders.
- Tutoring can help when the child's learning disorder is diagnosed very early to help them develop more tactics to perform at the average level. Because of the wide variety of problems found under the diagnosis of mathematics disorder, plans vary considerably. Concrete, hands-on instruction is more successful than abstract or theoretical instruction.
- Individualized Education Programs (IEPs) also address other language or reading disabilities that affect a child's ability to learn mathematics and assist children in overcoming them and coping with them.
- Parents and teachers can look for the following signs to asses a potential mathematical disorder: problems counting, problems memorizing multiplication tables, inability to grasp the difference between addition and subtraction, poor computational skills, slowness in performing calculations, difficulty arranging numbers in order, inability to understand place values, difficulty understanding word problems, inability to understand mathmatical symbols, and inability to align two or three digit numbers to perform calculations. In most cases, the symptoms are present simultaneously with each other.

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6.69: Disorder of Written Expression (315.2)

DSM-IV-TR criteria

- A. Writing skills, as measured by individually administered standardized tests (or functional assessments of writing skills), are substantially below those 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 the composition of written texts (e.g., writing grammatically correct sentences and organized paragraphs).
- C. If a sensory deficit is present, the difficulties in writing skills are in excess of those usually associated with it.
- Coding note: If a general medical (e.g., neurological) condition or sensory deficit is present, code the condition on Axis III.

Associated features

- This disorder was previously called developmental expressive writing disorder. This disabilitiy affects both the physical reproduction of letters and the organization of thoughts and ideas in written compositions. Disorder of written expression is one of the more poorly understood learning disorders. Learning disabilities that only manifested themselves in written work were first described in the late 1960's. These early studies described three types of written disorders: 1.) Inability to form letters and numbers correctly, also called dysgraphia 2.) inability to form words spontaneously or form dictation 3.) inability to organize words into meaningful thoughts.
- There are several in studying disorder of written expression and in implementing a remedial program. Disorder of written expression usually appears in conjunction with other reading and learning disorders, making it difficult to seperate manifestations of the disability related to only to written expression. Delays are noted in attention, visual-motor integration, visual processing, and expressive language.
- Children with Disorder of Written Expression experience great difficulty with the use of their writing skills. The writing skills of these students are significantly lower than their peers according to a typical child's age, acumen, and schooling. Writing complete sentences and forming adequate paragraphs are challenges for those with disorder of written expression. Also, the individuals with the disorder tend to make excessive errors and appear to have poor understanding in the areas of punctuation, grammar, and spelling. Some common symptoms of people with disorder of written expression include: poor or illegible handwriting, poorly formed letters or numbers, excessive spelling errors, excessive punctuation errors, excessive grammar errors, sentences that lack logical cohesion, paragraphs and stories that are missing elements and that do not make sense or lack logical conclusions, and dificient writing skills that significantly impact academic achievement or daily life.
- Disorder of written expression is almost always associated with other learning disorders like a reading or mathematics disorder, and it is frequently accompanied by low self-esteem, social problems, increased rates of school dropout, conduct disorder, attention deficit disorder, and possibly depression. Often times, people assume because a person is diagnosed with a learning disability, such as disorder of written expression, the individual must also have lower intelligence. However, people diagnosed with disorder of written expression often have average or above average intelligence.

Child vs. adult presentation

Typically, an individual is diagnosed with disorder of written expression around the age of eight, which is usually around the time that children begin to read and write. Due to the fact that a child's motor skills are still developing, the diagnosis is not usually made prior to age eight. Parents tend to recognize signs and symptoms of disorder of written expression in their children around grades four and five when writing skills become a big part in the classroom exercises. Ddsorder of written expression has no cure. Therefore, while the disorder is typically diagnosed in young children, it continues to be present throughout adulthood as well.

Gender and cultural differences in presentation

Most researchers say males are more commonly diagnosed with the disorder of written expression than females. In these cases, studies pertaining with learning disabilities, no significant gender difference has been found. On the other hand, general or special education teachers identify twice as many males than females. For the purpose of identifying cultural differences, a random sample of the population is tested, as well as the individualized testing that is performed to diagnose the disorder. Equally vital, is the inclusion of a similar socioeconomic and educational status for the participants that are being researched.

Epidemiology

- Three to ten percent of school aged children in the United States are estimated to have disorder of written expression. Fifteen percent of the United States population are said to have a type of Learning Disability. When it is not comorbid with other learning disorders, a solitary experience with the disorder of written expression is extremely rare.
- Deficits in written work may be attributed to a reading, language, or attention disorder, limited educational background, or lack of fluency in the language of the institution.

Etiology

- The cause of disorder of written expression is unknown because of lack of research surrounding the disorder. Certain facts support the idea that biological and environmental factors can contribute to learning disorders. Research has shown that high levels of testosterone in the fetus may cause language delays. Which could contribute to the idea that disorder of written expression is more prevalent in boys. Also, the particular conditions to which the fetus is exposed to while in utero may be linked to learning disorders, but not just specifically disorder of written expression. Environmental factors can also cause learning disorders, however, there is no certain cause of disorder of written expression.
- There are different factors that could contribute to written expression disorder. Some of these factors include: prenatal, environmental, and intrinsic factors. Prenatal factors refer to potential toxins, infections, and/or nutritional deficits to a fetus. Intrinsic factors refers to neurobiology, biochemical, genetic, and other medical conditions.

Empirically supported treatments

- There are no standard tests specifically designed to evaluate disorder of written expression.
- Some tests that might be helpful in diagnosing disorder of written expression include the Diagnostic Evaluation of Writing Skills (DEWS), the Test of Early Written Language (TEWL), and the Test of Adolescent Language (TAL).
- Intense writing remediation may help, but no specific method or approach has proved particularly successful. The person being evaluated should also perform tasks such as writing from dictation or copying written material as part of diagnostic testing.
- The most effective treatment approach for disorder of written expression is remedial education. Because little is known about disorder of written expression, treatment is often aimed toward learning disorders that are more common or familiar. Noticeable improvement is frequently seen after treatment, but the degree to which one recovers depends on the severity of the disorder.
- A qualified evaluator should compare multiple samples of the student's written work with the written work normally expected from students of comparable backgrounds. The symptoms should be evaluated in light of a person's age, intelligence, educational experience, and culture or life experience. Written expression must be substantially below the samples of produced by other's of the same age, intelligence, and background.

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6.70: Learning Disorder Not Otherwise Specified (315.9)

DSM-IV-TR criteria

This category is for disorders in learning that do not meet the criteria for any specific learning disorder. This category might include problems in all three areas (reading, mathematics, or written expression) that alone or simultaneously significantly interfere with academic achievement even though intelligence levels on tests measuring each individual skill is not substantially below that expected given the person's chronological age, measured intelligence, and appropriate education.

Associated features

- These features may include deficits in intelligence or genetic influences that make them the way they are. The referece to "reading, writing, and arithmetic" applies to the learning disorders. People are different and have different abilities when it comes to reading, writing, and arithmetic. Some present as having deficits in reading that may slow the pace of the reader and/or bad comprehensive abilities in which the individual may not or have difficulty actually understanding what is being read or being able to explain what one reads.
- Writing is much easier to replicate and to teach such as movement of a writing utensil of just simply tracing over different words or symbols. There is an eraser on a pencil so if one messes up it is alright, as compared to speech where one might offend somebody.
- Arithmetic is the most complicated to learn as it involves comprehension of equations, words and even more symbols. Comprehension and replication of how to work out problems is key to learning the processes of some of the operations such as the addition, subtraction, division, and multiplication signs. There is an order of operations in higher level math involving multiplication, division, addition, and subtraction. Arithmetic takes the most practice as compared to reading and writing, which are essential components to acquire the ability to effectively communicate in social environments. Repetition of these skills and processes is essential to an individual in this category in order to commit this knowledge to long-term memory.

Child vs. adult presentation

- There seems to be about the same presentation in children versus adults in overall status. There are more children with these deficits in learning that affect their ability to function on a daily basis in school especially. These are the children that are put in these special classes that get help with their school work and are in a different environment than the majority of the school children. Bullying becomes a major problem when children with learning disabilities and typically learning children are placed in the same environments without supervision. The children just see these differences and are not fully mature enough to express empathy or view other perspectives.
- Learning disorders usually begin during childhood in their school years, because that is when they are most noticeable. If the disorder is not treated or the child does not respond well to offered treatments, the disorder can be carried into adulthood and cause problems throughout their life.

Gender and cultural differences in presentation

There has been no significant studies that show gender preference for learning disabilities, however some research has shown that certain disorders, such as written expression, have higher rates when elevated levels of tetosterone are present in fetuses. Other disorders show a prevalence for males because of the difference in disruptive behavior between girls and boys. There has also been no significant studies that show that culture plays any role in weather or not an individual has a learning disability. However, minorities usually report a lower socioeconomic status, which could result in a higher prevalence of learning disabilities. There is no research regarding the specifics of learning disorder not otherwise specified. However, research for many learning disorders, specified or not specified, reveal correlations between low socioeconomic status and a increase in learning disabilities. This can be attributed to the lack of funding needed to provide better education, medical care (both physical and mental), poor nutritional states, and environmental factors such as location. For the purpose of identifying cultural and socioeconomic differences, a random sample of the population is tested, as well as the individualized testing that is performed to diagnose the disorder. Equally vital, is the inclusion of a similar socioeconomic and educational status for the participants that are being researched.

Epidemiology

Overall, anywhere from 2-10% of children have a learning disorder. However, there is a lack of research involving learning disorders not otherwise specified. There are no estimates on how many children have this disorder.

Etiology

Learning disorders must be differentiated from normal variations in achievement and distinguished from difficulties due to lack of opportunity, poor teaching, inadequate schooling, or psychosocial, cultural, or other factors. No one is certain of the causes of learning disorders, but they may be linked to genetic factors, environmental factors, or pregnancy complications.

Empirically supported treatments

- The most common and helpful treatment for all learning disorders is an individualized special education plan. In other words, children are evaluated by a professional, a determination of a learning disorder is made, and a specific plan is constructed for their specific needs.
- Learning disorders can now be diagnosed in the presence of a sensory deficit or general medical (e.g., neurological) condition as long as the learning deficit exceeds that associated with the other deficit or condition.

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6.71: Specific Phobia

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 difficultly 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.

F. 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 mention 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 is 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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6.72: Autistic Disorder (299.00)

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 are 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 or 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.

- Blueler 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 contac 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 *pervasivedevelopmentaldisorder*-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*retractedthe 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 eduction 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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=236

- 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.
  - 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

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6.73: Childhood Disintegrative Disorder (299.1)

Introduction

- This disorder is also known as Heller's syndrome for the educator Theodore Heller who discovered the disorder in 1908 (Hoffman, 2009).
- However, the research on this disorder is limited and rare.

DSM-IV-TR criteria

- A. Apparently normal development for at least the first two years after birth as manifested by the presence of age- appropriate verbal and nonverbal communication, social relationship, play, and adaptive behavior.
- B. Clinically significant loss of previously acquired skills (before the age 10 years) in at least two of the following areas: Expressive or receptive language, Social skills or adaptive behavior, Bowel or bladder control, Play, Motor skills.
- C. Abnormalities of functioning in at least two of the following:
  - Qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity).
  - Qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play).
  - Restricted, repetitive, and stereotyped patterns of behavior, interest and activities, including motor stereotypes and mannerisms.
- D. The disturbance is not better accounted for by another specific pervasive developmental disorder or by schizophrenia.

Associated features

A child's development progresses around the same speed as his/her peers, but still he/she will develop their skills at their own rate. A diagnosis of CDD should be considered with either development stops or begins to decline. A parent might notice that their child is no longer toilet trained. The child may lose the ability to speak normally (expressive or receptive language) or walk. Parents may notice that their child does not play as he/she did before. With CDD, a child slowly begins to lose both previously learned skills and the ability to learn new ones. Control over bowel and bladder processes, and play skills are also known to be correlated with the development of CDD. This typically occurs after the first 2 years but prior to 10 years of age.

Children with childhood disintegrative disorder are usually linked with severe mental retardation. EEG abnormalities and seizure disorders increases with Childhood Disintegrative Disorder. CDD can also be associated with certain medical conditions such as metachromatic leukodystrophy, Schilder's disease, tuberous sclerosis, and nuerolipidoses (Hoffman, 2009).

Symptoms of CDD are more commonly diagnosed between 3 – 5 years of age. However, symptoms can onset rapidly within days or weeks or they can onset gradually over weeks to even months (Hoffman, 2009).

This disorder is sometimes misdiagnosed as autism. Autism is by far the more common of the two and is slightly different. The symptoms of CDD occur more rapidly. The skills are lost in shorter time period. Autism usually presents itself much sooner than CDD tends to.

Child vs. adult presentation

This disorder follows a period of approximately two years of normal development with regression occurring in multiply areas of functioning. After two years of life, but before ten years, the child's loss of previously required skills are clinically and significantly lost. This usually occurs before the age of ten and typically does not occur after the age of ten and adulthood. The age of onset in most cases is between the ages 3 and 4 years and this condition may develop abruptly. Increased activity levels, irritability, and anxiety followed by a loss of speech and other skills are indications that help parents identify this disorder and seek treatment.

Gender and cultural differences in presentation

Researcher had thought that CDD was the same in boys and girls, but it has been found to be four times more common in boys than girls. The girls were misdiagnosed and they had the Retts Disorder.

CDD has shown to be sporadic in families that have not been diagnosed with other members showing signs and symptoms of this disorder (Hoffman, 2009).

Epidemiology

Statistical data has been difficult to compile due to the variable diagnostic criteria used. It has been found that it is at least one tenth as common as autistic disorder. It is estimated that there is one case in 100,000 of boys. It is also estimated that it is occurring in one girl to four to eight boys. In one study, it is shown that 1.7 per 100,000 subjects have Childhood Disintegrative Disorder. CDD it is said to be rare and has a prevalence 60 times less than autism.

The onset can be insidious or abrupt. Pre-monitory signs include increased activity levels, irritability, and anxiety followed by a loss of skills. The child may also lose interest in his environment. The loss of skills usually reaches a plateau, after which there may be some limited improvement. The loss of skills is often progressive, especially when the disorder is associated with a neurological condition.

Deterioration does reach a plateau with CDD but produces minimal gains and a “limited recovery.” Some cases do show deterioration to be progressive but this is only apparent in a minority of patients (Hoffman, 2009).

Etiology

Etiology of childhood disintegrative disorder has not been determined. It has been connected with other neurological conditions such as tuberous sclerosis, seizures and metabolic disorder.There is some evidence that CDD is linked to insult to a growing central nervous system ,however, this has not been proven inclusively.

Genetic studies are limited providing inconclusive results as to a specific abnormal gene that would identify a family trigger (Hoffman, 2009).

Empirically supported treatments

There is currently no cure for CDD. Because of the neurological complications such as epilepsy occur the children with CDD function at a severe to profound level of mental retardation, an approach from multiple disciplines must be used. Although their are no medications that can reverse the negative affects of CDD, there is medication available that can control associated behaviors such as aggression, seizures and iterative movements. Behavior therapy can also be used help treat CDD. The treatment for CDD is very similar to Autism and even with the best treatment the outcome is usually negative.

Some parents choose not to go the usual drug route and add various forms of therapy such as art or music therapy. Parents should be skeptical, however, of these added therapies because they are not very well supported and as noted above, the prognosis of CDD is not a good one.

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6.74: Rett's Disorder (299.80)

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.

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6.75: Hypoactive Sexual Desire Disorder (302.71)

DSM-IV-TR criteria

- Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and context of the person's life.
- The disturbance causes marked distress or interpersonal difficulty.
- The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- Specify type:
  - Lifelong Type
  - Acquired Type
- Specify type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

Associated Features

- Hypoactive Sexual Desire Disorder affects women's sexual desires, and contributes too many sexual dysfunctions. HSDD is a common reason for women's sexual dissatisfaction. HSDD causes a lack in sexual desire, and usually leads to relationship problems, involving lack of communication, distrust, anger, and lack of a connection. Women will experience sexual aversion, sexual apathy, and sexual desire. The person will usually not initiate sex, and will be unresponsive to another person's initiations. In extreme cases of HSDD some patients may have never felt sexual desire, and if they did at one time, but no longer have an interest, could be due to some traumatic event, such as incest,sexual abuse, or rape. However, if sexual trauma is absent it could be due to rigid religious training. Another possibility is that the initial attempts at sexual intercourse resulted in pain or sexual failure. Rarely, HSDD in both males and females may result from insufficient levels of the male sex hormone, testosterone.
- Low sexual interest is frequently associated with problems of sexual arousal or with orgasm difficulties. The deficiency in sexual desire may be the primary dysfunction or may be the consequence of emotional distress induced by disturbances in excitement or orgasm. General medical conditions may have a nonspecific effect on sexual desire due to weakness, pain, problems with body image, or concerns about survival. Depressive disorders are often present with low sexual desire, and the onset of depression may precede, co-occur with, or be the consequence of the deficient sexual desire. Individuals with Hypoactive Sexual Desire Disorder may have difficulties developing stable sexual relationships and may have marital dissatisfaction and disruption.
- Acquired HSDD- is acquired, situational HSDD in the adult is commonly associated with the boredom in the relationship with the sexual partner. Depression, the use of psychoactive or antihypertensive medication, and hormonal deficiencies may contribute to the problem. HSDD may also result from impairment of sexual function, particularly erectile dysfunction in the male, or vaginismus in the female. Vaginismus is defined as a conditioned voluntary contraction or spasm of the lower vaginal muscles resulting from an unconscious desire to prevent vaginal penetration. An incompatibility in sexual interest between the sexual partners may result in relative HSDD in the less sexually active member. This usually occurs in the presence of a sexually demanding partner.
- Painful Intercourse- (dyspareunia) is more common in women than in men, but may be a deterrent to genital sexual activities in both sexes. The causes are usually physical in nature and related to an infection of the prostate gland, urethra, or testes. Occasionally, an allergic reaction to a spermicide preparation or condom may interfere with sexual intercourse. Painful erections may be a consequence of Peyronie's disease, which is characterized by fibrotic changes in the shaft of the penis that

prevent attainment of a normal erection. In the female, dyspareunia may be caused by vaginismus or local urogenital trauma or inflammatory conditions such as hymenal tears, labial lacerations, urethral bruising, or inflammatory conditions of the labial or vaginal glands.

- Priapism- the occurrence of any persistent erection of more than four hours duration occurring in the absence of sexual stimulation. It is not associated with sexual excitement and erection does not subside after ejaculation. Priapism can occur at any age, by is more common between the ages of five to ten years and between ages twenty to fifty. In children, priapism is commonly associated with leukemia and sickle cell disease, or occurs following trauma. The most common cause in adults is the intrapenile injection of agents to correct erectile dysfunction.
- Prolactinoma- is a rare but important case of HSDD, it is a functioning prolactin-secreting tumor of the pituitary gland. Men who have this condition typically state that ehy can achieve an erection, but they have no interest in sexual relations with their partner. In females, prolactinomas are is associated with galactorrhea (lactation in the absence of pregnancy), amenorrhea, systems of estrogen deficiency, and dyspareunia.
- Delayed maturation- is a potential cause of HSDD. It is present in boys if there is not testicular enlargement by age thirteen and a half or if there are more than five years between the initial and complete growth of the genitalia. In girls, delayed sexual maturation is characterized by a lack of breast enlargement by age thirteen or by a period greater than five years between the beginning of breast growth and the onset of menstruation. Delayed puberty may be the result of familial constructional disorders, genetic defects, such as turner's syndrome in females and Klinefelter's syndrome in males, central nervous system disorders such as pituitary conditions that interfere with the secretions of gonadotropic hormones, and chronic illness such as diabetes mellitus, chronic renal failure, and cystic fibrosis.
- Sexual Anhedonia-s is a rare variant of HSDD seen in males, in which the patient experiences erection and ejaculation but no pleasure from orgasm. The cause is attributed to penile anesthesia, due to psychological or emotional factors in a hysterical obsessive person. Psychiatric referral is indicated unless there is evidence of spinal cord injuries or peripheral neuropathy. Loss of tactile sensation of the penis is unlikely to be organic in cause unless there is associated anesthetic areas in the vicinity of the anus or scrotum.

Child vs. Adult presentation

- Hypoactive Sexual Desire Disorder is not common in children. The typical age of onset for Lifelong forms of Hypoactive Sexual Desire Disorder is puberty. More frequently though, the disorder develops in adulthood, after a period of adequate sexual interest, in association with psychological distress, stressful life events, or interpersonal difficulties.

Gender and cultural differences in presentation

- Across cultures, there is a higher prevalence of HSSD among men from the Middle East (21.6%) and South East Asia (28.0%) compared to European, North American, and South American men.
- The prevalence of low sexual desire in American and Swedish women ranges from 27% to 34% of the population. HSDD is reported by 43% of women from the Middle East and Southeast Asia.

Epidemiology

- Sexual desire decreases with age, relationship duration, and children. Nearly half of all women will have some sexual dysfunction during their life, and HSDD accounts for a large portion of those dysfunctions. Approximately 33% of women in the United States and Canada reported having little sexual desire. This number represents the number of women who periodically have little sexual desire. Only 7.9% of women reported that they frequently lack sexual desire.
- Because of a lack of normative age- or gender- related data on frequency or degree of sexual desire, the diagnosis must rely on clinical judgment based on the individual's characteristics, the interpersonal determinants, the life context, and the cultural setting.
- Low desire occurs in approximately 15% of men aged 19 to 59. In men, operationalized low sexual desire as reduced thoughts, fantasies, and sexual dreams. Reduced sexual behavior with a partner, and reduced sexual behavior through masturbation. Men in the 50 to 59 age category were three times as likely to experience low desire as men in the 18 to 29 age category.

Etiology

In some cases Hypoactive Sexual Desire Disorder is considered lifelong, or beginning in adolescence. Most cases of HSDD can be linked to a point in life when libido decreased. Social problems, like marital problems or depression, may cause HSDD. Anorexia

nervosa and Bulimia nervosa can also be a determining factor for HSDD. Hormonal deficiencies such as low estrogen lead to vaginal dryness and can promote HSDD. Physical ailments like endometriosis and pelvic inflammatory disease can cause the disorder too (West et al., 2008). This disorder can also be due to a general medical condition which causes pain (dyspareunia) or discomfort during intercourse.

Empirically supported treatments

- Sex therapy is very common for people with this disorder. Typically, the therapist tries to find a psychological or biological cause of the HSDD. It is very common for both partners to join in therapy, but women generally accept sex therapy more readily.Therapy treatment generally focuses more on relationship and communication issues, improved communication (verbal and nonverbal), working on non-sexual intimacy, or education about sexuality may all be possible parts of treatment. Counseling/Sex therapy can open each partner up to the other's point of view, and is often seen as the best chance to make improvements in sexual desire.
- Psychotherapy may involve exploration of interpersonal issues, including anger, trust, exploration of an affair, and feelings of attractiveness. Treatment might also encourage men to use fantasies, erotic stimuli, and include forms of sexual activities besides intercourse.
- Among the pharmacological treatments for HSSD, bupropion is a norepinephrine and dopamine agonist with an efficacy rate of approximately 86% in nondepressed men.
- Testosterone replacement has been the primary hormonal treatment and is administered as an injection, a patch, or as a gel. Testosterone treatment in women is recommended against, due to increased risk of cardiovascular disease and/or breast cancer. If testosterone treatment is considered in men with low desire, close consultation with an endocrinologist is essential because of possible negative side effects on prostate size and gynecomastia (males).
- The synthetic hormone, tibolone, which has estrogenic, androgenic, and progestogenic effects while not stimulating the uterus lining is licensed for the treatment of menopausal symptoms in Europe. Tibolone was found to significantly increase sexual desire, the frequency of sexual fantasies, and sexual arousability relative to control (woman).

Prognosis

The prognosis for HSDD depends primarily on the underlying cause or causes. In certain medical conditions, the prognosis for development, or recovery of sexual interest, is good.

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6.76: Asperger's Disorder (299.80)



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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 is communication
        - Lack of empathy and intellectualization of feelings
        - School behavioral problems
          - i.e. aggression stemming from social deficits

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 (Bonnel, 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 conclsive evedience to support that Asberger'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 Syndome? on YouTube
- About Austism 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:



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6.77: Pervasive Developmental Disorder Not Otherwise Specified or PDD-NOS (299.80)

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, Schizotypical 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 to participate in imaginative play; however, they tend to exhibit repetitive behaviors.
    - Individuals in middle to late childhood tend not to utilize gerstures.
    - 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 characteristcs 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
  - Unsual 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 sparatic: 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 excells 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
- 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 enabaling 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:
  - Preacademic 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
  - 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.



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6.78: Mental Retardation

There are three classification systems used when defining mental retardation criterion in North America, the DSM-IV-TR, AAMR, and the Educational System.

DSM-IV-TR criteria

- A. Significantly sub average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly sub-average intellectual functioning).
- B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her culture group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- C. The onset is prior to 18 years of age.
- Code based on degree of severity reflecting level of intellectual impairment:
    - 317 Mild Mental Retardation: IQ level 50-55 to approximately 70 (accounts for 85% of retarded population). Mild Mental Retardation is roughly equivalent to what used to be referred to as the educational category of "educable." This group constitutes the largest segment (about 85%) of those with the disorder. As a group, people with this level of Mental Retardation typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.
    - 318.0 Moderate Mental Retardation: IQ level 35-40 to 50-55 (accounts for 10% of retarded population). Moderate Mental Retardation is roughly equivalent to what used to be referred to as the educational category of "trainable." This outdated term should not be used because it wrongly implies that people with Moderate Mental Retardation cannot benefit from educational programs. This group constitutes about 10% of the entire population of people with Mental Retardation. Most of the individuals with this level of Mental Retardation acquire communication skills during early childhood years. They profit from vocational training and, with moderate supervision, can attend to their personal care. They can also benefit from training social and occupational skills but are unlikely to progress beyond the second-grade level in academic subjects. They may learn to travel independently in familiar places. During adolescence, their difficulties in recognizing social conventions may interfere with peer relationships. In their adult years, the majority are able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general workforce. They adapt well to life in the community, usually in supervised settings.
    - 318.1 Severe Mental Retardation: IQ level 20-25 to 35-40 (accounts for 3-4% of retarded population). The group with Severe Mental Retardation constitutes 3%-4%of individuals with Mental Retardation. During the early childhood years, they acquire little or no communication speech. During the school-age period, they may learn to talk and can be trained in elementary self-care skills. They profit to only a limited extent from instruction in pre-academic subjects, such as familiarity with the alphabet and simple counting, but can master skills such as learning slight reading of some "survival" words. In their adult years, they may be able to perform simple tasks in closely supervised settings. Most adapt well to life in the community, in group homes or with their families, unless they have an associated handicap that requires specialized nursing or other care.
    - 318.2 Profound Mental Retardation: IQ level below 20-25 (accounts for 1-2% of retarded population). The group with Profound Mental Retardation constitutes approximately 1%-2% of people with Mental Retardation. Most individuals with this diagnosis have an identified neurological condition that accounts for their Mental Retardation. During the early childhood years, they display considerable impairments in sensorimotor functioning. Optimal development may occur in a highly structured environment with constant aid and supervision and an individualized relationship with a caregiver. Motor development and self-care and communication skills may improve if appropriate training is provided. Some can perform simple tasks in closely supervised and sheltered settings.

- 319 Mental Retardation, Severity Unspecified: when there is strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests. The diagnosis of Mental Retardation, Severity Unspecified, should be used when there is a strong presumption of Mental Retardation but the person cannot be successfully tested by standardized intelligence tests. This may be the case when children, adolescents, or adults are too impaired or uncooperative to be tested or, with infants, when there is a clinical judgment of significantly sub average intellectual functioning. The available tests (e.g., The Bayley Scales of Infant Development, Cattell Infant Intelligence Scales, and others) do not yield IQ values. In general, the younger the age, the more difficult it is to assess for the presence of Mental Retardation except in those with profound impairment. The Bayley Scales of Infant Development (BSID) measure the mental and motor development and test the behavior of infants from one to 42 months of age. The BSID are used to describe the current developmental functioning of infants and to assist in diagnosis and treatment planning for infants with developmental delays or disabilities. The test is intended to measure a child's level of development in three domains: cognitive, motor, and behavioral.

American Association of Mental Retardation

The American Association on Mental Retardation is another one of the three classification systems currently used in North America. Instead of focusing on the severity of the disorder, AAMP focuses on how intense the intervention is (intermittent, limited, extensive, or pervasive). Another difference between the DSM-IV-TR and AAMP is that the AAMP does not view MR as a metal disorder (Axis II) or a medical disorder. However, both classification systems view MR as having limited intellectual and adaptive skills. The two also agree that the age of onset it prior to the age of 18, the IQ level should be 70 or below, and that you must meet criteria other than an IQ score. The most recent definition in AAMP focuses on considering ecological and multidimensional influences when you are developing interventions. The nine areas in which you must rate the intensity of intervention are: human development, education, home living, community living, employment, health and safety, behavior, social, and protection issues.

Educational System

The third classification system for defining mental retardation is the Educational System. In the educational system there has been many changes regarding the cutoff level for placement in the special education system. In the 1970s the IQ level designated for mental retardation was 85. It is difficult for the educational system to define mental retardation criterion by themselves because the special education system is funded by the state governments in which their criteria corresponds with the DSM-IV-TR and AAMP.

Associated features

There are no specific personality traits associated with Mental Retardation. Some individuals are passive, placid, and dependent, but others may be aggressive. Lack of communication skills may cause dispose them toward disruptive behaviors as a substitute for language. Developmental delays vary widely with the nature of mental retardation. For example, in some cases, incapacity is only limited to impaired academic performance, but all adaptive skills are adequate. Some have aggressive features with comorbid behavior problems. This problem would make adjustment difficult. Negative features include self-injurious behavior, aggression, stereotypical movements, communication problems, and overactivity. Mild cases of MR can function adequately at a slower pace when goals have been modified. Cognitive limitations tend to be less noticeable in a predictable and structured environment. Those with Mental Retardation have a prevalence of comorbid disorders that are much higher than the general population, although there is no evidence to suggest that the disorder will present itself differently than in someone without Mental Retardation. It is more difficult to diagnose comorbid mental disorders, though, because of their difficulty in communication to give an adequate history. The most commonly seen comorbid disorders are Attention-Deficit/Hyperactivity Disorder, Mood Disorders, Pervasive Developmental Disorders, Stereotypical Movement Disorder, and Mental Disorders Due to a General Medical Condition. One of the key defining features in making a diagnosis of MR is that in MR the person will commenstraut with expected IQ but have low academic achievement. There is, however, a significant discrepency between IQ and achievement. There are four levels of severity of MR based on the individuals level of functioning and associated expectations: mild, moderate, severe, and profound. Many have problems in central processing, or classification of stimuli through the use of memory. Memory is also difficult. They also have deficits in executive function, the decision-making element that controls reception, central processing, adn expression.

Child vs. adult presentation

Since one criteria is onset before 18 years of age, children are more likely to statistically have Mental Retardation. Children are at a higher risk for MR because most Mental Retardation comes from within the womb and birth, (infections, chromosomal abnormalities, environmental, metabolic, and nutritional), but Mental Retardation can occur in other ways. Adults can also be diagnosed with Mental Retardation. Adult MR can also come about from toxic exposure and trauma (most likely to the brain). There are also unexplained reasons; this particular reasoning is the largest one because there are so many cases of Mental Retardation that cannot be explained. (Mental Retardation, 1997).

Gender and cultural differences in presentation

Individualized testing are always required to make the diagnosis of Mental Retardation. Mental Retardation due to known biological factors is similar among children of upper and lower socioeconomic classes, except that certain etiological factors are linked to lower socioeconomic status. Some biological factors are irregular genes or genes that did not fuse together properly, an example being down syndrome (when there is the presents of an extra chromosome). In cases in which no specific biological causation can be identified, the Mental Retardation is usually milder and individuals from lower socioeconomic classes are overrepresented. There is no cultural differences in presentation of mental retardation. Mental Retardation is more common among males, with a male-to-female ratio of approximately 1.5:1. (Mental Retardation, 2009)

Epidemiology

Testing for MR has become increasingly improved over the years. New testing has come about biotechnological progress such as antenatal and neonatal screenings are some of these new types of testing. The real factor is that this new testing are not always available for all individuals. Also, these tests are at high risk and are still unsound for specific results. (Leonard & Wen, 2002) Mental retardation occurs about 2.5% to 3% of the total population. In most cases, it is a lifelong condition. Socioeconomic status & ethnicity plays a role in MR. MR tends to be more common among low SES and minority groups. Relationship between mild MR and parental SES and its highly correlated measure, parental IQ. A classic study by Reed & Reed (1965). Association of mild MR and race is more complicated. IQ couldn't be used to put someone in special classes. Test bias, de-emphasis by schools of the importance of IQ in diagnostic decisions. A classic cases that describes the importance of IQ is the Larry P. v. Riles case in California and its effects.

Links

- Reed & Reed
- Larry P. v Riles

Developmental Theories

Double ABCX Model is known as a crisis of raising a child with MR (x) is a function of child's characteristics (A), family's resources (B), and family's perceptions (C). The concept of stress was first introduced into family studies by researcher's examining impacts of the 1930s great depression. Hill (1949) ABCX Model, McCubbin and Patterson (1981) Double ABCX Model, and McCubbin and Figley (1938) stated that families generally operate on a predictable normal cycle, anticipating and accepting a sequence of events that will occur throughout the life-force. Below is a picture of the Double ABCX Model.



Etiology

There are a number of causes of mental retardation. The majority of causes come from Down Syndrome, Fetal Alcohol Syndrome, and Fragile X Syndrome.

- Genetic causes occur when errors are made when genes combine. Chromosome errors result in Down Syndrome and Fragile X Syndrome. This is the most common cause of mental retardation.
- Problems during pregnancy can also result in mental retardation. If the mother is using alcohol or drugs such as LSD, STP, marijuana, or alcohol, she may cause damage to the brain. Thalidomide has also been shown to cause Mental Retardation, and the effects of lead can also play a role. Other illness that the mother has during the pregnancy, such as rubella or German measles, syphilis, or toxoplasmosis can cause mental retardation. Also, if the brain is not formed properly during the growth of the baby, mental retardation can result.

- Problems during birth can cause mental retardation as well, such as prematurity, the umbilical cord being around the neck, or the misuse of forceps.
- After birth, children can develop mental retardation from diseases such as measles or whooping cough. Also, exposure to high amounts of mercury or lead can cause damage to the brain and nervous system.
- Another cause is related to poverty and cultural deprivation. Children can become mentally retarded because of malnutrition, environmental hazards, and poor medical care due to poverty. Also, research has been shown that under-stimulation regarding culture can result in damage to the brain.
- Disorders of metabolism can also lead to Mental Retardation, such as phenylketanuria, gelactosemia, and maternal malnutrition.

Down Syndrome is one cause of mental retardation. It is caused by a chromosome abnormality in the 21st chromosome. The incidence of Down Syndrome increases the older the mother is. However Down Syndrome is not directly caused by something the mother does during pregnancy.They are at increased risk for diseases of the cardiovascular and respiratory systems, Alzheimer's Disease, and hearing and vision loss. Individuals with down syndrome are usually characterized by moderate mental retardation, slowing rate of development, social strengths, and weaknesses in grammar and speech. People with Down Syndrome have developmental delays and physical attributes that distinguish the disorder, such as almond-shaped "puffy" eyes, straight hair, shortness, a small skull that is flat in the back, a simean crease across the palm, leathery texture to the palms and soles, a small mouth, a flat philtrum, and square hands and stubby fingers. However, some people with Down Syndrome do not have these physical characteristics that set them apart. Also, they developmental and cognitive delays vary from person to person. People with Down Syndrome have a shorter lifespan. However, recently the life expectancy for people with Down syndrome has increased. In 1929, their average lifespan was nine years, and now it is common for them to live to age fifty and above. http://www.nichd.nih.gov/publications/pubs/downsyndrome.cfm#DownSyndromeAssociated

Check out the link below to view the facial features of people who are diagnosed with Down Syndrome: Notice the almond shaped eyes, light-colored spots in their eyes, small flat noses, small ears, small mouth with protruding tongues, and round faces. There are many other features, these are just to name a few.

- Facial Features of Down Syndrome

Fragile X Syndrome is the most common cause of an inherited mental impairment. It can be passed on to children, even if there are no apparent symptoms of the disorder in the parents. People are carriers of a certain gene (FMR1) and not even know it. The only way to know this is through genetic counseling. The FMR1 gene mutates in the development of the child and that is how the child could get it. Normally, at least one parent has to be a carrier of the gene, because new mutations are rare. Individuals with fragile X usually have moderate mental retardation, strength in Gestalt reasoning, and weakness in sequential processing. They are also usually autistic and exhibit ADHD-like behaviors. People with fragile X syndrome have physical attributes that distinguish the disorder, such as a long narrow face, prominent ears, prominent jaw & forehead, high arched palate, flat feet, hyperextensible joints, and enlarged testicles in males.

Males with fragile X syndrome and autism (FXS/autism) represent a distinct subgroup of males with FXS at risk for markedly poorer outcomes. Early identification and intervention can improve outcomes for males with autism spectrum disorder. Both social and repetitive behaviors distinguished males with FXS/autism, with repetitive behaviors playing a more prominent role than previously documented in the literature. Healthcare workers and early interventionists may be able to interview parents about a few key behaviors to determine if young child with FXS should be formally evaluated for autism. Evidence-based practices identified for children with autism spectrum disorder can be implemented as early as possible (Brock, & Hatton, 2010).



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=246

Williams Syndrome is a rare genetic condition (estimated to occur in 1/10,000 births) which causes medical and developmental problems. It is present at birth, and affects males and females equally. It can occur in all ethnic groups and has been identified in countries throughout the world. Individuals who are diagnosed with this disease have a small upturned nose, long philtrum (uppper lip length), wide mouth, full lips, small chin, and puffiness around the eyes. They have heart and blood vessel problems because they are born with small blood vessels, as well as feeding problems. The usually have good verbal and language skills. Individuals with this disease have high death rates.

external image abc_gma_syndrome2_070719_mn.jpg

- Condition Makes People Extremely Friendly But Lacking Social Skills – ABC News
  - For more information about the other abnormalities that are associated with this disease check this link out:
  - To learn more about unconditional trust associated with Williams Syndrome click on this NPR link from Your Health.
  - To learn more about adults with Williams Syndrome, click on this NPR link from Your Health.

Prader-Willi Syndrome (PWS) is an uncommon genetic disorder. It causes poor muscle tone, low levels of sex hormones and a constant feeling of hunger. The part of the brain that controls feelings of fullness or hunger does not work properly in people with PWS. They overeat, leading to obesity. Babies with PWS are usually floppy, with poor muscle tone, and have trouble sucking. Boys may have undescended testicles. Later, other signs appear. These include:

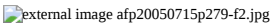
- Short stature
- Poor motor skills
- Weight gain
- Underdeveloped sex organs
- Mild mental retardation and learning disabilities

Fetal Alcohol Syndrome (FAS) is caused by drinking alcohol during pregnancy. The problems that arise from this often intensify when children grow up. There are many developmental delays that occur with FAS as well as physical attributes that are distinguishable.

- Signs and Symptoms:
  - low birth weight
  - small head circumference
  - developmental delay
  - organ dysfunction
  - facial abnormalities, including smaller eye openings, flattened cheekbones, and indistinct philtrum (an underdeveloped groove between the nose and the upper lip)
  - epilepsy
  - failure to thrive

- poor coordination/fine motor skills
- poor socialization skills, such as difficulty building and maintaining friendships and relating to groups
- lack of imagination or curiosity
- learning difficulties, including poor memory, inability to understand concepts such as time and money, poor language comprehension, poor problem-solving skills
- behavioral problems, including hyperactivity, inability to concentrate, social withdrawal, stubbornness, impulsiveness, and anxiety

- Children can also be born with Fetal Alcohol Effects (FAE). This has the same symptoms of FAS but are less severe.



http://www.aafp.org/afp/2005/0715/p279.html

Mental Retardation can be associated with mental disorders having the commonality of head trauma that can result in Mental Retardation and in personality change due to head trauma. The etiological factors are both biological and psychosocial. In approximately 30%-40% of individuals seen in clinical settings, no clear etiology for the Mental Retardation can be determined despite extensive evaluation efforts. Some of these predisposing factors are heredity, alterations of embryonic development, environmental influences, mental disorders, pregnancy and prenatal problems, and general medical conditions acquired in infancy or childhood.

Empirically supported treatments

Applied behavior analysis is a type of discipline that is applied in a genuine setting such as schools and clinics. This type of analysis deals with socially important issues such as learning disabilities and behavioral difficulties. (Hagopian & Boelter, 2005) Cognitive and adaptive functioning can also play a role in helping control problems faced with mental retardation.

The most effective treatment are individualized educational and skill plans that are based on the child's needs. The federal government mandates this and it as no extra cost to the family. A loving and supportive family is key to the treatment of mental retardation. Families can benefit from family therapy by learning to cope with the stress and other day-to-day activities involved with raising a child with mental retardation. Some children can go far in school while others cannot, it just depends on the severity of their retardation.

Preventing mental retardation can be done in a few ways. Avoiding alcohol and drugs, eating a healthy diet, and taking prenatal vitamins during pregnancy all are proactive steps to be taken to help prevent mental retardation. Also, getting children vaccinated against diseases such as measles can be helpful as well.

Links

- Hilly, Sam, Lucy and Megan, 4 friends with Down's Syndrome who share a house in Brighton with their friend Lewis who has Williams Syndrome. Their lives are followed in the internet documentary series "The Specials."

- Researchers Identify Critical Gene for Brain Development, Mental retardation on YouTube

	Organic MR	Cultural-familal MR
Definition	Individual shows a clear organic cause of mental retardation	Individual shows no obvious cause of retardation; sometimes another family member is also retarded
Characteristics	More prevalent at moderate; severe and profound levels of retardationEqual or near-equal rates across all ethnic and SES levelsMore often associated with other physical-disabilities	More prevalent in mild mental retardationHigher rates within minority groups and low SES groupsFew associated physical or medical disabilities
Causes	Prenatal (genetic disorders, accidents in utero)Perinatal (prematurity, anoxia)Postnatal (head trauma, meningitis)	Polygenic (i.e., parts of low IQ)Environmentally deprivedUndetected organic conditions

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6.79: Mental Retardation, Severity Unspecified (319)

DSM-IV-TR Criteria

- A. Significantly subaverage intellectual functioning: An IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning).
- B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- C. The onset is before age 18 year
- Code based on degree of severity reflecting level of intellectual impairment:
  317 Mild Mental Retardation: IQ level 50-55 to approximately 70.
  318.0 Moderate Mental Retardation: IQ level 35-40 to 50-55
  318.1 Severe Mental Retardation: IQ level 20-25 to 35-40
  318.2 Profound Mental Retardation: IQ level below 20 or 25
  319 Mental Retardation, Severity Unspecified: when there is strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests.

Associated Features

Associated descriptive features and mental disorders. No specific personality and behavioral features are uniquely associated with Mental Retardation. Some individuals with Mental Retardation are passive, placid, and dependent, whereas others can be aggressive and impulsive. Lack of communication skills may predispose to disruptive and aggressive behaviors that substitute for communicative language. Some general medical conditions associated with Mental Retardation are characterized by certain behavioral symptoms (e.g., the intractable self-injurious behavior associated with Lesch-Nyhan syndrome). Individuals with Mental Retardation may be vulnerable to exploitation by others (e.g., being physically and sexually abused) or being denied rights and opportunities.

Individuals with Mental Retardation have a prevalence of comorbid mental disorders that is estimated to be three to four times greater than in the general population. In some cases, this may result from a shared etiology that is common to Mental Retardation and the associated mental disorder (e.g., head trauma may result in Mental Retardation and in Personality Change Due to Head Trauma). All types of mental disorders may be seen, and there is no evidence that the nature of a given mental disorder is different in individuals who have Mental Retardation. The diagnosis of comorbid mental disorders is, however, often complicated by the fact that the clinical presentation may be modified by the severity of the Mental Retardation and associated handicaps. Deficits in communication skills may result in an inability to provide an adequate history (e.g., the diagnosis of Major Depressive Disorder in a nonverbal adult with Mental Retardation is often based primarily on manifestations such as depressed mood, irritability, anorexia, or insomnia that are observed by others). More often than is the case in individuals without Mental Retardation, it may be difficult to choose a specific diagnosis and in such cases the appropriate Not Otherwise Specified category can be used (e.g., Depressive Disorder Not Otherwise Specified). The most common associated mental disorders are Attention-Deficit/Hyperactivity Disorder, Mood Disorders, Pervasive Developmental Disorders, Stereotypic Movement Disorder, and Mental Disorders Due to a General Medical Condition (e.g., Dementia Due to Head Trauma). Individuals who have Mental Retardation due to Down syndrome may be at higher risk for developing Dementia of teh Alzheimer's Type. Pathological changes in the brain associated with this disorder usually develop by the time these individuals are in their early 40s, although the clinical symptoms of dementia are not evident until later.

Associations have been reported between specific etiological factors and certain comorbid symptoms and mental disorders. For example, fragile X syndrome appears to increase the risk for Attention-Deficit/Hyperactivity Disorder and Social Phobia; individuals with Prader-Willi syndrome may exhibit hyperphagia and compulsivity, and those with William's syndrome may have an increased risk of Anxiety Disorders and Attention-Deficit/Hyperactivity Disorder

Gender and cultural differences in presentation

Mental Retardation is more common among males, with a male-to-female ratio of approximately 1.5:1.Care should be taken to ensure that intellectual testing procedures reflect adequate attention to the individual's ethnic, cultural, or linguistic background. This is usually accomplished by using tests in which the individual's relevant characteristics are represented in the standardization sample of the test or by employing an examiner who is familiar with aspects of the individual's ethnic or cultural background. Individualized testing is always required to make the diagnosis of Mental Retardation. The prevalence of Mental Retardation due to known biological factors, is similar among children of upper and lower socioeconomic classes, except that certain etiological factors are linked to lower socioeconomic status (e.g., lead poisoning and premature births). In cases in which no specific biological causation can be identified, the Mental Retardation is usually milder (although all degrees of severity are represented) and individuals from lower socioeconomic classes are overrepresented. Developmental considerations should be taken into account in evaluating impairment in adaptive skills because certain of the skill areas are less relevant at different ages (e.g., use of community resources or employment in school-age children).

Epidemiology

The prevalence rate of Mental Retardation has been estimated at approximately 1%. However, different studies have reported different rates depending on definitions used, methods of ascertainment, and population studied.

Etiology

The diagnosis of Mental Retardation requires that the onset of the disorder be before age 18 years. The age and mode of onset depend on the etiology and severity of the Mental Retardation. More severe retardation, especially when associated with a syndrome with a characteristic phenotype, tends to be recognized early (e.g., Down syndrome is usually diagnosed at birth). In contrast, Mild Retardation of unknown origin is generally noticed later. In more severe retardation resulting from an acquired cause, the intellectual impairment will develop more abruptly (e.g., retardation following encephalitis). The course of Mental Retardation is influenced by the course of underlying general medical conditions and by environmental factors (e.g., educational and other opportunities, environmental stimulation, and appropriateness of management). If an underlying general medical condition is static, the course is more likely to be variable and to depend on environmental factors. Mental Retardation is not necessarily a lifelong disorder. Individuals who had Mild Mental Retardation earlier in their lives manifested by failure in academic learning tasks may, with appropriate training and opportunities, develop good adaptive skills in other domains and may no longer have the level of impairment required for a diagnosis of Mental Retardation.

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6.80: Parenting and Epidemiology for Disruptive Disorders

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 practioner 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 c ommon 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 CDl
- 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.

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6.81: Introduction to Disruptive Behavior Disorders

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)

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6.82: Oppositional Defiant Disorder (313.81)

- Classifed 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
  - (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 negativeistic, defiant, disobedient, and hostile behavior towards authority figures.
- Occurs ouside 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 agverage 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 thier daily routines and errands dispite the behavior of thier 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-KC9tkn0_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 anitsocial personality disorder.

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6.83: Conduct Disorder

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 accidently 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 basses. 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.

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6.84: Conduct Disorder (CD), Childhood-Onset Type (312.81)

- Classified as an externalizing disorder. More severe than operational 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.
  - 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 wile 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 confrontion (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 disordered (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 ration then seems to drops 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 inhabit 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 choldhood-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.



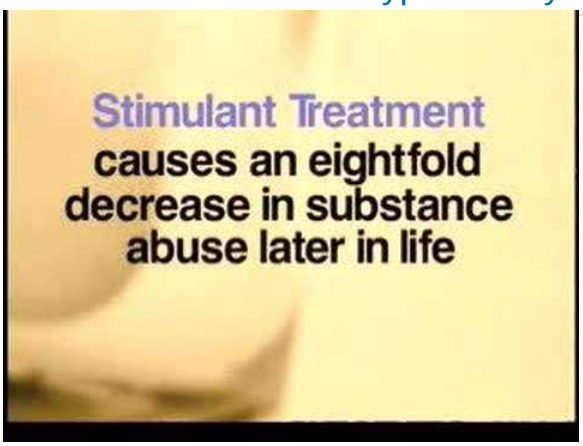
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Summary

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).

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6.85: Attention-Deficit/Hyperactivity Disorder



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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 mountng 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.

Their 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 verse 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 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 durationof 6 month; some support for a 12 month period.
- Requirement of impairment 2/3 environments.
  - Situational specificity
  - Lack of parent-teacher agreement
- Problems likely to be addressed in DSM-V, but can be used for more effective diagnosis now.
- Many critics of the realisy of ADHD, say that it is merely pathologizing normal behavior.
  - Includes Rush Limbaugh, Psylis Schafly, 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.



A YouTube element has been excluded from this version of the text. You can view it online here: http://pb.libretexts.org/apsy/?p=258

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6.86: Male Erectile Disorder (302.72)

DSM-IV-TR criteria

- A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.
- B. The disturbance causes marked distress or interpersonal difficulty.
- C. The erectile dysfunction is not better accounted for by another Axis I disorder (other than a Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition
- Specify if:
  - Lifelong Type
  - Acquired Type
- Specify if:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

Associated Features

- It is normal for older men to need more stimulation to gain an erection, and they may require more time in between erections too. However, older men should still be able to achieve erection and enjoy sex. When a man of any age, younger or older, cannot achieve an erection or maintain one long enough for sexual satisfaction for both partners, it is considered Erectile Dysfunction (ED).
- Child vs. adult presentation
- Premature ejaculation one form of ED can occur at any age, and it is a common disorder. The occurrence of Premature Ejaculation in men aged 18-30 is common, it but may also occur in conjunction secondary to impotence in men aged 45-65. The inability to achieve an erection and ED, in general, is more commonly seen in older men, and sexual function drastically declines after one reaches the age of 50. This disorder only occurs in men.

Gender and cultural differences in presentation

There is no significant data that supports major differences in premature ejaculation between races, however, recent surveys suggest some racial variation. An analysis by Laumann et al (1999), found that premature ejaculation was more prevalent in African American men (34%) than white men (29%) or Hispanics (27%).

Epidemiology

Approximately 5-20% of men have moderate-to-severe ED.

Etiology

The majority of these cases with this disorder have an organic etiology, most commonly vascular disease that decreases blood flow into the penis. Diabetes, Hypertension, and Artherosclerosis are associated and linked to causal explanations for ED. If a person's hormones are imbalanced, it can result in ED as well. A few physical causes of ED are: excessive alcohol and tobacco use, fatigue, brain and spinal-cord injuries, Hypogonadism, liver or kidney failure, Multiple Sclerosis, Parkinson's Disease, radiation therapy to the testicles, stroke, or some types of prostate or bladder surgeries. Emotions or feelings which can lead to ED are similar to those associated with Male Orgasmic Disorder and include: nervousness due to previous bad sexual experiences or prior episodes of impotence, stress from external situations (ie. work, school, or family), depression, crowding insecurities, being preoccupied, and thinking the partner is displaying negative reactions. Values and conceptions regarding what is perceived as a normal duration should be considered. Age is an important factor as well; as individuals age, they typically engage in less sexual activity for shorter durations. Some evolutionary theorists have posited that ED in older individuals may serve an evolutionary function; ED may

reduce the chances that a genetically degenerated sperm will couple with an ovum (egg cell). Hence, ED may be a natural mechanism that, to an extent, safeguards the species from genetic anomalies.

Empirically supported treatments

- Testosterone supplements may be used for cases due to hormonal deficiency.
- The cause is usually due to lack of adequate penile blood supply as a result of damage to inner walls of blood vessels. This damage is more frequent in older men, and often associated with disease, for example, diabetes.
- ED can, in many cases, be treated by drugs which are taken orally, injected, or as penile suppositories.
- Exercise, particularly aerobic exercise is an effective cheap treatment for erectile dysfunction.
- Alprostadil can be injected into the penis or inserted using a special applicator – usually just before sexual intercourse.
- A purpose-designed external vacuum pump can be used to attain erection, with a separate compression ring fitted to the penis to maintain it.
- Often, as a last resort if other treatments have failed, the most common procedure is prosthetic implants which involves the insertion of artificial rods into the penis.
- One medication used to treat this disorder is Viazil. See how it works by clicking here.

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6.87: Disruptive Behavior Disorder Not Otherwise Specified (312.9)

DSM-IV-TR criteria

This category is for disorders characterized by conduct or oppositional defiant behaviors that do not meet the given criteria for Conduct Disorder (CD) or Oppositional Defiant Disorder (ODD). For example, it includes clinical presentations that do not meet the full criteria for Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD), but in which there is clinically significant impairment. There may be unique circumstances of the child's behavior, or there may not have been enough information collected early to make a full diagnosis. The Disruptive Behavior Disorder NOS allows for examining clinicians to document that a child has a behavior problem, and allows the clinician to make a more precise diagnosis in the future.

Empirically Supported Treatments

The treatment for Disruptive Behavior Disorders is a combination of specialized Parent Skills training. Parent training and therapy with the child or adolescent tends to be most effective when done in the family home.

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6.88: Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)

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 seperated 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 ma 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.

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6.89: Attention-Deficit/Hyperactivity Disorder (ADHD)

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. They 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 hangs 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 co-morbid 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 process 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 our 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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6.90: Dissociative Identity Disorder (300.14)

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.

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6.91: Pain Disorder (307)

DSM-IV-TR criteria

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or malingering).

E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows:

307.80 **Pain Disorder Associate With Psychological Factors:** psychological factors are judged to have the major role in the onset,severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role on the onset,severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder in not diagnosed if criteria are also met for Somatization Disorder.

Specify if:

- **Acute:** duration of less than 6 months
- **Chronic:** duration of 6 months or longer
- 307.89 **Pain Disorder Associated with both psychological factors and general medical condition:** both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain(see below) is coded on Axis III

Specify if:

- **Acute:**duration of less than 6 months
- **Chronic:** duration of 6 months or longer

Note: The following is not considered to be a mental disorder and is included here to facilitate differential diagnosis.

Pain Disorder Associated with a General Medical Condition: a general medical condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established(see Appendix G) or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established-for example, low back(724.2) sciatic (724.3), pelvic (625.9), headache (784.0), facial (784.0), chest (786.5), joint (719.4), bone (733.9), abdominal (789.0), breast (611.71), renal(788.0), ear (388.70), eye (379.91), throat(784.1), tooth (525.9), and urinary (788.0).

Associated features

Pain may severely disrupt different aspects of a person's daily life. It may lead to unemployment, disability, and family problems. It may also have an effect on Iatrogenic Opiod Dependence or Abuse and Benzodiazepine Dependence or Abuse as well as Substance Dependence or Abuse. It is also associated with severe depression with terminal illness as well as a risk to suicide. It may lead to inactivity and social isolation, reduction in physical endurance, and fatigue. Also, other associated features include: musculoskeletal conditions, neuropathies, malignancies. There is comorbidity with Osteoporosis, Osteoarthritis, and Fibromyalgia.

Child vs. Adult presentation

It may occur at any age but there are not any known differences.

Gender and cultural differences

- Females will appear to experience certain chronic pain conditions, most migraine and tension-type headaches and musculoskeletal pain more often than males.

- It is different in each individual therefore it is hard to determine cultural differences.

Epidemiology

- 10-15 % of adults in the United States
- Depressive Disorders, Alcohol Dependence, and chronic pain may be more common in the first degree biological relatives with Pain Disorder.

Etiology

- Pain disorder may develop due to a conversion mechanism and some patients may have what is called a “pain-prone personality:” where they have old feelings of guilt and worthlessness about themselves, and they constantly feel that they are in need of punishment, pain gives them this.
- Physical pain may play such a role, and the onset of the pain may be seen in these patients when things seem to be going otherwise unexpectedly well in their lives. There is some connection between this personality style and a history of childhood abuse. Others, often women, experience pain for which no cause can be found. It appears unexpectedly, usually after a stress, and may fade away in days or it can last years.

Empirically supported treatments

It’s associated with a General Medical Condition may be treated with a course of general pain killers. This term is used for any patient who has pain that is mainly caused, worsened or maintained by a general medical condition, so long as any psychological factors play at most a minor role. This is not considered to be a mental disorder.

DSM-5 Changes (taken from DSM5.org)

The work group is recommending that this disorder be subsumed into a new disorder: Complex Somatic Symptom Disorder.
The following optional specifiers may be applied to a diagnosis of CSSD where one of the following dominates the clinical presentation:
3. 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 major depression or adjustment disorder.

Rationale:

Major Change #1: Rename Somatiform disorders to Somatic Symptom Disorders and combine with PFAMC 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 hypochodriasis, undifferentiated somatiform disorder, and pain disorder into a new category entitled “Complex Somatic System 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.

Severity:

Severity metrics are readily available for somatic symptoms (viz PHQ, Kroenke 2002) and for the cognitive distortions and misattributions associated with CSSD (viz Whiteley Index, Pilowsky. 1967).

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6.92: Somatization Disorder (300.81)

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, Hypochonddiasis, 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.

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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.
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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.

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6.93: Trichotillomania (312.39)

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)

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6.94: Intermittent Explosive Disorder (312.34)

This is a short video by Dr. Gary Solomon explaining what Intermittent Expolsive 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), propranolol (a heart medication), and lithium (used to treat Bipolar type two manic-depression disorder).

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6.95: Delusional Disorder

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 want 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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6.96: Kleptomania (312.32)

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.

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6.97: Premature Ejaculation (302.75)

DSM-IV-TR criteria

- A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.
- B. The disturbance causes marked distress or interpersonal difficulty.
- C. The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).
- Specify type:
  - Lifelong Type
  - Acquired Type
- Specify type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

Associated Features

- Premature Ejaculation can be categorized as one of two types – Primary PE and Secondary PE. Primary PE refers to the type that has been present in an individual since becoming sexually functional. Secondary PE refers to the type that is acquired later in life in individuals who have had normal levels of sexual function. Both forms of PE are categorized as psychological conditions, as physiological factors such as organic diseases and brain lesions cannot be implicated.
- Individuals suffering from Premature Ejaculation display symptoms included but not limited to abdominal pain, involuntary movements of the eyes, accentuated fall in systolic pressure, and urinary problems.

Child vs. adult presentation

Premature ejaculation can happen at any point during a man’s life but is more common in young men aged 18-30. It may also occur in conjunction with secondary impotence in men aged 45-65.

Gender and cultural differences in presentation

- Premature Ejaculation is limited to the male sex, though its effects can pose problems for both sexes..
- Research shows that only men suffer from this disorder and it is common. Although all races can have premature ejaculation, there is some evidence that it occurs more in African Americans than in Hispanic and white men. In an analysis by Laumann et al (1999), they found that premature ejaculation occurred more among African American men (34%) and white men (29%) than in Hispanic men (27%).
- Rates are relatively uniform around the world except in the Middle East, where the rate is approximately 12.4%

Epidemiology

- This disorder affects 25%-40% of men in the U.S.
- According to the NHSLS, PE affects approximately 30% of men aged 18 to 59, making it the most prevalent male sexual dysfunction.

Etiology

There is no clear cause for premature ejaculation. It is believed that some psychological factors such as anxiety, guilt, or depression may be causing premature ejaculation. It may also be caused by medical conditions, such as hormonal problems, history of injuries, or side effect from certain medications. It has been suggested that PE may have conferred males an evolutionary advantage; males who were able to ejaculate faster would have been able, potentially, to impregnate females more efficiently. The cultural shift of

sexual activity to a more recreational function has largely eliminated whatever potential benefits PE may have conferred evolutionarily.

Empirically supported treatments

- Treatments are focused on gradually training and improving mental habituation to sex and physical development of stimulation control.
- In clinical cases, various medications are being tested to help slow down the speed of the arousal response.
- Serotonergic medications, such as SSRIs, can delay ejaculation. Clinical trials indicate that Paroxetine gives the largest increase in intravaginal ejaculation latency time.
- Clomipramine often helps with serious cases that are related to the central nervous system (as opposed to psychological factors). Tramadol has also been shown to be effective in delaying ejaculation.
- The stop-start method requires the men to provide direct feedback to his partner for when the ejaculatory urge nears. At this point, sexual stimulation stops, allowing for his arousal to subside before stimulation is resumed. The efficacy of the stop-squeeze technique is approximately 60%.
- The squeeze technique is where the woman teases her partner to erection and prior to his ejaculation, she squeezes the tip of the penis, which temporarily prevents ejaculation. This process is repeated three or four times in a 15-20 minute session before the man purposely ejaculates.

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6.98: Narcolepsy (347.00)

DSM-IV-TR criteria

A. Irresistible attacks of refreshing sleep that occurs daily over at least 3 months.

B. The presence of one or both of the following:

Cataplexy (brief episodes of sudden bilateral loss of muscle tone, which is most often associated with intense emotion.)

Recurrent intrusions of elements of rapid eye movement (REM) sleep into the transition between sleep and wakefulness, as manifested by either hypnopompic or hypnagogic hallucinations or sleep paralysis at the beginning of end of sleep episodes.

C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another general medical condition.

Associated features

Narcolepsy is a neurological disorder in which the brain conveys sleep evoking signals at unexpected and inappropriate times. People with narcolepsy experience an inadequate order and length of NREM and REM sleep stages which are disrupted REM sleep episodes during sleep onset instead of after NREM sleep. During a time of excessive sleepiness, an individual with narcolepsy may temporarily experience muscle instability leading to paralysis or cataplexy of the head and body while the person remains awake and entirely conscious. Symptoms also include hypnagogic hallucinations, automatic behavior, insomnia and fragmented sleep associated with excessive day time sleepiness (EDS). Occurrences of narcolepsy may be prompted by sudden emotional reactions such as anger, surprise, fear, or even laughter. The episodes can last anywhere from several seconds to several minutes. Approximately forty percent of individuals with narcolepsy experience comorbidity with depression, anxiety, or substance-related abuse, and some may also experience all symptomatologies associated with narcolepsy.

Child vs. adult presentation

Narcolepsy can occur in children as young as five, but is more prominent during adolescence, though it is also possible for it to develop during young adulthood. Children with narcolepsy also suffer from excessive daytime drowsiness and cataplexy which is most often described as fainting in young children. Children frequently exert confusion and aggressive behaviors when woken up. Frequently, narcolepsy is misdiagnosed in children as a learning disability or attention deficit disorder. However, narcolepsy is usually more difficult to identify in children.

Gender and cultural differences in presentation

Narcolepsy is prevalent in relatively equal rates among males and females; however it has a genetic component that predisposes individuals to develop narcolepsy. Having a close relative that has narcolepsy increases an individual’s risk of developing the disorder by anywhere from twenty to forty times. There are very few variations in the severity and appearance of symptoms between different ethnic groups. Asians usually tend to report less severe incidents of negative emotions and hostility associated with narcolepsy, whereas Caucasian patients tend to report higher rates of cataplexy than many other ethnic groups.

Epidemiology

Studies have shown that Narcolepsy can be found anywhere between 25 and 50 per 100,000 people in European countries, Japan, and the US. Therefore about one in two thousand Americans suffer from narcolepsy. Still the exact prevalence rate continues to remain unclear and the disorder may perhaps affect a bigger section of the population than what is currently estimated.

Etiology

Many advances in determining the cause of narcolepsy have been made in recent years, but a direct causation has not yet been established. Most people who have narcolepsy have low levels of hypocretin, which is a chemical that helps control the level of a person’s wakefulness. The reason for low hypocretin levels, however, is unknown. The main consensus among researchers is genetics. Some scientists think narcolepsy could also be caused by various environmental stressors that occur before the age of onset in the genetically opportunistic individuals. Some factors that could influence development are the individuals BMI, immune response, and other stressful life events. These triggers are still being activated.

Empirically supported treatments

- Since there is not a cure for narcolepsy, clinicians strive to improve the patient's alertness as well as attentiveness during the daytime. Stimulants, antidepressants, and anticataplectics are the types of medications currently used to treat narcolepsy. Stimulants have been around for the longest period of time. Antidepressants are used to suppress the REM sleep and they can help prevent cataplexy, hypnagogic hallucinations, and sleep paralysis. The two types of antidepressants that are commonly used are the selective serotonin reuptake inhibitors (SSRI's) and tricyclics. GHB, or gammahydroxybutyrate (also known as Sodium oxybate [Xyrem]), gained FDA approval in the year 2002. It is the only drug of its kind (anticataplectic) used to treat patients that experience cataplexy caused by narcolepsy. The Food and Drug and Administration approved a drug called modafinil for excessive daytime sleepiness.
- Behavioral treatments have also been studied. Adjustments in life-style are necessary for improvement. Some suggestions include following a strict sleep-wake schedule; taking short naps one or two times each day; increasing physical activity and avoiding repetitive tasks as well as potentially dangerous activities such as diving, swimming, and cooking unless under supervision or at a peak alert time.

Proposed DSM-5 Changes (dsm5.org)

Narcolepsy/Hypercretin Deficiecy

A. Recurrent daytime naps or lapses into sleep that occurs daily or almost daily over at least the last 3 months (when the patient is untreated).
B. The presence of one or both of the following:
1. Cataplexy defined as brief (a few seconds to 2 minutes) episodes of sudden bilateral loss of muscle tone with maintained consciousness, most often in association with laughter or joking. These episodes must occur at least a few times per month providing the patient is untreated for this symptom.
2. Hypocretin deficiency, as measured using CSF hypocretin-1 immunoreactivity measurements (<1/3 of normal reference values).

C. Do not occur exclusively during the course of another mental or medical disorder but may occur simultaneously with these disorders.
Rationale: In 2000, it was discovered that most cases with narcolepsy-cataplexy have hypocretin deficiency. Animal models without hypocretin have narcolepsy, establishing causality. Advantage: the name "narcolepsy/hypocretin deficiency" now encompasses a real disease entity with a single etiology and generally consistent set of symptoms. Therapy is more codified for this entity, which was previously "contaminated" by 20-50% (depending of the case series) of patients with other problems. Disadvantage: Some patients with "narcolepsy" but without cataplexy/hypocretin deficiency (generally narcolepsy without cataplexy) could be "undiagnosed". To mitigate this problem, we insist that the category 307.44 "Primary hypersomnia" be renamed "primary hypersomnia/narcolepsy without cataplexy"

Criterion B2

Rationale: Recurrent intrusions of elements of REM sleep such as "hypnopompic or hypnagogic hallucinations or sleep paralysis at the beginning or end of sleep episodes" have been shown to occur frequently in normal individuals (especially after sleep deprivation/interruptions), and to be frequently absent in genuine narcoleptic patients. It is neither specific nor sensitive and must be deleted. In contrast, measuring CSF hypocretin-1 immunoreactivity identifies the actual cause of the symptomatology (title change). It also has only very few false positive in patients without a serious associated neurological condition (~0.1%). Advantage: Fewer patients will be diagnosed for life as "narcoleptic" and treated with stimulants unnecessarily if not carelessly. Disadvantage: Some patients diagnosed as "narcolepsy" because they were sleepy and had some sleep paralysis, and hypnagogic hallucinations could feel they are being undiagnosed. To mitigate this problem, we insist that the category 307.44 "Primary hypersomnia" be renamed "primary hypersomnia/narcolepsy without cataplexy".
A question may be whether or not a positive Multiple Sleep Latency Test (MSLT mean sleep latency ≤8 min, ≥2 Sleep onset REM periods), a nap sleep polysomnography test that has been developed to diagnose narcolepsy, should be added as a third possible criteria. The MSLT is reasonably sensitive (95%) for narcolepsy/cataplexy with hypocretin deficiency. Problematically however, two recent studies have shown it is not very specific, being positive in approximately 2-4% of the general population and probably more in patients with sleep apnea, sleep deprivation or other sleep disorders. Many normal subjects who do not complaint of any symptoms are positive for the test. As the MLT is increasingly used to diagnose narcolepsy independently of the clinical picture, an

epidemic of “narcolepsy with cataplexy cases” defined with by a positive MSLT alone is now being diagnosed and aggressively treated, often inappropriately. These subjects often think they have a life long biochemical condition, which is not established. In the revised classification, these subjects will be pulled with “primary Hypersomnia cases”, a mixed bag of cases with sleepiness or excessive sleep of unknown etiologies.

Of note, as it is, the revised classification will remain similar to that of the International Classification of sleep Disorders (ICSD2), except that two instead of 4 categories are included. Narcolepsy/cataplexy would roughly correspond to narcolepsy-cataplexy/hypocretin deficiency. Primary hypersomnia/narcolepsy without cataplexy will be a category merging ICSD2 narcolepsy without cataplexy, hypersomnia with long sleep time, and narcolepsy without long sleep time. As these three entities are not known to be pathophysiologically distinct, and are treated and evaluated similarly, the DSMV will be easier to use than the ICSD2.

Relationship to International Classification of Diseases-10

Narcolepsy and Cataplexy G47.4

Relationship to International Classification of Sleep Disorders 2nd Edition

The revised classification will remain similar to that of the ICSD-2, except that two instead of 4 categories are included. Narcolepsy/cataplexy would roughly correspond to narcolepsy-cataplexy/hypocretin deficiency. idiopathic hypersomnia, with/without long sleep time, 327.11, 327.12; narcolepsy with cataplexy 347.01

Severity

1. Stanford Sleep Inventory (1)
2. Epworth sleepiness Scale
3. Multiple Sleep Latency Test
4. Maintenance of Wakefulness test

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6.99: Dissociative Amnesia (formerly Psychogenic Amnesia) (300.12)

DSM-IV-TR criteria

- The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
- The disturbance does not occur exclusively during the course of Dissociative Identity Disorder, Dissociative Fugue, Post traumatic Disorder, Acute stress Disorder, or Somatization Disorder and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a neurological or other general medical condition (e.g., Amnestic Disorder Due to Head Trauma).
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic Features

The essential feature of Dissociative Amnesia is an inability to recall important personal information. Dissociative Amnesia most commonly presents as a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history. This acute form is more likely to occur during wartime or in response to a natural disaster or other form of severe trauma.

Localized amnesia

- The individual fails to recall events that occurred during a circumscribed period of time, usually the first few hours after the event (e.g., the uninjured survivor of a car accident in which a person has been killed may not be able to recall anything that happen from the time of the accident until two days later).

Selective Amnesia

- The person can recall some, but not all, of the events during a circumscribed period of time (e.g., a combat veteran can recall only parts of a series of violent combat experiences).

Generalized Amnesia

- The person has a failure of recall encompasses the person's entire life.

Continuous Amnesia

- It is defined as the inability to recall events subsequent to a specific time up to and including the present.

Systematized Amnesia

- The person's loss of memory for certain categories of information, such as all memories relating to one's family or to a particle person.

Individuals who exhibit these latter three types of Dissociative Amnesia may ultimately be diagnosed as having a more complex form of Dissociative Disorder (e.g., Dissociative Identity Disorder).

Associated Features

Some individuals may report depressive symptoms, anxiety, depersonalization, trance states, analgesia, and spontaneous age regression. Other problems that have been reported include sexual dysfunction, impairment in work and interpersonal relationships, self-mutilation, aggressive impulses, and suicidal impulses and acts. Individuals with Dissociative Amnesia may also meet the criteria for Conversion Disorder, a Mood Disorder, a Substance-Related Disorder, or Personality Disorder. Associated laboratory findings.**Individuals with Dissociative Amnesia often display high hypnotizability as measured by standardized testing.**

Child vs. Adult Presentation

This disorder is especially difficult to assess in preadolescent children, because it may be confused with inattention, other childhood disorders, or learning disorder. Outside observation or evaluations by several different examiners may be used to make an accurate diagnosis.

Epidemiology

In the last twenty years there has been an increase in reported case that involves previously forgotten early-childhood traumas. It has been debated if this is due to the growing awareness of this disorder, or the over diagnosed in Individuals who are highly suggestible.

Etiology

Has been linked to overwhelming stress, which could be due to a traumatic event (war, abuse, or disasters). There may also be a genetic link to Dissociative Amnesia. *Note: Many people with this disorder tend to have close relatives with similar conditions.

Empirically supported treatments

- Psychotherapy, for mental and emotional disorders uses psychological techniques designed to encourage communication of conflicts and increase insight into problems.
- Cognitive therapy, focusing on changing dysfunctional thinking patterns and the resulting feelings and behaviors.
- Pharmacotherapy, there is no medication to treat the dissociative disorders themselves; however, a person with a dissociative disorder who also suffers from depression or anxiety might benefit from treatment with a medication such as an antidepressant or anti-anxiety medicine.

PROPOSED DSM-5 CHANGES (DSM5.org)

Dissociative Amnesia

A. Inability to recall important personal information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting. Note: There are two primary forms of Dissociative Amnesia: (1) localized amnesia for a specific event or events, and (2) Dissociative Fugue: generalized amnesia for identity and life history. Fugue may be accompanied by either purposeful travel or bewildered wandering.
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The memory loss is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a neurological or other general medical condition (e.g., Amnestic Disorder Due to Head Trauma).
D. The memory loss is not restricted to the symptoms of another mental disorder (e.g., inability to remember an important aspect of the traumatic event in Posttraumatic Stress Disorder or Acute Stress Disorder, or amnesia occurring as a symptom of Dissociative Identity Disorder or Somatization Disorder).

Specify if:

Dissociative Fugue subtype:
1. Amnesia includes inability to recall one's past, confusion about personal identity, or assumption of a new identity (partial or complete)
2. Sudden, unexpected travel away from home or work.

Rationale:

Minor wording changes for clarity.
B and C switched.

Changes to new C allow comorbid diagnoses to be made when warranted.

Severity:

Brief Dissociation Scale (Carlson E & Dahlenberg C, 2009)

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