

---

## CHAPTER 10: DISORDERS INVOLVING SOMATIC SYMPTOMS

---

### DISORDERS FOCUSING ON SOMATIC SYMPTOMS

- Several DSM-5 categories focus on somatic symptoms, including *factitious disorder*, *conversion disorder*, *somatic symptom disorder*, *illness anxiety disorder*, and *psychological factors affecting medical condition*.
- In these disorders, the somatic symptoms are primarily caused by psychosocial factors, or the symptoms trigger excessive anxiety or concern.

### FACTITIOUS DISORDER

- People with *factitious disorder* feign or induce physical disorders, typically for the purpose of assuming the role of a sick person.
- The disorder is not well understood or treated.
- In a related pattern, *factitious disorder imposed on another*, a parent fabricates or induces a physical illness in his or her child.
- **Dx Checklist**
  - **Factitious Disorder Imposed on Self**
    1. False creation of physical or psychological symptoms, or deceptive production of injury or disease, even without external rewards for such ailments.
    2. Presentation of oneself as ill, damaged, or hurt.
  - **Factitious Disorder Imposed on Another**
    1. False creation of physical or psychological symptoms, or deceptive production of injury or disease, in another person, even without external rewards for such ailments.
    2. Presentation of another person (victim) as ill, damaged, or hurt.

### CONVERSION AND SOMATIC SYMPTOM DISORDERS

- *Conversion disorder* involves bodily symptoms that affect voluntary motor and sensory functions, but the symptoms are inconsistent with known medical diseases.
- Diagnosticians are sometimes able to distinguish conversion disorder from a “true” medical problem by observing oddities in the patient’s medical picture.
- In *somatic symptom disorder*, people become excessively distressed, concerned, and anxious about bodily symptoms that they are experiencing, and their lives are greatly and disproportionately disrupted by the symptoms.

- Freud developed the initial psychodynamic view of conversion and somatic symptom disorders, proposing that the disorders represent a conversion of underlying emotional conflicts into physical symptoms.
- According to behaviorists, the physical symptoms of these disorders bring rewards to the sufferer, and such reinforcement helps maintain the symptoms.
- Some cognitive theorists propose that the disorders are forms of *communication* and that people express their emotions through their physical symptoms.
- Treatments for these disorders include insight, exposure, and drug therapies and may include techniques such as suggestion, reinforcement, or confrontation.
- **Dx Checklist:**
  - **Conversion Disorder**
    1. Presence of at least one symptom or deficit that affects voluntary or sensory function.
    2. Symptoms are found to be inconsistent with known neurological or medical disease.
    3. Significant distress or impairment.
  - **Somatic Symptom Disorder**
    1. Person experiences at least one upsetting or repeatedly disruptive physical (somatic) symptom.
    2. Person experiences an unreasonable number of thoughts, feelings, and behaviors regarding the nature or implications of the physical symptoms, including one of the following:
      - Repeated, excessive thoughts about their seriousness.
      - Continual high anxiety about their nature or health implications.
      - Disproportionate amounts of time and energy spent on the symptoms or their health implications.
    3. Physical symptoms usually continue to some degree for more than 6 months.

## **ILLNESS ANXIETY DISORDER**

- People with *illness anxiety disorder* are chronically anxious about and preoccupied with the notion that they have or are developing a serious medical illness, despite the absence of substantial somatic symptoms.
- Theorists explain this disorder much as they do anxiety disorders.
- Treatment includes drug, behavioral, and cognitive approaches originally developed for obsessive-compulsive disorder.
- **Dx Checklist**
  - **Illness Anxiety Disorder**

1. Person is preoccupied with thoughts about having or getting a significant illness. In reality, person has no or, at most, mild somatic symptoms.
2. Person has easily triggered, high anxiety about health.
3. Person displays unduly high number of health-related behaviors (e.g., keeps focusing on body) or dysfunctional health-avoidance behaviors (e.g., avoids doctors).
4. Person's concerns continue to some degree for at least 6 months.

## PSYCHOPHYSIOLOGICAL DISORDERS

- **Psychophysiological disorders** are those in which biological, psychosocial, and sociocultural factors interact to cause or worsen a physical problem.
- Factors linked to these disorders are:
  - biological factors, such as defects in the autonomic nervous system or particular organs;
  - psychological factors, such as particular needs, attitudes, or personality styles;
  - sociocultural factors, such as aversive social conditions and cultural pressures.
- For years, clinical researchers singled out a limited number of physical illnesses as psychophysiological.
- These traditional psychophysiological disorders include **ulcers, asthma, insomnia, chronic headaches, hypertension, and coronary heart disease.**
- Recently many other psychophysiological disorders have been identified.
  - Scientists have linked many physical illnesses to stress and have developed a new area of study called **psycho-neuroimmunology.**
- **Dx Checklist**
  - **Psychological Factors Affecting Other Medical Conditions**
    1. The presence of a medical condition.
    2. Psychological factors negatively affect the medical condition by:
      - Affecting the course of the medical condition.
      - Providing obstacles for the treatment of the medical condition.
      - Posing new health risks.
      - Triggering or worsening the medical condition.

## PSYCHONEUROIMMUNOLOGY

- The body's *immune system* consists of **lymphocytes** and other cells that fight off **antigens**—bacteria, viruses, and other foreign invaders—and cancer cells.

- Stress can slow *lymphocyte* activity, thereby interfering with the immune system's ability to protect against illness during times of stress.
- Factors that seem to affect immune functioning include *norepinephrine and corticosteroid activity, behavioral changes, personality style, and social support*.

## PSYCHOLOGICAL TREATMENTS FOR PHYSICAL DISORDERS

- **Behavioral medicine** combines psychological and physical interventions to treat or prevent medical problems.
- Psychological approaches such as *relaxation training, biofeedback training, meditation, hypnosis, cognitive techniques, support groups, and therapies that heighten the awareness and expression of emotions and needs* are increasingly being included in the treatment of various medical problems.

---

## CHAPTER 13: DISORDERS OF SEX AND GENDER

---

### SEXUAL DYSFUNCTIONS

- The **human sexual response cycle** consists of four phases: *desire, excitement, orgasm, and resolution*.
- **Sexual dysfunctions**, disorders in which people cannot respond normally in a key area of sexual functioning, make it difficult or impossible for a person to have or enjoy sexual activity.

### DISORDERS OF DESIRE

- The DSM-5 lists two disorders of the *desire phase* of the *sexual response cycle*: **male hypoactive sexual desire disorder** and **female sexual interest/arousal disorder**.
- **Dx Checklist**
  - **Male Hypoactive Sexual Desire Disorder**
    1. For at least 6 months, individual repeatedly experiences few or no sexual thoughts, fantasies, or desires.
    2. Individual experiences significant distress about this.
  - **Female Sexual Interest/Arousal Disorder**
    1. For at least 6 months, individual usually displays reduced or no sexual interest and arousal, characterized by the reduction or absence of at least three of the following:
      - Sexual interest

- Sexual thoughts or fantasies
  - Sexual initiation or receptiveness
  - Excitement or pleasure during sex
  - Responsiveness to sexual cues
  - Genital or nongenital sensations during sex.
2. Individual experiences significant distress.
- Men with the former disorder persistently lack or have reduced interest in sex and, in turn, engage in little sexual activity.
  - Women with the latter disorder lack normal interest in sex, rarely initiate sexual activity, and may also feel little excitement during sexual activity or in the presence of erotic cues.
  - Biological causes for these disorders include abnormal hormone levels, certain drugs, and some medical illnesses.
  - Psychological and sociocultural causes include specific fears, situational pressures, relationship problems, and the trauma of having been sexually molested or assaulted.

## DISORDERS OF EXCITEMENT

- Disorders of the *excitement phase* include **erectile disorder**, a repeated inability to attain or maintain an erection during sexual activity.
- **Dx Checklist**
  - **Erectile Disorder**
    1. For at least 6 months, individual usually finds it very difficult to obtain an erection, maintain an erection, and/or achieve past levels of erectile rigidity during sex.
    2. Individual experiences significant distress.
- Biological causes of erectile disorder include abnormal hormone levels, vascular problems, medical conditions, and certain medications.
- Psychological and sociocultural causes include the combination of *performance anxiety* and the *spectator role*, situational pressures such as job loss, and relationship problems.

## DISORDERS OF ORGASM

- **Premature ejaculation** has been attributed most often to behavioral causes, such as inappropriate early learning and inexperience.
  - In recent years, possible biological factors have been identified as well.
- **Delayed ejaculation**, a repeated absence of or long delay in reaching orgasm, biological causes, such as low testosterone levels, neurological diseases, and certain drugs, and psychological causes, such as performance anxiety and the spectator role.

- The dysfunction may also develop from male hypoactive sexual desire disorder.
- **Female orgasmic disorder**, which is often accompanied by arousal difficulties, has been tied to biological causes such as medical diseases and changes that occur after menopause, psychological causes such as memories of childhood traumas, and sociocultural causes such as relationship problems.
- **Dx Checklist**
  - **Premature Ejaculation**
    1. For at least 6 months, individual usually ejaculates within 1 minute of beginning sex with a partner and earlier than he wants to.
    2. Individual experiences significant distress.
  - **Delayed Ejaculation**
    1. For at least 6 months, individual usually displays a significant delay, infrequency, or absence of ejaculation during sexual activity with a partner.
    2. Individual experiences significant distress.
  - **Female Orgasmic Disorder**
    1. For at least 6 months, individual usually displays a significant delay, infrequency, or absence of orgasm, and/or is unable to achieve past orgasmic intensity.
    2. Individual experiences significant distress.
- Most clinicians agree that orgasm during intercourse is not critical to normal sexual functioning, provided a woman can reach orgasm with her partner during direct stimulation of the clitoris.

## SEXUAL PAIN DISORDERS

- **Genito-pelvic pain/penetration disorder** involves significant pain during intercourse.
  - In one form of this disorder, **vaginismus**, involuntary contractions of the muscles around the outer third of the vagina prevent entry of the penis.
  - In another form, **dyspareunia**, the person has severe vaginal or pelvic pain during intercourse. This form of the disorder usually occurs in women and typically has a physical cause, such as injury resulting from childbirth.
- **Dx Checklist**
  - **Genito-Pelvic Pain/Penetration Disorder**
    1. For at least 6 months, individual repeatedly experiences at least one of the following problems:
      - Difficulty having vaginal penetration during intercourse

- Significant vaginal or pelvic pain when trying to have intercourse or penetration
- Significant fear that vaginal penetration will cause vaginal or pelvic pain
- Significant tensing of the pelvic muscles during vaginal penetration.

2. Individual experiences significant distress from this.

## TREATMENTS FOR SEXUAL DYSFUNCTIONS

- In the 1970s, the work of William Masters and Virginia Johnson led to the development of *sex therapy*.
- Today sex therapy combines a variety of cognitive, behavioral, couple, and family systems therapies.
- It generally includes features such as careful assessment, education, acceptance of mutual responsibility, attitude changes, *sensate-focus* exercises, improvements in communication, and couple therapy.
- In addition, specific techniques have been developed for each of the sexual dysfunctions. The use of biological treatments for sexual dysfunctions is also increasing.

## PARAPHILIC DISORDERS

- *Paraphilias* are patterns characterized by recurrent and intense sexual urges, fantasies, or behaviors involving objects or situations outside the usual sexual norms.
  - For example, nonhuman objects, children, non-consenting adults, or experiences of suffering or humiliation.
- When an individual's paraphilia causes great distress, interferes with social or occupational functioning, or places the individual or others at risk of harm, a diagnosis of *paraphilic disorder* is applied.
- **Dx Checklist**
  - **Paraphilic Disorder**
    - For at least 6 months, individual experiences recurrent and intense sexually arousing fantasies, urges, or behaviors involving objects or situations outside the usual sexual norms (nonhuman objects; non-genital body parts; the suffering or humiliation of oneself or one's partner; or children or other non-consenting persons).
    - Individual experiences significant distress or impairment over the fantasies, urges, or behaviors. (In some paraphilic disorders—pedophilic disorder, exhibitionistic disorder, voyeuristic disorder, frotteuristic disorder, and sexual sadism

disorder—the performance of the paraphilic behaviors indicates a disorder, even in the absence of distress or impairment.

- Paraphilic disorders are found primarily in men.
- The paraphilic disorders include *fetishistic disorder*, *transvestic disorder*, *exhibitionistic disorder*, *voyeuristic disorder*, *frotteuristic disorder*, *pedophilic disorder*, *sexual masochism disorder*, and *sexual sadism disorder*.
- **Fetishistic disorder** consists of recurrent and intense sexual fantasies, urges, or behaviors that involve the use of a nonliving object or non-genital part.
- **Transvestic disorder**, also known as *transvestism* or *cross-dressing*, is characterized by repeated and intense sexual fantasies, urges, or behaviors that involve dressing in clothes of the opposite sex.
- **Exhibitionistic disorder** features repeated and intense sexual fantasies, urges, or behaviors that involve exposing one's genitals to others.
- **Voyeuristic disorder**, a person has repeated and intense sexual fantasies, urges, or behaviors that involve secretly observing unsuspecting people who are naked, undressing, or engaging in sexual activity.
- **Frotteuristic disorder**, a person has repeated and intense sexual fantasies, urges, or behaviors that involve touching or rubbing against a non-consenting person.
- **Pedophilic disorder**, a person has repeated and intense sexual fantasies, urges, or behaviors that involve watching, touching, or engaging in sexual acts with children.
- **Sexual masochism disorder** is characterized by repeated and intense sexual fantasies, urges, or behaviors that involve being humiliated, beaten, bound, or otherwise made to suffer.
- **Sexual sadism disorder** is characterized by repeated and intense sexual fantasies, urges, or behaviors that involve inflicting suffering on others.
- Although various explanations have been proposed for paraphilic disorders, research has revealed little about their causes.
- A range of treatments have been tried, including *aversion therapy*, *masturbatory satiation*, *orgasmic reorientation*, and *relapse-prevention training*.

## GENDER DYSPHORIA

- People with **gender dysphoria** persistently feel that they have been born the wrong gender and, along with this, experience significant distress or impairment.
- Gender dysphoria in children usually disappears by adolescence or adulthood, but in some cases it develops into adolescent and adult forms of gender dysphoria.
- **Dx Checklist**
  - Gender Dysphoria in Adolescents and Adults

1. For 6 months or more, individual's gender-related feelings and/or behaviors is at odds with those of his or her assigned gender, as indicated by two or more of the following symptoms:
  - Gender-related feelings and/or behaviors clearly contradict the individual's primary or secondary sex characteristics
  - Powerful wish to eliminate one's sex characteristics
  - Yearning for the sex characteristics of another gender
  - Powerful wish to be a member of another gender
  - Yearning to be treated as a member of another gender
  - Firm belief that one's feelings and reactions are those that characterize another gender.
2. Individual experiences significant distress or impairment.
  - The causes of this disorder are not well understood.
  - *Hormone treatments, facial surgery, speech therapy, and psychotherapy* have been used to help some people adopt the gender role they believe to be right for them.
  - *Sex-change operations* have also been performed, but the appropriateness of surgery as a form of treatment has been debated heatedly.

---

## CHAPTER 14: SCHIZOPHRENIA

---

### THE CLINICAL PICTURE OF SCHIZOPHRENIA

- **Schizophrenia** is a disorder in which personal, social, and occupational functioning deteriorate as a result of disturbed thought processes, distorted perceptions, unusual emotions, and motor abnormalities.
- Approximately 1 percent of the world's population suffers from this disorder.
- **Dx Checklist**
  - **Schizophrenia**
    1. For 1 month, individual displays two or more of the following symptoms much of the time:
      - Delusions
      - Hallucinations
      - Disorganized speech
      - Very abnormal motor activity, including catatonia
      - Negative symptoms

2. At least one of the individual's symptoms must be delusions, hallucinations, or disorganized speech.
3. Individual functions much more poorly in various life spheres than was the case prior to the symptoms.
4. Beyond this 1 month of intense symptomology, individual continues to display some degree of impaired functioning for at least 5 additional months.

## SYMPTOMS OF SCHIZOPHRENIA

- The symptoms of schizophrenia fall into three groupings.
  - **Positive symptoms** include *delusions*, certain *formal thought disorders*, *hallucinations* and other *disturbances in perception and attention*, and *inappropriate affect*.
  - **Negative symptoms** include *poverty of speech*, *restricted affect*, *loss of volition*, and *social withdrawal*.
  - **Psychomotor symptoms**, collectively called *catatonia* in their extreme form.
- Schizophrenia usually emerges during late adolescence or early adulthood and tends to progress through three phases: *prodromal*, *active*, and *residual*.

## DIAGNOSING SCHIZOPHRENIA

- DSM-5 calls for a diagnosis of schizophrenia after symptoms of the disorder continue for *six months* or more.
  - This diagnosis also requires that people have active symptoms for at least one of those months and show a deterioration from previous levels of functioning.
- **Type I schizophrenia** patients with the former type seem to be dominated by positive symptoms.
- **Type II schizophrenia** patients with the former type seem to be dominated by negative symptoms

## BIOLOGICAL EXPLANATIONS

- The biological explanations of schizophrenia point to genetic, biochemical, structural, and viral causes.
- The *genetic* view is supported by studies of relatives, twins, adoptees, and genetic linkage, and by molecular biology.
- The leading *biochemical* explanation holds that the brains of people with schizophrenia, particularly those with largely positive symptoms, may contain an unusually large number of *dopamine* receptors, especially *D-2 receptors*, leading to excessive dopamine activity.
- Brain-imaging techniques have also detected *abnormal brain structures* in many people with schizophrenia, particularly those with a number of negative

symptoms, including *enlarged ventricles* and *abnormal blood flow* in certain parts of the brain.

- Some researchers believe that schizophrenia is related to a *virus* that settles in the fetus and perhaps lies quiet until adolescence or young adulthood.

## PSYCHOLOGICAL EXPLANATIONS

- The leading psychological explanations for schizophrenia come from the psychodynamic, behavioral, and cognitive models.
- In influential *psychodynamic* explanations, **Freud** theorized that schizophrenia involves *regression* to a state of primary narcissism and efforts to *restore* ego control, and **Fromm-Reichmann** proposed that *schizophrenogenic mothers* help produce schizophrenia.
  - Contemporary psychodynamic theorists, however, ascribe the disorder to a combination of biological and psychodynamic factors.
- *Behaviorists* suggest that people with schizophrenia fail to learn to attend to appropriate social cues.
- *Cognitive* theorists contend that when people with schizophrenia try to understand their strange biological sensations, they develop delusional thinking.
- None of these theories have received compelling research support.

## SOCIOCULTURAL EXPLANATIONS

- One sociocultural explanation holds that *multicultural* differences may influence the prevalence and character of schizophrenia, as well as recovery from this disorder, both within the United States and around the world.
- Another sociocultural explanation says that society expects people who are *labeled* as having schizophrenia to behave in certain ways and that these expectations actually lead to further symptoms.
- Other sociocultural theorists point to *family dysfunctioning*—including such interactions as *double-bind communications*—as a cause of schizophrenia.
- Such specific family features have not been implicated by research, although general *family stress and conflict* have repeatedly been linked to schizophrenia.
- The theorist **R. D. Laing** has presented schizophrenia as a *constructive* process by which people try to cure themselves of the confusion and unhappiness caused by their society and family.

---

CHAPTER 15: TREATMENTS FOR SCHIZOPHRENIA AND OTHER  
SEVERE MENTAL DISORDERS

---

### OVERVIEW OF TREATMENT

- For years, all efforts to treat schizophrenia brought only frustration.
- Schizophrenia is still difficult to treat, but today's therapies are more successful than those of the past.

### PAST INSTITUTIONAL CARE

- For more than half of the twentieth century, the main treatment for schizophrenia and other severe mental disorders was *institutionalization* and *custodial care*.
- Because patients failed to respond to traditional therapies, they were usually placed in overcrowded public institutions (*state hospitals* in the United States), typically in *back wards* where the primary goal was to maintain and restrain them.
- Between 1845 and 1955 the number of state hospitals and mental patients rose steadily, while the quality of care declined.

### IMPROVED INSTITUTIONAL CARE

- In the 1950s, two in-hospital approaches were developed, *milieu therapy* and *token economy programs*.
- They often brought improvement and particularly helped patients to care for themselves and feel better about themselves.

### ANTIPSYCHOTIC DRUGS

- The discovery of *antipsychotic drugs* in the 1950s revolutionized the treatment of schizophrenia and other disorders marked by psychosis.
- Today they are almost always a part of treatment.
- Theorists believe that the first generation of antipsychotic drugs operate by reducing excessive dopamine activity in the brain.
- These "conventional" antipsychotic drugs reduce the positive symptoms of schizophrenia more completely, or more quickly, than the negative symptoms.
- The *conventional* antipsychotic drugs can also produce dramatic unwanted effects, particularly movement abnormalities called *extrapyramidal effects*, which include *Parkinsonian and related symptoms*, *neuroleptic malignant syndrome*, and *tardive dyskinesia*.

- More than 10 percent of the people who take conventional antipsychotic drugs for an extended time develop **tardive dyskinesia**, a syndrome that can be difficult or impossible to eliminate, even when the drugs are stopped.
- Recently, *atypical*, or *second-generation*, antipsychotic drugs (such as clozapine, risperidone, and olanzapine) have been developed; these seem to be more effective than the conventional drugs and to cause fewer or no extrapyramidal effects.

## **PSYCHOTHERAPY**

- *Psychotherapy* is often employed successfully in combination with antipsychotic drugs.
- Helpful forms include *cognitive-behavioral therapy*, *family therapy*, and *social therapy*.
- *Family support groups* and *family psychoeducational programs* are also growing in number.

## **THE COMMUNITY APPROACH**

- A *community approach* to the treatment of schizophrenia and other severe mental disorders began in the 1960s, when a policy of *deinstitutionalization* in the United States brought about a mass exodus of hundreds of thousands of patients from state institutions into the community.
- Among the key elements of effective community care programs are coordination of patient services by a *community mental health center*, *short-term hospitalization* (followed by *aftercare*), *day centers*, *halfway houses*, *occupational training and support*, and *case management*.
- Unfortunately, the quality and funding of community care for people with schizophrenia and other severe disorders have been inadequate throughout the United States, often resulting in a “revolving door” pattern.
- One consequence is that many people with such disorders are now homeless or in jail.
- Still others live in *nursing homes* or *rest homes* where they do not receive effective treatment, and many live in *boardinghouses* or *single-room-occupancy hotels*.

## **THE PROMISE OF COMMUNITY TREATMENT**

- The potential of proper community care to help people recovering from schizophrenia and other severe disorders continues to capture the interest of clinicians and policy makers.
- One major development has been the formation of *national interest groups* that are successfully promoting community treatment for people with these disorders.

## PERSONALITY DISORDERS AND DSM-5

- People with a **personality disorder** display an enduring, rigid pattern of inner experience and outward behavior.
- Their personality traits are much more extreme and dysfunctional than those of most other people in their culture, resulting in significant problems for them or those around them.
- It has been estimated that as many as 9 to 13 percent of adults have such a disorder.
- DSM-5 uses a *categorical approach* that lists 10 distinct personality disorders.
- In addition, the framers of DSM-5 have proposed a *dimensional approach* to the classification of personality disorders, an approach that they assigned for further study and possible inclusion in a future revision of the DSM.
- **Dx Checklist**
  - **Personality Disorder**
    1. Individual displays a long-term, rigid, and wide-ranging pattern of inner experience and behavior that leads to dysfunction in at least two of the following realms:
      - Cognition
      - Emotion
      - Social interactions
      - Impulsivity.
    2. The individual's pattern is significantly different from ones usually found in his or her culture.
    3. Individual experiences significant distress or impairment.

## “ODD” PERSONALITY DISORDERS

- Three of the personality disorders in DSM-5 are marked by the kinds of odd or eccentric behavior often seen in schizophrenia.
- People with **paranoid personality disorder** display a broad pattern of distrust and suspiciousness.
- Those with **schizoid personality disorder** persistently avoid social relationships, have little or no social interest, and show little emotional expression.
- People with **schizotypal personality disorder** display a range of interpersonal problems marked by extreme discomfort in close relationships, very odd forms of thinking and behavior, and behavioral eccentricities.
- People with these three kinds of disorders usually are resistant to treatment, and treatment gains tend to be modest at best.

## “DRAMATIC” PERSONALITY DISORDERS

- Four of the personality disorders in DSM-5 are marked by highly dramatic, emotional, or erratic symptoms.
- People with *antisocial personality disorder* display a pattern of disregard for and violation of the rights of others.
- No known treatment is notably effective.
- People with *borderline personality disorder* display a pattern of instability in interpersonal relationships, self-image, and mood, along with extreme impulsivity.
- Treatment apparently can be helpful and lead to some improvement.
- People with *histrionic personality disorder* (once called *hysterical personality disorder*) display a pattern of extreme emotionality and attention seeking.
- Clinical case reports suggest that treatment is helpful on occasion.
- People with *narcissistic personality disorder* display a pattern of grandiosity, need for admiration, and lack of empathy. It is one of the most difficult disorders to treat.

## “ANXIOUS” PERSONALITY DISORDER

- Three of the personality disorders in DSM-5 are marked by anxious and fearful behavior.
- People with *avoidant personality disorder* are consistently uncomfortable and inhibited in social situations, overwhelmed by feelings of inadequacy, and extremely sensitive to negative evaluation.
- People with *dependent personality disorder* have a persistent need to be taken care of, are submissive and clinging, and fear separation.
- People with *obsessive-compulsive personality disorder* are so preoccupied with order, perfection, and control that they lose their flexibility, openness, and efficiency.
- A variety of treatment strategies have been used for people with these disorders and apparently have been modestly to moderately helpful.

## MULTICULTURAL FACTORS

- Despite the field’s growing focus on personality disorders, relatively little research has been done on gender and other *multicultural* influences.
- Nevertheless, many clinicians believe that multicultural factors play key roles in the diagnosis and treatment of personality disorders, and researchers have recently begun to study this possibility.

## ARE THERE BETTER WAYS TO CLASSIFY PERSONALITY DISORDERS?

- The personality disorders listed in DSM-5 are commonly misdiagnosed, an indication of serious problems in the validity and reliability of the categories.
- Given the significant problems posed by the current *categorical approach*, a number of today's theorists believe that personality disorders should instead be described and classified by a *dimensional approach*.
- One such approach, the "**Big Five**" model, may be included in the next edition of the World Health Organization's International Classification of Diseases.
- Another dimensional approach, the "*personality disorder—trait specified*" model, is under study for possible inclusion in a future revision of DSM-5.

---

### CHAPTER 17: DISORDERS COMMON AMONG CHILDREN AND ADOLESCENCE

---

## DISORDERS COMMON AMONG CHILDREN AND ADOLESCENTS

- Emotional and behavioral problems are common in childhood and adolescence, but in addition, at least 20 percent of all children and adolescents in the United States have a diagnosable psychological disorder.
- A particular concern among children is that of being *bullied*.
- According to surveys, more than 25 percent of students are bullied frequently and more than 70 percent have been victims of bullying at least once.
- *Cyberbullying* is on the rise.
- *Anxiety disorders* are particularly common among children and adolescents.
- This group of problems includes adultlike disorders, such as social anxiety disorder and generalized anxiety disorder, and the childhood form of **separation anxiety disorder**, which is characterized by excessive anxiety, often panic, whenever a child is separated from a parent.
- **Dx Checklist**
  - **Separation Anxiety Disorder**
    1. Individual displays fear or anxiety concerning separation from attachment figures, anxiety that is unreasonable or excessive for his or her age group.
    2. Individual's excessive anxiety features three or more of the following symptoms:
      - Repeated separation-related upset
      - Repeated loss-related concern
      - Repeated fear of experiencing separation-caused events

- Repeated resistance to leaving home
  - Repeated resistance to being alone
  - Repeated resistance to sleep-aways
  - Repeated separation-focused nightmares
  - Repeated separation-triggered physical symptoms.
3. Individual's symptoms last 4 or more weeks for children and at least 6 months for adults.
  4. Significant distress or impairment.
- Those with separation anxiety disorder have great trouble traveling away from their family, and they often refuse to visit friends' houses, go on errands, or attend camp or school.
  - Many cannot even stay alone in a room and cling to their parent around the house. Some also have temper tantrums, cry, or plead to keep their parents from leaving them.
  - Two percent of children and 8 percent of adolescence experience **depression**.
  - Depression in the young may be triggered by negative life events (particularly losses), major changes, rejection, or ongoing abuse.
  - Childhood depression is often characterized by such symptoms as headaches, stomach pain, irritability, and a disinterest in toys and games.
  - Although there is no difference between the rates of depression in boys and girls before the age of 13, girls are twice as likely as boys to be depressed by the age of 16.
  - In the past two decades, there has also been an enormous increase in the number of children and adolescents who receive diagnoses of *bipolar disorder*.
    - Such diagnoses are expected to decrease now that DSM-5 has added a new childhood category, **disruptive mood dysregulation disorder**.
  - **Dx Checklist**
    - **Disruptive Mood Dysregulation Disorder**
      1. For at least a year, individual repeatedly displays severe outbursts of temper that are extremely out of proportion to triggering situations and different from ones displayed by most other people of his or her age.
      2. The outbursts occur at least three times per week and are present in at least two settings (home, school, with peers).
      3. Individual repeatedly displays irritable or angry mood between the outbursts.
      4. Individual receives initial diagnosis between 6 and 18 years of age.
  - Children with **oppositional defiant disorder** and **conduct disorder** exceed the normal breaking of rules and act very aggressively.
  - Children with oppositional defiant disorder argue repeatedly with adults, ignore adult rules and requests, and feel intense anger and resentment.

- Dx Checklist
  - Conduct Disorder
    1. Individual repeatedly behaves in ways that violate the rights of other people or ignore the norms or rules society, beyond the violations displayed by most other people of his or her age.
    2. At least three of the following features are present over the past year (and at least one in the past 6 months):
      - Frequent bullying or threatening of others
      - Frequent provoking of physical fights
      - Using dangerous weapons
      - Physical cruelty to people
      - Physical cruelty to animals
      - Stealing during confrontations with a victim
      - Forcing someone into sexual activity
      - Fire-setting
      - Deliberately destroying others' property
      - Breaking into a house, building, or car
      - Frequent lying
      - Stealing items of value under non-confrontational circumstances
      - Frequent staying out beyond curfews, starting before the age of 13
      - Running away from home overnight at least twice
      - Frequent truancy from school, starting before the age of 13
    3. Significant impairment.
- Those with conduct disorder, a more severe pattern, repeatedly violate the basic rights of others.
- Children with this disorder often are violent and cruel and may deliberately destroy property, steal, and run away.
- Several types of conduct disorders have been identified.
- Clinicians have treated children with conduct disorders by using approaches such as *parent-child interaction therapy*, *video modeling*, *parent management training*, *treatment foster care*, *problem-solving skills training*, and the *Coping Power Program*.
- Some individuals with this disorder have been institutionalized in *juvenile training centers*.
  - A number of *prevention* programs have also been developed.
- Children with an *elimination disorder*—*enuresis* or *encopresis*—repeatedly urinate or pass feces in inappropriate places.

- Behavioral approaches, such as the *bell-and-battery technique*, are effective treatments for enuresis.

## NEURODEVELOPMENTAL DISORDERS

- Neurodevelopmental disorders are a group of disabilities in the functioning of the brain that emerge at birth or during very early childhood and affect the person's behavior, memory, concentration, and/or ability to learn.
- They often have a significant impact throughout the person's life.
- *Attention-deficit/hyperactivity disorder*, *autism spectrum disorder*, and *intellectual disability* are all neurodevelopmental disorders.
- **Dx Checklist**
  - **Attention-Deficit/Hyperactivity Disorder**
    1. Individual presents one or both of the following patterns:
      - a. For 6 months or more, individual frequently displays at least six of the following symptoms of inattention, to a degree that is maladaptive and beyond that shown by most similarly aged persons:
        - Unable to properly attend to details, or frequently makes careless errors
        - Finds it hard to maintain attention
        - Fails to listen when spoken to by others
        - Fails to carry out instructions and finish work
        - Disorganized
        - Dislikes or avoids mentally effortful work
        - Loses items that are needed for successful work
        - Easily distracted by irrelevant stimuli
        - Forgets to do many everyday activities.
      - b. For 6 months or more, individual frequently displays at least six of the following symptoms of hyperactivity and impulsivity, to a degree that is maladaptive and beyond that shown by most similarly aged persons:
        - Fidgets, taps hands or feet, or squirms
        - Inappropriately wanders from seat
        - Inappropriately runs or climbs
        - Unable to play quietly
        - In constant motion
        - Talks excessively
        - Interrupts questioners during discussions
        - Unable to wait for turn
        - Barges in on others' activities or conversations.

2. Individual displayed some of the symptoms before 12 years of age.
  3. Individual shows symptoms in more than one setting.
  4. Individual experiences impaired functioning.
- Children who display **attention-deficit/hyperactivity disorder (ADHD)** attend poorly to tasks, behave over actively and impulsively, or both.
    - *Ritalin* and other *stimulant drugs* and *behavioral programs* are often effective treatments.
  - People with **autism spectrum disorder** are *extremely unresponsive to others*, *have severe communication deficits*, and *display very rigid and repetitive behaviors, interests, and activities*.
  - **Dx Checklist**
    - **Autism Spectrum Disorder**
      1. Individual displays continual deficiencies in various areas of communication and social interaction, including the following:
        - Social-emotional reciprocity
        - Nonverbal communication
        - Development and maintenance of relationships.
      2. Individual displays significant restriction and repetition in behaviors, interests, or activities, including two or more of the following:
        - Exaggerated and repeated speech patterns, movements, or object use
        - Inflexible demand for same routines, statements, and behaviors
        - Highly restricted, fixated, and overly intense interests
        - Over- or underreactions to sensory input from the environment.
      3. Individual develops symptoms by early childhood.
      4. Individual experiences significant impairment.
  - The leading explanations of this disorder point to cognitive deficits, such as failure to develop a **theory of mind**; and biological abnormalities, such as abnormal development of the **cerebellum**, as causal factors.
  - Although no treatment totally reverses the autistic pattern, significant help is available in the form of *cognitive-behavioral treatments*, *communication training*, *training and treatment for parents*, and *community integration*.
  - People with **intellectual disability** are significantly below average in *intelligence* and *adaptive ability*.
  - **Dx Checklist**
    - **Intellectual Disability**
      1. Individual displays deficient intellectual functioning in areas such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, and learning from experience. The deficits are reflected by clinical assessment and intelligence tests.

2. Individual displays deficient adaptive functioning in at least one area of daily life, such as communication, social involvement, or personal independence, across home, school, work, or community settings. The limitations extend beyond those displayed by most other persons of his or her age and necessitate ongoing support at school, work, or independent living.
  3. The deficits begin during the developmental period (before the age of 18).
- **Mild ID**, by far the most common level of intellectual disability, has been linked primarily to environmental factors such as unstimulating environments during a child's early years, inadequate parent-child interactions, and insufficient learning experiences.
  - **Moderate, severe, and profound ID** are caused primarily by biological factors, although people who function at these levels also are affected enormously by their family and social environment.
  - The leading biological causes of intellectual disability are *chromosomal abnormalities, metabolic disorders, prenatal problems, birth complications, and childhood diseases and injuries*.
  - Today intervention programs for people with intellectual disability emphasize the importance of a comfortable and stimulating residence, either the family home or a small institution or group home that follows the principles of **normalization**.
  - Other important interventions include *proper education, therapy for psychological problems, and programs offering training in socializing, sex, marriage, parenting, and occupational skills*.
  - One of the most intense debates in the field of education centers on whether people with intellectual disability profit more from *special classes* or from *mainstreaming*.
  - Research has not consistently favored one approach over the other.

---

## CHAPTER 18: DISORDERS OF AGING AND COGNITION

---

### DISORDERS OF LATER LIFE

- The problems of elderly people are often linked to the losses and other stresses and changes that accompany advancing age.
- As many as 50 percent of the elderly would benefit from mental health services, yet fewer than 20 percent receive them.
- *Depression* is a common mental health problem among those in this age group.
- Older people may also suffer from *anxiety disorders*.

- Between 4 and 6 percent exhibit *alcohol use disorder* in any given year, and many others *misuse prescription drugs*.
- In addition, some elderly people display psychotic disorders such as *schizophrenia* or *delusional disorder*.

## DISORDERS OF COGNITION

- Older people are more likely than people of other age groups to experience **delirium**, a fast-developing disturbance marked by great difficulty focusing attention, staying oriented, concentrating, and following an orderly sequence of thought.
- **Dx Checklist**
  - **Delirium**
    1. Over the course of hours or a few days, individual experiences fast-moving and fluctuating disturbances in attention and orientation to the environment.
    2. Individual also displays a significant cognitive disturbance.
  - **Neurocognitive disorders**, characterized by a significant decline in cognitive function, become increasingly common in older age groups.
  - **Dx Checklist**
    - **Major Neurocognitive Disorder**
      1. Individual displays substantial decline in at least one of the following areas of cognitive function:
        - Memory and learning
        - Attention
        - Perceptual-motor skills
        - Planning and decision-making
        - Language ability
        - Social awareness.
      2. Cognitive deficits interfere with the individual's everyday independence
    - **Mild Neurocognitive Disorder**
      1. Individual displays modest decline in at least one of the following areas of cognitive function:
        - Memory and learning
        - Attention
        - Perceptual-motor skills
        - Planning and decision-making
        - Language ability
        - Social awareness
      2. Cognitive deficits do not interfere with the individual's everyday independence.

- There are many types of neurocognitive disorders, the most common being *Alzheimer's disease*.
- Alzheimer's disease has been linked to an unusually high number of *senile plaques* and *neurofibrillary tangles* in the brain.
- **Dx Checklist**
  - Neurocognitive Disorder Due to Alzheimer's Disease
    1. Individual displays the features of major or mild neurocognitive disorder.
    2. Memory impairment is a prominent feature.
    3. Genetic indications or family history of Alzheimer disease underscore diagnosis, but are not essential to diagnosis.
    4. Symptoms are not due to other types of disorders or medical problems.
- According to a leading explanation of late-onset Alzheimer's disease—the most common kind of Alzheimer's disease—people who inherit *ApoE-4*, a particular form of the *apolipoprotein E (ApoE) gene*, are particularly vulnerable to the development of Alzheimer's disease.
- Apparently, the ApoE-4 gene form promotes the excessive formation of *beta-amyloid proteins*, helping to spur the formation of plaques and, in turn, the breakdown of the *tau protein*, the formation of numerous tangles, the death of many neurons, and ultimately, the onset of Alzheimer's disease.
- A number of other causes have also been proposed for this disease, including high levels of *zinc*, *lead*, or *other toxins*; *immune system problems*; and a *virus* of some kind.
- Researchers are making significant strides at better assessing Alzheimer's disease and other types of neurocognitive disorders and even at identifying those who will eventually develop these disorders.
- Drug, cognitive, and behavioral therapies have been used to treat Alzheimer's disease, with limited success.
- Addressing the needs of caregivers is now also recognized as a key part of treatment. In addition, sociocultural approaches such as day-care facilities are on the rise.
- Major treatment breakthroughs are expected in the coming years.

## KEY ISSUES

- In studying and treating the problems of old age, clinicians have become concerned about three issues:
  - *the problems of elderly members of racial and ethnic minority groups*;
  - *inadequacies of long-term care*;
  - *the need for health maintenance by young adults*.

---

**CHAPTER 19: LAW, SOCIETY, AND THE MENTAL HEALTH  
PROFESSIONAL**

---

**LAW AND MENTAL HEALTH**

- The mental health profession interacts with the *legislative and judicial systems* in two key ways.
  - First, clinicians help assess the mental stability of people accused of crimes.
  - Second, the legislative and judicial systems help regulate mental health care.

**CRIMINAL COMMITMENT**

- The punishment of people convicted of crimes depends on the assumption that individuals are *responsible for their acts* and are *capable of defending themselves in court*.
- Evaluations by clinicians may help judges and juries decide the culpability of defendants and sometimes result in criminal commitment.
- If defendants are judged to have been *mentally unstable at the time they committed a crime*, they may be found *not guilty by reason of insanity* and placed in a treatment facility rather than a prison.
- “Insanity” is a legal term, one defined by legislators, not by clinicians. In federal courts and about half the state courts, insanity is judged in accordance with the *M’Naghten test*, which holds that defendants were insane at the time of a criminal act if they did not know the nature or quality of the act or did not know right from wrong at the time they committed it.
  - Other states use the broader *American Law Institute test*.
- The insanity defense has been criticized on several grounds, and some states have added an additional option, *guilty but mentally ill*.
- Defendants who receive this verdict are sentenced to prison with the proviso that they will also receive psychological treatment.
- Still another verdict option is *guilty with diminished capacity*.
- A related category consists of convicted *sex offenders*, who are considered in some states to have a mental disorder and are therefore assigned to treatment in a mental health facility.
- Regardless of their state of mind at the time of the crime, defendants may be found *mentally incompetent to stand trial*, that is, incapable of fully understanding the charges or legal proceedings that confront them.
  - These defendants are typically sent to a mental hospital until they are competent to stand trial.

## CIVIL COMMITMENT

- The legal system also influences the clinical profession.
- Courts may be called upon to commit non-criminals to mental hospitals for treatment, a process called **civil commitment**.
- Society allows involuntary commitment of people considered to be *in need of treatment and dangerous to themselves or others*.
- Laws governing civil commitment procedures vary from state to state, but a *minimum standard of proof*—clear and convincing evidence of the necessity of commitment—has been defined by the Supreme Court.

## PROTECTING PATIENTS' RIGHTS

- The courts and legislatures significantly affect the mental health profession by specifying legal rights to which patients are entitled.
- The rights that have received the most attention are the *right to treatment* and the *right to refuse treatment*.

## OTHER CLINICAL–LEGAL INTERACTIONS

- Mental health and legal professionals also cross paths in four other areas.
  - First, *malpractice suits* against therapists have increased in recent years.
  - Second, the legislative and judicial systems help define *professional boundaries*.
  - Third, lawyers may solicit the advice of mental health professionals regarding the *selection of jurors* and case strategies.
  - Fourth, psychologists may *investigate legal phenomena* such as *eyewitness testimony* and *patterns of criminality*.

## ETHICAL PRINCIPLES

- Each clinical profession has a *code of ethics*.
- The psychologists' code includes prohibitions against *engaging in fraudulent research* and against *taking advantage of clients and students, sexually or otherwise*.
- It also establishes guidelines for respecting patient *confidentiality*.
- The case of **Tarasoff v. Regents of the University of California** helped to determine the circumstances in which therapists have a *duty to protect* the client or others from harm and must break confidentiality.

## MENTAL HEALTH, BUSINESS, AND ECONOMICS

- Clinical practice and study also intersect with the business and economic worlds.
- Clinicians often help to address psychological problems in the workplace, for example, through *employee assistance programs* and *stress-reduction and problem-solving seminars*.
- Reductions in government funding of clinical services have left much of the expense for these services to be paid by insurance companies.
- Private insurance companies are setting up **managed care programs** whose structure and reimbursement procedures influence and often reduce the duration and focus of therapy.
- Their procedures, which include *peer review systems*, may also compromise patient confidentiality and the quality of therapy services.

### **TECHNOLOGY AND MENTAL HEALTH**

- The remarkable technological advances of recent times have affected the mental health field, just as they have affected all other fields and professions.
- In particular, these advances have contributed to new vehicles and triggers for psychopathology, new forms of psychopathology, and various kinds of cybertherapy.

### **THE PERSON WITHIN THE PROFESSION**

- Mental health activities are affected by the personal needs, values, and goals of the human beings who provide the clinical services.
- These factors inevitably affect the choice, direction, and even quality of their work.