

# **CDC 4C051N**

## **Mental Health Service Journeyman**

### **Volume 2. Mental Health Fundamentals**



**Extension Course Program (A4L)  
Air University  
Air Education and Training Command**

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**Author:** MSgt Jeff L. Johnson  
383d Training Squadron  
US Air Force School of Health Sciences (AETC)  
383 TRS/TRR  
939 Missile Road  
Sheppard Air Force Base, Texas 76311-2363  
DSN: 736-1965  
E-mail address: jeff.johnson@sheppard.af.mil

**Instructional Systems Specialist:** Todd Knowles  
DSN: 596-1189

**Editor:** Julie A. Lockhart  
DSN: 596-3621

Extension Course Program (A4L)  
Air University (AETC)  
Maxwell Air Force Base, Gunter Annex, Alabama 36118-5643

THIS 4C051N career development course (CDC), Mental Health Fundamentals, will provide you with foundations of psychological and physiological development. Once the foundation is soundly explained, you will build on this knowledge and begin exploring selected mental health disorders and psychopharmacological interventions. You will also have the opportunity to expand your knowledge in the areas of family advocacy and critical incident stress.

Unit 1 begins with the very basic theories of psychological and physiological development. These areas are a must in understanding the potential causes and/or origins of mental disorders which will be studied in unit 2. You will have the opportunity to briefly become familiar with Freud, Erikson, and Sullivan's theories of development. Study this unit carefully as it is the foundation for much of the diagnostic criteria.

Unit 2 opens with the diagnostic process. This is followed by how you as a journeyman should recognize and respond to patients with mental disorders. This is perhaps one of the more interesting units as you will become familiar with each diagnostic category. You will also learn about the different types of medications that are used to treat the different disorders. This unit will close with a look at mental conditions not related to mental disorders.

Unit 3 will include information on the interventions for family maltreatment.. You will be introduced to proper terms and definitions used in the Family Advocacy Program. You will also learn how to identify resources to achieve safety for victims and alleged offenders alike. The unit ends with an overview of the family advocacy prevention program.

Unit 4 will take you through Traumatic Stress Response. You will learn about the different types of disasters and how to prepare for those disasters. Finally, you will learn about the four phases of a group informational briefing.

A glossary of abbreviations and acronyms is included for your use.

The use of a name of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

To get a response to your questions concerning subject matter in this course, or to point out technical errors in the text, unit review exercises, or course examination, call or write the author using the contact information on the inside front cover of this volume.

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This volume is valued at 12 hours and 4 points.

**NOTE:**

In this volume, the subject matter is divided into self-contained units. A unit menu begins each unit, identifying the lesson headings and numbers. After reading the unit menu page and unit introduction, study the section, answer the self-test questions, and compare your answers with those given at the end of the unit. Then accomplish the unit review exercises.

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## **Student Notes**

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## **Student Notes**

# Unit 1. Theories of Development and Personality

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**L**IFE DOESN'T STAND STILL. We're in a state of constant change throughout our lives. When asked who we are, we respond by providing a description of ourselves in terms of who we are *now*. But we have been, and will be, many different people in our lifetime—a child, an adolescent, and an adult. To understand ourselves fully, we must understand the process of development and the predictable changes in behavior associated with increasing age. An understanding of this process serves as a framework within which each individual patient can be assessed and understood. To give you a firm foundation for acquiring this knowledge, you will begin with a review of some of the factors involved with the human growth and development process. You will look at some basic concepts about developmental changes that take place from childhood through older adulthood. In addition to the process of development and aging, you will study the dimensions of self-concept and the development of self-image.

## 1–1. Developmental Psychology

Normally, we all proceed through the same general sequences of development; however, there is a wide range of individual differences. Some are purely individual while others are common to certain groups (e.g., age groups, generations, or people who were raised and lived in particular cultures or societies). As you can see, our development is subject to many influences such as the characteristics we are born with plus the effects of the individual's experiences. Some influences have more impact than others. Let's look at some.

### 201. Developmental process

The developmental and biological influences that contribute to who we become are many and often complicated. This lesson will guide you through the variables that affect each individual's personality. In this lesson, you will look at the basic processes of development.

#### Influences

Many factors play a major role in an individual's growth and development. Some factors that affect our personality development are beyond our control while others are a compilation of environmental events and experiences. Frequently, you hear that someone has a nice personality, a nasty personality, very little personality, or no personality at all. Actually, everyone has a personality. Our personality is

the sum total of all that a person is, feels, or does, either on a conscious or subconscious level. With this in mind, let's consider the following four factors that determine one's personality:

- Hereditary.
- Environmental.
- Development.
- Physiological.

### ***Hereditary factors***

Hereditary factors affecting human development are the result of predisposed genetically transmitted features without external intervention to affect the outcome. An individual's height, weight, appearance, and potential muscular build are examples of hereditary factors that can have an effect on their feelings about themselves.

### ***Environmental factors***

Environmental factors have a continuous influence on our personality development. Children raised in the same household do not always experience the same shared environment. If you have siblings, think of the differences that may exist in your personal values, political or religious beliefs, and likes and dislikes. The environment may not be different but the personality of the each child will allow him or her to respond differently. What forces cause us to change as we pass through life?

Environmental factors include all of the outside influences and conditions that affect a person's life and development. Families, peers, religious figures, authority figures and communities are examples of the environmental factors that shape his or her personality. The following are types of genetic environmental correlations that will help you better understand how they relate to the environment's influence on the individual.

#### ***Genetic environmental—passive correlation***

In this environment, the child has no control over their environment. A child's parents who are athletic are more likely to emphasize outdoor activities. They may influence their children in the same manner by enrolling them in sports, gymnastics, or other athletic activities which would mirror the parents' interests.

#### ***Genetic environmental—evocative correlation***

In this environment, the child conducts himself or herself in ways that solicit positive responses from others. A pleasant child that receives positive "strokes" from their parents will seek the same response from others as a means of approval.

#### ***Genetic environmental—active correlation***

This environment is more common as the child grows older. In this correlation, the child will actively seek environments that fit their genetic tendencies; the intellect will seek environments with opportunities for academic achievements; the athlete will seek environments that include participating in or attending sporting events; the musician may join a band, etc.

### ***Developmental factors***

Every person traverses chronological milestones in development. Any number of factors can create unexpected interruption of normal development in a child. For instance, if a child experiences the death of a parent, this event alone can alter a child's personality regarding vulnerability and their place of safety in the world. An abusive home can alter the child's developing personality as they attempt to grasp the dynamics and how or why they are being abused. Personality develops through several different stages before a person reaches adulthood. The individual's experiences during these successive stages are considered the developmental factors that determine his or her adult personality.

***Physiological factors***

Physiological factors such as physical health, proper function of the endocrine system, chronic illness, and the level of vitality also play important roles in determining how one feels about oneself. Consequently, physiological factors play an important role in determining adult personality. Some physiological factors can be attributed to hereditary disease or illness, while others are the result of prenatal or perinatal and postnatal influences. The focus is not on hereditary issues, but rather on dysfunctions that are attributed to events occurring during pregnancy or at the time of birth or infancy.

***Prenatal influences***

The following list includes examples of activities, diseases, or behaviors the pregnant mother can engage in which can cause damage to the fetus' brain and cause dysfunctions to be "wired in."

- Teratogens: alcohol, tobacco, cocaine, heroin, methadone, lead, mercury, radiation.
- Diseases: rubella, syphilis, gonorrhea, Acquired Immune Deficiency Syndrome (AIDS).
- Poor prenatal care.
- Malnutrition.

***Perinatal and postnatal influences***

These are influences the parent can have that will affect the child after birth:

- Medication.
- Anoxia.
- Accident.
- Illness.
- Malnutrition.
- Poisoning.

**Nature or nurture?**

Years ago, some psychological theorists maintained that nearly all important developmental changes are controlled by biological factors (i.e., nature). Our behavior "unfolds" over time, like a plant growing from an acorn into an oak tree. Then, there are other theorists that proclaim the psychological environment (i.e., nurture) is the director of our development. Our development is "molded" by experiences, like flour dough in the hands of a baker. Current thinking asserts that both nature and nurture combine to influence our actions, thoughts, and feelings.

***Child development***

An example of the blending of nature and nurture prevails in child development. Few children learn to play a piano unless they are taught to do so or at least see others play the piano. However, you cannot effectively teach children to do much with a piano until physical development takes place, after age 3 or so. As you can see, we are creatures of both nature and nurture.

***Language development***

Speech and language are the tools humans use to communicate by sharing thoughts, ideas, and emotions. The most intensive period of language development is during the first three years of life, a key period of time when the brain is developing and maturing. This means the developing brain is best able to absorb a language, any language, during this period.

**Maturation**

Genetics usually come to mind when we think of biological factors in the development of behavior. However, in the study of development, maturation is the most important biological factor to consider. Maturation refers to systematic physical growth of the nervous system and other bodily structures.

The young child learns to stand upright as a result of biological maturation. An older person's strength of grip may weaken as a result of aging.

Both experience and maturation play an important role in most areas of behavior, but maturation is particularly strong in many specific contexts. For example, experience obviously plays an important role in toilet training. The child must be taught to use the toilet. But according to research, successful toilet training is difficult for most children before age 2. They have not matured enough to learn that task.

## 202. Stages of development

Just as we cannot understand the evolution of butterflies without understanding their transformation from caterpillars, we cannot understand human development without understanding how we change across the life span. In this section, three levels of development will be characterized:

- Childhood (0–12 years).
- Adolescence (15–19 years).
- Adulthood (20 years–to death).

Some of these age groups will be subdivided further for review. The categories as presented will contain generalizations about age groups. In other words, the descriptions given will apply to most individuals of a designated group. It is important to keep in mind that a person can show deviation in their development and still be considered “normal.”

### Childhood

Probably the simplest way to discuss childhood is by breaking this age into four different periods: infancy (birth–12 months), early childhood (12 months–3 years), middle childhood (3–5 years), and late childhood (5–12 years).

### Infancy

Infancy is a time of fast change in everything that a baby does. Physical development during infancy is greater than at any other time in the life cycle.

#### *Psychological and physical traits*

The newborn infant is physically helpless. The newborn is emotionally agreeable if able to communicate their needs and if their caregivers are able to translate their cues. The newborn demonstrates the “Moro” or “startle” reflex in which the infant grasps symmetrically with both arms when startled. By 6 weeks, infants begin to develop a social smile, which is a very significant milestone. The following table explains the different reflexes and the ages they occur:

Major Reflexes Present At Birth			
Reflex	Stimulus	Response	Other Comments
Moro or startle	Sudden movement or loud noise	Legs draw up, back arches; arms are brought forward in hugging or embracing motion.	Basic reflex is lost 3 to 6 months after birth. Can appear in modified form even in adult.
Planter Grasp	Any object pressed on the infant's soles.	Toes flex and curl downward.	Reflex is lost by 12 months.
Palmer Grasp	Any object pressed on the infant's palms.	Fingers flex and curl inward.	Reflex is lost by 12 months.
Sucking (accompanies swallow reflex)	Touch on lips	Mouth makes sucking movements.	Reflex is lost if not stimulated. Generalized at first but with time become more efficient.

Major Reflexes Present At Birth			
Reflex	Stimulus	Response	Other Comments
Rooting	Touch on cheek.	Head and tongue turns toward touch.	
Swimming	Placement in water.	Head goes down; breath is exhaled slowly through mouth.	Reflex is present at 6 months to 12th month; infant probably can make smooth transition to voluntary swimming.

I'm sure you have had the experience of seeing how fast a baby grows during this stage. The baby's growth follows a predictable pattern. The cephalocaudal principle guides physical development. This principle means that development starts at the head and moves to lower body parts. For example, newborns learn to make sucking sounds but do not learn how to control their hands until they are older. Another guide of development is the proximal-distal principal. This principal states that infants learn in an inward to outward direction. For example, infants move their entire arm before they can grasp something with their hand. By 4 to 5 months, they can roll over and demonstrate active hand-to-mouth activity. By 6 to 7 months, they can grasp a toy, and transfer a toy or an object from hand to hand. By 7 to 8 months, infants sit steadily and are able to feed themselves a cracker. They may have some understandable words, such as "mama" and "dada," but this is variable.

#### *Psychosocial developmental tasks*

As infants get older, they begin to shift their focus from their own body to their environment. The important task in this stage is for them to develop a sense of self, which means infants are learning they are separate from their mothers and the environment. Establishing trust is the basis of distinguishing the self from the environment. Slowly, the infants begin to discriminate between their mother and other objects or people in their environment.

#### **Early childhood**

Between 10 months and 2 years, the children are developing a sense of their own individuality and willpower.

#### *Physical traits*

Physical growth slows but continues at a steady rate. The children are awkward as they learn to walk and they frequently fall. As they grow older, they have greater agility in walking and running. Their neuromuscular coordination increases, and this is seen in their gross and fine motor skills.

#### *Psychosocial developmental tasks*

In early childhood, issues of autonomy and learning to relate to others are the major psychosocial developmental concerns. As the children advance in age, their sense of trust and confidence becomes stronger, allowing them to develop a sense of self and establish boundaries. They are learning that they are separate from mother, brother, etc. Also, during this age the children are learning basic social skills as their world expands away from the home to include friends. Interacting with other children helps the children learn how to get along with others, and they learn self-control, which assists them in establishing a sense of autonomy without shame or doubt.

These children no longer learn only by trial and error; they are beginning to remember events and what will happen in a sequence of events. For example, if someone throws them a ball, they now remember that the ball will hit them if they don't catch it. Development of language is one of the most important abilities to emerge during this age. By the end of the second year, they typically have a vocabulary of 50 words. Nouns and verbs are the usual parts of speech used, but adjectives are also used occasionally. At the end of the early childhood period, language is well established.

***Middle childhood***

During middle childhood the child is more social and is less concerned about interdependent rights.

***Physical traits***

Physical growth slows down during this time, but *fine* and *gross* motor abilities are developed. *Fine* motor skills include learning how to button a shirt and how to write. *Gross* motor skills developing during this time are things like running, jumping rope, etc. Children become more athletic during this age as their skill in manipulating objects and their own body increases.

***Psychosocial developmental tasks***

During this age, the children show egocentric thinking, which means that everything is considered from their points of view. For example, did you have a younger brother or sister who had a favorite toy? Did you ever try to take that toy away? If you did, the child probably had a temper tantrum and no amount of reasoning helped. That's egocentric thought; the child only saw the world from his or her perspective. Another characteristic of this age is imitative behavior. The child identifies with an adult figure and then imitates what that adult does. Language development continues to grow with a 5 year old typically having a vocabulary of 2,500 words. Reading skills are learned during these years.

Socialization and learning are the major psychosocial development tasks. Play is an important part of a child's life during this age. Through play children learn to give and receive feedback, empathize, share, cooperate, and enjoy peer contact. Symbolic play is common, occurring when children imitate adults by playing tea parties, cowboys and Indians, movie stars, etc. Children also parallel play as they are learning how to get along with others. Parallel play occurs when a group of children play alongside each other rather than play together and cooperate. During this time, school is a major learning environment.

***Late childhood***

During late childhood, children build on the accomplishments of the previous stage.

***Physical traits***

During this stage, they are capable of learning the three R's (reading, 'riting and 'rithmetic), and continue to develop fine and coarse motor skills. They can tie their own shoes, ride a bicycle, roller-skate, and throw a ball. They understand abstract concepts. The children begin to play games of skill, thought, and chance, and develop social relationships and concepts of sexuality. Individual and gender differences in growth patterns are evident during this age. Boys tend to be somewhat taller and heavier at the start of this stage. Girls have a growth spurt around age 10; boys have their growth spurt around age 13 or 14. Children are very competitive during this age, matching their skills on the playground and in team sports.

***Psychosocial developmental tasks***

Abstract thinking and the ability to classify and see connections, mark a major shift toward adult styles of reasoning. Another major change that takes place in late childhood is moral judgment. Children begin to question parental rules and they no longer automatically follow these rules. They are beginning to learn what is right and wrong and make some of their own decisions. The ability for a child to perform and relate to others is very important in the development of the self-concept. When children receive positive feedback in school, at home, and from their friends, they develop a strong and positive self-image. If they don't receive positive feedback, then low self-esteem develops. Social relationships continue to be important for children and these relationships are marked by competition, compromise, and cooperation. Hopefully, children will learn to balance these elements to feel good about themselves in relating and achieving with others. Also, during this age children are becoming interested in their developing bodies and in sexuality, especially in relation to procreation and sexual activity. Their bodies may be physically changing and they may need information about sexuality.



We have discussed some of the childhood developmental issues, and looked at the four different age periods occurring during this stage. Hopefully, you have a better understanding of what is normal childhood development. Let's now look at the next developmental stage, adolescence.

### **Adolescence**

Adolescence means "becoming adult." Different people mature at different rates and different times; it is impossible to set down specific ages as the beginning and end of adolescence. Generally speaking, adolescence starts with the onset of puberty, around age 12, and lasts until the end of the growth period, around age 20. Some of you may still be in the adolescent age group. Adolescence is an extremely difficult period in life because it's an interruption between the care-free days of childhood and the need for adult maturity. During this time, the individual is confronted with conflicting ideas and feelings, where inconsistency and disharmony are normal.

#### ***Physical traits***

There are many physical and sexual changes occurring during this time. Physical development and growth are typified by variability between the sexes and among individuals of the same sex. While many adolescents reach physical and sexual maturity by their mid-teens, others may show considerable, but normal, developmental lags ("late bloomers"). Boys may grow 4 or 5 inches in a single year, which makes buying clothes very expensive. Generally, females mature physically, and emotionally, earlier and more rapidly than males. Girls may start menstruating and begin to develop breasts over the course of a summer. Secondary sex characteristics are observed. These are physiological signs of sexual maturation, but do not directly involve the sex organs (e.g., boys voice deepens; girls develop breasts, pubic hair, etc.). Puberty is reached and the individual is now physically sexually mature and able to reproduce.

#### ***Psychosocial developmental tasks***

Adolescents typically have a lot of informal and idealistic plans about themselves and life. They have ideas about improving the government, making the planet a better place to live, etc. Cognitively, adolescents are able to consider several alternative solutions to problems; they make multiple combinations of cause and effect relationships and are able to see other people's perspectives.

Adolescents must attain a degree of mastery in certain developmental tasks if they are to achieve adult maturity as defined by our culture. Some of the more important tasks include:

- Accepting physique and sexuality.
- Achieving a sense of emotional and financial independence from the family.
- Selecting and preparing for a life vocation.
- Developing skills to make meaningful social relationships possible.
- Establishing a sense of personal "identity."

This age is an extremely unstable time, when numerous doubts, uncertainties, and fears are common. Peers are also extremely important as the adolescent identifies with peers, and not adults, they gain a sense of belonging and self-acceptance. During late adolescence, energy is invested in establishing intimate relationships with the opposite sex.

Many different coping mechanisms may be used as adolescents try to master the various developmental tasks of their age group. Transient mood swings, impulsive behavior, and alternating levels of activity are not unusual. Although adolescence is a period of stress and change, a majority of teenagers are able to successfully transit this period of their lives without experiencing major psychological problems.

You now have a greater appreciation of the difficulties and changes that occur during adolescence. I am sure you have experienced a lot of these changes and stressors yourself. Let's now move into the last age period, adulthood.

**Adulthood**

Most states have laws that define the age of an adult. Generally, a person is legally considered an adult at the age of 21. However, there are some states where men and women are legally adults at age 18. Reaching legal adult age means a person becomes a full citizen and is a responsible member of society. In this section, as in childhood, we divide adulthood into the following four age periods:

- Young adulthood (20–29 years).
- Adulthood (30–42 years).
- Middle age (43–65 years).
- Late adulthood (65 till death).

***Young adulthood***

This period of life covers a span of years from the close of adolescence to the late twenties.

***Physical traits***

The majority of physical and cognitive development is completed by young adulthood. However, males may continue to have some growth early in this stage. This is the healthiest period in life, characterized by peaks in muscular strength and reproductive ability. Age-related health problems are rare. Some refinement of cognitive development occurs as the young adult attempts to meet educational and employment goals.

***Psychosocial developmental tasks***

Young adulthood is also known as “psychosocial moratorium,” which means a second period of delay after adolescence. This delay provides an opportunity for an individual to try out different roles, jobs, or adventures, before settling down to the responsibility of adulthood. The psychological purpose of this moratorium is to allow the individual time to harmonize the different parts of his or her personality and to assimilate adolescence completely before assuming an adult identity.

Women, more than men, seem to have a harder time establishing an identity. This may have to do with the outdated cultural expectation that women will marry and assume the identity of their husband; however, this idea is beginning to change as women are beginning to delay marriage and establish their own identity prior to marriage. Men may marry to conform to social expectations, or they may marry so they have someone to depend on emotionally. The decision seems to be based on the degree of their self-identity.

***Adulthood***

This stage of life involves the thirties through the early forties age range.

***Physical traits***

There is great variation in physical changes during this period; however, some signs of aging typically appear. Changes in stamina, expanded waistlines, wrinkles, hair loss, or graying, are all common. A person’s physical conditioning, life-style, diet, and genetic heritage may influence physical signs of aging.

***Psychosocial developmental tasks***

This age period is a very productive time for work and family life. It is characterized not by new abilities but by an enhanced ability to apply abstract and logical thinking to problems.

In adulthood, hopefully, the individuals have developed into responsible and independent people who can make decisions and maintain relationships. However, this period may be a difficult time for some individuals as they may be struggling with conflicting decisions about settling down and enjoying life or needing to make some major changes while they are still young enough. Some examples of major changes might be a divorce, changing careers, or reentering school. Being a parent is a major task

during this age level, even though they may have started their family while they were in their twenties.

A mid-life crisis occurs for some people between the ages of 39 and 42. Individuals may become uncomfortable as they face the fact that their youthful ambitions and actual achievements may not match. Perhaps when they were younger they had planned to be married, have children, and make \$50,000 a year by the time they were 40. Well, now they are 40, and they may not be married, and only make \$20,000 a year. Some people may experience feelings of boredom, dissatisfaction, ambivalence, and uncertainty about what they want from life. If they are too uncomfortable during this crisis stage, they may make some major decisions to change their lifestyle.

### ***Middle age***

This period of life covers a span of years, from 43–65 years. It is a time for reappraising life and matching past experiences with actual accomplishments.

#### ***Physical traits***

Many physical changes occur as the body begins to slow down and there is a gradual decrease in functioning capacity of all organ systems. Some physical conditions (e.g., cardiovascular disease and cancer, are common concerns at this age. For women between the ages of 45 and 55, menopause occurs. Menopause results in secondary sex characteristic changes, such as a decrease in breast size. Libido does not typically decrease; however, a woman may have psychological reactions about the loss of her physical sexuality and may experience sadness over the loss of her youth and ability to have children. Men experience a plateau of sexual responsiveness with a decrease in responsiveness during the latter part of middle age.

#### ***Psychosocial developmental tasks***

Cognitive ability may stabilize or even peak as people achieve career goals or move into new arenas. When people reach middle age they are freer to pursue intellectual interests that they may not have had time to pursue when they were younger. This period may be a time of stability without major cognitive gains, and there may be a focus on maintaining a job until retirement.

Ideally, people in this age group are less competitive with others and more interested in being independent and following their own personal interests. As these individuals become preoccupied with their inner life, philosophy, and religion, emphasis is placed on personal values, and the opinions of other people are less important. Outward manifestations of success (i.e., physical appearance and material possessions), that may have been important when they were younger, become less important as the individuals focus on inner peace.

### ***Late adulthood***

The “later adult years” begin at age 65. Many persons at 65 or even older have changed little from their middle years and are mature, capable, productive, and confident. The “elderly” comprise a spectrum of individuals with varying personality traits. Therefore, it is useful to distinguish persons with signs of “senescence” (i.e., normal aging without significant loss of function) from those with signs of “senility” (i.e., aging accompanied by considerable physical and psychological deterioration).

#### ***Physical traits***

How old people are does not predict what their state of health will be. Even though all body systems undergo change, some are more common than others. Bones lose mass and density, resulting in a decrease in height, changes in posture, and a high risk of bones breaking. People in their late adulthood experience a decline in vision and hearing, which you may have noticed in your grandparents. Their sexual drive may decrease and reproductive function is lost for women and diminished or lost for men; however, sexual relations remain a source of affection and pleasure. The three leading causes of death for individuals in late adulthood include heart disease, cancer, and cerebrovascular accident.

*Psychosocial developmental tasks*

Normal cognitive changes are the result of the aging process and include slower retrieval of information from memory, slower learning capability, and increased caution in making decisions. Surprisingly, only 10 to 20 percent of the elderly experience cognitive impairment including confusion; disorientation to time, place, or person; confabulation (i.e., making something up to fill in the gap when you can't remember everything); dementia (i.e., a permanent personality disorganization and loss of cerebral function); and transient ischemic attacks resulting from inadequate flow of blood to the brain.

Changes in roles and relationships are hallmarks of psychosocial development during this period. Retirement may be very difficult for some people to accept as their identity may be built on what they did for a living. Perhaps they are no longer a senior master sergeant and may have difficulty acknowledging themselves without their rank. Financial concerns may occur as people may be on a 'fixed' income with no other options for making more money (i.e., another job). Role reversal happens when the elderly depend on their children for financial support or to take care of them as their health fades. In addition to these stressors, elderly individuals must adjust to changes in their physical health and loss of loved ones. They may discover all of their friends are dying, so they are frequently faced with the issue of death and dying. Something very beneficial to individuals during this age is to develop nurturing relationships with members of the younger generation through volunteer work, grandchildren, etc.

In review, unique as each of us is, our development consists of the same stages that are encountered at about the same age and resolved in the same manner. You learned developmental stages are growth processes that all human share. It should now be clear to you how the consequences of people's actions influence their development and ability to cope later in life. This is important information to remember. We need to ask a person about their background to have a better understanding of how that person turned out to be who they are. If we know what normal development is, we can be alert to abnormal, or problematic, developmental issues and successfully intervene.

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### **Self-Test Questions**

**After you complete these questions, you may check your answers at the end of the unit.**

**201. Developmental process**

1. What factors affecting human development determine an individual's height, weight, and appearance?
2. Which factors include all of the outside influences and conditions that affect a person's life and development?
3. What physiological factors are important roles in determining how one feels about one's self?
4. What are some examples of prenatal influences which can cause brain damage or dysfunctions for a fetus?
5. Identify examples of perinatal or postnatal influences a parent can have on a child.

6. What is the most important biological factor to consider in the study of development?

## **202. Stages of development**

1. When is physical development greater than at any other time in the life cycle?
2. During what stage of development do children develop a sense of their own individuality and willpower?
3. During what stage of development do children become more athletic?
4. Socialization and learning are major psychosocial development tasks during which stage of development?
5. What does adolescence mean?
6. When does adolescence generally start?
7. Who does the adolescent identify with and gain a sense of belonging and self-acceptance from?
8. What does the term “psychosocial moratorium” mean? What is its psychological purpose?
9. During which developmental stage does the body begin to slow down and there is a gradual decrease in functioning capacity of all organ systems?
10. What are some signs of senescence?
11. What are some examples of senility?
12. What are the three leading causes of death for individuals in late adulthood?

## 1-2. Personal Growth

This lesson focuses on understanding patient behavior through the development of desirable attitudes. Our job deals with helping patients become honest with themselves and others, developing new coping skills, discovering alternatives to maladaptive behavior, and aiding patients to clarify their own values. In the process of doing this, we act as role models for our patients' families and visitors. This requires that we demonstrate a positive attitude and self-image. It also requires we accept ourselves as adequate, capable, and worthwhile individuals.

To be effective in our work with others, it is essential that we establish a relationship of acceptance. Our ability to recognize, appreciate, and meet the needs of the patient is fostered through self-understanding and having a positive self-image.

In this lesson, we'll study several perspectives on self-concept and self-image.

### 203. The self-concept

Our *self-concept* is our subjective perception of who we are and what we are like. Of all of our subjective views of life, our view of ourselves is most important to our personalities. It is important that we in the mental health career field are knowledgeable of the dimensions and basic nature of the self-concept to avoid becoming overly judgmental or hypocritical of others.

#### Dimensions of the self-concept

The self-concept adds integration to the diversity of life activities. It also gives momentum and direction to future growth. Following are seven dimensions of the self:

1. Bodily self.
2. Self-recognition.
3. Extension of the self.
4. Reflective self.
5. Personal competence.
6. Aspirations and goals.
7. Self-esteem.

Each dimension adds content, depth, and energy to the self-concept.

#### *Bodily self*

The flow of air through your mouth, nose, throat, and lungs and the tightening and relaxing of muscles are examples of physical sensations that give a continuing physical reality to self-concept. In addition, these familiar sensations, feelings of pleasure and pain, mark the range of physical sensations associated with the self. The body is a basic source of intimate knowledge and commitments to the self.

#### *Self-recognition*

Our response to our reflected images, our name or photographs of us, are examples of self-recognition. These familiar experiences add stability to the self-concept. The importance of self-recognition is illustrated by the sense of uncertainty that male trainees experience in basic training when their hair is shaved away, or the disorientation that patients feel after plastic surgery that changes their facial features.

#### *Extensions of the self*

The self extends beyond the physical boundaries to objects, spaces, and important people. Identifying the self with specific objects, space, or other people begins in children as young as 2 or 3 and continues into adulthood. People may use objects to prove their importance or status. They may guard

their homes or business with weapons, and even take the lives of those who threaten to destroy or take a valued object.

### ***The reflected self***

People make comments about you and treat you in a certain way. Their behavior reveals their attitudes and opinions about who you are. In your life, you receive many messages from others about who you are thought to be. These include simple things like being recognized by another person or being confused with someone else. Messages from others also include evaluation about your self-worth. From the kind of reflected images, you gain certain *attributes* that are taken to be an accurate description of the self. Whether or not these attributes are accurate may be hard to evaluate.

Some people resist the messages that are implied in the reflected self. They may not accept another person's negative opinion of them. They may struggle to surpass what others describe as insurmountable limitations. Take for example the Olympic triple gold medal winner, Wilma Rudolph. As a child she was crippled by polio and told she would always have difficulty walking. She did not allow her apparent physical impairment and the sometimes crude remarks and poor opinions of others to dishearten her from aspiring to be a runner. Most people, however, are likely to take the opinions of important others quite seriously. These opinions then become part of the person's own definition of selfhood.

It is important for you to keep in mind that although the opinions of others about you may come free and voluntarily, they may be a result of another person's jealousy or another person's appreciation of you. It may be a serious mistake to believe another person's low opinion of you. By the same token, it may be a mistake to trust too heavily the opinions of people who only compliment you. Accurate and honest feedback about one's strengths and weaknesses is not easy to find.

### ***Personal competence***

The things you do well contribute to your personal competence. Personal competence appears in each stage of development. In addition to developmental skills, there are special areas of talent that increase a person's expertise or effectiveness. Competence may provide direct sources of satisfaction through the experiences of skills mastery. They may also stimulate the positive responses of others. The knowledge of one's competence lends a sense of confidence that certain challenges or problems can be managed. A history of the effectiveness should contribute a general tone of optimism to the self-concept.

Likewise, areas of incompetence also feed into the self-concept. Repeated experiences of failure, clumsiness, boredom, or confusion signal areas in which one may not excel. When failure is experienced as very shameful when it results in public ridicule, the person may be reluctant to strive for excellence in the areas that produced this shame. Each person's self-concept contains negative elements. These include things the person does not do well and challenges the person does not feel were adequately met.

<b>Dimensions of the Self-Concept</b>	
The bodily self	Physical experiences, body boundaries, sensations of pleasure and pain.
Self-recognition	Awareness of one's appearance.
Extension of the self	Important objects, spaces, or people
The reflected self	Opinions, comments, or actions of others toward the self.
Personal competence	Skills and talents.
Aspirations and goals	Meaningful life goals that give a sense of purpose to the self.
Self-esteem	Evaluation of the self as worthy or unworthy.

### ***Aspirations and goals***

One of the components of the self involves the formulation of life goals. This aspect of self is most important during adolescent and adult life. The process of deciding on goals lends a forward movement to the self-concept. A person is not content to exist but seeks to grow; to become. The hope of future achievement makes immediate problems endurable.

### ***Self-esteem***

For every aspect of the self-concept including the physical self, the reflected self, or the array of personal aspirations and goals, the person makes an evaluation of the worthiness of those characteristics. Self-esteem influences behavior and expectations about the likely outcome of life choices. Feelings of being loved, valued, admired, or successful contribute to a positive sense of worth. Feelings of being ignored, rejected, despised, or inadequate contribute to a negative sense of worthlessness. Self-esteem can be changed depending on whether one succeeds or fails at an important goal.

Each of the seven dimensions of the self-concept listed in the chart contributes to the continuity, the creativity, and the persistence of the self-concept. The self is recognizable through our physical experiences, physical appearances, and identification of objects, spaces, and people.

### ***Additional views of self-concept***

Humanistic, psychoanalysis, and social learning theorists take very different views of the basic nature of self-concept. However, most of them agree that how we see and evaluate ourselves is important because it often determines how we behave. Take for example people who do not believe they can swim; they will not jump off the high board. That's just one of many views. Let's take a look at another view of self-concept.

### ***The looking-glass self***

Charles Cooley, co-founder of the humanists' movement, coined the phrase the *looking-glass self* to refer to the origins and nature of self-concepts. The looking-glass self possesses the following three elements:

1. Our imagination or image of how we appear or present ourselves to others.
2. An imagination or image of the other's judgment of that appearance or presentation.
3. Some self-feeling about that judgment, such as pride or shame that sees us in that way. In other words, we accumulate a set of beliefs and evaluations about ourselves, and about whom we are and what that means in our society.

The way the looking-glass self operates implies we learn our self-concepts from and through interactions with others. In the same way that we find out what we look like by looking at our reflection in the mirror, we find out how we appear to others by inspecting their reactions to us. When someone says, "What would people think if I did that," the people he or she is thinking about are generalized peers, and how he or she appears to them and others. According to the looking-glass concept this is our *self-concept*.

### ***Self-concept predictions***

The facts about the nature of self-concept make possible two kinds of prediction that create the conditions for their own fulfillment. The first kind, *self-fulfilling prophecies*, are those we bring on ourselves, and the second one, the *Pygmalion effect*, others impose upon us.

### ***Self-fulfilling prophecies***

This term is commonplace in the mental health field because it is often seen as the basis for maladaptive behavior. Self-fulfilling prophecies are the things we expect to happen that are brought about by our own expectations. If we really believe that other people are unfriendly and



manipulative, we are likely to find many people treating us that way. Our own expectations will cause us to behave in ways that produce the responses we expect from others.

### *Pygmalion effect*

The Pygmalion effect works in a similar way in that the expectations that others hold for us may produce confirming behavior. You may be familiar with the Greek myth in which the sculptor Pygmalion falls in love with his statue and miraculously brings it to life. The Pygmalion effect also works in the other direction. People may learn to be stupid, crazy, or “bad” to fit with others’ expectations for them. Children considered dull by their teacher often act so as to confirm the teacher’s expectations. This, of course, causes the teacher to continue to treat them as if they were dull and so the process is circular, or self-confirming.

The self-concept acts as a guide, selecting which experiences are important and which are not. It also serves as an anchor point for guiding future activities. Each new skill, each new role relationship, each encounter with past events has the potential for bringing about revisions in the self-concept. At every life stage, changing skills, new social roles, a history of past failures and successes, and new mental abilities all work together to change the exact nature of the self-concept.

## **204. The self-image development**

We are not born with a self-image. Self-image is acquired through feedback and social responses from those around us who make up our social environment. Personality includes all the traits that influence or make up one’s behavior. The key word here is traits, since the total personality is a composite of inherently good or bad traits. One secures, or develops, his or her own good or bad traits based on the evaluation received by people. Self-image, then, can be thought of as the subjective evaluation that one has about all of his or her own personality traits. In this lesson, we will discuss both positive and negative results from the process of human interaction.

### **Positive and negative self-image foundation**

A positive self-image results from a person having more perceived positive traits than negative traits. A negative self-image results from a person having more perceived negative than positive personality traits. The following is a basis for these personality traits:

- Family, positive/negative reinforcement.
- School, success/failure and the self-image.
- Parents/teachers/“significant others”.

### *The family*

Our immediate family represents the first significant primary group in our lives that gives us information about the kind of person we believe we are. The family teaches us the reality of the world and the expected role behavior of males and females. This is done through the interaction of the parents and children.

The first self-image state acquired in the natural process of growing up is that of the child. At birth the child is totally dependent on adults for his or her survival. The child tends to respond at the emotional and instinctual levels in fulfilling needs. In life, we like to avoid pain and seek pleasure. We want to feel good. The testing of reality is closely tied to reward and punishment, with significant adults giving direction. In the early years of childhood, the family is the total social and psychological environment that a child experiences.

The child develops much of his or her own personality and self-awareness in the family setting. This is done through imitating the behavior of family members and identifying with their values, attitudes, morals ethics, religion, prejudices, likes, and dislikes. The child begins his socializing experiences and learns to become a social being in the family. He or she is taught proper kinds of behavior and

social expectations. The family provides experiences that are building blocks of personality. It is through these experiences that the child begins to develop a self-image.

In the early years of childhood, we experience both good and bad emotions. We first experience and express the emotions of love, anger, hate, rebellion, trust, security, and insecurity in the family setting. The family is the primary group that communicates the basic values of the society, culture, and subculture to the child. The family shapes the child's attitudes and beliefs about himself or herself and the world.

### ***Positive/negative reinforcement***

Youngsters exposed to a family social environment that fails to enhance a positive self-image can be recognized by their treatment of themselves and others. Youngsters who feel badly about themselves are unlikely to take care of themselves, either physically or mentally. They will not behave in productive ways. They may withhold negative feelings and become withdrawn and depressed, or they may act out negative feelings in antisocial and destructive ways. These young individuals compare themselves to others whom they assume are better than they actually are, causing themselves to view interpersonal relationships as threatening. To ward off such threats, they tend to exaggerate the use of self-image or defense mechanisms, which can act as counter-growth.

The significance of positive reinforcement responses during childhood cannot be overemphasized. Everyone throughout life has a potential for growth and change. It is true that many personality traits and beliefs about the self may become fairly rigid and fixed during the early years. The impact on a child's self-image through family relationships is almost limitless. Hopefully, however, we have discussed enough here to impress upon you the significance of the family environment in the process of self-image development.

As the child's world extends beyond the physical and social environment of the home and family, he or she is exposed to many other sources of self-image feedback. As the child starts on the road to adolescence, the family begins to lose some of its socializing influences to other institutions, groups, and social experiences.

### ***The school***

One of the first real-life experiences of the child beyond the home is that of the school. Within the school environment, there are several goals towards which students aspire. Goals such as academic achievement, athletic proficiency, and interpersonal relationships are all important for recognition and self-esteem. A youngster failing to achieve these goals may see less desirable alternatives to compensate for these failures. He or she may, at this point, turn to drug abuse activity or delinquent behavior to cope with uncomfortable feelings or to achieve "peer" self-esteem and group identity. The role of the school in the development of a positive self-image plays an integral part in the educational process. Within this environment, the student is subject to the critical evaluation of both peers and teachers, and is continually reminded of his or her failings and shortcomings or strengths and potentials.

### ***Success/failure and the self-image***

Nothing is more nourishing to the growth of a positive self-image than the experience of success. At the same time, however, nothing is more destructive to the self-image than continuously imagining failure. Much has been said about the phenomenon of the "self-fulfilling prophecy" and its relation to success or failure. It seems clear that it is possible for a person to program himself or herself for failure, thereby fulfilling his or her expectations. The problem of failure identity or negative self-image regarding ability to learn is obviously a very serious handicap in the educational process. It is almost certain that if an individual expects to fail, he or she will most likely fail.

### ***Parents/teachers/“significant others”***

Parents, teachers, and significant others play a major role in the development and formation of a child's self-image. Establishing and maintaining a healthy level of both self-worth and self-esteem is essential in early childhood years. This is so children can accomplish problem-solving and needs-fulfillment as they grow to adulthood. Considerable research supports the fact that most children whose backgrounds reflect positive support and feedback tend to do well in adult life. Others who experience mostly negative responses often do not become self-actualized. Significant others within the child's social environment who send constant and often unintentional messages provide the material that goes into the building of the child's self-image. It is most important that parents, teachers, and significant others make every effort to give children constructive feedback and positive social responses to build and maintain their self-image.

### **How people maintain or change their self-image**

Since the self-image is a product of social learning, it is subject to both retention and change. What is learned about self can be modified. A person's self-image has significant influences on his or her perceptions, interpretations, and behaviors. The self-image includes the beliefs and feelings that one comes to formulate about his or her concept of being a person. Are you wondering now what type of self-image you may have? Is it positive or negative? Let's see if we can answer those questions.

### ***Positive/negative self-image***

A person with a *positive self-image* is also sensitive and aware of the real self. Such a person gives proper appreciation and credit to himself or herself as both an adequate and worthwhile person. There are positive feelings of self-acceptance, self-confidence, self-reliance, and self-trust. Through rational self-thought, the person is knowledgeable of his or her real needs and values. There is awareness of strengths as well as weaknesses. The person has the ability to take responsibility for individual actions and accept the rewards as well as less desirable consequences of his or her own behavior.

A person with a *negative self-image* is a victim of irrational thinking and beliefs that he or she uses in self-demeaning thoughts. When one fails to appreciate individual potential and denies a sense of worth and dignity as a person, he or she is reinforcing a negative self-image.

A person's positive or negative self-image is said to begin forming at a young age. Think of your own situation growing up. Most of us like to say we had a “normal” upbringing, but what exactly is normal? A client who comes into our clinic feeling they are a worthless person might tell you it was “normal” for their parents to call them “stupid,” “worthless,” or an “idiot” when they were younger.

As children, we are like tape recorders and committing terms (positive and negative) into our long term memory. For some, even as adults, these words are hard to forget. When you are about to start a new task and your first thought is “I'll probably mess this up,” you should stop and try to figure out where that thought is coming from. This is why self affirmation has become such a popular treatment technique. Self affirmation is one way of trying to change the negative tape that may have been recorded in our heads.

### ***The self-ideal***

The self-ideal refers to the beliefs that a person holds regarding the kind of person he or she should be or wants to become. The self-ideal is understood as self-expectations or self-demands. The self-ideal has its beginnings in early childhood as the result of parental and “significant other” expectations of the child. The self-ideal continues to develop and be reinforced by the child's acquired or learned value system and beliefs about the kind of person the child would like to be. The self-ideal is very often formulated by the process of comparison with others. Almost everyone has or has had someone to identify with, admire and emulate. This figure becomes a role model the child wishes to be like or copy. Once a self-ideal has been formulated, it provides a standard by which the individual assesses his or her own conduct and behavior. This self-ideal can be positive or negative in a person's life and

can contribute to the self-image. The closer one's self image matches one's self-ideal, the more positive the overall image of self will be.

### ***The changing self***

As stated earlier, self-image is changeable. What changes one's self-image strictly depends on the individual. If we think of the Johari Window and the four panes of self, we are aware of one-half of ourselves. Those around us know the other one-half. What we know and what we want to change is our own decision. We can self-feed this information and choose to do something about it. Sometimes we first learn from the information others tell us about ourselves. Again, the decision to change is left with each of us.

	Known to Self	Unknown to Self
Known to others	<b>A</b> Open Shared Area	<b>C</b> Blind Area
Unknown to others	<b>B</b> Private Secret Area	<b>D</b> Unknown Undiscovered Area

### ***Change factors***

There are two factors influencing self-image maintenance and change:

1. Self-talk.
2. Selective perceptions.

#### ***Self-talk***

As the name implies, self-talk refers to what we tell ourselves about ourselves. Negative self-talk is demeaning and leads to self-dislike and self-rejection. Positive self-talk requires the ability to think rationally about yourself and to forgive yourself for any shortcomings. Positive self-talk can help us in overcoming self-doubts and self-rejection. Self-acceptance is essential in both acquiring and maintaining a positive self-image.

#### ***Selective perception***

Essentially, selective perception means perceiving what we want or expect others to perceive. If we choose to perceive ourselves as a worthless or inadequate person, we will see only those things that reinforce a negative image. We will have a "failure identity" and see only failing experiences. We will have completed the "self-fulfilling prophecy" that leads to more failures. This will prevent any positive changes, resulting in an inability to grow, learn, or behave differently.

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## **Self-Test Questions**

**After you complete these questions, you may check your answers at the end of the unit.**

### **203. The self-concept**

1. What is the definition of self-concept?

2. Our response to our name or to photographs of ourselves is an example of what dimension of the self-concept?
3. In which dimension of the self concept might some people use objects to prove their importance or status?
4. According to Charles Cooley, what does the phrase the *looking-glass self* refer to?

#### **204. The self-image development**

1. What is the result of a person having more positive traits than negative traits?
2. What is the first significant primary group in our lives that gives us information about the kind of person we believe we are?
3. The child develops much of his or her own personality and self-awareness by imitating the behavior of family members and identifying with what traits?
4. Beyond the home, what is one of the first real-life experiences of the child?
5. Who are the major role players in the development and formation of a child's self-image?
6. What is meant by the term self-ideal?
7. How is the self-ideal often formulated?
8. What is meant by the term self-talk?
9. What is meant by the term selective perception?

### 1–3. Personality Developmental Theories

Now that you have a better understanding of some of the physical traits and psychosocial tasks that an individual faces as they grow older, let's look at how a person develops his or her personality. There are many different theories of psychological development. In this lesson, you'll focus primarily on psychoanalytic, humanistic, behavioral, cognitive, interpersonal, reality, and biological theories. You'll also study Freud's psychoanalytic and psychosexual theories, Erikson's developmental phases, and Sullivan's interpersonal theory.

No two people are exactly alike. There are important differences in the ways that individuals think, act, and feel. In other words, people have a variety of different personality traits. Why is my personality the way it is? Why did I develop a very different personality than my parents? Several theories of personality have been offered as answers. This lesson will acquaint you with a few of the major personality development theories and the second section explores other perspectives of personality development. For the moment, let's take a look at Freud's psychoanalytic and psychosexual theories, Erikson's developmental phases, and Sullivan's interpersonal theory.

#### 205. Freud's psychoanalytic theory

We begin by studying Freud's psychoanalytic theory, the levels of mind awareness, and his theory of personality. Sigmund Freud is not only the founder of psychoanalysis but is also considered the father of modern psychology. Freud theorized that human behavior results from forces beyond a person's conscious control, not his or her own free will; a concept he coined the "deterministic view" of human behavior. Freud felt that personality is determined by unconscious sexual and aggressive drives, which we are born with, and that our behavior is directed by unconscious motivation. Freud believed that anything we experienced as pleasurable was from our sexual drives and may include such experiences as eating, smoking, etc. In psychoanalysis, treatment places the emphasis on past development, especially childhood experiences.

#### Freud's three levels of mind awareness

According to Freud, there are three levels of mind awareness:

- Conscious.
- Subconscious (or preconscious).
- Unconscious.

#### *Conscious mind*

This is the part of the mind we see at work. It is the part of thought that is processing and conscious. As you read this, the visual picture of the words are translated into thoughts. These thoughts take place in the conscious mind.

#### *Subconscious mind*

This part of the mind contains memories just below immediate awareness. It contains memories that are easily recalled. It is the sum total of our past experiences. These experiences tend to mold your expressions, reactions, and involuntary responses based upon stimuli you have experienced in the past with application to current events in your life.

#### *Unconscious mind*

The unconscious mind holds all past life experiences. It's considered a vast storehouse of those items that are very difficult and/or impossible to recall. All repressed and painful conflicts are held here. One good example is the memory of being born. This is probably the most traumatic of all memories and virtually impossible to recall. The unconscious mind is the source of our emotional pain.

### Freud's theory of personality development

Freud's theory of personality states that personality is determined by the interaction of three psychological forces:

1. Id.
2. Ego.
3. Superego.

#### *Id—the selfish beast*

The id operates from the unconscious level. It is present from birth and operates on the *pleasure principle* that is governed by a tendency to seek pleasure and avoid pain. The id is the source of instinctual drives that are sexual and aggressive. The id also generates mental images and fantasies. One could say that the id is the primitive part of the mind. It operates on the premise, "I want what I want, when I want it, and if you get in my way I'll hit you." Very primitive, basic, instinctual actions come from the id. The id is also the source of our creativity and the "fun" part of our personality.

#### *Ego—the executive of personality*

The ego operates primarily in the conscious mind. The ego is not present at birth but develops over time. The ego operates according to the *reality principle*. This means that it holds the id in check until a safe realistic way has been found to satisfy its motives. The ego helps us evaluate and judge reality. It mediates between id demands and external world realities. The ego works out compromises between the id and superego.

#### *Superego—the conscience and ego ideal*

The superego operates partly in the conscious mind. The superego is an outgrowth of our learned moral values and is often referred to as our "conscience." We learn these values from our parents, religion, teachers, etc. They taught moral principles to us by punishing misbehavior and rewarding appropriate or good behavior. The superego works to enforce the ego to restrain id demands that the superego has learned are "bad" or considered inappropriate by cultural or societal norms. According to Freud, parental punishment creates the set of moral constraint known as the conscience, while their rewards set up a standard of perfect conduct in the superego called *ego ideal*. The two parts of the superego work together by punishing behavior that breaks the moral code through guilt and rewarding good behavior through pride. According to Freud, most of us do not murder, steal, and rape because our superegos hold these desires in check, not because we do not want to, or because our egos could not find some safe ways to do so. Review the chart below to identify common terms used in describing Freud's analytical theories.

Freudian Theory of Personality Development	
Term	Definition
Id	The inborn part of the unconscious mind that uses the primary process to satisfy its needs and acts according to the <i>pleasure principle</i> .
Ego	The part of the mind that uses the <i>reality principle</i> to satisfy the id.
Superego	The part of the mind that opposes the desires of the id by enforcing moral restrictions and by striving to attain a goal of perfection.
Pleasure principle	The attempt of the id to seek immediate pleasure and avoid pain regardless of how harmful it might be to others.
Reality principle	The attempt by ego to find safe, realistic ways of meeting the needs of the id.
Conscience	The moral inhibition of the superego.
Ego ideal	The standard of perfect conduct of the superego.

**Anxiety and ego defense**

The concept of anxiety, or psychic pain, is a central construct in psychoanalytic theory. Freud believed that people develop defense mechanisms to protect them from anxiety, or psychic pain. Anxiety is a warning of impending danger, so it forces the individual to undertake corrective action. Freud recognized three types of anxiety:

Anxiety	Description
Reality anxiety	The fear of real dangers.
Neurotic anxiety	The fear that threatening impulses will break down ego controls.
Moral anxiety	The fear of one's conscious.

Often the ego can cope with anxiety by rational measures. If these do not work, then irrational protective measures, referred to as ego-defense mechanisms, are used. These defense mechanisms eliminate painful anxiety, but they do so by pushing painful ideas out of consciousness. This gives the person a distorted view of reality, rather than forcing him or her to deal directly with the problem.

Keep in mind that we all use some defense mechanisms throughout our lives. By using them we are not doing anything unhealthy; however, problems arise when we use defense mechanisms too frequently or when we never deal with the underlying issues or reality. Let's take a look at some of the more common defense mechanisms.

***Repression***

Repression is the involuntary exclusion of a painful or conflicting thought, memory, feeling, or impulse from awareness. It offers us protection from a sudden traumatic experience until we are able to deal with it. From the individual's point of view, a repressed memory is "forgotten" and cannot be deliberately brought to awareness. The repressed feelings remain out of awareness but continue to exert pressure for expression. In situations of extreme anxiety and in febrile or toxic states, repression may begin to fail. Clients who are intoxicated by alcohol or drugs, or who are emerging from anesthesia, may verbalize feelings that have been repressed.

***Denial***

Denial is one of the simplest of the ego-defense mechanisms. In denial, painful or anxiety-producing aspects of awareness are blocked out of consciousness. The reality of a situation is usually completely disregarded so it is no longer threatening. Denial is commonly used against the stress of being diagnosed with a terminal illness and is easily seen in the first few minutes of receiving the news by saying, "It didn't happen," or "I don't believe it." Sometimes, denial is the best temporary solution for a person. For example, a terminally ill cancer patient needs time to face the reality of their situation.

Usually, in the mental health field, we see denial as a destructive mechanism. Often, our clients refuse to take psychotropic medications because they believe nothing is wrong with them. In these cases our clients need to face reality. If not, they may not get better and sometimes worsen. Helping clients to understand their problems in a gentle, tactful way, will decrease the need for denial. The technician can help by taking care not to reinforce patterns of denial.

***Regression***

Regression occurs when individuals are faced with a conflict or problem that cannot be solved the way the individual normally solves problems, by using the ego defense mechanisms. In such a situation, the individual may resort to behavior that was successful at an earlier stage of development. An example of regression is when someone wanted something and was unable to get it, and he or she pouted or even threw something much like a child throws a temper tantrum.



***Projection***

Projection is an unconscious means of dealing with personal difficulties or unacceptable wishes by attributing (projecting) problems to others. Individuals blame other people for their own unacceptable feelings or thoughts. People may have difficulty in expressing anger, so they may think that someone else is angry with them when actually they are the ones who are angry. It is common knowledge that people tend to criticize in others their own unacknowledged inferiority.

***Rationalization***

Rationalization is the substitution of a plausible reason for the motivation behind one's behavior. It is used to justify specific behavior or deal with disappointment. Many people use rationalization because they wish to prove to themselves and others that their actions are governed by reason and common sense. Such explanations may be needed to maintain personal integrity. An example of rationalization is when you cheat on your income taxes by saying, "everyone does it," when not everyone cheats on their taxes and you just want to pay less money.

***Identification***

Identification is the wish to be like another person and to assume the characteristics of that individual's personality. Identification with admired people can serve as an important function in maturation. The little girl who identifies with her mother learns the behavioral characteristics of womanhood. In adulthood, over-identification with another person may prevent someone from developing his or her own needs and desires.

***Displacement***

Displacement is the discharging of pent-up feelings (usually hostility) on objects less dangerous than the object that aroused the feelings. This defense is often used when emotions are aroused in a situation where it would be dangerous to express them. Displacement differs from projection in that people who use displacement are not distorting their feelings towards someone else. Their feelings are clear and the people acknowledge those feelings. The difference is that in displacement, the people are simply attributing their feelings to the wrong person or thing. A person that gets angry at work but doesn't tell the boss, but then goes home and gets angry at his or her spouse is displaying the displacement mechanism.

***Reaction formation***

Reaction formation is a means of defense whereby an undesirable impulse is kept out of awareness by emphasizing its opposite. Hostility may be concealed behind a facade of love and kindness. People who crusade passionately against alcohol, pornography, or cruelty to animals may be dealing with an underlying desire to enjoy these things.

***Sublimation***

Sublimation is a mechanism by which the energy involved in primitive impulses and cravings is redirected into socially constructive and acceptable channels. This is one of the chief mechanisms operating when a child learns to redirect the pleasurable sensations involved in expelling excrement at will, into the more socially acceptable patterns of toilet training. Sublimation is a more positive ego defense mechanism of adjustment, and is partially responsible for the artistic and cultural achievements of the civilized world.

***Compensation***

Compensation is a pattern of adjective behavior in which the individuals make up for a personal lack of feeling or inadequacy. People who use compensation emphasize some personal or social attribute that overshadows their weakness and gains social approval. In adults, compensation is usually prompted by feelings of guilt or inferiority. Compensation may be operating in the behavior of a man who is very small in stature, but extremely successful in the business world through his aggressive practices.

***Conversion***

Conversion refers to the expression of emotional conflicts through a physical symptom for which there is no physiological basis. These conflicts appear as a physical symptom without the individual's awareness of the connection between the two. The symptom always serves to distract attention from the individual's real problem. This mechanism is entirely unconscious, and is not usually used by a well-adjusted person.

***Introjection***

Introjection is closely related to identification. It is the process of accepting someone else's values and opinions as one's own, even if they contradict the values previously held. A man whose employer engages in dishonest work practices may introject his employer's values, even though they are contrary to his own moral beliefs, because he may be afraid of losing his job.

***Suppression***

Suppression is when a person consciously keeps unacceptable feelings and thoughts out of his or her awareness. An example would be when you are taking a test and you are upset about an argument you had with your spouse. You put that argument out of your mind so you can concentrate on the test.

***Intellectualization***

Intellectualization occurs when an individual separates an emotion from an idea or thought because the emotional reaction is too painful to be acknowledged. An example of intellectualization is if people are told by their doctor they have cancer, and they begin to study about the physiology of cancer without experiencing any emotions about having cancer.

***Dissociation***

Dissociation is when a person handles emotional conflicts, or internal or external stressors, by a temporary alteration of consciousness or identity. An example of this is when people develop amnesia for the events surrounding a fatal automobile accident in which they were driving under the influence of alcohol.

Hopefully, this discussion of Freud's theory of personality development helped you understand your own personality just a little bit more. However, don't feel bad if it didn't. Freud derived most of his ideas from the patients he treated. Consequently, his theory may describe not so much human behavior in general as disturbed behavior. Let's take a look at one more of his theories.

**206. Freud's psychosexual development and psychoanalysis theories**

According to Freud, each person goes through a series of psychosexual development stages. The outcome of each stage has a major impact on his or her personality development. Early Freudian theorists used these psychosexual development stages in their classical psychoanalytical approaches.

**Psychosexual stages**

Freud also believed that personality is formed in the first few years of a person's life. He identified five stages from these developmental years, and as previously mentioned, referred to them as the Psychosexual Stages. The method every person uses to cope with changes in each of these stages is very important in determining adult personality and mental health. One of the problems with Freud's theory is that it fails to explore any phases of adult development. This may be due to the fact that Freud placed a lot of emphasis on the idea that personality is formed early in life.

Let's look at each of Freud's stages of psychosexual development. The following chart will give you a glimpse of the stages and their consequences:

Freud's Psychosexual Stages and Consequences for Later Development		
<b><i>Psychosexual Stage</i></b>	<b><i>Erogenous Zone</i></b>	<b><i>Major Consequence for Personality</i></b>
Oral (birth to age 2)	Mouth	Ability to form interpersonal attachments
Anal (age 2 to 3)	Anal membrane	Behavior is focused on anal pleasure and activities.
Phallic (age 3 to 6)	Genitalia	Development of conscience and guilt
Latency (age 6 to puberty)	None	Ability to be with others without sexual or aggressive feelings
Genital (puberty and after)	Genitalia	Ability to sustain a loving heterosexual relationship

### ***Oral stage***

During the oral stage (birth to 2 years) the infant derives satisfaction from and copes with discomfort or anxiety through oral activity, such as sucking.

### ***Anal stage***

In this stage (2–3 years) the young child needs to learn to delay gratification and exert the muscle control necessary for toilet training. This control is needed not only for toilet training but also in other aspects of daily life as the toddler learns to gain some mastery over what he or she does. The parental expectations and limits that the child learns are the foundations of the superego.

### ***Phallic stage***

During this stage (3–6 years) the child learns to identify with the same-sex parent, has a growing awareness of the genital area, and learns gender identification. During this period the *Oedipus conflict* occurs in which boys are thought to have incestuous feelings toward their mother and hostile feelings toward their father as they vie for their mother's affection. The *Electra complex*, a parallel phenomenon in girls, occurs when girls are thought to have incestuous feelings for their father. The desired outcome of this stage is for the child to identify with the parent of the same sex.

### ***Latency stage***

In this stage (6–12 years) sexual urges decrease in importance as the child enters school and becomes preoccupied with learning skills and other activities.

### ***Genital stage***

This is the period after puberty of complete personality organization. Sexual urges reemerge and motivate the individual to form heterosexual relationships.

## **Psychoanalytical therapeutic approach**

The psychoanalytical therapeutic approach utilizes several techniques. Two of the more common ones are:

1. Free association.
2. Dream analysis.

### ***Free association approach***

Common words are relayed in quick succession to the client and they are to say the first thing that comes to mind. The client is placed in a comfortable position and asked to “just talk about anything” with very little guidance from the therapist. The expectation is that the associations will reveal unconscious conflicts.

### ***Dream analysis***

Freud commonly analyzed the dreams of his clients. Since your fantasies and dreams are generated by the id and are rooted in the unconscious, analyzing dreams will provide insight into the individual's wants, desires, and conflicts.

As you can see, psychoanalysis is an extremely long process. The psychoanalytic theory is also the historical basis of all modern theories of psychology.

### 207. Erikson's developmental phases

Erik Erikson's theory is that the life cycle is a series of developmental phases, and that each phase has a major developmental task. A developmental task is a challenge that occurs during predictable time periods and the individual needs to use all his or her skills to complete the task successfully. By successfully completing the task, the individual moves to the next developmental stage and has a good chance of successfully completing that task. During each of these developmental phases, there are two opposing energies—a positive and negative force. These two forces must be synthesized for healthy personality development.

Erikson describes eight stages of psychosocial development that represent a critical stage during which development must take place successfully or unsuccessfully. According to Erikson, successful mastery of the development tasks of each stage will add strength to an individual's personality, whereas failure results in various maladaptive behavior patterns. Erikson's developmental phases are a universally experienced sequence of biological, social, and psychological events. This means that everyone in the world experiences these developmental tasks, no matter in which culture they live. Erikson believed a person's personality is constantly redeveloping in response to changing inner and outer requirements. The following chart gives you an overview of Erikson's eight stages:

<b>Erikson's Eight Stages of Psychosocial Development</b>		
<b>Stage (ages are approximate)</b>	<b>Psychosocial Crisis</b>	<b>Significant Relations</b>
I. Birth through first year	Trust vs. mistrust	Maternal person
II. Second year	Autonomy vs. shame	Parental person
III. Third year through fifth year	Initiative vs. guilt	Basic family
IV. Sixth year to onset of puberty	Industry vs. inferiority	Neighborhood, school
V. Adolescence	Identity vs. role confusion	Peer groups
VI. Early adulthood	Intimacy vs. isolation	Partners in friendship and sexual relationships
VII. Middle adulthood	Generativity vs. stagnation	Divided labor and shared household
VIII. Old age	Integrity vs. despair	Humankind

#### Stage I. Infancy—trust vs. mistrust

The major developmental task during infancy is the establishment of a loving, reliable relationship between the child and the mother or primary caretaker. Upon successful completion of this stage, children develop the ability to trust others. They have a sense of their own trustworthiness, as well as a sense of hope. Unsuccessful completion of this major task leaves the child withdrawn and estranged of others.

#### Stage II. Early childhood—autonomy vs. shame and doubt

Upon successful completion of this phase, children have self-control without loss of self-esteem and the ability to cooperate and express themselves. Autonomy allows children to view themselves as persons in their own right. Unsuccessful completion of this stage leads to compulsive self-restraint or compliance, defiance, willfulness. Children who are constantly tormented by a parent will grow up feeling ashamed and doubtful and will lack the spirit for healthy autonomy.

#### Stage III. Preschool age—initiative vs. guilt

When children reach the age of four, new skills must be developed. The newly acquired skill of language enables children to initiate a variety of activities. Successful completion of this stage leads to a realistic sense of purpose and some ability to evaluate personal behavior. Unsuccessful completion of this stage results in self-denial and self-restriction.

**Stage IV. School age—industry vs. inferiority**

During middle childhood, or school age, the central scheme is to develop scholastic and social competency. Successful completion of this stage leaves children with the realization that they are competent and the need for perseverance. Unsuccessful completion of this stage leaves children feeling they will never be ‘any good’, and they will begin to withdraw from school and peers.

**Stage V. Puberty and adolescence—identity vs. role confusion**

The developmental task for the fifth stage is to integrate childhood identification with biological drives and social roles. Upon successful completion of this stage, the adolescents have a coherent sense of self and plan to actualize their abilities. Unsuccessful completion leads to feelings of confusion, indecisiveness, and possibly antisocial behavior.

**Stage VI. Early adulthood—intimacy vs. isolation**

After young adults have begun to feel secure in their identity, they are expected to make an intimate commitment to another individual, as well as to a meaningful line of work. Successful completion of this stage results in the capacity for love as mutual devotion and a commitment to work and relationships. Unsuccessful completion results in impersonal relationships and prejudice.

**Stage VII. Middle adulthood—generativity vs. stagnation**

During this stage, the developmental task is to abandon self-related interests in favor of the younger generation. Successful completion results in creativity, productivity, and concern for others. Unsuccessful completion leads to self-indulgence and impoverishment of self.

**Stage VIII. Old age—integrity vs. despair**

Integrity is the culmination of successful growth. It implies the acceptance of the life a person has lived without regrets for what might have been. It also implies an acceptance of death. Success results in acceptance of the worth and uniqueness of a person’s life. Unsuccessful completion of this stage leads to a sense of loss and contempt for others. As you can tell, Erikson’s theory is different from Freud’s because it extends into adult development, all the way until death. Even today, Erikson’s theory of development remains very important in explaining personality.

**208. Sullivan’s interpersonal theory**

Harry Stack Sullivan, an American psychiatrist, established a theory of personality development, called the *interpersonal theory*, which emphasized the uniqueness of human interdependence. The basic principal of interpersonal theory is that past and present interpersonal relationships influence our personality. According to Sullivan, children develop a “good-me” or “bad-me” self-image early in life, based on their relationship with their primary caregiver. Sullivan wrote, “A good-me self-image results from a warm and caring mother. A bad-me self-image results from an anxious, disapproving mother who rejects the child and shows a lack of love and/or hostility. When infants grow, they inevitably encounter people who do not respond to them in the accustomed manner. This experience produces anxiety. Sullivan believes for children to protect themselves against anxiety, they develop *security operations*. Sullivan theorized that personality development consists of a series of interpersonal based learnings in which security operations are used as individuals attempt to gain approval and avoid the anxiety associated with disapproval. He identified developmental tasks specific to seven stages of development. Before we learn Sullivan’s developmental stages lets begin our study with his security operations theory.

**Security operations**

In order for children to protect themselves against anxiety, they develop security operations that are similar to what Freud called defense mechanisms. Interpersonal theorists use the following security operations:

Security Operation	Description
Somnolent detachment	This operation occurs when people sleep to avoid anxiety. Do you ever find yourself wanting to sleep when you are anxious about something?
Apathy	Apathy is an emotional detachment or numbing even though the experiences are remembered. It is when you just don't care about anything; your feelings are shut out.
Selective inattention	The process of tuning out or not noticing details which are associated with anxiety-producing events is called selective inattention. This means that you just remember what you want to remember about something, and if it's something that makes you anxious, then you just don't remember it.
Anger	Anger occurs when anxiety is changed to anger. Have you ever found yourself being angry about something that is really making you nervous?

### Stages of development

Personality development proceeds through various stages involving different patterns of interpersonal relationships. Our personality, according to Sullivan, is based on how well we did in all these different types of relationships. Sullivan identified significant interpersonal learnings that take place during each of seven stages. Failure to progress satisfactorily through the various stages of development paves the way for later maladaptive behavior.

Sullivan's Personality Developmental Stages	
Stages of Development	Developmental Task
Infancy	Self-concept
Early childhood	The use of power
Later childhood	Language
Juvenile era	The ability to compete and to compromise
Preadolescence	The ability to experience intimacy
Early adolescence	The development of a heterosexual orientation
Late adolescence	The integration of intimacy and lust in a heterosexual relationship

### *Infancy (birth–18 months)*

Sullivan believed the development of the self-concept begins in this stage and is closely related to the quality of the infant's feeding experiences. If the infants generally experience satisfaction and security from their mothers (or primary caregivers) during the feeding process, they begin to see themselves as worthwhile individuals, the "good me" self-concept. On the other hand, if the infants' experience during the feeding process is commonly mixed up with tension and inconsistency, the framework is formed for the development of a "bad me" self-concept.

### *Early childhood (18 months–3 yrs)*

During this stage, Sullivan emphasized the sense of power the children feel as they attempt to control themselves and others, particularly the primary caregivers during the toilet training process. Sullivan believed children see their feces as an extension of themselves. Therefore the primary caregiver's response to the child's pleasure in his feces is seen by the child as a reflection of their view of him. Thus, the self-concept established during infancy is either reinforced or altered.

### *Later childhood (3–6 yrs)*

Sullivan believed the major distinction of this stage is that of language, children become capable of giving up their personal language and substituting it with a language that has universal meaning.

### *Juvenile era (6–10 yrs)*

According to Sullivan, this stage is very crucial to the development of a healthy adult personality. Children no longer see their parents as the most significant person in their lives. They look to their peers of the same sex to fill the function of providing them with the sense of security and

companionship once derived from their parents. During this stage children try to find their place among their peers. In doing so, the children acquire the ability to compete and to compromise.

***Preadolescence (11–12 yrs)***

Children maintain great interest in their peer group, but at the same time develop a deep love relationship with a specific person of the same sex whom they consider to be very similar to themselves. In this relationship, children learn to put the needs of someone else before their own. Sullivan saw this experience as a necessary prerequisite to the establishment of a satisfactory heterosexual relationship in later stages of development.

***Early adolescence (12–17 yrs)***

As the adolescents experience sexual urges, they turn from the preadolescent relationship to the task of establishing a relationship with a peer of the opposite sex.

***Late adolescence (18–on)***

The major task during this stage is the incorporation of intimacy with sexual urges (which Sullivan called lust) so that these urges are not experienced in isolation of each other. Sullivan identified the late adolescence stage as the mark of adult maturity and did not identify any additional stages of development. However, Sullivan implied that it may take the rest of the adolescents' lives for them to develop the maturity that theoretically should have been achieved by this period.

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## Self-Test Questions

**After you complete these questions, you may check your answers at the end of the unit.**

**205. Freud's psychoanalytic theory**

1. What are Freud's three levels of mind awareness?
2. According to Freud's theory of personality development, what three psychological forces determine personality?
3. What did Freud believe people try to protect themselves from when they develop defense mechanisms?
4. How is repression defined according to Freud's theory of personality development?
5. According to Freud, what defense mechanism is commonly used against the stress of being diagnosed with a terminal illness?
6. According to Freud, how is the defense mechanism of identification defined?

**206. Freud's psychosexual development and psychoanalysis theories**

1. What is one of the problems with Freud's theory of development?
2. According to Freud's psychosexual development theory, during what stage does the young child derive satisfaction from and copes with discomfort or anxiety by sucking?
3. According to Freud's psychosexual development theory, during what stage does the young child need to learn to delay gratification and exert the muscle control necessary for toilet training?
4. According to Freud, during what period does the Electra complex occur?
5. In Freud's psychoanalytical therapeutic approach, what will analyzing dreams provide?

**207. Erikson's developmental phases**

1. According to Erikson's theory, what two forces must be synthesized during the developmental phases for a healthy personality development?
2. According to Erikson, what will add strength to an individual's personality?
3. According to Erikson, what is the central scheme during middle childhood, or school age?
4. Erikson believed that unsuccessful completion of what developmental stage during infancy will cause the child to withdraw from school and peers?

**208. Sullivan's interpersonal theory**

1. In Sullivan's theory, what do children develop to protect themselves against anxiety?
2. According to Sullivan, what security operation occurs when a person sleeps to avoid anxiety?



## 1-4. Additional Perspectives on Personality Development

In addition to the theories of Freud, Erickson, and Sullivan, there are other theories or approaches to mental health that you should be knowledgeable about. In the following lessons, you'll study some of the more important ones you'll encounter in your work. Specifically, these include the cognitive-behavior, humanistic, existential, and biologically based theories.

### 209. Cognitive-behavior theories

Cognitive development was once summarized as *doing, doing knowingly, and concept formation*. Once the individual is able to invent proposals based on real life experiences, and is able to organize these proposals and apply them to real life issues, cognitive development is complete. The individual can now think for himself or herself. Psychologists are sometimes in disagreement as to how this developmental process proceeds. Jean Piaget, a noted Swiss child psychologist, has been most influential with his theory of cognitive development. Piaget felt that a person's intellectual functions were at the core of personality formation and served to coordinate all development areas. Let's take a look at his theory.

#### Piaget's theory on cognitive development

Piaget was the first modern theorist to emphasize that infants are actively exploring and trying to master their surroundings from their very first breath of life. He felt this desire is inherited by all infants and proceeds through a series of developmental phases. Each phase is dependent upon completion and success in mastering the elements of the preceding phase. This sounds similar to Freud's and Erikson's theories except Piaget held that there were two fundamental processes that human beings adopt that make all of the mastery and success possible. These processes of assimilation and accommodation assist individuals to adjust to the environment.

#### *Assimilation*

This term is used to describe the "taking in" experiences as a whole and fitting them into the existing intellectual or individual structure. An individual will filter information selectively and use what he or she can to compliment personal needs and intellectual desires. Let's look at an example. If you enjoyed working with wood and had an opportunity to view a videotape on the latest woodworking methods, you'd probably listen with earnest and assimilate as much information as possible for your future use. On the other hand, if you viewed a tape on something you didn't care for, such as data processing, your attention wouldn't be as great and your tendency to assimilate any information would be much less.

#### *Accommodation*

This is the term for the process by which you change your intellectual approach to the environment or existing situation to adjust to it. That is, the way you look at things changes as you grow. Your way of thinking *accommodates* to new material to allow you to deal within your own intellectual structure and needs. This allows you to react to an increasingly complex world with an increased awareness. Let's look at another example: as a small child, when you rode in your parent's car, your deepest thought about that automobile may have been, "I'm going for a ride in the car with daddy or mommy." As you grew, you became more aware of the abilities of the vehicle, how it was constructed, how it ran, what the possibilities were if you owned one, and finally, the expense and upkeep of owning your own vehicle. Through each of these lessons, you had to accommodate your intellect by using different approaches to increased knowledge (assimilation) of the environment surrounding the operation and abilities of the automobile.

#### Piaget's stages theory

Piaget described four stages of cognitive (intellectual) development. He felt it was essential that each stage be successfully mastered before the next could be undertaken with any degree of success or progression. The rate at which children progress through each stage varies with individual

circumstances and abilities and the environment. If a very bright child can master an advance stage very quickly, without benefit of progressing through a previous stage, chances are he or she may not be able to do simple tasks associated with the lesser stage, due to lack of training or experience in that area. In other words, he or she may not be able to fully function in some situation that requires experience with simple motor or intellectual tasking later in life. Piaget felt that the individual intellect would interpret previous knowledge learned in past stages and reorganize that material to deal with new lessons being learned. Thus, it is important to go through each stage systematically. The four stages Piaget identified are:

1. Sensorimotor stage (age 0–16/24 months).
2. Stage of preoperational thought (age 2–6).
3. Stage of concrete operations (age 6–12).
4. Stage of formal operations (age 12 onward).

The following chart lists Piaget's stages along with the cognitive development expected to occur during that stage.

Piaget's Stages Of Cognitive Development	
Stage	Description
Sensorimotor stage (age 0–16/24 months)	At this stage, children are unable to reason. The child deals with reality in terms of sensations and motor movement.
Stage of preoperational thought (age 2–6)	During this stage, the child is capable of symbolic thought and rapidly acquires the ability to use language.
Stage of concrete operations (age 6–12)	The child has the ability to reason like an adult in every way except for reasoning and abstract concepts such as justice, infinity, or the meaning of life.
Stage of formal operations (age 12 onward)	By this stage most individuals have progressed to full adult cognition, including the ability to reason using abstract concepts.

In Piaget's stage theory, you noticed that the children's cognitive capacities develop rapidly until about the time of puberty, but change little after that. You also saw, on the average, children progress from human beings who cannot reason in mental symbols to persons fully capable of adult reasoning in 11 short years, with many dramatic changes along the way.

Most individuals who work with children are indebted to Piaget for his support of developmental psychology. His studies of children and how they respond and learn were extremely insightful. Most importantly, his findings that children learn differently from adults because they view the world differently have been extremely helpful in understanding childhood behavior and their response to illness and other dilemmas.

## 210. Behavioristic approach

The central theme of the behavioristic approach dealt with the role of *learning* in developing human behavior. The Russian physiologist, Ivan Pavlov, can probably be credited with the first work using the behavioristic approach. However, three American psychologists, J. B. Watson, E. L. Thorndike, and B. F. Skinner, are credited with expanding Pavlov's original work.

### Pavlov's work

Pavlov's famous experiment, salivary responses in dogs, led to the concepts of conditioned reflex and conditioning. He taught dogs to salivate upon hearing a bell by repeatedly offering them food immediately after the bell sounded. The dogs had learned to associate the sound of the bell with the food. Eventually the bell induced salivation even when no food was offered. This was to be a major building block in the systematic study of learning.

**Watson's work**

Watson felt that Pavlov's experiments with conditioning could be used to study human behavior more objectively. Watson's approach emphasized the social environment in conditioning personality development and behavior. He was the first behaviorist to apply *stimulus-response* theories of learning to the study of child development. Watson's famous experiment demonstrating an example of stimulus response was "Little Albert." In this experiment, a 9-month-old baby showed no fear of animals until laboratory experimenters made a loud noise each time little Albert would reach toward a white rat. Inevitably, Albert would cry as soon as he saw the rat. The response of crying that Albert made to the rat (and later to a rabbit and a Santa Claus mask) was a conditioned response.

As a result of the work of Pavlov and Watson, many investigators believed all learning is based on conditioned reflex, including both abnormal and normal behavior.

**Thorndike's concept**

Thorndike formulated the concept that behaviors that have rewarding consequences are strengthened or learned and behaviors that elicit negative consequences are weakened. He placed emphasis on the concept of reward and punishment to control behavior.

**Skinner's development**

Skinner further developed this concept by stating that the most important determinants of behavior are in the environment and not the individual. In addition, he felt that these determinants could be manipulated to control the individual's behavior.

**Behavioristic basic principles**

Behaviorists feel that since behavior is learned, there's a need to take a look at how learning comes about. With this as a central thought, let's take a look at some of the basic principles of the behaviorist approach.

***Respondent (classical) and operant conditioning***

Even before learning takes place, there are some stimuli that may produce responses. For example, in Pavlov's experiments with dogs, the dogs salivating in the presence of food is called an "unconditional response." When they were conditioned to get the same response from another stimulus, it was called "respondent conditioning." Much of this occurs during infancy and childhood. We learn to stay away from stimuli that may hurt us. However, it's considered maladaptive when we learn irrational fears or phobias. In what's called "operant conditioning" when we respond to achieve a goal. In other words, we "operate" on the environment to achieve the goal. The goal may be something satisfying or rewarding or something to avoid. As we grow up, "operant learning" becomes important in separating the desirable from the undesirable. However, during this process we may also learn maladaptive methods for reaching our desired goals.

***Reinforcement***

Reinforcement is the strengthening of a new response by its repeated association with some unconditioned stimulus. This stimulus is called a *reinforcer* and may be either positive or negative. For example, punishing a child for something he or she was not supposed to do would be a negative enforcer.

***Generalization and discrimination***

When one stimulus becomes associated or elicits a like response as others that are similar, the response is referred to as a generalization. The more similar the stimuli, the better the chance for generalization. The opposite of generalization is discrimination. The discrimination process means that an individual learns to distinguish between stimuli and respond differently. These are important concepts when we're concerned with maladaptive behavior. Inappropriate generalization and an inability to discriminate may lead an individual to develop maladaptive behavior.

***Modeling and shaping***

Modeling is exactly as the term implies; parents and other important persons in a child's life demonstrate the desired response patterns. Parents are extremely important models because the children often imitate their behavior and often adopt maladaptive responses. Shaping is a way to bring about new responses by reinforcing responses that are consecutively more like the desired one. For example, the parents of a child that refuses to sleep alone in his own bed might first give the child a treat for getting into the bed. Then the parents would give the child the treat only after he lies down in the bed, and then only when he stays in his bed. If the responses aren't available, they may be shaped by reinforcement. Initially, responses that aren't available to the individual may be reached gradually through shaping.

**211. Humanistic approach**

The humanistic approach is drawn from both the psychoanalytic and behaviorist approaches but has major disagreements with both. Humanists disagree with the behaviorists in what they feel is the oversimplification of stimulus and behavior without considering an individual's inner experiences and self-direction. This humanistic theoretical approach emerged in the 1950s and 1960s, influenced by psychologists such as Abraham Maslow, Charlotte Buhler, Carl Rogers, and Fritz Perls.

**Humanistic fundamentals**

The focus of humanistic theory is on people's conscious experiences and perceptions and on freeing them from disabling assumptions and attitudes so they can develop their potential. The humanistic approach places an emphasis on self-growth and self-actualization rather than on a cure of disease; consequently, practitioners do not usually work with people suffering from serious mental disorders. The focus is on the future of the person, not the past and less attention is placed on unconscious processes.

**Basic principles**

The humanistic approach has the following three basic principles—self as a unifying theme, strong emphasis on value and personal growth, and positive view of human nature and its potential.

***Self as a unifying theme***

The self, according to the humanists, is somewhat the same as Freud's ego. But the humanists are also concerned with coping, problem solving, etc. They expand the self to include a person's sense of identity and relationship to the world, as well as self-fulfillment and evaluation. The concept of self as a unifying theme emphasizes the importance of individuality.

***Strong emphasis on value and personal growth***

Humanists feel that we should develop our own values based on our own experiences rather than accepting the values of others. By doing this we can develop our own sense of identity and become the person we want to be and know why.

***Positive view of human nature and its potential***

Humanists believe that under favorable conditions, our basic personality is good, and that aggression and cruelty are a result of distortion, denial, and frustration of our basic nature.

**Humanistic intervention**

Therapeutic intervention is aimed at fostering personal growth toward a socially constructive and personally fulfilling way of life. Methods of interventions include encounter groups, awareness training, and other experimental techniques for fostering personal growth, building satisfying relationships with others, and finding effective methods of coping. Humanists or psychopathologists view our basic human nature as "good" and believe that conscious, as well as unconscious, process influences our behavior. We can get a better perspective on these theories by looking at two leaders of the humanistic psychotherapy movement.

### ***Buhler's five phases***

Charlotte Buhler was the first president of the Association of Humanistic Psychology. She maintained self-fulfillment is the key to healthy development and unhappy people are unfulfilled in some way. She emphasized the intentionally human nature, with special attention to those activities people do on their initiative. She contended people who lead fulfilling lives have a lifelong orientation toward goals, even though in the early years they may not be conscious of those goals. Buhler's five phases of goal setting and goal attainment is described in the table below.

<b>Buhler's Five Phases of Goal-Orientation</b>	
Childhood (until age 15)	People have not yet determined life goals: they think about the future in vague ways.
Adolescence and young adulthood (15 to 25)	People first grasp the idea that their lives are their own, analyze their experiences so far, and think about their needs and their potential.
Young and middle adulthood (25 to 45–50)	People adopt more specific, definite goals.
Mature adulthood (45 to 65)	People take stock of their past and revise their planning for the future.
Old age (after 65 or 70)	People rest from their concentration on achieving goals.

### ***Maslow's hierarchy of needs***

Abraham Maslow developed the "Hierarchy of Needs" pyramid. Maslow theorized that people form a hierarchy of needs, ranging from survival to self-actualization. Lower order needs must be satisfied before higher order needs can be met. The following is a list of the needs, starting with the lowest ranking needs first:

1. *Physiological needs*—include items we need to survive, such as food, water, air, elimination, and some authorities include sex as a basic need for survival of the species.
2. *Safety needs*—we need to be safe from both physical and psychological dangers.
3. *Belonging needs*—this is the first of the 'growth' needs, what we need for our psychological well-being. For a healthy personality, people need to be loved and to love.
4. *Esteem needs*—related to self-respect and self-admiration. We need to feel good about ourselves and that we are worthy of respect from others.
5. *Self-actualization*—the highest level. This occurs when a person is functioning at his or her full creativity and fulfilling the person's greatest potential.

Summarily, the humanist's assumption is that people have within themselves the resources to understand their view of the self and to direct their own behavior.

## **212. Existential approach**

The existential approach is very similar to the humanistic approach with its emphasis on values, search for meaning, self-direction, and self-fulfillment. It differs, though, in that it isn't as optimistic regarding our basic nature. Existentialists place emphasis on a person's irrational tendencies and difficulties encountered in reaching self-fulfillment, especially in our dehumanizing mass society with all of its red tape. The writings of European philosophers Heidegger, Jaspers, Kierkegaard, and Sartre, set forth the basic concepts of existentialism, and were further developed in the United States by Theologian Paul Tillich and psychologist Rollo May. The basic theme is to find sound values, grow as a person, and build a meaningful and socially constructive life.

### **Existence and essence**

One of the basic concepts of existentialism is that we are given life (existence); however, what we make of it is up to us (essence). Making something of our lives is not an easy task because of the major social changes that go on in our world. Our traditional values and beliefs are constantly being challenged. This often causes confusion and emotional turmoil in our lives. So, how can we solve this

problem? We have two choices: (1) giving up the search and trying to find some satisfaction by conforming or, (2) trying for increased self-definition in the reality of our existence. It is through the second choice we find self-fulfillment.

**Choice, freedom, and courage**

What we make of our lives or our essence is created by our choices, and in making these choices we are seen to have absolute freedom. When we make these choices we must also have the courage to seek the values that offer us self-fulfillment and the courage to break away from the old patterns that have little meaning to us.

**Meaning, value, and obligation**

Another main theme of existentialism is the will-to-meaning. This means that individuals find values and live their lives by them. In addition, existentialists believe we can only find self-fulfillment by obligating our lives to each other and by living socially constructive lives.

**Existential anxiety and the encounter with nothingness**

We are the only creatures who live with the awareness of our own inevitable death, or nonbeing, or nothingness. It's this awareness that leads to existential anxiety, which basically is a concern of whether or not we're leading a meaningful and fulfilling life.

The focus of the therapist in existential therapy is to help the patient clarify his or her values and work out a meaningful way of "being in the world." Abnormality is seen by the existentialist as a failure to develop our potential. Therapy is used to help lead the individual toward personal growth and a socially constructive and personally fulfilling life.

You can now understand why adopting one of these theories has significant consequences. These theories influence your perception of what maladaptive behavior is, what symptoms mean, and how you can be therapeutic with clients. Each of these theories has a different approach to use for psychopathology, and you may find one or another approach more useful in working with a particular type of maladaptive behavior, disorder, or specific client.

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**Self-Test Questions**

**After you complete these questions, you may check your answers at the end of the unit.**

**209. Cognitive-behavior theories**

1. According to Piaget's theory, what two fundamental processes do human beings adopt that make all of the mastery and success possible?
2. In Piaget's stages of cognitive development, what stage are children unable to reason?

**210. Behavioristic approach**

1. What famous behaviorist experiment is the Russian physiologist Ivan Pavlov credited with?
2. Define modeling and shaping?

**211. Humanistic approach**

1. What is the focus of humanistic theory?
2. What are the three basic principles of the humanistic approach?
3. According to Charolette Buhler's five phases of goal-orientation, during what phase do people begin to think about their needs and potential?

**212. Existential approach**

1. What is the focus of the therapist in existential therapy?
2. What is existential therapy used for with patients?

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**Answers to Self-Test Questions****201**

1. Hereditary factors.
2. Environmental factors.
3. Physical health, proper function of the endocrine system, chronic illness, and the level of vitality.
4. Teratogens, diseases, poor prenatal care, malnutrition.
5. Medication, anoxia, accident, illness, malnutrition, poisoning.
6. Maturation.

**202**

1. Infancy.
2. Early childhood.
3. Middle childhood.
4. Middle childhood.
5. Becoming adult.
6. Around age 12.
7. Adolescents identify with peers.
8. Young adulthood, or a second period of delay after adolescence. It allows the individual time to harmonize the different parts of his or her personality and to assimilate adolescence completely before assuming an adult identity.
9. Middle age.
10. Normal aging without significant loss of function.
11. Aging accompanied by considerable physical and psychological deterioration.
12. Heart disease, cancer, and cerebrovascular accident.

**203**

1. Our subjective perception of who we are and what we are like.
2. Self-recognition.
3. Extensions of the self.
4. The origins and nature of self-concepts.

**204**

1. Positive self-image.
2. Our immediate family.
3. Identifying with their values, attitudes, morals, ethics, religion, prejudices, likes, and dislikes.
4. School.
5. Parents, teachers, and significant others.
6. Refers to the beliefs that a person holds regarding the kind of person he or she should be or wants to become.
7. By the process of comparison with others.
8. Refers to what we tell ourselves about ourselves.
9. Perceiving what we want or expect others to perceive.

**205**

1. Conscious, subconscious (or preconscious), and unconscious.
2. Id, ego, and superego.
3. Anxiety or psychic pain.
4. The involuntary exclusion of a painful or conflicting thought, memory, feeling, or impulse from awareness.
5. Denial.
6. The wish to be like another person and to assume the characteristics of that individual's personality.

**206**

1. It fails to explore any phases of adult development.
2. Oral stage.
3. Anal stage.
4. Phallic stage.
5. Insight into the individuals wants, desires, and conflicts.

**207**

1. Positive and negative forces.
2. Successful mastery of the development tasks of each stage.
3. To develop scholastic and social competency.
4. School age.

**208**

1. Security operations.
2. Somnolent detachment.

**209**

1. Assimilation and accommodation.
2. Sensorimotor stage.

**210**

1. Salivary responses in dogs.
2. Parents and other important persons in a child's life demonstrate the desired response patterns.



**211**

1. People's conscious experiences and perceptions and on freeing them from disabling assumptions and attitudes so they can develop their potential.
2. Self as a unifying theme, emphasis on value and personal growth, and a positive view of nature and its potential.
3. Adolescence and young adult.

**212**

1. To help the patient clarify his or her values and work out a meaningful way of "being in the world."
2. To help lead the individual toward personal growth and a socially constructive and personally fulfilling life.

**Do the unit review exercises before going to the next unit.**

## Unit Review Exercises

**Note to Student:** Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

1. (201) Which term is *not* a factor that determines one's personality?
  - a. Hereditary.
  - b. Maturation.
  - c. Environmental.
  - d. Developmental.
2. (201) Which type of genetic environmental correlation occurs when a child conducts himself or herself in a manner which solicits positive responses from others?
  - a. Active.
  - b. Present.
  - c. Passive.
  - d. Evocative.
3. (201) Which type of genetic environmental correlation occurs when a child seek environments that fit his or her genetic tendencies?
  - a. Active.
  - b. Present.
  - c. Passive.
  - d. Evocative.
4. (201) Which term is considered a prenatal influence which can cause damage to a fetus?
  - a. Accident.
  - b. Teratogens.
  - c. Poisoning.
  - d. Anoxia.
5. (202) At what month is the palmer grasp reflex lost?
  - a. 8.
  - b. 10.
  - c. 12.
  - d. 14.
6. (202) By the end of the second year a child's vocabulary consists of how many words?
  - a. 25.
  - b. 50.
  - c. 75.
  - d. 100.
7. (202) By the time a child reaches 5 years of age their vocabulary consists of how many words?
  - a. 1,000.
  - b. 1,500.
  - c. 2,000.
  - d. 2,500.
8. (202) Around what age do boys experience a growth spurt?
  - a. 10-11.
  - b. 11-12.
  - c. 12-13.
  - d. 13-14.

9. (202) During what stage of development do children begin to question parental rules?
  - a. Infancy.
  - b. Late childhood.
  - c. Early childhood.
  - d. Middle childhood.
10. (202) The majority of physical and cognitive development is completed by what developmental stage?
  - a. Adulthood.
  - b. Middle age.
  - c. Late adulthood.
  - d. Young adulthood.
11. (202) What is considered the healthiest developmental stage of life?
  - a. Adulthood.
  - b. Middle age.
  - c. Late adulthood.
  - d. Young adulthood.
12. (202) What developmental stage is considered a very productive time for work and family?
  - a. Adulthood.
  - b. Middle age.
  - c. Late adulthood.
  - d. Young adulthood.
13. (202) At what age does menopause typically occur in women?
  - a. 40.
  - b. 50.
  - c. 60.
  - d. 65.
14. (203) During which dimension of self-concept is sense of purpose to the self gained?
  - a. Self-esteem.
  - b. Self-recognition.
  - c. Personal competence.
  - d. Aspirations and goals.
15. (204) Who shapes a child's attitudes and beliefs about himself or herself and the world?
  - a. Family.
  - b. School.
  - c. Religion.
  - d. Parents/teachers.
16. (204) A person with which attribute is also sensitive and aware of the real self?
  - a. Self-ideal.
  - b. Changing self.
  - c. Positive self-image.
  - d. Negative self-image.
17. (204) Using Johari's window and the four panes of self, how much are we aware of in ourselves?
  - a. All panes.
  - b. One-half.
  - c. One-fourth.
  - d. Three-quarters.

18. (205) Who is considered the father of modern psychology?
  - a. Sigmund Freud.
  - b. Harry Sullivan.
  - c. Erik Erikson.
  - d. Jean Piaget.
19. (205) What part of the mind is the source of our emotional pain?
  - a. Conscious mind.
  - b. Subconscious mind.
  - c. Preconscious mind.
  - d. Unconscious mind.
20. (205) According to Freud's theory of personality development, which psychological force is the source of instinctual drives that are sexual and aggressive?
  - a. Id.
  - b. Ego.
  - c. Ultraego.
  - d. Superego.
21. (205) Which defense mechanism is used when emotions are aroused in a situation where it would be dangerous to express them?
  - a. Projection.
  - b. Displacement.
  - c. Sublimination.
  - d. Rationalization.
22. (206) During which of Freud's psychosexual stage does the Oedipus conflict and Electra complex occur?
  - a. Oral.
  - b. Anal.
  - c. Phallic.
  - d. Latency.
23. (207) Unsuccessful completion of which stage of psychosocial development leaves the individual withdrawn and estranged?
  - a. Stage I—Infancy.
  - b. Stage II—Early Childhood.
  - c. Stage VII—Middle Adulthood.
  - d. Stage VIII—Old Age.
24. (207) Unsuccessful completion of which stage of psychosocial development leads to compulsive self-restraint or compliance, defiance and willfulness?
  - a. Stage I—Infancy.
  - b. Stage II—Early Childhood.
  - c. Stage VII—Middle Adulthood.
  - d. Stage VIII—Old Age.
25. (208) Sullivan's personality developmental stages concluded that language was a major distinction of which stage of development?
  - a. Early childhood.
  - b. Later childhood.
  - c. Preadolescence.
  - d. Juvenile era.

26. (208) During which of Sullivan's personality developmental stages do adolescents begin to experience sexual urges?
- a. Preadolescence.
  - b. Early adolescence.
  - c. Late adolescence.
  - d. Post adolescence.
27. (208) Sullivan's personality developmental stages concluded that intimacy and sexual urges was the distinction of which stage of development?
- a. Early childhood.
  - b. Later childhood.
  - c. Preadolescence.
  - d. Late adolescence.
28. (209) Who was the first modern theorist to emphasize that infants are actively exploring and trying to master their surroundings from their first breath of life?
- a. Sigmund Freud.
  - b. Harry Sullivan.
  - c. Erik Erikson.
  - d. Jean Piaget.
29. (209) According to Piaget's stages of Cognitive Development, in which stage does the individual have the ability to reason using abstract concepts?
- a. Preoperational thought.
  - b. Concrete operations.
  - c. Formal operations.
  - d. Sensorimotor.
30. (209) According to Piaget's stages of Cognitive Development, in which stage does the child have the ability to reason like an adult in every way except for reasoning and abstract concepts?
- a. Preoperational thought.
  - b. Concrete operations.
  - c. Formal operations.
  - d. Sensorimotor.
31. (210) Who is credited as being the first to work using the behavioristic approach?
- a. Harry Sullivan.
  - b. Erik Erikson.
  - c. Ivan Pavlov.
  - d. Jean Piaget.
32. (210) Which behaviorist stated the most important determinants of behavior are in the environment and not the individual?
- a. E.L. Thorndike.
  - b. J.B. Watson.
  - c. Ivan Pavlov.
  - d. B. F. Skinner.
33. (210) Who are considered extremely important models for children as they are often imitated?
- a. Peers.
  - b. Parents.
  - c. Teachers.
  - d. Siblings.

34. (211) Which theory of personality development is focused on people's conscious experiences and perceptions and on freeing them from disabling assumptions?
- a. Existential.
  - b. Humanistic.
  - c. Psychoanalytic.
  - d. Cognitive-behavioral.
35. (211) Who developed the five phases of goal setting and goal attainment?
- a. Maslow.
  - b. Watson.
  - c. Buhler.
  - d. Piaget.
36. (211) Who developed the "Hierarchy of Needs" pyramid?
- a. Maslow.
  - b. Watson.
  - c. Buhler.
  - d. Piaget.
37. (212) Which of the following is *not* a basic theme of the existential concept?
- a. Values.
  - b. Grow as a person.
  - c. Adopt vacillating opinions regarding self.
  - d. Build a meaningful and socially constructive life.

## Unit 2. Characteristics of Selected Mental Disorders

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**A**N ACCURATE ASSESSMENT is at the heart of every evaluation. The patient’s diagnosis becomes the benchmark against which treatment planning is formulated. In this unit we will provide information to help you recognize key areas of the diagnostic criteria. Your focus will be on those mental disorders that cause an individual significant discomfort and may interfere with his or her ability to function effectively. It is important for you to be able to identify the behavior, signs, and symptoms of the various diagnostic categories. You’ll study criteria, classification, and indicators used to diagnose mental disorders.

The material in this unit is based on the American Psychiatric Association (APA), *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR), 2000. The DSM-IV-TR is the source for official classification of mental disorders. The diagnoses are universally recognized throughout the behavioral health and medical community. A brief synopsis or section overview review will be provided for each mental disorder; however, you are encouraged to read the DSM-IV-TR for detailed diagnostic information.

### 2–1. Diagnostic Process

The basic process of diagnosis is to observe patterns of signs and symptoms characteristic of a specific disorder or syndrome. These signs and symptoms specify the type, intensity, duration, and effect of the various behaviors and symptoms required for the diagnosis. It involves two processes that will be discussed in the following lessons.

## 213. Classification of mental disorders

The diagnosis begins with organizing a set of symptoms and signs elicited from the history, as well as the physical and mental status examinations. Let's look at the organization process, beginning with the classification system and the criteria associated with making a diagnosis of mental disorders.

### Diagnostic criteria

Diagnostic criteria provide a description of specific information to associate with each mental disorder. The DSM-IV-TR provides diagnostic criteria for each mental disorder. These criteria include a list of essential features that must be present for the diagnosis to be entertained or made. They specify the type, intensity, duration, and effect of various behaviors and symptoms required to make the diagnosis. The criteria also help make up the clinical basis for classifying an individual behavior as a mental disorder.

### Governing criteria

The diagnoses of all disorders (except Substance Related Disorders) in DSM-IV-TR are governed by three criteria:

1. The disorder is not due to the direct effects of a substance.
2. The disorder is not due to the direct effects of a General Medical Condition.
3. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

### Preventing misdiagnosis

The first two criteria guard against misdiagnosis of identifiable physical causes for psychiatric syndromes. For example, the patient may be using/abusing a substance or illicit drug or using medication that could cause symptoms emulating mental illness. The patient could also have a history of a medical disorder that may cause disorientation, distorted thought processes, depression, or other symptoms of mental illness.

### Basic principle

The third restates the basic principle that all mental health disorders are considered to cause clinically significant impairment or distress.

Remember, clinical judgment plays an important part in the utilization of the criteria to the evaluation of any individual.

### Classifying mental disorders

The classification of mental disorders is often misunderstood. A common misunderstanding of the novice behavioral health paraprofessional is to use the DSM-IV-TR as a way to classify *people* with mental disorders. However, what are really being classified are the *disorders* that people have. To classify something means to arrange according to a system. The system organizes all the information obtained about the patient and allows us to communicate more clearly between ourselves and other professionals. As a mental health service journeyman, you will need to become familiar with this classification. The 18 major diagnostic classes are shown in the following chart.

18 Major Diagnostic Classes	
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	Dissociative Disorders
Delirium, Dementia, Amnestic, and Other Cognitive Disorders	Sexual and Gender Identity Disorders
Mental Disorders Due to a General Medical Condition	Eating Disorders
Substance-Related Disorders	Sleep Disorders
Schizophrenia and Other Psychotic Disorders	Impulse Control Disorders, Not Elsewhere Classified
Mood Disorders	Adjustment Disorders
Anxiety Disorders	
Somatoform Disorders	



### 18 Major Diagnostic Classes

Factitious Disorders

Personality Disorders  
Other Conditions that May  
Be a Focus of Clinical  
Attention  
Additional Codes

### *Diagnostic and statistical manual—IV- text revision classification*

The classification system used in the DSM-IV-TR allows mental health providers to communicate more clearly in a universal language among themselves and to provide standard care. It also provides standard practices of care based on the classifications. The DSM-IV-TR uses a multiaxial system. The purpose of this system is to ensure that attention is given to certain types of disorders, aspects of the environment, and areas of functioning that might be overlooked if the focus was on assessing a single presenting problem.

### *Multiaxial system*

The multiaxial evaluation requires that each patient seen for mental health issues be assessed on several axes, each referring to a different class of information. There are five different axes in the DSM-IV-TR multiaxial classification.

You'll briefly study Axes I, II, III, IV, and V.

I'm sure you have noticed this classification system does not explain the how and why of mental illness; however, it does describe the characteristics of each mental disorder or syndrome. Making a mental disorder diagnosis involves the following three processes:

1. A careful history.
2. Physical examination.
3. The mental status examination.

These observations are then grouped into the following signs and symptoms:

DSM-IV Multiaxial Approach		
Axes	Classification	Documentation
Axis I	Clinical disorder	Includes the diagnosis that best describes the patient's presenting complaint.
Axis II	Personality disorders and mental retardation	Describes personality disorders and degrees of mental retardation.
Axis III	General medical conditions	Describes any coexisting medical problems.
Axis IV	Psychosocial and environmental problems	The effects of stressors on the patient (e.g., marital, occupational domestic or environmental factors like natural disasters).
Axis V	Global assessment of functioning	A measurement of how well the patient has functioned over the past year. It also includes the patient's present level of functioning (based on a 1–100 scale).

Axis I, II, and III will sometimes have more than one diagnosis. If this occurs, you will need to prioritize your diagnostic impressions with the primary or principal reason for the visit listed first. There may also be occasions when a patient has both an Axis I and II diagnosis. Axis I will always be assumed to be the principal diagnosis unless Axis II is identified as such. Novice Mental Health Journeyman will sometimes question their own competence if they do not provide a “rule-out” diagnosis for each of the diagnostic axis. If you are unsure, do not label someone simply to fill a square. Consult with peers, supervisors, and providers regarding your findings and your impressions. You will receive valuable feedback and training as you continue to hone your skills.

Before we go much further, remember the following: you cannot diagnose patients/clients as a Mental Health Journeyman. Diagnosing a patient or client is accomplished by credentialed providers with the professional and legal authority to do so. You can provide a diagnostic impression or what is referred to as a “rule-out” diagnosis. This simply means, based on your impression of the clients presenting problems and after a thorough interview, you are asking a credentialed provider to entertain your diagnostic impression.

## **214. Mental disorders indicators**

We have looked at the way mental disorders were classified and how patient information is utilized in the diagnostic process, now it's time to discuss the behavior that warrants investigation for presence of a mental disorder. In the diagnosis of mental disorders, there usually is not clear-cut evidence, as there is with a broken arm or appendicitis. A mental disorder diagnosis implies the signs and symptoms observed in a particular patient are similar to the pattern observed in other patients with the same diagnosis. The signs, behavior, and symptoms are sometimes specific, but most of the time there is a combination of these symptoms. There are three general criteria that may be used to assess the presence of a mental disorder—discomfort, abnormal behavior, and inefficiency. For better identification, we will discuss each one individually.

### **Discomfort**

An examination of emotional discomfort as an indication of mental disorders will reveal the following three distinctions—anxiety, depression, and physical symptoms.

#### ***Anxiety***

Anxiety is defined as a feeling of strong apprehension or uneasiness, while the source is largely unknown or unrecognized by the individual. There are countless stressful situations that either alone, or in combination, may lead to feelings of anxiety such as the following examples:

- Marital problems.
- Financial troubles.
- Involuntary separations.
- Sickness in the family.

I'm sure you can add a few of your own stressors to this list. When anxiety is irrational, incapacitating, or persistent, it may be an indicator of a mental disorder. Activation of the sympathetic nervous system can cause physical symptoms such as increased heart rate, sweating, headaches, upset stomach, etc. Mental distress includes feelings of apprehension, impaired concentration, feelings of tension, and sleep disturbance, just to name a few. As a Mental Health Journeyman, it is important for you to be able to recognize when anxiety becomes intense or chronic enough to warrant treatment.

#### ***Depression***

Depression is another type of emotional discomfort. Some forms of depression are experienced by nearly everyone at some time in their life. It is a natural response to loss, failure, and disappointment. However, when depression continues long after the event that caused it, or there is no apparent reason for its occurrence, the depression is considered an indicator of a mental disorder. A loss of self-esteem, presence of excessive guilt, feelings of helplessness, and occurrence of definite changes in one's eating, sleeping, and social behaviors are signs of depression. The seriously depressed person is often pessimistic about himself, the world, and his future. Common physical complaints expressed are exhibited by the depressed person include low-back pain, constipation, weight loss, chronic indigestion, and decreased libido (sexual desire).

#### ***Physical symptoms***

Another type of emotionally related discomfort is the appearance of one or more physical symptoms, brought on by psychological and emotional factors. Psychological factors affecting physical

conditions cover a wide range of disturbances where emotional factors play an important, though not necessarily exclusive, causative role. Examples of such disorders are headaches, asthma, skin rashes, urticaria (hives) and peptic ulcers.

The presence of enduring anxiety or depression is sufficient evidence of mental difficulties to warrant treatment. Even if the depression or anxiety is found to be a by-product of a physical disease, these types of symptoms still require some psychological intervention. Although an illness may be considered primarily physical or mental, it always involves the total person as well as psychological stress, and being emotionally upset may lower one's resistance to physical disorders.

### **Abnormal behavior**

In psychological terms, abnormal behavior is described as actions, thoughts, and feelings harmful not only to that individual, but also to others around that individual. In the United States, around 20 percent of all people exhibit actions, thoughts, and feelings that are considered harmful enough to be labeled abnormal at any one time. This harm may take many forms ranging from a type of personal discomfort to physical harm (e.g., assaulting another person). Notice that abnormality is defined only in terms of harm. It's not enough that a pattern of behavior is *unusual* (statistically uncommon for that culture) to be considered abnormal. Extreme intelligence and total honesty are unusual, but they are not considered abnormal. On the other hand, some patterns of behavior that are not uncommon are clearly harmful. The intense prejudice against blacks in the military during World War II was common, but abnormal. There are two levels of abnormal behavior that are considered indicators of mental disorder and they are:

- Loss of contact with reality.
- Deviation from social standards.

#### ***Loss of contact with reality***

Behaviors indicating loss of contact with reality are considered abnormal. Hallucinations and delusions are major indicators of a loss of contact with reality. Since hallucinations and delusions create a disturbed picture of the world, the person experiencing them usually is unable to adapt to his or her physical and social environment. Generally, this class of unusual or abnormal behavior is easily recognizable. Failure to be in contact with reality appears to be universally considered abnormal because accurately perceiving and interpreting reality is a universal necessity.

#### ***Deviation from social standards***

Obvious examples of significant or major deviations from accepted standards of behavior may include robbing banks, vandalism, larceny, and drug abuse. However, you should keep in mind that not all types of nonconformity are considered signs of mental disorders; some types are accepted as normal, more or less. For example, a student engaging in the relatively acceptable college fad of "streaking" probably would not be considered mentally disturbed, even though running naked in public is against social norms and might be unlawful. On the other hand, a man exposing his genitals on a public street corner would likely be considered mentally troubled. As you can see, deviation is defined socially. Each culture takes responsibility for defining specific acts of behavior as being minor or major deviations. What may be considered as deviant or unacceptable in one culture may be acceptable in another country. We can say the majority defines the norm.

### **Inefficiency**

Inefficiency is another criterion often used to identify mental disorder. Inefficiency can be defined as the inability of the individual to function capably in his daily life. The two types of standards for efficiency include:

- Social.
- Personal.

***Social standards of inefficiency***

Social standards involve role expectations. All members in a society have roles they are expected to perform. Role assignment is partially dependent on variables such as sex, age, vocation, and social status. In fulfilling social roles, each person is expected to maintain a certain level of efficiency. This is often informally measured in terms of the individual's ability to manage his or her affairs and responsibilities within the respective role. Although a certain amount of inefficiency to performance is tolerated in any social role, greater degrees of inefficiency are considered an indication of psychological difficulties.

***Personal standards of inefficiency***

Personal standards are another way of measuring inefficiency. A frequent complaint of patients is that they are not able to perform as well as they think they should. Such a complaint may be the first indication of emotional disturbance. Therefore, you should pay serious attention to a patient's complaint of feeling inefficient, even if you believe the patient's performance level is really adequate.

Problems arise in measuring efficiency in everyday situations. People are seldom totally efficient, or inefficient in all aspects of their lives. Additionally, evaluating efficiency is often a subjective process involving personal value judgment. Despite these difficulties, the concept of functional inefficiency serves as a practical, qualitative guide for evaluating the presence and a mental disorder.

**215. Dual disorders**

What happens when a patient surfaces with multiple mental disorder indicators? In some cases the diagnostic criteria is masked by other presenting cases as in the case of substance abuse or dependence. These are some of the most difficult cases to unravel. Dual disorders is not a diagnosis in and of itself, but is a term used to describe cases where the presence of both a substance-related disorder and mental disorder occur in tandem. Let's look at some of the basic features that may cause you to entertain the notion of a dual diagnosis.

**Recognizing dual diagnosis**

The multiple symptoms and indicators often displayed by patients with substance abuse/dependence and other mental disorders present will often mimic or even mask each other. Those who struggle with both mental illness and substance abuse face problems of enormous proportions. The patient may come to the clinic with a crisis involving either substance use or mental illness. For instance, the Airman that reports to the clinic after appearing at work in the morning still intoxicated from the night before will often be seen as a substance user and nothing more. Diagnostic materials will be geared towards ascertaining the extent of the patient's substance usage and so forth. However, the most essential technique we have available to determine the extent of a patient's substance usage is the one-on-one interaction with a client.

If after an interview the client reveals he or she is self medicating due to depression, simply treating the client for substance abuse or dependence will not cure the depression. There is often a misnomer that by treating one of the patient's problems, a domino effect will occur and the client will then be 'cured' of their depression, as in this case. While this approach sometimes works when establishing goals which you will learn about later in your career development courses (CDC), it is not the case, particularly when dealing with substance abusing patients. That said, it is often stated that you wouldn't do an intake on a drunken client. Similarly, it may take a good amount of time for a person to be away from a substance before he or she is truly ready to deal with the psychological aspects of his or her situation.

The bottom line is that it doesn't matter which of the diagnoses came first; neither will be treated completely unless the patient addresses each problem individually. Your skills in the interviewing process as a 4C0 will be tested with the dually diagnosed patient. Always be alert to the possibility of a dual diagnosis when dealing with substance abusing patients. That is not to say all substance abusing patients will have a dual diagnosis, but the subject should be addressed.

## Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

### 213. Classification of mental disorders

1. What do the diagnostic criteria provide?
2. How is the diagnosis of DSM-IV-TR governed?
3. What does it mean to classify something?
4. What does the classification system used in the DSM-IV-TR allow mental health providers to do?
5. Match each DSM-IV-TR documentation in column A with its Axis in column B. Each item in column A may be used more than once or not at all.

<i>Column A</i>	<i>Column B</i>
____ (1) Describes any coexisting medical problems.	a. Axis I
____ (2) The effects of stressors on the patient.	b. Axis II
____ (3) Measurement of how well the patient has functioned over the past year.	c. Axis III
____ (4) Describes personality disorders and degrees of mental retardation.	d. Axis IV
____ (5) Includes the diagnosis that best describes the patient's presenting complaint.	e. Axis V

### 214. Mental disorders indicators

1. When may anxiety be considered an indicator of a mental disorder?
2. What are the common physical complaints expressed or exhibited by the depressed person?
3. Define abnormal behavior in psychological terms.

### 215. Dual disorders

1. What is the term dual diagnosis used to describe?
2. When should the mental health journeyman always be alert to the possibility of a dual diagnosis?

## 2-2. Recognizing and Responding to Patients with Mental Disorders

As a member of the mental health team, you will encounter patients with a variety of behavioral, emotional, and mental problems. For your interaction with the patient to be effective, you must be able to recognize abnormal behavior to establish a therapeutic relationship. This lesson will provide you with the basic information regarding the categories identified earlier. You will also learn some intervention approaches for responding to patients with some of the more common mental disorders. It is recommended you review the DSM-IV-TR for an additional or in-depth analysis.

### 216. Disorders usually first diagnosed in infancy, childhood, or adolescence

Some behavior patterns are normal at certain developmental stages; however, some can become pathological beyond a particular stage. The disorders in this section are the latter. The first nine categories are grouped according to a specific subject. For example, the diagnoses in the communication disorders center on impairments of language development, speech, and articulation. For the disorders in this group that do not fit any of the more specific categories, the tenth category is used. To help you differentiate one from another, we will look at their signs and symptoms individually. Disorders usually first diagnosed in infancy, childhood, or adolescence include the following:

- Mental retardation.
- Learning disorders.
- Motor skills disorders.
- Communication disorders.
- Pervasive disorders.
- Attention-deficit disorders and disruptive behavior disorders.
- Feeding and eating disorders of infancy and early childhood.
- Tic disorders.
- Elimination disorders.
- Other disorders of infancy, childhood, or adolescence.

#### Mental retardation

This disorder can be chronic with symptoms persisting into adult life. It is characterized by below average intellectual functioning; for example, an intelligence quotient (IQ) of 70 or below. In addition, significant deficits are displayed in areas such as social skills, communication, and daily living skills. Further, the onset of these symptoms typically occurs before the age of 18. There are four different degrees of severity of mental retardation. These recognized levels are listed on the table below.

Categories of Mental Retardation	IQ Levels
Mild retardation	50-55 to approximately 70
Moderate retardation	35-40 to 50-55
Severe retardation	20-25 to 35-40
Profound retardation	Less than 20-25

The observable effects of mental retardation are deviations from normal adaptive behaviors, ranging from learning disabilities and uncontrollable behavior to severe cognitive and motor skill impairment.

Mentally retarded children require special education and training. It is important for you to remember that they have all the ordinary needs of normal children, in addition to those created by the handicap. They especially need affection, acceptance, stimulation, and consistent discipline.

### **Learning disorders**

This disorder is sometimes referred to as the Academic Skills Disorder. It is characterized by inadequate development of specific academic skills (e.g., reading, math, and written expression). These deficits are not the results of mental retardation, pervasive development disorder, or any physical or neurological disorders. Diagnoses in this group include:

- Reading disorder.
- Mathematics disorder.
- Disorder of written expression.
- Learning disorder not otherwise specified (NOS).

Children with these disorders have related academic abilities that are substantially below that of someone of their age, intelligence, and education. The disturbance significantly interferes with all aspects of their life that requires that particular skill.

### **Motor skills disorder**

Children with this disorder have substantial impairment in motor coordination that significantly interferes with academic achievement or daily activities. These may be evidenced by marked delay in achieving normal milestones (e.g., sitting, walking), poor performance in sports, or poor handwriting. The diagnosis for this disorder includes Developmental Coordination Disorders (DCD), also known as developmental dyspraxia.

### **Communication disorders**

The communication disorders are characterized by difficulty expressing or understanding verbal or sign language. Individuals with this disorder also have difficulty articulating speech sounds or speaking with the age-appropriate fluency or rhythm. These disorders include:

- Expressive Language Disorder—limited vocabulary; inability to recall words.
- Mixed Receptive-Expressive Language Disorder—difficulty understanding words.
- Phonological Disorder—difficulty articulating normal speech sounds.
- Stuttering—difficulty producing speech with normal fluency and time patterning.

### **Pervasive developmental disorders**

Pervasive Developmental Disorders (PDD) are a diverse group of conditions characterized by impairment in the development of verbal and nonverbal skills. The characterization also includes impairment in social interactions; impairment in communication; and the appearance of restricted, repetitive, and stereotyped patterns of behavior, limited range of interests, and activities. The term *pervasive* is used because of the massive deficits affecting many areas of functioning and requiring long-term care that usually results in limited improvement. Although Autistic Disorder (often referred to as autism), is the most severe and most typical of the Pervasive Developmental Disorders, there are others that are similarly debilitating. These include:

- Rett's Disorder.
- Childhood Disintegration Disorder.
- Asperger's Disorder.

### **Attention-deficit disorders and disruptive behavior disorders**

Attention-deficit disorders (ADD) and disruptive behavior disorders are characterized by behaviors that are socially unacceptable or potentially harmful to the individual. Disruptive behavior is seen in "normal" school children as well as in child psychiatric patients. Children diagnosed with disruptive behavior disorders see no problems in their behavior and, in most cases, the disruptive behavior causes more stress in parents and teachers than in the children. This disorder is an umbrella term used

to encompass Attention-Deficit/Hyperactivity Disorders (AD/HD), conduct disorders, and Oppositional Defiant Disorders.

### ***Attention-deficit/hyperactivity disorders***

Children with this disorder usually have difficulty with attention span, impulsivity, and hyperactivity, with symptoms beginning before age seven. In small children, inattention and impulsiveness are likely to be shown by frequent shifting from one activity to another, and a low frustration tolerance. With older children and adolescents, the dominant features are excessive fidgeting and restlessness. Studies show that ADHD runs in families, specifically those diagnosed as having mood and anxiety disorders, alcohol dependence, and antisocial personality disorders.

### ***Conduct disorder***

Children with this disorder do not just misbehave; they show behaviors that are closer to delinquency. They violate norms and rules of society or they interfere with the basic rights of others in a persistent and repetitive pattern. Their behaviors include:

- Cruelty to people and animals.
- Destruction of property.
- Serious violation of rules.
- Deceitfulness or theft.

### ***Oppositional defiant disorder***

In this disorder, the children's behavior is seen as negativistic, hostile, and defiant. All children are oppositional from time to time, particularly when tired, hungry, stressed, or upset. They may argue, talk back, disobey and defy parents, teachers, and other adults. Oppositional behavior is often a normal part of development for 2 to 3 year olds and early adolescents.

Usually, these children are argumentative with adults, angry or resentful, quickly annoyed by others, and easily lose their temper and swear. A critical feature of this oppositional struggling is the self-defeating stand that these children take in arguments. An example of this disorder is if a child is told to be home by 10:00 p.m., he or she would stay at home sulking rather than going out with friends and coming home by 10:00 p.m.

### **Feeding and eating disorders of infancy and early childhood**

Feeding disorders of infancy or early childhood are displayed in children that persistently fail to gain weight or lose a significant amount of weight because they do not eat adequately. This usually occurs before the child is six years old.

These disorders are characterized by disturbances of eating, including eating substances that have no nutritional value, repeat regurgitation of food, and failure or refusal to eat.

Pica disorder is the persistent ingestion of non-nutritional substances (which may include dirt, paint chips, etc.) after the age of 18 months.

Rumination disorder is a rare syndrome where swallowed food is repeatedly returned to the mouth, pleasurably sucked on or re-chewed, and then swallowed again.

### **Tic disorders**

These disorders are characterized by problems in motor coordination, abnormal involuntary movement, and stereotypic movements that interfere with the child's usual activities. The diagnoses for this disorder include:

- Tourette's Disorder.
- Chronic motor or vocal tic disorders.
- Transient Tic Disorder.



- Tic disorder NOS.

### **Elimination disorders**

The major characteristic of elimination disorders is the involuntary or voluntary passage of feces or urine in inappropriate places, based on the child's developmental stage.

#### ***Encopresis***

Children with this disorder pass feces into inappropriate places. The child must be at least four years of age.

#### ***Enuresis***

This disorder is seen in children who are at least five years old, who repeatedly urinate into their beds or clothes.

### **Other disorders of infancy, childhood, or adolescence**

This disorder group contains five diverse diagnoses.

#### ***Stereotypic movement disorder (stereotypic/habit disorder)***

Patients with this disorder have repetitive, seemly driven, nonfunctional motor behavior (i.e., stereotyped movement) that interfere with usual activities or result in bodily injury.

#### ***Separation anxiety disorder***

Children with this disorder have inappropriate or excessive anxiety about separation from home or those to whom the child is attached. Age of onset is before the child is 18 years.

#### ***Selective mutism***

This disorder's essential feature is the child's failure to speak in specific social situations in which there is an expectation of speaking (e.g., at school) despite speaking in other situations (e.g., at home). The child's failure to speak can not be due to a lack of knowledge or comfort with the spoken language.

#### ***Reactive attachment disorder of infancy or early childhood***

This disorder is characterized by either excessively inhibited, hyper-vigilant, or mixed feelings and contradictory responses to most social interactions or diffuse indiscriminate attachment to other people.

## **217. Delirium, dementia, amnestic, and other cognitive disorders**

The cognitive disorders group (delirium, dementia, amnestic), is identified by the presence of impairments in cognition that appear to be caused by one or more substances and/or general medical conditions. They are characterized by memory deficit, language disturbance, perceptual disturbance, impairment in the capacity to plan and organize, failure to recognize or identify objects. However, in delirium, the patient also has a disturbance in consciousness.

### **Delirium disorder**

A delirium is distinguished by a disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention. It also includes a change in cognition, such as memory deficit, disorientation, and language disturbance. The disturbance develops over a short period of time, usually hours to days, and fluctuates during the course of the day.

### **Dementia disorder**

Dementia is distinguished primarily by impairment in memory. For example, the patient with dementia is forgetful, has difficulty learning new information, and will often try to minimize or deny the deficits. Typically, recent memory is worse than remote memory. The impairment may be the

result of a non-psychiatric medical condition, a substance, or a mixture of the two. Depending on the mode of onset and underlying cause, the dementia may have a progressive or remitting course.

The memory impairment could be one or more of the following:

Memory Impairment	Characteristic
Aphasia	Language disturbance.
Apraxia	Inability to carry out motor activities despite intact motor function.
Agnosia	Failure to recognize or identify objects despite intact sensory function.
Disturbance in executive functioning	Deficiencies in planning, organizing, and abstracting.

### Amnestic disorder

Amnestic disorder refers to a deficit in memory and new learning. It is relatively uncommon. Memory loss is categorized as *antegrade* or *retrograde*. With antegrade amnesia, the patient cannot recall events since the trauma occurred to the brain. With retrograde amnesia, the patient cannot recall events before the trauma occurred to the brain. The impairment may also be caused by a non-psychiatric medical condition, a substance, or a mixture of the two problems. Usually, when there is a significant amount of amnesia, the individual will tend to be disoriented. Confabulation (filling in memory gaps with imaginary events) often is seen in these individuals. They usually lack insight into their memory deficit and often deny the disturbance. When they are aware of the memory loss they may even act unconcerned. These individuals often appear apathetic, show a lack of initiative, and are emotionally bland.

## 218. Mental disorders due to a general medical condition not elsewhere classified

This lesson provides you with diagnoses which are characterized by the presences of mental symptoms, however they are deemed to be the result of physiological consequences of a medical condition. We will briefly look at the three diagnoses in this category including, Catatonic Disorder due to a general medical condition (CDGMC), personality change due to a general medical condition, and mental disorder not otherwise specified due to a general medical condition.

### Catatonic disorder due to a general medical condition

Patients with this disorder have catatonia as manifested by motoric immobility, excessive purposeless motor activity, and extreme negativism, peculiarities of voluntary movement, echolalia, or echopraxia. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a general medical condition.

### Personality change due to a general medical condition

Patients with this disorder have a persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern. The personality disturbance manifests in eight separate patterns seen in the following chart.

Personality Change Due to a General Medical Condition	
Type	Personality Change
Labile	Affective lability
Disinhibited	Poor impulse control
Aggressive	Aggressive behavior
Apathetic	Indifference and apathy
Paranoid	Suspiciousness or paranoid ideation
Other	Personality change associated with a seizure
Combined	More than one major feature

Personality Change Due to a General Medical Condition	
Type	Personality Change
Unspecified	Personality disturbances does not meet any specific personality disorder

### **Mental disorder not otherwise specified due to a general medical condition**

This diagnosis is used when the symptoms do not meet the criteria for the previous two diagnoses but are the direct result of a physiological issue or medical condition.

## **219. Substance-related disorders**

The four primary characteristics for this group of disorders include the occurrence of adverse social, behavioral, psychological, and physiological effects caused by use or misuse of one or more substances from the classes of abused substances. The DSM-IV-TR identifies the diagnostic criteria for substance-related disorders in four general sets of criteria: substance dependence, substance abuse, substance intoxication, and substance withdrawal.

### **Substance-related disorders group**

The diagnosis of substance-related disorders requires the identifications of the abused substance(s) and the description of the current pattern of use. The DSM-IV-TR identifies the diagnostic criteria for substance-related disorders as four separate categories:

#### ***Substance dependence***

A substance dependence diagnosis is used to describe continued use of drugs or alcohol, even when significant problems related to their use have developed. Features indicative of substance dependence include an increased tolerance or need for increased amounts of substance to attain the desired effect, withdrawal symptoms with decreased use, increased time spent in activities to obtain, use or recover from the substance, unintended excessive usage, inability to decrease the amount of the substance being used, unable or unwilling to participate in important social, occupational or recreational activities, and continued usage despite contraindications to the individuals psychological or physiological well-being.

A diagnosis of substance dependence can be applied to every class of substances except caffeine. Substance dependence is the most globally debilitating of the substance-related disorders. Dependence is defined as a cluster of three or more of the criteria listed in the DSM-IV-TR occurring any time in the same 12-month period.

#### ***Substance abuse***

This category is characterized by a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Some examples might include failure to attend school, substance use in dangerous situations (i.e., driving a vehicle), substance-related legal problems, or continued substance use that interferes with friendships and/or family relationships.

The category of substance abuse does not apply to caffeine and nicotine. All of the criteria identified for substance abuse must occur recurrently during the same 12-month period.

#### ***Substance intoxication***

This category is the development of a temporary reversible substance-specific syndrome resulting from the recent ingestion of, or exposure to, a substance. Its substance-specific syndrome is the maladaptive behavioral or psychosocial changes resulting from the effect of the substance on the central nervous system (CNS).

***Substance withdrawal***

This is the development of a substance specific syndrome resulting from the cessation or reduction of heavy and prolonged substance use. The substance specific syndrome causes significant distress or impairment in social, occupational, or other important areas of functioning.

Substance-related disorders can cause a variety of complications with both physical and mental deterioration. Based on these factors, a doctor must diagnose each patient's present condition.

**Classes of abused substances**

The DSM-IV-TR provides a description of the behavioral, psychological, and physiological substances. As you review the classes of abused substances, you will notice that not all of the substances are illegal or illicit. An abused substance can be one that has a defined medicinal purpose but is misused for purposes other than what it is intended. This lesson will briefly review key aspects of each of the 12 classes of abused drugs which are as follows:

- Alcohol.
- Inhalants.
- Amphetamines.
- Nicotine.
- Caffeine.
- Opioids.
- Cannabis.
- Phencyclidine.
- Cocaine.
- Sedatives, Hypnotics, or Anxiolytics.
- Hallucinogens.
- Other or Unknown Substances.

***Alcohol***

The criteria for alcohol abuse are identical to sedative, hypnotic, and anxiolytics use disorders and will be discussed in greater detail later in the course.

***Inhalant***

The classification of inhalants includes gasoline, airplane glue, rubber cement, aerosol sprays (especially spray paints), varnish remover, lighter fluid, and cleaning fluids. Used primarily by the young and poor because they are cheap and legal, inhalants produce a central nervous system depression. Intoxication usually comes on within 5 minutes and may last for 15 to 20 minutes.

***Amphetamines (or amphetamine-like)***

The amphetamines and similarly acting drugs comprise a large group of central nervous system stimulant drugs. These drugs include dextroamphetamine (Dexedrine), methylphenidate (Ritalin), and methamphetamine (Methedrine). Amphetamines are rapidly absorbed orally and act quickly. Amphetamine abusers may also use the drug intravenously. Methamphetamine, one of the derivatives of amphetamines, is a pure stimulant that has enjoyed a resurgence of popularity in the last few years and is currently the most abused form of amphetamine.

***Nicotine***

The use of nicotine in the United States is slowly decreasing for the population as a whole. Unfortunately, the percentage of female, black, and teenage smokers is rising. Nicotine is found in cigarettes, snuff, and chewing tobacco and is a CNS stimulant that serves to stimulate initially and depress the CNS after continued usage.

***Caffeine***

Caffeine is used throughout the world in many different forms—coffee, tea, chocolate, cola drinks, cocoa, and some over-the-counter cold preparations. Caffeine is the most widely consumed drug in western society. It is a CNS stimulant.

***Opioids***

Opioids are the most prescribed of all medications. This class of substances includes heroin, morphine, codeine, opium, and meperidine (Demerol). With the exception of Heroin, which has no medical purpose, the primary purpose of opioids is to relieve pain. Addiction to opioids is a common and significant problem. Once considered an addictive problem only in the inner city and lower socioeconomic populations, it is no longer the case. Prescription medication abuse has gained in popularity among upper income abusers.

***Cannabis***

Cannabis has been known for thousands of years as an intoxicant and as a medicine. While mainly used as an intoxicant during this century, there is a renewed interest in using cannabis as a medicine to treat numerous conditions including glaucoma, arthritis, Crohn's Disease, AIDS, multiple sclerosis, and to combat the nausea associated with chemotherapy. Marijuana is any intoxicating product of the cannabis sativa L. plant (including hashish) or any cannabis synthetic.

***Phencyclidine (or phencyclidine-like)***

A relatively new drug, as compared to other drugs of abuse, phencyclidine (PCP) was initially developed in the 1950s as an anesthetic. When significant problems developed with its use, it was removed from the market for human use in 1965 and is now only available for veterinary use. Before 1965, PCP was normally used in three ways: snorted, smoked, or eaten. While dosages less than 5 milligrams (mg) are considered low, determining how much PCP an individual has ingested is difficult to determine due to the ease of manufacturing and lack of "quality control" by illicit PCP manufacturers. PCP acts as a CNS depressant.

***Cocaine***

A derivative of a plant found primarily in South America, cocaine is inhaled, smoked, injected, or used topically. The "high" from cocaine is similar to amphetamines, but shorter in duration typically lasting less than 40 minutes. Crack, a particularly potent form of cocaine, is easily and cheaply produced and has greatly contributed to cocaine's rapid rise in abuse. The high from Crack lasts 30 seconds to one minute with the after effects of "coming down" lasting approximately 10 minutes. Crack is a street name for a "freebase" form of cocaine, a powerful CNS stimulant.

***Sedatives and hypnotics (or anxiolytic)***

Sedatives reduce activity and induce calmness and are considered a CNS depressant. Intoxication from this class of drugs emulates alcohol intoxication. The term sedative is virtually synonymous with the term anxiolytic, that is, a drug that reduces anxiety. Hypnotics induce drowsiness and sleep. These drugs are also frequently called minor tranquilizers or anti-anxiety medications. Of particular danger with the sedatives/hypnotics is their cross-tolerance with each other and alcohol; the synergistic result of mixing them could be lethal.

***Hallucinogen***

Hallucinogens are drugs that produce psychosis-like symptoms including loss of contact with reality, hallucinations, and alter mood, thought, perception and brain function. Hallucinogens include natural and synthetic drugs. Lysergic acid diethylamide (LSD) is the most potent psychoactive drug known. The physiological effects of hallucinogens vary as they are often adulterated or tailored with other drugs causing a variety of effects for the user.

### ***Other (or unknown) substances***

This category is for classifying substance related disorders associated with the other substances, including anabolic steroids, nitrate inhalants (“poppers”), nitrous oxide, and over-the-counter and prescription medications not otherwise covered by the other 11 categories. The emergence and popularity of “club drugs” are sometimes identified in this area. Methylenedioxymethamphetamine (MDMA), Ketamine, Gamma Hydroxybutyric Acid (GHB), and Dextromethorphan (DXM) are a few of the more popular club drugs at the time of this writing. There are many more that are not identified here. The 4C0 should educate themselves on the latest trends in this area.

## **220. Schizophrenia and other psychotic disorders**

This lesson will take the student through an overview of schizophrenia as well as other psychotic disorders. The labels associated with schizophrenia and other psychotic disorders are often misused in a derogatory manner. People with these disorders are sometimes referred to as “crazy” because the speaker is unfamiliar with the terminology. Take the opportunity to educate yourself as we traverse this very debilitating mental illness. In terms of personal and economic costs, schizophrenia has been described as among the worst diseases to afflict humankind.

### **Common features**

Schizophrenia and the related disorders within this lesson include:

- Brief psychotic disorder.
- Schizophreniform disorder.
- Schizoaffective disorder.
- Delusional disorder.

These disorders are characterized by psychotic symptoms, which may include delusions, hallucinations, disorganized thinking and speech, and bizarre and inappropriate behavior. Typically, these disorders affect patients in late adolescence or early adulthood and are often life long. The effects of this disorder group seriously impair the thoughts, mood, and behavior of the individual. The schizophrenia, schizophreniform disorders, schizoaffective disorders, delusional disorders, brief psychotic disorders, and shared psychotic disorders are included in this group. Let’s review some of their characteristics.

<b>COMMON FEATURES SEEN IN THIS DISORDER GROUP</b>	
<b>Type Disorder</b>	<b>Characteristics</b>
Ambivalence	Coexistence of contradictory ideas, emotions, attitudes, or in rapid succession.
Clang associations	Words that rhyme or sound alike used in an illogical, nonsensical manner.
Delusions	A false belief firmly held despite obvious proof or evidence to the contrary.
Disorganized behavior	Behavior that is not goal-directed or guided by any rational, preconceived plan, and may appear random or odd.
Disorganized speech	Speech where ideas shift from one to another in an unrelated manner.
Echolalia	Repetition of a recently heard sound or phrase. Often repeats the last words spoken by the interviewer.
Flights of ideas	Verbal skipping from one idea to another. The ideas appear to be continuous but are fragmented. Thoughts come so quickly that no single thought can be expressed clearly.
Hallucinations	A sensory perception that is the product of the patient’s mind and does not exist in the outside world. May occur in any of the senses.
Loose associations	Rapid shifts among unrelated events.
Neologisms	Bizarre words that have meaning only for the patient.
Regression	Return to an earlier developmental stage.
Thought blocking	Sudden interruption in patient’s train of thought.

COMMON FEATURES SEEN IN THIS DISORDER GROUP	
Type Disorder	Characteristics
Withdrawal	Disinterest in objects, people, or surroundings.
Word salad	Illogical word groupings, i.e., He had a moon, bike, door.

### Schizophrenia disorders

The characteristic symptoms for this disorder involve a range of cognitive and emotional dysfunction that includes delusions, hallucinations, disorganized speech, catatonic behavior, and negative symptoms (e.g., affective flattening). In addition to these symptoms, the schizophrenic patient will demonstrate dysfunctional patterns in their interpersonal relationships, occupational or academic functioning, and their own self-care.

The patient must demonstrate the symptoms on a continuous basis for at least six months. The age of onset is usually in the patient's 20s.

The diagnoses of a specific schizophrenia subtype require the patient meet the common criteria and additional criteria that distinguish the subtypes from each other. The following information includes the five subtypes of diagnoses for the schizophrenia disorder, including paranoid, disorganized, catatonic, undifferentiated, and residual:

#### *Paranoid type*

This is a type of schizophrenia where the patient is preoccupied with delusions or auditory hallucinations. This type of schizophrenia differs in several ways from the other forms of the disorder by the following characteristics:

1. Age of onset generally is older—late 20s or early 30s.
2. Cognitive functioning remains relatively intact.
3. Generally, there is less regression and deterioration of the personality.

The primary symptom that distinguishes the paranoid from other forms of schizophrenic disorder is the presence of rather ornate delusions of persecution and/or grandeur. In addition, hostility, suspicion, and ideas of reference are far more evident in this form of schizophrenia. Excessive religiosity is often seen as well.

#### *Disorganized type*

With this type of schizophrenia, the patient suffers from extremely disorganized thinking and often experiences hallucinations and delusions. The disorganized type is characterized by frequent and inappropriate emotional displays, especially unexplainable giggling and grimacing, disorganized speech, disorganized behavior, and flat or inappropriate affect is prominent. There is no evidence of catatonia.

#### *Catatonic type*

The primary feature that distinguishes catatonia from the other types of schizophrenia is the presence of abnormal psychomotor behavior. Either the patient is in a withdrawn, stuporous state or a highly agitated, excited state. Thus, the catatonic schizophrenic appears in two forms—excited or stuporous.

In the withdrawn form of catatonia (stupor), patients show no interest in their surroundings and often are mute. If left alone, they will tend to stay in one place. These patients often will respond to verbal orders, but only to the exact wording, ignoring any of the implied behavior most of us take for granted. This type of behavior is called automatic obedience. Two other notable symptoms are echolalia, when a patient mimics exactly the words of the individual they are talking to, and echopraxia, when a patient mimics the actions. One outstanding characteristic of catatonia is waxy flexibility, where the patients assume any position they are put in and remain for a long time. Patients who are in a catatonic stupor appear to be totally oblivious to their surroundings, but in actuality their

consciousness is very clear. Many times, after their recovery, they can talk about the events that went on around them while they were in the stupor.

Catatonic excitement is characterized by a state of general psychomotor agitation. The patient constantly moves about, often talking in an incoherent fashion. The patient's behavior is disorganized and non-purposeful. The patient can be hostile and have feelings of resentment. Unprovoked violence and destructive behavior may occur. The catatonic patient can move relatively rapidly and unpredictably from a stuporous to excited state and vice versa.

### ***Undifferentiated type***

This type of schizophrenia refers to manifesting prominent delusions, hallucinations, incoherence, or grossly disorganized behavior. However, the symptom pattern is not consistent with disorganized type, catatonic type, or paranoid type.

### ***Residual type***

This type of schizophrenia is reserved for persons who have had at least one schizophrenic episode, but are not currently exhibiting prominent psychotic symptoms. However, the individual shows continued evidence of the illness, such as blunted or inappropriate affect, social withdrawal, eccentric behavior, illogical thinking, or loosening of associations. In this form of schizophrenia, symptoms must be present for more than six months.

### **Schizophreniform disorder**

Patients with this disorder meet the common criteria set for schizophrenia. Schizophreniform is often used as a prelude to schizophrenia as the patient may not have demonstrated symptoms long enough to meet the criteria for schizophrenia. The symptoms associated with schizophreniform last at least one month but less than six months. This disorder appears rapidly and is transitory. If the disorder persists beyond six months, the individual should be reclassified into one of the more formal categories of schizophrenia.

### **Schizoaffective disorder**

Patients with this disorder meet the common criteria for schizophrenia and experience a major depressive episode or a mixed episode for a substantial period of the illness. The patient has delusions or hallucinations for at least six weeks in absence of mood symptoms. The diagnosis traditionally has been employed when symptoms of both schizophrenia and affective disorder are present.

### **Delusional disorder**

Since the delusion is the principle feature of the delusional disorder, it is appropriate to begin by examining the nature of delusion. Delusions are simply defined as fixed, false beliefs that arise without appropriate external cause, and remain unchanged in the face of reason. Furthermore, the belief is not shared by other members of the patients' sociocultural group.

Patients with this disorder experience nonbizarre delusions (i.e., involving situations that occur in everyday life) for at least one month. They function reasonably well in their routine daily activities aside from the impact or ramification of their delusions. The DSM-IV-TR identifies delusional disorders in the following six subtypes:

- Persecutory.
- Jealous.
- Erotomantic.
- Somatic.
- Grandiose.
- Unspecified.

This lesson will look at each subtype briefly.



***Persecutory type***

The prominent theme of this delusion is that the individual or someone close to the individual is being treated maliciously in some way. This is the most common of all delusional subtypes, and the patient's delusion may be simple or very elaborate. The delusion may involve a single theme or a series of connected themes, such as being conspired against, cheated, lied to, spied on, followed, poisoned, or drugged. The patient may take an insignificant incident and exaggerate it until it becomes the focus of a delusion. For example, when a young Airman overhears the commander and first sergeant mention his name, he decides they are planning to bring trumped up charges against him that will end his career and future plans. Patients with persecutory delusions often are resentful and angry, and may use violence if they believe others intend on hurting them.

***Jealous type***

The prominent theme of this delusion is that one's sexual partner is unfaithful. When this delusion is evident, the person is convinced without any evidence, that his or her romantic partner is unfaithful. As with the patient with a persecutory delusion, the patient with this delusion will take the smallest of evidence and justify the delusion. Usually, the patient with the delusion will take steps to limit their partner's infidelity. These attempts may include restricting when and where their partner can traverse unaccompanied, secretly following the partner, and even investigating the other "lover." The person with this delusion rarely confronts the other lover, but may physically attack the partner.

***Erotomantic type***

The prominent theme of this delusion is that a person, usually of higher status, such as a superior at work, or a complete stranger, is in love with the patient. This delusion focuses on idealized romantic love rather than sexual attraction. The patient may contact the proposed love by phone or letters, with lavish gifts, and even by surveillance and stalking.

***Somatic type***

The prominent theme of this delusion is that the patient has some physical disorder, defect, or disease. The somatic delusions occur in several forms. Examples are when patients are convinced that a foul odor is emanating from their bodies, insects have infested their skin, parasites are eating their internal organs, or, despite evidence to the contrary, certain parts of their bodies are misshapen or ugly.

***Grandiose type***

A person with grandiose delusions usually is convinced that he or she possesses some extraordinary, unidentified talent or insight. This person may have a delusion of being a prominent person, and the actual person, if still alive, is regarded as being a fake. A less common delusion of a grandiose person is the belief he or she has a special relationship with an important figure (e.g., being the son of a famous athlete or a military adviser to the president).

***Unspecified type***

This category is used when the disorder does not fit any of the previous subtypes. For example, people who have persecutory and somatic themes without either being dominant in their thinking.

***Mixed type***

This category is used when the delusions consist of one or more of the above types but no one theme predominates.

**Brief psychotic disorder**

Patients with brief psychotic disorder experience one of the following symptoms: delusions, hallucinations, disorganized speech, or catatonic behavior for at least one day but less than one month. Brief psychotic disorder is transient and the client should recover. If the aforementioned symptoms continue for more than one month, the diagnosis of schizophreniform should be entertained.

**Shared psychotic disorder (Folie a Deux)**

Patients with this disorder develop a delusion similar in content to the already fixed delusion of another person with whom they have a close relationship.

**Substance-induced psychotic disorder**

This disorder includes hallucinations or delusions associated with evidence that the symptoms occurred within one month of significant substance intoxication or withdrawal, or is etiologically related to medication use or toxin exposure.

**Psychotic disorder due to a general medical condition**

The main delusions or hallucinations of this disorder are judged to be the result of a general medical condition and occurs only during the course of delirium or dementia.

**Psychotic disorders not otherwise specified**

These disorders include syndromes with prominent psychotic features that do not meet the criteria for any specific psychotic disorder.

**221. Mood disorders**

Mood refers to a feeling tone that is experienced internally by an individual. Everyone has experienced some degree of depression and euphoria in their lives. In mood disorders, the patient's mood becomes so intense and persistent that it interferes with his social and psychological functioning. The distinction between usual fluctuation in mood and a mood disorder is best described in the core concept of the diagnostic group.

<b>Mood Disorder Diagnostic Groups</b>	
<b>Depressive Disorders</b>	<b>Bipolar Disorders</b>
Major depressive disorder	Bipolar I disorder
Dysthymic disorder	Bipolar II disorder NOS
Depressive disorder NOS	Cyclothymic disorder
	Bipolar disorder NOS

**Mood disorder diagnostic groups**

The mood disorders are divided into two categories—bipolar disorders and depressive disorders. Each category contains diagnoses for severe disorders, less severe, more chronic disorders, and nonspecific disorders.

Patients exhibiting both manic and depressive episodes, and manic episodes alone, are diagnosed with bipolar disorder. Other categories of mood disorder are hypomania, cyclothymia, and dysthymia. Cyclothymia and dysthymia represent less severe forms of bipolar disorder and major depression.

**Depressive disorders**

This disorder is characterized by the occurrence of a depressive episode without either a manic or hypomanic episode. The primary features of major depression disorders are a predominantly sad mood and a loss of interest or pleasure in daily activities. Other common signs include difficulty concentrating or thinking clearly, distractibility, and indecisiveness.

***Major depressive disorder***

Major depression occurs in up to 17 percent of adults, affecting all racial, ethnic, and socioeconomic groups. While it affects both men and women, it is more common in women.

Suicide is the most serious complication of major depression, resulting when the patient's feelings of worthlessness, guilt, and hopelessness are so overwhelming that he or she no longer feels life is worth

living. Nearly twice as many women as men attempt suicide; however, men are far more likely to die from completing a suicide.

DSM-IV-TR distinguishes this disorder by two subtypes. *Major depressive disorder, single episode*, is reflective of an individual who has had a single major depressive episode. *Major depressive disorder, recurrent episode*, is indicative of an individual who has had two or more major depressive episodes, separated by at least two months of “normal” functioning.

The depressive symptoms associated with major depressive disorders include the following:

- Depressed mood (sadness or feelings of emptiness).
- Social isolation.
- Sleep disturbances (including not enough sleep or too much sleep).
- Decreased energy.
- Poor concentration.
- Suicidal ideations.

### ***Dysthymic disorder***

The primary feature of dysthymic disorder is chronic depression. The patient’s mood is depressed for most of the day and for more days than not. The depressive feelings have existed for at least two years without the occurrence of a manic episode. Two or more of the following symptoms will be present including under eating or over eating, insomnia or hypersomnia, fatigue, low self-esteem, difficulty concentrating, and feelings of hopelessness.

### ***Depressive disorder—not otherwise specified***

Depressive disorder NOS is used to describe depressive disorders that have all the qualities of depressive disorders but are not specifically identified by name or in the instance when the clinician is unable to determine the etiology of the depression.

## **Bipolar disorders**

Bipolar disorders are characterized by severe pathologic mood swings from mania and euphoria to sadness and depression. Bipolar disorders involve one or more manic episodes usually accompanied by one or more major depressive episodes. The bipolar disorders are further defined by three distinct subtypes:

- Mixed.
- Manic.
- Bipolar depressed.

The *mixed* sub-classification is used when the current or most recent episode involves both a manic and major depression. *Manic* type is used when the current or most recent episode is of a manic nature. *Bipolar depressed* identifier is used when there have been one or more manic episodes, and the current or most recent episode is a major depressive episode. In some patients, bipolar disorders assume a seasonal pattern, marked by a cyclic relation between the onset of the mood episode and a particular 60-day period of the year.

The disorder is equally common among men and women. It is more common in higher socioeconomic groups. It typically begins after adolescence, but first attacks usually occur between the ages of 20 and 35. Bipolar disorders recur in 80 percent of the patients. As they grow older, the attacks recur more frequently and last longer.

Bipolar disorders are associated with a significant mortality. An estimated 20 percent of these patients are victims of suicide. Ironically, many of the suicides are committed just as the depression lifts.

The following table shows the different types of bipolar disorders:

Bipolar Disorders	
Term	Characteristics
Bipolar I	For a diagnosis of Bipolar I disorder, the patient must have had at least one manic episode. Individuals experiencing a manic episode often feel euphoric, almost indestructible when dealing with personally important issues such as finances, business dealings, or relationships. This overindulgence and poor judgment often leads to the patient making extremely rash business and personal decisions resulting in engaging in dangerous sexual activity and drugs or alcohol. The depressive nature of Bipolar I is often the result of the consequences of their activities while manic. These episodes can result in adverse legal or occupational problems for the patient.
Bipolar II	Bipolar II is similar to Bipolar I when the patient experiences manic episodes; however they experience hypomanic rather than manic episodes. In other words, the mania is not as severe as that described in the Bipolar I lesson. Typically the patient does not experience occupational or legal problems to the degree the Bipolar I patient would experience.
Cyclothymic disorder	Similar to Bipolar II, symptoms of cyclothymia include periods of hypomania and depressive symptoms are also present as the hypomania decreases. However, the symptoms associated with cyclothymia are not as severe as those found in Bipolar disorder.
Bipolar disorder NOS	Bipolar Disorder NOS is a mood disorder with Bipolar features that fits no other category. Examples of what would be appropriate for this diagnosis include fast cycling manic and depressive episodes. Bipolar disorder is not the primary disorder but is still present with symptoms of hypomanic or manic episodes with no depressive episodes.

### Mood disorder due to a general medical condition

The primary focus of this diagnosis is a disturbance, normally with neurovegetative symptoms, in a patient's mood which is the direct result of the physiological effects of a medical condition.

## 222. Anxiety disorders

Although the anxiety disorders do not involve gross personality disorganization or gross distortion of reality, they can interfere significantly with an individual's ability to function effectively and to enjoy life. Patients with these disorders usually experience anxiety, worry, and apprehension that is more intense and last for a longer period of time than the anxiety experienced by the average person in everyday life. They often develop avoidance mechanisms, ritual acts, or repetitive thoughts as a means of protecting themselves from the anxiety.

The anxiety disorders are classified in five basic types:

- Phobias.
- Generalized anxiety disorder.
- Panic disorders.
- Obsessive-compulsive disorder.
- Post-traumatic stress disorder.

Terms Associated With Anxiety Disorders	
Terms	Definitions
Anxiety	The internal feeling that results from conflict and frustration, usually experienced as unexplained discomfort or uneasiness from anticipation of danger.
Normal anxiety	Feelings of tension, nervousness, and apprehension that accompany a realistic situation.
Compulsion	An uncontrollable, insistent, repetitive, intrusive, and unwanted urge to perform an act that is contrary to one's wishes or standards.
Conflict	The mental struggle that arises from simultaneous operation of opposing impulses, drives, or external or internal demands.

Terms Associated With Anxiety Disorders	
Crisis	A state of psychological disequilibrium resulting from severe emotional overload, where the usual problem-solving and decision-making methods are no longer adequate for effective coping.
Ego Dystonic	An aspect of a person's thoughts and behavior that is inconsistent with the total personality. (Unacceptable to the ego.)
Ego Syntonic	An aspect of a person's thoughts and behavior that is consistent with the total personality. (Acceptable to the ego.)
Fear	An emotional and physiological reaction to a recognized external threat (i.e., a sudden drop in altitude on an aircraft, a runaway train).
Obsession	Persistent ideas, thoughts, or impulses that cannot be eliminated from consciousness by logical effort.
Phobia	An obsessive, persistent, unrealistic fear of an object or situation. The fear is believed to arise through the process of displacing an internal unconscious conflict to an external object that is symbolically related to the conflict.

### Phobias

Phobia is a persistent and irrational fear of a specific object, activity, or situation, resulting in a compelling desire to avoid the perceived hazard. The patient recognizes his or her fear is out of proportion to any actual danger, but can't control their thoughts.

Seven percent of all Americans suffer from a phobic disorder. In fact, phobias are the most common psychiatric disturbance in women and the second most common in men. More men than women experience social phobias, whereas agoraphobia and specific phobias are more common in women. The onset of a social phobia usually occurs in late childhood. Phobic disorders are classified as the following types:

Phobia	Description
Agoraphobia	Agoraphobia may occur with or without panic attacks. Individuals with this disorder have a marked fear of, and thus avoid, being alone or in public places where escape might be difficult or help not available in case of sudden incapacitation. The most common situations avoided are being in crowds, in tunnels, on bridges, on elevators, or in public transportation. These individuals usually ask a friend or family member to accompany them whenever they leave home. They may become so impaired they become housebound. This is the most common disorder among those seeking treatment of phobic disorders.
Social phobia	Individuals suffering this phobia normally have a persistent and irrational fear of being in situations where they may be exposed to scrutiny by others. Consequently, they have a compelling desire to avoid these situations. They have a fear they may behave in a manner that will humiliate or embarrass themselves. Examples of social phobias are fears of speaking or performing in public, using public restrooms, eating in public, and writing in the presence of others.
Specific phobia	Individuals suffering this phobia usually have a persistent fear of, and compelling desire to avoid an object or situation. The most common specific phobias involve animals—particularly dogs, snakes, insects, or mice. Other simple phobias are claustrophobia (fear of closed spaces) and acrophobia (fear of heights). Individuals with specific phobias may experience panic attacks if they suddenly encounter the phobic stimulus.

### Generalized anxiety disorder

A rational response to a real threat is a normal part of life. Overwhelming anxiety can result in a generalized anxiety disorder (GAD). This is characterized by uncontrollable and unreasonable worry that persists for at least six months and narrows perceptions or interferes with normal functioning.

The age of onset can be at any age, but it typically begins in one's 20s and 30s. It is equally common in men and women. Psychological symptoms of anxious states vary with the degree of anxiety.

### ***Mild anxiety***

This state mainly causes psychological symptoms, with unusual self-awareness and alertness to the environment.

### ***Moderate anxiety***

This state leads to selective inattention, yet with the ability to concentrate on a single task.

### ***Severe anxiety***

This state causes an inability to concentrate on more than scattered details of a task. A panic state with acute anxiety causes a complete loss of concentration, often with unintelligible speech.

### **Panic disorder**

Panic disorders represent anxiety in its most severe form. This disorder is characterized by recurrent episodes of intense apprehension, terror, and impending doom. The primary features associated with a panic disorder include several unexpected panic attacks must provoke fear of subsequent attacks or the effects of attacks or change behavior significantly. Unpredictable, these "panic attacks" may come to be associated with specific situations or tasks.

Many Americans experience a panic attack in the course of a year. Equal numbers of men and women are affected by panic disorder. Onset is usually in late adolescence, often in response to a sudden loss. It also may be triggered by severe separation anxiety experienced in early childhood. These patients are at a high risk for psychoactive substance abuse disorder, resorting to alcohol in an attempt to relieve their fears.

### **Obsessive-compulsive disorder**

The major symptoms of obsessive-compulsive disorder (OCD) are obsessions and compulsive acts. Obsessions refer to unwanted irrational thoughts, ideas, images, or impulses to act, often in an aggressive or sexual fashion. The patient feels as if they lack control of their thoughts as it relates to an obsession and the unwelcome thoughts force themselves into the individual's consciousness. Compulsive acts are defined as observable patterns of behavior the individual feels compelled or forced to carry out. Again, as with all forms of anxiety disorders, a precipitating event takes place that weakens the individual's defenses or strengthens unconscious impulses, leading to the reaction of anxiety as a danger signal. Defenses called into action fail and a defense mechanism breakdown starts to occur. Two major defenses the person uses in forming OCD symptoms are isolation and undoing.

### ***Isolation***

The mechanism of isolation most often is seen in this patient's obsessive thoughts. The thoughts retain their impulse or drive content. For example the patient may have an intrusive thought of, "I have a crazy urge to kill my family." The feeling behind the thought (anger), in this example, is missing (unconscious).

### ***Undoing***

The mechanism of undoing is often seen in this person's compulsive acts. Many such acts are attempts to undo the harm or danger the person fears or anticipates from his or her obsessions. For example, if the individual has an obsessive urge to kill everyone in his or her family, he or she might go through a compulsive ritual or act every evening (e.g., ritualistically kissing the family portrait that sits on the mantle) to undo the aggressive wish. Two other types of defense mechanisms these patients commonly use are intellectualization and reaction formation.

Some common obsessions include thoughts of violence (e.g., stabbing, shooting, or hitting), thoughts of contamination (images of dirt or germs), repetitive doubts and worry about a tragic event, and

repeating or counting images, words, or objects in the environment. The patient recognizes the obsessions are a product of his or her own mind and that they interfere with normal activities.

### **Post-traumatic stress disorder**

The essential feature of post-traumatic stress disorder (PTSD) is the development of symptoms after a psychologically traumatic event that is outside what individuals would normally experience. This event or stressor includes things such as natural disasters such as a tornado or earthquake, airplane or auto accidents, rape, unexpected death of a family member, and military combat. The simultaneous terrorist attacks on the World Trade Center and the Pentagon are examples of unexpected catastrophic events both for the survivors as well as the responders. As you can see, it does not include stressors that everyone may encounter such as normal bereavement, financial loss, marital conflict, or chronic illness. The individual may re-experience the traumatic event in a variety of ways. Recurrent dreams, nightmares, or intrusive painful recollections of the event are common in patients with PTSD. In rare instances, individuals experience dissociative-like states where the individual's behavior resembles an actual re-experience of the event. Such states have been reported in combat veterans.

These individuals will usually show a diminished responsiveness to the external world soon after the event. This is referred to as psychic numbing or emotional anesthesia. They complain of feeling "detached" from other people and unable to generate interest in activities they previously enjoyed. Other symptoms individuals suffering from PTSD describe include hyper-alertness, difficulty falling asleep, recurrent nightmares, impaired memory, or difficulty concentrating. In cases where the event was life-threatening, they may experience guilt because they survived while others did not. These individuals also may avoid situations or activities that would remind them of the traumatic event.

PTSD is identified by three specific classifications which include:

- Acute—with onset of symptoms within 6 months of the trauma or their duration is less than six months.
- Chronic—with symptoms lasting six months or more.
- Delayed—with the onset of symptoms at least six months after the traumatic event.

## **223. Somatoform disorders**

The patient with a somatoform disorder complains of physical signs and symptoms and typically travels from doctor to doctor in search of treatment. Laboratory test and physical examinations fail to reveal any organic basis for their signs and symptoms. This differs from malingering in that in somatoform disorders, the symptom production is not under voluntary control.

Somatoform disorders may also be confused with factitious disorders. Factitious means not genuine or natural. In the DSM-IV-TR, factitious disorders include physical or psychological symptoms that are consciously and voluntarily produced by the client. For example, a patient may take anticoagulants to produce blood in the urine or intentionally dislocate a shoulder for no reason other than to assume a dependent role. The distinctions between factitious and somatoform disorders are that in factitious disorders, the physical symptoms are under voluntary control. Both conditions must be thoroughly assessed for the presence of a true, primary physical disorder.

In this lesson, you'll study a brief overview of the seven disorders in the somatoform disorder diagnostic group.

### **Somatization disorder**

When multiple recurrent signs and symptoms of several years' duration suggest that physical disorders exist without evidence of a medical condition to account for them, somatization disorder is present. This disorder usually is chronic with exacerbations during periods of stress. The onset typically occurs in adolescence or, rarely, in one's 20s. This disorder primarily affects women and is seldom diagnosed in men. Patients believe they have been sickly a good part of their lives and report

lengthy lists of symptoms (e.g., nausea and other gastrointestinal difficulties, and painful menstruation, etc.).

### **Undifferentiated somatoform disorder**

Patients with this disorder have physical complaints lasting at least six months where no organic problem can be found to support them; fatigue, loss of appetite and gastrointestinal complaints are just a few examples. When related organic diseases do exist, the complaints or impairments are grossly excessive or exaggerated.

### **Conversion disorder**

In conversion disorder, patients report loss or alteration of physical functioning that suggests a physical disorder, but in fact is related to the expression of a psychological conflict. Two mechanisms, *primary gain* and *secondary gain*, are thought to explain what a person “gets” from having a conversion disorder. There is believed to be an ulterior motive which will ultimately benefit the patient in the outcome.

#### ***Primary gain***

This mechanism helps the person keep the psychological need or conflict out of awareness. For example, a conflict about acknowledging a traumatic event a patient has seen may be expressed as “blindness.” In this instance, the symptom can be a partial solution to the underlying conflict (not having to acknowledge witnessing the traumatic event because one has suddenly been struck blind).

#### ***Secondary gain***

This mechanism helps the person to avoid a distressing, uncomfortable, or repugnant activity while, at the same time, receiving support from others. For example, a soldier with a paralyzed arm could hardly be expected to fire a gun; however, he or she is likely to receive sympathy for the paralysis.

The problem usually begins in adolescence or early adulthood, although a conversion disorder may appear at any time during the life cycle. Regardless of the time that it appears, a conversion disorder can seriously impede one’s normal life activities. A lack of concern by the patient about the severity of the impairment is common.

### **Pain disorder**

In pain disorder, the patients experience pain in the absence of physiologic findings and the presence of possible psychological factors. Some of the clinical syndromes where idiopathic pain may be the predominant complaint are conversion disorders, worker compensation injuries, and masochistic personality styles. In conversion disorders, pain symbolizes the punishment for having an unacceptable wish, perhaps sexual or aggressive, aroused by a frustrating lifestyle or situation. In workers compensation cases, the patients may unconsciously use pain and the monetary compensation received for the suffering to strike back against employers or others the employee feel treated him or her unfairly. Some individuals seem to need to suffer to achieve any sort of gratification without guilt. They seem to assume they are otherwise unworthy of any pleasure. Often their entire lives are conducted according to self destructive patterns of expecting punishment and eliciting it from the environment.

This disorder is more common in women than in men. The age of onset is in the 30s and 40s. The pain is usually chronic, and often interferes with social and occupational functioning.

### **Hypochondriasis disorder**

Patients with hypochondriasis are preoccupied with the fear or belief they have a serious disease, or misinterpret body sensations as the onset of a serious illness despite reassurances from medical providers to the contrary. This fear impairs the social or occupational functioning of the patient.



Hypochondriasis disorders appear to be equally common in men and women. The age of onset can be at any age, but most frequently occurs between age 20 and 30. This disorder is usually chronic, although the severity of symptoms may vary.

### **Body dysmorphic disorder**

Patients with body dysmorphic disorder are preoccupied with some imagined defect in physical appearance. The preoccupation is out of proportion to any actual abnormality. The belief is overvalued, but not of delusional proportion.

### **Somatoform disorder not otherwise specified**

Patients with somatoform symptoms that do not meet the criteria for any of the specific somatoform disorders fall into this category.

## **224. Factitious disorders**

Factitious disorders are characterized by physical or psychological symptoms that are intentionally produced or faked. There are no external incentives for this behavior. These individuals feign illnesses with the sole purpose of becoming a patient. In fact, most of these individuals make hospitalization a way of life. Oftentimes, their past experiences in hospitals have been positive, which usually contrasts their emotionally deprived personal lives. These patients are so adept at being admitted into hospitals that they can fool the most experienced care provider. They are very knowledgeable about most disorders that usually require hospitalization or medications. They often insist on having an examination and surgery. Usually, the physician will find them to have many scars from previous procedures. Once they are in the hospital, they become abusive, argumentative, and difficult. As clinical tests are found to be negative, they will accuse the medical staff of incompetence and threaten to file legal suits. Once discharged from the hospital, they usually find a new facility and the cycle will start again.

The symptoms in the factitious disorder diagnostic group are intentionally produced and can be both physical and psychological. More men than women have this disorder.

<b>Disorder</b>	<b>Description</b>
Factitious disorder with predominantly psychological signs and symptoms.	This disorder is characterized by intentional feigning of symptoms suggestive of a mental disorder. However, the symptoms represent how the patient views the mental disorder and hardly ever coincides with any of the diagnostic categories listed in the DSM-IV having predominantly psychological signs and symptoms.
Factitious disorder with predominantly physical signs and symptoms.	This disorder, the most common factitious disorder, is also called Munchausen syndrome. In this disorder the individuals have predominantly physical signs and symptoms. They may have an extensive knowledge of medical terminology. In their history, there is usually evidence of previous medical treatment, such as surgery. They show an eagerness to undergo hazardous and painful procedures.
Factitious disorder with combined psychological and physical signs and symptoms.	Individuals with this disorder have psychological and physical signs and symptoms but neither predominates in the clinical presentation.
Factitious disorder NOS.	In this disorder, the individuals' signs and symptoms do not meet the criteria for a specific factitious disorder.

## **225. Dissociative disorders**

Most people have experienced brief moments of dissociation when they feel separated or detached from the environment, acted out of character, or forgot certain events. The experience can occur when you are tired, confronting a new environment, or preoccupied. All these characteristics differ from the

dissociative disorders in the quality, intensity, duration, and setting. For the average person, dissociation is a *short-lived* experience that usually can be blended into other parts of his or her life. For the patient with the dissociative disorder, the experiences are characterized by *prolonged* periods of amnesia, personality change, and detachment, often associated with intense affect. In this lesson, a synopsis for each of these dissociative disorders diagnostic groups will be presented.

### **Dissociative disorders diagnoses**

Major dissociative disorders symptoms include amnesia, identity (multiple personality), fugue, and depersonalization disorders.

<b>Terms Associated with Dissociative Disorder</b>	
<b>Terms</b>	<b>Definitions</b>
Anterograde amnesia	The inability to form new memories after the condition producing the amnesia occurs.
Dissociative	The splitting off of a group of mental processes from conscious awareness.
Ego-dystonic	Thoughts, affect, and behavior elements of an individual's personality that are considered unacceptable and inconsistent with the individual's personality or self-identity.
Fugue	A period of amnesia where the patient appears to be conscious and makes rational decisions. The patient has no memory of the period on recovery.
Ictus	A seizure.
Interictal period	The time between seizures (the ictus).
Retrograde amnesia	A loss of memory for events that occurred before the onset of the amnesia and the condition causing it.

### **Dissociative amnesia**

This disorder involves a loss of memory for past events occurring within a specified period. It is usually precipitated by a traumatic event in the individual's life. In its most extreme form, amnesia involves a total loss of identity and memory for past personal history.

### **Dissociative fugue**

This disorder is characterized by total amnesia and wandering away from home. Experiencing a dissociative fugue is very rare and is often the result of exposure to extreme stress such as war or a major natural disaster. Often the victim takes on a new identity and settles in another area of the country, completely oblivious of his or her former life.

### **Depersonalization disorder**

The essential feature of this disorder consists of "out of body" experiences, a feeling of unreality, or a feeling of being in a dream, or "mechanical" state. Individuals with this disorder have persistent or recurrent experiences of feeling detached from their own thoughts or body, as if they were an outside observer. Again, this disorder is typically precipitated by a traumatic or extremely stressful event.

### **Dissociative identity disorder**

This disorder was once referred to as the multiple personality disorder. Dissociative identity disorder is usually associated with severe psychological stress as a child including ritualistic sexual or physical abuse. Individuals with dissociative identity disorder have two or more distinct personalities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment. At least one of the personalities or personality states recurrently takes full control of the person's behavior.

The transition from one personality to another is often triggered by stress or environmental cues. Although usually sudden (seconds to minutes) the transition can occur over hours or days.

## 226. Sexual and gender identity disorders

In this lesson you'll review aspects of sexual dysfunctions, paraphilia, and gender identity disorders. It should be noted that sex therapy is a rarity in the military and very few providers are credentialed to administer this treatment.

Sexuality is an important part of everyone's life. This includes the performance of sexual acts as well as the development of sexual identity. The process of making a diagnosis of sexual disorder is often straightforward and starts with the identification of category or categories that best describe the patient's sexual problem. The DSM-IV-TR has divided sexual disorders into three primary groups. The three primary groups are Sexual Dysfunctions, Paraphilias, and Gender Identity Disorders. This lesson will briefly review these three major categories.

Four Phases of a Normal Sexual Cycle	
Phase	Sexual Response
Desire	Includes sexual fantasies and the desire for sexual activity.
Excitement	Feelings of sexual arousal and pleasure accompanied by physiological changes. For example males develop an erection and females develop vascongestion in the pelvis and vaginal lubrication.
Orgasm	Sexual pleasure reaches a peak. In males there is an ejaculation and in females there are contractions in the wall of the vagina.
Resolution	A sense of relaxation and well-being.

### Sexual Dysfunctions

Sexual dysfunctions are characterized by inhibitions in sexual desire or the psychophysiological changes that characterize the sexual response cycle. This disorder includes problems with sexual desire, arousal, orgasm, pain, and dysfunction due to physiological condition or a substance. It also includes disorders of the normal sexual cycle. There are four phases to the normal sexual cycle: desire, excitement, orgasm, and resolution. Sexual dysfunction may occur in any one of the four phases of this cycle. The following six sexual dysfunction disorders and identified subtypes are detailed in the table below:

Sexual Dysfunction	Symptoms
Sexual desire disorders	<i>Hypoactive sexual desire disorder</i> : Primary symptoms are a deficient or absence of sexual fantasies and desires for sexual activity. <i>Sexual aversion disorders</i> : An extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner. This can also include kissing or touching of any kind for the purpose of sexual stimuli.
Sexual arousal disorders	<i>Female sexual arousal disorders</i> : Primary symptom is the inability to attain or maintain adequate lubrication-swelling until completion of sexual activity or in response to sexual excitement. <i>Male erectile disorders</i> : The inability to achieve or maintain an adequate erection until completion of sexual activity.
Orgasm disorders	<i>Female and male orgasmic disorders</i> : Primary symptom is the inability to, or persistent delay of, orgasm at the conclusion of or during sexual activity. <i>Premature ejaculation</i> refers to men who ejaculate with minimal sexual stimulation before, upon, or shortly after penetration.
Sexual pain disorders	<i>Dyspareunia (not due to a medical condition)</i> involves persistent genital pain before, during, or after sexual intercourse. <i>Vaginismus (not due to a medical condition)</i> involves the involuntary constriction of the muscles at the entrance to the vagina. Constriction will normally occur upon anticipation or penetration of the vagina with tampon, penis, finger, etc.

Sexual Dysfunction	Symptoms
Sexual dysfunctions due to general medical condition	Individuals with this disorder have a clinically significant sexual dysfunction. There is evidence from the patients' history, physical examination, or laboratory findings of a general medical condition judged to be etiologically related to the sexual dysfunction. Subcategories of this dysfunction include: <i>Female hypoactive sexual desire disorder due to ... (general medical condition).</i> <i>Male hypoactive sexual desire disorder due to ... (general medical condition).</i> <i>Male erectile desire disorder due to ... (general medical condition).</i> <i>Male dyspareunia desire disorder due to ... (general medical condition).</i> <i>Female dyspareunia due to ... (general medical condition).</i>
Sexual dysfunctions related to substance intoxication or withdrawal	Sexual dysfunction may also be related to the use of, or withdrawal from, a prescribed medication or other substance. The specific criteria for this diagnosis are in DSM-IV-TR.

### Paraphilias

The paraphilias are named for the sexual content that is the primary focus of the sexual fantasy. According to DSM-IV-TR, paraphilias are characterized by arousal in response to objects or situations that are not part of normal arousal patterns. It usually includes sexual fantasies, intense sexual urges, and repetitive behavior that is distressing to the individual. Paraphilias may interfere with the capacity for mutual, affectionate sexual activity. Their intense sexual urges and sexually arousing fantasies involve nonhuman objects, humiliation or suffering, or children or other non-consenting persons. The chart below identifies the most common paraphilias warranting a diagnosis in the DSM-IV-TR.

Paraphilia	Symptoms
Exhibitionism	This disorder involves recurrent, intense sexual urges and sexually arousing fantasies involving exposure of genitals to unsuspecting strangers. There is no attempt at further sexual activity with the target female.
Fetishism	This disorder is distinguished by recurrent, sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects. Common fetishes involve items of female footwear or undergarments
Frotteurism	This diagnosis involves the sexual fantasy or arousal by touching or rubbing against an unsuspecting or non-consenting victim, usually female. Typically, this diagnosis is the result of an act by a male upon a female. He may touch or fondle erogenous zones of the target female, such as the breast, thighs, or buttocks. In other instances the male may attempt to rub his penis, usually with an erection, against the buttocks, or crotch of an unsuspecting woman. It is the touching, not the forcible nature of the act, that is sexually exciting.
Pedophilia	This disorder involves recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child. Prepubescent for diagnostic purposes of this paraphilia is generally considered a child under 13 years of age. According to DSM-IV-TR, the individual with this disorder must be at least 16 years old and more than five years older than the child.
Sexual masochism	Individuals with this disorder have recurrent, intense sexually arousing fantasies, sexual urges, or behavior involving the acts of being humiliated, beaten, bound, or otherwise made to suffer.
Sexual sadism	Individuals with this disorder have intense, sexually arousing fantasies, sexual urges, or behavior involving acts where the psychological or physical suffering of the victim is sexually exciting to the person.
Transvestic fetishism	Heterosexual men with this disorder experience recurrent, intense, sexually arousing fantasies, sexual urges, or behavior involving cross-dressing.

Paraphilia	Symptoms
Voyeurism	Voyeurism is the counterpart of exhibitionism. With this disorder, he or she repeatedly watches an unsuspecting person who is naked, in the process of disrobing, or engaged in sexual activity.
Paraphilia NOS	Individuals with this disorder have a paraphilia that does not meet the criteria for any specific paraphilias. Examples of these acts include telephone scatologia (obscene phone calls for the purpose of arousal) necrophilia (corpses), zoophilia (animals), etc.

### Gender identity disorders

Gender identity disorders remain a controversial diagnosis. Gender identity disorders are essentially disturbances in an individual's sense of masculinity and femininity. They are characterized by a strong and persistent cross-gender identification that is not concurrent with their natural physical anatomical condition. As the DSM notes, the term *gender identity* should be distinguished from the term *sexual orientation*, which refers to erotic attraction to males, females, or both. We will briefly review each disorder.

#### *Gender identity disorder in children*

This disorder is characterized by identification with the opposite gender, combined with a discomfort with the child's own sex. Gender identity disorders in children are infrequently diagnosed or referred for treatment. Boys, much more often than girls, come to the attention of health care providers for exhibiting preferences for cross-role activities. Girls may be identified as tomboys but are rarely brought for professional evaluation of gender identity disorder.

#### *Gender identity disorder in adolescent or adults*

Adolescents or adults with gender identity disorder are people who strongly identify with the opposite sex. In fact, they may identify with the opposite sex to the point of believing they are a member of the opposite sex trapped in the wrong body. This often causes problems for the individual in social and occupational settings where they rarely feel comfortable in societal assigned roles of gender.

Adolescents or adults with gender identity disorders sometimes will present with a request for sex reassignment or with confusion about sexuality and gender status.

#### *Gender identify disorder—not otherwise specified*

This is a residual NOS category for individuals who present with complaints of discomfort with their own sex or identification with the other gender, but do not meet the criteria for a gender identity disorder in childhood, adolescents, or adults.

## 227. Eating disorders

This disorder is characterized by an ever-changing interaction between the amount of food the patient consumes and the patient's perception of his or her weight or shape. In this lesson, you'll study anorexia nervosa disorder and bulimia nervosa disorder, the two main eating disorders.

Definitions for Commonly Used Eating Disorder Terms	
Anorexia	Loss of appetite accompanied by inability to eat.
Binge	Excessive eating beyond the amount necessary to satisfy normal appetite.
Purge	Emptying the stomach by induced vomiting or the bowels by induced evacuation with enemas or laxatives.

### Anorexia nervosa

Anorexia nervosa is primarily characterized by the individual's obsession with food and the intentional restriction of food to the point of starvation. Anorexia is often believed to be defined as the loss of appetite. This misnomer as a loss of appetite is rare and the sufferer is normally very

hungry. It occurs in 5 to 10 percent of the population, and about 90 percent of those affected are women. This disorder primarily surfaces in adolescents and young women but may affect older women, too. The occurrence among males is rising.

The key feature of this disorder is self-imposed starvation resulting from a distorted body image and an intense, irrational fear of gaining weight. Individuals with anorexia nervosa are preoccupied with their body size, describe themselves as “fat,” and commonly express dissatisfaction with a particular aspect of their physical appearance. They go to incredible extremes to lose weight. They begin by drastically reducing caloric intake, with virtually complete avoidance of high-carbohydrates and fat-containing food. They exercise (i.e., walking, running, dancing, and performing calisthenics) incessantly. Some patients alternate fasting with bulimic episodes. Large quantities of laxatives are sometimes utilized in an attempt to lose weight. Diet pills and diuretics may also be abused to affect the weight loss.

Mortality ranges from 5 to 15 percent, the highest mortality associated with a psychiatric disturbance. One-third of the deaths can be attributed to suicide.

### **Bulimia nervosa**

This disorder is characterized by recurrent episode of binge eating and recurrent inappropriate compensatory behavior to prevent weight gain (i.e., misuse of laxatives, self-induced vomiting, enemas, fasting, and excessive exercise).

Bulimia nervosa disorder usually begins in adolescence and can occur simultaneously with anorexia nervosa. It primarily affects females, with nearly 2 percent of adult women meeting the diagnostic criteria.

Recognizing the patient with bulimia nervosa disorder isn't easy. Unlike the patient with anorexia nervosa disorder, the patient with bulimia nervosa doesn't deny that their eating habits are abnormal. However, they commonly conceal their behavior out of shame and humiliation. The patients may appear thin and emaciated. However, even though the patient's weight may fluctuate frequently, it typically stays within the normal range. They usually control their weight through the use of laxatives, diuretics, vomiting, and exercise. So, unlike the patient with anorexia nervosa disorder, the patient with bulimia nervosa usually can keep their eating disorder hidden.

## **228. Sleep disorders**

Sleep disorders are distinguished from the normal sleep difficulties that most people have by severity and length of time. Everyone suffers from a restless night due to the normal stresses of everyday life. However, when sleep disturbance is chronic and not related to any other psychiatric disorder, then the diagnosis of sleep disorder usually is selected. In DSM-IV-TR, sleep disorders are divided into four major categories:

- Primary Sleep Disorder (dyssomnias and parasomnias).
- Sleep Disorders Related to Another Mental Disorder.
- Sleep Disorder Due to a General Medical Condition.
- Substance-Induced Sleep Disorder.

In this lesson, you'll learn about two of the major categories including primary sleep disorders and substance-induced sleep disorders. These categories are what you are most likely to encounter.

### **Dyssomnias**

The focus of the dyssomnias is the major disturbance in the amount, quality, or timing of sleep. The dyssomnias are insomnia, hypersomnia, and sleep-wake schedule disorders.

***Primary insomnia***

Patients with this disorder often complain of difficulty initiating or maintaining sleep, or not feeling rested even after sleeping an adequate amount of time. Characteristically, insomnia occurs at least three times a week for at least one month, and is usually associated with either significant daytime fatigue or impairment in occupational or social functioning.

***Primary hypersomnia***

Individuals with this disorder have excessive sleepiness for at least one month that cannot be accounted for by an inadequate amount of sleep. The difficulties occur almost daily for at least one month, or episodically for longer periods of time. Consequently, the difficulties cause distress in occupational, social, and interpersonal relationships.

***Narcolepsy***

With this disorder, the individuals have irresistible attacks of refreshing sleep daily for at least three months. They also have cataplexy and hypnologic hallucinations or paralysis at the beginning or end of the sleep episode.

***Breathing-related sleep disorder***

Individuals with this disorder experience a disruption of sleep leading to excessive sleepiness or insomnia. The sleep disruption is considered to be the result of a sleep-related breathing condition such as sleep apnea or other similar problems.

***Circadian rhythm sleep disorder***

This disorder is also referred to as the sleep-wake schedule disorder. This diagnosis is used when patients complain of not being able to fall asleep when they choose, yet they are able to fall asleep at other times. In comparison, they can't be fully awake when they want to be fully awake, but are able to be awake at other times. This usually results in complaints of either insomnia or hypersomnia.

Individuals on rotating night-shift and day-shift schedules often have difficulty adjusting to the alternating sleep schedules and may experience symptoms of circadian rhythm sleep disorder. An individual suffering from jet-lag is an example of a transient sleep wake schedule disorder that occurs because the person's sleep-wake schedule is out of sync with the sleep-wake schedule of the new environment. If you get a chance to deploy overseas, you may experience something like this for a short time. Flying for 10 hours to get to your destination can be a disorienting process.

***Dyssomnias not otherwise specified***

Individuals with this disorder have an insomnia, hypersomnia, or circadian rhythm disturbance that does not meet the criteria for any specific dyssomnia.

***Parasomnias***

The parasomnias are a mixed group of episodic night-time events that usually occur during sleep or just between wakefulness and sleep. The parasomnias are dream anxiety, sleep terror, and sleep walking disorders.

***Nightmare disorder***

Previously referred to as dream anxiety disorder, patients who experience this disorder are characterized by repeated awakenings from sleep with specific recall of frightening dreams. The nightmares usually are quite vivid, long, and typically focus on threats to the individuals' survival, security, or self-esteem. Some people have frequent nightmares as a lifelong condition; others experience them as a result of increased stress, illness, or changes in the sleep environment. Usually, upon awakening from the dream, the individual is oriented and alert. In most cases, the person can give a detailed account of the dream experience. Many people who suffer from this disorder have

difficulty in falling back to sleep after an episode. This disorder, like most parasomnias, is seen more frequently in children than in adults.

### ***Sleep terror disorder***

Patients who complain of this disorder experience repeated episodes of sudden awakening from sleep, usually caused by a piercing scream or cry by the individual. The episodes usually occur when the individual is in the deepest part of the sleep cycle. During a typical episode, the person will sit up in bed abruptly with a frightened expression, scream loudly, and exhibit signs of intense anxiety. Associated features are dilated pupils, excessive sweating, hair standing, and rapid and quick breathing.

### ***Sleepwalking disorder***

The essential feature of this disorder is repeated episodes of the patient arising from where they are sleeping and walking about, without being aware of the episode or remembering it later. The patient usually sits up and, at times, performs repetitive acts (walking, talking, dressing, or going to the bathroom). During the episode, the individual mainly is unresponsive to attempts to communicate with him or her and can only be awakened with great difficulty. It's a myth that a sleepwalker is very careful during an episode. The truth is that the person can stumble or lose balance or be injured by taking a dangerous path. Sometimes, the individual will awaken confused and disoriented; more frequently, the individual returns to bed with no knowledge of sleepwalking.

### ***Parasomnias not otherwise specified***

This disorder has abnormal behavioral or physiological events during sleep or sleep-wake transitions that do not meet the criteria for any specific parasomnias.

### **Substance-induced sleep disorder**

The primary feature of the Substance-Induced Sleep Disorder is a disturbance in the patient's sleep pattern as a direct physiological result of substance usage. The sleep disturbance could also be caused from withdrawals as a result of discontinuing the use of substances.

Some substances such as alcohol, opioids, sedatives, hypnotics, and anxiolytics induce or increase sleep periods while other substances such as amphetamines, caffeine, and cocaine are stimulants and can cause insomnia. It should be noted that the stimulants identified have the opposite effect after their discontinuation and often leave the user sleeping excessively to recover from their extended periods of alertness.

## **229. Impulse-control disorders not elsewhere classified**

This category is used for disorders where the repeated expression of impulsive acts that lead to physical or financial damage to the patient or another person, and often result in a sense of relief or release of tension. Individuals with impulse control disorders share certain characteristics such as:

- A failure to resist an impulse, drive, or temptation to perform some action that is harmful to themselves or others.
- Increased tension or arousal before committing the act.
- Feelings of pleasure, gratification or release while performing the act.
- After the act, the individual may or may not feel regret, self-reproach, or guilt.

This disorder group contains six specific disorders that are united solely by the destructive nature of the individual's impulsive act.

- Kleptomania.
- Impulse-control disorder.
- Intermittent explosive disorder.



- Pathological gambling.
- Pyromania.
- Trichotillomania.

### **Kleptomania**

This disorder focuses on individuals who fail to resist impulses to steal objects they do not need. The theft is not committed to express anger or vengeance and is not a response to a delusion or hallucination. The individuals experience an increasing sense of tension before the theft and pleasure, gratification, or relief while committing the theft.

### **Impulse-control disorder—not otherwise specified**

In this NOS disorder, individuals have problems with impulse control that do not meet the criteria for any specific impulse-control disorder.

### **Intermittent explosive disorder**

Individuals with this disorder have a severe discrete episode of loss of control of aggressive impulses, resulting in serious assaultive acts or destruction of property that are grossly out of proportion to the precipitating stressors.

### **Pathological gambling**

Individuals with this disorder have a persistent and recurrent maladaptive gambling behavior. They experience many of the physiological reactions while gambling as the kleptomaniac does both pre and post event.

### **Pyromania**

Patients with this disorder are fascinated with fires and have deliberately and purposely set fires on more than one occasion. They experience a sense of tension or affective arousing preceding the fire-setting act and pleasure, gratification, or relief once they start or witness a fire. The fire is not set for monetary reasons, to make a political statement, to conceal activity, or to express anger or vengeance. Nor are the fires set to improve the person's living circumstances, or in response to a delusion or hallucination.

### **Trichotillomania**

Individuals with this disorder repeatedly pull out their hair. They experience an increasing sense of tension before pulling out the hair and gratification or relief when pulling out their hair.

## **230. Adjustment disorders**

This diagnostic category focuses on transient emotional disorders or reactions of any severity that cannot be accounted for by the presence of any previously existing emotional disorder. These disorders represent significant emotional reactions to environmental stress. Such reactions are regarded as transient in the sense they do not persist when the stress is removed. Many of the patients seen in a clinic setting will fall into this category. For the most part, they are people who have managed to do well despite the everyday stresses we all face. However, sometimes the stress is just too much (acute) or it lasts too long (chronic). When this happens, an individual may have difficulty using past coping skills and may seek outside help.

Individuals experiencing adjustment disorders may display a wide variety of symptoms and behavioral manifestations. These will vary, depending on the severity and nature of the stress and the individual personality makeup. Symptoms often include tension, nausea, irritability, headaches, loss of appetite, anhedonia, and sleep disturbances, to name a few. The symptoms experienced during an adjustment disorder can involve mood or behavioral disturbances. The DSM-IV-TR classified adjustment disorders according to the predominant symptom(s). These disorders can occur at any age of life in response to normal life events everyone experiences from time to time. The symptoms are

not extreme, but are what might be expected given the catalyst for the stressor. The following table identifies the adjustment disorders and their symptoms.

Adjustment disorder	Symptoms
With depressed mood	Reactions when depressed mood, tearfulness, and hopelessness are dominant.
With anxiety	Nervousness, worry, and jitteriness.
With mixed anxiety and depressed mood	Anxiety and depression.
With disturbance of conduct	Disturbance of conduct with the violation of the rights of others or breaking rules or expectations such as truancy, vandalism, fighting, etc.
With disturbances of emotions and conduct	Both emotional features and behavior are dominant.

Symptoms associated with adjustment disorders should subside and not last longer than six months of onset. Repeated adjustment disorder diagnoses or symptoms that last longer than six months should warrant further evaluation for a chronic condition or personality disorder.

### 231. Personality disorders

One of the most difficult patients that you will work with is the patient with a personality disorder. This is because most individuals with personality disorders generally accept their maladaptive traits as normal and, at times, even as valuable assets. They rarely desire to change these traits and usually are only minimally aware of how their behavior affects others. In this lesson, we will look at the types of personality disorders and the behavior they demonstrate.

These disorders are characterized by exaggerated cognitive or emotional tendencies, usually manifested in maladaptive social behavior. We could say these people fit between those who are mentally ill and mentally healthy. Their adjustments to life are not healthy and indicate serious problems, but reality remains intact for them, and they can adapt socially. They do not experience specific symptoms. Many times, clients will have certain traits associated with a personality disorder. These traits don't always constitute a disorder unless it's a documented life-long pattern of maladaptive behavior and it interferes with occupational, social, and interpersonal relationships. All personality disorders are documented on Axis II in DSM-IV-TR classification.

As we traverse each of the personality disorders, you might possibly have the inclination to begin diagnosing your friends, family, or others you know. Remember, these are maladaptive traits and severely impact the individual's ability to function.

#### Avoidant personality disorder

Because of fears of criticism, disapproval, or rejection, people with this personality disorder avoid social or occupational activities that involve significant interpersonal contact. They show restraints within intimate relationships because of the fear of being shamed or ridiculed. These individuals are preoccupied with being criticized or rejected in social situations. Their feeling of inadequacy inhibits them in new interpersonal situations. They view themselves as socially inept, personally unappealing, or inferior to others. They are usually reluctant to take personal risks or to engage in any new activities because the activities may prove embarrassing.

People with this personality disorder show hypersensitivity to potential rejection, humiliation, or shame; an unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance; social-withdrawal in spite of desire for affection and acceptance; and low self-esteem. Unlike people with schizoid personality disorders, who are socially isolated but have no desire for social relations, those with avoidant personality disorder yearn for affection and acceptance.

They are distressed by their lack of ability to relate comfortably to others and suffer from low self-esteem.

**Antisocial personality disorder**

People with this disorder are at least 18 years old. They have a *history* of continuous and chronic antisocial behavior where the rights of others are violated. This pattern of persistent antisocial behavior that normally begins before the age of 15 continues into adult life. Usually there is a failure to sustain good job performance over a period of several years. Lying, stealing, fighting, truancy, and resisting authority are typical childhood signs. In adolescence, unusually early or aggressive sexual behavior, excessive drinking, and illicit drug use are frequent. These behaviors usually continue into early adulthood, but after age 30 the more flagrant aspects may diminish.

**Borderline personality disorder**

People with this personality disorder frequently manifest features of other personality disorders such as schizotypal, histrionic, narcissistic, and antisocial personality disorders. Quite often, social contrariness and a generally pessimistic outlook are seen. Alteration between dependency and self-assertion are common. The essential feature is instability in a variety of areas, including interpersonal behavior, mood, and self-image. A profound identity disturbance may be manifested by uncertainty about several issues relating to identity (e.g., self-image, gender identity, or long-term goals or values). Suicide gestures and feelings of boredom or emptiness are common.

**Dependent personality disorder**

People with this personality disorder passively allow others to assume responsibility for major areas of life because of a lack of self-confidence and an inability to function independently. Such individuals leave major decisions to others. They are unwilling to make demands on the people they depend on for fear of jeopardizing the relationships and being forced to rely on themselves. They invariably lack self-confidence and tend to belittle their abilities and assets.

**Histrionic personality disorders**

People with this personality disorder are overly dramatic, reactive, have intensely expressed behavior, and have disturbances in interpersonal relationships. They tend to draw attention to themselves and are prone to exaggeration. Minor stimuli give rise to emotional excitability. People with this disorder crave novelty, stimulation, and excitement. They quickly become bored with normal routines. They frequently are perceived as shallow and lacking genuineness, though superficially charming and appealing. They form friendships quickly but then become demanding, egocentric, and inconsiderate; manipulative suicide threats, gestures or attempts may be made. Such individuals typically are attractive and seductive. They attempt to control the opposite sex or enter into a dependent relationship. It is more common among females than males and may lead to violation of “fraternization” rules on inpatient units or in therapy.

**Narcissistic personality disorder**

People with this personality disorder have a grandiose sense of self-importance or uniqueness, and a preoccupation with fantasies of unlimited success. They have exhibitionistic needs for constant attention and admiration. They are also indifferent or overly emotional in their responses to threats to self-esteem and disturbances in interpersonal relationships. Narcissistic personality disorder is characterized by feelings of entitlement, interpersonal exploitativeness, relationships that alternate between the extremes of over-idealization and devaluation, and lack of empathy. Relations with others lack sustained positive regard.

**Obsessive-compulsive personality disorder**

People with this personality disorder are characterized by a restricted ability to express warm and tender emotions, perfectionism that interferes with the ability to grasp “the big picture,” insistence that others submit to his or her way of doing things, excessive devotion to work and productivity to

the exclusion of pleasure, and indecisiveness. Everyday relationships have a conventional, formal, and serious quality. Preoccupation with rules, efficiency, trivial details, procedures, or form interferes with the ability to take a broad view of things. They tend to be excessively conscientious, moralistic, scrupulous, and judgmental of self and others. Often military positions, where precision and attention to detail are encouraged, are filled by compulsive people.

### **Paranoid personality disorder**

This behavior pattern is characterized by frequent suspiciousness, hypersensitivity, jealousy, envy, and an excessive sense of self-importance. These individuals tend to view the world as hostile and threatening, often blaming others and accusing them of evil motives. They tend to feel slighted or resentful in dealing with other people. They also are likely to be oversensitive, intolerant, and critical. These individuals usually display attitudes of arrogance and superiority, and are incapable of admitting any defects or weaknesses in themselves.

### **Schizoid personality disorder**

People with this personality disorder have a defect in their capacity to form social relationships evidenced by the absence of warm and tender feelings for others and an indifference to praise, criticism, and the feelings of others. People with this disorder show little or no desire for social involvement, prefer to be “loners,” and have few, if any, close friends. They usually are humorless or dull and present a flat or blunted affect. However, they lack eccentricities of speech, behavior, or thought that is so characteristic of schizotypal personality disorder.

### **Schizotypal personality disorder**

People with this personality disorder have various oddities of thought, perception, speech, and behavior but it is not severe enough to meet the criteria for schizophrenia. Thought content may include magical thinking, ideas of reference, or paranoid ideation. Perceptual disturbances may include recurrent illusions, depersonalization, or realization. Speech may show marked peculiarities (e.g., concepts may be expressed unclearly or oddly or words may be used deviantly, but not to the degree of loosening of associations or incoherence). Behavioral manifestations often include social isolation and constricted or inappropriate affect that interferes with rapport in face-to-face interaction.

As you gain experience as a mental health journeyman, you will discover that all of the patient visits to mental health services are not necessarily the results of a mental disorder. You will find that the majority of our patients are moderately well adjusted and functional people. You will also see the conditions our patients experience (i.e., social, occupational, and behavioral) are such that any one of us may be faced with. We will also discuss the nursing processes and how a mental health patient's conditions and problems are assessed and documented.

## **232. Psychopharmacology**

Although the psychoactive drugs do not cure mental illness, they do help to “normalize” behavior. Thus, many people are able for the first time to participate therapeutically with others in a variety of group activities. Mental health centers, hospitals, institutions, etc. are able to focus more attention on providing therapeutic experiences instead of expending time controlling behavior and custodial care such as keeping individuals fed, clothed, and bathed. One of the most dramatic results of the use of psychoactive agents, especially the antipsychotic agents, is the ability of many severely disturbed persons to return to their community after a relatively short period of time. Some are able to reestablish their roles in the family, and others to return to their jobs. These drugs have made possible the movement of thousands of individuals out of large public psychiatric hospitals into community treatment centers. Thus the care and treatment of mentally challenged people have been dramatically altered by the introduction of psychoactive drugs. Let's look at some of these medications and their expected effects.

## Antipsychotic agents

The drugs in this group have similar benefits but they may have different mechanisms. They are beneficial for individuals who demonstrate psychotic symptoms. For this reason, they are referred to as antipsychotic drugs because they reduce psychotic symptoms. Thus excited, overactive, agitated individuals are calmed by these drugs; withdrawn, inactive individuals and hallucinatory, delusional people become less symptomatic. In general, antipsychotic medications treat and manage acute and chronic psychosis and control excessive agitation.

Commonly used antipsychotic drugs include the phenothiazines: chlorpromazine (Thorazine, Largactil), fluphenazine (Perimitil, Prolixin), perphenazine (Trilfon), prochlorperazine (Compazine), thioridazine (Melleril), and trifluoperazine (Stelazine). Others will include droperidol (Inapsine), haloperidol (Haldol), pimozide (Orap), and promazine (Sparine). There are many new ones available now including olanzapine (Zyprexa). Olanzapine is an atypical antipsychotic that is particularly well liked due to the few extrapyramidal side effects. There allure has also been the potential to reduce positive and negative symptoms to a better degree than some conventional antipsychotics and some other 'atypical' antipsychotics.

## Side effects

Side effects may be seen in varying degrees or not at all. Some require the medication be discontinued while others may be counteracted by additional medication or subside with continued usage. Others are considered so minor that the need for medication outweighs the side effects. Now let's look at major categories of side effects. Your continuous contact with the patient often allows you to be the first to observe a side effect or adverse reaction of an antipsychotic medication in a patient. You also may be the first person the patient complains to about the uneasiness associated with their medication. Report any physical complaints of a patient to the nurse or doctor immediately. The side effects of antipsychotic medications that Mental Health Journeyman must recognize can be divided into the following classes according to the body system affected:

### *Autonomic nervous system*

Antipsychotic medications possess properties that interfere with the transmission of nerve impulses by acetylcholine and epinephrine. These are anticholinergic and antiadrenergic properties. The most common are the anticholinergic effects, which include blurred vision, constipation, dry mouth, and urinary retention. Postural hypotension is a common antiadrenergic effect.

### *Extrapyramidal*

These are the effects of the medication on the extrapyramidal tracts of the central nervous system, which are involved with the production and control of involuntary movements. The five types of extrapyramidal effects are listed in the table below.

Extrapyramidal Effects	
Dystonic	<p>This reaction includes muscle spasms usually of the head, neck, lips, and tongue and sometimes the back and legs. They appear as:</p> <p>Torticollis (twisting of the neck and unnatural position of the head).</p> <p>Retrocollis (head drawn directly backward).</p> <p>Opisthotonus (head and heels drawn back while spine is bowed forward).</p> <p>Oculogyric crisis (eyes rolling back into the head).</p> <p>They also include slurred speech, <i>dysphagia</i> (difficult swallowing), and <i>laryngospasm</i> (closure of the larynx), which can be life threatening.</p>
Akathisia	<p>This effect is characterized by motor restlessness and usually begins in the second week. The patient paces and is unable to sit still.</p>

Extrapyramidal Effects	
Akinesia	This effect is usually seen in the same time frame as akathisia. Akinesia is fatigue or weakness of muscles in the arms or legs and usually is not very distressing to the patient.
Pseudo-parkinsonism	Because of its similarity to Parkinson's disease this effect is called pseudoparkinsonism. It usually occurs in the third or fourth week of treatment. It is characterized by a masked face (immobile), shuffling walk, pill-rolling movement of the hands, coarse tremor, drooling, and waxy skin. There also may be weakness, rigid muscles, and diminished drive.
Tardive or persistent dyskinesia	This effect usually occurs after long-term use (years) of antipsychotic medications. Tardive dyskinesia is considered the severest extrapyramidal effect because it is usually irreversible. It is characterized by involuntary movement of the face, jaw, and tongue. This usually involves a protrusion of the tongue and involuntary lip smacking.

### ***Other central nervous system effects***

The antipsychotic medications increase sedation and are known to lower the seizure threshold. A history of seizures does not necessarily mean that a patient should not be on medication, but closer observation is required. Now let's look at several more categories of side effects.

### ***Allergic reaction***

One of the primary adverse effects is cholestatic jaundice, which occurs with the use of chlorpromazine (Thorazine).

### ***Blood***

Agranulocytosis (lowering of leukocytes in the blood) is one of the most serious side effects of the antipsychotic agents because it can be potentially fatal. Fortunately, agranulocytosis is rare. It is characterized by sore throat, fever, weakness, or other signs of infection. These signs in patients should be reported to the physician immediately.

### ***Skin***

Patients taking phenothiazines, especially chlorpromazine (Thorazine), should be cautioned about excessive exposure to the sun. Their skin can be extremely sensitive to sunlight, breaking out in a sunburn-like rash. Also, a contact dermatitis may occur with staff members who handle the medications, especially the concentrated forms.

### ***Eye***

Thioridazine (Mellaril) may cause retinitis pigmentosa in patients taking more than 500 milligrams (mg) per day, which could then lead to blindness.

### ***Endocrine***

Lactation in females and impotence in males are a couple of endocrine effects that can be a result of antipsychotic medication.

### **Anxiolytics**

These agents are used exactly as their name indicates, to relieve anxiety. Antianxiety agents are similar to the central nervous system (CNS) depressants in that they can become habit forming and cause withdrawal symptoms with long-term use. They may be used to induce sleep when given in large quantities. Antianxiety agents often are referred to as "*minor tranquilizers*." This can be misleading because the agents do not have any antipsychotic properties similar to the major tranquilizers; they are more closely aligned with the CNS depressant family of drugs.

These drugs are best used to:

- Relieve or reduce anxiety.

- Relieve muscle spasm (Valium).
- Induce sedation (especially before anesthesia).
- Treat individuals suffering from delirium tremors (severe withdrawal from alcohol symptoms).
- Potentiate anticonvulsant drugs.
- Manage status epilepticus—administered intravenously (IV)

Antianxiety agents have a limited number of side effects. However, patients often complain of tiredness and drowsiness, especially following the initial dose or significant increases thereafter.

**CAUTION:** Patients should be advised not to drive a car or operate other machinery when in the drowsy state. Also patients should be warned against the ingestion of alcohol in conjunction with antianxiety agent use.

In some patients, the same side effects seen with antipsychotic drug use may be observed, except to a lesser degree. Extra-pyramidal effects are not seen with antianxiety agents. Tolerance and dependence are problems seen in long term use. A definite withdrawal syndrome could develop in cases where the patient was on high doses for a relatively long period of time and is abruptly stopped. For chronic treatment of anxiety the current standard is the use of antidepressants. The following table gives a good description of common anxiolytic agents:

Common Anxiolytic Agents	
Valium (Diazepam)	This drug is one of the most widely prescribed drugs in the world and is the most abused of these legally prescribed drugs. It can be given orally in tablet form as well as intramuscularly and intravenously. Recommended adult dose is 2–60 mg a day.
Librium (Chlordiazepoxide)	Often given to patients who are withdrawing from alcohol. It can be given orally, intramuscularly, or intravenously. Recommended adult dose is 15–100 mg a day.
Tranxene (Clorazepate)	Indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. Also indicated as adjunctive therapy in the management of partial seizures. Given orally. Recommended adult dose is 7.5–60 mg a day.
Xanax (Alprodam)	Indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. Anxiety associated with depression is also responsive to Xanax. Recommended adult dose is 0.5–6 mg a day.
Ativan (Lorazepam)	Indicated for the management of anxiety or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms. Available in an injectable form or orally. Recommended adult dose is 2–6 mg a day.
Klonopin (Clonazepam)	While used for the management of anxiety, it is primarily indicated for use as an anticonvulsant.

### Antidepressants

A third major group of psychoactive medication used extensively are antidepressants. Depressive illnesses are not uncommon in the general population, with a lifetime prevalence of 5–20 percent depending on the population studied. The stigma often associated with seeking help with preventable psychiatric illnesses is waning. Why suffer unnecessarily? Similar to pain management on the medical side of the house, the provider or Mental Health Technician should query the patient to determine how much psychological pain he or she is able to endure.

Antidepressants are usually the treatment of choice for major depression and for depressive episodes. Endogenous depression (depression in reaction to internal psychic factors, conflicts, guilt, etc.) is

more likely to be alleviated than are other depressive states (depression in reaction to situations, loss, or grief exogenous depression).

Once the depressive symptoms have subsided and improvement has been noted, patients are placed on maintenance doses of antidepressants that are usually continued for six months to one year. A gradual reduction is then started. Thus, a person will not show lessening of depressed mood until a week to ten days following the initiation of an adequate dose of the antidepressant. Some of the antidepressants also have a sedating effect. The patient may appear to be getting worse after the first initial doses. All antidepressant medications warn of the risk of suicide while taking the medication as suicide is an inherent risk of depression, not necessarily a byproduct of the medication.

Antidepressants are divided into many different types. You will be studying four in this lesson: Selective Serotonin Reuptake Inhibitors (SSRI), Selective Norepinephrine Reuptake Inhibitors (SNRI), Tricyclic (refers to molecular structure), and Monoamine Oxidase (MAO) Inhibitors. The SSRI and SNRI are considered the more modern approaches to treating depression, however the tricyclics and MAO Inhibitors continue to provide a significant role in the treatment of depression.

### ***Selective Serotonin Reuptake Inhibitors***

SSRIs have become widely accepted as the drug class of choice for the treatment of depression. One of the allures of this class of drugs is the lack of some of the serious side effects often found in tricyclics and MAO inhibitors. SSRIs do have side effects, but they are less often life threatening than other medications. You'll study those later in this lesson. The fact that SSRIs act on only one chemical in the body instead of several like MAOIs, Tricyclics, etc., may explain the decrease in the number of side effects.

<b>Common Antidepressant SSRIs</b>	
Celexa (Citalopram)	Focusing primarily on depression, this medication is also used in the treatment of panic attacks, eating disorders, impulse control, and anxiety. Recommended adult dosage is 20–40 mg a day.
Lexapro (Escitalopram)	Again, depression is the target of this medication. Other uses that have been successful by using this medication include the treatment of panic attacks and anxiety. Recommended adult dosage is 10 mg a day.
Paxil (Paroxetine)	This medication can take as long as up to four weeks to reach its full effect. Used for the treatment of depression as well as social phobia, panic attacks, anxiety, eating disorders, and impulse control. Recommended adult dosage is 20 mg a day with increases of up to 10 mg per day to 50 mg if deemed appropriate by the physician.
Prozac (Fluoxetine)	Indicated for the treatment of depression you may also see this medication prescribed for the treatment of panic attacks, anxiety, eating disorders, impulse control, and OCD. Recommended adult dosage is 20 mg per day to 80 mg if deemed appropriated by the physician.
Zoloft (Sertraline)	Indicated for the treatment of major depression, Zoloft is also used in the treatment of panic attacks, anxiety, eating disorders, impulse control, and OCD. Recommended adult dosage is 25–50 mg per day. This dosage can reach as high as 200 mg per day.

Side effects from using SSRIs can include: dry mouth, nausea, headache, insomnia, and sexual dysfunction (about 40–60%). Extra-pyramidal effects from the use of SSRIs are rare. On a rare occasion akathisia, or what is described as an “inner relentlessness,” can occur. The lack of extra-pyramidal effects is considered a benefit of this class of drugs.

### ***Selective Norepinephrine Reuptake Inhibitors***

SNRIs are considered a modern class of drugs that work by stopping the body from reabsorbing neurotransmitters, in particular, serotonin and noradrenaline. This can be used to elevate the levels of



these neurotransmitters in the body and produce therapeutic effects without having to introduce the neurotransmitters directly, which has been shown to be very ineffective.

The most common SNRI used as a psychotropic is Effexor (Venlafaxine) which is used for the treatment of major depression and occasionally for anxiety. The recommended adult dosage is 75–150 mg per day. Patients should closely follow their physicians' instructions regarding the discontinuation of an Effexor. Abrupt discontinuation can exacerbate the patient's depression or the side effects he or she may be experiencing.

Common side effects associated with the use of Effexor can include the following:

- Sweating.
- Nausea.
- Vomiting.
- Dizziness.
- Constipation.
- Dry mouth.

### ***Tricyclics***

Because tricyclics are prescribed for depression, the risk of a suicide attempt should never be overlooked. Overdoses with tricyclics are very serious primarily due to the often irreversible toll exacted on the patient's liver. Immediate medical help should be sought if a patient reports an overdose of a tricyclic.

Tricyclics may cause withdrawal symptoms if there is an abrupt withdrawal of the medication. Nausea, vomiting, abdominal cramps, diarrhea, chills, insomnia, and anxiety may all be experienced. They usually begin 4 to 5 days after discontinuing the medication and last 3 to 5 days.

Common tricyclics that you may see prescribed are imipramine (Tofranil), amitriptyline (Elavil), desipramine (Norpramin, Pertofran) nortriptyline (Aventyl), and doxepin (Sinequan). Tricyclics are generally considered safer than the MAO inhibitors.

### ***Monoamine oxidase inhibitors***

MAO Inhibitors are used much less since the advent of a new generation of medications described above. This is primarily due to the many precautions and contraindications associated with the use of MAO inhibitors.

Patients taking any of the MAO inhibitors should be given a list of these foods and warned about their side effects. Foods such as aged cheese, beer, chocolate, pickled herring, Chianti wine, yeast products, broad beans, and chicken livers should be avoided. Patients taking MAO inhibitors should have their vital signs monitored closely, and any sharply elevated blood pressure (BP) or temperature should be reported immediately. Additional symptoms that you should be aware of are sweating, throbbing headache, nausea, vomiting, and stiff neck. Tranylcypromine (Parnate) and Iproniazid (Marsilid) are considered two of the most effective MAO inhibitors, with phenelzine (Mardin) close behind.

Due to the potential serious or fatal side effect of the MAO inhibitors when used in tandem with SSRIs, SNRIs, or tricyclics, they are never used at the same time. There should be a period of time ranging from seven to 14 days between discontinuation from one to the other to allow for the patient's body to physiologically adjust before the introduction of another medication.

### **Sedatives and hypnotics (central nervous system depressants)**

Sedatives and hypnotics come in the following two categories:

- Barbiturates.

- Nonbarbiturates.

They have a limited but important use in the field of mental illness. They are undesirable because of their physiological addiction, overdose potential, and dangerous interaction with alcohol and other drugs. However, they are helpful for treating severe sleep disturbances.

### ***Barbiturates***

Barbiturates usually are prescribed for their sleep inducing effects. One of the most common barbiturates prescribed is secobarbital (Seconal), which is very addictive. It is the drug most often used by people who successfully complete suicide. Other barbiturates include amobarbital (Amytal), pentobarbital (Nesbutal), and phenobarbital (Eskaphen, Eskabarb, Luminal). Phenobarbital is often prescribed for detoxifying patients who are addicted to other barbiturates. Phenobarbital is also used in managing epilepsy.

### ***Nonbarbiturates***

Some of the nonbarbiturate drugs often prescribed for sleep disturbances are Placidyl, glutethimide (Doriden), methyprylon (Noludar), chloral hydrate (Felsules, Rectules, Noctec), and paraldehyde. However, even these present special problems. Ethchlorvynol's (replaces placidyl's) therapeutic dose is only one-fifth of the amount needed to be fatal. Glutethimide (replaces doriden) is very addicting and difficult to manage in cases of overdose. Chloral hydrate and paraldehyde often are prescribed for severe sleep disturbances because of their limited abuse potential.

### **Antimania agent—lithium carbonate**

No other drug has proven as effective in the treatment of a patient with the acute manic phase of bipolar disorder as lithium carbonate. It has been effective in over 90 percent of the cases. It has not proven to be beneficial in the other phases of this illness and, therefore, requires an accurate diagnosis.

An important factor in the use of lithium carbonate is that the therapeutic level is very close to the toxic level. In addition, patients can tolerate high doses of lithium carbonate during acute mania, but as the mania subsides so does a patient's tolerance. Fortunately, lithium carbonate is an ion that can be measured in the blood. Patients who have been started on lithium carbonate will usually have blood tests to determine the serum lithium levels. Initially, these are usually done two or three times a week as the medication is adjusted to reach a therapeutic level. Once a therapeutic level is reached and the patient stabilized, the blood tests need not be done as often.

Intoxication signs such as vomiting, diarrhea, confusion, mild ataxia, coarse tremor, muscle twitching, and difficulty in speech should be reported to the physician immediately since they may indicate that the toxic level has been reached. Because lithium carbonate is an electrolyte, conditions that affect the electrolyte and fluid balance (vomiting, diarrhea, and excessive perspiring) should be noted. Patients should be urged to consume adequate fluids and salts to maintain the electrolyte balance. They should also be cautioned regarding the use of saunas, whirlpools, and extremely hot baths. Use of these mediums can cause rapid fluid loss due to perspiration, which, in turn, may create possible electrolyte imbalance.

After the patient has been stabilized, lithium carbonate acts as a preventative of future manic attacks as long as therapeutic levels are maintained.

### **Antiparkinsonian agents**

The extra-pyramidal side effects that we discussed in the section on antipsychotic medication can be controlled, with the exception of tardive dyskinesia, with antiparkinsonian agents. The type, dosage, and method administered depends on the patient's need and the physician's experience with the agents. Some physicians will start the antiparkinsonian agents in conjunction with antipsychotic agents. Others prefer to wait until the extrapyramidal effects appear.

Antiparkinsonian agents can be administered intravenously, intramuscularly, or orally, depending on the patient's need. A patient experiencing a severe dystonic reaction usually will receive the medication intravenously for immediate relief. As was mentioned earlier, these reactions can be very frightening, quite painful, and, at times, life threatening, so immediate relief is needed. Pseudoparkinsonian syndrome and akathisia do not need immediate relief and usually are treated with oral medication.

Antiparkinsonian agents include benztropine, biperiden, procyclidine, trihexyphenidyl, and diphenhydramine. Benztropine (replaces cogentin) is the most powerful agent. The side effects of the antiparkinsonian agents are atropine-like effects, blurred vision, and dry mouth.

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### **Self-Test Questions**

**After you complete these questions, you may check your answers at the end of the unit.**

#### **216. Disorders usually first diagnosed in infancy, childhood, or adolescence**

1. What are some of the observable effects of mental retardation?
2. Learning disorders are characterized by inadequate development of what specific academic skills?
3. Why is the term pervasive used when describing Pervasive Developmental Disorders?
4. What specifically do children with attention-deficit/hyperactivity disorder have difficulty with?
5. Identify the behaviors children with conduct disorder demonstrate?

#### **217. Delirium, dementia, amnestic, and other cognitive disorders**

1. How are delirium disorders distinguished?
2. How is dementia distinguished?
3. What is the difference between antegrade and retrograde amnesia?

#### **218. Mental disorders due to a general medical condition not elsewhere classified**

1. Describe the conditions a patient with catatonic disorder may experience.

2. What personality disturbance is manifested by poor impulse control?
3. What are the personality changes for apathetic type?

**219. Substance-related disorders**

1. What are the four primary characteristics for substance-related disorders?
2. What are the features indicative of a substance dependence disorder?
3. What two classes of abused drugs do not apply to the category of substance abuse?
4. Which opioid has no medical purpose?
5. Phencyclidine (PCP) was removed from the market for human use in 1965, what is its primary use now?
6. Intoxication from which class of drugs emulates alcohol intoxication?
7. What is the particular danger of sedatives and hypnotics?

**220. Schizophrenia and other psychotic disorders**

1. Match each common feature in column A with its definition in column B. Each item in column A may be used more than once or not at all.

<i>Column A</i>	<i>Column B</i>
____ (1) Disorganized speech	a. A false belief firmly held despite obvious proof or evidence to the contrary.
____ (2) Delusions	b. A sensory perception that is the product of the patient's mind and does not exist in the outside world.
____ (3) Echolalia	c. Behavior that is not goal-directed or guided by any rational, preconceived plan, and may appear random or odd.
____ (4) Clang associations	d. Bizarre words that have meaning only for the patient.

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____ (5) Ambivalence	e. Coexistence of contradictory ideas, emotions, attitudes, in rapid succession.
____ (6) Withdrawal	f. Disinterest in objects, people, or surroundings.
____ (7) Word salad	g. Illogical word groupings, i.e., He had a moon, bike, door.
____ (8) Neologisms	h. Rapid shifts among unrelated events.
____ (9) Hallucinations	i. Repetition of a recently heard sound or phrase.
____ (10) Regression	j. Return to an earlier developmental stage.
____ (11) Flights of ideas	k. Speech where ideas shift from one to another in an unrelated manner.
____ (12) Thought blocking	l. Sudden interruption in patient's train of thought.
____ (13) Loose associations	m. Verbal skipping from one idea to another.
____ (14) Disorganized behavior	n. Words that rhyme or sound alike used in an illogical, nonsensical manner.

2. What are the characteristic symptoms for schizophrenia disorders?
3. What is the primary symptom that distinguishes the paranoid from other forms of schizophrenia disorders?
4. What is the disorganized type of schizophrenia characterized by?
5. What behavior is demonstrated in the withdrawn form of catatonia?
6. How is the patient with catatonia excitement characterized?
7. Which type of schizophrenia refers to manifesting prominent delusions, hallucinations, incoherence, or grossly disorganized behavior?
8. In addition to meeting the common criteria for schizophrenia, what else do patients with Schizoaffective Disorder experience?
9. What does the patient with a grandiose type of delusional disorder believe?

**221. Mood disorders**

1. What is the most serious complication of major depression?
2. What is the primary feature of dysthymic disorder?
3. What features characterize bipolar disorders?

**222. Anxiety disorders**

1. What are the five types of anxiety disorders?
2. Which disorder is characterized by recurrent episodes of intense apprehension, terror, and impending doom?
3. Describe obsessions.
4. How are compulsive acts defined?

**223. Somatoform disorders**

1. How do somatoform disorders and malingering differ?
2. What two things does a patient “get” from having a conversion disorder?
3. Describe the symptoms of a patient with hypochondriasis disorder.

**224. Factitious disorders**

1. How are factitious disorders characterized?
2. Which disorder is characterized by intentional feigning of symptoms suggestive of a mental disorder?

**225. Dissociative disorders**

1. How are the experiences characterized for a patient with a dissociative disorder?
2. How is a dissociative fugue characterized?
3. Which disorder was once referred to as the multiple personality disorder?

**226. Sexual and gender identity disorders**

1. How are sexual dysfunctions characterized?
2. How are paraphilias characterized?
3. How are gender identity disorders characterized?

**227. Eating disorders**

1. What is the key feature of anorexia nervosa?
2. How is bulimia nervosa characterized?

**228. Sleep disorders**

1. What is the focus of dyssomnias?
2. How long must excessive sleepiness occur for patients to be considered a primary hypersomnia?
3. What disorder is also referred to as the sleep-wake schedule disorder?
4. What disorder was once referred to as the dream anxiety disorder?

**229. Impulse-control disorders not elsewhere classified**

1. How are the six specific impulse control disorders united?
2. Describe what the person diagnosed with pyromania experiences preceding setting a fire.

**230. Adjustment disorders**

1. What does the adjustment disorder diagnostic category focus on?
2. At what age do patients usually experience adjustment disorders?

**231. Personality disorders**

1. What are personality disorders characterized by?
2. Which personality disorder is characterized by feelings of entitlement, interpersonal exploitativeness, relationships that alternate between the extremes of over-idealization and devaluation, and lack of empathy?
3. How are patients with obsessive-compulsive personality disorder characterized?

**232. Psychopharmacology**

1. What is one of the most dramatic results of the use of psychoactive agents?
2. In general, what do antipsychotic medications treat and manage?
3. Define akinesia.
4. What are antianxiety agents often referred to as?
5. What problems are seen in long-term use of antianxiety agents?



6. The lack of extra-pyramidal effects is considered a benefit of which class of drugs?
7. The abrupt discontinuation of Effexor can cause what reaction?
8. Why are overdoses with tricyclics considered a very serious matter?
9. What is one of the most common barbiturates prescribed?
10. What is the most effective drug used in the treatment of the acute manic phase of bipolar disorder?
11. Most extra-pyramidal effects associated with antipsychotic medication can be controlled with what agents?

## **2–3. Patients without Mental Disorders**

In this section we will review a few conditions that are not related to a mental disorder, but for which mental health attention or treatment is often sought. They become the focus of attention or treatment.

Our patients' problems may vary from mild to severe mental and emotional disorders. Some function normally but need help in making some decisions or coping with life experiences. The nature of a patient's condition or problem should not influence the quality of the care and treatment the patient receives.

### **233. V codes classification of mental conditions not related to mental disorders**

The V codes are used to classify conditions that are not directly related to a mental disorder, but are the focus of attention or treatment. Usually, this label is used when:

- A provider has not had enough time to rule out a mental health disorder.
- There is not enough evidence to justify a mental health diagnosis.
- There is a mental health disorder, but the main focus of treatment is on a situation that was not caused by the disorder.

For example, a client with an OCD may be seen for marital problems not related to the personality disorder itself.

### **Classification of other mental health conditions**

Despite the stigma mental health carries, many people will seek help for a multitude of everyday problems or advice seeking. This could include such mundane problems as relational problems to high risk problems such as child abuse. Problems related to abuse or neglect is often a focus of attention among individuals seen in the mental health service. These problems warrant more attention than this section will permit and will be addressed in more detail later in the course. However, there

are just as many individuals who come to the mental health services because of misinformation as those wanting to learn new coping skills. The DSM-IV-TR, utilizes V codes to classify these problems. V codes allow the care provider to see the client and provide assistance without labeling the situation as a mental health problem.

**Problems related to abuse or neglect**

This area focuses on the physical, sexual, or neglect of an adult or child. The V codes are listed below without explanation as the title is self-explanatory as it relates to the problem.

- Physical Abuse of Child.
- Sexual Abuse of Child.
- Neglect of Child.
- Physical Abuse of Adult.
- Sexual Abuse of Adult.

***Relational problems***

This group of problems includes examples of interactions between members of a relational unit. These problems are much the same as mental disorders in that they have clinically significant impairment in functioning, or symptoms among one or more members of the relational unit. This group of problems is V-coded on Axis I.

***Parent-child relational problems***

This category is used when a problem occurs that affects either parent or child and is not due to a mental disorder. There are many instances when a “normal family” can have difficulties (e.g., in divorce situations problems can arise from the custodial or noncustodial parent). Another situation that can cause a parent-child problem is a child developing a crippling or chronic illness. Also, illnesses such as leukemia, epilepsy, birth defects (e.g., Down’s syndrome), cerebral palsy, and sickle cell anemia, can all put additional stress on parent-child relationships.

***Partner relational problems***

This category is used when the focus of attention or treatment is an interpersonal problem that apparently is not due to a mental disorder. The interpersonal problem is usually related to situations such as conflict with romantic partners, co-workers, neighbors, teachers, friends, or even social groups. This term is used when the situation is not a marital or parent-child problem.

***Sibling relational problems***

Rivalry between brothers and sisters is natural. However, this category is used when their interaction interferes significantly with normal family functioning.

***Relational problems related to a mental disorder or general medical condition***

This category should be used when the pattern of impaired interaction is associated with a mental disorder or general medical condition in a family member.

***Relational problems—not otherwise specified***

In this category, the focus is on specific family problems that are not classifiable by any of the specific problems or NOS listed above (e.g., difficulties with co-worker). This term is used when the diagnosis of marital, sibling, or child-parent problems is not appropriate.

**234. Additional conditions that may be a focus of clinical attention**

This group of problems is different from relational problems in that it does not involve interactions between members of a relational unit. This group of problems is related more or less to the individual’s interaction with society and the affected functioning. These problems are also V-coded.

**Compliance with treatment**

Compliance is the degree to which an individual carries out the recommendation of the health care provider. Compliant behavior often depends on the situation, the nature of the illness, and the treatment regimen. In other words, an individual is more likely to follow a treatment program if the situation is life-threatening, the illness is serious, and if the individual understands the benefits of following the treatment plan.

**Noncompliance with treatment**

The category of noncompliance with medical treatment is used when, for whatever reason, the patient does not follow the treatment program.

**Malingering**

Behavior in this category is characterized by the conscious fabrication of false or grossly exaggerated physical or psychological symptoms. Most malingerers present subjective, vague, or ill-defined symptoms (e.g., low back pain, stomach aches, dizziness, amnesia, anxiety, and depression). They often complain of feeling ill with no recognizable signs. This category differs from the factitious disorder in that in malingering there is always an external motivation for being sick. The following are just two examples of malingering:

- A medical technician is scheduled to see the commander in the morning, but instead reports to sick call for severe headaches.
- A person, fearing he or she may be fired from a job, suddenly develops back spasms that require hospitalization. The boss, feeling sorry and perhaps guilty, may keep the individual on staff for a while longer.

**Adult antisocial behavior**

Behavior in this category is characterized by undertakings that are immoral, illegal, or both, and violates society's laws. Examples of this type behavior include drug dealing, fraud, and stealing.

**Child or adolescent antisocial behavior**

The antisocial acts in this category usually are isolated and not a pattern of behavior. Again, this label is used only when there is no apparent mental health disorder.

**Borderline intellectual functioning**

In this category, the focus of attention or treatment is based on a deficit in functioning associated with borderline intelligence. Borderline intelligence is defined as an intelligence quotient (IQ) in the 71 to 84 range, determined by psychological testing. This problem may often be hidden when there is evidence of more serious psychopathology.

**Bereavement**

Normally, this category is used when the focus of attention or treatment is a normal reaction to the loss of a loved one. With the death of a loved one, most people go through a normal period of bereavement. Individuals usually will experience feelings of sadness, tearfulness, irritability, insomnia, and preoccupation about the death of the loved one. Difficulty in concentrating and carrying out daily tasks also is characteristic. However, if there is abnormal preoccupation, extended and marked functional impairment, and psychomotor retardation, the individual may be experiencing a mental health disorder that is complicating the bereavement process.

**Academic problems**

The focus of attention or treatment in this category is on an academic problem apparently not due to a mental health disorder. A student failing classes that he or she has the intellectual ability to pass is an example of this type behavior. To use this category, there cannot be any other mental health disorder that would explain the problem.

**Occupational problem**

Some work areas are stressful and unpleasant work environments. Even a “psychiatrically normal” individual can develop emotional problems that are not the result of a mental health disorder. Job-related stress often occurs when company goals or the mission is not clear, when a person has several bosses, when there’s too much or too little work, and when supervisors are responsible for areas or people over which they have no authority. Occupational problems are the category used when problems do occur in the work place and there is no apparent mental health disorder. Examples of occupational problems are situations such as facing retirement, job boredom, and/or being denied advancement because of racism.

**Phase of life problem**

Life events can overwhelm a person’s coping abilities, especially if the events are unexpected, numerous, and occur in a relatively short period of time. Situations that are most likely to produce stress in a person’s life and even lead to anxiety and depression are major life cycle changes (e.g., marriage, parenthood, and change or loss of occupation—as we have recently seen with the loss of hundreds of thousands of jobs in late 2008 and 2009). This category differs from an adjustment disorder in that the behavior seen in the individual is not beyond the normal, usual, or expected response to a stressor.

**Age-related cognitive decline**

This area is the focus of attention when the patient’s chronological age becomes a factor in their cognitive functioning. For example, if a patient has problems recalling specific numbers or events and it is not the result of a specific mental disorder or neurological condition, this would be the appropriate venue to address the cognitive decline.

**Identity problem**

Unlike identity disorders, which tend to focus on sexual orientation, the V code is more the focus of acclimating oneself to their surroundings or attempting to find their place in a group setting. This could involve goal setting, career path, moral convictions, etc.

**Religious or spiritual problem**

This area focuses on a patient’s struggle with questioning their faith in their religious or spiritual beliefs. This might include converting to a new religion or discovering aspects of their religious beliefs which are not compatible with their personal beliefs.

**Acculturation problem**

This area of attention is the focus when it involves adjusting to an entirely different culture. This could include individuals who have permanently relocated to a new country or you may have experienced this to a degree when you have a permanent change of station (PCS) to another country and attempt to fit into your unfamiliar surroundings.

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**Self-Test Questions**

After you complete these questions, you may check your answers at the end of the unit.

**233. V codes classification of mental conditions not related to mental disorders**

1. When are V codes usually used?
2. What does using a V code allow the provider to do?

**234. Additional conditions that may be a focus of clinical attention**

1. How does malingering differ from factitious disorder?
2. What is the focus of treatment for bereavement?
3. Give examples of a patient diagnosed with the V code of identity problem.

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**Answers to Self-Test Questions**
**213**

1. A description of specific information to associate with each mental disorder.
2. By three criteria: the disorder is not due to the direct effects of a substance; the disorder is not due to the direct effects of a general medical condition; the disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
3. To arrange according to a system.
4. To communicate more clearly in a universal language among themselves and to provide standard care.
5. (1) c.  
(2) d.  
(3) e.  
(4) b.  
(5) a.

**214**

1. When it is irrational, incapacitating, or persistent.
2. Low-back pain, constipation, weight loss, chronic indigestion, and decreased libido (sexual desire).
3. Actions, thoughts, and feelings harmful not only to that individual but also to others around that individual.

**215**

1. Cases where the presence of both a substance-related disorder and mental disorder occur in tandem.
2. When dealing with substance abusing patients.

**216**

1. Deviations from normal adaptive behaviors, ranging from learning disabilities and uncontrollable behavior to severe cognitive and motor skill impairment.
2. Reading, math, and written expression.
3. Because of the massive deficits affecting many areas of functioning and requiring long-term care that usually results in limited improvement.
4. Attention span, impulsivity, and hyperactivity.
5. Cruelty to people and animals, destruction of property, serious violation of rules, and deceitfulness or theft.

**217**

1. By a disturbance of consciousness with reduced ability to focus, sustain, or shift attention.
2. By impairment in memory.
3. With antegrade amnesia, the patient cannot recall events since the trauma occurred to the brain. With retrograde amnesia, the patient cannot recall events before the trauma occurred to the brain.

**218**

1. Motoric immobility, excessive purposeless motor activity, extreme negativism, peculiarities of voluntary movement, echolalia or echopraxia.
2. Disinhibited.
3. Indifference and apathy.

**219**

1. Adverse social, behavioral, psychological, and physiological affects.
2. Increased tolerance or need for increased amounts of substance to attain the desired effect, withdrawal symptoms with decreased use, increased time spent in activities to obtain, use or recover from the substance, unintended excessive usage, inability to decrease the amount of the substance being used, unable or unwilling to participate in important social, occupational or recreational activities, and continued usage despite contraindications to the individuals psychological or physiological well-being.
3. Caffeine and nicotine.
4. Heroin.
5. Veterinary use.
6. Sedatives and hypnotics (or anxiolytic).
7. Their cross-tolerance with each other and alcohol; the synergistic result of mixing them could be lethal.

**220**

1. (1) k.  
(2) a.  
(3) i.  
(4) n.  
(5) e.  
(6) f.  
(7) g.  
(8) d.  
(9) b.  
(10) j.  
(11) m.  
(12) l.  
(13) h.  
(14) c.
2. A range of cognitive and emotional dysfunction that include delusions, hallucinations, disorganized speech, catatonic behavior, and negative symptoms.
3. The presence of rather ornate delusions of persecution and/or grandeur.
4. Frequent and inappropriate emotional displays, especially unexplainable giggling and grimacing disorganized speech, disorganized behavior, and flat or inappropriate affect is prominent.
5. Patients show no interest in their surrounding and often are mute.
6. A state of general psychomotor agitation.
7. Undifferentiated type.
8. They experience a major depressive episode or a mixed episode for a substantial period of the illness.
9. That he or she possesses some extraordinary, unidentified, talent or insight.

**221**

1. Suicide.
2. Chronic depression.
3. Severe pathologic mood swings from mania and euphoria to sadness and depression.

**222**

1. Phobias, generalized anxiety disorder, panic disorders, obsessive-compulsive disorder, and post-traumatic stress disorder.
2. Panic disorder.
3. Unwanted irrational thoughts, ideas, images, or impulses to act, often in an aggressive or sexual fashion.
4. Observable patterns of behavior that the individual feels compelled or forced to carry out.

**223**

1. In somatoform disorders the symptom production is not under voluntary control.
2. Primary gain and secondary gain.
3. Preoccupied with the fear or belief that they have a serious disease or misinterpret body sensations as the onset of a serious illness despite reassurances from medical providers to the contrary.

**224**

1. Physical or psychological symptoms that are intentionally produced or faked.
2. Factitious disorder with predominantly psychological signs and symptoms.

**225**

1. Prolonged periods of amnesia, personality change, and detachment, often associated with intense affect.
2. Total amnesia and wandering away from home.
3. Dissociative identity disorder.

**226**

1. Inhibitions in sexual desire or the psychophysiological changes that characterize the sexual response cycle.
2. Arousal in response to objects or situations that are not part of normal arousal patterns.
3. Strong and persistent cross-gender identification that not concurrent with their natural physical anatomical condition.

**227**

1. Self-imposed starvation resulting from a distorted body image and an intense, irrational fear of gaining weight.
2. Recurrent episode of binge eating and recurrent inappropriate compensatory behavior to prevent weight gain.

**228**

1. The major disturbance in the amount, quality, or timing of sleep.
2. Almost daily for at least one month, or episodically for longer periods of time.
3. Circadian rhythm sleep disorder.
4. Nightmare disorder.

**229**

1. By the destructive nature of the individual's impulsive act.
2. Sense of tension or affective arousing.

**230**

1. Transient emotional disorders or reactions of any severity that cannot be accounted for by the presence of any previously existing emotional disorder.
2. Any age of life.

**231**

1. Exaggerated cognitive or emotional tendencies, usually manifested in maladaptive social behavior.
2. Narcissistic.

3. A restricted ability to express warm and tender emotions, perfectionism that interferes with the ability to grasp “the big picture,” insistence that others submit to his or her way of doing things; excessive devotion to work and productivity to the exclusion of pleasure, and indecisiveness.

**232**

1. The ability of many severely disturbed persons to return to their community after a relatively short period of time.
2. Treat and manage acute and chronic psychosis and control excessive agitation.
3. Fatigue or weakness of muscles in the arms or legs and usually is not very distressing to the patient.
4. Minor tranquilizers.
5. Tolerance and dependence.
6. Selective Serotonin Reuptake Inhibitors (SNRI).
7. It can exacerbate the patient’s depression or side effects they may be experiencing.
8. Due to the often irreversible toll exacted on the patient’s liver.
9. Secobarbital (Seconal).
10. Lithium carbonate.
11. Antiparkinsonian agents.

**233**

1. A provider has not had enough time to rule out a mental health disorder; there is not enough evidence to justify a mental health diagnosis; there is a mental health disorder, but the main focus of treatment is on a situation that was not caused by the disorder.
2. To see the client and provide assistance without labeling the situation as a mental health problem.

**234**

1. In malingering there is always external motivation for being sick.
2. A normal reaction to the loss of a loved one.
3. Goal setting, career path, moral convictions.

**Do the unit review exercises before going to the next unit.**



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## Unit Review Exercises

38. (213) How many axes are in the DSM-IV-TR multiaxial classification?
- a. 3.
  - b. 4.
  - c. 5.
  - d. 6.
39. (213) Which axis will *not* have more than one diagnosis?
- a. I.
  - b. II.
  - c. III.
  - d. IV.
40. (213) Axis I will always be assumed to be the principal diagnosis unless which axis is identified as such?
- a. II.
  - b. III.
  - c. IV.
  - d. V.
41. (214) Which symptom is *not* one of the general criteria used to assess the presence of a mental disorder?
- a. Abnormal behavior.
  - b. Inefficiency.
  - c. Discomfort.
  - d. Irritability.
42. (214) An indication of emotional discomfort consists of depression, anxiety, and
- a. mania.
  - b. anoxia.
  - c. physical symptoms.
  - d. body dysmorphic disorders.
43. (214) What is defined as a feeling of strong apprehension or uneasiness, while the source is largely unknown or unrecognized by the individual?
- a. Mania.
  - b. Anxiety.
  - c. Depression.
  - d. Abnormal behavior.
44. (215) Dual disorders is a term used to describe the presence of both a mental disorder and
- a. substance abuse.
  - b. schizophrenia.
  - c. anxiety.
  - d. mood.
45. (215) What is essential in determining the extent of a patient's substance usage?
- a. Supervisor input.
  - b. Commander input.
  - c. Diagnostic materials.
  - d. One-on-one interaction.

46. (216) Mental retardation is characterized by an intelligence quotient (IQ) below
- 50.
  - 60.
  - 70.
  - 80.
47. (216) Which term is *not* a behavior associated with oppositional defiant disorder?
- Hostile.
  - Defiant.
  - Assertive.
  - Negativistic.
48. (216) What disorder is characterized by the persistent ingestion of non-nutritional substances after the age of 18 months?
- Rumination.
  - Encopresis.
  - Enuresis.
  - Pica.
49. (217) A language disturbance is the primary characteristic of which memory impairment?
- Aphasia.
  - Apraxia.
  - Agnosia.
  - Disturbance in executive functioning.
50. (217) What memory impairment's primary characteristic is a failure to recognize or identify objects despite intact sensory function?
- Aphasia.
  - Apraxia.
  - Agnosia.
  - Disturbance in executive functioning.
51. (218) How many separate personality patterns are seen in patients with personality change due to a general medical condition?
- 4.
  - 6.
  - 8.
  - 10.
52. (218) What type of personality is exhibited by a patient with a personality change due to a general medical condition demonstrating indifference?
- Labile.
  - Disinhibited.
  - Apathetic.
  - Paranoid.
53. (219) A diagnosis of substance dependence can be applied to every class of substances *except*
- caffeine.
  - nicotine.
  - cannabis.
  - opioids.

54. (219) Substance dependence is defined as a cluster of criteria occurring any time in what period of time?
- a. 3 months.
  - b. 6 months.
  - c. 9 months.
  - d. 12 months.
55. (219) A substance-related disorder that is characterized by the development of a temporary reversible substance-specific syndrome resulting from the recent ingestion of or exposure to a substance is called substance
- a. abuse.
  - b. dependence.
  - c. withdrawal.
  - d. intoxication.
56. (219) How many minutes does intoxication from an inhalant last?
- a. 20–25.
  - b. 15–20.
  - c. 10–15.
  - d. 5–10.
57. (219) What is the most abused amphetamine?
- a. Methylphenidate.
  - b. Methamphetamine.
  - c. Levoamphetamine.
  - d. Dextroamphetamine.
58. (219) What is the most widely consumed drug in western society?
- a. Caffeine.
  - b. Nicotine.
  - c. Alcohol.
  - d. Opioids.
59. (219) Which drug is considered the most potent psychoactive drug known?
- a. Dextromethorphan.
  - b. Lysergic acid diethylamide.
  - c. Gamma hydroxybutric acid.
  - d. Methylenedioxymethamphetamine.
60. (220) At what age does the onset of schizophrenia usually surface?
- a. Teens.
  - b. 20s.
  - c. 30s.
  - d. 40s.
61. (220) Patients with disorder symptoms lasting at least 1 month, but less than 6 months, have most likely been diagnosed with
- a. schizophreniform.
  - b. schizoaffective.
  - c. schizophrenia.
  - d. delusional.

62. (220) Which subtype of a delusional disorder has a prominent theme of the individual being treated maliciously in some way?
- a. Persecutory.
  - b. Erotomantic.
  - c. Grandiose.
  - d. Jealous.
63. (220) Which subtype of a delusional disorder has a prominent theme that a person, usually of higher status, is in love with the patient?
- a. Persecutory.
  - b. Erotomantic.
  - c. Grandiose.
  - d. Jealous.
64. (220) In which subtype of delusional disorder is the patient convinced that he or she possesses some extraordinary, unidentified talent or insight?
- a. Persecutory.
  - b. Erotomantic.
  - c. Grandiose.
  - d. Jealous.
65. (221) Which term is *not* a subtype for bipolar disorder?
- a. Mixed.
  - b. Manic.
  - c. Depressed.
  - d. Dysthymic.
66. (222) Which anxiety disorder is characterized by uncontrollable and unreasonable worry?
- a. Obsessive-compulsive.
  - b. Post-traumatic stress.
  - c. Generalized anxiety.
  - d. Panic.
67. (222) Which anxiety disorder is characterized by recurrent episodes of intense apprehension, terror, and impending doom?
- a. Obsessive-compulsive.
  - b. Post-traumatic stress.
  - c. Generalized anxiety.
  - d. Panic.
68. (223) Which disorder best describes a patient who reports loss or alteration of physical functioning that suggests a physical disorder, but in fact is related to the expression of a psychological conflict?
- a. Conversion.
  - b. Somatization.
  - c. Hypochondriasis.
  - d. Body dysmorphic.
69. (223) Which somatoform disorder is preoccupied with some imagined defect in physical appearance?
- a. Conversion.
  - b. Somatization.
  - c. Hypochondriasis.
  - d. Body dysmorphic.

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70. (224) The factitious disorder that is also called Munchausen Syndrome has
- combined psychological and physical signs and symptoms.
  - predominantly psychological signs and symptoms.
  - predominantly physical signs and symptoms.
  - not otherwise specified.
71. (225) Which term describes the inability to form new memories after the condition producing the amnesia occurs?
- Anterograde amnesia.
  - Retrograde amnesia.
  - Fugue.
  - Ictus.
72. (225) Which term describes a period of amnesia where the patient appears to be conscious and makes rational decisions but has no memory of the period on recovery?
- Ego-dystonic.
  - Dissociative.
  - Fugue.
  - Ictus.
73. (226) Which term is *not* one of the phases of a normal sexual cycle?
- Excitement.
  - Resolution.
  - Foreplay.
  - Orgasm.
74. (226) Which paraphilia is distinguished by recurrent sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects?
- Fetishism.
  - Voyeurism.
  - Frotteurism.
  - Exhibitionism.
75. (226) Which paraphilia involves the sexual fantasy or arousal by touching or rubbing against an unsuspecting or non-consenting victim?
- Fetishism.
  - Voyeurism.
  - Frotteurism.
  - Exhibitionism.
76. (227) Emptying the stomach by induced vomiting or emptying the bowels by induced evacuation with enemas or laxatives is called
- anorexia.
  - bulemia.
  - binging.
  - purging.
77. (228) Which parasomnia was previously referred to as dream anxiety disorder?
- Nightmare disorder.
  - Sleep terror disorder.
  - Sleepwalking disorder.
  - Parasomnia not otherwise specified.

78. (229) Which disorder is defined as individuals who have a severe discrete episode of loss of control of aggressive impulses resulting in serious assaultive acts or destruction of property that are grossly out of proportion to the precipitating stressors?
- a. Intermittent explosive disorder.
  - b. Impulse-control disorder.
  - c. Trichotillomania.
  - d. Kleptomania.
79. (229) A disorder where individuals repeatedly pull out their hair is called
- a. intermittent explosive disorder.
  - b. impulse-control disorder.
  - c. trichotillomania.
  - d. kleptomania.
80. (230) A person experiencing symptoms of nervousness, worry, and jitteriness has an adjustment disorder with
- a. anxiety.
  - b. depressed mood.
  - c. mixed anxiety and depressed mood.
  - d. disturbances of emotions and conduct.
81. (231) Instability in a variety of areas, including interpersonal behavior, mood, and self-image describes a personality disorder that is called
- a. antisocial.
  - b. borderline.
  - c. dependent.
  - d. narcissistic.
82. (231) Which personality disorder is characterized by overly dramatic, reactive, intensely expressed behavior, and have disturbances in interpersonal relationships?
- a. Histrionic.
  - b. Borderline.
  - c. Dependent.
  - d. Narcissistic.
83. (231) Which personality disorder is characterized by frequent suspiciousness, hypersensitivity, jealousy, envy, and an excessive sense of self-importance?
- a. Obsessive-compulsive.
  - b. Schizotypal.
  - c. Paranoid.
  - d. Schizoid.
84. (231) Which personality disorder is characterized by individuals who have a defect in their capacity to form social relationships evidenced by the absence of warm and tender feelings for others and an indifference to praise, criticism, and the feelings of others?
- a. Obsessive-compulsive.
  - b. Schizotypal.
  - c. Paranoid.
  - d. Schizoid.
85. (232) Which of the following drugs is often given to patients who are withdrawing from alcohol?
- a. Tranxene.
  - b. Librium.
  - c. Valium.
  - d. Xanax.

86. (232) Which substance is *not* considered an antidepressant?
- a. Selective Norepinephrine Reuptake Inhibitors (SNRI).
  - b. Selective Serotonin Reuptake Inhibitors (SSRI).
  - c. Anxiolytics.
  - d. Tricyclic.
87. (232) What drug is most often used by people who successfully complete suicide?
- a. Seconal.
  - b. Amytal.
  - c. Nesbutal.
  - d. Luminal.
88. (233) Which V code is used when the focus of attention or treatment is an interpersonal problem that apparently is not due to a mental disorder?
- a. Relational problems not otherwise specified.
  - b. Parent-child relational problem.
  - c. Partner relational problem.
  - d. Sibling relational problem.
89. (233) Which V code is used when the focus of attention or treatment is on rivalry between brothers and sisters to such a degree it disrupts normal family functioning?
- a. Relational problems not otherwise specified.
  - b. Parent-child relational problem.
  - c. Partner relational problems.
  - d. Sibling relational problems.
90. (234) Which V codes focus involves adjusting to moving to another country and attempting to fit into unfamiliar surroundings?
- a. Acculturation problem.
  - b. Assimilation problem.
  - c. Phase of life problem.
  - d. Relocation problem.

## **Student Notes**



## Unit 3. Family Maltreatment Interventions

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**E**VERY FAMILY HAS UNIQUE characteristics that blend individual personalities together to form a cohesive group. Unfortunately, cohesion is not always the interaction that occurs among family members. In this lesson, you'll study the characteristics of violent families and define the forms of abuse that can occur. You'll also identify resources that are available for both the victim and the offender.

Family violence, or domestic violence, as it is sometimes called, entails a range of harmful behaviors. You may have thought the professional nature of the military exempted it from many of the civilian community's woes as it relates to family violence. This simply isn't the case and as a 4C0, you can expect to be exposed to family violence if you work in the Family Advocacy Program (FAP). Your ability to remain objective will be paramount.

### 235. Dimensions of family violence

You will need to familiarize yourself with the Air Force's recognized dimensions of abuse which will be defined in the following information. Let's begin by identifying the different kinds of both child and spouse abuse.

#### Child

A child is an unmarried person under the age of 18 who is eligible for care through a Department of Defense (DOD) military treatment facility (MTF). The term "child" means a baby, youth, toddler, adolescent, teenager, etc., who is related to the sponsor biologically, or is adopted, or is a stepchild, a foster child, or ward. The term also includes an individual of any age who is incapable of self-support because of a mental or physical incapacity and for whom care in a medical treatment facility (MTF) is authorized.

#### Child emotional maltreatment

Child emotional maltreatment is defined as acts or a pattern of acts, omissions or a pattern of omissions, or passive-aggressive inattention to a child's emotional needs resulting in an adverse effect upon the child's psychological well-being. Maltreatment includes intentional berating, disparaging, or other verbally abusive behavior toward the child, and violent acts that may not cause observable injury. An emotionally maltreated child manifests low self-esteem, chronic fear or anxiety, conduct disorders, affective disorders, or other cognitive or mental impairment.

#### Child neglect

Child neglect refers to a type of child abuse/maltreatment whereby a child is deprived of needed age-appropriate care by act or omission of the child's parent, guardian, or caregiver under circumstances indicating the child's welfare is harmed or threatened. Child neglect is identified in the following examples:

Name of Child Neglect	Description
Abandonment	Neglect in which the caregiver is absent and does not intend to return or is away from the home for an extended period without having arranged for an appropriate surrogate caregiver.
Deprivation of necessities	Neglect that includes the failure to provide appropriate nourishment, shelter and clothing.

Name of Child Neglect	Description
Educational neglect	Neglect that includes knowingly allowing the child to have extended or frequent absences from school, neglecting to enroll a child in school, or preventing the child from attending school for other than justified reasons.
Lack of supervision	Neglect characterized by the absence or inattention of the parent, guardian, foster parent, or other caregiver that results in injury to the child, in the child being unable to care for him/herself, or an injury or serious threat of injury to another person because the child's behavior was not properly monitored.
Medical neglect	Neglect in which a parent or guardian refuses or fails to provide appropriate, medically necessary healthcare for the child although the parent is financially able to do so or was offered other means to do so.
Non-organic failure to thrive (FTT)	Neglect which manifests itself in an infant's or young child's failure to grow and develop when no organic basis for this deviation is found. Usually such children register below the third percentile in height and weight.

### **Child physical abuse/maltreatment**

This includes any of the following acts such as grabbing, pushing, holding, slapping, choking, punching, kicking, sitting or standing on, lifting and throwing, burning, immersing in hot liquids or pouring hot liquids on, hitting with an object (such as a belt or electrical cord), and assaulting with a knife, firearm, or other weapon that caused or may cause bodily injuries. Such injuries include brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocations or sprains, internal injury, poisoning, burns or scalds, severe cuts, lacerations, bruises, or welts. In infants and toddlers, abusive acts include shaking or twisting, which may cause brain damage, subdural hemorrhage, and hematoma. An injury does not have to be visible for physical maltreatment to be present.

### **Child Sexual Maltreatment**

Child sexual maltreatment refers to any incidents of sexual activity with a child for the purpose of sexual gratification of the alleged offender or some other individual.

#### ***Exploitation***

Exploitation is sexual maltreatment in which the victim is made to participate in the sexual gratification of another person without direct physical contact between them. Exploitation includes forcing or encouraging a child to do any of the following:

- Expose the child's genitals or (if female) breasts.
- Look at another individual's exposed genitals or (if female) breasts.
- Observe another's masturbatory activities.
- Forcing/encouraging the child to view pornographic photographs or read pornographic material.
- Hear sexually explicit speech.
- Forcing/encouraging the child to participate in sexual activity with another person, such as in pornography or prostitution, in which the alleged offender does not have direct physical contact with the child.

#### ***Molestation***

Fondling or stroking of a child's breasts or genitals, oral sex, or attempted penetration of the child's vagina or rectum.

#### ***Rape/intercourse***

Sexual intercourse between an alleged offender and a child that involves the penetration of the vagina or rectum, however slightly, by means of physical force. The penetration may result from emotionally manipulating the child or taking advantage of a child's naiveté rather than physical force.

***Other sexual maltreatment***

All other types of child sexual abuse or maltreatment not included in the definitions of “exploitation,” “molestation,” or “rape/intercourse.”

***Spouse***

The term *spouse* refers to an individual who is married and who is eligible for benefits in the MTF. This may include an individual less than 18 years of age.

***Spouse neglect***

This is the failure of a spouse to provide necessary care or assistance for his or her spouse who is incapable of self-care physically, emotionally, or culturally.

***Spouse physical abuse/maltreatment***

This is described as physical harm, mistreatment, or injury of a spouse by the other spouse. Examples of what constitutes spouse physical abuse/maltreatment include grabbing, pushing, kicking, sitting or standing on, hitting with an object and assaulting with a knife, firearm or other weapon that caused or may cause bodily injuries. Such injuries include brain damage, skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocations or sprains, internal injury, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts.

***Spouse sexual abuse/maltreatment***

Spouse sexual abuse/maltreatment includes the use of physical violence, intimidation, or explicit or implicit threat of future violence by a spouse or to coerce the other spouse to engage in any sexual activity; sexual intercourse between an alleged offender and a spouse that involves the penetration of the vagina or rectum, however slight, by means of physical force; or sexual abuse of a spouse to participate in sexual activity with another person, as in pornography or prostitution.

**236. Family characteristics of abuse and neglect**

This unit began by recognizing the uniqueness each family possesses to form a cohesive group. Abusive families also share uniqueness in the sense that they all have characteristics that are common to a majority of violent families. Society’s willingness to accept or justify abuse often provides a platform for which violence is tolerated. For example, a spouse’s use of violence is sometimes considered legitimate if their partner is having an extramarital affair. Historical attitudes toward women and children, particularly the belief that women and children are property, often enhances the notion of violence as an acceptable means to resolve problems.

Let’s look at four factors common to violent families, to include multigenerational transmission, social isolation, use and abuse of power, and alcohol and drug abuse.

***Multigenerational transmission***

Multigenerational transmission relies on the concept that the abusive or violent behavior is learned or modeled after an adult; usually a parent. The social learning theory related to violence endorses the idea that violence is an acceptable or legitimate behavior to solve problems. The child who is privy to violence learns specific aggressive behaviors and then as an adult will often rely on this learned behavior and respond with violence.

Multigenerational transmission also endorses the idea that adults who abuse children were often abused as children themselves. Of course, there is no predestination in the child’s future foretelling that because he or she was abused, the individual will grow up to be an abusing adult. Many people who were abused as children have consciously or otherwise not engaged in abusive behavior. The context of the abuse one may have suffered is usually a factor as well. With this said, it is widely believed that children who witness parental violence during childhood or adolescence is considered one of the strongest indicators for spouse abuse in adulthood.

***Social isolation***

A family structure that includes violence is often isolated from other family members, friends, neighbors, etc. This is a purposeful approach by the abuser to keep their behaviors from being exposed. As was discussed in the introduction, some abuse is historically ignored, particularly if it involves a disobedient child or a cheating partner; however, some abuse is so heinous or considered abnormal or illegitimate that the abuser will attempt to isolate the family members.

***Use and abuse of power***

The need for abusers to exercise control over their victim is part of the abuse cycle. A male figure in the home who sexually abuses a female child in the home uses his authority or position of power to victimize the subordinate. Power issues are usually the key element in spouse abuse. Spouse abuse will generally involve trivial events that are escalated or twisted into a power struggle. Any amount of independence the spouse attempts to exercise is met with resistance and contempt. The spouse's attempt to work, attend school, or make financial decisions are unacceptable in the spouse abusers mind.

***Alcohol and drug abuse***

Victims of abuse often report substance abuse as a factor in their abuse. This is not to say that every person who abuses substances is consistently violent or that people who are violent must be under the influence of a substance. What is known, however, is there is a much greater risk of being seriously abused if the abuser is intoxicated. Alcohol in particular removes inhibitions and people use less judgment in their decision making process. Studies on aggressiveness have shown that heroin and marijuana are rarely involved in a domestic violence incident. However, such illicit drugs as crack, cocaine, amphetamines, mescaline, Phencyclidine (PCP), and steroids have been involved with increased violence.

It should be noted that substance abuse/dependence and child/spouse abuse, which may occur in tandem, are entirely separate treatment issues. Simply treating the alcoholic will not make him or her less abusive anymore than treating the abuser will make him or her drink alcohol less. The two issues are entirely separate treatment issues and should be approached as such.

**Reporting**

Air Force Instruction (AFI) 40-301, *Family Advocacy*, mandates all Air Force active duty personnel, as well as civilians, to report any instance of suspected family maltreatment. The FAP is responsible for providing specialized training to all medical personnel and childcare providers on base. The only exclusion to the mandatory reporting requirement is clergy receiving information in a penitent-clergyman relationship or receiving confidential communications in the course of their duties. The Area Defense Counsel (ADC) is also exempt if they receive the information during an established attorney-client relationship.

**237. Methods of victim safety**

You hope to never have to identify the resources that exist for the safety of a victim of abuse, but should it occur, you will need to be knowledgeable and resourceful in your capacity when asked to participate. Once an incident of child or spouse abuse/maltreatment has occurred, or the potential for additional abuse is evident, the safety of the victim is paramount. The following areas will outline responsibilities as well as methods and resources for victims of child or spouse abuse/maltreatment.

**Responsibilities**

The Family Advocacy Committee (FAC) is responsible for developing installation policy and procedures to ensure victim safety. This is usually accomplished via a Memorandum of Understanding (MOU) in the continental United States (CONUS) between Child Protective Services (CPS) and the Family Advocacy Program (FAP).

***Child victim safety***

Unable or unwilling to protect themselves, children often need a voice of sound judgment and advocacy. Advocacy for safety on behalf of the child may include the removal of the child from an abusive situation or a situation that may become abusive, as in the instance of a parent or guardian abusing the child in a retaliatory manner for revealing abuse in the home. Several options are available to assist victims of abuse depending on the incident, age, and relationship with the offender. CONUS abuse allegations that involve a child that is in danger and immediate action must be taken to remove a child from the home without parental consent or in their absence will require the intervention of the local CPS or equivalent. This is an example of the importance of maintaining an MOU with the local CPS office. The Air Force FAP does not have the authority to remove children from their home.

Outside the continental United States (OCONUS) in overseas areas, not covered by agreements with the host country CPS or equivalent services, the Family Maltreatment Case Management Team (FMCMT), FAC, and senior wing leadership will develop policies and procedures in high-risk situations for temporary arrangements. The FAP is not responsible for any form of foster care in overseas locations.

Several factors are considered to determine the need to remove a child from the home. With this said, removing a child, or children, from the home is the least desirable outcome and will usually only be engaged as a last resort. Circumstances that require further consideration include:

- Severity and frequency of the alleged abuse.
- Nature of any threats.
- Offender access to the victim.
- Available support systems and their ability to ensure the safety of the child.
- Drug or alcohol involvement.
- Impulse control and stress levels of the alleged offender/perpetrator.
- Suicide risk.

A child is in greater need of protection when any of the following are observed:

- There is no supportive, protective caretaker and the alleged offender would be the primary caretaker.
- The alleged offender denies knowledge of the maltreatment despite obvious to the contrary or refuses to take responsibility for his or her actions related to the maltreatment or states the child victim is lying about the maltreatment incident.
- The alleged offender appears angry with the child.
- The alleged offender expresses no remorse for injuring the child, lacks empathy/compassion for child's feelings or fears in this situation.
- The alleged offender refuses to agree to discontinue corporal punishment of a child or children until the FAP assessment process is complete.
- The alleged offender threatened to kill the victim or to inflict bodily harm for noncompliance or disclosure.
- There were bizarre or ritualistic acts performed as part of the abuse.
- Sexual abuse occurred.
- The alleged offender incapacitated the victim with drugs or alcohol.
- Both parents or caretakers participated in the abuse of the child.
- The victim sustained serious injury requiring medical exam/treatment and the alleged offender still has access to the child.

- The non-offending caretaker does not believe the child's story and voices support for the offender.

In CONUS only CPS, immediately followed by a civilian court order, can carry out emergency separation of children from their families.

### ***Adult victim safety***

When spouse abuse occurs, it is sometimes difficult to ascertain the gravity of the problem for a variety of reasons. Many victims will minimize the danger to cope emotionally with their situations. Others may minimize to protect their abusive spouse, particularly if the abuser is active duty and has convinced the victim that any revelation regarding abuse will result in a complete loss of benefits and pay for the family. The victim may feel trapped and fear the consequences to the family unit or their abusive spouse if they report the violence.

The following factors should be considered when assessing risk:

1. Offender access to the victim.
2. Severity, frequency and violence or other maltreatment in the relationship.
3. Nature and extent of threats used.
4. Psychological state of the offender.
5. Psychological impact of spouse abuse on the children.
6. Likelihood of suicide by the offender/victim/children.
7. Availability of weapons to the offender/victim.
8. Offender's and victim's response to recommendations.
9. Parent(s) ability to provide appropriate care for the children.
10. Relevant history such as previous charges for violent crimes, separations, restraining orders.
11. Previous violations of restraining orders.
12. Recent triggers such as initiation of divorce proceedings or legal charges.
13. Obsession with partner, which may include stalking behaviors.
14. Increased use or abuse of alcohol or drugs.
15. Victim's level of fear and reports of significant change in alleged offender's recent behavior.

If a spouse is in danger and immediate action must be taken to provide for his or her safety, options to remove the offender from the home must be entertained. If the victim does not feel safe, arrangements such as a shelter, a friend, or community resources for the spouse, victim, and any children involved, should be considered.

The Staff Judge Advocate (SJA) may provide assistance in maltreatment incidents through the Victim and Witness Assistance Program. This program may provide services such as temporary housing, victim advocates, and transportation to court.

## **238. Resources for victims and offenders**

Despite all the prevention efforts offered and provided by Family Advocacy, family violence affects the entire family structure. Knowing the resources available, both on base and off, as well as the limitations and parameters you can work within, will prove beneficial.

Stopping the violence and teaching families acceptable coping mechanisms will be the challenge of the Family Advocacy staff.

### **Resources for victims**

Interventions with victims of maltreatment will require a complete understanding and assessment of the patient's needs. Resource matching will be age-appropriate and tailored to the specific needs of

the child or adult. Unfortunately, many victims are so wrapped up in the victimization cycle and feel it is impossible or dangerous to seek help. The victims may feel the offenders could become more violent, or fear the unknown of being on their own or living as single parents. As a result, they won't get the support needed from family and friends. Consequently, you will probably see a large mix of both voluntary and involuntary participants to the Family Advocacy Program.

### ***Voluntary participants***

Treatment options and interventions offered by Family Advocacy include the following:

- Teaching the dynamics of family maltreatment, including power and control issues
- Guidance regarding safety risks and assistance in developing safety plans
- Identification of dynamics of the family unit
- Mechanisms to empower the victims
- Promoting healthy autonomous behaviors in relating to others
- Promoting effective parenting behaviors
- Identifying needed social resources to decrease social isolation
- Teaching non-violent conflict resolution skills to couples

For children, the treatment options should be tailored to accommodate their age specific needs. The efforts should focus on assisting a child in feeling safe, including the following: restoring the child's sense of power and control, teaching him or her identification and appropriate management of warning signs and dangerous situations, building his or her assertiveness and self-protective skills, teaching him or her the importance of breaking secrecy, and developing trust in appropriate social and family support systems. The current and future safety of the child continues to be an important focus and an ongoing task of effective treatment.

FAP staff should familiarize themselves with federal and state laws regarding a child's ability to consent to treatment without parental consent or knowledge. The base SJA can provide legal guidance and parameters for working with children. In the case of a child not of the age of consent, only one parent's consent for treatment is required. If the child is not of the age of consent and both parents refuse to give consent, the FAP staff should assess based on the presenting information whether the refusal constitutes significant harm to the child. An assessment for medical neglect may be indicated.

Treatment resources for victims, child or adult, of sexual maltreatment may include specialized treatment programs conducted by selected individual providers with expertise in this area. If these services are not available in the local area and the FMCMT cannot arrange the appropriate services, a reassignment may be indicated.

### ***Non-volunteers***

Victims of maltreatment cannot be mandated into treatment; however, FAP providers will offer services and intervention, with participation on a voluntary basis. When victims choose not to participate, the FAP services clinicians will still address safety needs and will offer the following:

- Ongoing information regarding identified safety issues.
- Availability of services at a later date.
- Information regarding local victim services.

### **Resources for offenders**

The treatment decision that the FMCMT labels as substantiated is a treatment term only, not a legal determination. The perpetrators of any maltreatment are referred to as "alleged offenders" as the decision has not been deemed a violation of the law by a court of law.

FAP providers will secure a treatment regimen that focuses on long-term behavioral modification techniques. If treatment is solicited or obtained off base, the client will sign a release of information

for the FAP staff and off base provider to provide Family Advocacy with case summaries from the off base provider so the case manager can monitor the alleged offender's participation.

Accountability will be emphasized during the intervention process. Occasionally, during the intervention process, the alleged offender may choose to separate or divorce from their spouse in an attempt to avoid or decline treatment as they are no longer married. This does not excuse the alleged offender from treatment. Intervention plans will be amended as necessary and continue for all eligible beneficiaries. The behavior which caused the alleged offender to be identified still must be addressed.

Services may also be available in the community for husbands who are batterers. You may be asked to assist in locating and identifying resources in the community for a continuity book. The court system is an excellent source of information to begin and can provide you with approved intervention programs.

The FAP staff will not provide sex offender treatment.

### **239. Programs under the family advocacy prevention program**

The family advocacy prevention program provides not only treatment services but also prevention. Working with the family advocacy staff will allow you the opportunity to become involved in many prevention activities. This lesson will cover both the primary and secondary areas of prevention with which you need to be familiar.

The purpose of the family advocacy prevention program is to enhance mission and family readiness by reducing the number and severity of incidents of maltreatment through advocacy for nonviolent communities.

Prevention efforts are accomplished through a variety of formal programs as well as briefings such as the ones provided to commanders and first sergeants. All new commanders and first sergeants receive FAP orientation training within 60 days of their arrival or assumption of command. All commanders and first sergeants receive annual Family Violence Education and Prevention training within 180 days of the fiscal year.

#### **Primary prevention**

Primary prevention services in family advocacy are targeted at all members of the community and offered on a voluntary basis. These services specifically offer prevention training/education to leadership, active duty personnel, school age youth, and adult family members. The family advocacy outreach manager (FAOM) is the team coordinator for primary prevention services. As a mental health journeyman, you can expect to have a role in planning, coordinating, or providing some of the primary prevention.

Primary prevention uses special events to promote family violence awareness such as during Child Abuse Prevention Month and Domestic Violence Prevention Month. A variety of other venues are employed as well. The media, base paper, and other community activities may provide opportunities to gain exposure as well.

#### **Secondary prevention**

Secondary prevention activities address specific risk factors that contribute to family maltreatment. Participation in any secondary prevention program is voluntary; however a screening of need must be accomplished to participate. In other words, there is an attempt to ensure the client is participating in the appropriate program for the maximum benefit.

Secondary services include, but are not limited to:

- New Parent Support Program (NPSP).
- Family Advocacy Strength based Therapy (FAST).



- Advocacy and support groups for pregnant teens, single parents, new parents, and geographically separated spouses.
- Skill building classes for at-risk groups.

Skill building classes include the following:

- Anger Management.
- Couples Communication.
- Conflict Resolution.
- Transition into Parenthood.
- Newborn Language.
- Newborn Care.
- Child Growth and Development.
- Parenting.
- Fatherhood.

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### Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

#### **235. Dimensions of family violence**

1. Define child emotional maltreatment.
2. Define non-organic failure to thrive.
3. Identify what behaviors are included in child sexual exploitation.
4. How does the Air Force classify a spouse in terms of the need for intervention?

#### **236. Family characteristics of abuse and neglect**

1. What is multigenerational transmission?
2. What AFI mandates the reporting of suspected family maltreatment?

#### **237. Methods of victim safety**

1. In the CONUS, what agencies are included in a Memorandum of Understanding (MOU) as part of an installation policy?

2. What factors require further consideration when a determination to remove children from a home is entertained?
3. What are some reasons why victims of spouse abuse will minimize the incident?

**238. Resources for victims and offenders**

1. In the case of a child not of the age of consent, does the child need consent and if so who consents?
2. What happens when the appropriate services a family may need are not available in the local area?
3. What happens to the treatment process if the alleged offender chooses to separate or divorce during treatment?

**239. Programs under the family advocacy prevention program**

1. Who is the target of family advocacy primary prevention services?
2. What services are included in the family advocacy secondary services?
3. What kind of skill building classes is offered in secondary services?

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**Answers to Self-Test Questions****235**

1. Acts or a pattern of acts, omissions or a pattern of omissions, or passive-aggressive inattention to a child's emotional needs resulting in an adverse effect upon the child's psychological well-being.
2. Neglect which manifests itself in an infant's or young child's failure to grow and develop when no organic basis for this deviation is found.
3. Exploitation includes forcing or encouraging a child to do any of the following: expose the child's genitals or (if female) breasts; look at another individual's exposed genitals or (if female) breasts; observe another's masturbatory activities; forcing/encouraging the child to view pornographic photographs or read pornographic material; hear sexually explicit speech; forcing/encouraging the child to participate in sexual activity with another person, such as in pornography or prostitution, in which the alleged offender does not have direct physical contact with the child.

4. An individual who is married and who is eligible for benefits in the MTF. This may include an individual less than 18 years of age.

**236**

1. The concept that the abusive or violent behavior is learned or modeled after an adult, usually a parent.
2. AFI 40-301, *Family Advocacy*.

**237**

1. Child Protective Services (CPS) and FAP.
2. Severity and frequency of the alleged abuse; nature of any threats; offender access to the victim; available support systems and their ability to ensure the safety of the child; drug or alcohol involvement; impulse control and stress levels of the alleged offender/perpetrator; suicide risk.
3. Many victims will minimize the danger in order to cope emotionally with their situations. Others may minimize to protect their abusive spouse, particularly if the abuser is active duty and has convinced the victim that any revelation regarding abuse will result in a complete loss of benefits and pay for the family. The victim may feel trapped and fear the consequences to the family unit or their abusive spouse if they report the violence.

**238**

1. Only one parent's consent is needed.
2. The FMCMT cannot arrange the appropriate services, a reassignment may be indicated.
3. This does not excuse the alleged offender from treatment. Intervention plans will be amended as necessary and continue for all eligible beneficiaries. The behavior which caused the alleged offender to be identified still must be addressed.

**239**

1. All members of the community and offered on a voluntary basis.
2. New Parent Support Program; family Advocacy Strength-Based Therapy Services; advocacy and support groups for pregnant teens, single parents, new parents, and geographically separated spouses; skill building classes for at-risk groups.
3. Anger Management; Couples Communication; Conflict Resolution; Transition into Parenthood; Newborn Language; Newborn Care; Child Growth and Development; Parenting; Fatherhood.

**Do the unit review exercises before going to the next unit.**

### Unit Review Exercises

91. (235) What kind of child neglect is characterized by failure to provide appropriate nourishment, shelter, and clothing?
- Deprivation of necessities.
  - Lack of supervision.
  - Medical neglect.
  - Abandonment.
92. (235) What form of child sexual maltreatment is characterized by the victim being made to participate in the sexual gratification of another person without direct physical contact between them?
- Other sexual maltreatment.
  - Exploitation.
  - Molestation.
  - Rape.
93. (236) Which one of the following is not a common factor in violent families?
- Social isolation.
  - Socially impoverished.
  - Alcohol and drug abuse.
  - Multigenerational transmission.
94. (237) Who is responsible for developing installation policy and procedures to ensure victim safety?
- Staff Judge Advocate (SJA).
  - Area Defense Counsel (ADC).
  - Family Advocacy Committee (FAC).
  - Family Maltreatment Case Management Team (FMCMT).
95. (237) Who can provide assistance in maltreatment incidents through the Victim and Witness Assistance Program?
- Staff Judge Advocate (SJA).
  - Area Defense Counsel (ADC).
  - Family Advocacy Committee (FAC).
  - Family Maltreatment Case Management Team (FMCMT).
96. (238) What is the proper treatment term of identifying the individual who may have committed an act of family violence?
- Alleged offender.
  - Accused offender.
  - Active duty member.
  - Abuser.
97. (239) Within how many days of assuming command do commanders and first sergeants receive Family Advocacy Program (FAP) orientation?
- 15.
  - 30.
  - 45.
  - 60.

## Unit 4. Traumatic Stress Response

240. Types of disasters and human responses .....	4-1
241. Pre-exposure preparation training.....	4-5
242. Group informational briefing.....	4-7

**W**E LIVE IN A POST 9-11 era where the improbable no longer seems impossible. Very real threats of attack and mayhem permeate our daily activities. Who could have ever fathomed the complete destruction of the World Trade Center or an attack on the very power center of our military, the Pentagon? There is an uneasiness that lies just below the surface as we go about our lives. How do we prepare ourselves and our patients for the unknown without creating fear unnecessarily? There is a balance and we will discuss each aspect of traumatic stress response in this section.

Some events are so traumatic that no matter how experienced the first responder is, or how prepared an individual may appear, it can still be overwhelming. Your abilities as a Mental Health Journeyman to respond to contingencies and disaster situations depend largely on the extent of preparation and training you have received as well as social maturity. Maturity is mentioned many times throughout these career development courses (CDC) with emphasis. This is for good reason. Immaturity has no place in the mental health treatment arena and will dismantle whatever confidence may have been gained. Remember, respect is lost much quicker than earned.

### 240. Types of disasters and human responses

In this lesson, you will become familiar with defining disaster, pre-exposure preparation, and expected psychological responses to disasters so you can effectively discuss traumatic stress responses. The Air Force has implemented Traumatic Stress Response (TSR) as a formal response to unexpected incidences that can adversely impact individual effectiveness via Air Force Instruction (AFI) 44-153, *Traumatic Stress Response*.

According to AFI 44-153, the primary goal of TSR teams is to foster resiliency in those exposed to potentially traumatic stress. This is accomplished through preparatory education for those likely to experience potentially traumatic stress, and through education, screening, psychological first aid, and referral for those exposed to potentially traumatic stress. Before going fully into TSR in the next learning objective, let's discuss the classifications of potential disasters, periods of disaster, and the five reactions to disaster.

#### Classification of potential disasters

There are many possible classifications for disasters which may have important consequences with regard to the way people react and the types of help required. From the prevention and preparedness viewpoint, the following classifications are generally used:

- Natural disasters—Earthquakes, flood, cyclone, hurricane, tornado, landslides, volcanic eruption, and drought.
- Man-made disasters—Terrorist attacks, technological disasters such as toxic, chemical and nuclear accidents, dams collapse, transportation accidents, and humanitarian disasters (due to conflict, war, or genocide).

#### Periods of disaster

During a disaster there will generally be five different periods. Knowing what to expect from individuals during these various periods will be of great help to you when you are called to respond to a disaster or emergency situation.

- Pre-impact period.
- Warning period.

- Impact period.
- Immediate reaction period.
- Period of delayed response.

### ***Pre-impact period***

The pre-impact period can be said to exist whenever there is a high probability that disaster will occur within a time period from weeks to months. The behavior of an individual during this period will usually consist of *under-activity* or non-effectiveness. They will normally take no constructive or defensive measures to prepare for the impact of the disaster. If they seriously consider the situation, they will certainly increase their level of anxiety.

Therefore, during this period the average person will attempt to escape from reality and either denies that a problem exists or adopts a fatalistic attitude to justify his lack of preparation for the emergency. They may also adopt various rationalizations which will prove that an emergency will not occur. Such apathy and disinterest during this period are usual reactions.

In an era of color-coded warnings regarding the potential of a terrorist attack, you can observe some of these periods as individuals react to the vacillating threat. Arbitrarily or frequent fluctuations in the warnings without any observable terrorist activity often causes the public to become complacent or even distrustful of the warnings themselves.

### ***Warning period***

The warning period of approaching danger is usually minutes or hours in duration. Behavior during this period is often manifested by *over-activity*. People who are unprepared or do not have anything to do will spend their time frantically attempting to seek information as to how they can evade the impending impact. Disorganized or destructive behavior may result and some people may respond to the warning as if the disaster has already occurred. These people can be grouped into the following two types:

1. There are those who have undergone a previous disaster in which they were helpless. As a consequence, they have developed a specific fear or helpless response to disaster or its warning.
2. There are those who always become helpless in any dangerous situation.

Both types may be recognized by their reactions under stress. Overactive behavior and a tendency to flee during this period may occur and have often been described as panic. However, flight in itself is not considered abnormal behavior, because it may be the best action to take for survival. More important is whether people flee in the proper direction and use good judgment in deciding whether to take flight or seek shelter.

### ***Information reliability***

People will be searching for reliable information during this period. Confusion and over anxiousness behavior often result from lack of clear warnings and relevant information. The needs of the individuals involved in the emergency situation should be met as soon as possible to prevent possible blind flight.

The reliability of the warning is also a factor to the reaction of individuals. Warnings of emergencies that do not occur are generally well received if the people are convinced the disaster could have actually happened. People will resent even the well intentional warnings that are prematurely over cautious.

### ***Impact period***

People will experience many frightening feelings during the period of impact. Although behavior has been established by drills and training, the immediate effect of the disaster will probably result in a temporary period of confusion.

Again, if you will reflect on the impact period of September 11th, there was mass confusion. Who's in charge? Should everyone be seeking shelter? Who's attacking the United States?

### ***Immediate reaction period***

This period is sometimes called the *recoil period*. During this period, immediately after the impact, some people will begin to observe conditions in the area and start constructive activity. They will try to understand the catastrophe that has just taken place. Each person may feel that only they have been the victims. They may feel a shocking sense of loneliness and loss. As they realize the extent of the damage and find there are others in the same condition, they will mostly likely feel blessed or thankful that they are still alive.

People usually react to a catastrophe within minutes. When their reaction is delayed, they may demonstrate under-activity, helplessness, aimless wandering, dazed apathy, or mute, motionless behavior. This has been referred to as *critical incident stress reaction*. People in this state are unable to cope with any effects which follow the disaster such as fire, explosion, or collapse of building.

Those who show a more severe emotional reaction, and cannot be influenced by the usual means of communication, should be sent to a medical facility. These individuals will seem "shocked" and unable to respond to even simple direction. They are best treated as soon as possible and as near the disaster site as possible. Evacuation and hospitalization will only confirm to them that they are helpless.

Those who are unhurt or slightly injured will soon become active. He or she will walk around the scene attempting to locate associates and will attempt to understand the extent of the damage. Rumors, as well as strange sights and sounds may add to their anxiety.

Non-effective behavior during this period may prove very damaging. Conceivably, more than at any other time, effective action will save lives, diminish disability, reduce abnormal behavior, and often limit confusion. The resumption of normal behavior is important to the person and the organization.

### ***Period of delayed response***

This last stage, the delayed-response period begins when immediate danger from the disaster has passed. Characteristically, there is a rising tide of activity. Reactions from the disaster may be observed in a majority of the survivors, but will tend to subside within a few days. These reactions may include insomnia, digestive problems, nervousness, and other such results of emotional tension.

Those who have lost loved ones, their homes, or valued possessions will slowly begin to appreciate and define the extent of the problem. Some will have a tendency to show anger or resentment toward those administering the emergency plan or other organizations or individuals the survivors can blame for their predicament. Cases of delayed apprehension may develop, especially if there is a danger of the repetition of the disaster impact.

Victims during this period have a tendency to move toward each other. Group feelings and loyalties may develop initially. Later, survivors may become angry and look for areas on which their hostility can be expended. Those who have not suffered from the disaster may find themselves the targets of such hostility or resentment.

As soon as the threat has passed, it is important that everyone be informed that danger no longer exists. However, some people may be incapable of speaking or carrying on a conversation. Information should be given to them by facial expressions or signs. If they know the danger is over, they will have some sense of security.

### **Five reactions to disaster**

The reaction of people to a disaster can be divided into five general categories:

- Normal reaction.
- Depressed reaction.

- Overactive responses.
- Physical reactions.
- Individual panic or blind flight.

Most of these reactions have already been mentioned as the normal temporary responses of many to unusual stresses. Equipped with this information, you will be better prepared to respond and understand an individual's reaction in a danger situation. Study the list of principle responses to disaster reactions; it provides you with some additional information that will be helpful in the future when you respond to a disaster or emergency situation.

Principle Responses and Reactions To Disaster			
Reaction	Symptoms	Do's	Don'ts
Normal (Quickly regaining control)	Perspire. Tremble. Feel nauseated. Momentarily confused.	No Help Required.	
Individual panic (Blind panic)	Unreasonable attempt to flee. Loss of judgment. Uncontrollable weeping. Wild running about.	Try gentle firmness first. Give something to eat or drink. Get help, if necessary, to isolate.	Don't use brutal restraint. Don't strike. Don't administer sedative or give alcohol.
Depressed (Psychomotor retardation, numbed)	Stand or sit without moving or talking. Vacant expression. Seem to be without emotion.	Establish contact gently. Try to get them to tell you what happened. Tell them what you think may have happened. Assign simple, routine job. Give something to eat or drink.	Don't tell them to snap out of it. Don't overwhelm with pity. Don't feel resentful toward them or show it. Don't administer sedatives or give alcohol.
Overactive	Argumentative. Talk rapidly. Joke inappropriately. Make endless suggestions. Jump from job to job.	Give them your attention for a few minutes to talk about disaster. Find them jobs which require physical activity. Give something warm to eat or drink.	Don't tell them they shouldn't feel the way they do. Don't administer sedative or give alcohol. Don't argue with them.
Physical	Severe nausea and vomiting. Conversion hysteria (can't use some part of body).	Show them you are interested. Try to find them some small job to make them forget disability. Make comfortable to await medical help. Give something warm to eat or drink.	Do not tell them there is nothing wrong with them. Do not blame or ridicule.



## 241. Pre-exposure preparation training

Your role as a Mental Health Journeyman in preparing for pre-exposure preparation (PEP) training will include researching the anticipated environment and conditions of the event which the target audience will be exposed. You may also be asked to present information to prepare the individuals for what they can anticipate upon arrival or for participation in a disaster.

PEP attempts not only to prepare participants for what they may encounter at the scene but also for how they may respond emotionally and physiologically. Again, the emphasis will be on the normalcy of the feelings of stress in an abnormal situation. Focus on practicing effective stress management and avoiding ineffective and destructive approaches. With this said, PEP is not a seminar on stress management, but rather designed to focus on preventative aspects.

Potentially traumatic events are defined as direct exposure or personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity, learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, and mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disaster, severe automobile accidents, or being diagnosed with a life-threatening illness.

Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or close friend; learning about the sudden, unexpected death of a family member or a close friend, or learning that one's child has a life-threatening disease.

The senior wing commander or installation commander at each active duty Air Force installation with a medical treatment facility will ensure the establishment of at least one TSR, with a privileged Life Skills provider designated as the TSR team chief. At geographically separated units and bases without medical treatment facilities, the need to provide TSR services can be met by ensuring there is a TSR team available to respond as needed. TSR teams will assist individuals and units in preparing for and dealing with potentially traumatic events. When forming these teams, commands should consider TSR resources available through nearby active and/or Air Force Reserve Command/Air National Guard (AFRC/ANG) military installations.

### Traumatic Stress Response team membership and formation

TSR teams will be composed of individuals fulfilling the following roles:

TSR Teams	Description of Individual Roles
Life Skills	Typically a psychiatrist, psychologist, social worker, mental health nurse, 7-level mental health technician, or fully-trained 5-level if assigned with one of the above. Again, a privileged Life Skills provider serves as the TSR team chief.
Spiritual Support	A chaplain and chaplain assistant.
Family Support Center	A community readiness consultant.

NOTE: Personnel from the above areas who may be deployed are highly encouraged to be selected as team members, or if not, to participate in TSR training to enable them to apply TSR training in deployed situations.

These multidisciplinary teams will include, as a minimum, individuals in each of the three roles noted, with at least one officer. Identification and training of primary and alternate members for each role is required to ensure continuous availability.

The TSR team chief may request additional volunteer personnel, such as non-caregiver workforce representatives, to serve as TSR members on either a long-term or short-term basis. Long-term team members will participate in all team training, while volunteers used for single incidents will receive just-in-time training. The TSR team chief must ensure all team augmentees have sufficient training to assist with education, screening and referral activities.

The wing commander will appoint a privileged Life Skills provider as the TSR team chief, who has overall responsibility for TSR training and service implementation. The TSR team chief will be identified to the command post by the wing commander to ensure required notification in the event of a potentially traumatic event. The TSR team chief will coordinate with the Family Support Center and other agencies as appropriate to arrange TSR services to family and community members at installations impacted by a potentially traumatic event.

All TSR teams will establish standard operating procedures that will include, as a minimum, an assessment of local conditions and high-risk groups, a survey of locally trained resources, and a plan addressing various response scenarios. TSR teams will support the Medical Group in developing and executing Medical Risk Communication plans for Chemical, Biological, Radiological and High-Yield Explosive (CBRNE) events.

### **Reasons for conducting pre-exposure preparation training**

Many times people will not verbalize or articulate their feelings of stress, fear, or anxiety in anticipation of an event. Openly discussing what the individual can anticipate based upon past experiences and more importantly validating their fears will serve to diminish their feelings of inadequacy. It's been said that "fear of the unknown is sometimes worse than fear of the known." This is the case with participating in mass casualty events or search and recovery. An individual left to their own imagination can sometimes catastrophize the anticipated event to a higher level provoking additional anxiety. PEP is typically employed prior to deployment of a search and recovery (SAR) team for body retrieval or to a disaster area where significant loss of life is anticipated.

People are generally less anxious when they know what they can expect. Educating the participants about what they can expect psychologically and physiologically, as well as short- and long-term negative effects, will allow them to maximize their coping skills.

For some, stress is debilitating and distracting, yet for others it can serve as inspiring or motivating and enhances performance. There is no "right" reaction to dealing with stress and both reactions are acceptable so long as each realize their limits.

Reactions can vary from lack of any visual signs to overt demonstrations of stress; however, neither reaction indicates "strength versus weakness." Reassure participants that this experience is going to be challenging, but remember to reinforce the fact that they are healthy and capable individuals who will grow with the challenge.

### **Pre-exposure preparation's three-step process**

The PEP process involves three steps that are explained in the following paragraphs.

#### ***Step one—acknowledging stress***

This step involves encouraging the participants to feel comfortable with acknowledging they are stressed and being able to verbalize his/her feelings to one another. Often pairing up the team members with one another will allow them to have someone to talk to once they reach the "field." The buddy system is an excellent way to ensure participants are not wandering through the disaster scene or carnage alone and overwhelmed.

#### ***Step two—identifying and practicing positive stress behaviors***

Instill in the participants that they are not alone in this endeavor. Identify and recognize what can and cannot be controlled. Not everyone at the scene of a mass casualty incident can be saved. "It's not

your fault personally for those who you cannot save.” This is part of “acceptance” and understanding that the participant may not necessarily like the outcome of a situation, but acknowledges it is beyond his or her control. Several points that should be addressed in step two include following:

#### *Focus*

Participants should be reminded to stay focused on their purpose at the scene. The distractions such as dead bodies can lead to debilitating anger, revenge seeking, helplessness, and hopelessness in being able to offer any assistance. Again, stay focused on your purpose.

#### *Team work!*

Emphasize to the participants that they alone are not expected to solve, resolve, recover, etc. They are a member of a team. This means looking out for themselves as well as others. “Think *we*, instead of *me*.”

#### *Team morale*

Instill a sense of confidence. “You can do it.” The synergy of a group feeling confident is contagious and inspiring to others.

#### *Spirituality*

Participants should be encouraged to practice or seek out their religious or spiritual beliefs as a source of support.

#### *The buddy system*

Pair up with a buddy. Make a friend. Every one of the participants should be connected with another member of the team. No one should face this challenge alone.

#### ***Step three—recognizing ineffective coping mechanisms***

The pneumonic HALT that is often associated and emphasized for alcoholics is very appropriate to be examined at this stage. HALT represents *Hungry, Angry, Lonely or Tired*. People are most vulnerable when they exceed any of the HALT thresholds. Encourage the participants to not only take care of themselves, but keep tabs on their buddy as well to ensure they are taking period breaks to replenish as well.

Participants should also be discouraged from sources of ineffective coping to include the following:

- Insufficient sleep.
- Insufficient nourishment.
- Insufficient fluid intake.
- Alcohol and other drug abuse.
- Breakdown of respect for those in the chain of command.
- Breakdown of respect for lawful orders and directives.
- Breakdown of communication within the chain of command.

All of this seems nice and tidy; however, you will not always have the luxury of conducting a PEP training prior to an event. The terrorist attacks of September 11, 2001 are a good example.

Pre-exposure training is defined as a preventative approach prior to exposure to a potentially traumatic event that uses an educational approach to emphasize the normalcy of stress response and basic techniques in stress management.

## **242. Group informational briefing**

A single act of violence or terrorism can adversely affect thousands of people. The psychological effects from one of these incidents will more than likely involve more people than the physical effects. The direct targets of a terrorist act are really an afterthought. Typically, the goal of terrorism

is to create a feeling of fear, uncertainty and helplessness. Imagine if our enemy in Afghanistan used chemical weapons against us.

Even though we have all been training on dealing with chemical weapons, it has rarely been something used against us. Even if the enemy only killed or wounded a small number of our military with this action, the “terror” it would cause would be enormous. Operating Instructions and Air Force Instructions would be modified to account for the new threat. Even at our bases in the states or overseas, we all may have to attend more frequent chemical weapons awareness briefings or have more exercises involving Mission Oriented Protective Posture (MOPP) gear. Doing this extra training and raising awareness is good to prepare people operationally, but it will also raise anxiety for some. One way of helping large groups of individuals deal with these feelings in the wake of terrorism, violence, disasters, and other crises is conducting a group informational briefing.

If a co-worker was killed in an accident, many people might spend parts of their day wondering if they could have done something different to help that person. Having a group informational briefing about the incident would help us all find out information without rumors or misinformation and give people a time to express their feelings publicly.

School shootings get our attention through the media because they are dreadful, senseless events. While it seems to happen every day somewhere, the reality is that it’s a pretty rare event. But think of all of the time, money, and resources that are poured into many struggling educational budgets so they can be ready for a disaster like this, just in case.

Group informational briefings, also known as Crisis Management Briefings (CMB), are a highly efficient way to brief large (10–300 people) groups of victims or those populations effected similarly in the wake of violence, mass casualty, terrorist attack, or suicide/murder. These briefings are not really meant for first responders or military members, but are more appropriate for primary victims in a civilian population. Group informational briefings are a four phase process with specific goals for each. The entire briefing should last approximately 60 to 90 minutes.

These group informational briefings for smaller crowds might have a sort of respite center with food, beverages, shelter, and one-on-one guidance. For larger crowds, you might be able to provide information about the incident, control rumors, educate about symptoms of distress, inform about basic stress management and identify resources available for continued support. This is especially useful in response to violence/ terrorism.

Incidents needing a group informational briefing are as follows:

- Suicide of a colleague, friend or family member.
- Line of duty death/death at the workplace.
- Serious line of duty/workplace injury.
- Disaster/multi-casualty incident.
- Police shootings/accidental killing or wounding of an innocent person.
- Events with extreme threat to participants.
- Significant events involving children.
- Prolonged incidents, especially with loss.
- Events in which the victims are relatives or are known to operations personnel.
- Events with excessive media interest.
- Any significant event capable of causing considerable emotional distress in those who are exposed to it.

Phase	Characteristics
Phase 1	Common cause phase. This phase brings individuals together who collectively experienced the same event. For instance, a suicide in a squadron would affect the entire squadron population. The unexpected death or murder of a teacher or a terrorist attack or threatened attack could affect an entire community. Assembling the entire affected population is empowering and is significant in reestablishing a sense of community
Phase 2	Fact revelation phase. Once all of the individuals are assembled, you should provide the group with the facts regarding the precipitating or anticipated crisis. The person presenting the facts should be a respected and knowledgeable person regarding the event(s). Providing credible information will assist in managing destructive rumor control, decrease anxiety of the unknown, and allow the victims to regain a sense of control.
Phase 3	Sense of normalcy phase. During this stage, the victims/participants should be provided with information which validates their feelings as a normal anticipated reaction to the events which they have experienced. The briefer should be knowledgeable and credible to the participants. This area should be tailored to the facts of the events. For instance, if the facts involve a suicide, validate the participant's feelings of responsibility guilt as normal. If terrorism or random crime has taken the life of someone in the community, discussing survivor guilt would be appropriate. Again, validating the normalcy of the participant's feelings will be the focus.
Phase 4	Self aid and buddy care. The final phase should focus on suggestions for coping that each participant should be aware of. Knowing limits, resources for personal crisis, being aware of their peer's reaction and when to intervene or become involved should all be addressed. Each participant should leave with a reference sheet of suggestions and resources that are readily available to assist them if needed.

### Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

#### 240. Types of disasters and human responses

1. What AFI provides a formal response for Traumatic Stress Response (TSR)?
2. Identify types of disasters.
3. During which disaster period do people normally take no constructive or defensive measures to prepare for the impact of the disaster?
4. Why is it best to treat individuals as near the disaster site as possible when they seem shocked and unable to respond during the immediate reaction period?
5. During which principle response and reaction to disaster would you try gentle firmness, give something to eat or drink, and get help?

#### 241. Pre-exposure preparation training

1. What does PEP attempt to prepare participants for?

2. Who will ensure the establishment of at least one TSR, with a privileged Life Skills provider designated as the TSR team chief?
3. When is PEP typically employed?
4. What are some sources of ineffective coping?

**242. Group informational briefing**

1. What is the typical goal of terrorism?
2. If a co-worker is killed in an accident, what might those left behind wonder?
3. Identify the phases of a group informational briefing.

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**Answers to Self-Test Questions****240**

1. AFI 44-153, *Traumatic Stress Response*.
2. Natural disasters, Man-made disasters.
3. Pre-impact period.
4. Evacuation and hospitalization will only confirm to them that they are helpless.
5. Individual panic.

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1. For what they may encounter at the scene but also for how they may respond emotionally and physiologically.
2. The senior wing commander or installation commander at each active duty Air Force installation with a medical treatment facility.
3. Prior to deployment of a search and recovery (SAR) team for body retrieval or to a disaster area where significant loss of life is anticipated.
4. Insufficient sleep, insufficient nourishment, insufficient fluid intake, alcohol and other drug abuse, breakdown of respect for those in the chain of command, breakdown of respect for lawful orders and directives, breakdown of communication with in the chain of command.

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1. To create a feeling of fear, uncertainty, and helplessness.
2. If they could have done something differently to help that person.
3. Phase 1—Common cause phase, Phase 2—Fact revelation phase, Phase 3—Sense of normalcy phase, Phase 4—Self aid and buddy care.

## Unit Review Exercises

**Note to Student:** Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to ECI (AFIADL) Form 34, Field Scoring Answer Sheet.

**Do not return your answer sheet to AFIADL.**

98. (240) Which disaster period is sometimes called the recoil period?
- a. Immediate reaction period.
  - b. Pre-impact period.
  - c. Warning period.
  - d. Impact period.
99. (241) What is step one of the pre-exposure preparation training?
- a. Identifying and practicing positive stress behaviors.
  - b. Recognizing ineffective coping mechanisms.
  - c. Acknowledging stress.
  - d. Recovering.
100. (242) What is the final phase of a group informational briefing?
- a. Sense of normalcy phase.
  - b. Self aid and buddy care.
  - c. Common cause phase.
  - d. Fact revelation phase.

## **Student Notes**



## Glossary of Abbreviations and Acronyms

<b>ADC</b>	Area Defense Counsel
<b>ADD</b>	attention deficit disorder
<b>AD/HD</b>	attentiondeficit/hyperactivity disorder
<b>AFRC/ANG</b>	Air Force Reserve Comman/Air National Guard
<b>AFI</b>	Air Force Instruction
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>APA</b>	American Psychiatric Association
<b>BP</b>	blood pressure
<b>CBRNE</b>	chemical, biological, radiological nuclear and high yield explosive
<b>CDC</b>	career development course
<b>CDGMC</b>	catatonic disorder due to a general medical condition
<b>CMB</b>	crisis management briefings
<b>CNS</b>	central nervous system
<b>CONUS</b>	continental United States
<b>CPS</b>	Child Protective Services
<b>DCD</b>	Developmental Coordination Disorders
<b>DOD</b>	Department of Defense
<b>DSM-IV-TR</b>	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
<b>DXM</b>	Dextromethorphan
<b>FAC</b>	Family Advocacy Committee
<b>FAP</b>	Family Advocacy Program
<b>FAOM</b>	Family Advocacay Outreach Manager
<b>FAST</b>	Family Advocacy Strength Based Training
<b>FMCMT</b>	Family Maltreatment Case Management Team
<b>FTT</b>	failure to thrive
<b>GAD</b>	generalized anxiety disorder
<b>GHB</b>	Gamma Hydroxybutyric Acid
<b>HALT</b>	mnemonic device— <b>H</b> ungry, <b>A</b> ngry, <b>L</b> onely, <b>T</b> ired
<b>IQ</b>	intelligence quotient
<b>IV</b>	intravenous
<b>LSD</b>	lysergic acid diethylamide
<b>MAO</b>	monoamide oxidase
<b>MDMA</b>	methylenedioxyamphetamine

<b>mg</b>	milligram
<b>MOPP</b>	Mission Oriented Protective Posture
<b>MOU</b>	Memorandum of Understanding
<b>MTF</b>	medical treatment facility
<b>NOS</b>	not otherwise specified
<b>NPSP</b>	New Parent Support Program
<b> OCD</b>	Obsessive-compulsive disorder
<b> OCONUS</b>	outside the continental United States
<b>PCP</b>	phencyclidine
<b>PCS</b>	permanent change of station
<b>PDD</b>	pervasive developmental disorders
<b>PEP</b>	pre-exposure preparation
<b>PTSD</b>	Post-Traumatic stress disorder
<b>SAR</b>	search and recovery
<b>SJA</b>	Staff Judge Advocate
<b>SNRI</b>	Serotonin-Norepinephrine reuptake inhibitor
<b>SSRI</b>	Selective serotonin reuptake inhibitors
<b>TSR</b>	Traumatic Stress Response

## **Student Notes**

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