UNIT 11: CLINICAL

QUESTION #11.1: What is mental illness?

Abnormal psychology (psychopathology) is the branch of psychology specializing in mental disorder (illness). In the broadest sense, mental disorder is defined as behavior that is maladaptive, i.e., conduct that is dysfunctional or harmful to self or others.

Mental health professionals who work in this area come from a variety of professions: medicine, psychiatry, social work, and nursing. **Psychiatrists are medical doctors** with residency training and board certification in the specialty of treating mental disorders. As physicians, they **can prescribe medication**. Those psychologists who work in the field of mental health are those in the **clinical** branch, and must have a doctoral level degree and state licensure.

Insanity is a term now used only in a **legal** context to refer to a judgment that a person is not to be considered mentally capable of managing his own affairs, or be held legally culpable for his actions. Standards for a legal judgment of insanity vary from state to state. Some jurisdictions rely heavily upon the testimony of mental health professionals that a specific mental disorder is present, while other jurisdictions stick to older legal standards, such as "did the patient, at the time that he committed the act, have an understanding that it was wrong?"

Case Study: Mr. W, at age 77 was declared "not competent" to manage his own affairs. This happened after he had set fire to his house, and was wandering around dazed when the fire fighters arrived. After talking with neighbors and his physician, the court suspected a case of dementia, and so Mr. W was not charged with the crime of arson. He was sent to a nursing home, and his closest relative, a nephew, was appointed conservator of his estate.

Diagnosis (plural, diagnoses) is the process of observing the patient's symptoms, and inferring the most likely underlying disorder. Other sources of relevant data from the patient might include the patient's own description of the problem, the views of other family members, background case history, and what other mental health professionals have previously diagnosed or prescribed. The results of psychometric tests (e.g., the MMPI) and laboratory results should also be included.

OBSERVATION	INFERENCE
Symptoms Self-description Family's description Background Previous prescriptions Lab tests Psychometric test scores	Diagnosis

Case Study: Mr. W's main symptom was a lack of orientation. He was confused about where he was, when it was, and with whom he was speaking. His own description of his problem is that he was worried about the terrorists stealing his old schematic diagrams. (This did not seem plausible, for although Mr. W was a retired aeronautical engineer, he had not designed a plane for twenty years, and was not in the possession of any classified documents.) Mr. W's neighbors said that he had grown increasingly withdrawn over the past year, and that his wife seemed to be in charge of handling his affairs. When she died two months ago, he let the garden go, failed to pick up the mail, and became more suspicious about everyone. His physician reported that Mr. W had scored poorly on the Mental Status Questionnaire, a test for short term memory, and had prescribed a low dose of Aricept, which is intended to slow down the progression of dementia. A psychologist used a battery of other psychometric tests indicative of dementia, and confirmed the diagnosis.

Diagnostic validity and reliability have been greatly improved since 1952 when the American Psychiatric Association issued its first **Diagnostic and Statistical Manual** that is the accepted guideline. Now in edition **DSM-IV-TR**, mental disorders are listed along with the specific criteria for a patient to be labeled as having that disorder. (By 2013, the next major edition, DSM-5, should be in use.)

Prognosis (plural, prognoses) refers to a prediction about the course of the disorder over time. Factors to consider in prognosis might be the usual natural course of the disorder, the unique background of the patient, social support and coping abilities, the usual effectiveness of the prescribed treatment, the patient's own previous response to treatment, and how well the patient is likely to comply with it.

OBSERVATION	INFERENCE
Background Coping skills Social support Course of disorder Previous response to treatments Usual effectiveness of treatment Patient compliance with treatment	Prognosis

Case Study: Mr. W's prognosis was poor: it was extremely unlikely that he would make a full recovery to his former state of mental health. This is based upon the fact that the natural course of most forms of

dementia is steadily downward until death. Aricept and other medications at best slow the decline. Mr. W had already been given a prescription, but it had obviously not helped him. His greatest source of social support, is wife, was now gone.

Epidemiology refers to the investigation of diseases in a population, both the incidence (current level), and prevalence (lifetime occurrence). Diseases can be **acute** (intense, with rapid onset) or **chronic** (gradual onset, long standing) or **episodic** (those disorders which come and go).

We rarely speak of a "cure" of mental disorders, but rather the **remission** (cessation) of symptoms. When we evaluate a treatment, we look at how complete the remission, how rapid, and how resistant to relapse.

Etiology refers to the origin or causal nexus of disease. Some causes are essential (necessary) to produce their effects: without the cause, the effect cannot be produced. You can reason from the existence of an effect to all causes that were essential for its production. Some causes are adequate (sufficient) to produce their effects: whenever the cause exists, the production of the effect is guaranteed. You can reason from the existence of any adequate cause to the existence of its effect. Some causes are both adequate and essential, while most are merely contributory in that they make the event more likely to occur.

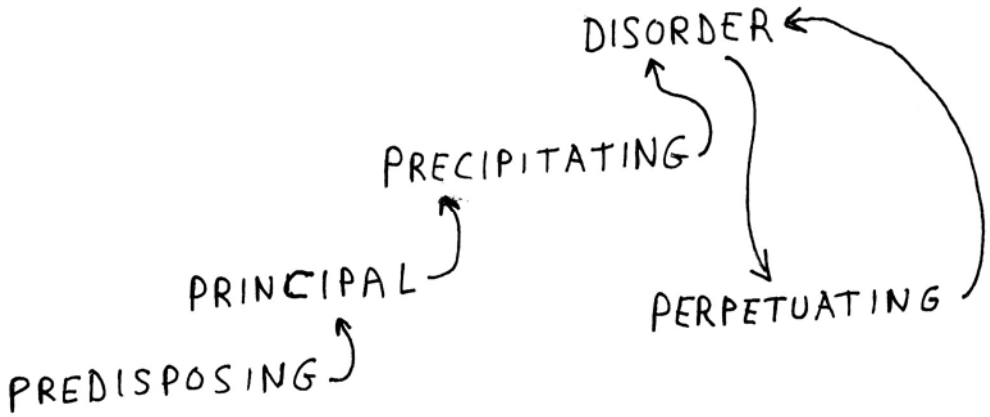
Any mental disorder can be analyzed in terms of four types of causes. **Principal** causes are those that have the most impact. They are usually essential and sometimes adequate. **Predisposing** causes are found in the distant background (e.g., heredity, early parenting, culture), and make the patient more susceptible or vulnerable or "at risk" for certain disorders. These predisposing causes are sometimes essential, but never adequate. Indeed, many individuals with these predisposing backgrounds do not get the disorder, but demonstrate great resilience. **Precipitating** causes are those that occur just before the disorder and trigger it. They are never adequate, and only rarely essential. Environmental stress usually has only a precipitating role in most mental disorders. Those things that occur after the onset of the disorder, but tend to perpetuate it in a vicious cycle, are known as **perpetuating** (or reinforcing) causes. They are neither essential nor adequate, but can contribute much to sustaining the cycle.

Comparison of causes of mental disorder				
Cause	*Essential?*	*Adequate?*	*Role?*	*When in sequence?*
PRINCIPAL	Usually	Sometimes	Major	Sometime before onset
PREDISPOSING	Sometimes	Never	Minor	Early
PRECIPITATING	Sometimes	Never	Minor	Just before onset
PERPETUATING	Never	Never	Varies	After onset

Case Study: Mr. W's disorder was his confused behavior. There was probably no specific predisposing cause with any important role in this case (although there is a genetic predisposition to develop some

dementias). The principle cause was a chronic brain syndrome, probably Alzheimer's (a post-mortem autopsy would be required for confirmation). The precipitating cause would be the recent death of his wife, which made his confusion more difficult to cope with or hide. His suspicious and belligerent behavior also served the role of a perpetuating cause, deterring his neighbors from having a closer relationship and offering more help.

How causes relate in a chronological path



There are several theoretical models for understanding the principal cause of mental disorders.

MAGICO-RELIGIOUS: This is the oldest model, found in many tribal societies before the development of the modern sciences of biology, chemistry, and psychology. The view of the world is animistic: every being and object has a living spirit or soul that determines its action. Depression might be considered a loss of soul, schizophrenia as possession of an evil spirit. The usual solution is exorcism, a ritualistic expulsion of the evil spirit.

THE CAUSE OF MENTAL ILLNESS (magico-religious viewpoint)

cause *effect*

DEMONIC
POSSESSION =======> EMOTIONS, BELIEFS, BEHAVIORS

BIO-MEDICAL: This neuroscience perspective began with Hippocrates and Galen who argued that human behavior was determined by the brain, nervous system, and bodily fluids. This model emphasizes the necessity of diagnosing specific diseases. Hippocrates classified disorders into dementia, frenzy (schizophrenia, mania), and melancholia (depression). He also looked for physical treatments: medicines, surgery. Major advances in this perspective came in the last three centuries with the advance of organic chemistry and **pharmacology** (the development of medications).

The great leap in psychiatric classification occurred in the 19th century with **Emil Kraepelin** who **systematically classified all psychiatric disorders**. Research on this perspective emphasizes genetics and chemical imbalances. The disorders that clearly fit this model include dementias such as Huntington's and Alzheimer's. With the introduction of effective psychiatric medications, this model has come to predominate in contemporary psychiatry.

THE CAUSE OF MENTAL ILLNESS (bio-medical viewpoint)

cause *effect*

ANATOMY &
METABOLISM =======> EMOTIONS, BELIEFS, BEHAVIORS

PSYCHOTHERAPEUTIC: This model views the mind as having important internal (e.g., unconscious) and external (e.g., interpersonal) relations. Some of the early humanistic reformers have fed into the modern psychotherapeutic model: the medieval shrine for the mentally ill at Gheel, Pinel in revolutionary France, Dorothea Dix in 19th century America, Tuke in England, Bucke in Canada. They shared the view that people, even those mentally ill, were essentially good, and deserving of kind treatment, and would probably improve more rapidly with kindness. Modern psychotherapists such as Alfred Adler, and Carl Rogers have shared this view. Another root of the psychotherapeutic approach would be those who see the unconscious as a fearful repository that can distort an individual's behavior and relationships: Charcot and **Freud** (psychoanalysis). The psychotherapeutic approach frequently emphasizes attacking defense mechanisms and provoking a catharsis (purifying release of stored up emotions). This model dominated at mid-century: psychoanalysis from 1930-1960 in American psychiatry and psychotherapy, the humanistic approach in American psychotherapy 1960-1980.

THE CAUSE OF MENTAL ILLNESS (Freud/Gestalt/Rogers)

cause *effect*

EMOTION ==========> BEHAVIORS, BELIEFS

BEHAVIORAL: This model says that behaviors are learned, due to conditioning (Pavlov, Watson, Skinner). Since the background of the founders was more in the area of experimental psychology, it took awhile for clinicians such as Mary Cover **Jones** and James Wolpe to suggest possible therapeutic applications of conditioning and other forms of learning. Only a few mental disorders (e.g., phobias like Little Albert's conditioned fear of the mouse) neatly fit the model.

THE CAUSE OF MENTAL ILLNESS (Behaviorist viewpoint)

cause *effect*

BEHAVIORS ==========> BELIEFS, EMOTIONS

COGNITIVE: This approach focuses on the role of the patient's interpretations and expectations (thoughts) in generating and sustaining the emotions (e.g., Beck, Ellis). This approach offers one (among many) useful understanding of depression, and has grown in favor among psychotherapists since 1980.

THE CAUSE OF MENTAL ILLNESS (cognitive viewpoint)

cause *effect*

BELIEFS ==========> EMOTIONS, BEHAVIORS

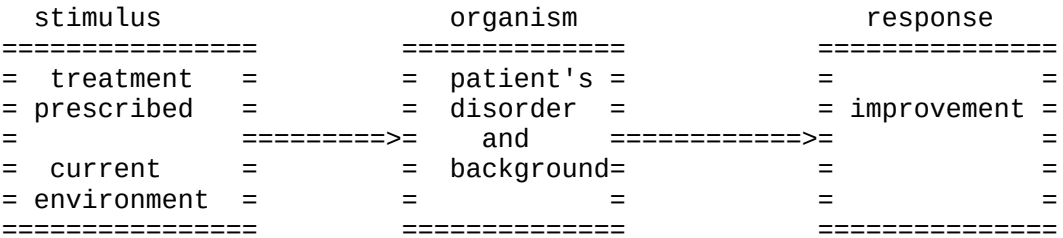
SYSTEMS: This approach emphasizes the role of the culture and especially the family system. It may help explain such diverse disorders as running amok in Malaya, and anorexia in the U.S. This systems model has become increasingly popular among social workers and family counselors.

THE CAUSE OF MENTAL ILLNESS (systems viewpoint)

cause *effect*

CULTURAL
NORMS AND
FAMILY ==========> EMOTIONS, BEHAVIORS, BELIEFS
INTERACTIONS

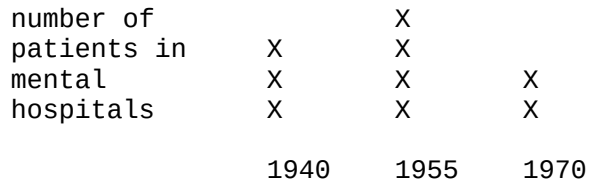
Many mental health professionals now regard themselves as **eclectic**, drawing from several of these perspectives at once depending upon the unique characteristics of the case at hand. One of the advantages of an eclectic approach is that it can yield a variety of insights into which principal or perpetuating cause might be targeted by therapeutic intervention to help this patient at this time.



Models of mental disorder				
Model	**Advocate(s)**	**Main theme**	**Disorders explained**	**Started**
Magico-religious	Ancient	Spirit possession	Depression Dissociative	Pre-historic
Bio-medical	Hippocrates Kraepelin	Structural or metabolic abnormalities	Depression Dementia Delirium Schizophrenia	1860s
Psycho-therapeutic	Freud Adler Rogers	Difficulties In childhood	Depression Dissociative Anxiety	1900s
Behavioral	Jones Wolpe	Conditioning	Depression Anxiety	1960s
Cognitive	Beck Ellis	Irrational expectations and inferences	Depression	1970s
Systems	Social work Family Counselors	Dysfunctional group relations	Depression Dissociative	1970s

QUESTION #11.2: What are the main psychiatric treatments today?

Since the 1950's, the use of **psychotropic medications** has become the **most widespread treatment** for most mental disorders. This is because these medications are relatively cheap and relatively effective. The introduction of these medications made possible the out-patient treatment of thousands of patients who would otherwise have been institutionalized in mental hospitals. Even for those patients who still needed to be hospitalized, the advent of the medications greatly reduced the need for straight jackets and other physical restraints and meant that more patients could be trusted with razors, mirrors, tools, and craft materials.



These psychiatric drugs should not be confused with illegal street drugs, with their risks of habituation, dependence, and addiction. Only a few psychiatric medications (e.g., benzodiazepines) pose these risks. A greater problem in practice has been securing patient **compliance: making sure that patients keep on taking their medication** once they have been released from the hospital.

The specific side effects of these medications differ greatly depending upon the medication and the patient. Side effects can stretch the continuum from very serious neurological damage (e.g., the Parkinson-

like **tardive dyskinesia** of the phenothiazines) to the merely discomforting (e.g., the dry mouth of the tricyclics).

Anti-psychotic medications are known as the major tranquilizers (e.g., phenothiazines). These are prescribed for treating the symptoms of schizophrenia (e.g., delusions, hallucinations, violent behavior) but can also be used with such behaviors in dementia and mania. These medications may carry a risk of side effects with long term use (e.g., tardive dyskinesia). Newer anti-psychotic medications (e.g., respiridone) have different side effect profiles from the older anti-psychotics (e.g., Thorazine, Haldol).

Anti-anxiety medications are also known as minor tranquilizers (e.g., benzodiazepines). These are prescribed for treating physical symptoms of anxiety. They are quick acting, but carry some risk of addiction. Newer anti-anxiety agents (e.g., Buspar) may have less addictive risk, but their effectiveness and side-effect profile must be matched to the individual patient.

Anti-manic medications are mood stabilizers (e.g., lithium) that are appropriate for mania and bipolar disorders. They take about four weeks to work and have to be carefully monitored to be sure that the dosage is sufficient without compromising liver or kidney functioning. Newer mood stabilizers (e.g., valproate) may have less renal and hepatic risk, but must be matched to the needs and limits of the patient.

Anti-depressant medications are in three main families. Monoamine oxidase inhibitors (MAOIs) have been around since the 1950s, and have a variety of side effects and dietary restrictions. Heterocyclics (e.g., Elavil) have side effects such as dry mouth. Selective serotonin reuptake inhibitors (**SSRIs**) have been around for about two decades and are the most popular (e.g., Prozac, Zoloft, Paxil). More new anti-depressants come on the market each year. All of these pharmaceuticals have about 70% effectiveness, and take about four weeks to work. The difference is in their pattern of side effects. The good news is that if one anti-depressant does not appear to be effective, or if it has distressing side effects, another can be tried.

The important thing to keep in mind with all psychiatric medications is that the patient must stay on the schedule and dosage prescribed, and if any problems occur, confer with the physician so that the dosage or medication can be changed.

Case Study: Ms. R, at age 19 became very depressed. She was placed upon Prozac, which lifted her depression in four weeks. After six months, she decided to go off the medication, and remained fine for eight years. At age 27, depression returned. She went back on the Prozac, which kicked in a month later, but her behavior became more bizarre. Upon re-examining Ms. R (and discovering a family history of manic-depression), her physician switched her to lithium. Ms. R now enjoys a stable mood. If she were to adjust her dosage, or go off of her medication without her physician's consent, she would be running the risk of depression or mania.

Electro-convulsive Therapy (ECT) is also known as "shock treatment." It has been around since the 1930s, and is probably the most researched of all psychiatric treatments. It is **appropriate for severe depression** and catatonia. It is relatively rapid (e.g., about a week), effective, and safe.

The team administering ECT usually includes a psychiatrist, anesthesiologist and nurse. Patients are given injections of muscle relaxants in order to reduce physical expressions of the convulsion (and to prevent fractures of the vertebra). In order to protect the teeth and tongue, a plastic protective block is inserted prior to turning on the current. The voltage is that of wall current, but is only applied for a fraction of a second. Convulsions then occur, and may last up to a minute. The patient regains consciousness in a few minutes, but may not be fully alert and able to leave the treatment area for an hour. During this recovery period the patient may be confused and experience a headache.

ECT is not the dangerous procedure that some people imagine. Deaths occur in less than four in 100,000 cases. (This is equivalent to the death rate for general anesthesia without ECT.) Conditions that are considered to be contraindications are brain tumor and postpartum depression. Age, cardiovascular problems and pregnancy are not generally regarded as contraindications, but many child psychiatrists may question the use of ECT with pre-adolescents.

One limitation is that ECT is not a permanent cure. There is always the danger that the patient might become depressed again. While this is true of medication and psychotherapy, the relapse rates seem to be higher for ECT. (Perhaps this is influenced by the fact that ECT only gets tried on the most serious cases in the first place.)

The most frequently reported side effect of ECT is memory loss, both in the form of retrograde amnesia (especially for what happened just before ECT) and anterograde amnesia. Almost half of ECT patients complain of memory impairments right after treatments, but this only lasts a few weeks. Newer procedures for administering ECT (multiply monitored micro-seizures) may reduce memory loss.

Case Study: Mr. N, age 68, became depressed after retirement at age 64. He was placed on a heterocyclic medication, and responded after four weeks. After five months he went off the medication, and felt fine. Last year, his wife died, and his depression returned, and became even more severe. He did not respond to the medication, and constantly thought about suicide. After six ECT sessions, he was able to return home and participate in group psychotherapy.

The greatest problem with ECT is not that it is cruel or barbaric, but that the general public regards it as such. (Although the patient experiences no pain in the procedure, the clouded consciousness of the recovery period is not pleasant.) A few states have reacted by putting obstacles in the path of ECT. Many community, private, and even teaching hospitals do not perform ECT.

A new treatment which also uses electricity to change the brain's functioning is Transcranial Magnetic Stimulation (TMS). It also seems to be effective on severe depression, but does not require anesthesia or hospitalization. TMS may also have a lower risk of amnesia.

Psychosurgery involves cutting the brain in order to change the patient's emotional processing. Back in the 1930s Moniz developed the primitive **pre-frontal lobotomy** that severed the connective tissues between the thalamus and frontal lobe. This generally reduces the overall level of emotionality of the patient. Most lobotomized patients remain institutionalized, but are more manageable. In rare cases, the improvement is so substantial that the patient may return home. Modern forms of psychosurgery are more targeted to specific disorders and have a better prognosis, but this treatment has become very rare in this country, due to the effectiveness of psychotropic medication.

Comparison of somatotherapies for mental illness

Treatment	Type	Assumes	Effective on	Disadvantages
Lobotomy	Surgery	Disorder is in the structure of the brain	Lowering level of emotion	Irreversible
ECT	Shock	Disorder is metabolic	Depression (1-2 weeks)	Relapse
MAOIs (e.g., phenelzine)	Pharmacology	Disorder is metabolic	Depression (3-5 weeks)	Side-effects serious
Tri-cyclics (e.g., Elavil)	Pharmacology	Disorder is metabolic	Depression (3-5 weeks)	Side-effects bothersome
SSRIs (e.g., Prozac)	Pharmacology	Disorder is metabolic	Depression (3-5 weeks)	Side-effects rare, mild
Anti-psychotic Phenothiazines (e.g., Thorazine)	Pharmacology	Disorder is metabolic	Psychotic symptoms	Side-effects neurological
Anti-psychotic Atypical (e.g., Clozaril, Risperdal	Pharmacology	Disorder is metabolic	Psychotic Symptoms	Side-effects potentially serious
Anti-manic (e.g., lithium)	Pharmacology	Disorder is metabolic	Mania, bipolar (3-5 weeks)	Side-effects nausea
GABA antagonists (e.g., valproic acid)	Pharmacology	Disorder is metabolic	Mania, bipolar (3-5 weeks)	Side-effects
Anti-anxiety benzodiazepines (e.g., Valium, Xanax)	Pharmacology	Disorder is metabolic	Anxiety	Addictive
Anti-anxiety Other types (e.g., Buspar)	Pharmacology	Disorder is metabolic	Anxiety	Side effects minimal

Case Study: Mr. K, age 74, was diagnosed with schizophrenia and institutionalized in his 20s. His tendency to be violent led to a lobotomy at age 40. He was transferred to a private, locked, nursing home when the state mental hospital closed down. He is docile and manageable, never getting upset about anything for more than a few seconds. He spends most of the day just walking around the facility in a set course.

Patient response to medication, ECT and psychosurgery is not distributed like a bell curve. If patients respond, the response tends to be marked and the patient experiences substantial symptomatic relief. If the patient is a non-responder, that is usually obvious in the first couple of weeks. Semi-responders are rare: the treatment works or it does not. About two-thirds to three-quarters of patients respond well to medication. For ECT and psychosurgery the rates approach 90 percent.

Because medications are so widespread and effective today, the need to resort to treatments like ECT and lobotomy has lessoned. Several states (e.g., California) have imposed legal hurdles that must be cleared before patients can be treated with ECT or lobotomy.

Ideally, a patient who is receiving medication (or ECT) should also be receiving some form of psychotherapy, but in practice, many insurance plans may not cover any treatment beyond the medication.

QUESTION #11.3: What is psychotherapy?

Psychotherapy involves communication between a patient and a therapist, individually or in a group, verbally or non-verbally.

P S Y C H O T H E R A P Y
A E
L A
K R

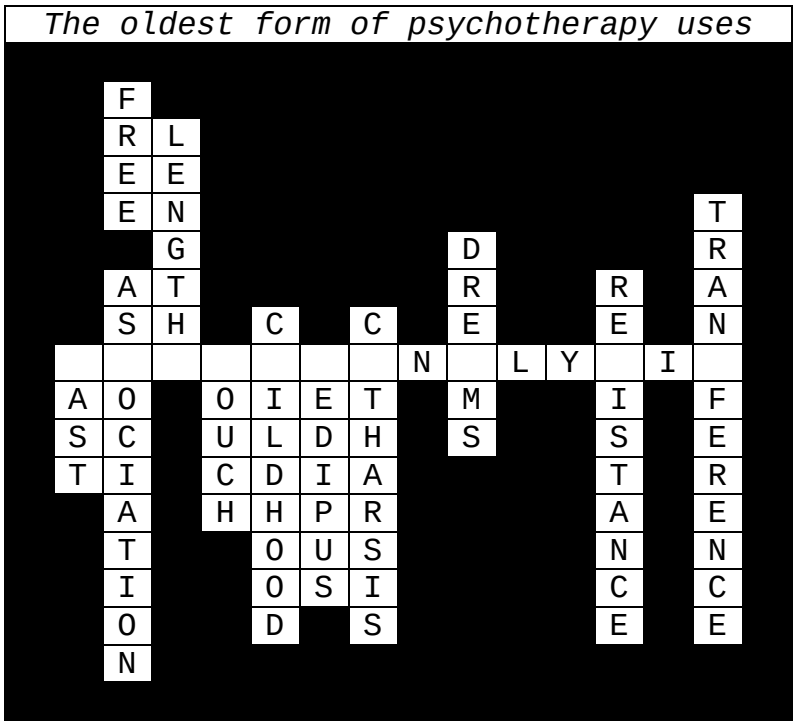
At the very middle of the word "psychotherapy" are the letters T and H and they stand for talking and hearing, the kind of communication that goes on in psychotherapy.

Psychotherapy is a specialized form of counseling. All counseling tries to help the client (patient). In the more superficial forms of counseling, we assume that the client is a responsible adult, capable of making her own decisions, and is only in need of expert information. In deeper forms of counseling, we assume that more than mere information might be necessary. The patient may need to grow and change. This is sometimes understood as insight into self motivation, release of distressing emotions, or the learning of new coping skills.

Psychotherapy is an in depth form of counseling

Psychodynamic approaches to psychotherapy emphasize the techniques of **Freud**. The patient free associates, just saying whatever comes to mind, and the therapist listens, occasionally offering an interpretation. The patient is encouraged to bring in a dream, and after awhile, this may come to dominate the therapy sessions. Whenever the patient cannot continue on in the process of free association, or cannot answer a question, or rejects an interpretation posed by the therapist, this is termed a resistance, which itself becomes a further topic for discussion. Sessions of fifty minutes long take place at least once a week, and the median time for completed therapy is two years. This long term relationship with the therapist will evoke powerful emotions that the patient transfers onto the therapist (transference) and this becomes a yet another topic of conversation. This treatment can be effective in depression, anxiety, obsessive-compulsive, conversion, and dissociative reactions. It seems to work best with patients who are intelligent, educated, and fluent. Psychoanalysis dominated American psychotherapy and psychiatry until about 1960.

Freud offered several explanations for why his therapy worked. Early in his career, he emphasized **catharsis**: that therapy lets off the drive pressures of the unconscious within the safety of the therapeutic relationship. Later, he developed more of an insight model: during therapy, the conscious self, the ego, comes to understand the origins and dynamics of the patient's problems. In his later years, Freud seemed to view psychoanalysis as a process of strengthening the ego so that it can take over the role of controlling the drives of the id, so that the superego's need to repress is diminished.



Case Study: Ms. G was born in 1925 on a farm in what was later to become Silicon Valley. She earned a degree from the state university and hoped to become a newspaper reporter. Upon graduation from college she married her old high school sweetheart, who had just graduated with a degree in civil engineering. He became a very successful homebuilder. Over the next five years they had three children (the last two pregnancies were due to contraceptive failure). She tried to count her blessings: good husband, three beautiful kids, big house, new station wagon, but she was becoming miserable and irritable. She hated hauling the kids around to school, ballet, music lessons, scouts, 4-H, Little League. She called up the psychiatry department at Stanford and got a referral. This was the 1950s, so the main form of psychiatric treatment was psychoanalysis. During the first few weeks, she said very little, but just reclined upon the couch and cried. The psychoanalyst did not push her to pull herself together or to try to talk sense. He allowed her time. After a while, the words came, and she was able to review her own childhood and her current frustrations. After about a year, she said that she had had enough therapy. She told her husband that they would be hiring a chauffeur to drive the kids around. She called up the local newspaper and volunteered her services as a reporter (which eventually became a high level position). Ms. G is to this day convinced that her psychoanalysis was one of the most important growth experiences in her life. She is the kind of intelligent and articulate person who is most likely to benefit from the process.

Carl **Rogers** developed a form of therapy that became known as **client-centered or person-centered**. This approach is **non-directive**: the therapist attempts to avoid making an interpretation. The goal is to get the patient in touch with his or her feelings. The basic technique is for the therapist to demonstrate empathy (reflecting the patient's

emotions) and "unconditional positive regard" for any emotion that the patient might express. This is not the same thing as positive reinforcement, but a permissive environment in which the patient comes to realize that he can say anything, and express any emotion, without being harshly criticized by the therapist. This form of therapy usually takes several months. The similarities with psychoanalysis probably outweigh the differences. In both forms of therapy, the focus is on getting in touch with buried emotions in a safe therapeutic context. Client-centered therapy is effective with the same conditions that psychoanalysis works with: depression, anxiety, obsessive-compulsive, conversion, and dissociative reactions. It also seems to work best with patients who are intelligent, educated, and fluent. Starting in the 1960s, Rogers became the main figure in American psychotherapy.

Other forms of humanistic therapy (e.g., existential, Gestalt) are generally similar to Rogers' in their assumptions and techniques. **Gestalt** therapy, developed by Fritz **Perls**, also assumes that repressed emotion is at the core of adult neurosis. It aims for a more direct and immediate catharsis for a growth experience. One technique is direct confrontation when the patient uses defense mechanisms. This approach can yield a more rapid remission of symptoms, but relapse rates can be higher.

Cognitive approaches to therapy can be traced back to Alfred **Adler** who sought to identify the patient's guiding fictions because they reinforced inferiority feeling and served as stumbling blocks to the development of social interest. In the 1960s Albert **Ellis** identified a list of irrational thoughts, and developed a form of Rational Emotive Therapy to challenge those thoughts. This seems to work rapidly with minor depression and anxiety. The predominant approach to cognitive therapy today is that developed by Aaron **Beck**. It is widely regarded as a **treatment for depression** that is highly effective, quick acting, and resistant to relapse. It involves structured homework assignments in which the patient begins to identify thoughts that trigger depressive emotions.

Case Study: Mr. C, age 50, had suffered from bouts of depression throughout his life. In college, he had received four months of client-centered counseling, and that seemed to lift his spirits. When he hit 30, his first marriage was cracking up, and it was unclear whether his depression was the result of the marital problems, or whether the marital problems were the result of his wife not being able to put up with his depression. He stayed on Elavil for three years, and this helped him get through an amicable divorce. At age 46 his depression returned, and he immediately sought help. Prozac worked for about 15 months, and then it was coming back. He found a cognitive therapist and was amazed at how directive the approach was (compared to what he remembered about Rogerian, client-centered therapy). After a few weeks his depression had lifted, and his therapy terminated. With his physician's approval, he stopped taking this medication, and has suffered no relapse. Mr. G credits the insights he got from cognitive therapy for really turning his life around.

Comparison of psychotherapy schools				
Treatment	**Main figure**	**Assumes**	**Effective on**	**Timeframe**
Psychoanalysis	Freud	Disorder is emotional	Anxiety Depression Dissociative	Months or years
Non-Directive Client-centered Person-centered	Rogers	Disorder is emotional	Anxiety Depression Dissociative	Months
Cognitive	Beck Ellis	Disorder is thought based	Depression	Weeks

Ideally, a patient who is receiving medication (or ECT) should also be receiving some form of psychotherapy, but in practice, many insurance plans may not cover any treatment beyond the medication.

The effectiveness of psychotherapy may follow more of a bell curve, with the majority of the patients getting at least moderate benefit in most forms of psychotherapy.

QUESTION #11.4: What is behavior modification?

Behavior modification, or behavior therapy, had its origins in conditioning. These techniques have been applied clinically for only about fifty years. They tend to work fast (three to twelve sessions), be highly effective (achieving desired results in 90% of the cases) and have low rates of relapse.

Positive reinforcement targets a skill deficit (e.g., speech in autistics) and schedules reinforcers to increase the desired behavior. The practical difficulties involve identifying an appropriate reinforcer (e.g., food) and then controlling the patient's environment in such a way that the only way to get the reinforcer is to exhibit the desired behavior. **Token economies** in institutions give the patients points on a punch card when they engage in behaviors such as turning in laundry and showing up for group therapy, and then these points may be exchanged for such things as videos or candy. **Biofeedback** uses monitoring of physiological processes to provide a tighter feedback loop for the conditioning of physiological responses, and is useful in panic attacks, migraines, and stress reduction.

Non-reinforcement is used to extinguish undesirable behaviors. Once again, the practical problem is to gain control of the patient's environment to make sure that the undesired behavior is not reinforced.

Case Study: Ms. T, 80, is a widow perhaps in the earliest stage of dementia. She has developed the delusion that her neighbors are stealing her possessions and her mail. Each night on the telephone, she talks to her daughter and makes charges, such as "Today, I noticed that they took my good new garden hose, and replaced it with an old leaky one." When the daughter tried to explain that maybe her hose was getting old, and she just did not notice it, the mother got angry and came up with additional complaints. The psychologist consulted by the daughter examined Ms. T, and suggested that in the near future it might

be necessary to relocate the mother, because her ability to live alone might be fading. In the meantime, he suggested that the level of complaints could be reduced by non-reinforcement. Whenever the mother started to make one of those complaints, the daughter was to find an excuse to hang up, and not call back. Over the next week, the phone conversations were pretty short, not like the usual forty minutes to an hour, because the daughter hung up as soon as the mother started on one of her diatribes. By the next week, the mother was waiting ten or twenty minutes before she brought up a complaint. After two weeks, the mother no longer came up with these charges over the phone, because they no longer got her attention or sympathy.

Flooding (implosive therapy) is used to treat phobias and related disorders (e.g., obsessive-compulsive). It subjects the patient to the full force of a feared stimulus. One who is obsessive-compulsive about cleanliness might be told to handle dirt. Getting the patients to comply with the treatment is the hard part, but if they do, most will overcome their irrational fear in short order.

Case Study: Ms. T, 25, was rising rapidly in the marketing department of a major corporation. She knew that she would have to make some major presentations in front of large audiences. She had always feared public speaking. At one recent department meeting, which was small by comparison, her Power Point presentation did not work properly and she became extremely anxious. Since that time she has feared that speaking in front of a large audience would make her vomit. Her therapist brought her to a large empty auditorium, and had her walk up to the stage, imagining all the bad things that could happen, and then try as hard as she could to vomit. When she realized that she could not make herself vomit, she overcome the fear of vomiting, and was able to accept the presentation assignments.

Systematic desensitization is another way to approach the feared stimulus, in a series of baby steps, small successive approximations, each one done in a relaxed state. This is probably the treatment of choice on most phobias. Here are the steps that might be used to treat a fear of heights.

SYSTEMATIC DESENSITIZATION OF ACROPHOBIA

1. master deep muscle relaxation

2. construct a hierarchy of feared stimuli approximations

3. work through the hierarchy while in a relaxed state

- outside on the roof of a tall building
- inside looking out the window of a tall building
- on roof of house
- on fifth rung of ladder
- on fourth rung of ladder
- inside on second story, looking out of a window
- on third rung of ladder
- on second rung of ladder
- on first rung of ladder
- on footstool
- standing on a book

Reciprocal inhibition is where an opposite response is modeled and reinforced to take the place of a dysfunctional response to a stimulus. Assertiveness training is an example of a different way to respond to feared social situations.

Aversive conditioning is the systematic provision of punishment in order to suppress an undesirable behavior.

Case Study: Mr. S, now 54, picked up smoking when he was in high school. When he was thirty, he went through a behavioral program emphasizing aversive conditioning. He received mild but painful electric shocks every time he took a puff. This suppressed his smoking for several months, but when things got particularly stressful at work again, he went back to smoking. Last year he began participating in a new program to end smoking at the Veterans Hospital. He received an anti-depressant medication (Wellbutrin) in addition to group psychotherapy, and behavioral modification. He stopped smoking in three weeks and has not returned to cigarettes.

Today many therapists combine behavioral techniques with psychotherapeutic techniques, especially those of cognitive therapy. Some of the more traditional psychoanalytic and humanistic approaches have not figured out how to integrate the behavioral processes as of yet. This may be due to a basic philosophical difference as to how to view the patient's suffering. Those who advocate medication, behavior mod, and cognitive therapy usually advocate symptomatic relief: target the specific symptoms that are distressing the patient and alleviate the suffering. Many traditional psychotherapists prefer to view suffering as only the surface effects of deeper, underlying causes (perhaps stretching back to early childhood). Rather than seek a "quick

fix" of removing the distressing symptoms, these psychotherapists hope that the deep levels of suffering will help the patient work through denial and facilitate growth experiences.

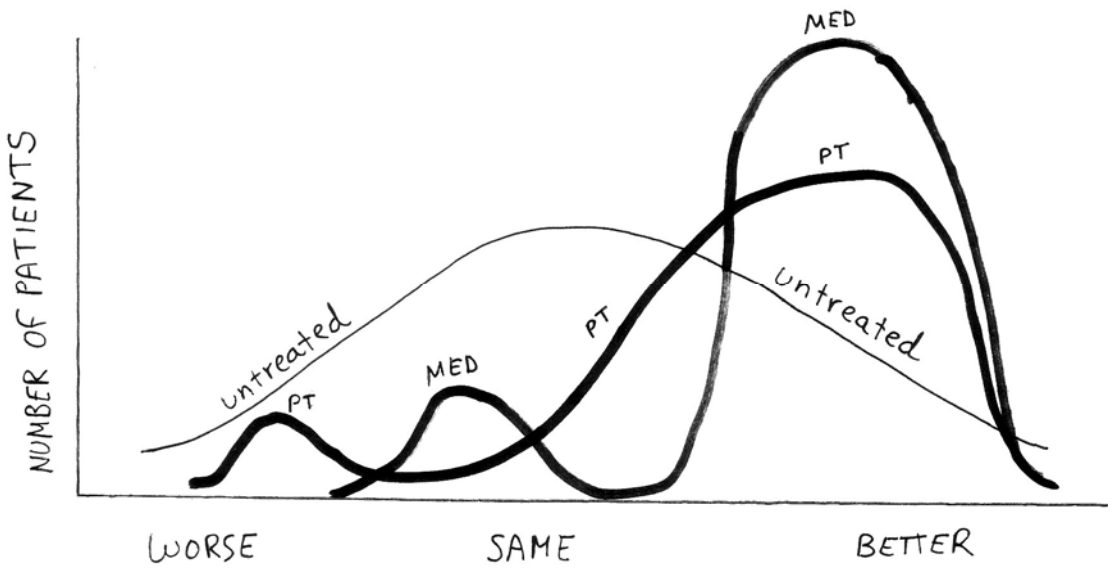
Comparison of behavior treatments for mental illness				
Treatment	**Type**	**Assumes**	**Effective on**	**Disadvantages**
Aversive conditioning	Behavioral Modification	Behavior can be suppressed	Bad habits	Painful
Extinction	Behavioral Modification	Behavior will cease when reinforcement is removed	Bad habits	
Token economy	Behavioral Modification	Behavior will increase when reinforced	Ward behavior	
Modeling	Behavioral Modification	Behavior will be adopted when shown	Phobia	
Systematic desensitization	Behavioral Modification	Disorder is conditioned	Phobia	
Flooding	Behavioral modification	Disorder is conditioned	Phobia	Scary

Treatments for mental disorders		
	Psychotherapeutic	**Other treatments**
Focus on body and emotions	Psychoanalysis Client-centered Gestalt	Psychosurgery ECT Pharmacology
Focus on thought and behavior	Cognitive	Behavioral modification

Case Study: Mr. S, age 31, had a hard time getting a job or making friends, because of his great shyness. At age 23 he spent four months in client-centered therapy, where the therapist kept urging him to get in touch with his inner child, but S said that he was in touch with that frightened child, and that was the problem. Even hypnotic regression did not bring relief. Mr. S quit going because he was convinced that he was disappointing the therapist. He later sought help from a psychoanalyst but after six months he could not see any improvement. Last year he heard about a new combined treatment program.

He was placed on a new SSRI medication, and in a cognitive-behavioral training program emphasizing the modeling of competent social skills. He completed the program in seven weeks. He declares that he is no longer shy. There is no evidence of relapse or symptom substitution.

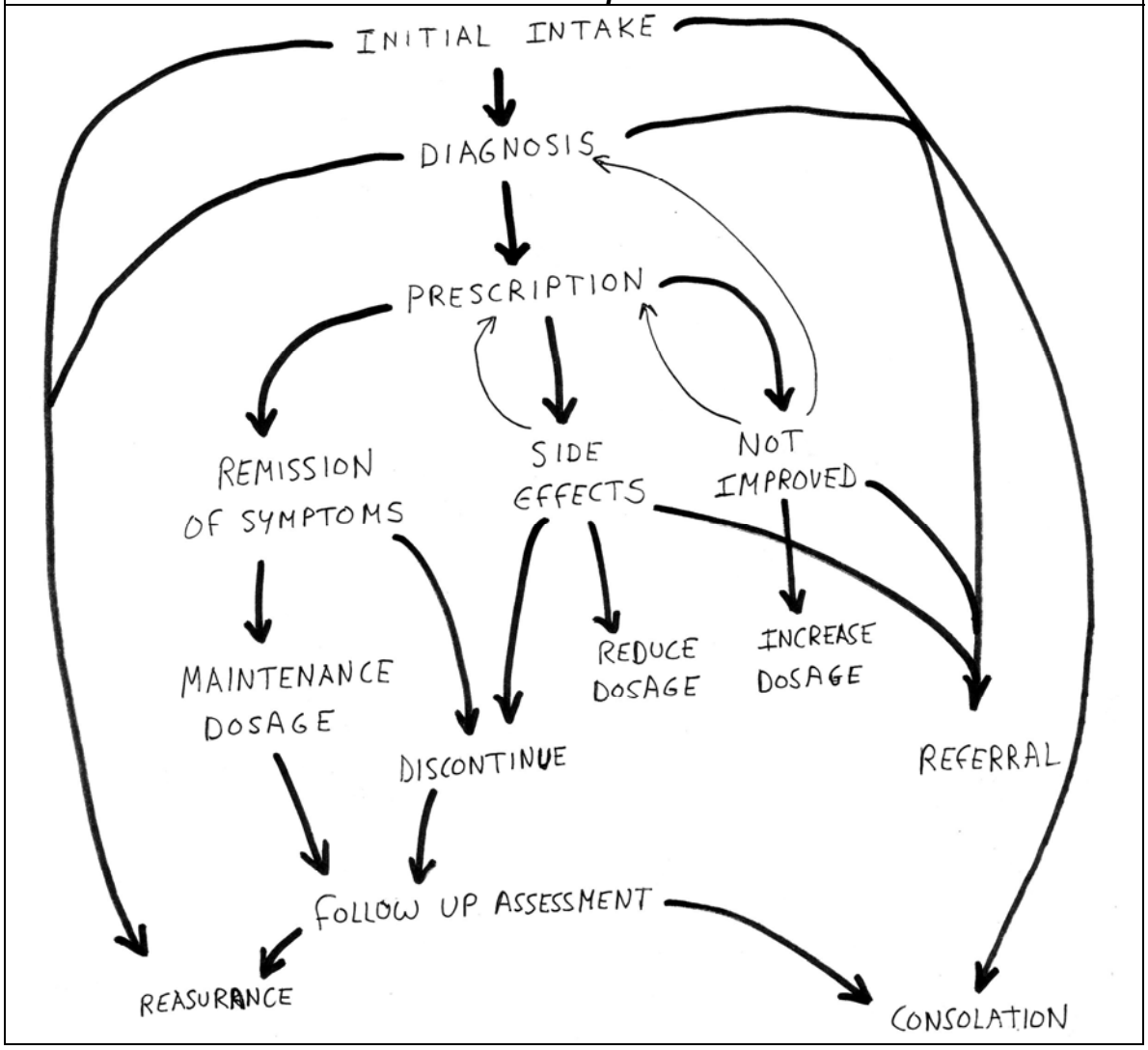
Comparison of Psychotherapy and Medication outcomes



Comparing the effectiveness of the different major forms of treatment, both psychotherapy and behavior modification are good at resisting relapse because they change the patient's underlying personality traits or habits. However, because psychotherapy has the capacity to deconstruct certain old defense mechanisms, it is possible that the patient might end up worse off after the psychotherapy, but most patients do experience some degree of benefit. With medications (e.g., anti-depressants) patients usually divide bimodally into responders (they get better) and non-responders (the medication did not work).

The treatment decisions that clinicians make actually constitute an ongoing process of assessment, treatment, and reassessment. The clinician has four basic responses to a patient seeking help: treatment, reassurance that there is nothing wrong, referral to another professional, or consolation when the case is hopeless. When treatment is not effective, or has side effects, the treatment (or even the initial diagnosis) needs to be reconsidered.

Clinician Options



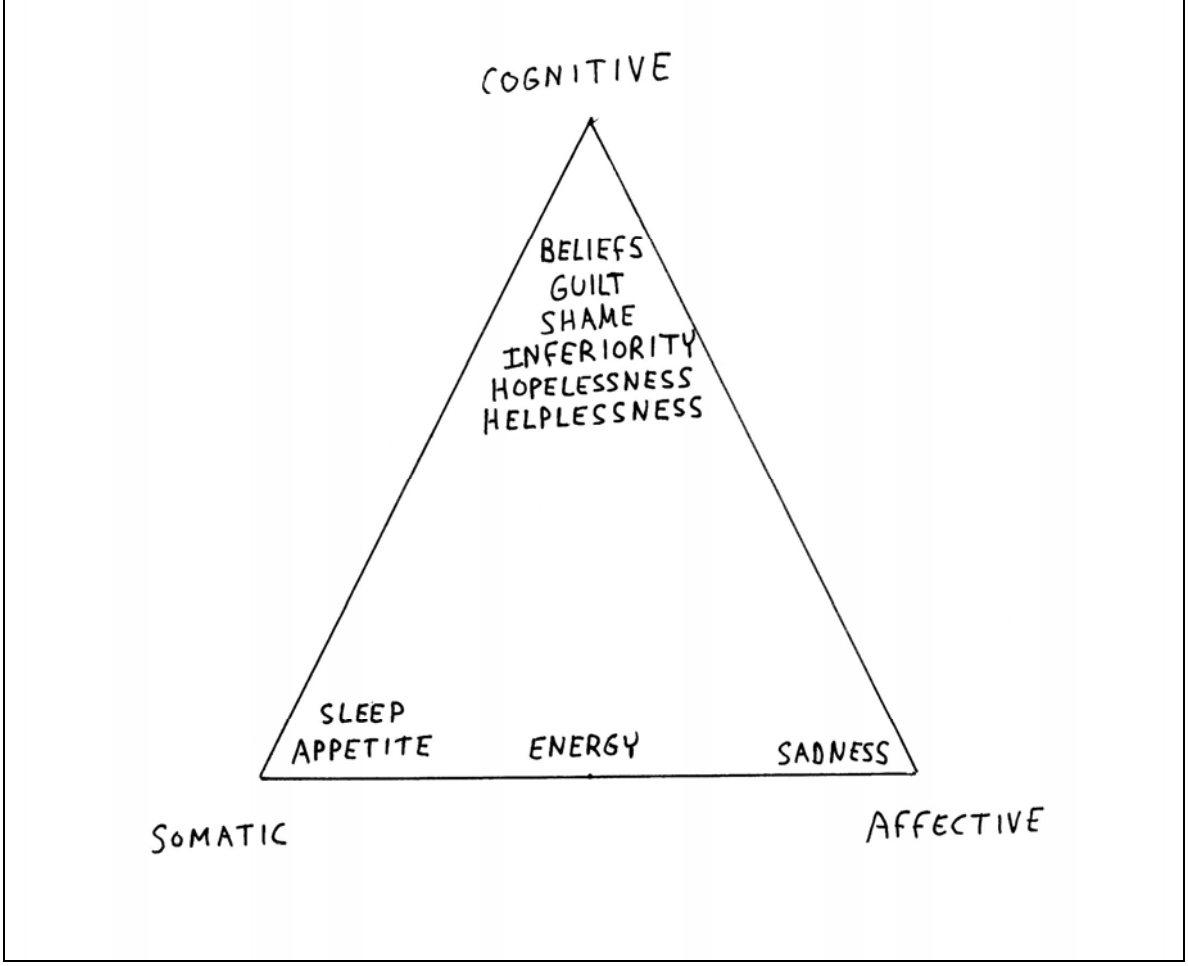
QUESTION #11.5: What are mood disorders?

Mood disorders include depression, mania and bipolar. This classification used to be known as affective disorders because they are distinguished by emotional lows (major depression or the mild dysthymia) or highs (mania) or both (bipolar).

Fill in the letters to see which type of disorder these are.

										A	**N**	**I**	**A**						
					B	**I**	**P**			**L**	**A**	**R**							
D	**E**	**P**	**R**	**E**	**S**	**S**	**I**			**N**									
										Y	**S**	**T**	**H**	**Y**	**M**	**I**	**A**		

Domains of Depression symptoms



Depression is the most widespread mental disorder in the U.S. today, probably at every age level. Major depression and its less severe form, dysthymia, are characterized by sadness, delusions of hopelessness and helplessness, even some somatic symptoms (e.g., disturbances of appetite, insomnia). The diagnosis of depression is made easier by the use of any of several valid and reliable depression scales.

Scales for assessing level of depression

ACRONYMN	DEPRESSION SCALE	RATING BY	MEASURES WITH
HRS	Hamilton Rating Scale	Observer	Emphasizes somatic symptoms
MMPI-D	Minnesota Multiphasic Personality Inventory Depression Scale	Patient	Emphasizes affective symptoms
SRS, SDS	Zung self-rating depression scale	Patient	Frequency of symptoms
CES-D	Center for Epidemiological Studies Depression Scale	Patient	Frequency of symptoms
BDI	Beck Depression Inventory	Patient	Intensity of symptoms
GDS	Geriatric Depression Scale	Patient	Yes/no format No somatic items

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DISORDER: depression

OLDER TERMS: melancholia

CLASSIFICATION: mood OLDER TERM: affective

PREVALENCE: 5 - 30 percent, women are more commonly diagnosed

SUBTYPES AND RELATED DISORDERS: dysthymia: chronic low grade depression; seasonal affective disorder (wintertime blues); post partum depression in new mothers

CAUSES: predisposing heredity (endogenous depression) and early childhood losses; precipitating causes include reaction to loss (reactive depression)

PSYCHOANALYTIC THEORIES OF DEPRESSION:

- loss of love object (mourning)
- superego turns death instinct against the ego
- dissipation of libido (neurasthenia)

COGNITIVE THEORY OF DEPRESSION: perpetuating causes are cognitive schemas which are pessimistic, global, and stable

BEHAVIORAL THEORY OF DEPRESSION: lack of positive reinforcement for recreational and social activities; social reinforcement for morose behavior

SYMPTOMS: sadness, lack of energy, problems in concentration, constipation, insomnia, lack of appetite; delusions of hopelessness, helplessness, guilt; suicidal thoughts

TREATMENT: cognitive-behavior therapy, psychoanalysis, Gestalt therapy, client-centered therapy; anti-depressant medications, electro-convulsive therapy, lobotomy

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GERIATRIC DEPRESSION SCALE		
1	Are you basically satisfied with your life?	N
2	Have you dropped many of your activities and interests?	Y
3	Do you feel that your life is empty?	Y
4	Do you often get bored?	Y
5	Are you hopeful about the future?	N
6	Are you bothered by thoughts that you just cannot get out of your head?	Y
7	Are you in good spirits most of the time?	N
8	Are you afraid that something bad is going to happen to you?	Y
9	Do you feel happy most of the time?	N
10	Do you feel helpless?	Y

11	Do you often get restless and fidgety?	Y
12	Do you prefer to stay home, rather than go out and do new things?	Y
13	Do you frequently worry about the future?	Y
14	Do you feel that you have more problems with memory than most?	Y
15	Do you think it is wonderful to be alive now?	N
16	Do you often feel downhearted and blue?	Y
17	Do you feel pretty worthless the way you are now?	Y
18	Do you worry a lot about the past?	Y
19	Do you find life very exciting?	N
20	Is it hard for you to get started on new projects?	Y
21	Do you feel full of energy?	N
22	Do you feel that your situation is hopeless?	Y
23	Do you think that most people are better off than you are?	Y
24	Do you frequently get upset over little things?	Y
25	Do you frequently feel like crying?	Y
26	Do you have trouble concentrating?	Y
27	Do you enjoy getting up in the morning?	N
28	Do you prefer to avoid social gatherings?	Y
29	Is it easy for you to make decisions?	N
30	Is your mind as clear as it used to be?	N

Fortunately, depression is one of the most treatable mental disorders. It responds to over fifty different medications, and most forms of psychotherapy work on depression. Probably the best treatment for most people would be a combination of an SSRI anti-depressant medication (e.g., Prozac) and cognitive psychotherapy.

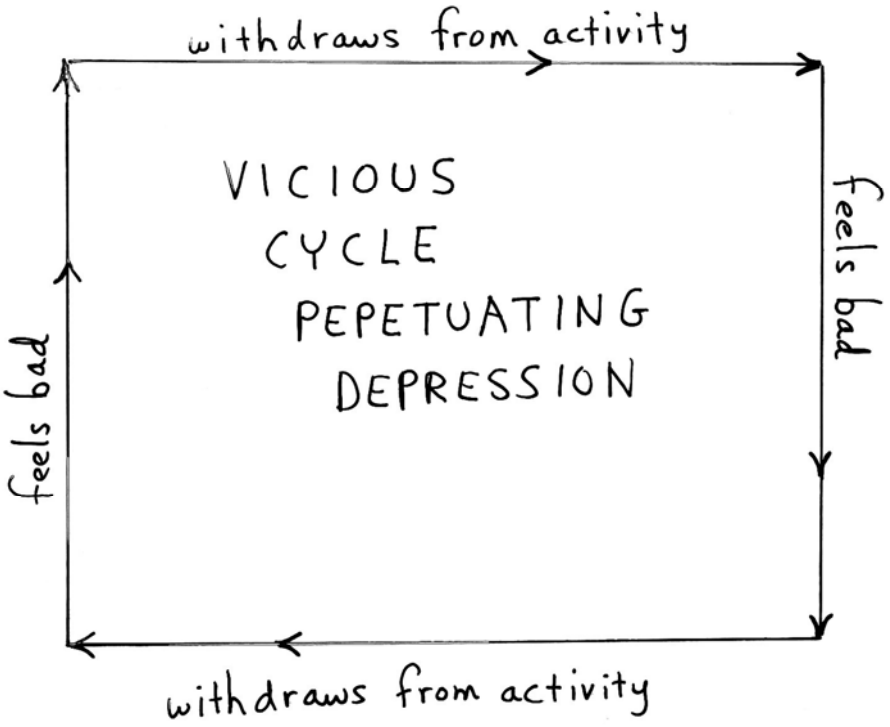
Perhaps because so many forms of treatment can work with depression, there are many theories that claim to explain its origins and dynamics. The bio-medical model would focus on metabolic abnormalities in levels of neurotransmitters such as serotonin. Further evidence for the importance of metabolic levels comes from Seasonal Affective Disorders (e.g., the winter reduced sunlight at the northern latitudes produces fluctuation in neurotransmitter levels).

There are several different psychoanalytic models for understanding depression. Freud in the 1890s described depression as the result of dissipation of libido. By 1915, he described it as a process of bereavement (mourning) over the loss of the object of one's love. Later, he explained it by saying that the superego turns the death energy against the ego.

The cognitive theory (e.g., Beck, Seligman) of depression focuses on perpetuating causes, such as beliefs (cognitive schemas) that are pessimistic ("bad stuff happens"), global ("this bad stuff is happening in every part of my life"), and stable ("this bad stuff is always going to be there in my life").

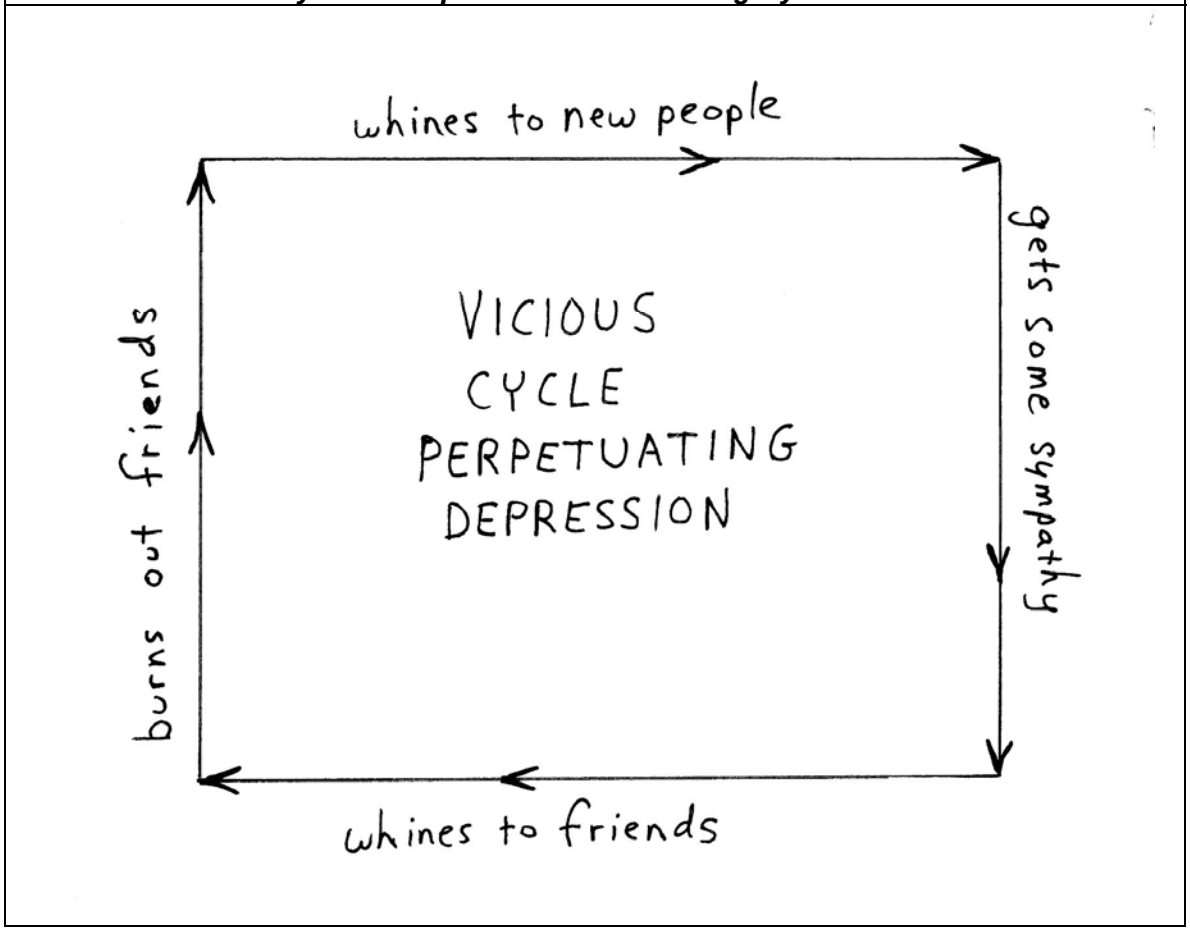
Behaviorists (e.g., Lewinsohn) have an interesting dual theory of depression. Depressed people tend to experience an anhedonia, and no longer get pleasure from their regular recreational and social activities, so they give up these activities, and this makes them more depressed.

Lewinsohn's cycle of depression: withdrawal and non-reinforcement



Also, depressed people are likely to whine about their problems to friends, and that will bring some (temporary) positive reinforcement as the friends try to be encouraging and make efforts to cheer up the depressed person. But after awhile, the friends get burned out, and stop calling or coming by. This intensifies the depression, and gives the patient something more to whine about with the next listener. This sets up another vicious cycle of perpetuation.

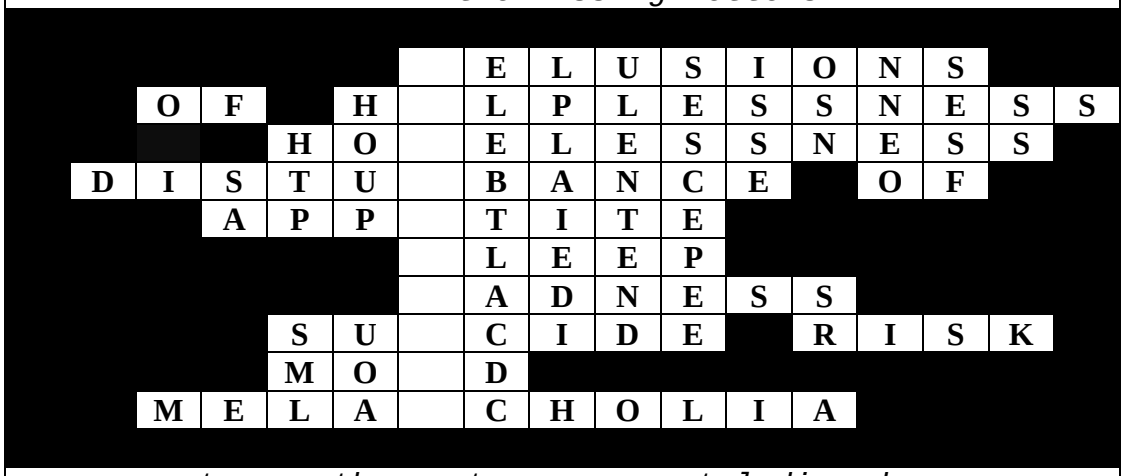
Lewinsohn's cycle of depression: reinforcing dysfunctional behavior



Most cases of suicide occur in depressives. One of the greatest challenges facing a clinical psychologist or psychiatrist is the prediction of suicide risk, knowing when to intervene with temporary hospitalization, and when to allow the patient to work out her own problems.

Mania is the opposite of depression. The patient has an **expansive (but unstable) mood**. The patient may feel great, so confident that he might engage in unwise or dangerous activity: gambling, driving fast, spending too much money, risky business deals, picking fights. Other manic symptoms include rapid, pressured speech, and a reduced need for sleep. Mania is usually episodic, lasting only for a period of days or weeks. There is less debate about the cause, an inherited biochemical disorder, which usually has its onset between the ages of 15 and 30. Medication is the core of treatment, and the greatest challenge is to keep the patient on his medication, even though he may claim not to need it, or he may want to re-experience the manic highs.

fill in the missing letters



to see the most common mental disorder

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DISORDER: bipolar (cycling of mania and depression)

OLDER TERM: manic-depression

CLASSIFICATION: mood OLDER TERM: affective

PREVALENCE: 1 percent, maybe more common among writers and artists

SUBTYPES AND RELATED DISORDERS: cyclothymia (less severe)

SYMPTOMS: in mania: expansive but unstable mood, rapid speech, lack of need for sleep; depressive cycles usually longer; suicidal risk when cycling out of depression

AGE OF ONSET: 15 - 30

CAUSE: inherited metabolic disturbance

TREATMENT: lithium, valproate acid

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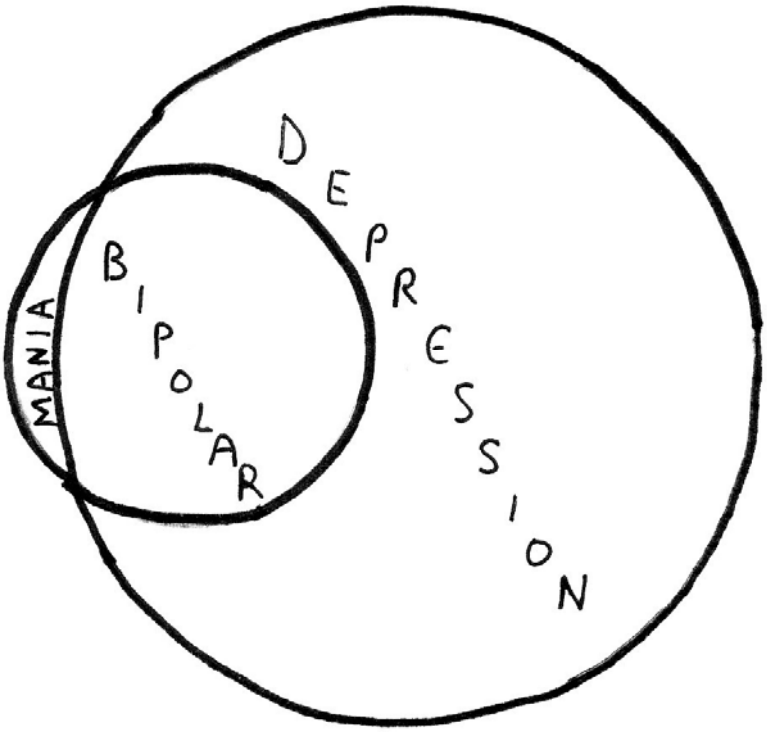
Most manic patients also experience longer depressive swings. However, most patients who experience depression do not also have manic episodes.

Fill in the letters to see

C	Y	C	L		N	G					
		D	E		R	E	S	S	I	O	N
			M		O	D					
					I	T	H	I	U	M	
			M		N	I	A				
	D	E	P		E	S	S	I	O	N	

an inherited disorder

Mood disorder cases: manic highs and depressive lows



QUESTION #11.6: What is neurosis?

Neurosis is an old term (plural, neuroses; adjective neurotic) for **minor mental disorder**. Since the DSM-III in 1980, it is preferable to use the term *anxiety disorders* to describe this cluster: generalized

anxiety, panic attacks, phobias, obsessive-compulsive, and post-traumatic stress disorder.

Generalized **anxiety** affects about one in ten Americans, and is slightly more common among women than men. The symptoms involve an overactive sympathetic nervous system: heart palpitations, sweating, queasy stomach. Cognitive symptoms might include difficulty of concentration. The closest emotion is fear or **general excitement**. Panic attacks are similar, but more episodic.

Medication may offer immediate symptomatic relief, but may carry some risk of addiction. Several forms of behavior modification (desensitization, flooding) as well as psychotherapy can bring long term relief.

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DISORDER: Generalized Anxiety Disorder

CLASSIFICATION: anxiety disorder   OLDER: neurotic disorder

PREVALENCE: 5 to 15 percent, more common in women

SYMPTOMS: palpitations, difficulty concentrating, trembling

TREATMENT: anti-anxiety medication (e.g., Valium, Xanax, Buspar), psychoanalysis, cognitive-behavioral therapy

= =

fill in the missing letters

P			J	F		
						Y
L	E	A	T	A	R	
P	R	N	T	R	E	
I	V	A	E	F	M	
T	O	X	R	U	B	
A	U		Y	L	L	
T	S				I	
I	N				N	
O	E				G	
N	S					
S	S					

= =

DISORDER: panic attack

CLASSIFICATION: anxiety disorder OLDER: neurotic disorder

PREVALENCE: 3 to 5 percent of adults, more common among women

AGE OF ONSET: usually between the ages of 15 - 24

TREATMENT: both minor tranquilizers (e.g., Xanax) and SSRI anti-depressants (e.g., Prozac) are effective; so is behavioral modification: systematic desensitization, modeling

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A **phobia** is an intense and irrational **fear**. It becomes disabling when it interferes with an important area of life, which may depend upon where the person lives.

What is a disabling phobia depends upon where you live	
LOCATION	**DISABLING FEAR**
New York	Elevators
San Francisco	Bridges
Mexico City	Subway
Los Angeles	Freeways
North Dakota	Open spaces

The object of the fear can be anything (e.g., heights, animals, dirt, loud noises, crowds, small enclosures, open unfamiliar spaces). One of the most disabled phobias is **agoraphobia**, also known as territorial apprehension.

Case Study: Mr. A, now 51, was a successful manufacturing entrepreneur by the time he was in his thirties. He had a beautiful home in the exclusive town of Atherton in northern California. One day when he was 45, he started to drive to his plant. He turned on El Camino Real, and the traffic was particularly stressful that day. He started to have chest pains, and feared that it might be a heart attack. He knew that he should head right for the hospital, but decided to turn off on a side street and go back home. As soon as he got in his long, tree-lined driveway, his chest cramps went away. Over the next few months, this scenario repeated several times. He decided to sell his business, but he could not enjoy his early retirement, because whenever he left his yard, he feared another panic attack. At this point he realized that he needed help. (Some agoraphobias get even worse, and cannot get out of the front door, or out of the bedroom, or even out of bed.) Mr. A was treated by *Terap*: a program that combined behavioral systematic desensitization and group psychotherapy. After his complete recovery, he went back to school and became a psychotherapist.

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DISORDER: phobia: an intense, unrealistic, disabling fear

CLASSIFICATION: anxiety disorder OLDER: neurotic disorder

PREVALENCE: about one in ten adults; more common among women

SUBTYPES AND RELATED DISORDERS: acrophobia (heights), claustrophobia (enclosed spaces), zoophobia (animals), agoraphobia (open spaces)

CAUSES: principal cause is usually unfortunate prior exposure to the stimulus (e.g., classical conditioning)

TREATMENT: behavioral modification: systematic desensitization, flooding

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Post traumatic stress disorder (PTSD) was first recognized on the field of military combat, but it has also been seen in victims of crime, natural disaster, and long term abusive relationships. The individual may have had a completely normal life prior to confronting a horrifying experience (e.g., military combat, rape, torture). The main symptom is painful flashbacks of the event that disrupt sleep, concentration, and normal emotional expression. Frequently, this may lead the patient to alcohol or other chemical dependency, which only serves to complicate the problem. Others find that they develop their own strong defense mechanisms and go on with their lives. Treatment usually requires some form of long term therapy, usually in a group context in which the survivors "debrief" their experiences over and over again.

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DISORDER: Post Traumatic Stress Disorder (PTSD)

OLDER TERMS: Shell Shock, Transient Situational Disorder, Combat Fatigue

CLASSIFICATION: anxiety disorder OLDER: neurotic disorder

SUBTYPES AND RELATED DISORDERS: within the first three months, known as adjustment disorder

SYMPTOMS: flashbacks, nightmares, disturbed concentration

CAUSES: principal cause is exposure to traumatic situation such as combat, torture, rape

TREATMENT: group psychotherapy

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Case Study: Mr. Z, age 81, was a new nursing home patient who had been admitted for purely physical reasons. He had no previous history of psychiatric disorders, but became extremely fearful and potentially combative when the certified nursing assistant tried to get him for the first time into the shower. A small dose of haloperidol was tried, but with no real improvement. A social worker then interviewed Mr. Z and discovered that he had survived a holocaust death camp, where he had learned to associate going to the shower with being gassed. Although this nursing home had a holocaust survivors reminiscence group, Mr. Z said that he preferred not to participate. The social worker agreed that his defense mechanisms had served him well for over fifty years and should not be tampered with now. The solution to the presenting problem was to remove the terrifying stimulus: Mr. Z would be given baths instead of showers.

Obsessive compulsive disorder **OCD** is usually a defense against a phobia. The patient obsesses about the feared stimulus or situation and then compulsively enacts some dysfunctional behavior. OCD patients come in several varieties. **Arrangers** get nervous when things are out of order and compulsively want to keep things tidy. **Cleaners** fear dirt or germs, and compulsively try to clean and disinfect (e.g., washing one's hands hundreds of times a day). **Counters** fear losing or forgetting something important, and compulsively count irrelevant things over and over again (e.g., "Do I still have 43 cents in my pocket or have I lost some coins?"). **Checkers**, before they leave home or go to bed, may have to go around the house a dozen times to make sure that the gas is off and the doors are locked, and then drive around the block again just to make sure. **Clutterers** are so afraid of throwing away something of future value that they keep everything, to the point where their houses may become an unlivable pile of junk and trash.

Treatment for OCD can include variants of anti-depressant medication along with different forms of psychotherapy. If a specific underlying phobia can be identified, then the behavioral approaches of flooding and desensitization can also be considered.

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DISORDER: Obsessive Compulsive Disorder (OCD)

CLASSIFICATION: anxiety disorders   OLDER: neurotic disorder

PREVALENCE: 2 percent

SYMPTOMS: intrusive thoughts and images, irresistible acts (e.g., cleaning, checking, counting, cluttering, arranging)

CAUSES: negative reinforcement: avoidance or escape conditioning

TREATMENT: cognitive-behavior therapy; SSRI anti-depressants (e.g., Prozac)

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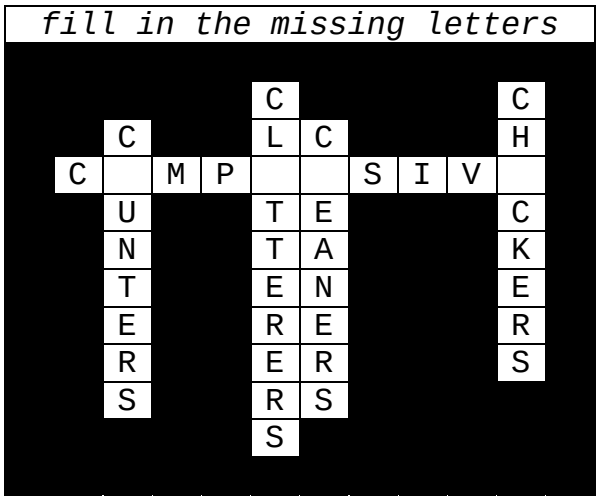

QUESTION #11.7: What is hysteria?

Hysteria is an old term used at the time when Freud was in training. **Hysteria refers to those mental disorders in which an unconscious mental block brings about the loss of a function**. Now we classify these disorders into somatoform and dissociative reactions.

Somatoform disorders deal with the body. These **conversion disorders** result in the upsetting or **loss of a physical function**. The function may be sensory (e.g., paresthesias, anesthesia, blindness, deafness) or motor (e.g., walking, talking, gagging, fainting, sneezing). These disorders were common during Freud's time, especially in women, but are now rather rare in the U.S. and other developed countries.

Case Study: Mr. D, age 19, comes from a small, rural village in Mexico where the public school system only went up to the sixth grade, and until five years ago, there was no electricity. Mr. D grew up in an environment in which regular contacts with the public health service were rare, and when someone was ill a local *curandero* or herbalist would be called in. He had a great aunt who at the age of 12 disappeared for a week, and then suddenly reappeared, claiming that she had been taken by the Devil. The entire village has heard that story, and no one has ever publicly doubted it. Mr. D knew that he would have to venture out of his village to find some opportunity in life so he joined the Mexican military. He was assigned to paratrooper training at the air base just west of Acapulco. He had not previously been close to an airplane, let alone up in one, and now he is being told that he will be jumping out of one. On the morning of the day that he was to make his first jump, he fell out of bed and claimed that his legs were paralyzed. He was not consciously faking it. The mental block was unconscious.

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DISORDER: conversion

OLDER TERMS: hysteria

CLASSIFICATION: somatoform; neurosis (old), functional (old)

PREVALENCE: widespread in 19th century, rare today in developed areas

SYMPTOMS: loss of a bodily function (e.g., sight, walking, talking, hearing, swallowing) for which no organic cause can be found

CAUSES: psychoanalytic theory: unconscious mental block; behavioral theory: secondary reinforcement of attention and escape

TREATMENT: psychoanalysis, sodium pentothal, hypnosis

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Somatoform patients present to physicians in general practice or one of the non-psychiatric specialties. The diagnosis of conversion reaction is a process of elimination. Extensive laboratory and neurological tests are performed and only when a physical cause of the disorder can be ruled out should a psychiatric diagnosis be considered. Before the unconscious mental block of conversion can be inferred, one more possibility must be ruled out: the conscious faking of a physical disability known as factitious disorder (i.e., malingering, goldbricking). This is a much more likely explanation, especially when the loss of physical function is associated with a chance for financial gain (e.g., an insurance settlement) or getting out of military duty.

= =

DISORDER: malingering, factitious disorder

OLDER TERMS: goldbricking

CLASSIFICATION: somatoform; neurosis (old)

PREVALENCE: widespread among military conscripts

SYMPTOMS: loss of a bodily function (e.g., sight, walking, talking, hearing, swallowing) for which no organic cause can be found; what differentiates this from conversion reaction is that the patient is consciously faking

CAUSES: behavioral theory: monetary gain or escape from duty

TREATMENT: non-reinforcement

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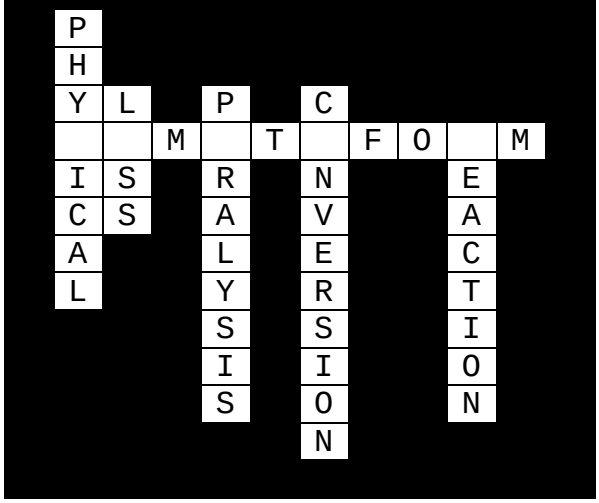
Once the diagnosis of conversion has been inferred, the quickest treatment for somatoform disorder remains hypnosis. If the patient is not easily hypnotized, a drug such as sodium pentothal ("truth serum") might be useful. (This was all that was needed for Mr. D, the Mexican paratrooper.) Long term psychotherapy may be called for in some patients.

fill in the missing letters



Do not confuse conversion reactions with hypochondriasis or psychosomatic disorders. Most **hypochondriacs** complain vigorously, but manifest no loss of physical function, while the conversion patient has lost a function, but may not seem all that upset. The treatment also differs. Hypochondriacs might benefit from a little supportive psychotherapy, but they are usually helped most by anti-depressant medication. **Psychosomatic** (psychophysiologic) disorders are where there is a real physical problem, exacerbated by stress.

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DISORDER: hypochondriasis

CLASSIFICATION: somatoform; neurosis (old), functional (old)

SYMPTOMS: delusions of physical illness, diverse somatic complaints, compulsive seeking of medical attention

CAUSES: behavioral theory: secondary reinforcement of attention and escape; seems to be activated by comorbidity of depression

TREATMENT: anti-depressant medication; non-reinforcement

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Comparison of disorders of the body			
Disorder	**Psychosomatic**	**Conversion**	**Hypochondriasis**
Also known as	Psychophysiologic	Somatoform	Crock
Examples	Skin rash, Migraines, Hypertension	Paralysis Paresthesias Blindness	Doctor shopping
Physical cause	Maybe some	No	No
Physical symptoms	Yes	Yes	Not real
Level of patient complaint or concern	Varies	Low	High
Environmental cause	Stress	Feared situation	Social obligation or manipulation
Behavioral modification	Biofeedback	Operant conditioning	Extinction
Medication	Symptomatic relief	Sodium pentothal	Anti-depressant
Psychotherapy	Supportive	In-depth	Supportive

Dissociative reactions involve an unconscious mental block that results in the patient losing the some function of memory or identity. Depersonalization may be the most common and mild form. The patient is troubled by recurring thoughts that he himself, and/or the entire world, are not really real.

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DISORDER: depersonalization

OLDER TERMS: hysteria

CLASSIFICATION: dissociative, neurosis (old)

PREVALENCE: more common than other dissociative disorders

SYMPTOMS: subjective perception of unreality of external world and/or self

TREATMENT: psychoanalysis, client-centered therapy

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Another relatively simple form is psychogenic **amnesia**. The patient presents a loss of memory too great to be explained by the normal processes of forgetting. This is also a diagnosis by exclusion. The most likely alternatives of dementia and physical trauma (e.g., blow to the head or electro-convulsive shock) must be ruled out. Malingering must also be considered.

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DISORDER: psychogenic amnesia

OLDER TERMS: hysteria

CLASSIFICATION: dissociative, neurosis (old), functional (old)

PREVALENCE: rare

SYMPTOMS: loss of memory that cannot be explained by normal forgetting, dementia, or physical trauma

CAUSES: exposure to an emotionally traumatic situation

TREATMENT: psychoanalysis, sodium pentothal, hypnosis

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Even more rare is a **fugue** disorder, a dissociative reaction in which the loss of memory is complete for the previous identity. The patient also travels several hundred miles from his residence or place of employment. They are then usually discovered in a dazed condition. Conscious fabrication (perhaps associated with criminal intent or psychopathy) is a good alternative explanation. Indeed, if there is any evidence of premeditation or planning (such as shifting money into different accounts or setting up a false identity) that would rule out fugue.

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DISORDER: fugue

OLDER TERMS: hysteria

CLASSIFICATION: dissociative, neurosis (old), functional (old)

PREVALENCE: rare

SYMPTOMS: loss of memory and previous identity, departure from usual surroundings; cannot be attributed to conscious intent

CAUSES: exposure to an emotionally traumatic situation

TREATMENT: psychoanalysis, sodium pentothal, hypnosis

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Case Study: Ms. H, 32, lives in rural Mexico, the common law wife of an agricultural laborer. She has been with Mr. H for twelve years and stuck with him only because of her two children. Mr. H has problems with drinking and battering, but most of the time he was away, north of the border working and sending a little money home. A few months ago, the two children and the parents of Ms. H died in a bus accident. When

Mr. H returned home from the U.S., he was especially brutal, blaming her for the loss of their children. She disappeared with just the clothes on her back, and was found two weeks later at a bus stop in the next state, claiming that she did not know who she was.

The rarest and most severe of all dissociative reactions would be **dissociative identity disorder** (i.e., "multiple personality"). The individual's regular (host) personality tends to be rather meek and passive. At least one other personality is developed. These alter personalities pop out without warning and take over the individual's behavior: posture, gestures, facial expressions, voice tone and word choice changes dramatically under the influence of the other personality. The alter personalities are aware of the host personality, but regard it with contempt for being too weak. The alter personalities tend to be more confident, bold, and daring. The host personality is not consciously aware of the existence of these other personalities, and the time when they pop out is later perceived as a blackout period. In most cases, the patient's childhood was a traumatic one and the dissociative identity can be seen as some sort of defense mechanism, "This is not happening to me, but to her, because she is so weak." Treatment for most dissociative reactions is similar: hypnosis or sodium pentothal interviews combined with long term psychotherapy (with an emphasis on the latter in the more severe cases).

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DISORDER: dissociative identity disorder

OLDER TERMS: hysteria, multiple personality

CLASSIFICATION: dissociative, neurosis (old), functional (old)

PREVALENCE: rare, but seen more often than it was fifty years ago

SYMPTOMS: host personality is weak, passive; alter personalities pop out and dominate the individual's behavior, and these periods of dominance are perceived as blackouts

CAUSES: enduring reaction to childhood abuse

TREATMENT: psychoanalysis, sodium pentothal, hypnosis

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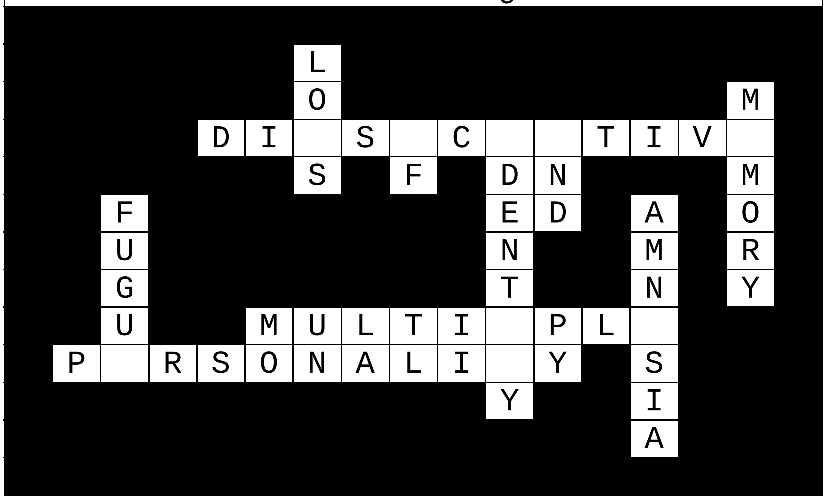

QUESTION #11.8: What is psychosis?

Psychosis (plural, psychoses; adjective, psychotic) refers to serious mental disorders (as opposed to the more mild, neurosis) and involves a severe inability to function within normal society. It used to be said in jest that the neurotic may build imaginary castles in the air, but it is the psychotic who actually tries to live in them.

Schizophrenia is a psychotic disorder. It is not a "split" or multiple personality (that is the rarer, dissociative reaction). Schizophrenia is defined by its symptomatic cluster. Schizophrenics have severe **delusions (false beliefs)** sometimes relating to identity. I have met the “President of Argentina,” holding an imaginary cabinet session, in *Hospital Borda* in Buenos Aires; and the Devil and the Son of the Devil (same patient) outside of Santo Domingo. Another frequent symptom is **hallucinations (sense experience in the absence of stimuli)** especially voices which the patient perceives as threatening and insulting. Another possible symptom is bizarre use of language. The patient may think that he is waxing profound and poetic, but it sounds like word salad with strange grammar and invented words. Most schizophrenics have difficulty expressing an emotion appropriate to the occasion. They may appear to be more happy, sad, angry, or frightened than the situation would call for. Another possibility is "flat affect" in which the patient seems entirely aloof to what is going on around him. Deficits in social skills may be observed in many patients.

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DISORDER: schizophrenia

OLDER TERM: dementia praecox

CLASSIFICATION: psychosis

PREVALENCE: 1 percent

SUBTYPES AND RELATED DISORDERS:

SCHIZOPHRENIFORM: all the required symptoms, but a duration of less than six months

PARANOID: bizarre and incredible delusions of persecution, plots and thought control

CATATONIC: extreme withdrawal to the point of acting like a statue

PROCESS: chronic, gradual onset, no stressful precipitant, poor prognosis

REACTIVE: acute, rapid onset after stressful event, better prognosis

REFRACTORY: term given to schizophrenia case which is not responsive to treatment

RESIDUAL: delusions, bizarre language, and hallucinations are absent, but the patient remains socially withdrawn

SYMPTOMS: "positive" symptoms include hallucinations, delusions, agitation, bizarre use of language; "negative" symptoms include deficits in social skills, affective response

AGE OF ONSET: 15 to 25

CAUSES: there is a genetic (and/or intrauterine congenital) predisposition; the principal cause would be abnormalities of brain structure or chemistry (e.g., surplus of dopamine)

TREATMENT: anti-psychotic medications (old: Thorazine, Mellaril, Haldol; new: Risperdal, Clozaril). Older medications carry high risk of tardive dyskinesia

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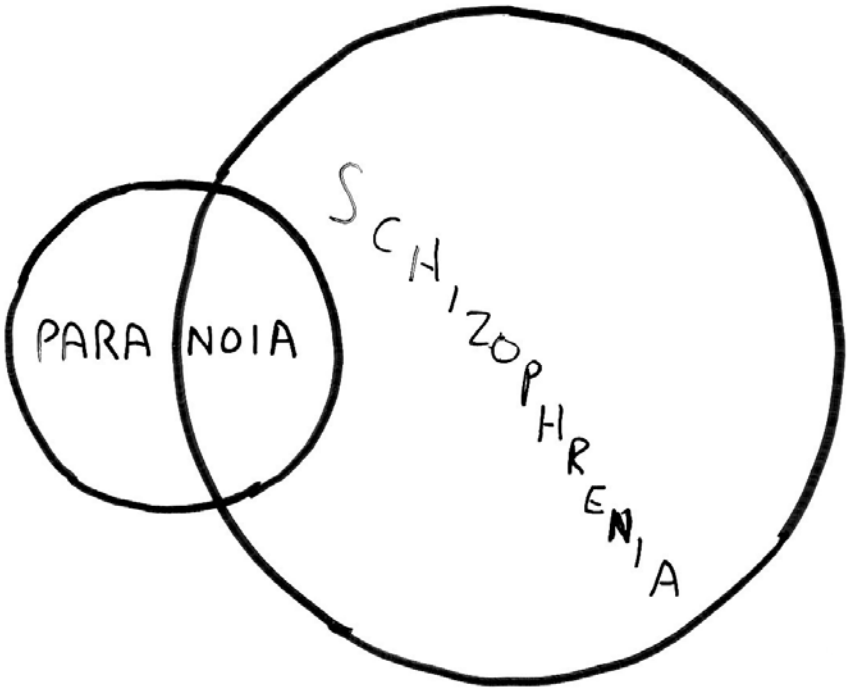
Case Study: Mr. L, was born in Cuba before the Castro Revolution. His family moved to Mexico in the early 1960s, and he was sent to a boarding school in the U.S. He finished his bachelor's degree at an Ivy League college and earned an M.B.A. from another prestigious university. He told his family he was having "adjustment" difficulties during his first year of graduate work, but his family began to fear that he was coming down with the strain of mental disorder found in an uncle and a couple of cousins. He returned to Mexico, and spent a short time working for the family business in Mexico City. With his next breakdown, they decided to send him to a luxurious mental hospital just outside of Guadalajara, where he remains today. When he is on his medication, he dresses impeccably, reads the *New York Times* each day, and has fooled more than one visitor into thinking that he is the director of the asylum instead of one of the patients. If he misses his medication, he cannot comprehend what he reads, sees, or hears, and quietly retreats to a private world. If the family were more motivated, he could probably be living at home, and perhaps helping out with the family business.

Relationship between Schizophrenia and Paranoia



Catatonia and paranoia are types of schizophrenia. **Catatonics withdraw into a statue-like stupor** for periods of several hours. **Paranoids have delusions of persecution and extreme suspiciousness**. Some depressed patients and many early stage dementia patients also develop paranoid delusions, but when schizophrenics become paranoid, their delusions are bizarre. The conspiracies might be incredible, involving the Mafia, CIA, and space aliens conspiring to read the patient's thoughts.

Schizophrenia has at least a biological predisposing cause (and probably that is also the principal cause). Some investigators have suggested that there might be some cause coming from a dysfunctional family of origin, perhaps a mother who is cold or too controlling. These factors might serve more as a perpetuating cause: the parents and other family members are reacting to the patient's deteriorated behavior, and unfortunately their reactions might make it worse.

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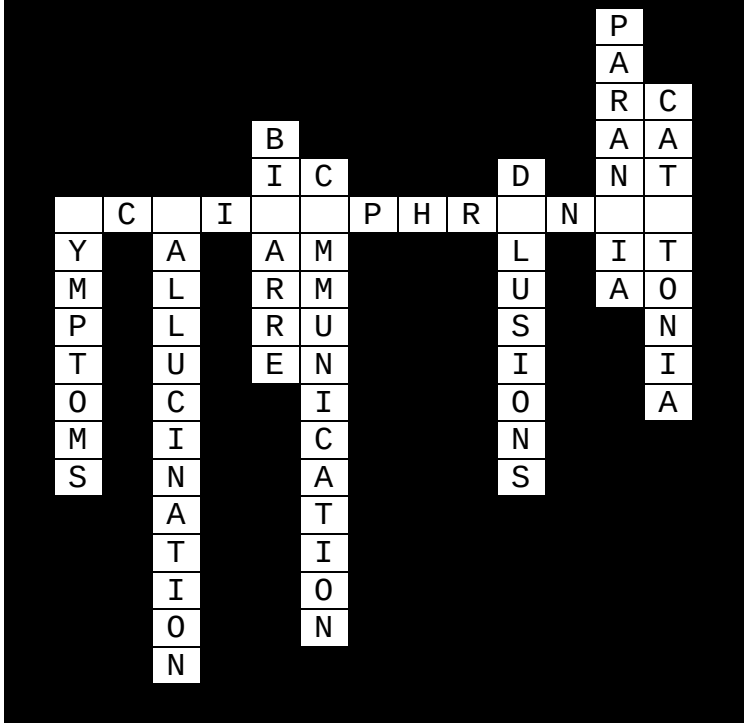

The genetic link in schizophrenia (and mania) is probable: the closer the genetic relatedness between two individuals, the more likely that if one is diagnosed with schizophrenia, so will the other one. The incidence of schizophrenia in the general population is about one percent, in children or siblings of schizophrenics it is about ten percent, but if one identical twin is diagnosed with the disorder, odds are about even that the other will also get that diagnosis. While most children of schizophrenics do not develop schizophrenia themselves, they might be carriers of a gene that makes for susceptibility to the disorder. It is very rare that someone will be diagnosed as schizophrenic unless someone else in the family tree has already received that diagnosis.

Treatment for schizophrenia must center on medication to control the symptoms. Schizophrenics generally do not follow very well the structured approach of cognitive therapy. Freud himself argued against using psychoanalysis with schizophrenics: they are already lost in their own free association. More client-centered, and Jungian therapists have reported some favorable results, especially with teenage, reactive patients. About a third of schizophrenics require lifetime hospitalization. Behavioral approaches (such as token economies) and psychosurgery are usually limited to making the patient more manageable within an institutional context.

Comparison of major mental disorders					
Disorder	**Depression**	**Anxiety**	**Bipolar**	**Schizophrenia**	**Multiple personality**
Classification	Mood	Anxiety	Mood	Psychosis	Dissociative
Incidence	Common	Common	Low	Low	Very rare
Gender predominance	Female	Female	Equal	Equal	Female
Age of onset	Anytime	Anytime	15-30	15-25	15-30
Link to heredity	Moderate	Moderate	Great	Great	Little
Link to childhood trauma	Moderate	Moderate	None	Little	Great

QUESTION #11.9: What is a psychopath?

Psychopath (also known as sociopath) is an older term for what the DSM now calls **anti-social personality**. This is one of several Axis II diagnoses known as personality disorders. The antisocial personality is best understood as **a person without a conscience**, someone who can easily exploit or harm someone else without guilt or remorse. Most criminals probably do not fall into this category: for many have a real sense of shame and remorse for what they have done. Not all psychopaths end up incarcerated. Many may stay on the fringes of legitimate business (or go into politics) and are clever enough to avoid getting caught. Psychopaths are skilled liars and charmers.

There are two basic types of anti-social personality: violent and non-violent. The violent ones are the rare serial killers who target strangers just for the thrill of the power. The non-violent are more common. They tend toward imposture and swindling.

Case Study: Mr. U, age 56, was finally brought to trial in Arizona for bigamy. It was discovered that he had married (and neglected to divorce) over a hundred women. His pattern was to court wealthy women who had been recently widowed. Although he was short, balding, and chubby, he was very charming. Soon after the marriage, he would figure out a way to abscond with the woman's fortune, and then go to another town and do the whole thing over again with some other victim.

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DISORDER: antisocial personality disorder

DSM-IV: Axis II

OLDER TERMS: psychopath, sociopath

PREVALENCE: two to three percent, more common among men

CLASSIFICATION: personality disorders, character disorder (older)

SYMPTOMS: exploits others without guilt, shame or remorse; manipulative, deceitful, some are violent; history of conduct problems as a child

AGE OF ONSET: childhood or adolescence

TREATMENT: none effective

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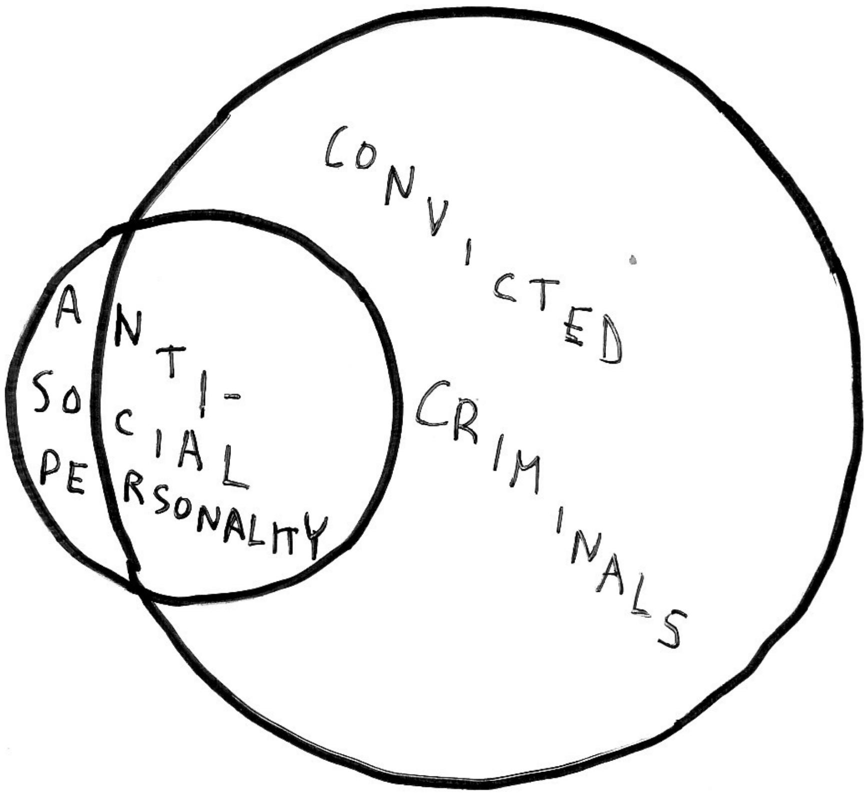
Anti-Social Personality and Convicted Criminals



Somewhat less dangerous are the histrionic and narcissistic types. They both crave to be the center of attention and demand to be treated with special status by those around them. Histrionics tend to be a little more obnoxious about it, with self-dramatizing behavior comparable to that of soap-opera characters.

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DISORDER: histrionic personality disorder

DSM-IV: Axis II

OLDER TERMS: hysterical personality disorder

PREVALENCE: two or three percent, more common among women

CLASSIFICATION: personality disorders, character disorder (older)

SYMPTOMS: chronic and excessive attention seeking; self-dramatization, irritability

AGE OF ONSET: childhood or adolescence

TREATMENT: none

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DISORDER: narcissistic personality disorder

DSM-IV: Axis II

PREVALENCE: two to three percent

CLASSIFICATION: personality disorders, character disorder (older)

SYMPTOMS: preoccupation with admiration of others, self-promoting, lack of empathy

AGE OF ONSET: childhood or adolescence

TREATMENT: none

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The **borderline** personality initially appears to be a case of depression or bipolar. The patient turns out to be non-compliant with medication, manipulative in psychotherapy, and frequently self-mutilating. The label of borderline personality is assigned when the therapist realizes that further treatment is fruitless.

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DISORDER: borderline personality disorder

DSM-IV: Axis II

CLASSIFICATION: personality disorders, character disorder (older)

PREVALENCE: two to three percent; more common among women

SYMPTOMS: impulsive, emotional instability, angry outbursts, fear of being alone, manipulative, boredom, self-mutilation, suicidal risk

AGE OF ONSET: childhood or adolescence

TREATMENT: none

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Personality disorders are not generally regarded as treatable. No medication controls their obnoxious behavior. No known psychotherapy has consistently brought about transformation. Indeed, friends and family members (victims) must decide if they even want these characters in their lives. Even after exploiting their victims horribly, psychopaths tend to return to their victims in hopes of another success.