MENTAL HEALTH AND MENTAL DISORDERS

AN ENCYCLOPEDIA OF CONDITIONS, TREATMENTS, AND WELL-BEING

LEN SPERRY, EDITOR-IN-CHIEF

Mental Health and Mental Disorders

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Volume 1: A–E

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This book discusses treatments (including types of medication and mental health therapies), diagnostic tests for various symptoms and mental health disorders, and organizations. The authors have made every effort to present accurate and up-to-date information. However, the information in this book is not intended to recommend or endorse particular treatments or organizations, or substitute for the care or medical advice of a qualified health professional, or used to alter any medical therapy without a medical doctor's advice. Specific situations may require specific therapeutic approaches not included in this book. For those reasons, we recommend that readers follow the advice of qualified health care professionals directly involved in their care. Readers who suspect they may have specific medical problems should consult a physician about any suggestions made in this book.

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Preface

The quest to understand mental health and its disorders is first noted in the writings of the ancient Greeks. With today's new technologies and constant research, scientists have uncovered many causes of mental disorders and conditions as well as new treatments to reduce symptoms as well as prevent these conditions. "Mental health" is a broad term that encompasses both dysfunction and well-being from conception through the life span.

The purpose of this encyclopedia is to provide a wide-ranging reference source on mental health and its disorders, written at a level accessible for upper high school and college students as well as for the layperson. The encyclopedia provides insights into the discipline of mental health and covers both healthy functioning and mental disorders or conditions, treatment methods, and factors that promote mental health and well-being.

Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being aims to open the door to mental health research for readers, as well as direct them to accurate and current resources for further investigation.

Scope

This encyclopedia helps the reader understand mental disorders and their treatment as well as normal development and prevention of mental illness. This reference work covers virtually every topic and consideration involving mental health. The reader will find that the 875 entries in this three-volume work comprise six areas of emphases:

- Mental disorders and conditions. These include both common and relatively rare disorders. Also included are diagnostic characterizations that follow the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, commonly known as DSM-5.
- Treatment of these disorders. These include prescribed medications, psychological therapies, and herbs and other natural remedies.
- Tests and assessment methods used in evaluating or diagnosing mental conditions. These include standardized paper and pencil tests as well as biological and brain-imaging methods.
- Common psychological terms and concepts associated with mental and emotional well-being.

- Highly regarded individuals and organizations influential in researching disorders, developing treatments, or fostering professional development.
- Popular and classic books and films as well as high-profile individuals and culture-changing events. These have significantly influenced our understanding of mental health and illness and are also profiled.

To increase readability, technical terms are defined near the beginning of most entries. Terms are also included in the glossary at the end of volume three.

Contributors

The 13 contributors to this encyclopedia are all uniquely qualified to speak with authority regarding at least one aspect of mental health and its disorders. They have formal training and experience in psychiatry, clinical psychology, clinical mental health counseling, or child and adolescent development. Most have specialized in working with children, adolescents, and young adults and recognize the critical role of culture in mental health and illness. The collective expertise of these contributors allows a much broader understanding of mental health issues than a single author could ever provide.

User-Friendly Features

Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being is organized in the customary A–Z encyclopedia format. At the front of each volume is an alphabetical listing of all entry headings ("Alphabetical List of Entries"), allowing the reader to scan the list of all entries. A "Guide to Related Topics" is an additional aid, listing all the entries in the book under broad topics. Readers can look under topics such as "Disorders," "People," and "Social Issues" to quickly see all the entries included for that topic.

All entries have a "See also" section that connects the reader to other relevant topics. For example, in the entry "Anxiety Disorders in Adults" the connecting and cross-references will direct the reader to other entries that discuss similar disorder symptoms (Agoraphobia, Generalized Anxiety Disorder, Panic Attack, Panic Disorder, Social Phobia, Specific Phobia), and various treatment methods and approaches (Antianxiety Medication, Antidepressant Medication, Cognitive Therapy, Exposure Therapy).

Further Reading and Selected Resources

Each entry also includes current, reliable sources for additional statistics, research, or consumer-friendly education. Books, articles, and websites are included, allowing the reader to choose the level of detail and depth for further data and material. "Recommended Resources," a specially chosen short list of good books and online resources that are helpful to the layperson or student, is featured at the end of volume three. That volume also includes the "Glossary" of terms, with succinct definitions or descriptions of concepts, disorders, treatments, tests, and important people. The "List of

Organizations" features more than 120 groups and resource centers, ranging from the Albert Ellis Institute to the Association for Applied Sport Psychology to the Workplace Bullying Institute. The encyclopedia concludes with a comprehensive index.

Where to Start?

Obviously a reader's starting point is individually driven; however, if you are interested in a specific mental disorder, please read that entry first and follow it up with reading the "See also" selections. If you are using this reference for a research paper on a specific topic, simply start at the index or list of entries to guide you through the encyclopedia. Moreover, the further reading sections at the end of every work will provide you with additional references for your investigation. Finally, if you have an inquisitive mind and are a lifelong learner, allow yourself to be immersed in this ever-growing field of mental health as detailed in entries in these three volumes. You will find interesting and valuable information about this ever-developing field that may just pique your interest as it has mine.

Concluding Note

While this encyclopedia broadly overviews the expanding field of mental health in its extensive number of entries, it does not provide complete information on any one topic. The "Recommended Resources" section at the end of volume three provides readers with additional information to explore selected topics more fully. Furthermore, the material in this encyclopedia is not intended to be used for diagnostic purposes or for psychological treatment. While self-knowledge can be very helpful, it is not a substitute for professional help. Finally, because indications for psychological treatments continually change, readers are advised to seek updates from health professionals, professional literature, or authoritative websites.

Acknowledgments

This project was a joy to work on as it allowed me to share my passion about mental health and well-being with everyone. However, this project was enormous and could not have been completed without the help and devotion of my coeditors, Alexandra Cunningham, PhD, Melissa Mariani, PhD, Mindy Parsons, PhD, and Steven Vensel, PhD, and the other contributing authors.

Len Sperry, MD, PhD

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Introduction: Mental Health

Mental health is a continuum, ranging from states of well-being to stressful life experiences to severe mental disorders. We hope that readers of *Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being* will find it a useful reference source for specific purposes like academic assignments, term papers, job reports, or, more generally, for better understanding themselves and others.

This three-volume encyclopedia is subtitled *An Encyclopedia of Conditions, Treatments, and Well-Being*. The following paragraphs will focus on these three concepts: conditions or mental disorders, treatments, and well-being. Before that let's first look at mental health.

Mental Health

So what is mental health? Mental health can be thought of as successful mental functioning that results in productive activities, fulfilling relationships, and the ability to cope with change and adversity. Another way of saying this is that mental health is indispensable to effective personal functioning, interpersonal and family relationships, and community life.

Change exerts a constant influence on mental health and can be a major source of anxiety for many in their personal and professional lives. Change, by itself, whether for good or not, can be a source of stress and can negatively influence mental health. For example, technological changes continue at an accelerating pace, and while they can be useful to many individuals, they pose a stressful challenge to others.

Advances in health care can positively or negatively affect mental health. For example, older adults today have increased their life and health expectancies compared with Americans 10 years ago. That means that those over the age of 65 have fewer physical health concerns. But a decline in mental faculties among an increasing number of aging adults can create significant mental health concerns. For instance, dementia and Alzheimer's disease were not major health and mental health concerns in the past because relatively few lived past the age of 60. In 1900 there were 120,000 Americans over age 85, while today there are more than 4 million older adults of that age, making them the fastest-growing age group. The U.S. Census Bureau estimates that by 2030 there will be 72 million adults over the age of 65, which represents 20% of the American population. Among those 85 and older it is estimated that 50% will be diagnosed with Alzheimer's disease (Vincent and Velkof, 2010). The point of these examples is that mental health and mental disorders are influenced by various factors.

Mental Disorders

Mental disorders are primarily disorders of the brain. These conditions usually have multiple causes and result from complex interactions between individuals' genes and their environment. Lifestyle factors and health behaviors, like smoking and exercise, and life experiences, such as severe and prolonged stress or a history of abuse, are such factors. Typically, such factors interact with an individual's genetic or biological predisposition to a mental disorder. For example, a traumatic brain injury or a mother's exposure to viruses or toxic chemicals while pregnant may play a part. Other factors that can increase the risk for mental illness are the use of illegal drugs or having a serious medical condition like cancer. Research on the causality of mental illness has convincingly replaced the now-disproved belief that mental illness is a moral failure.

Mental illnesses occur at similar rates around the world, in every culture and in all socioeconomic groups. Statistics reveal that one in five individuals suffer from a mental disorder. This represents at least 20% of Americans. However, only one-fourth of those individuals with disorders are receiving treatment (SAMHSA, 2014). And, currently, only about 4% of America's health-care budget is spent on mental health treatment and prevention.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (called DSM-5), published by the American Psychiatric Association, provides a common language and standard criteria for the classification of mental disorders. It is the most commonly used clarification system in North America. It classifies mental disorders into categories. There are more than 20 categories of which the following are the most common.

- Anxiety disorders are disturbances in brain mechanisms designed to protect you from harm.
- Mood disorders are disturbances in usual mood states.
- Psychotic disorders are disturbances of thinking perception and behavior.
- Personality disorders are maladaptive personal characteristics.
- Eating disorders are disturbances of weight and feeding behavior.
- Substance-related and addiction disorders are disturbances of cravings.
- Neurodevelopmental disorders are early disturbances in usual brain development.
- Trauma- and stressor-related disorders are disturbances related to significant stressful events.

For example, post-traumatic stress disorder (PTSD) is one of the trauma- and stressor-related disorders. It is a common occurrence in those who witnessed or survived traumatic situations. Many veterans of the war in Iraq and Afghanistan suffer from PTSD and experience symptoms of flashbacks, nightmares, feelings of constant vigilance, and depression. But not all who were deployed to Iraq experience PTSD. Rather, it is most likely to occur in those with a biological predisposition.

Depression is a mental disorder experienced by more than 120 million American adults each year. Depression is a leading cause of drug and alcohol use. Sleep difficulties result in nearly 50 million prescriptions being written for sleep medications per year. Many individuals manage their anxieties by overeating or smoking. Over

time, unhealthy ways of coping take their toll on physical as well as mental health, particularly in those who are predisposed to such conditions.

Treatment

Significant advances have been made in the treatment of mental disorders. This increased understanding of the causes of mental health disorders (at least some of them) and increasingly effective treatments allow clinicians to better tailor treatment to those disorders. As a result, many mental health disorders can now be treated almost as effectively as medical conditions.

Generally, treatment for mental health disorders is characterized as either somatic (biological) or psychological. Somatic treatments include drugs, electroconvulsive therapy, and other therapies that stimulate the brain. Psychological treatments include psychotherapy (individual, group, or family and marital), behavior therapy techniques (e.g., relaxation training or exposure therapy), and hypnotherapy. Research suggests that for major mental health disorders like major depressive disorder, a treatment approach involving both drugs and psychotherapy is more effective than either treatment method used alone.

Clinicians who treat mental disorders include psychiatrists, clinical psychologists, mental health counselors, social workers, and psychiatric nurse practitioners. However, in most states, psychiatrists and psychiatric nurse practitioners are the only mental health clinicians licensed to prescribe drugs. Other clinicians practice psychotherapy primarily. Many primary care doctors and other medical specialists also prescribe drugs to treat mental health disorders.

Well-Being

In the past, mental health treatments focused largely on reducing symptoms or returning the individuals to their previous level of functioning. Today, however, treatment may also focus on increasing individuals' functioning, resilience, and prevention. This focus is known as well-being. Well-being is defined as how individuals think about and experience their lives. It is an indicator of how well individuals perceive their lives to be going. It reflects several health, job, family, and social outcomes. Accordingly, higher levels of well-being are associated with decreased risk of disease, illness, and injury. It is associated with faster recovery for illness, better immunity, increased longevity, and better mental health. Those with high levels of well-being are more productive at work, tend to get along better with others, and are more likely to contribute to their communities.

While there is not yet consensus among researchers or clinicians on the definition of well-being, most agree that well-being involves the presence of positive emotions and the absence of negative emotions. Most would agree that it includes satisfaction with life, a sense of personal fulfillment, and positive functioning. In short, it is about judging life positively and feeling good. Furthermore, most agree that well-being is broader and more inclusive than mental health. In fact, several kinds of well-being can be described and are currently being researched. These are physical well-being, economic well-being, social well-being, emotional well-being, and psychological

well-being. Depression, anxieties, addictive behaviors, and severe physical pain make it difficult to attain and maintain well-being. The reason is that these conditions interfere with the ability to see beyond one's immediate negative experience.

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A

Abandonment

Abandonment is a psychological concept that defines a set of emotional reactions and behavioral responses to perceptions of rejection or loss in personal relationships.

Description

Abandonment, sometimes referred to as "abandonment issues," is a psychological concept related to the fear of rejection, loss, and helplessness in personal relationships. Abandonment issues develop in childhood, cause stress in relationship, and are treatable. Abandonment issues are associated with intense feelings of fear, sadness, loneliness, anger, and worry in response to perceived rejection and disapproval. Breaking up with a boyfriend or girlfriend, not being accepted by peers, someone not returning a phone call, or not being included in activities are examples of events that can cause feelings of abandonment. Abandonment dynamics are not identified as a specific psychological diagnosis but are included in the list of symptoms of various disorders such as borderline personality disorder and attachment disorders.

Abandonment dynamics involve how events are perceived and the intensity of feelings resulting from those perceptions. Perceptions are the thoughts and beliefs about the event. Feelings are the emotional reaction connected to the thoughts and beliefs. For example, it would be appropriate for an individual who was not asked to go to the movies with a group of friends to feel disappointed. If the person believes he or she was not included because friends thought the person was not available, even though available, the person perceives he or she was not included due to a misunderstanding about schedules. The person may feel disappointed or annoyed but is able to quickly get over it. A person with abandonment issues would perceive this as a personal rejection. The person would excessively worry over what he or she may have done to cause the rejection. The person may become enraged at being treated that way and spend days thinking about it and wondering why he or she was treated so unfairly. People with abandonment issues take things very personal and perceive events as extremely hurtful and are often overwhelmed by emotion.

Abandonment issues develop in childhood and are related to physical or emotional neglect and loss. Children need unconditional love and nurture. The loss of a parent through divorce, prolonged separation, or death can result in abandonment issues. A child who is emotionally abandoned may have one or both parents in the home but receive little love, guidance, warmth, approval, or emotional support from them. A child who is physically neglected by parents grows up alone, helpless, and rejected. Neglect and loss cause intense emotions, which become part of the child's personality. Neglect and loss in childhood can result in individuals who are always on the lookout for signs of being abandoned. Adults with abandonment issues are extremely insecure and sensitive.

Symptoms of abandonment include the following categories and examples:

- Clinging: desperation to remain close, needing constant reassurance of approval, an excessive need for affection and attention.
- Emotional blackmail: Use of threats of self-harm or rejection to continue the relationship.

- Low self-worth: personal value is determined by how others feel about you.
- Overreaction: excessive fear or panic reactions to small matters such as someone not answering a phone or not calling back right away.
- Submissive behaviors: doing things you do not want to do to keep others from rejecting you.

Current Status

Overcoming abandonment issues requires the help of mental health professionals. Talking therapies such as cognitive behavior therapy or dialectical behavior therapy can be effective in the treatment of abandonment issues. The focus of treatment is to decrease the emotional intensity and excessive behaviors associated with abandonment perceptions. Psychiatric medications are not prescribed in the direct treatment of abandonment issues but may be prescribed for individuals suffering from excessive anxiety and panic that is often associated with abandonment issues.

Steven R. Vensel, PhD

See also: Borderline Personality Disorder; Foster Care; Neglect

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Abilify (Aripiprazole)

Abilify is an atypical antipsychotic medication useful in treating the symptoms of schizophrenia and bipolar disorder and agitation in dementia. Its generic name is aripiprazole.

Definitions

- **Atypical antipsychotics** are a newer group of antipsychotic medications that are useful in treating schizophrenia and other psychotic disorders.
- **Extrapyramidal symptoms** are side effects caused by certain antipsychotic drugs. They include repetitive, involuntary muscle movements, such as lip smacking, and the urge to be moving constantly.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions. They are generated by the mind rather than by an external stimuli and can be caused by a medication, recreational drug, or mental disorder.

Description

Abilify is part of a class of drugs called atypical antipsychotics. They are called "atypical" because of their relatively lower risk of certain adverse side effects compared to traditional antipsychotic drugs. Abilify is useful in the short-term treatment of acute psychotic and acute manic states, as well as agitation in dementia. It is also used in the long-term treatment of chronic psychotic disorders. Abilify is thought to work by influencing dopamine, the neurotransmitter (chemical messengers) that affects movement and balance. Abilify appears to bind to dopamine receptors in the brain and prevent dopamine from fully activating them. This differs from traditional antipsychotics, which completely block dopamine receptors. Besides resulting in some relief of psychotic symptoms, these conventional drugs can cause severe movement side effects, called extrapyramidal symptoms, which Abilify does not.

Precautions and Side Effects

Abilify may increase the risk for diabetes, so those who are taking it and develop extreme thirst, frequent urination, or other diabetes symptoms should consult a physician. Women who are pregnant, intend to become pregnant, or are nursing should talk to their physician before beginning or discontinuing Abilify. There is increased risk for extrapyramidal symptoms,

and withdrawal symptoms in newborns whose mothers took Abilify during their third trimester of pregnancy.

Because Abilify can cause drowsiness and impair judgment and motor skills, individuals are advised not to operate a motor vehicle or machinery. Since it has a sedative effect, alcohol use should be limited when taking Abilify. Because Abilify can affect the body's ability to regulate temperature, potentially leading to overheating and dehydration, those taking it should be cautious when exercising.

While Abilify tends to cause fewer neurological side effects than the traditional antipsychotic medications, it does have some side effects. The most common ones are anxiety, constipation, difficulty sleeping, dizziness, drowsiness, headache, nausea, nervousness, numbness, tremor, vomiting, and weight gain. Because it can cause significant weight gain and the development of metabolic syndrome (prediabetes), a practitioner may use Glucophage (metformin—the generic name for this diabetes drug) in patients who may be developing this syndrome, in an effort to avoid the development of diabetes and cardiovascular disease.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Dopamine; Tourette's Syndrome

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Abuse

Abuse is the intentional physical, psychological, or sexual maltreatment of an individual.

Definitions

- **Adverse childhood experience** is a traumatic experience in an individual's life that occurs before the age of 18 and is remembered as an adult. The three main types are abuse (e.g., sexual), neglect (e.g., emotional), and household dysfunction (e.g., divorce).
- **Child abuse** is the physical, sexual, or emotional abuse of a child or minor, usually under the age of 18.
- **Domestic abuse** is the abuse by one partner against the other in an intimate relationship. It can involve physical, sexual, and/or psychological abuse.
- **Elder abuse** is the physical, sexual, or emotional abuse of individuals, usually one who is disabled or frail.
- **Neglect** involves refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- **Physical abuse** involves inflicting, or threatening to inflict, physical pain or injury on individuals or depriving them of a basic need.
- **Psychological abuse** involves inflicting mental pain, anguish, or distress on individuals through verbal or nonverbal acts. It is also called emotional abuse.
- **Sexual abuse** involves nonconsensual sexual contact of any kind, coercing an elder to witness sexual behaviors.

Description

Abuse is any action that intentionally harms or injures an individual. There are several types of abuse. These include neglect, physical abuse, sexual abuse, elder abuse, and psychological abuse. Substance abuse is another type of abuse. All forms of abuse in the United States are illegal and carry criminal penalties. A brief overview of the common forms of abuse across the lifespan follows.

Child abuse. Child abuse is a crime that all health and social service professionals are mandated to report. It takes various forms. The four main types are neglect, physical abuse, sexual abuse, and emotional abuse. The 2010 Child Maltreatment Report (NCANDS) found that neglect was the most common form of child abuse. It accounted for 78.3% of cases. By comparison, physical abuse accounted for 17.6% of cases. Sexual abuse accounted for 9.2% of cases, while psychological abuse accounted for 8.1% of cases. Adverse childhood experiences such as childhood sexual abuse may significantly impact the individual's health in adulthood.

Sexual abuse. "Sexual abuse" refers to nonconsensual sexual behavior between two adults, between an adult and child, or between two children, one of whom is forcefully dominant or significantly older. Sexual behaviors can include touching breasts, genitals, and buttocks while the victim is either dressed or undressed. Sexual abuse is also a reportable crime.

Domestic violence. Domestic violence involves abuse of an individual by another with whom the victim is living, has lived with, or is in a significant relationship. It is also known as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence. It also includes rape. It can involve physical, psychological, and/or sexual abuse, including rape. The National Coalition Against Domestic Violence estimates that 1 in 5 women and 1 in 33 men will be the victim of a rape or an attempted rape during their lifetime.

Elder abuse. Like child abuse, elder abuse is also a reportable crime. It can also involve emotional abuse, neglect, physical abuse, or sexual abuse. Often, more than one type of abuse occurs. It is committed by caretakers and may occur in the home or in a residential facility. The National Center on Elder Abuse reported that in 2013 nearly 6 million cases of elder abuse were reported.

Len Sperry, MD, PhD

See also: Adverse Childhood Experience; Child Abuse; Elder Abuse; Neglect; Sexual Abuse

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Help Hotlines in the United States

Childhelp National Child Abuse Hotline 1-800-4-A-CHILD. TDD for the Deaf 1-800-2-A-Child. Help for children who are being abused or adults who are concerned that a child they know is being abused or neglected.

Elder Abuse Hotline 1-800-252-8966. Assistance in reporting and counseling about elder abuse.

National Domestic Violence Hotline 1-800-799-SAFE (7233). TTY for the Deaf: 1-800-787-3224. Help for both men and women who are victims of domestic violence.

Abusive Personality

"Abusive personality" is a term used to describe the personality of those who criticize, dominate, undermine, and physically harm their intimate partners (spouses).

Definitions

- **Abuse** is any behavior that intends to harm another's self-esteem or restrict autonomy (independence).
- **Antisocial personality disorder** is a mental disorder characterized by a pattern of disregarding and violating the rights of others.
- **Borderline personality disorder** is a mental disorder characterized by a pattern of instability in interpersonal relationships, self-image, affects, self-harm, and a high degree of impulsivity.
- **Domestic violence** is a form of abuse between intimate partners (spouses). It is also called domestic abuse.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.

- **Emotional abuse** is a form of abuse characterized by a person subjecting or exposing another to behavior that may result in anxiety, chronic depression, or post-traumatic stress disorder.
- **Intermittent explosive disorder** is mental disorder characterized by impulsive, aggressive, violent behavior or angry verbal outbursts.
- **Male privilege** is the belief in some societies that men have power which exempts them from certain responsibility which women are expected to perform because of their subordinate status.
- **Post-traumatic stress disorder** is a mental disorder characterized by nightmares, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed.
- **Spousal battering** is a type of domestic violence which involves a systematic pattern of intimidation, control, terror, and physical violence for the purpose of gaining total control over the partner.
- **Trauma symptoms** are any symptoms (anxiety, angry outburst, depression, etc.) that occur as a result of a severely distressing event.

Description

The abusive personality is a psychological profile of individuals (usually males) who engage in a pattern of criticism, domination, undermining, and physical harm to their intimate partners. This profile and pattern has been described in detail by the research of Canadian psychologist Donald Dutton (1943–). He found that these individuals tend to be jealous, easily threatened, and fearful. They also tend to mask these feeling with anger and controlling behavior. Dutton's research indicates that these individuals also show borderline personality or antisocial personality disorder behaviors. They are also likely to display chronic trauma symptoms. Most have a history of physical abuse, shaming, and rejection as children.

Dutton's research also found that this pattern of abusiveness is more than learned behavior. It is also the outgrowth of particular personality dynamics, typically the antisocial or borderline personalities. Among those with the abusive personality, the borderline personality is the more common. According to Dutton, the individual's abusive behavior results from the cyclical and unstable dynamics of this personality disorder. This abusiveness has a cyclic pattern: tension building, spousal battering, and contrition and the resolve to never hurt the partner again.

While this characterization of the abusive personality emphasizes personality dynamics and early life experiences, it is limited. It does not include other considerations such as biological factors, social factors, nor the feminist view, particularly of male privilege. In this view, domestic violence against women by men is "caused" by the misuse of power and control because of male privilege. DSM-5 does not have a specific diagnosis for abusive personality. However, if the diagnostic criteria for intermittent explosive disorder are met, this diagnosis can be used to identify this abusive pattern.

Len Sperry, MD, PhD

See also: Antisocial Personality Disorder; Borderline Personality Disorder; Domestic Violence

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Acceptance and Commitment Therapy (ACT)

Acceptance and commitment therapy is a psychological treatment approach that assists individuals to accept what is outside their control and commit to action that enriches their lives. It is also known as ACT.

Definitions

- **Acceptance** is the process of opening up, making room, and dropping the struggle for painful feelings and sensations.
- **Cognitive defusion** is the process of stepping back or detaching from unhelpful thoughts, worries, and memories.
- **Committed action** is action guided by one's values.
- **Mindfulness** is conscious awareness of the present moment with openness and non-evaluation.
- **Observing self** is that part of the individual that is responsible for awareness and attention. It is separate from but aware of the thinking self.
- **Psychological flexibility** is the capacity to live in the present moment fully as a conscious human being.
- **Relational frame theory** is a framework for describing the relationship between two entities based on prior experience.
- **Third-wave approaches** are a type of behavior therapy that emphasizes acceptance and mindfulness.

Description

Acceptance and commitment therapy (ACT) is a form of behavior therapy that assists individuals to increase their acceptance of difficult and painful experiences and to increase their commitment to action that can improve and enrich their lives. ACT assumes that suffering results from the avoidance of emotional pain rather than the experience of it. It also assumes that language is at the root of most problems, particularly when it generates negative thoughts.

Instead of reducing symptoms like other treatment approaches, the goal of ACT is to learn how to accept and detach from them. When acceptance occurs, symptom reduction is a by-product. ACT treatment involves the use of metaphors, exercises, behavioral interventions, and mindfulness skills training. It uses mindfulness skills to develop psychological flexibility and clarify and foster values-based living.

Acceptance of situations without evaluation or attempts to change them is a skill that is developed through mindfulness exercises in and out of session. Instead of attempting to directly change or stop unwanted thoughts or feelings, ACT focuses on developing a mindful relationship with those experiences that can free an individual to be more receptive to take action that are life giving. ACT has proven effective with several clinical conditions. These include anxiety, depression, stress, chronic pain, anorexia (eating disorder), heroin and marijuana abuse, and schizophrenia.

ACT utilizes six basic principles and strategies to develop psychological flexibility in clients. (1) Acceptance is a strategy for allowing thoughts to come and go without struggling with them. (2) Cognitive defusion is a strategy for reducing the tendency to be dominated by negative or painful thoughts, images, emotions, and memories. (3) Contact with the present moment is a strategy for increasing awareness of the present moment and experiencing it with openness and receptiveness. (4) Observing the self is a strategy for accessing a continuity of consciousness which is unchanging. (5) Values is a strategy for discovering what is most important to the true self. (6) Committed action is a strategy for setting goals based on basic values and achieving them in a responsible manner.

Developments and Current Status

ACT was developed by psychologist Steven C. Hayes (1948–) in the 1980s. It is an outgrowth of behavioral therapy and cognitive behavior therapy (CBT). It is based on relational frame theory, which is its underlying theory of human language and cognition. ACT is also based on functional contextualism, which means that instead of viewing clients as damaged or flawed as many other approaches, it focuses instead on identifying the function and context of behavior. ACT is considered one of the new third-wave behavior therapies that build on older behavior therapies (first wave) and cognitive therapies (second wave). ACT is a therapeutic

approach that is attracting attention and research support. It is increasingly being taught in graduate programs and practiced in various treatment settings. It also has garnered considerable research support. As of 2011 there were approximately 60 research studies that demonstrate the effectiveness of ACT.

Len Sperry, MD, PhD

See also: Behavior Therapy; Cognitive Behavior Therapy; Mindfulness

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Acculturation and Assimilation

Acculturation and assimilation are terms used to describe the process of adapting to cultural differences between the minority and majority group.

Definitions

- **Acculturative stress** defines the psychological, somatic, and social challenges that members of a racial or ethnic minority group experience as they adapt to the culture of the majority group.
- **Biculturalism** refers to the coexistence of two separate, distinct cultures.
- **Culture** defines the customary language, practices, attitudes, and traditions of a particular racial or ethnic group.
- **Enculturation** describes the process of first-culture learning typically experienced by infants or young children as they grow up and encounter their primary culture.

Description

"Acculturation" refers to the change process that one goes through when moving from one culture to another. This process is interactive and continuous. The terms "acculturation" and "assimilation" are often used interchangeably. *Enculturation* explains an individual's first-culture, or primary culture, learning experience. Acculturation would then be described as a second-culture learning experience. Several minority groups, immigrants, refugees, and indigenous peoples encounter assimilation issues when they come in contact with the dominant culture. Differences in language, food, and dress are often most apparent though varying beliefs, customs, and practices may also exist.

Anthropologists, psychologists, and sociologists have been investigating the concept of acculturation since the early 1900s and have focused primarily on the adaptations minority group members make in order to ease their transitions. John Wesley Powell first coined the term "acculturation" in an 1880 U.S. Bureau of American Ethnography report and subsequently used it to describe the psychological changes that resulted from cross-cultural imitation. A more widely used definition was proposed by Redfield, Linton, and Herskovits in 1936 defining acculturation as the process of change that happens when groups of individuals from different cultures come into contact with one another. Numerous variations of this definition have followed.

Multiple theories on acculturation have been developed. One of the most popular is a fourfold model that focuses on two dimensions. The first dimension relates to whether the individual retains or rejects his or her native culture and the second dimension relates to the individual's adoption or denial of the majority culture. Four strategies of acculturation can result: assimilation, separation, integration, or marginalization.

Individuals who assimilate adopt the cultural norms of the majority over their minority culture. If separation occurs, the individual rejects the majority culture and preserves his or her native customs. Group members who integrate adopt the norms of the dominant culture while still maintaining their original cultural identity. Those who are able to integrate the two are referred to as *bicultural*. Finally, marginalization is defined as when an individual rejects both the native culture and the culture of the majority group. Research suggests that while some individuals maintain one acculturation strategy, others may adopt different strategies in their public and private lives. Likewise, varying strategies may be applied to particular areas (religion, politics, education, and family values) depending on the value the individual places on them.

One's arrival to a new place can be coupled with positive and negative emotions. "Culture shock" is defined as the transitional anxiety one experiences on leaving familiar people and surroundings and replacing them with unfamiliar words, food, clothing, and customs. Pressure to conform to the dominant group's culture can also result in *acculturative stress* referring to the psychological, somatic, and social stress experienced by minority group members as they attempt to assimilate. Stress and anxiety can be compounded if either side lacks multicultural competence or if prejudicial/discriminatory views are held. Societal attitudes regarding multiculturalism can impact the acculturation process. Melting pot societies promote assimilation, group differences are respected, but blending among groups is expected. The opposite is seen in a segregationist society where various groups lack understanding and remain isolated from one another. In a multiculturalist society diversity is valued and members acculturate more gradually, slowly integrating the dominant culture into their lives. Simultaneously, members of the larger culture become exposed to and learn to respect aspects of the minority groups' culture.

Current Status and Impact (Psychological Influence)

Research regarding acculturation and assimilation continues to be conducted on immigrants, refugees, and indigenous peoples of all ages. Studies have examined various acculturation styles, resiliency factors, and similarities/differences across subgroups. Evidence suggests that certain protective factors are associated with positive outcomes, including the existence of social support and engaging in active coping styles. Findings also suggest that communication plays a central role in the acculturation process. Language development and fluency can facilitate or impede the rate at which one assimilates. Furthermore, effective communication between minority and majority group members has been associated with shorter transition periods, reduced levels of anxiety and stress, fewer conflicts, more personal connections, and positive emotions.

Melissa A. Mariani, PhD

See also: Acculturative Stress

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Acculturative Stress

"Acculturative stress" refers to the psychological, somatic, and social difficulties that members of a racial or ethnic minority group experience as they adapt to the culture of the majority group.

Definitions

- **Acculturation** describes the acclimation process people go through when moving from one culture to another.
- **Assimilation** refers to the gradual adaptation of a minority group member's customs, attitudes, and practices to those of the majority culture.
- **Culture** defines the customary language, practices, attitudes, and traditions of a particular racial or ethnic group.

Description

When an individual, family, or group moves from one place to another, they typically encounter differences between the cultures of their former residence and their new one. The process of reconciling cultural differences between the minority and majority group is known as *acculturation* or *assimilation*. Acculturation has been observed in most immigrants who relocate. Minority group members may feel self-imposed pressure to adjust or may perceive or experience pressure from the majority group to assimilate.

Adapting to a new culture can result in stress and anxiety. The term "acculturative stress" refers to the psychological, somatic, and emotional challenges that minority group members face as they attempt to adapt to the culture of the majority group. Changes in food, clothing, and surroundings may be more apparent while differences in attitudes, perceptions, traditions, and views may show up more gradually over time. Language proficiency of residents is often assumed, which can be a significant source of pressure and anxiety for immigrants. Lack of intercultural competence and discrimination can also contribute to challenges with acculturating. Families from foreign countries may immigrate in waves, meaning that all members may not be experiencing acculturation issues at the same time. In addition, children of immigrants tend to assimilate more quickly than parents/older minority group members providing another possible source of conflict.

Assimilation takes time and can be either a seemless process or a more difficult one depending on various factors. Protective factors that ease this transition include having positive relationships with others and healthy coping mechanisms. Social support can come from multiple sources such as family members, peers, mentors, and other significant individuals in one's life who can provide different levels and forms of ease. Active, rather than avoidant, coping strategies have also been linked to resiliency and more favorable outcomes. Active coping strategies include having realistic expectations, attempting to problem-solve, using humor, engaging in physical activity, and practicing calming/relaxation techniques.

Current Status and Impact (Psychological Influence)

Much research on the topic of acculturative stress has focused on college students who have immigrated in order to further their education in different countries. Moving away from one's support system while incurring financial, academic, and social pressure can be difficult for students. Acculturative stress has been associated with reduced academic performance, decreased levels of social engagement, and impaired physical health. Higher levels of depression and anxiety have also been noted in the literature for persons experiencing acculturative stress. Many studies have focused on the impact of acculturative stress on Latino, African American, and Asian families as traditionally these cultures have placed high value on familial relationships and a strong sense of interconnectedness.

Melissa A. Mariani, PhD

See also: Acculturation and Assimilation

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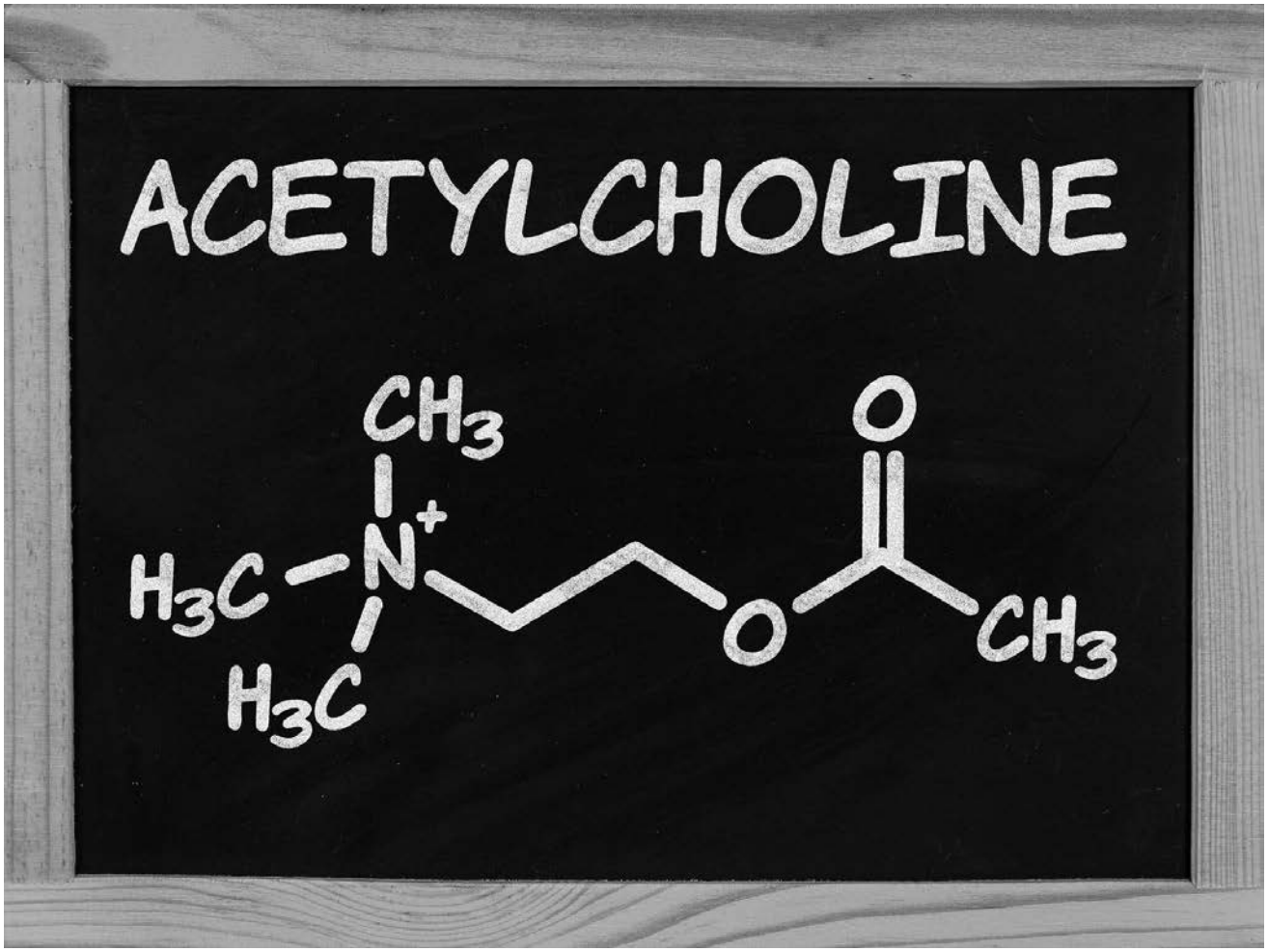
Acetylcholine

Acetylcholine is a chemical messenger in the brain that is involved in learning and memory.

Definitions

- **Acetylcholine esterase inhibitors** are medications that block the action of acetylcholinesterase which is the enzyme that degrades



Acetylcholine is a neurotransmitter and among other functions is involved in learning and memory. People with Alzheimer's disease have greatly diminished amounts of acetylcholine. (Zerbor/Dreamstime.com)

(breaks down) acetylcholine and increases it in the brain.

- **Alzheimer's disease** is a progressive neurodegenerative disease in which dementia results from the degeneration and death of brain cells because of low levels of acetylcholine, plaques, and neurofibrillary tangles.

Description

Acetylcholine is a neurotransmitter (chemical messenger) in the brain. Acetylcholine was the first neurotransmitter to be discovered. It has various functions in both the peripheral and central nervous systems. In the peripheral nervous system, it plays a vital role in activating muscles. In the central nervous system it acts as a major neurotransmitter for the autonomic nervous system, which controls heart, respiration, and secretion. Acetylcholine plays a vital role in maintaining all these functions.

It is also involved in learning and memory, and is greatly diminished in those with Alzheimer's disease. Some Alzheimer's medications work by inhibiting the action of acetylcholine esterase. Called acetylcholinesterase inhibitors, these medications increase acetylcholine levels in the brain. They appear to slow down the rate of cognitive decline in the early stages of Alzheimer's disease. These medications include Aricept, Reminyl, Cognex, and Exelon.

Acetylcholine is made from choline. Choline is similar to the B vitamins and is found in foods such as liver, muscle meats, fish, nuts, beans, peas, spinach, wheat germ, and eggs. Choline is also available as nutritional supplements. Like prescribed acetylcholinesterase inhibitors, choline supplementation is used for memory loss, Alzheimer's disease, and dementia. It is also used for depression, chronic hepatitis, cirrhosis, Huntington's chorea, Tourette's disease, certain types of seizures, and schizophrenia. Athletes use it for bodybuilding and delaying fatigue in endurance sports. Choline is taken by pregnant women to prevent neural tube defects, and it is used as a supplement in infant formulas. Other uses include preventing cancer, lowering cholesterol, and controlling asthma.

Precautions and Side Effects

Choline supplementation is considered safe when taken by mouth and used appropriately. Doses up to 3.5 grams daily appear to be safe for most pregnant and breast-feeding women and are not likely to cause unwanted side effects. There are relatively few side effects of taking choline supplements. These include sweating, a fishy body odor, stomach pain, diarrhea, and vomiting. Sweating (hyperhidrosis) can be bothersome. It involves abnormally increased perspiration on the hands, feet, armpits, and the back. There are no medications interactions reported with choline.

Len Sperry, MD, PhD

See also: Alzheimer's Disease

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Acupressure

The practice of acupressure dates back 5,000 years in China by physicians who noted the healing benefits of applying pressure to certain locations on the body. This type of therapy, alone or in conjunction with other methods, has been used to alleviate nausea, pain, fatigue, and stress/anxiety.

Definition

- **Acupressure** is an ancient art of healing that uses tactile manipulation of pressure points on the body to relieve pain and promote wellness.

Description

Acupressure is an ancient healing art that applies tactile pressure to determined locations throughout the body in an attempt to stimulate healing, relieve pain, alleviate stress, and promote positive energy. Twelve channels, or meridians, have been identified along which these points lie. These points have a high electrical conductivity at the skin's surface, making them potent healing sites. Applying pressure to these sites releases tension and increases circulation of blood throughout the body. Relief at the site where pressure is applied, as well as added benefits to internal organs, has been discovered.

Acupressure is similar to acupuncture; however, acupuncture uses needles, while acupressure uses firm pressure from the fingers and thumbs. Acupressure has been used to treat many conditions, including nausea, muscular pain, chronic fatigue, stress, anxiety, addiction, learning issues, and mental disorders. This type of therapy has also been used in patients seeking to promote healing, detoxify the body, boost overall wellness, and even stimulate sexual reproduction.

Development (History and Application)

Discovered in Asia over 5,000 years ago, acupressure is a healing/therapeutic technique that employs the use of pressure to alleviate discomfort and illness in the body. The origins of this type of therapy date back to the early Chinese dynasties; soldiers would use stones and arrows in wartime. Physicians noted that wounded

soldiers reported no longer experiencing chronic symptoms that they had suffered from years prior. A logical connection was then made between the ensued trauma and subsequent healing. These physicians then began developing healing techniques that incorporated making cuts or applying pressure to certain pressure points in the body. Over the years, physicians came to a consensus upon 12 trigger points lying along the meridians in the body. These meridians, invisible lines of energy, flow from the fingertips to the brain as well as to other vital organs and organ systems throughout the body. The application of pressure at these sites was shown to stimulate healing, permitting positive energy to flow freely throughout the body.

Terminology used in acupressure therapy can vary. The Chinese refer to healing energy as Qi or Chi. Japanese use the term "Ki," to refer to the life force, and "Reiki," to refer to the healing energy. Yogis use the word "prana" to describe this same life force and refer to pranic energy. However, all of these terms relate to the same universal energy that links all forms of life. By applying pressure to acupoints, blocked energy is released and able to flow to sites in need of healing.

Acupressure methods and styles also vary. Some methods incorporate different rhythms and pressures at the pressure points. Other styles use not only the fingers but also the hands, arms, legs, and feet. Shiatsu therapy is the traditional form of Japanese acupressure. This type of therapy uses deep pressure applied to each pressure site for three to five seconds. Jin Shin acupressure is different from Shiatsu because instead of one pressure site, two are focused on, and pressure is gently applied for a minute or longer. Tuina Chinese Massage and Thai Massage use acupressure techniques in combination with full body stretches and massage.

Current Status

Acupressure therapy can be used a standalone treatment or in conjunction with other treatments such as herbal/nutritional therapy, meditation, stretching, massage therapy, and counseling. Though this type of therapy is considered safe, it should be conducted only by a licensed or certified practitioner.

Western medicine does not endorse acupressure as a reliable treatment method. Many medical practitioners do not even believe that the meridians exist. Instead they attribute the healing qualities of acupressure to factors such as muscle manipulation, increased blood flow, and the stimulation of endorphins, all of which are natural sources of pain relief.

Melissa A. Mariani, PhD

See also: Acupuncture

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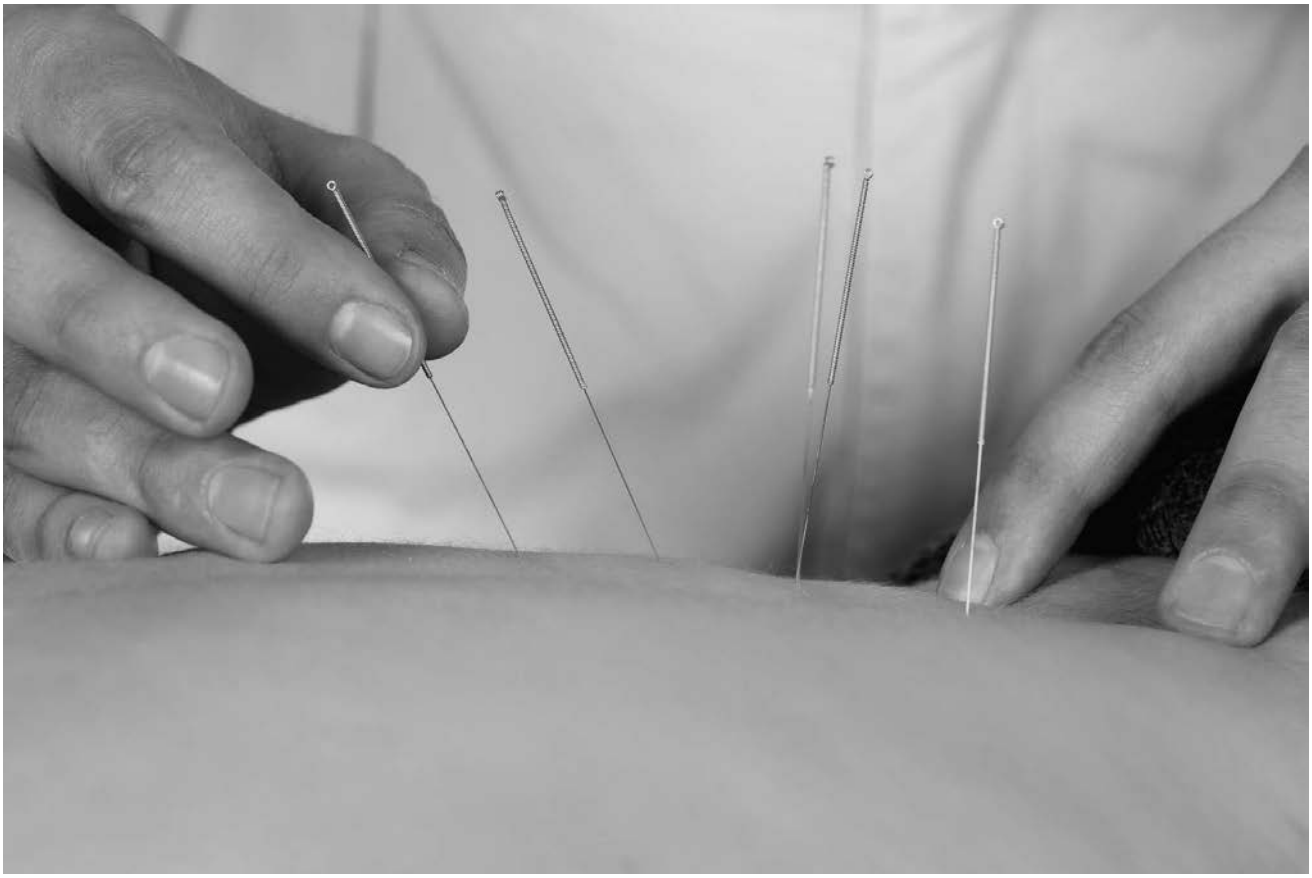
Acupuncture

Acupuncture is a Chinese medical procedure that treats medical conditions with needles inserted at specified sites of the body.

Definitions

- **Acupressure** is a form of massage using acupuncture points.
- **Auricular acupuncture** is a form of acupuncture using only points found on the ears to stimulate and balance various internal organs.
- **Chi** is basic life energy.
- **Meridian** is a channel through which chi travels in the body.
- **Traditional Chinese medicine** is an ancient but still practiced form of healing based on the harmony and balance. It emphasizes diet and prevention and uses acupuncture and herbal to stimulate the body's own natural curative powers and reestablish balance.



Acupuncture may be effective at reducing symptoms associated with certain mental disorders, such as depression, post-traumatic stress disorder, schizophrenia, bipolar disorder, and insomnia, but further research is needed. (Handmademedia/Dreamstime.com)

- **Yin and yang** are the two complementary forces in the universe. Life is better when there is a balance between yang (positive or masculine) and yin (negative or feminine).

Description

Acupuncture is a form of traditional Chinese medicine (TCM) in which sharp, thin needles are inserted in the skin at specific points of the body where the flow of energy is blocked. In TCM, disease is viewed as an imbalance in the organ system or chi meridians. The goal of treatment is to assist the body in reestablishing its balance. In TCM, disease can be caused by external factors such as the environmental stressors, by internal factors like emotional stressors, and other factors such as diet, injuries, or trauma. Infection is not viewed as a cause of disease but rather as weakness in the energy of the body that permits illness. Acupuncture is believed to work by adjusting the flow of chi throughout the organ system, which strengthens the body and prompts it to physically or mentally heal itself.

Underlying the practice of TCM is a unique view of the world and of the human body that is very different from the scientific view of American medicine. A basic premise is that humans are microcosms of the larger, surrounding universe where everything is interconnected. The human body is made up various organs, tissues, and fluids which have distinct functions but are all interdependent. Health and disease involve degrees of balance or imbalance of these functions.

The theoretical framework of TCM has a number of key components. The first is yin-yang theory. Ying and yang are two opposing but complementary forces that shape the world and all life. The second is chi. It is the vital energy or life force that circulates in the

body through a system of pathways called meridians. Health is an ongoing process of maintaining balance and harmony in the circulation of chi. The third is the eight principles that are used to analyze symptoms and categorize conditions. They are cold/heat, interior/exterior, excess/deficiency, and yin/yang. The fourth is the theory of five elements, which are fire, earth, metal, water, and wood. These elements help to explain how the body works and how these elements correspond to particular organs and tissues in the body. The *Yellow Emperor's Classic of Internal Medicine*, an ancient text written about 2,500 years ago, describes these components, principles, and elements.

In China, acupuncture is usually combined with herbal medicine. In Japan, acupuncture uses extremely thin needles and does not incorporate herbal medicine. Auricular acupuncture uses acupuncture points only on the ear, which are believed to stimulate and balance internal organs. In France, acupuncture is popular and widely accepted by the medical establishment. The medical establishment uses a system of acupuncture based on neuroendocrine theory rather than on TCM. Several forms of acupuncture are used in the United States with and without herbal medicine. Acupressure is also common.

Developments and Current Status

Acupuncture originated in China and has been practiced there for more than a thousand years. Acupuncture is also deeply embedded in the medical history of Japan, Korea, Vietnam, Taiwan, and other Asian regions. Although acupuncture had been used for hundreds of years ago in Europe, it was only during the second half of the 20th century that it began to spread rapidly in Western Europe, Canada, and the United States.

American medicine has been slow to accept acupuncture. Though many physicians use it, the American Medical Association does not recognize it as a specialty. Medical research in acupuncture is growing. The National Center for Complementary and Alternative Medicine of the National Institutes of Health funds research on acupuncture for medical conditions, such as chronic pain, anesthesia, and insomnia. When acupuncture is practiced by traditional medical professionals, its effectiveness to relieve pain is primarily believed to be due to acupuncture points being able to stimulate muscles, nerves, and connective tissue, which act to increase the production of natural painkillers found within the body, and the increased flow of blood to these targeted locations. Some research has found that acupuncture is effective at reducing symptoms associated with other mental disorders, such as depression, post-traumatic stress disorder, schizophrenia, bipolar disorder, and insomnia. However, other medical studies do not support these findings, and further research into these applications is needed.

Nevertheless, the National Center for Complementary and Alternative Medicine, the American Medical Association, and other organizations from the United States have generally agreed that acupuncture is safe to be used when under the guidance of a trained practitioner who uses sterile needles. The World Health Organization recommends acupuncture as an effective treatment for over 40 medical problems, along with many mental disorders, and alcohol and substance abuse disorders.

Len Sperry, MD, PhD

See also: Acupressure

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Acute Stress Disorder

Acute stress disorder is a mental disorder characterized by recurrent and upsetting thoughts, inability to sleep or concentrate, or dissociation following a traumatic event.

Definitions

- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing

maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.

- **Cognitive restructuring** is a psychotherapy technique for identifying maladaptive (unhealthy) thoughts and changing them to present a more accurate view of a situation.
- **Dissociation** is a mental state in which the integrated functioning of an individual's identity is significantly disrupted or changed.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure therapy** is a behavior therapy intervention (method) in which a client is exposed to a feared object or situation. It is also referred to as flooding.
- **Mood** is an individual's subjective emotional experience.
- **Pessimism** is a way of relating to one's world where the future is expected to hold more negative than positive outcomes.
- **Post-traumatic stress disorder** is a mental disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. It is also referred to as PTSD.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Trauma** is a singular or recurrent event that is both extraordinary and severely distressing. It is also called traumatic event.
- **Trauma- and stressor-related disorders** are a group of mental disorders characterized by exposure to a traumatic or stressful event. These include post-traumatic stress disorder, reactive attachment disorder, and acute stress disorder.

Description and Diagnosis

Acute stress disorder is one of the DSM-5 trauma and stressor-related disorders. This disorder follows a traumatic event and is characterized by inability to experience positive emotions, recurrent and upsetting thoughts, inability to sleep or concentrate, avoidance of situations similar to the trauma, and dissociation. Traumatic events that cause this disorder include being subjected to attack, mugging, rape, robbery, murder, natural disaster, terrorism, war, or catastrophic accident. This disorder is similar to post-traumatic stress disorder and is often confused with it. Both disorders are distinguishable by the duration of symptoms, with the symptoms of acute stress disorder lasting less than one month.

Those with this disorder often reexperience the event with accompanying distressing symptoms. This trauma can include direct experience as well as witnessing trauma. Consequently, emergency responders and hospital staff often suffer from this disorder. The severity of the disorder increases if the event is a purposeful act that violates the individual directly and is further worsened by the degree of severity of the incident itself. Individuals who manifest this disorder are likely to experience intrusive and recurrent thoughts related to the traumatic event. These thoughts may also include guilt as a consequence of being unable to prevent trauma inflicted on another. These thoughts may also be expressed in dreams, including thematic elements from the event. Individuals may avoid places or things associated with the event. These individuals may be very reactive, irritable, or temperamental. They might also be anxious and hypervigilant of threats. The stress symptoms might be worsened by exposure to stimuli that is similar to those associated with the traumatic event.

The prevalence of this disorder is relatively high following traumatic events. In cases of trauma that do not involve personal violations, it is estimated that slightly less than one in every five individuals will experience acute stress disorder. In cases that do involve personal violation, the proportion increases to between 20% and 50% of individuals. Acute stress disorder is more common in females, probably because of the increased likelihood of physical violations such as rape. Other risk factors include a high level of worry, pessimism, and living or working in environments where

trauma is likely to occur such as a war zone or emergency room (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they are exposed to a traumatic event and exhibit associated symptoms. These associated symptoms might include avoiding situation similar to that of the trauma, inability to experience positive emotions following the event, recurrent and upsetting thoughts about the event, inability to sleep or concentrate, and dissociation. When dissociation is present, symptoms may manifest as flashbacks where the individual relives the traumatic event or the inability to recall aspects of the event. These dissociative symptoms are also associated with post-traumatic stress disorder and are often confused. These two disorders are distinguishable by the duration of symptoms. If symptoms are present for less than one month, then acute stress disorder is applicable. Once symptoms have been present for one or more months, the appropriate diagnosis is post-traumatic stress disorder. It is also important to note that individuals cannot be diagnosed with acute stress disorder if they have only become aware of a trauma (e.g., reading a news article); they must have experienced or observed the trauma directly. Also, those with traumatic brain injury may exhibit symptoms of acute stress disorder (American Psychiatric Association, 2013).

The cause of this disorder is twofold. In part, it can be attributed to the traumatic event itself. However, certain attributes may play a role in the manifestation of this disorder in individuals who are more susceptible to this and other mental disorders. These attributes include having been exposed to past traumas, one's belief that one can influence outcome of one's life, and the unique meaning the individual gives to the traumatic event. As with most psychological disorders, research on the cause this disorder is ongoing.

Treatment

ASD is usually treated with psychotherapy. The most common form of therapy utilized is cognitive behavior therapy. Specific interventions (techniques) may include exposure techniques and cognitive restructuring. Prompt use of psychotherapy is critical to inhibit the development of the more severe and often chronic condition, post-traumatic stress disorder.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Dissociative Disorders; Mood; Post-Traumatic Stress Disorder (PTSD); Psychotherapy; Trauma

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Addiction

Addiction is the compulsive use of a habit-forming substance or the irresistible urge to engage in a behavior despite harmful consequences.

Definitions

- **Addictive disorder** is a mental disorder that involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Behavioral addiction** is a form of addiction caused by the compulsion to repeatedly engage in a behavior that causes harmful consequences. It is also referred to as process addiction or non-substance-related addiction.
- **Craving** is a strong desire for more of a substance or behavior (sex, shopping, Internet use) in order to experience a euphoric effect or to avoid withdrawal symptoms.
- **Dependence** is the need for a drug to function normally. Dependence can be psychological and/or physical. Psychological dependence is

dependence on a psychoactive substance for the reward it provides. "Physical dependence" refers to the unpleasant physiological symptoms if the drug is stopped.

- **Detoxification** is a process of purging the body of the toxic effects of a drug or substance. During this process the symptoms of withdrawal are also treated. Also called detox, it is the first step in drug treatment program.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Psychoactive** refers to a drug or other substance that produces mood changes and distorted perceptions.
- **Relapse** is the recurrence of symptoms after a period of improvement or recovery.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.
- **Tolerance** refers to the need for higher doses of a substance or more frequent engagement in a behavior to achieve the same effect.
- **Twelve-Step group** is a self-help group whose members attempt recovery from various addictions and compulsions based on a plan called the Twelve Steps.
- **Withdrawal** is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of certain drugs after prolonged regular use.

Description

The American Society of Addiction Medicine (2013) offers the following definition of addiction. "Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors." This comprehensive definition emphasizes that addiction is a chronic brain disease that involves compulsiveness and which negatively impacts an individual's overall well-being. Persistent use typically leads to dependence and to tolerance. Discontinuation of the addiction can lead to withdrawal, increased cravings, and even relapse.

DSM-5 describes addiction and addictive disorders in the category called "substance-related and addictive disorders." It includes 10 classes of drugs: alcohol, caffeine, inhalants, opioids, hallucinogens, cannabis, sedatives-hypnotics and anxiolytics, stimulants, tobacco, and other substances. It also includes gambling disorder, which is a behavioral addiction. The behavioral addictions activate reward systems in the brain similar to drugs of abuse. They also produce behavioral symptoms comparable to symptoms produced by substance disorders. Assuming there is sufficient research to warrant their inclusion, other behavioral addictions are expected to be added in future DSM editions. These might include Internet addiction, sex addiction, exercise addiction, and shopping addiction (American Psychiatric Association, 2013).

Nicotine dependence is the most common type of addiction, while alcoholism is the most common addiction to a psychoactive substance. According to the National Survey on Drug Use and Health (NSDUH) in 2012, 23 million Americans age 12 or older had alcohol and drug addiction. Of these, more than 15 million were dependent on alcohol. Some 4 million were dependent on drugs, while the rest were dependent on both. Statistics from the National Drug Intelligence Center (2010) estimate the annual cost of addictions for the U.S. economy. It reports that abuse of tobacco, alcohol, and illicit drugs cost more than $600 billion annually in crime, lost work productivity, and health-care services.

Treatment

Treatment of addictions often requires a combination of medical, psychological, and social approaches.

Treatment often begins in specialized addiction treatment programs and clinics. These programs involve various treatment methods that focus on detoxification, reducing cravings, and preventing relapse. Common to many programs are Twelve-Step groups like Alcoholics Anonymous and Narcotics Anonymous. The prognosis for recovery from any addiction depends on the substance or behavior and the individual's personality and circumstances. Relapse is common, and those with addictions often make repeated attempts to quit before they are successful. Users of more than one drug typically have the more challenges in recovering from their addictions.

Len Sperry, MD, PhD

See also: Relapse and Relapse Prevention; Substance-Related and Addictive Disorders

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Addiction Counseling

Addiction counseling is therapy provided to people who are dependent on the use of one or more substances or activities.

Definitions

- **Addiction** is a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Addiction recovery** is the state of abstinence from addictive behaviors, usually achieved through self-reflection and spiritual exploration.
- **Relapse** is the recurrence of symptoms after a period of improvement or recovery.
- **Sober** means not consuming alcohol and drugs or engaging in other addictive activities.

Description

The American Medical Association defines addiction as a chronic disease with physical and emotional factors that impair control over the use of substances. Some examples of substances and activities people can become addicted to are alcohol, drugs, sex, gambling, and the Internet. For addiction counselors, working with people who are substance dependent or abusive is difficult because of a high rate of relapse, defensiveness, and a lack of research as how to best treat the conditions. The addiction counselor offers a different view and believes the problem of addiction is how you respond or fail to respond to substances and treatment. Addiction counseling rests on the idea that alcohol and drug problems become independent of their beginnings.

In counseling training, students have been taught to remove their own experience from the client's recovery processes. In addiction counseling there is more of a demand for personal involvement than seen in other counseling professions. Providing hope is a crucial dimension for addiction counselors as they offer themselves as "living proof" of hope. It is important to model the potential for long-term recovery through their own story and by guiding the client to a community of people in recovery.

Addiction counselors are exposed to many frustrations and losses. First, there is a high mortality rate of substance abusers. Many counselors use these experiences to deepen their understanding of the nature of addiction

and to recommit themselves to finding new ways to reach their clients. Addiction counselors are aware that their clients are often involved in a life or death struggle for recovery. The stakes involved in this work are high and awareness brings its own burdens and rewards.

There are several rituals that are considered best practice for addiction counselors. These activities include rituals such as prayer, meditation, and self-reflection. Also included are mirroring rituals like reaching out to others for support and inspiration. Acts of self-care for the body and mind are also important for addiction counselors. Lastly, unpaid acts of service such as serving as a sponsor or giving back to the recovery community are valued.

Development

As early as 1774, the effects of alcohol abuse were known to be devastating. Substance-related problems in the United States began with the attack on Native Americans in the 18th and 19th centuries. Treatments for these problems at the time included use of native medicines, religion, and limiting its use and availability.

Addiction counseling started as a grassroots recovery community. Therapy with this population began in 1913 at a church in Boston with religious leaders called the Oxford Group. However, most laypeople believe that alcohol and drug treatment did not begin until the founding of Alcoholics Anonymous (AA) in 1935. Bill Wilson and Bob Smith used the Oxford Group as a model when they founded AA with a shift away from religion. AA viewed alcoholics as having an allergy to alcohol, which formed the basis of the disease or medical model. This was a change in the view of alcoholism, which had previously been viewed as a moral weakness. Soon after AA was founded, members began to be employed at substance abuse treatment centers.

In the early days alcoholics did not go to treatment centers through AA; they simply went through a detoxification process. This usually occurred in their local hospital, and from there most were referred to AA meetings. Supporters of AA and other Twelve-Step groups, believe it is the most effective way of treating addiction and should be the primary treatment program. Accordingly, it became the norm that clients needing help with alcoholism or substance abuse were referred to. This often was recommended instead of professional help or as an add-on to addiction counseling treatment.

In the 1940s it became clear that a definition and formalization of the addiction counselor should occur. The next major event in the treatment and counseling of alcoholics and other drug abusers was the opening of the Hazelden Treatment Center in Minnesota in 1949. Hazelden developed what later became known as the Minnesota Model. This model includes a combination of therapy, spirituality, group treatment, and the Twelve Steps. At Hazelden they integrated recovering, nonprofessionally trained counselors as part of the alcoholism treatment team. In 1954 addiction counselors were provided a professional role in Minnesota and other states later followed. The Substance Abuse and Mental Health Services Administration reports that today most residential treatment centers are a variation of the Minnesota Model.

Current Status

Currently, AA has over 115,000 independent groups throughout the world, with over 2,100,000 members (Alcoholics Anonymous, 2010). In the field of substance abuse there are three main approaches to addiction counseling. The traditional approach is the disease model which treats the addiction in the same medical model as other conditions. The research approach seeks the scientifically supported methods to treatment. And last, the managed care approach wants to identify the greatest benefit for the least cost.

These three movements conflict with one another, resulting in unrest among professional addiction counselors. The medical model believes in dependency where the research approach finds there is not enough evidence to support the claim. The managed care approach is unlikely to pay for anything that is highly disputed among professionals. Therefore, the conflicts in the field have led to difficulty in uniting and identifying common goals in addiction counseling.

Alexandra Cunningham, PhD

See also: Relapse and Relapse Prevention; Smoking Cessation; Substance Abuse and Mental Health Services and Administration (SAMHSA)

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Addictive Personality

Addictive personality is the concept that addiction is the result of preexisting personality traits or defects.

Definitions

- **Addiction** is the persistent, compulsive dependence on a substance or a behavior for coping with unmanageable conflict and stress.
- **Antisocial personality** is a mental condition characterized by a pattern of disregarding and violating the rights of others.
- **Self-control** is the capacity for self-discipline. Some use this term interchangeably with willpower.
- **Willpower** is the ability to resist a short-term temptations in order to achieve a long-term goal. It also involves the ability to delay gratification. Some use this term interchangeably with self-control.

Description

Several factors influence the development of addiction. These include biological, environmental (social), and psychological factors. Of the psychological factors, personality traits are considered important in understanding why certain individuals seem to be more prone to developing an addiction than others. The question has been, why do some individuals develop a physical and psychological dependence on substances such as alcohol or drugs, or behaviors such as gambling or Internet use? For years there has been considerable debate over whether there is actually an "addictive personality." Several books and articles in newspapers and magazines suggest that there is, in fact, such a personality.

But research, to date, has yet to confirm the existence of the addictive personality. Notable is a study sponsored by the National Academy of Sciences by Lang (1983). It concluded that there is no single set of psychological traits that characterized proneness to the various addictions. However, the study did identify several common elements among those with various addictions. Individuals prone to addiction are more likely to engage in impulsive behavior and sensation (thrill) seeking and have difficulty with self-control, willpower, and delaying gratification. They tend to value nonconformity and have little commitment to socially value goals for achievement. They are also likely to be socially alienated, tolerate deviance, and have an antisocial personality. Finally, they commonly experience considerable stress but lack sufficient coping skills to deal with that stress. Lang suggested that this element helps to explain why drug and alcohol problems are highest during high periods of stress. For most individuals, adolescence and other stressful life transitions are the most stressful periods.

While there is insufficient research support for concept of the addictive personality, those with addiction seem to share certain commonalities. The value of identifying and further researching these common elements is twofold. First, they can help in predicting proneness to addiction. Second, they can help in devising better treatments for those with addiction.

Len Sperry, MD, PhD

See also: Addiction; Antisocial Personality Disorder; Willpower

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Adjustment Disorder

Adjustment disorder is a mental disorder characterized by short-term emotional distress or behavioral problems following a stressful event.

Definitions

- **Acute stress disorder** is a mental disorder that affects individuals who have been exposed either directly or indirectly to a traumatic situation such as death, rape, or serious bodily harm. Those suffering from this disorder often reexperience the event with accompanying distressing symptoms.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Culture** is the common beliefs, customs, and behaviors of a particular group, society, or nation.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Family therapy** is a type of psychotherapy for families that focuses on improving relationships and understanding between family members.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Post-traumatic stress disorder** is a mental disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. It is also referred to as PTSD.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Trauma- and stressor-related disorders** are a group of mental disorders characterized by exposure to a traumatic or stressful event. These include post-traumatic stress disorder, reactive attachment disorder, and disinhibited social engagement disorder.

Description and Diagnosis

Adjustment disorder is one of the trauma- and stress-related disorders as expressed in the DSM-5. This disorder is a common, short-term mental disorder characterized by difficulty coping with a significant but nontraumatic stressor. Individuals with this disorder are likely to experience emotional distress, difficulty in social or work settings, or both. An important aspect of this disorder is that the symptoms manifested are disproportionate to what might be normally expected following the stressful event. This may seem a simple task, but it can be a difficult assessment for a clinician to make. What qualifies for disproportionate varies significantly by a number of factors including culture, age, and personal history. Adjustment disorder is often associated with close personal relationships and financial, employment, or business issues. The symptoms of this disorder typically appear immediately following certain events such as news of a layoff. In contrast, this disorder may develop over the course of days or

weeks following the finalization of a divorce. Adjustment disorder is most likely to manifest as psychological symptoms in adults and behavioral symptoms (e.g., defiance, fighting, and vandalism) in adolescents.

Adjustment disorder is common in mental health settings. It is estimated that adjustment disorder is present in 5%–20% of those treated in mental health settings but can be as high as 50%. This disorder is more likely to occur in individuals from lower socioeconomic backgrounds (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if the following criteria are met. There must be an identifiable stressor followed by related symptoms. These symptoms must arise within three months. These symptoms must be related to a disproportionate level of emotional distress, disturbance in social or work-related functioning, or both. If the symptoms persist for longer than six months following the end of the stressor, then a different diagnosis is appropriate. Also, adjustment disorder is differentiated by the types of symptoms present; some individuals may indicate that they feel depressed, anxious, or both. Some individuals may have disturbances in conduct, while others may have conduct disturbance combined with depressed mood and/or anxiety (American Psychiatric Association, 2013). Adjustment disorder differs from both acute stress disorder and post-traumatic stress disorder in that the stressor does not involve threat of unnatural death, personal violation, or significant bodily harm. Specifically, adjustment disorder follows a life event that is in some way meaningful to the individual. Also, differing cultures maintain differing expectations pertaining to one's reactions to particular life events. Consequently, a clinician must carefully consider these expectations in his or her assessment of what reaction might be normally expected. For example, an individual from a collectivist (i.e., family-focused) culture may exhibit significantly more distress following a family crisis than someone from an individualistic (i.e., personal-focus) culture.

The cause of this disorder is a combination of the stressor and a number of personal factors. Like most mental disorders, the exact etiology (cause) is unclear, although it is believed to be a combination of genetics and environmental factors. However, the culture of the individual plays a significant role in the meaning given to the stressor by the individuals. Therefore, the cultural context in which this disorder occurs is very important to ascertain in each case.

Treatment

This disorder is usually treated with psychotherapy. Psychotherapy is most often aimed at reducing symptoms and improving any inhibited functioning that has resulted from this disorder. Specific forms of psychotherapy used in the treatment of this disorder may include family therapy, mindfulness practices, and cognitive behavior therapy. Individuals who develop depressive or anxiety symptoms may also be treated with medications, although this is not a preferred practice considering the short-term duration of symptoms. Self-help books and support groups are also common forms of informal treatment. Typically, these books and groups are specific to the stressor. For example, an individual suffering from adjustment disorder following divorce might read a self-help book about divorce or attend a support group with other divorcees.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Acute Stress Disorder; Cognitive Behavior Therapy; Culture; Depression and Depressive Disorders Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Family Therapy; Mindfulness; Post-Traumatic Stress Disorder; Psychotherapy; Trauma- and Stressor-Related Disorders

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Adler, Alfred (1870–1937)

Adler was an Austrian medical doctor and psychotherapist who is best known as the founder of Individual Psychology, the theoretical approach which, in contrast to traditional psychoanalysis, offers a holistic, or more whole, view of the individual and stresses the importance of social factors.

Description

Alfred Adler was born on February 7, 1870, in Rudolfsheim, a suburb of Vienna, Austria, the second of seven children to a Jewish grain merchant and his wife. A sickly child, Alfred developed rickets which prevented him from walking until he was four and was later hospitalized with pneumonia. These early experiences inspired Alfred to pursue medical school at the University of Vienna where he also met his future wife, Raissa Timofeyewna Epstein, at a social political meeting. The couple went on to have four children together, Valentine, Alexandra, Kurt, and Cornelia. Adler graduated in 1895 and began practicing as an ophthalmologist, later moving into general practice, though his interest in psychology, sociology, and philosophy continued. In 1902, he was invited by Sigmund Freud to join a weekly discussion group at his home at which the foundations of the psychoanalytic movement were born. Freud respected Adler's ideas and considered him a colleague though the two were not friends. Adler remained an active member of the society for several years until his break from the group in 1911. The first dissenter from traditional psychoanalysis, he soon founded the Society for Individual Psychology in 1912 where he further honed his own theory and clinical approach.

Freud and Adler disagreed primarily about the impact of social factors on human development and behavior. While Freud stressed only internal dynamics (biological, sexual, and physiological), Adler emphasized the importance of external dynamics (social and environmental), adopting a more holistic view of the individual. Holism, or the holistic view, is a concept stressing the importance of all aspects of an individual or system (biological, chemical, emotional, physical, psychological, social) as equally whole parts that contribute to an entity's makeup and functioning. Adlerian psychology thus contends that humans are social, creative beings whose behavior is purposeful and goal-oriented. Though Freud and Adler (as well as Carl Jung) studied how feelings of inferiority can impact psychological wellness, Adler further defined "inferiority complex" as a concept that stresses how feelings related to inadequacy, low self-esteem, and poor self-worth contribute significantly to an individual's personality, social development and relationships, and propensity for later mental health issues. According to Individual Psychology, experiences, both early and subsequent, impact one's personality and lifestyle; however, much depends on the person's subjective interpretation of these events. Birth order, family constellation, and early recollections can also affect the accomplishing of tasks

Alfred Adler was an Austrian medical doctor and prominent psychotherapist who is best known as the founder of Individual Psychology. (Bettmann/Corbis)

related to work, family, and friends. Those who learn to cooperate with others and contribute to the general welfare (social interest) achieve significance and become self-actualized. Social interest is one of Adler's key concepts (in German, "gemeinschaftsgefuhl"), which describes a feeling of community, when a person acts in the best interests of others, as opposed to being consumed by personal needs and concerns.

Impact (Psychological Influence)

The Individual Psychology movement gained considerable momentum during the early 1900s as Adler spoke internationally and opened clinics in his honor. In addition, he taught at Columbia University and later at the Long Island College of Medicine, which prompted him to move his family permanently to the United States. Adler influenced the works of Erich Fromm, Abraham Maslow, Rollo May, Karen Horney, and Carl Rogers and is revered as one of the top psychologists of the 20th century. His impact on modern-day psychology and counseling practice remains evident today in organizations such as the North American Society for Adlerian Psychology and educational institutions including The Adler School of Professional Psychology in Chicago, Illinois. Alfred Adler died of heart complications during a lecture tour in Aberdeen, Scotland, on May 28, 1937.

Melissa A. Mariani, PhD

See also: Adlerian Therapy; Freud, Sigmund (1856–1939); Individual Psychology

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Adlerian Therapy

Adlerian therapy is a psychotherapy approach that emphasizes the individual's lifestyle, belonging, and social interest.

Definitions

- **Family constellation** is the early developmental influences on an individual, including siblings, parents, peers, neighbors, and other key individuals like teachers.
- **Inferiority complex** is a behavioral manifestation of a subjective feeling of inferiority.
- **Inferiority feeling** is the emotional reaction to a self-appraisal of deficiency that is subjective, global, and judgmental.
- **Life style** refers to one's attitudes and convictions about belonging and finding a place in the world.
- **Lifestyle convictions** are the attitudes and beliefs that direct an individual's sense of belonging.
- **Life tasks** are the main challenges (work, love, and friendship) that life presents to all individuals.
- **Private logic** is convictions that run counter to social interest and fail to foster a constructive sense of belonging with others.
- **Projective technique** is a psychological test in which an individual's responses to ambiguous stimuli like are analyzed to determine underlying personality traits, feelings, or attitudes.
- **Safeguarding mechanisms** are the behaviors of attitudes that individuals select to evade responsibility and not meet the life tasks. It is called defense mechanism by other approaches.
- **Social interest** refers to the behaviors and attitudes that display an individual's sense of belonging, concern for, and contributions to the community.

Description

Adlerian therapy is a form of psychotherapy developed by Alfred Adler that emphasizes the individual's lifestyle, connectedness with others (belonging),

meeting the life tasks, and contributions to society (social interest), which are considered the hallmarks of mental health. Adler considered all behavior as purposive and that individuals are motived to seek "belonging" or significance and meaning in their lives by the manner in which they functioned in social systems. He postulated that it was within the family constellation that individuals first learn how to belong and interact. Adler emphasized the unique and private beliefs which he called "private logic." This logic serves as a reference for attitudes, private views of self, others, and the world, and behavior which he called the "lifestyle" and "lifestyle convictions." Individuals form their lifestyle as they endeavor to relate to others, to overcome "feelings of inferiority," and to find a sense of belonging. Furthermore, Adler believed that healthy and productive individuals are characterized by "social interest," whereas those with poor adjustment or psychopathology show little social interest and tend to be self-focused.

Developments and Current Status

Adlerian therapy was developed by the Viennese physician Alfred Adler (1870–1937). Early in his professional career, Adler was invited by Freud to join the Viennese Psychoanalytic Society and remained friendly with Freud for some 10 years. As he came to view Freud as inflexible in his views and obsessed with sex and death, Adler broke with Freud in1911 and continued to refine his own theory and psychotherapeutic approach. Subsequently, Adler influenced many others including Karen Horney, Gordon Allport, Aaron Beck, and Abraham Maslow. Maslow, Rollo May, and Viktor Frankl all studied under Adler, and credited him with influencing their own views.

Adlerian therapy fosters the process of change by stimulating cognitive, affective, and behavior changes. Although the individual is not always fully aware of his or her specific pattern and goal, through analysis of birth order, repeated coping patterns, and early memories, the psychotherapist infers the goal as a working hypothesis. Recognizing this pattern of limiting schemas and beliefs, the therapist helps the client to see life from another perspective. Change occurs when the client is able to see his or her problem from another view, so he or she can explore and practice new behavior and a new philosophy of life.

Besides eliciting traditional intake material, for example, present concerns, mental status exam, and general social, occupational, and developmental history, the Adlerian psychotherapist collects and analyzes the client's family constellation and lifestyle convictions. The family constellation consists of the client birth order, identifications with parents and peers, family values, and family narrative. Lifestyle convictions are inferred from both habitual coping patterns and early recollections. Because a client's recollection of his or her earliest memories reflect past childhood events in light of current lifestyle convictions, early recollections are a powerful projective technique that quickly and accurately provides a working hypotheses of the way clients view themselves, others, and the world. The therapist elicits three or more memories, and the description of these memories are analyzed according to themes and developmental maturity and from these derives the client's lifestyle convictions which reflect the impact of the client's family constellation. Information from the family constellation and lifestyle convictions is useful in specifying a case formulation, including a diagnostic formulation and a clinical formulation, that is, an explanation of why and how the client perceives, feels, and acts in a patterned and predictable fashion.

Individuals develop three lifestyle convictions: a self-view—the convictions about who they are; a world view—convictions about how the world treats them and expects of them; and their ethical convictions—their personal moral code. When there is conflict between the self-concept and the ideal, inferiority feelings develop. It is important to point out that feelings of inferiority are not considered abnormal. However, when the individual begins to act inferior rather than feel inferior, the individual expresses an "inferiority complex." Thus, while the inferiority feeling is universal and normal, the inferiority complex reflects the discouragement of a limited segment of our society and is usually abnormal.

The goal of treatment is not merely symptom relief but the adoption of a contributing way of living. Adlerians view pain and suffering in a client's life as the result of choices made. This value-based theory

of personality hypothesizes that the values a client holds and lives his or her life by are learned, and when they no longer work as evidenced by suffering or lack of happiness, the client can relearn values and lifestyles that work more "effectively." Some Adlerians believe that a client's lifestyle is best viewed as personal schemas or narratives. Because such maladaptive schemas or basic mistakes are believed to be true for the individual, the individual acts accordingly. Adler noted that these basic mistakes are overgeneralizations, for example, "people are hostile," "life is dangerous," or misperceptions of life, "life doesn't give me any breaks," which are expressed in the client's physical behavior, language, dreams, values, and so on. The goal of intervention in Adlerian therapy is re-education and reorientation of the client to schemas that work "better." The actual techniques employed are used to this end. Adlerians tend to be action orientated. They believe the concept of insight is just a proxy for immobility. Insight is not a deep understanding that one must have before change can occur. For Adlerians, insight is understanding translated into action. It reflects the client's understanding of the purposeful nature of behavior.

Adlerian therapy is structured around four basic overlapping phases.

Relationship. In the relationship phase, the goal is to establish an empathic relationship between therapist and client in which the clients feels understood and accepted by the therapist. Establishing a mutual and collaborative relationship is essential for effective therapeutic outcomes to be achieved.

Assessment. In this phase, the purpose is to evaluate the client's concerns and objective and subjective circumstances. In addition to traditional initial assessment information, the Adlerian therapist elicits family constellation and lifestyle conviction material. This phase is described in more detail later.

Insight. In this phase the purpose is to explain the client to himself or herself, which is, to say, to develop insight into lifestyle convictions, mistaken goals, and self-defeating behavior patterns. While such a corrective cognitive experience is usually necessary for treatment to be effective, it is by no means sufficient to effect a corrective emotional experience or behavior change. Furthermore, insight does not always precede emotional and behavior change, which are the province of reorientation. Thus, while theoretically distinct, the insight and reorientation phases often overlap in clinical practice.

Reorientation. The purpose of this phase is to help clients to consider alternatives to the problems, behaviors, or situations and to commit to change. It involves strengthening the client's social interest. It attempts to bring each individual to an optimal level of personal, interpersonal, and occupational functioning. In so doing exaggerated self-protection, self-absorption, and self-indulgence are replaced with courageous social contribution. Therapeutic techniques include creative and dramatic approaches to treatment such as role-play, the empty chair technique, acting "as if," and psychodrama.

Overall, Adlerian therapy is a psychotherapy approach that reflects various psychodynamic, cognitive-behavioral, existential, constructivist, and humanistic principles. Yet it is unique in its focus on the lifestyle and its emphasis on belonging, meeting the life tasks, and social interest as the hallmarks of mental health.

Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Early Recollections

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Adoption

Adoption is a process in which a child is legally raised by someone other than his or her biological parents (also sometimes referred to as birthparents). A child can be adopted by family members, such as aunts, uncles, and grandparents, or by unrelated individuals. Adoption fills

a variety of societal needs, including providing parents for children given up by their birthparents, as well as for children whose parents are deceased or who have lost their parental rights, most often due to abuse or neglect.

Adoption also offers individuals and couples a way to create a family when they cannot become pregnant or carry a pregnancy to term. Adoption offers a legal relationship between an adult and a nonbiological child as a way of formally creating a parent–child relationship, such as in the case of a stepparent or grandparent raising a child.

Famous adoptees include Aristotle, Steve Jobs, Nelson Mandela, Babe Ruth, Moses, Jesse Jackson, Edgar Allan Poe, Marilyn Monroe, John Lennon, Malcolm X, and Bill Clinton.

Adoption is the legal process of establishing the parental rights for a child by an individual or couple who is not the child's biological parent(s) and raise the child as his or her own. In ancient times, adoption was used for political and economic reasons, usually to continue the male line of a family's lineage. These days, adoption is quite different; it is used as a means to create a family by both traditional and nontraditional families alike. This includes infertile couples and gay and lesbian couples, as well as those who choose adoption for altruistic reasons.

Adoptions peaked in 1970 most likely due to the stigma of being an unwed mother or single parent as well as more restricted access to birth control. Adoptions are fairly rare, with fewer than 3% of children in the United States being adopted.

Domestic adoption involves U.S. parents adopting U.S. children who are available due to a variety of reasons such as an unwed mother, financial instability, abandonment, abuse, neglect, placement in foster care, or the death of one or both parents. An estimated 18,000 infants are adopted each year in the United States, and in 2009 nearly 70,000 children were adopted from foster care. However, the number of adoptive families far exceeded demand as an additional 114,500 foster children were still waiting to be adopted at the end of 2009.

In addition to domestic adoptions, some prospective parents choose to adopt children from other countries. These are known as international adoptions, whereby U.S. citizens adopt orphans from countries, including Romania, China, Guatemala, and Ethiopia. The number of international adoptions has dropped by more than one-third from approximately 45,000 per year in 2004 to fewer than 29,000 in 2010. Through a variety of sources, including both domestic and international, more than 127,000 children are adopted each year in the United States.

There are several types of adoption, including open, closed, and semi-open. In closed adoptions, parents receive little or no information about their adopted child's biological parents. This is often done to protect the confidentiality of the biological parent(s). In contrast, open adoptions have become increasingly popular over the past 20 years, although those adults who had been adopted when they were babies or young children joined their new parents through closed adoptions.

An open adoption is one in which the biological parents and adoptive parents disclose information about themselves and, in many cases, the biological parents continue to have contact with the adopted child and his or her family. A combination of the two is known as semi-open adoptions. In these situations, non-identifying information is exchanged between birth parents and adoptive parents. This can include letters, photos, or e-mails and correspondence is handled by an agency or other third party.

The adoption process includes the use of an adoption agency or an attorney specializing in adoptions. All potential adoptive parents are required by federal law to complete a home study that prepares and educates the prospective adoptive parents, evaluates their ability to parent, and offers insight and information to the agency or attorney in order to make a proper placement. The home study includes background checks and interviews of the prospective parents and often extended family, as well as a visit to the home to make sure it is a safe environment for the child.

The psychological impact of adoption depends on a number of factors, including the age of the child, the parenting styles of the adoptive family, and circumstances surrounding the adoption, as well as cultural factors in both domestic and many international adoptions. Research has shown that most adoptees adjust well to their adoptive families; however, there are areas in which both adopted children and even adult adoptees can struggle.

Anxiety, depression, trust, relationship difficulties, and identity formation are noted challenges for adoptees. In some cases, more severe psychological disturbances have been reported. Notably, international adoptions from specific orphanages and from certain countries have shown to have a number of children who are later diagnosed with reactive attachment disorder. This often presents in children before the age of five as an inability to connect socially or to attach appropriately to caretakers.

Mindy Parsons, PhD

See also: Attachment Styles; Child Abuse; Child Neglect; Foster Care; Group Homes; Reactive Attachment Disorder

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Organization

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Website: https://www.adoptioncouncil.org/

Adrenaline (Epinephrine)

Adrenaline is a neurotransmitter involved in the fight or flight response that increases heart rate, pulse rate, and blood pressure.

Definitions

- **Catecholamines** are a class of brain neurotransmitters released in the fight or flight response. They include epinephrine, norepinephrine, and dopamine.
- **Enzymes** are proteins that trigger chemical reactions in the body.
- **Glycogen** is a form of glucose (sugar) that is stored in the liver and muscles.
- **Norepinephrine** is a hormone produced by the adrenal gland, along with epinephrine, as part of the fight or flight response. It is also known as noradrenaline.
- **Tyrosine** is the amino acid from which epinephrine is made.

Descriptions

Adrenaline (also known as epinephrine) is a neurotransmitter (chemical messenger) released by the adrenal gland in response to stress. Adrenaline is made from noradrenaline (norepinephrine). It makes up about 80% of the catecholamines that are released as part of the body's stress response. When the body is confronted with a threat or stressful situation, the brain releases nerve signals to the adrenal gland to release adrenaline and noradrenaline. This is called the fight or flight response in which energy is diverted away from areas where it is not needed to those where it is most required, particularly the heart and muscles. When released, adrenaline circulates through the bloodstream until it reaches its target organs—the heart, blood vessels, liver, and fat cells. It binds to alpha-adrenergic and beta-adrenergic receptors. Each of these receptors triggers a different action within cells. Alpha receptors initiate smooth muscle contraction and blood vessel constriction, while beta receptors stimulate the heart

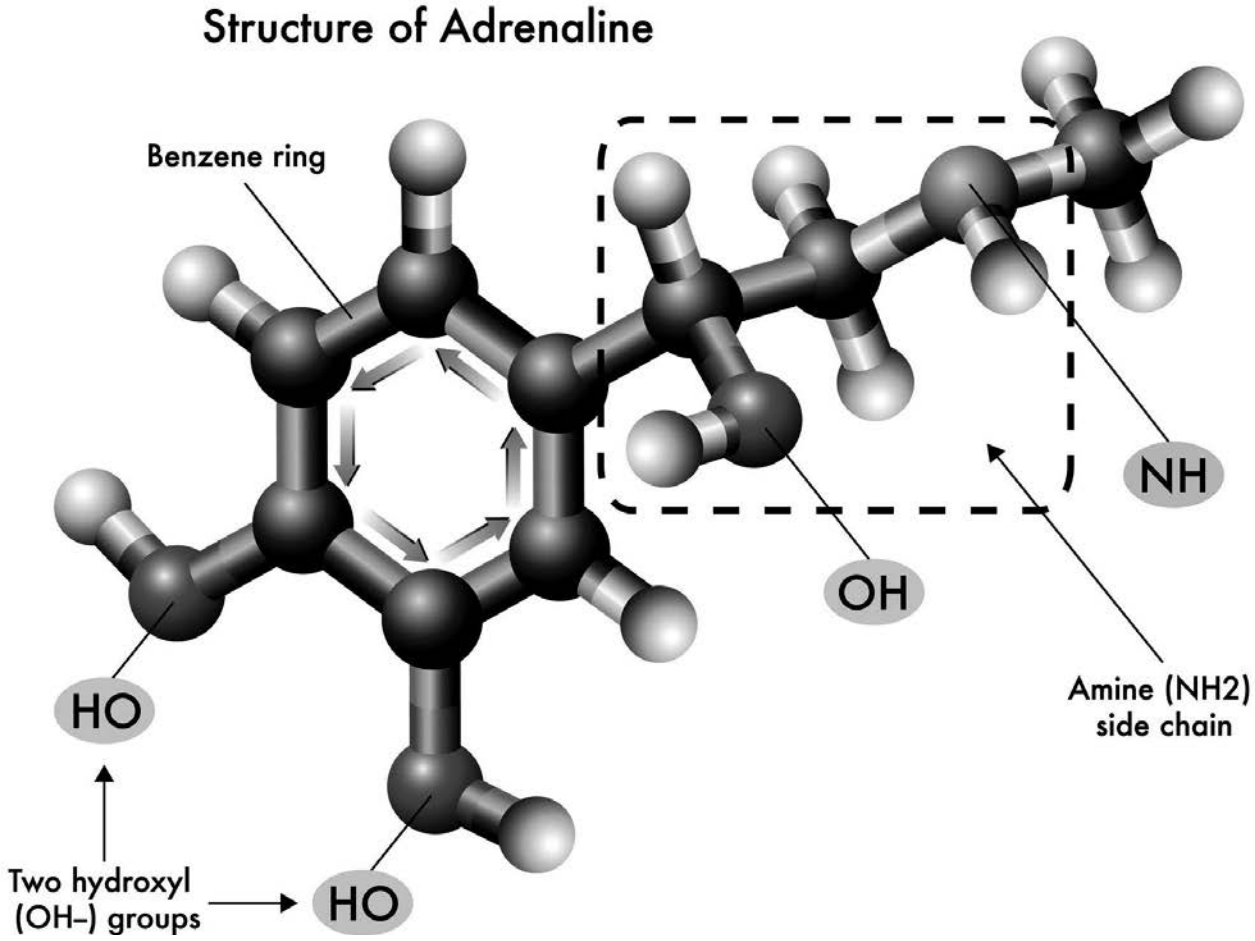

Illustration of the structure of adrenaline. Adrenaline is a neurotransmitter involved in the fight-or-flight response that increases heart rate, pulse rate, and blood pressure. Some people can become addicted to the "adrenaline rush," which happens in extreme sports or in gambling. (Rob3000/Dreamstime.com)

muscle. The release of adrenaline prepares the body for action by causing an increase in blood and oxygen flow to the muscles, releases stored energy from the liver and fat cells, and constricts blood vessels raising the blood pressure.

Some experience a drug-like high from engaging in activities that trigger the fight or flight response. Called "adrenaline junkies" or "adrenaline addicts" these individuals skydive, mountain climb, or engage in extreme behaviors to experience a rush of adrenaline. Some compulsive gamblers attribute their addiction to the rush they get while gambling.

Adrenaline is used to treat life-threatening emergencies such as anaphylactic shock (severe allergic reaction) and cardiac arrest (heart stops beating). It has a very rapid effect on the heart, blood vessels, and the lungs. Administration of adrenaline by injection stimulates the heartbeat, makes the blood vessels narrower which raises blood pressure, and relaxes lung muscles which eases breathing. Adrenaline injections are also used for snake bites, bee stings, and other allergic reactions.

Precautions and Side Effects

Adverse reactions to adrenaline include palpitations, tachycardia (fast heart rate), arrhythmia, anxiety, headache, tremor, hypertension (high blood

pressure), and acute pulmonary edema (fluid in the lungs).

Len Sperry, MD, PhD

See also: Anxiety

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Advance Directives

"Advance directives" refers to a legal document that gives directions about what medical practices, procedures, and actions should be taken on a person's behalf if the person becomes incompetent or unable to communicate his or her health or mental health-care needs to caregivers and/or medical providers.

Description

In general, the term "advance directives" refers to a legal document that clearly outlines the actions a person would want carried out if his or her health became jeopardized. Caregivers must follow the steps listed in this document in order to fulfill the patient's wishes. Living wills and do-not-resuscitate orders are common types of advance directives. Mental health directives, or psychiatric advance directives (pads), specifically refer to measures that should be taken if a person becomes mentally incapable or loses the ability to make rational judgments for himself or herself. Pads come in two general forms: instructional directives and proxy directives. Instructional directives describe a person's mental health treatment preferences, while proxy directives allow the person to name a health-care agent, or proxy, responsible for making treatment decisions if the person is unable to do so. A proxy must be a capable, competent adult (at least 18 years of age or older) who is not the person's current health-care provider. Most states include pads in general medical advance directives and require these documents to be witnessed, signed, and possibly notarized to ensure their legality. These papers should be kept on file along with a person's medical records and copies should also be given to caregivers.

Certain conditions must exist in order for a person to move forward with an advance directive. For one, the person must be considered mentally and physically competent at the time the document is created. Next, the language in the document must clearly communicate the person's wishes. In addition, once the directives are executed, steps must be taken to ensure that the items listed in the document are complied with.

History

The Cruzan case of 1990 had the most profound impact to date on the use of advance directives in providing end-of-life treatment decisions. Nancy Cruzan suffered life-threatening injuries after a serious automobile accident. She was hospitalized, in a vegetative state, and unable to communicate. Cruzan's parents, her caregivers, wanted to end Nancy's life knowing that she did not wish to be kept alive on life support. Nancy had told this to a friend of hers at an earlier point in time; however, these wishes were not formally documented. After much back-and-forth the courts finally ruled that it is a competent individual's constitutional right to control his or her medical care. More important, the courts extended this right to incompetent individuals provided that they had indicated their wishes before they become incapacitated. On December 1, 1991, as a direct result of the Cruzan case, Congress put into effect the Patient Self-Determination Act. This act mandated that health-care providers inform adult patients of their rights in end-of-life medical care decisions. Any health-care institution eligible to receive Medicare or Medicaid funds is now required

to share information and engage in meaningful discussion with patients regarding their self-determination rights.

Current Status

All 50 states and the District of Columbia have laws that authorize certain forms of advance directives. Many of these laws though do not specifically reference mental health or psychiatric decision making. Minnesota was the first state to enact a law that clearly outlined psychiatric advance directives in 1991. Eleven states have followed, including Alaska, Hawaii, Idaho, Illinois, Maine, North Carolina, Oklahoma, Oregon, South Dakota, Texas, and Utah. These laws establish the rights of a mentally ill person. They permit ill persons to communicate their directives in writing when they are competent and outline their acceptance or refusal of psychiatric treatment.

Research indicates that opting for medical advance directives can be affected by factors such as individual attitudes, cultural beliefs, current state of health, and a patient's relationship with his or her health-care provider. The likelihood that a person will elect advance directives also increases with age. Though medical advance directives are more common, psychiatric advance directives are relatively new. Questions continue to be raised regarding their use. Research in this area is ongoing, and there are several pending court decisions on this topic. In the meantime, advance directives should be considered a viable way to empower people to take a more active role in their treatment. They can assist in the communication and execution of a person's wishes in the event of an unforeseen medical or psychiatric illness. Advance directives can also help to maintain a person's dignity and avoid conflicts among caregivers.

Melissa A. Mariani, PhD

See also: Caregivers

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Adverse Childhood Experiences

Adverse childhood experience is a traumatic experience that occurs before the age of 18, is remembered as an adult, and negatively affects health.

Definitions

- **Child abuse** is the physical, sexual, or emotional abuse of a child or minor, usually under the age of 18.
- **Domestic abuse** is the abuse by one partner against the other in an intimate relationship. It can involve physical, sexual, and/or psychological abuse.
- **Household dysfunction** is a category or of adverse childhood experience that includes household substance abuse, household mental illness, and parental separation or divorce.
- **Neglect** involves refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- **Physical abuse** involves inflicting, or threatening to inflict, physical pain or injury on individuals or depriving them of a basic need.
- **Psychological abuse** involves inflicting mental pain, anguish, or distress on individuals through verbal or nonverbal acts. It is also called emotional abuse.
- **Sexual abuse** involves nonconsensual sexual contact of any kind, coercing an elder to witness sexual behaviors.

- **Traumatic experience** is an event that causes physical or psychological distress or harm and is experienced as a threat to one's safety or the stability of one's world.

Description

Adverse childhood experiences are traumatic experiences that can significantly impact health in adult life. An important study of certain adverse childhood experiences has been ongoing by the Centers for Disease Control (CDC). The study grew from the 1980s when health-care professionals at the Kaiser Permanente managed care health system in San Diego were frustrated by a high dropout rate in their obesity prevention clinic. Kaiser Permanente eventually began a study of 17,000 participants, from 1995 to 1997, which looked at the effect of particular adverse childhood experiences on adults with serious health problems, comparing them with adults who did not report such early trauma. In 1997, the CDC joined and began its prospective research study called the Adverse Childhood Experiences (ACE) study. It included the 17,000 original participants and has tracked their health status ever since. The following is a brief description of the ACE study and its results.

For the ACE study, the three main types of adverse childhood experiences were abuse, neglect, and household dysfunction during the first 18 years of life. The category of neglect included emotional neglect and physical neglect. The experience of emotional neglect included not feeling special and not being loved, or that the person's family was not a source of strength, support, and protection. The experience of physical neglect included not having enough to eat, having to wear dirty clothes, not having someone to take the child to the doctor, or that his or her parents' drinking interfered with the child's care and upbringing. The category of household dysfunction included several factors. The first among these was the experience of having a mother or stepmother who often pushed, grabbed, slapped, threw something, kicked, bit, hit with a fist, or threatened or actually hurt the child with a knife or gun. It also included the experience of living with anyone who was a problem drinker or used street drugs. Also included was living with a household member who was depressed, mentally ill, or who had attempted suicide. The experience may have also included living with parents who were separated or divorced or a household member who went to prison.

Almost two-thirds of those studied reported at least one adverse childhood experience. More than one of five reported three or more of those early adverse experiences. The result of these childhood exposures was a multitude of medical and psychiatric conditions and health behavior problems. All of these appeared during adulthood, usually by the age of 35 or so. Medical conditions included a greater likelihood of having chronic obstructive pulmonary disease, heart disease, liver disease, sexually transmitted diseases, and reduced health-related quality of life. Substance abuse and psychiatric conditions included high levels of alcoholism and alcohol abuse, illicit drug use, depression, and suicide attempts. Problematic health behaviors included increased levels of early initiation of sexual activity, adolescent pregnancies, multiple sexual partners, and unintended pregnancies. It also included increased likelihood of being a smoker, early initiation of smoking, and the increased risk for domestic violence.

Len Sperry, MD, PhD

See also: Child Abuse; Domestic Violence; Neglect; Sexual Abuse; Trauma

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Advocacy Counseling

Advocacy counseling is a method in which a therapist and client work together to empower the client to get access to services they need. Counselors who promote advocacy within their clients assist them in

seeking a way to change social or political systems that exist.

Definition

- **Advocacy** is a process in which an individual or group aims to influence decisions in political, economic, or social policy.

Description

The goal of advocacy counseling is to increase clients' feelings of empowerment and belonging. Usually these services are provided for individuals who are disadvantaged in different ways. A social justice approach to advocacy counseling involves advocating for clients within systems. By teaching clients how to access services and encouraging them to become self-advocates the counselor hopes to become obsolete. Specific techniques of advocacy counseling involve having client join self-help groups, speak out to others on client's rights, and consult with various groups. Counselors who are of the social justice model of counseling validate their clients' reality and empower them to take an active role in resolving their own issues.

The American Counseling Association (ACA) Advocacy Competencies are the basis for advocacy counseling. They provide guiding principles for counseling in three areas. These include client/student, school/community, and the public. Advocacy counselors help their clients respond to the challenges in the environment that prevent growth. They assist them in connecting with organizations and key people that seek social, economic, and political change. It is also important for advocacy counselors to share knowledge of their client's human development. This awareness through communication can help to alert the public about injustices. Lastly, it is important for advocacy counselors to act as change agents in their own systems that affect their clients. They can do this by getting involved in social justice movements.

Development

The history of advocacy in counseling began with Frank Parsons and Carl Rogers. These two inspired changes in social policy at individual and group levels. In addition to advocacy, people who strongly believed in ending oppression demonstrated advocacy through social justice. In the early 1900s, Clifford Beers advocated on behalf of the mentally ill and the reform of psychiatric hospitals.

The theme of counseling and social revolution was formally organized in 1971 when the American Personnel and Guidance Association (APGA) became the American Association for Counseling and Development (AACD). APGA and the AACD made advocacy a major focus. The focus called for social change through personal, professional, and political activities. Later in 1998 the former APGA, now the ACA, created the Council on Social Justice to implement social action to empower clients, students, and oppressed individuals and groups.

Current Status

Many professionals view advocacy counseling as being a philosophy and practice. To be an advocate in counseling one needs to hold strong beliefs about equality and act on behalf of those who are less powerful. This form of counseling addresses the personal issues of clients but also focuses on changing the environment of the client.

The history of advocacy in counseling provides a foundation for teaching advocacy skills from a social justice perspective. The awareness, knowledge, and skills model used in the multicultural competencies support advocacy-oriented counselors. Over the years advocacy counseling has not changed radically; it adjusts flexibly to the issues relevant to the time, place, and clients' needs.

Alexandra Cunningham, PhD

See also: Rehabilitation Counseling

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Affect

Affect is an observable pattern of behavior that describes an individual's prolonged emotional experience.

Definitions

- **Emotion** is a feeling state of consciousness (awareness) in which an emotion like joy, sorrow, and fear is experienced, as distinguished from cognitive (mental) states of consciousness. It is also referred to as emotional state.
- **Mental status exam** is an essential part of the initial assessment of an individual's status in the practice of counseling, psychology, and psychiatry.
- **Mood** describes an individual's subjective emotional experience.
- **Subjective** is the description of one's personal and distinct experience of an outer or inner event. It is the opposite of objective.

Description

"Affect" is a psychological term that describes the overt (observable) expression of one's emotion. It describes the immediate expression of an individual's emotional state, moment-to-moment. Affect is distinctly different from mood. Affect describes the observable characteristics of the individuals' emotional state. By contrast, mood describes individuals' subjective experience of their emotional state. It would be expected that if individuals describe their mood as "happy," then their affect would match. For example, a smiling and relaxed posture (indicators of affect) is consistent with a self-report of being happy (mood). Sometimes, there is a discrepancy between a self-reported mood and the observed affect.

A number of factors are used in the description of affect. These include congruence, intensity, range, reactivity, and appropriateness of emotional expressions. Affect is useful in understanding the degree of emotional functioning of individuals and their relationship to both their inner and outer conditions at any given moment. Affect is a key element of the mental status exam. Some of the possible affective states a clinician might use to describe an individual in the mental status exam include the following:

- **Blunted** is a severe lack or reduction of affective expression.
- **Euthymic** describes normal expression of affect.
- **Flat** indicates a lack of intensity of affect such as a monotone voice or blank face.
- **Inappropriate** is an affective expression inconsistent with the individual's statements or thoughts.
- **Labile** is a rapidly changing affective response.
- **Restricted** represents a mild reduction of affective expression.

As it pertains to the expression of certain emotions (happy, sad, angry, surprise, fear, disgust, and contempt), affect is considered universal across culture, regardless of geography. It follows that individuals from any nationality or culture are able to recognize these seven basic emotions in individuals.

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See also: Mental Status Examination; Mood

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The Affordable Care Act document. The Affordable Care Act, the law aiming to modify private and public health insurance so that all Americans can have health-care insurance by the year 2023, includes a number of requirements for mental health-care providers. (Redfinch/Dreamstime.com)

Affordable Care Act

The Affordable Care Act is the law that aims to modify private and public health insurance systems so that all Americans can have health-care insurance by the year 2023.

Definitions

- **Congress** is made of the individuals in the Senate and the House of Representatives responsible for creating the laws in the United States.
- **Evidence-based practice (EBP)** is the integration of research evidence, clinical expertise, and client values to provide quality health services that reflect the needs of the client. EBPs serve to promote quality care and monitor client/patient outcomes.
- **Health reform** is the modification of the delivery of health care to offer insurance to uninsured people, improve access to health care, improve the quality of health care, and reduce the cost of health care.
- **Health-care disparities** refer to the difference between the occurrence of disease, type of health outcomes, access to medical care, and quality of medical care between particular populations, especially between racial and ethnic minority groups and nonminority groups.
- **Insurance exchanges (also known as insurance marketplaces)** are online sites where

Americans can go to compare and purchase health insurance, find answers to questions, and learn about health-care tax credits.

- **Interdisciplinary health care** is the collaboration of different types of health-care providers to deliver comprehensive care to individuals from a biological, psychological, and social perspective.
- **Mental health** refers to a person's psychological, emotional, and social well-being.
- **Outcomes research** is research that incorporates a client's experiences, values, and preferences as they relate to health services and treatment. Outcomes research is used by practitioners to make clinical decisions.
- **Summary of Benefits and Coverage (SBC)** is a universal health insurance form written in simple and easy-to-understand language that people can use to compare different health-care plans and types of coverage.

Description

The Affordable Care Act (ACA) is the health reform law passed by Congress and signed by President Barack Obama on March 23, 2010, that offers insurance exchanges online where Americans can go to find information on, and sign up for, affordable health insurance. The main goal of this law is not only to offer insurance coverage to uninsured people but also to increase the number of benefits individuals receive and lower the costs of health care. The law also removes limitations on preexisting conditions and extends the coverage of young adults under their parents' health insurance policy until the age of 26.

Goals of the ACA include reducing the high uninsured rate, stabilizing and decreasing health-care spending, emphasizing prevention, improving health outcomes, and reducing health inequalities. The ACA allows uninsured Americans, such as the 42 million uninsured people under the age of 65, access to health care at an affordable cost (HHS.gov/HealthCare). At the same time, the act is designed to begin reducing the total health-care spending in the United States. One way costs can be reduced is by providing more funding for the prevention of diseases like diabetes, high blood pressure, obesity, heart disease, and cancer, which in many cases are avoidable. Prevention will also help improve people's long-term health and help them to live longer. Finally, the ACA aims to provide minorities with quality medical services in an effort to reduce and eliminate health-care disparities.

The ACA requires all insurance companies to offer customers health insurance information in simple language which is easy to understand so they can make comparisons among different insurance carriers and evaluate different types of coverage. All insurance companies must use what is called the Summary of Benefits and Coverage (SBC) form with plain language and a glossary of commonly used terms to help customers compare different health-care plans. Also under the ACA, insurance companies can no longer cancel policies when a person makes an honest mistake on an application or place a dollar limit on how much they will pay for medical services (on most of the covered benefits on an insurance policy).

Under the ACA, health insurance carriers on the insurance exchanges must provide benefits for mental health counseling and substance abuse services. Mental health services also include preventive care for depression, nutrition, weight loss, smoking cessation, and decreasing alcohol use. As with medical services, insurance companies cannot deny anyone mental health benefits due to a preexisting condition, charge more because of a preexisting condition, or place a dollar limit on necessary mental health care.

The ACA law has several implications for mental health training and practice. First, training and education models must be founded on evidence-based practices (EBPs) that are adaptable to different clinical settings and serve diverse populations. Second, training and education curricula must emphasize research methodology and the application of outcomes research to evaluate EBPs in prevention and treatment. Third, training and education programs must prepare graduate students for interdisciplinary, team-based health care in which the collective competencies of health and mental health professionals across disciplines combine to provide integrated quality treatment at a lower cost. Finally, the ACA requires mental health training and

education programs to teach students how to conduct continuous assessments of client outcomes to measure the effectiveness of treatment (Chor, Olin, and Hoagwood, 2014, 96–100).

In terms of mental health practice, the ACA establishes practitioner accountability by creating networks of health-care providers, called accountable care organizations. Medical practitioners and specialty practitioners (such as mental health practitioners) merge together in a central location to better coordinate health and mental health services—improving health service quality, lowering costs, and making it easier for clients to access care. Network health-care providers are required to measure and track client outcomes, maintain credentialing and accreditation, and use the electronic medical record to coordinate care and report measurement data (Chor, Olin, and Hoagwood, 2014, 91–92).

Christina Ladd, PhD, and Len Sperry, MD, PhD

See also: Evidence-Based Practice

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Aggressive and Antisocial Behavior in Youth

Aggressive and antisocial behaviors in youth represent a set of specific emotional states and behaviors that are severe enough to come to the attention of adults and authority figures.

Description

Aggressive behaviors are negative and hostile verbal and physical acts used to defy authority, get one's way, or express anger. Antisocial behaviors are acts that violate the rights of others. Losing one's temper and learning to control aggressive behaviors such as shouting, screaming, shoving, hitting, grabbing, and stealing are part of growing up. Aggressive behaviors in children and teens do not become a cause for counseling until they create significant problems in relationships, school, or work. Aggressive behaviors are also considered to be a problem when the behavior doesn't match a person's age. For instance, a teenager having a temper tantrum would be an example of behavior immature for the age. When behaviors go against the rights of others, they are called "antisocial" behaviors. Antisocial behaviors include harming others, breaking property on purpose, stealing, bullying, being cruel to animals, beating people up, selling drugs, defying authority, and breaking the law.

Causes and Symptoms

There are many causes for aggressive and antisocial behaviors. Researchers have identified conditions in the home, and the influence of others, as playing a large part in aggressive or antisocial behaviors. Researchers have also identified problems within a person, such as their ability to control themselves, how they feel about themselves, or their personality, to be at the root of bad behavior.

What happens in the home can play a significant part in causing aggressive behavior. Parents who are mean or abusive don't care about how a child performs in school, or their unloving attitude toward their child can result in aggressive behavior in children. Parents who do not discipline or correct their children nor teach them to control their aggressive behavior create an environment that fosters a sense of aggressiveness in their children. Parents' aggressive and hostile attitudes can result in a child learning to behave in aggressive and antisocial ways as a way of coping with life.

Being a part of the wrong crowd, such as a gang, can lead to the development of aggressive and antisocial behaviors. When people who are admired reward, or reinforce, bad behaviors, these behaviors can become part of the way a person lives. For instance, a "friend" who dares a person to shoplift and then goes on telling others about how great it was can result in more antisocial behaviors. Sometimes children who have learning disorders or have emotional problems act out aggressively and develop antisocial behaviors.

Diagnosis and Prognosis

When aggressive and antisocial behaviors become severe enough to require counseling, they are generally referred to as "behavior disorders" and include a number of specific disruptive, impulse-control, or conduct disorders, as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. People with behavior disorders have significant problems in relationships, school functioning, or work performance. To be diagnosed with a specific behavior disorder, the behaviors must be very disruptive to others and happen more often than is usual for a person of that age. There are two primary psychological conditions or disorders that are included in behavior disorders.

Oppositional defiant disorder (ODD) describes a person who is younger than 18 years and is very negative, purposefully annoying, and defiant of rules and adults. People with ODD often lose their temper, are very stubborn, argue a lot, and don't follow directions. They are angry, emotionally hurtful, and blame others for their problems. They are most likely to be verbally aggressive but are not usually physically aggressive.

Conduct disorder (CD) is a more severe form of behavior disorder. A person with CD is younger than 18 years and behaves in ways that violate other people's right to live safely and peacefully. Youth with CD cause harm to people, animals, and property. There are four types of behaviors that violate people's rights:

(1) Aggressive conduct that causes or threatens physical harm to other people or animals. This behavior includes threatening or causing harm and intimidating or bullying others. It also includes starting fights, forcing people to do things they do not want to do, including sexual acts, and taking other people's belongings by force or intimidation.
(2) Behaviors that cause property damage or loss such as starting fires or breaking other people's belongings on purpose.
(3) Theft and dishonest behaviors such as breaking into someone else's home, lying to get things, and stealing.
(4) Serious violation of rules. This behavior includes defying parental rules, running away from home, sneaking out at night, returning home very late or staying out all night, and skipping school.

Behavior disorders can be treated with psychotherapy. How much change can occur is related to the severity of the disorder, the home life of the child, and the psychological health of the child. Cognitive behavior therapy can be helpful in the development of problem-solving skills, social skills, and anger management. Counseling for children or adolescents who are diagnosed with ODD or CD is most effective when both the individual and the family are the focus of counseling. Family counseling focuses on helping parents develop appropriate expectations for their children and providing training in parenting, boundary setting, and positive discipline. Family counseling also focuses on establishing and maintaining a positive relationship among all family members. Individual counseling focuses on helping the child or adolescent improve his or her coping and problem-solving skills, learn how to appropriately express his or her feelings, and learn to identify and change his or her negative internal thoughts leading to disruptive behaviors.

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See also: Conduct Disorder; Intermittent Explosive Disorder; Oppositional Defiant Disorder (ODD)

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Aging and Older Adults

"Aging and older adults" is the phrase used to describe the group of individuals aged 65 and older.

Definitions

- **Alzheimer's disease** is a form of dementia that affects thinking, memory, and behavior. It gradually worsens over time making it difficult, and eventually impossible, to communicate.
- **Baby boomers,** up until 2015 the largest generation of Americans, were born after World War II from 1946 to 1964.
- **Behavior disorders** are illnesses such as anxiety, emotional, and dissociative disorders.
- **Cerebrovascular disease** is a group of brain malfunctions that restrict or block blood flow to the brain.
- **Chronic obstructive pulmonary disease** is a disease that worsens over time because of obstructions in the lungs, which makes breathing difficult.
- **Dementia** is the loss of mental functions such as thinking, reasoning, memory, and language that is associated with diseases like Alzheimer's.
- **Hypochondriasis** is persistent fear and worry about having a particular physical or mental health illness even when health-care professionals cannot find evidence of any problem.
- **Socioeconomic status** is a person's social class standing that is determined by education level, income, occupation. The three levels of socioeconomic status are low, middle, and high.
- **Suicidality** is the likelihood an individual will intentionally kill himself or herself.

Description

Aging and older adults is the way we refer to people aged 65 and older. The number of these individuals in the United States has tripled over the last 100 years. The most significant increase occurred in January 2011 when the first group of baby boomers turned 65. By the year 2030, 20% of the American population will be 65 and older (Anderson et al., 2012). The aging of the baby boomers, coupled with an increase in life expectancy, has resulted in many more people living with chronic physical ailments. As people grow older, they begin to experience age-related changes that affect their ability to function. Common physical changes include hearing or vision loss, high blood pressure, heart disease, diabetes, and arthritis. Decreased cognitive functioning also becomes an issue. It takes older adults longer to learn new information and longer to recall information. With age, long-term memory declines significantly more than short-term memory (American Psychological Association, 2014).

The incidence of psychological problems also increases with age and interferes with normal functioning. Older adults may experience dementia, anxiety, depression, sexual dysfunction, substance abuse, suicidality, hypochondriasis, behavior disorders, and Alzheimer's disease (American Psychological Association, 2014). Furthermore, aging and older adults experience delayed and/or longer response times. They may require help with daily living activities such as housework, shopping, and yard work.

The aging and older adult population is becoming more racially, socially, and economically diverse as the number of older black and Hispanic minorities continues to increase. It is expected that the aging black population will increase from 8% to 10% and the aging Hispanic population will increase from 4% to 16% by the year 2050 (American Psychological Association, 2014). There are significant differences between older White adults and older minority adults. Minorities experience age-related illnesses earlier in life, have a higher occurrence of obesity and diabetes, less frequently report health issues to health-care workers, and put off obtaining health-care intervention. The increased rate of mental health problems among older minorities may be attributed to low socioeconomic status, dysfunctional communities, lack of education, unemployment, stereotyping, discrimination, and a lack of quality health care.

Health-care providers must be aware of the implications of aging. While most people are primarily concerned with physical health in later life, it is equally important to focus on mental health. The stress of coping with a physical illness can negatively impact mental well-being. The reverse is also true. The stress of a mental illness can negatively impact physical well-being. As people are living longer and as the baby boomers age, the number of adults aged 65 and over will rapidly increase. This is significant to note because the baby boom generation has a higher rate of mental health issues such as anxiety, depression, substance abuse, and dementia than the group of older adults before them. They are also more likely to seek mental health services than the aging cohort before them. However, these services must reflect the cultural differences of the population being served; therefore, it is imperative that practitioners develop the cultural competence necessary for effective treatment. Finally, as people age, the possibility of dementia increases. Therefore, the number of older adults living with dementia increases. As the baby boomers age and the incidence of mental illnesses increases, there is greater demand for culturally appropriate mental health services.

Health-care providers must consider the affordability and accessibility of quality health care. The primary source of income for people aged 65 and over is from Social Security benefits. Furthermore, 13% of older adults live in poverty (American Psychological Association, 2014). Economic factors significantly impact the ability of aging and older adults to access and pay for health care. The most efficient and cost-effective means of providing comprehensive health care to aging and older adults is through networks of health-care providers and centrally located practitioners who collaborate to offer a full range of quality services that are easily accessible at a reduced cost. As people live longer, the goal of health-care professionals is to help people maintain their physical and mental well-being over the years, regardless of age-related illnesses and challenges.

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See also: Alzheimer's Disease; Baby Boomers; Dementia

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Agoraphobia

Agoraphobia is extreme fear of public spaces, crowds, or areas from which escape may be difficult and results in intense anxiety.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Anxiety** is apprehension or worry about an imagined danger.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety as a central or core symptom. The group includes agoraphobia, specific phobias, and social anxiety disorder.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Fear** is an emotional response to a known danger.
- **Panic attack** is an episode of sudden, intense, and debilitating sense of fear that is short lived.
- **Panic disorder** is an anxiety disorder characterized by severe panic attacks that occur so frequently as to produce significant distress and/or impaired functioning.

- **Phobia** is an intense fear of a person, place, or thing that significantly exceeds the actual danger posed.

Description and Diagnosis

Fear and anxiety are commonly used interchangeably in everyday conversation. However, these terms have different technical meanings. With disorders like agoraphobia it is useful to know and appreciate this distinction. In this disorder both are present in that the feared place or situation causes the symptoms of anxiety. Agoraphobia is a phobia in which individuals experience an intense fear of crowds, public places, open spaces, or places from which they believe that they cannot easily escape. Alternatively, the primary fear may also be embarrassment of being observed panicking by others in the public space. Those with this disorder commonly avoid exposure to such situations, while a minority tolerate their symptoms. Agoraphobia is classified as an anxiety disorder. In fact, agoraphobia is more likely to occur together with panic disorder than by itself.

Agoraphobia and its commonly co-occurring diagnosis can severely impact an individual's life. Those with disorder may become so fearful that they completely avoid leaving their home. In some cases, these individuals have lost their jobs and close relationships, as well as their independence. Agoraphobia is typically diagnosed in adolescence through early adulthood. The likelihood of developing this disorder is approximately 1.7% in adolescence and adulthood but is considerable less after the age of 65 (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, an individual may be diagnosed with agoraphobia if he or she experiences extreme fear when either anticipating or directly being exposed to public transportation, open or closed public spaces, being present in large groups of individuals including lines, or being outside of his or her own home. Also, the panic symptoms must be the direct consequence of the agoraphobic situation, last at least six months, be out of proportion to the actual risk or danger, and be that escape would be difficult. The symptoms must also cause significant distress or result in significant level of impaired functioning. In addition, the disorder is not the result of a medical condition or another mental disorder. This disorder is to be diagnosed despite whether a panic disorder is present. If it is present both diagnoses should be made (American Psychiatric Association, 2013).

Like other mental disorders, agoraphobia have various causes, including genetic and environmental factors. Because it tends to run in families, genetic factors appear to contribute to its development. Various environmental factors may also trigger or predispose an individual to develop this disorder. These include other anxiety disorders, particularly panic disorder. A history of trauma or childhood abuse may be another factor.

Treatment

Treatment for agoraphobia may include therapy, medication, or a combination of both. Often, behavior therapy is used to reduce the fear and related anxiety. Antidepressant medications like Prozac or Zoloft may be prescribed to reduce the intensity of the chronic worry. Also, antianxiety medications, such as Ativan and Xanax, may be prescribed. Typically, treatment begins with medications that are used only until the fear and anxiety responses are reduced with behavior therapy. Since this disorder tends to co-occur with panic disorder, it is important that clinicians diagnose and treat both disorders simultaneously.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Ativan (Lorazepam); Behavior Therapy; Panic Attack; Panic Disorder; Phobic Disorder; Prozac (Fluoxetine); Social Anxiety Disorder; Xanax (Alprazolam); Zoloft (Sertraline)

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Alcohol Use Disorder

Alcohol use disorder is a mental disorder involving a pattern of alcohol use which leads to significant problems for the user.

Definitions

- **Addiction** is a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **American Society of Addiction Medicine** is an organization of physicians whose purpose is to improve the care and treatment of individuals with the disease of addiction and to advance the practice of Addiction Medicine. It is also referred to as ASAM.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

Description and Diagnosis

Alcohol use disorder is one of the substance-related and addictive disorders. It is characterized by the use of alcohol which results in significant distress or disrupted daily functioning. While drinking alcohol can be a pleasant way to relax and enjoy the company of others, individuals with alcohol use disorder drink to excess. As a result, they endanger themselves and others. "Alcohol use disorder" is the term used in DSM-5 to include the conditions of "alcohol abuse" and "alcohol dependence." In the past, these conditions were considered separate disorders. "Alcohol abuse" referred to short-term and less severe problems with alcohol, such as college students who binge drink. Alcohol dependence referred to long-term and more severe problems and was synonymous with alcoholism. Alcohol use disorder is a common disorder affecting approximately 16% of the adult population (American Psychiatric Association, 2013).

Alcohol use has both short- and long-term effects. Short-term effects include reduced coordination, decreased alertness, impaired ability to drive, clumsiness, slurred speech, and inability to walk without help. Other such effects include life-threatening unconsciousness and coma. Even with moderate use most drivers have slower reaction time and are a danger to themselves and others driving a vehicle. Long-term effects include various digestive and liver diseases such as alcoholic hepatitis, cirrhosis, gastritis, and pancreatitis; hypoglycemia; and other malnutrition-related problems. Long-term effects of alcohol also cause cardiovascular disease, nervous system problems including dementia, and death from lung and heart failure. Some of these long-term effects can occur in as little or less than 10 years of alcohol use.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they use alcohol in larger amounts than intended and have a persistent desire to cut back or control alcohol use. Craving (a strong desire or urge to use alcohol) is another criteria, as is tolerance (increasing amounts needed to become intoxicated) and withdrawal symptoms. The severity of this disorder can diagnosed or specified on a continuum of severity. Those presenting with two to three symptoms are classified as "mild," those with four to five symptoms are "moderate," and those with six or more are "severe" (American Psychiatric Association, 2013).

The cause of this disorder involves biological, psychological, and social-cultural factors. In addition to a strong neurological basis, psychological traits such

as impulsiveness, low self-esteem, and a need for approval may be involved. Other factors include peer pressure, cultural acceptability, and the availability of alcohol. Early use of this drug is associated with impulsivity and lifelong problematic use. Alcohol is commonly used as a way of coping when other ways have failed or no longer work.

Treatment

The goal of treatment for this disorder is abstinence (no longer using alcohol). Treatment has three stages. The first is detoxification, which involves discontinuing alcohol use and treating withdrawal symptoms. The second is rehabilitation, which involves counseling and medications to give the recovering alcoholic the skills needed for maintaining abstinence. The third is maintenance, which includes the support of others to remain abstinent. This commonly involves regular Alcoholics Anonymous meetings and getting a sponsor. Effective treatment of this disorder involves determining the proper level of care for specific individuals. The American Society of Addiction Medicine has developed criteria for five levels of care assessed over six dimensions. The ASAM criteria are required in over 30 states and are considered the gold standard for determining the proper level of care.

Len Sperry, MD, PhD

See also: Addiction; Addictive Personality

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Alcoholics Anonymous (AA)

Alcoholics Anonymous (AA) is a self-help fellowship that was founded by Bill Wilson and Dr. Bob Smith in 1935 to help people struggling with alcoholism.

Definitions

- **Addiction** is a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **Self-help fellowship** is a community in which individuals struggling with the same problem (e.g., alcoholism) help one another. It is also known as a mutual aid fellowship.
- **Temperance movement** was a national crusade that encouraged total abstinence from alcohol.
- **Twelve Steps** refer to the 12 guiding principles on which AA is based.
- **Twelve-Step Programs** are self-help groups whose members attempt recovery from various addictions based on a plan called the Twelve Steps.
- **Twelve Traditions** are the rules that govern how Twelve-Step Program groups operate.

Description

Alcoholics Anonymous is a mutual aid fellowship intended to help people with alcohol problems. AA is the first of many Twelve-Step Programs based on it. AA developed from an early 20th-century temperance movement called the Oxford Group. Members believed that alcoholism was a spiritual illness rather than the result of a weak will. They proposed a spiritual program that involved accepting a higher power and helping others. Many of these practices were carried over to AA.

AA members assist one another through sharing personal experiences, offering guidance, and sponsorship. This generally takes place during attendance at AA meetings, which may focus on members' stories, the Twelve Steps, or some other topic.

The AA fellowship is nonprofessional and does not employ doctors, counselors, or any other type of trained helper. A main principle of AA is that an alcoholic is best suited to understand and help another alcoholic. AA is not considered to be formal treatment but rather an additional method of support. AA groups operate independently from one another, though there is a small governing body based in New York. The organization does not take part in political, religious, or any other kind of debate. This is to protect its stated primary purpose of helping alcoholics achieve sobriety. AA claims that its current membership is nearly 2 million people worldwide. There are AA meetings in many different countries and those which cater to specific genders, age groups, and sexual orientations.

The core of AA is the Twelve Steps and Twelve Traditions. These have remained unchanged since their original format. The Twelve Steps focus on the process of addiction recovery. They include tasks such as admitting powerlessness, completing a moral inventory, making amends to those who were harmed, and helping other alcoholics. For example, Step 1 is "We admitted we were powerless over alcohol—that our lives had become unmanageable." The ultimate goal of the Twelve Steps is to achieve a spiritual awakening which will help the alcoholic remain sober. The Twelve Traditions focus on AA's organizational principles. They include maintaining anonymity in the press, staying out of public debates, and declining outside financial contributions. Both the Twelve Steps and Twelve Traditions are found in *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*. This text is popularly called the "Big Book" by AA members. It is frequently read during AA meetings and contains chapters devoted to employers, unbelievers, and the family members of alcoholics.

Bill Wilson (1895–1971) was a founding member of AA. Born in East Dorset, Vermont, Wilson was a shy man who struggled with depression and anxiety throughout his young adult years. He served in the military during World War I and enrolled in law school on his return home. To deal with his increasing social anxiety in law school, Wilson drank excessively. The result was being dismissed from law school for drunkenness. After that he worked as a stock speculator and traveled the country with his wife, Lois. His drinking continued to worsen, resulting in financial failure and numerous hospitalizations at Towns Hospital in New York.

It was during one of these hospitalizations that he was reacquainted with Ebby Thatcher (1896–1966), an old friend who had stopped drinking with the help of the Oxford Group. Wilson continued to drink until he had what he described as a "spiritual experience" during another hospitalization. He reported that he saw a bright light and felt the presence of God. Wilson never drank again after this event. He joined the Oxford Group and helped another alcoholic, Dr. Bob Smith (1879–1950), during a business trip to Akron, Ohio, in 1935. The two began helping other alcoholics and promoting a spiritual program of recovery. They eventually split from the Oxford Group and started their own fellowship with the publication of *Alcoholics Anonymous*. Wilson was the primary author of this book, which contained the original Twelve Steps.

Bill Wilson continued to develop the AA program throughout his lifetime and remained a central figure in the movement. Some controversy surrounds his experimentation with lysergic acid diethylamide (LSD) in the 1950s and alleged infidelity. Wilson eventually died from emphysema in 1971 presumably because of long-term tobacco use.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Addiction; Addictive Disorder; Alcohol Use disorder; Twelve-Step Programs

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Alexithymia

Alexithymia is the inability to identify or describe one's emotions.

Definitions

- **Autism spectrum disorder** is a mental disorder characterized by impaired social and communication skills, repetitive behaviors, and a restricted range of emotions and interests.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Emotion** is a complex physiological, cognitive, and behavioral reaction to a situation perceived to be personally significant. Happiness, sadness, surprise, disgust, anger, and fear are the six basic emotions recognized across cultures.
- **Emotional intelligence** is the ability to accurately identify and respond to emotions in oneself and others.
- **Feelings** are the subjective expression of emotion.

Description

The term "alexithymia" means "no words for feelings" in Greek. It was originally described by American psychiatrist Peter Sifneos (1920–2008) in 1973. Alexithymia is characterized by poor awareness of one's emotions, difficulty relating to others, confusing feelings with physical symptoms, lack of empathy, overly logical thinking, and lack of imagination or creativity. People may get lost in trivial details. These characteristics may differ from person to person. Those with alexithymia often lack insight and may appear robotic or detached to those around them. They may be able to identify basic emotions like "happy" or "sad" but cannot go into greater detail about their feelings. Rather than the complete absence of emotions, alexithymia is a problem of emotional expression. It often leads to interpersonal problems because these individuals tend to avoid intimate relationships or position themselves in either dependent or dominant roles. Those in romantic relationships with alexithymics are likely to find their relationships less than satisfying. It is not surprising that those with alexithymia have low levels of emotional intelligence.

Alexithymia is not a diagnosis included in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. However, it is often found in those with other mental disorders such as autism spectrum disorder. It is also linked with medical conditions such as migraine headaches, hypertension (high blood pressure), and lower back pain. It appears that unexpressed emotions somehow build up and are expressed indirectly in these medical conditions.

There are several theories about the cause of this disorder. These include genetic factors like neurological problems and environmental factors like childhood abuse. Problems in communication between the two hemispheres (sides) of the brain are believed to be its cause. Others believe that it is caused by an individual's fear of being overwhelmed by emotions and the decision to shut them out for protection. Alexithymia occurs in about 10% of adults.

Treatment

Traditional counseling may not be successful for those with alexithymia because they are not able to connect with their feelings. However, there are specialized cognitive behavior therapy interventions that have developed for those with this condition.

Len Sperry, MD, PhD, and George Stoupas, MS

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Emotion; Emotional Intelligence

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Allostatic Load

Allostatic load is the by-product of chronic stress over time. It is a result of allostasis, which is the process of maintaining balance in the body through physiological (physical) changes.

Definitions

- **Adrenaline** is a neurotransmitter (chemical messenger) involved in the fight or flight response that increases heart rate, pulse rate, and blood pressure.
- **Brain** is the organ at the center of the nervous system. It is responsible for a wide range of functions, including learning, movement, and regulation of the body.
- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **Hormones** are chemicals in the body that are produced by glands to regulate physical functions like sleep, metabolism, and mood. Cortisol and testosterone are examples of hormones.
- **Neurotransmitters** are chemicals in the brain responsible for a variety of functions, including pleasure, motivation, and mood. Dopamine, serotonin, and gamma-aminobutyric acid are examples of neurotransmitters.
- **Stress** is the pattern of specific and nonspecific responses to events that tax or exceed an individual's ability to cope. Stress can be acute (short term) or chronic (long term).
- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description

Allostasis is the process of maintaining balance in an organism through physiological adjustments in response to environmental stimuli. The term literally means "maintaining stability through change." These changes are controlled by the brain through the release of hormones and neurotransmitters. They are intended to meet the expected demands of the individual. One example is epinephrine, also known as adrenaline. It is secreted by the adrenal gland when an individual perceives danger or experiences excitement. Adrenaline results in increased heart rate, respiration rate, and blood glucose levels. Cortisol is another stress hormone. It increases energy production in the body and suppresses the immune system. Neurotransmitters like dopamine are also released in response to stress. They act to increase concentration, motivation, and memory. All of these changes enhance performance and enable quick movements such as running or fighting. They involve many different regulatory systems in the body, such as the central nervous system and the inflammatory system. Once the perceived danger or excitement has passed, neurochemical levels decrease and the systems return to normal. This physiological process has clear short-term benefits. For example, being chased by a rabid dog would activate the stress response system and allow an individual to escape. Increased blood flow would enable faster movements and heightened awareness would lead to quick decision making. However, the long-term effects of stress can result in damage to the body and lead to disease.

The term "allostatic load" was originally used by biologist Bruce McEwen, PhD (1938–), and psychologist Eliot Stellar, PhD (1919–1993). They defined it as the by-product of chronic stress over time. It can be thought of as the price the body pays for constantly adapting to stress through allostasis. The neurochemical changes that accompany stress can negatively impact functioning if they occur frequently. While some stressful situations may happen on occasion, repeated activation of the stress response system may result from other environmental factors. For example, living in poverty can produce significant ongoing stress. Problems like insufficient food, large debt, and loss of a job can activate the body's stress response system. Unlike a chance encounter with a rabid dog, however, these environmental stressors do not quickly pass. Constant arousal leads to dysregulation (imbalance) of the body's stress response. An individual's allostatic load can be measured.

This measure includes factors such as cortisol levels, blood pressure, and cholesterol. High allostatic load scores have been associated with a number of mental and physical problems. These include increased risk of heart disease, impaired immune system, memory problems, and increased risk of death. Individuals who experience chronic stress are at risk for these conditions. An individual's response to stress depends on many factors like genetics, environment, and coping skills. There are ways to reduce the negative impact of stress through the use of techniques like stress management.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Adrenaline; Brain; Dopamine; Stress

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Allport, Gordon (1897–1967)

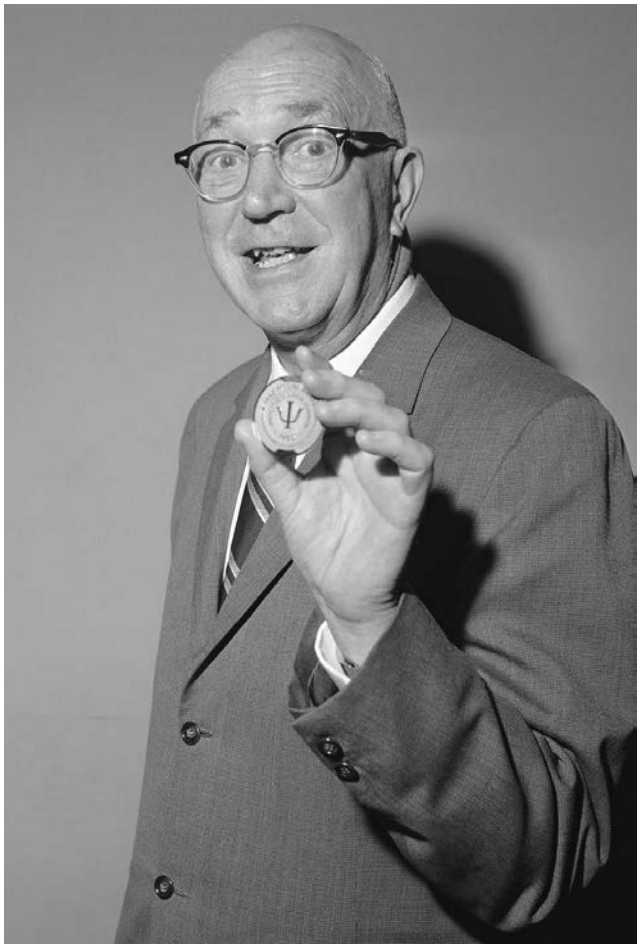
Gordon Allport is regarded as one of the founding fathers of personality psychology. He developed his own eclectic theory based on traits, moving away from psychoanalytic and behavioral approaches that were popular views at the time. His life's work was devoted to cultivating his theory, examining the impact of social justice issues, and developing personality tests.

Description

Gordon Willard Allport was born on November 11, 1897, in Montezuma, Indiana, to John Edwards Allport and Nellie Edith (Wise) Allport, a country doctor and school teacher. Gordon was the youngest of four boys. The Allports were devout Protestants who believed in hard work, which led to educational and later professional success for Gordon and his siblings. The family moved to Cleveland, Ohio, when Gordon was six and the boys attended local public schools. In his teenage years, Gordon ran his own printing business while serving as editor of the school newspaper. He graduated second in his class from Glenville High School, earning a scholarship to Harvard College. Gordon's brother, Floyd Allport, also a Harvard grad, went onto become an important social psychologist. Though the transition to college wasn't easy, Gordon soon acclimated, majoring in economics and philosophy and successfully earned his BA degree in 1919.

After graduating, Allport traveled to Istanbul, Turkey, to teach English and sociology at Robert College. He later returned to Harvard to pursue his master's degree and study under Herbert S. Langfeld. In 1921, he coauthored his first publication, *Personality Traits: Their Classification and Measurement*, with his brother Floyd. In 1922, he received his PhD in psychology. He then continued studying abroad, at places such as the University of Berlin, the Hamburg in Germany, and the University of Cambridge in England. In 1924, he returned to his alma mater and began teaching in the Department of Social Ethics. The remainder of his career was spent working on his Trait Theory from which came additional publications and personality assessments. He died in Cambridge, Massachusetts, on October 9, 1967.

A story always included in Allport's biographies surrounds his meeting the great Sigmund Freud in Vienna at the age of 22. The initial interaction consisted of complete silence, with Freud simply waiting for Gordon to begin talking, perhaps attempting to determine who could stand the silence longer. Gordon, feeling uncomfortable, blurted out an observation he made on the bus ride over to Freud's office. A little boy was very upset about having to sit in the seat where a dirty old man had previously sat. He hypothesized that the boy's behavior was likely the product of his apparently rigid, domineering mother. Rather than responding to Gordon's comments, Freud followed up with the question, "And was that little boy you?" Freud, of course, was referring to the unconscious process in Gordon's mind instead of the simplicity of the observation. This experience had a profound effect on Allport causing him to turn away from psychoanalytic theory, which he felt all too often sought reasons and answers where they did not exist. Allport did not believe it was necessary to look into a person's past in order to understand his or her present self. He even



Gordon Allport is regarded as one of the founders of personality psychology, moving away from psychoanalytic and behavioral theories toward humanistic theories of psychology. (AP Photo/Bill Ingraham)

coined the term "functional autonomy," to highlight his view that one's current actions and motives are independent (autonomous) of past origins. Trait Theory posits that each person has a foundational self, composed of both phenomenological and functional components. The phenomenological part is our essential self and is made up of experiences we view as most central. The latter component comprises functions we undergo at different points throughout our life. Allport defined seven functions: (1) sense of body—develops in first two years of life, distinct boundaries between bodily self and outside world; (2) self-identity—first two years, sense of individuality and continuity; (3) self-esteem—develops between ages 2 and 4, sense of value to ourselves and others; (4) self-extension—ages 4 to 6, people, things, events that are essential to one's identity (5); self-image—also develops between ages 4 and 6, how others view us, the impression we make on them; (6) rational coping—learned during ages 6 to 12, ability to deal with problems in a rational, effective manner; and (7) appropriate striving—begins after the age of 12, sense of direction and purpose in life. These functions, though they reflect time periods similar to Freud's, should not be likened to stages, as they simply describe ways in which people develop.

While our functional selves are developing, one also develops personal traits or, as Allport named them, personal dispositions. Dispositions are concrete, distinct, and easily recognizable patterns in a person's behavior. Originally using the term "traits," Allport changed to the term "dispositions" to distinguish between things a person may see or perceive about another person when looking at another person versus characteristics that were unique to that individual. This distinction caused Allport to strongly encourage the use of idiographic methods of study. Idiographic methods, nowadays referred to as qualitative methods, focus on studying one person at a time in depth by way of interviews, observations, analysis of writings, and so on.

Allport compiled a list of over 4,500 different traits before collapsing them down into three categories: cardinal traits, central traits, and secondary traits. Cardinal traits are traits that dominate a person's entire personality. These types of traits are quite rare and often do not develop, if at all, until later in life. Central traits are more common and describe people's personalities. Examples of central traits are shy, kind, friendly, and smart. Allport estimated that most people have between 5 and 10 central traits. Secondary traits are more fluid and may be present only under certain conditions and circumstances. Personal preferences and situational attributes are examples of secondary traits (i.e., getting anxious during a flight).

Impact (Psychological Influence)

Gordon Allport's ideas have remained a part of mainstream psychological thought. His works went on to influence the views of other highly regarded theorists, including Abraham Maslow and Carl Rogers. He had a profound impact in shaping humanistic theory as a whole.

Melissa A. Mariani, PhD

See also: Humanistic Psychotherapy; Maslow, Abraham (1908–1970); Rogers, Carl (1902–1987)

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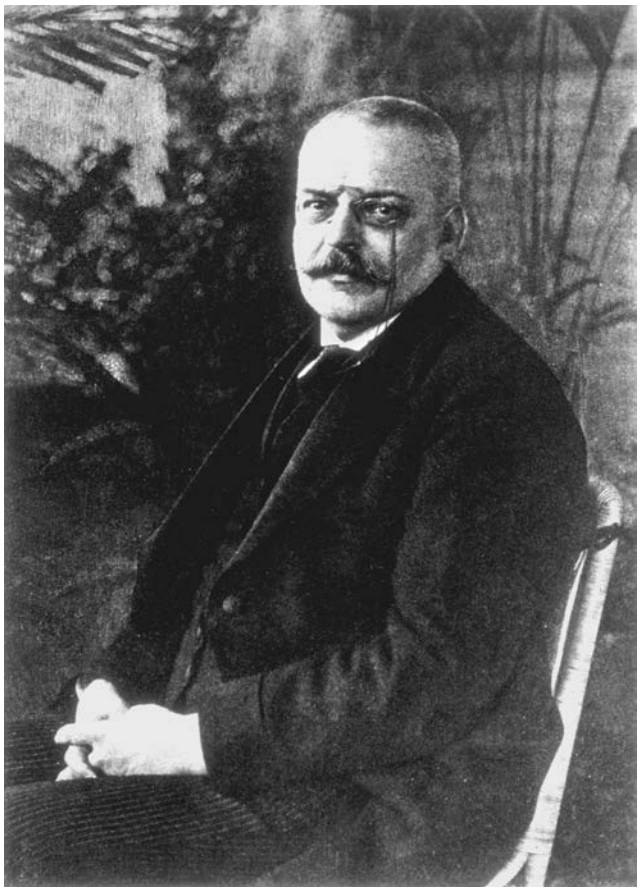
Alzheimer, Alois (1864–1915)

Alois Alzheimer is known for his work with dementia, particularly dementia of the Alzheimer's type, more commonly referred to as Alzheimer's disease.

Alzheimer's disease is a medical and mental disorder that causes dementia usually, but not always, after age 65. It is the most common form of dementia, which is a disease associated with memory loss and decreased cognitive functioning. Alzheimer's is the most common type of dementia. In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, it is referred to as Neurocognitive Disorder Due to Alzheimer's Disease.



Alois Alzheimer from Bavaria was a psychiatrist who became known for his work with senile dementia, now more commonly known as Alzheimer's disease. (Corbis)

Description

Alois Alzheimer (1864–1915) was a Bavarian psychiatrist who published the first case of dementia, which was later identified as dementia of the Alzheimer's type. He was born in Marktbreit, Bavaria. He received his medical degree from Würzburg University in 1886. He was cofounder and copublisher of the journal *Zeitschrift für die gesamte Neurologie und Psychiatrie*. Throughout his professional career, Alzheimer published his finding in various scientific journals. Dr. Alzheimer worked with patients with mental illness early in his career. He eventually took a position in the Frankfurt's Asylum for Lunatics and Epileptics. There he became increasingly involved in the diagnosis and treatment of dementia. In 1901 Auguste Deter (1850–1906) became one of Dr. Alzheimer's patients. She presented with strange behavioral symptoms and loss of short-term memory. Dr. Alzheimer became particularly interested in her symptoms and continued to monitor her condition. She died in 1906 after which Alzheimer had her medical records and brain sent to the lab of the famous German psychiatrist Emil Kraepelin (1856–1926) in Munich. The lab used special staining techniques and determined that Auguste Deter's brain contained amyloid plaques and neurofibrillary tangles. Amyloid plaques are protein fibers that are found in the brain of individuals with neurodegenerative disorders such as Alzheimer's, Parkinson's, and Huntington's disease. Neurofibrillary tangles are twisted masses of protein fibers in nerve cells which are found in the brains of individuals with Alzheimer's disease.

Afterward, Dr. Alzheimer gave several professional presentations about the pathology and symptoms of this form of senile dementia that differed from presenile dementia, which is a form of dementia that occurs in middle age (before 65 years) and progresses (worsens) rapidly, and other types of dementia. Kraepelin credited Alzheimer with the discovery of this form of

dementia and called it Alzheimer's dementia in his definitive textbook of psychiatry. Since 1911, physicians in the United States and throughout the world have used Alzheimer's list of symptoms to diagnose their patients.

Dr. Alzheimer's research differentiated the senile form of dementia (eventually coined "Alzheimer's" in Kraepelin's textbook) from the other types of dementia. His years of work and research serve as the foundation for the search for a cure for Alzheimer's by the medical community today. In addition, Alzheimer's is considered one of the most disturbing diseases of old age today.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Alzheimer's Disease; *Diagnostic and Statistical Manual of Mental Disorders* (DSM)

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Alzheimer's Disease

Alzheimer's disease is a medical and mental disorder that causes dementia, particularly late in life. It is also referred to as Neurocognitive Disorder Due to Alzheimer's Disease.

Definitions

- **Dementia** is a group of symptoms including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of neurons (nerve cells) in the brain.
- **The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*,** is the handbook mental health professionals use to diagnose mental disorders.
- **Mild cognitive impairment** is a mental condition characterized by memory problems that do not significantly impact daily functioning. Commonly, the condition is hardly noticeable or troublesome to the individual. It is also known as MCI.

Description and Diagnosis

Alzheimer's disease is a progressive disease that destroys memory and other important mental functions and results in the loss of intellectual and social skills. It is the most common cause of dementia in individuals over the age of 65. Before the age of 70 about 10% of adults are diagnosed with the disorder. That figure rises to at least 25% after age 70. Women are more likely than are men to develop this disease, in part because they live longer (American Psychiatric Association, 2013).

The decline in mental functioning is progressive in terms of person, place, time, and situation. At first, individuals have trouble articulating why they are where they are ("situation"). Next, they have difficulty identifying where they are ("place"). Later, as the disease progresses, they have difficulty identifying what day or year it is ("time"). Finally, in advanced cases, they will lose a sense of who they are ("person"). New learning, such as the ability to listen to a story and repeat it, also declines. Genetic testing is essential in making the diagnosis of Alzheimer's disease.

Three stages of the disease are recognizable: early, middle, and late. In the early stage of Alzheimer's, specific signs and symptoms can be observed. These include short-term memory loss, difficulty performing familiar tasks, and increasing problems with planning and managing activities, like balancing a checkbook. It may also include trouble with language, such as difficulty recalling words for everyday things. In the middle stage of this disease, the individual may have difficulty completing everyday tasks, such as preparing meals or getting dressed. Individuals may experience intense feelings of paranoia and anger, and they may wander away or get lost. In the late stage of the disease, individuals are unable to care for themselves. They may be unable to communicate with or recognize others or to walk by themselves. They may have difficulty swallowing and be unable to smile.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a steady progression of impairment of memory, learning, language, perception, or another cognitive domain. There must also be evidence of Alzheimer's disease from family history or genetic testing. In addition, there must be obvious evidence of decline in learning and memory, and this decline must be progressive. Furthermore, the absence of other neurological conditions is required (American Psychiatric Association, 2013).

Mild cognitive impairment (MCI) is an intermediate stage between the cognitive decline associated with normal aging and the more serious decline of dementia. MCI can involve problems with memory, language, thinking, and judgment. Individuals with MCI may recognized that their memory or mental function has "slipped." Family and close friends may also notice a change. However, these changes do not interfere with one's usual activities. For some, MCI may increase individuals' risk of progressing to dementia. Still, others with this condition experience no decline and may eventually get better.

The cause of this disorder is not yet well understood. However, brains affected by Alzheimer's disease have many fewer cells and many fewer connections than those with healthy brains. As brain cells die, significant brain shrinkage occurs. Two types of brain abnormalities are found in this disease. The first is plaques on the outside of brain cells. These plaques are clumps of a protein called beta-amyloid that interfere with cell-to-cell communication in the brain. Although the ultimate cause of brain-cell death in Alzheimer's isn't known, the collection of beta-amyloid on the outside of brain cells is a prime suspect. The second is tangles which are distortions in the cell's internal support and transport system involving a protein called tau. In this disorder, threads of tau protein twist into abnormal tangles inside brain cells.

Treatment

Because of the biological basis of this disorder, treatment is largely biological. Specific medications and management strategies may temporarily improve symptoms. Medications like Aricept can slow the progression of Alzheimer's symptoms for about half of those taking them for 6 to 12 months. Aricept is approved by the FDA (Food and Drug Administration) for all stages of Alzheimer's disease: early or mild stage, moderate or middle stage, and late or severe stage. It works by increasing levels of acetylcholine (a chemical) in the brain. Namenda is also FDA approved to treat moderate-to-severe Alzheimer's disease. It is thought to work in the brain by regulating the activity of glutamate (a chemical) in the brain.

While these medications may extend an individual's functioning and maintain his or her independence for a short time, there is no cure for this disorder. Therefore, it is important those with Alzheimer's and their caretakers seek supportive services and maintain a good support network. Family therapy can assist family members to understand, accept, and adjust to the individual's progressively deteriorating condition.

Len Sperry, MD, PhD

See also: Aricept (Donepezil); Dementia; Namenda (Memantine)

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Ambien (Zolpidem)

Ambien is a prescription medication used to treat sleep problems (insomnia) in adults. Its generic name is zolpidem.

Definitions

- **Gamma-aminobutyric acid** is a chemical messenger in the brain that leads to relaxation, calmness, and sleep by reducing nerve cell excitement.
- **Insomnia** is a chronic inability to fall asleep or to remain asleep throughout the night.
- **Sedative-hypnotics** are medications that induce calmness and sleep. Barbiturates and benzodiazepines are its main types. They are also called tranquilizers, sleeping pills, or sleepers.

Description

Ambien is in the class of medications known as sedative-hypnotics. Its primary use is in the treatment of insomnia. Ambien is believed to work by mimicking the neurotransmitter (chemical messenger) in the brain called gamma-aminobutyric acid which promotes relaxation and sleep. Unlike other sleeping medications, Ambien does not interfere with the quality of sleep or result in drowsiness on awakening. Instead, most who use Ambien awake feeling refreshed.

Precautions and Side Effects

Because Ambien is used to help individuals fall asleep, it should not be used with over-the-counter, herbal, or prescription medications, such as antihistamines or alcohol, which also cause drowsiness. Ambien should be used only with close medical supervision in people with liver disease and in the elderly, because these individuals are especially sensitive to the sedative properties of Ambien. Ambien should not be used before driving, operating machinery, or performing activities that require mental alertness. Those with a history of drug abuse, depression, or other mental disorders should be carefully monitored when using Ambien since it may worsen symptoms of some mental disorders.

Using Ambien can lead to sleep-related behaviors such as eating, talking, and driving while asleep, with no recollection of the events. More common side effects include headache, nausea, muscle aches, and daytime drowsiness. Such drowsiness may cause individuals, particularly those over age 65, to be less coordinated and more susceptible to falls. Other less common side effects include anxiety, confusion, dizziness, and stomach upset.

Taking Ambien and other medications that causes drowsiness may result in substantially decreased mental alertness and impaired motor skills. Some examples include alcohol, antidepressants such as Tofranil or Paxil, antipsychotics such as Mellaril, and the antihistamines in many allergy and cold medications.

Len Sperry, MD, PhD

See also: Sleep Disorders

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American Academy of Child and Adolescent Psychiatry (AACAP)

The American Academy of Child and Adolescent Psychiatry (AACAP) is a nonprofit group of psychiatrists and other related medical professionals created in 1953. It is a national organization with 7,500 members dedicated to helping children who have been diagnosed with psychiatric disorders.

Definition

- **Child and adolescent psychiatrists** are medical doctors with specialized training who assess, diagnose, and treat mental, behavioral, or developmental disorders in children and adolescents, usually by prescribing medication.

Description

The AACAP was organized to help improve the quality of life of the nearly 12 million U.S. youth who

suffer from mental, behavioral, or developmental disorders. This group also offers information and support for the families of these youth.

The AACAP's mission is to "promote the healthy development of children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment and to meet the professional needs of child and adolescent psychiatrists throughout their careers." Part of the work that the AACAP does includes setting guidelines for standards of care in treating children and adolescents who have been diagnosed with a mental illness.

Impact (Psychological Influence)

The organization offers many services to its members and to the families affected by mental illness. The AACAP provides information and support to parents and family members of affected children and adolescents. The group also is active in research that hopefully will lead to more effective treatments. The organization works to increase access to treatment and services for children and adolescents, and to reduce the stigma associated with mental illness. To do this, the organization provides a learning center for families who have a child diagnosed with a mental illness, behavioral or developmental disorder.

In an effort to support the families with information, the AACAP publishes a variety of informative guides for parents. For example, it publishes a *Parents' Medication Guide for Treating Childhood Depression* and the *Parents' Medication Guide for Bipolar Disorder*. These publications, as well as many prescription drug guides, are free and available at www.aacap.org.

The AACAP also is an advocate on behalf of the mental health of children and adolescents, focusing on access to services and improving national policies regarding mental health. Members are informed of upcoming legislation and regulatory actions so they can get involved in working with lawmakers on the importance of children's mental health.

The American Academy of Child and Adolescent Psychiatry is considered an Allied Assembly organization of the APA. The American Psychiatric Association (APA) was founded in 1844 and is considered the largest professional psychiatric organization. Being an Allied Assembly organization of the APA means that the AACAP's mission and code of ethics are compatible with the APA's. A similar organization to AACAP is the International Association of Child and Adolescent Psychiatrists and Allied Professionals (IACAPAP), which was founded in 1935. IACAPAP pursues a similar mission to AACAP but has expanded membership that includes working with allied professionals, such as psychologists, social workers, pediatricians, and nurses.

Mindy Parsons, PhD

See also: American Psychiatric Association (APA)

Further Reading

The AACAP has published a quarterly journal since 1962. The publication is known as the *Journal of the American Academy of Child and Adolescent Psychiatry*. The journal is highly regarded for its leading psychiatric research and treatment, including a focus on the psychopharmacology of child and adolescent disorders.

Organization

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American Counseling Association (ACA)

The American Counseling Association (ACA) is currently the world's largest nonprofit organization serving professional counselors working in various settings through education and professional development.

Definition

- **Professional counselors** are licensed/certified practitioners who work in educational or mental health settings and possess specialized skills that benefit clients in making progress emotionally, socially, behaviorally, or academically.

Description

The American Counseling Association is a not-for-profit organization responsible for the education, support, and development of professional counselors working in various settings (schools, mental health agencies, private practice, etc.). ACA was founded in 1952. It is currently the world's largest association exclusively representing professional counselors. It has a membership rate of more than 50,000. The mission of the ACA is "to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity."

ACA provides valuable services to counselors by providing leadership training, making available up-to-date resources and publications, and offering continuing education opportunities. It has been instrumental in providing counselors the means by which to enhance their skills and expand their knowledge base. Establishing professional and ethical standards has also been a goal of the ACA. The organization has made a concerted effort to raise standards in terms of accreditation, licensure, and national certification. Advocacy is another part of the mission. Elected members represent the interests of the profession before Congress and federal agencies. In addition, they seek to recognize the accomplishments of professional counselors in public forums.

The formation of the association now referred to as ACA began in Los Angeles, California, in 1952. Four independent organizations, the National Vocational Guidance Association, the National Association of Guidance and Counselor Trainers, the Student Personnel Association for Teacher Education, and the American College Personnel Association, convened in hopes of unifying their professional efforts. The American Personnel and Guidance Association was established, but the name was later changed to the American Association of Counseling and Development in 1983. Then, on July 1, 1992, the association adopted its current name, the American Counseling Association. The new name was meant to reflect a common purpose between members no matter what setting they worked in.

The ACA is headquartered in Alexandria, Virginia, just outside Washington, D.C. It services professional counselors living in the United States as well as in 50 other countries. Some of these nations include Europe, Latin America, the Philippines, and the Virgin Islands. The ACA encompasses a comprehensive network with 19 chartered divisions and 56 branches itself. However, it also works with outside corporations in related fields to enhance services and benefits for its members. The various ACA divisions provide information, resources, and services specifically tailored to areas of specialized practice or principles of counseling. Divisions include the Association for Assessment in Counseling and Education, the Association for Adult Development and Aging, the Association for Creativity in Counseling, the American College Counseling Association, the Association for Counselors and Educators in Government, the Association for Counselor Education and Supervision, the Association for Humanistic Counseling, the American Mental Health Counselors Association, the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, the Association for Multicultural Counseling and Development, the American Rehabilitation Counseling Association, the American School Counselor Association, the Association for Spiritual, Ethical, and Religious Values in Counseling, the Association for Specialists in Group Work, the Counselors for Social Justice, the International Association for Addictions and Offenders Counselors, the International Association of Marriage and Family Counselors, the National Career Development Association, and the National Employment Counseling Association. Members of ACA can enhance their professional identity and practice by joining one or more of these divisions. These divisions elect officers who govern their activities independently and are also permitted a say in national ACA governance. The Governing Council is the national governing body of the ACA. Nationally elected officers and representatives from each division and region serve terms of no longer than three years.

Impact (Psychological Influence)

The American Counseling Association has had a significant impact on professional counseling practice. It continues to set standards and make strides in the field. By 2009, ACA had enacted licensure in all 50

states. In 2010, ACA delegates announced their consensus on a definition of counseling to 20/20: A Vision for the Future of Counseling: "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals." By promoting public confidence and trust, the ACA provides a foundation of support for counseling professionals so that they can assist clients and students in dealing with life's challenges.

Melissa A. Mariani, PhD

See also: Counseling and Counseling Psychology

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American Mental Health Counselors Association (AMHCA), The

The American Mental Health Counselors Association (AMHCA) is a professional association of licensed clinical mental health counselors.

Description

The AMHCA is a professional organization with a membership of nearly 7,000 clinical mental health counselors. The mission of the AMHCA is to enhance the profession of clinical mental health counseling through licensing, advocacy, education, and professional development. The AMHCA sets standards of education, training, licensing, practice, advocacy, and ethics for the profession. Clinical membership in AMHCA requires a master's degree in counseling or a closely related mental health field and adherence to AMHCA's National Standards for Clinical Practice.

The AMHCA was founded in 1976 by a group of community mental health, community agency, and private practice counselors who identified their practice as "mental health counseling." The initial focus of the AMHCA was to establish a definition of mental health counseling, set education and training standards, create a national credentialing system, and establish a professional journal (*Journal of Mental Health Counseling*).

Impact (Psychological Influence)

The AMHCA defines the practice of clinical mental health counseling as the provision of professional counseling services involving the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology (how it develops) of mental illness and dysfunctional behavior. Counselors provide services to individuals, couples, families, and groups, for the purpose of promoting optimal mental health, dealing with normal problems of living, and treating psychopathology. The practice of mental health counseling includes, but is not limited to, diagnosis and treatment of mental and emotional disorders, psychoeducational techniques aimed at the prevention of mental and emotional disorders, consultations to individuals, couples, families, groups, organizations, and communities, and clinical research into more effective psychotherapeutic treatment services.

In 1979 the AMHCA created the first educational and training standards for mental health counselors. In 1988 the Council for Accreditation of Counseling and Related Educational Programs adopted and adapted the AMHCA training standards and established the first accreditation standards for master's degree programs in Mental Health Counseling. Also in 1979 the AMHCA established the first credentialing body for mental health counselors: the National Academy of Certified Mental Health Counselors. In 1993 this certification was absorbed into the National Board for Certified Counselors.

The AMHCA provides national and state legislative advocacy services for members. Advocacy includes ensuring that counselors are recognized in federal and state laws; educating policy makers about the role of mental health counselors; increasing lawmakers' awareness about mental illness and its effects on people's lives; and enhancing public and private insurance plans so mental health benefits are offered similar medical and surgical benefits.

The AMHCA code of ethics defines and guides ethical behaviors and best practices for mental health counselors. The code identifies six key principles.

I. Commitment to Clients: guidelines regarding the counselor–client relationship; the counseling process; counselor responsibilities and integrity; assessment and diagnosis; record keeping, fee arrangements and bartering; other roles.
II. Commitment to Other Professionals: guidelines regarding relationships with colleagues and clinical consultations.
III. Commitment to Students, Supervisees, and Employee Relationships: guidelines for the integrity and welfare of supervisees, students, and employees.
IV. Commitment to the Profession: guidelines for teaching; research and publications; service on public or private boards and other organizations.
V. Commitment to the Public: guidelines for public statements and advertising.
VI. Resolution of Ethical Problems: guidelines resolve ethical dilemmas, which may arise in clinical practice.

Steven R. Vensel, PhD

See also: Council for Accreditation of Counseling and Related Educational Programs; Mental Health Counselor

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American Psychiatric Association (APA)

The American Psychiatric Association (APA) is the world's largest professional organization serving psychiatrists seeking to provide effective treatments for patients with mental health disorders.

Definition

- **Psychiatrists** are medical doctors who specialize in the diagnosis, treatment, and prevention of mental health disorders including intellectual disabilities and substance abuse issues.

Description

The American Psychiatric Association is a medical specialty organization that seeks to be the voice and conscience of modern psychiatry. It currently serves approximately 36,000 psychiatrists in the United States and throughout the world. APA's mission is to provide the highest quality of care to patients suffering with mental health issues, promote research and education related to psychiatric problems, advance the field of psychiatry, and provide proper service to its members. This mission is accomplished through services provided to patients, members, and the profession. Founded in 1844, APA has a long-standing record of providing psychiatrists at all career levels with professional support. Members advocate for available and accessible care for all persons suffering with mental illness.

In October 1844, the *Association of Medical Superintendents*, the foundations of APA, was formed of 13 superintendents from the then existing 24 mental health hospitals. Their purpose was to share ideas, communicate their experiences, and assist one another in providing proper treatment for those deemed mentally insane. In 1892, the association changed its name to the *American-Medico Psychological Association* and now opened membership to practitioners working in mental hospitals and private practice. Prompted by the work of Sigmund Freud and other leading psychoanalysts of the time, the National Committee for Mental Hygiene was in 1912 to shed further light on the issue of mental health. In 1917, the association adopted the first diagnostic and statistical manual. An official name change from the American Medico-Psychological Association to the American Psychiatric Association occurred in 1921. In 1946, the association adopted its first set of standards for psychiatric patients and an official first edition of the *Diagnostic and Statistical Manual of Mental Disorders* was then released until

1952. The first Assembly of APA's district branches, 16 at the time, was held on May 5, 1953, in Los Angeles, California. Prior to this date no unified mission or official representation existed. Since that time the association has progressed its cause and grown exponentially in membership comprising some 36,000 members to date.

The American Psychiatric Association is headquartered in Arlington, Virginia. APA is governed by a board of trustees of national and regional representatives who are elected by members with the authority to make policy changes to the Bylaws and act on behalf of the association. At present, the association has 74 district branches/state associations that work to streamline communication, offer educational programs and training opportunities, provide public outreach materials, and advance APA's mission through promotional advertising. These services assist in ongoing professional development for members, allowing them to continue to advance their clinical and diagnostic skill sets. The APA website houses information, resources, and training for professionals. The Continuing Medical Education and Lifelong Learning Center allows members to take continuing education credits online through various formats. Annual meetings are available through this site to provide members with the most up-to-date research and interventions for their patients. Members have the ability to get recertified through the site as well. APA also publishes four professional journals, the *American Journal of Psychiatry, Psychiatric Services, FOCUS: The Journal of Lifelong Learning*, and the *Journal of Neuropsychiatry and Clinical Neurosciences*. A philanthropic offshoot of APA, the American Psychiatric Foundation, works to promote mental health and wellness worldwide by providing public and professional education, funding, and recognition.

Impact (Psychological Influence)

APA provides valuable services to psychiatrists by providing a professional support network, making available current resources and publications, and offering continuing education, training, and grant opportunities. APA has established professional and ethical guidelines to direct clinical practice and advocates for the profession as a whole. Recent concerns for the profession including enhancing privacy laws, protecting scope of practice, and advocating for fair treatment, insurance coverage, and reimbursement for those suffering with mental health disorders and substance related issues are also being advanced through APA's efforts. APA released the most recent edition of the DSM (DSM-5) in May 2013.

Melissa A. Mariani, PhD

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Psychiatrist

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American Psychological Association (APA)

The American Psychological Association (APA), the world's largest professional and scientific organization of psychologists, was established with the purpose of creating, communicating, and applying psychological knowledge to improve people's lives and to benefit the larger society.

Definition

- **Psychologists** are practitioners who hold doctoral-level degrees (PhD, PsyD, or EdD) in psychology and work in a variety of areas including education, research, private practice, health care, law, and business/industry to promote mental health and wellness.

Description

The American Psychological Association is comprised of over 134,000 members worldwide working in the psychology field to provide scientific research, education, treatment, and prevention care to people in need. As the largest professional association of psychologists, APA represents clinicians employed in diverse settings including schools, research labs, private practices, hospitals, courts, and businesses. Students pursuing degrees in psychology or other closely related fields are also eligible for membership. APA's mission is to "*to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives*." This is accomplished through encouraging the broad development and application of psychology, promoting psychological research, improving current psychological practice by raising qualifications and establishing high standards, and disseminating psychological knowledge and research findings to those within the profession and outside community.

Founded in July 1892 at Clark University in Worcester, Massachusetts, APA was formed by a small group of men seeking to further a new field of psychology. Electing themselves and others, APA then consisted of only 31 members. Granville (G.) Stanley Hall (1844–1924), psychologist and educator credited with spawning the Child Study Movement, served as president. APA's first official meeting was held in December 1892 at the University of Pennsylvania with governance comprised of a council and executive committee. Membership grew modestly over the first 50 years; however, once a new category of nonvoting membership was opened in 1926, that of *associate members*, numbers increased from the hundreds to the thousands. APA reorganized during World War II, merging with other psychological associations to encompass a broader more flexible view of psychology. The greatest increase in membership resulted after World War II between 1945 and 1970 when numbers rose from some 4,000 to over 30,000. Several factors contributed to a growing interest in psychology, and this subsequent boom in APA membership included (a) returning servicemen who were in need of psychological care, (b) health benefits that were now provided to veterans through the GI Bill, (c) the inception of the Veterans Administration Clinical Psychology training program, and (d) the creation of the National Institute of Mental Health (NIMH), a U.S. agency dedicated to the focus, treatment, and prevention of mental health problems. A revised divisional structure also occurred post–World War II contributing to APA's growth. With only 19 approved divisions in 1944, APA presently has 54 divisions in various subdivisions of psychology.

The American Psychological Association is chartered in Washington, D.C., and is governed by a council of representatives with a board of directors. The council of representatives, made up of elected members from regional associations and APA divisions, is the sole legislative body responsible for determining policy and budgetary changes. The board of directors advises and offers recommendations to the council while an elected president executes matters related to the Bylaws. Several affiliate organizations are associated with APA, including the American Psychological Foundation responsible for philanthropic work, the APA Insurance Trust that oversees financial and insurance matters, Ethnic Minority Psychological Associations that support minority needs, such as the Society for the Psychological Study of Culture, Ethnicity, and Race, the APA Practice Organization and Education Advocacy Trust charged with promoting advocacy, education, and training efforts, and various state, regional, and international associations, as well as the honor societies of Psi Chi and Psi Beta.

Impact (Psychological Influence)

APA continues to provide services to its members by offering professional development and training, a forum for publishing psychological articles in peer-reviewed journals, access to up-to-date resources, and funding opportunities for scientific endeavors. The APA website hosts the *PsychInfo, PsychArticles*, and *PsychNet* databases, allowing members ready access to materials. The sixth edition of the *Publication Manual of the American Psychological Association* was released in 2009 to direct writers, editors, students, and educators in the APA

writing style. The APA's *Ethical Principles of Psychologists and Code of Conduct*, now referred to as the *Ethics Code*, was amended in 2010 and is updated periodically to guide psychological practice and supervision. Supporting mental health for the general public is an additional goal of APA, furthered through advocating for federal policies and laws related to psychological wellness. The association also tracks current psychological trends in order to perpetuate knowledge, treatment, and prevention efforts.

Melissa A. Mariani, PhD

See also: Publication Manual of the American Psychological Association

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American Rehabilitation Counseling Association (ARCA)

The American Rehabilitation Counseling Association (ARCA) is an organization of counselors, teachers, and students who want to improve the lives of people with disabilities.

Definitions

- **Rehabilitation counseling** is a type of counseling that focuses on helping individuals who have disabilities in order to achieve their career, personal, and independent living goals.
- **Rehabilitation counselors** are certified counseling professionals who help people with emotional and physical disabilities live independently.
- **Scope of practice** includes the procedures, processes, and acts which professionals can legally use in their jobs.

Description and History

ARCA was established in 1958 as a division of the American Counseling Association (ACA). ACA is an association for all professional counselors. Its mission is to enhance the lives of people with disabilities across their life span. In 1971, ARCA was identified as one of the five organizations that comprise the Council on Rehabilitation Education (CORE). CORE was created based on a need to give credit to educational programs for rehabilitation counselors. Currently, both ARCA and CORE are involved with the training, evaluation, and employment of rehabilitation counselors in the United States.

Impact (Psychological Influence)

ARCA has several goals. One goal is to organize members who encourage excellent practice, research, consultation, and learning. Another goal is to remove barriers for people with disabilities who want to access education, jobs, and community activities. ARCA also increases public awareness about disabilities and counseling through outreach and education. Finally, it offers counselors activities with government and other leadership.

ARCA also lists values for rehabilitation counselors. These values include the belief that people with disabilities should be included in the community. All people should be treated with dignity and worth. They are committed to giving equal rights to people with disabilities and to help empower their clients to achieve this. They emphasize that human functioning is universal and should focus on a person's strengths.

The work that rehabilitation counselors do with clients consists of different tasks. These tasks are considered within their scope of practice. ARCA lists what is within the scope of practice for rehabilitation counselors. This involves communication, setting goals, and empowering clients with disabilities. Counselors should be able to help people with physical, mental, developmental, cognitive, and emotional disabilities. They utilize some of the following processes in their

work: assessment, diagnosis, career, individual and group counseling, case management, research, and more. These counselors can work with government systems to remove barriers and provide access to technology that might be helpful to the client.

Alexandra Cunningham, PhD

See also: American Counseling Association (ACA); Rehabilitation Counseling; Vocational Counseling

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American School Counselor Association (ASCA)

The American School Counselor Association (ASCA) is the school counseling division of the American Counseling Association (ACA) specifically developed to meet the needs of professional school counselors working in various educational settings.

Definition

- **Professional school counselors** are counseling practitioners employed in various educational settings who collaborate with parents and teachers to help students develop across academic, social, and career domains.

Description

Founded in 1952, the ASCA is an international nonprofit organization that was developed specifically to meet the needs of professional school counselors. ASCA welcomes school counselors with varying experience who work at different educational levels: elementary, middle, high school, and college. It believes in maintaining one vision and one voice for all counselors working in educational areas.

ASCA is the school counseling division of the ACA. Its current membership rate is over 31,000. ASCA provides professional development, guidance on best practices, and relevant resources to its members. Its vision statement reads, "The American School Counselor Association (ASCA) is the foundation that expands the image and influence of professional school counselors through advocacy, leadership, collaboration and systemic change. ASCA empowers professional school counselors with the knowledge, skills, linkages and resources to promote student success in the school, the home, the community and the world." The mission of the association is to represent professional school counselors and to promote professionalism and ethical practices. To date, ASCA's leadership board, the Delegate Assembly, has granted division charters to all 50 states and the District of Columbia.

Over the past two decades, ASCA has been at the forefront of driving policy and practice changes in the field of school counseling. The ASCA Ethical Standards for school counselors were adopted in 1984 and have been revised in 1992, 1998, 2004, and, most recently, 2010. In addition, ASCA and its parent organization, ACA, were influential in the passing of the Elementary School Counseling Demonstration Act of 1995. This piece of legislation provided funding for school counseling programs that proposed promising and innovative approaches. It also suggested a counselor to student ratio of 1:250 and that school counselors spend 80%–85% of their time engaged in direct services to students. Direct services include school counseling core curriculum, individual counseling and student planning, and responsive services. Indirect services refer to services provided on behalf of students after consulting with others (parents, teachers, other educators, community organizations). In 1997, after surveying more than 2,000 elementary, middle, and high school counselors working in K-12 settings, ASCA compiled a set of national standards for school counseling programs focused on the following key areas: (1) shifting the focus from counselors to counseling programs; (2) creating a framework for a national school counseling model; (3) establishing school counseling as an integral part of the academic mission of schools; (4) promoting equal access to school counseling services for all students; (5) emphasizing the key components of developmental

school counseling; (6) identifying the knowledge and skills that all students should have access to as a part of a comprehensive school counseling program; and (7) providing for the systematic delivery of a school counseling program. Then in 2001, a group of experts in the field assembled to discuss the progress made in the profession during the previous 100 years. The group agreed that a model was needed to help school counselors add value to their school's mission. As a result, ASCA published the first edition of the ASCA National Model in 2003, which became a framework for comprehensive, development school counseling programs. Contributors included Trish Hatch, Judy Bowers, Norm Gysbers, Curly and Sharon Johnson, Robert Myrick, Carol Dahir, Cheri Campbell, Pat Martin, and Reese House. The purpose of this model was twofold: (1) to help move school counseling from a responsive service for some students to a program for every student and (2) to reestablish school counseling as a critical function to remove barriers to learning and help foster academic achievement and overall student success. The model called for school counseling programs to be comprehensive, developmental, and evidence based. School counseling programs are also based on standards in three domains: academic, personal/social, and career. By establishing policy and practice standards, ASCA seeks to ensure the viability of the school counseling profession.

Impact (Psychological Influence)

The American School Counselor Association established the RAMP (Recognized ASCA Model Program) program in 2003 in order to recognize model school counseling programs throughout the country. Schools apply for this designation and have to undergo a rigorous evaluation process. To date, over 400 schools have earned RAMP status. The National Model was revised in 2005 and the most recent edition was released in 2012. On January 1, 2006, the U.S. Congress declared the first week of February as National School Counseling Week, in response to advocacy from ASCA members. ASCA released School Counseling Competencies in 2008 in an effort to guide effective implementation of National Model programs. Though ASCA recommends a school counselor to student ratio of 1:250, the most recent reports, from the 2010 to 2011 school year, indicate a national average ratio of 1:471.

Melissa A. Mariani, PhD

See also: American Counseling Association (ACA); Guidance Counselor

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American Society of Addiction Medicine (ASAM)

The American Society of Addiction Medicine (ASAM) is a professional organization whose purpose is to improve the treatment of addictions and to advance the practice of addiction medicine. It is also known as ASAM.

Addiction is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.

Addictions include alcoholism, a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.

Description

The American Society of Addiction Medicine is a professional organization that represents over 3,000 physicians and related professionals whose focus is on addiction and treatment. The founder of ASAM was Ruth Fox, MD (1895–1989). The origin of ASAM was in the early 1950s when Dr. Fox held meetings with other physicians who were interested in alcoholism and treatment. In 1954, this group of physicians developed the New York City Medical Society on Alcoholism. As the membership grew, the society was named the American Medical Society on Alcoholism (AMSA). The American Academy of Addictionology

was included in 1982, and efforts began to receive recognition for this specialty within the medical field. In 1983, AMSA formed a single national organization uniting all of these groups. In 1988, a house of delegates of the American Medical Association (AMA) accepted ASAM into membership as a national medical specialty society. The AMA is the largest association of physicians and medical students in the United States.

Impact (Psychological Influence)

ASAM's core motivation is to enhance the care and treatment of individuals with the disease of addiction while advancing the practice of addiction medicine. ASAM's mission is to improve the quality of addiction treatment and educate physicians, related professionals, and the public about addiction. In addition, ASAM advocates for research and prevention and promotes the proper role of physicians in the care of individuals with an addiction. ASAM has also established addiction medicine as a specialty recognized by purchasers and consumers of health-care services, physicians, governments, the general public, and professional organizations.

The values and goals of the framework of ASAM significantly contribute to the mental health field. These include leadership, integrity, respect, openness, advocacy, and connectedness. Some of these values and goals include having empathy and commitment for an individual with an addiction. In addition, ASAM promotes optimism for change, accepting the achievable, and determination for a healthy future. Furthermore, ASAM includes diversity of all medical specialists and treatments to assist individuals with an addiction.

Elizabeth Smith Kelsey, PhD, and
Len Sperry, MD, PhD

See also: Addiction; Addiction Counseling

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Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) is a civil rights law intended to protect against discrimination based on disability. It was originally adopted in 1990 and amended in 2008.

Definitions

- **Disability** is a physical or mental impairment that substantially limits one or more of the major life activities of an individual.
- **Disability evaluation** is a formal determination of the degree of a physical, mental, or emotional disability.

Description

The Americans with Disabilities Act is a civil rights law that was enacted by the U.S. Congress in 1990 and signed by President George H. W. Bush. It is considered a civil rights law because it safeguards the rights of citizens. This law extends the protections against discrimination introduced by the Civil Rights Act of 1964. This 1964 law applied to discrimination based on race, religion, sex, national origin, and other individual characteristics. The specific purpose of the ADA is to prohibit discrimination on the basis of disability. The ADA defines a disability as a physical or mental impairment that substantially limits one or more "major life activities" or bodily functions. This law also includes individuals with a history of such impairment and those who are perceived by others as having an impairment. Examples of major life activities are caring for oneself, eating, walking, and communicating. Major bodily functions described by the law include functions of the bowels, brain, and nervous system. The ADA does not list all of the impairments covered by the law. This is decided on a case-by-case

basis. Some conditions are specifically excluded, such as current substance abuse or vision problems that can be corrected with glasses. A 2008 amendment to the law called the ADA Amendments Act extended protections introduced by the original law. It also made the law more specific by listing major life activities that qualified for protection.

The Americans with Disabilities Act is broken down into five sections, or "titles," that address different aspects of the law. Title I refers to employment. The ADA states that qualified individuals with disabilities may not be discriminated against in various situations. These include applying for jobs, advancement within a company, and training. An example of the type of discrimination that this law prohibits is denying employment to qualified applicants on the basis of their disability. Employers must also make reasonable accommodations for employees with disabilities. These include providing readers and interpreters. Title II covers public entities, like schools, and transportation. It prohibits disability-based discrimination in organizations at the local, state, and national levels. Title II also sets standards for handicapped accessible parking and "paratransit" services. Finally, this section sets the standard for public housing, housing assistance, and referrals. Title III refers to public accommodations and commercial facilities. These include public parks and swimming pools, restaurants, and shopping malls. This section prohibits any feature that might impede an individual's enjoyment or use of the area. Wheelchair ramps and handrails are examples of modifications intended to comply with this section of the law. Title IV of the ADA covers telecommunications. The law requires that all telecommunication companies provide equal services to disabled individuals. Telecommunications devices for the deaf, blind, and speech impaired are intended to aid in this goal. Title V is the final section of the ADA and addresses technical issues. It also includes a provision that protects individuals from retaliation for asserting their rights.

The ADA has been somewhat controversial. Before the law was passed by Congress, disability rights activists gathered in Washington, D.C., to protest. Many individuals with physical disabilities left their wheelchairs and other assistive devices behind and crawled up the steps to the Capitol Building. This event became known as the "Capitol Crawl." Some have criticized the law on the grounds that it requires businesses as well as any nonprofit organizations that receive any federal funding to pay for costly renovations to buildings. Others state that the ADA actually makes it less likely that employers will hire disabled individuals due to increased oversight. But many agree that the law has considerably reduced discrimination against those with disabilities.

Len Sperry, MD, PhD, and George Stoupas, MS

See also: Disability and Disability Evaluation

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Amnesia

Amnesia is the inability to recall past events or retain new information. It usually occurs as a result of physical or psychological trauma.

Definitions

- **Alzheimer's disease** is a mental disorder characterized by amnesia and the decline of cognitive functions. It causes significant distress or impaired functioning in daily activities.
- **Anterograde amnesia** is the loss of memory that followed the causal event.
- **Cognitive** pertains to mental abilities and processes.
- **Dementia** is a loss of memory and mental ability that is sufficiently severe to interfere with normal activities of daily living.
- **Dissociative amnesia** is a mental disorder that involves amnesia and that causes significant distress or impaired functioning.

- **Retrograde amnesia** is the loss of memory that precedes the causal event.
- **Transient global amnesia** is a form of anterograde amnesia that is intense and short term and presents with no other symptoms.
- **Traumatic brain injury** is an insult or injury to the brain from an external force. In DSM-5, this disorder is known as Neurocognitive Disorder Due to Traumatic Brain Injury.

Description

Amnesia is the inability to recall important personal information that is different from ordinary forgetting (American Psychiatric Association, 2013). Individuals suffering from amnesia are likely to present firstly for the event that caused the amnesia. Consequently, they are likely to be encountered in a medical or crisis setting. In addition, amnesia can occur in other neurological or medical concerns and is not likely to be the primary diagnosis. Some individuals may exhibit a total inability to recall events leading up to the precipitating event. Others might exhibit profound forgetfulness or seem as if they very confused. Amnesia may last hours, weeks, years, or, in rare cases, a lifetime.

There are three kinds of amnesia: anterograde amnesia, retrograde amnesia, and transient global amnesia. Typically, retrograde amnesia does not involve a total loss of memory but is variable in regard to the period of memory loss preceding its onset. Transient global amnesia is often associated with physical or emotional stress. The isolated memory loss of amnesia does not affect an individual's awareness, general knowledge, intelligence, judgment, or personality. Those experiencing amnesia usually understand written and spoken words and can learn skills. They also understand that they have experienced some memory loss. Dissociative amnesia also involves amnesia. So too does dementia. However, in addition to the memory loss are other cognitive problems. Alzheimer's disease is common form of dementia.

Amnesia can be caused by damage to certain areas of the brain or through psychological means. The physical cause of amnesia is often traumatic brain injury that may result from car accidents, falls, or sport injuries. With psychological amnesia, the impairment is often attributed to assault, death of a loved one, or other disturbing event. Amnesia can also be caused by other medical conditions.

Treatment

Treatment begins with a thorough assessment to assess memory loss and identify likely causes. There is no direct treatment for amnesia. The primary goal of treatment is to resolve the underlying cause. That is to say if the amnesia is caused by traumatic brain injury, then it is the injury that is treated. Alternatively, if the cause is psychological trauma, then the psychological intervention will be aimed at helping the individual resolve the psychological issue directly in the hope that the amnesia will resolve as a consequence. A secondary goal is to increase the individual's capacity to better cope, enhance memory, and provide psychological support for these individuals and their families.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Alzheimer's Disease; Dementia; Dissociation; Dissociative Amnesia

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Amphetamines

Amphetamines are prescription medications that stimulate the nervous system and are used to treat depression and other conditions. They are also highly addictive.

Definitions

- **Anticonvulsants** are medications that relieve or prevent seizures.
- **Narcolepsy** is a disorder that causes individuals to fall asleep at inappropriate times during the day.

- **Tic** is a sudden involuntary behavior that is difficult or impossible for the person to suppress. Tics may be either motor (related to movement) or vocal (inappropriate language) and tend to be more pronounced under stress.
- **Tourette's syndrome** is a neurological disorder characterized by tics, including multiple involuntary movements and uncontrollable vocalizations.

Description

"Amphetamine" is the name of a class of drugs that stimulate the central nervous system. They produce their effects by altering chemicals that transmit nerve messages in the body. Amphetamines are used in the treatment of depression, obesity, attention-deficit hyperactivity disorder (ADHD), narcolepsy, and Tourette's syndrome. Brand names of commonly prescribed amphetamines are Biphetamine, Dexampex, Desoxyn, Ferndex, Methampex, Oxydess II, and Spancap. Generic names of amphetamines include amphetamine, dextroamphetamine, and methamphetamine. Stimulants used in the treatment of ADHD are methylphenidate (trade name: Ritalin), mixed amphetamine salts (trade name: Adderall), and dextroamphetamine (trade name: Dexedrine). Since most of these drugs tend to be short-acting, it is usually necessary to take several doses a day to maintain the therapeutic effect. Longer-acting versions of these drugs, such as Ritalin LA and Adderall XR, permit once or twice a day dosing. Amphetamines are usually given orally and their effects can last up to 20 hours.

Precautions and Side Effects

Because they are highly addictive, they should be prescribed only after other therapeutic approaches have failed. They should be used with great caution in children under three years of age and for anyone with a history of elevated blood pressure and those with tics and Tourette's syndrome. Also, those with a history of an overactive thyroid should not take amphetamines, nor should those with moderate-to-severe high blood pressure, glaucoma, or psychotic symptoms such as hallucinations and delusions. Also, those with a history of drug abuse, psychomotor agitation, or cardiovascular disease should not use amphetamines.

Caution is needed in the use of amphetamines in young children because of concerns about the possibility of sudden death or retarded growth. A small number of deaths have been reported, and some studies indicate that taking stimulants can slow growth rate in children. As a result some physicians recommend drug holidays in which the drug is temporarily stopped during times that require less focus or self-discipline, such as weekends or a summer vacation. Studies indicate that the adverse effects on growth rate are eliminated by these drug holidays.

For adults, amphetamine use should not be discontinued suddenly. Rather, the dose should be lowered gradually and then discontinued under the supervision of a physician. Generally these drugs should be taken early in the day so as not to interfere with sleep at night. Hazardous activities should be avoided until the person's condition has been stabilized with medication. The use of amphetamines during pregnancy has been associated with fetal growth retardation, premature birth, and heart and brain abnormalities.

Amphetamines can cause considerable side effects and may be toxic in large doses. The most common side effects associated with amphetamines are irregular heartbeat, increased heart rate or blood pressure, dizziness, insomnia, restlessness, headache, shakiness, dry mouth, metallic taste, diarrhea, constipation, and weight loss. Other side effects can include changes in sexual drive, nausea, vomiting, allergic reactions, chills, depression, irritability, and indigestion. High doses, whether for medical purposes or illicit ones, can cause addiction, dependence, increased aggression, and, in some cases, psychotic episodes.

Len Sperry, MD, PhD

See also: Narcolepsy; Tourette's Syndrome

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Anafranil (Clomipramine)

Anafranil is an antidepressant medication used primarily to treat obsessive-compulsive disorder. It is also used in treating depression and other medical and psychiatric conditions. Its generic name is clomipramine.

Definitions

- **Obsessive-compulsive disorder** is a mental disorder characterized by problematic obsessions (repetitive thoughts and impulses) and compulsions (repetitive behaviors).
- **Serotonin** is a neurotransmitter (chemical messenger) found throughout the body, including the digestive tract and the brain. It contracts smooth muscle and affects with mood, attention, and sleep. Low levels of Serotonin are associated with depression.

Description

Anafranil is a tricyclic antidepressant, a class of drugs with a three-ring chemical structure. Its primary use is the treatment of the obsessions and compulsions of obsessive-compulsive disorder when these symptoms greatly disrupt an individual's daily activities. It is also used in panic disorder, pain management, sleep problems like narcolepsy (uncontrollable attacks during deep sleep), and anorexia nervosa. It is also helpful in reducing other compulsive behaviors such as hair pulling, nail biting, Tourette's syndrome (tics and vocalizations), and childhood autism.

The first tricyclic, imipramine (trade name: Tofranil), was found to decrease depressive symptoms, presumably by increasing serotonin in the brain. Because Anafranil significantly increases serotonin levels in the brain, it is most effective in reducing compulsions.

Precautions and Side Effects

Seizures are the most important risk associated with Anafranil. The risk of seizure increases with larger doses and after abrupt discontinuation of it. Care must be taken in the use of Anafranil in those with a history of epilepsy or condition associated with seizures, such as brain damage or alcoholism. Anafranil may worsen glaucoma and adversely affect heart rhythm in those with cardiac disease. Because some studies associate antidepressants with increased suicidal thoughts in children and adults up to age 24, the use of Anafranil should be carefully monitored. The safety of Anafranil use during pregnancy has not been fully determined. However, it is known that tricyclic antidepressants pass into breast milk and may cause sedation and depress breathing in nursing infants.

Anafranil may cause several side effects. Like other tricyclic antidepressants its side effect may initially be more pronounced but decrease with continued treatment. Common side effects are headache, confusion, nervousness, restlessness, sleep difficulties, numbness, tingling sensations, tremors, nausea, loss of appetite, constipation, blurred vision, difficulty urinating, menstrual pain, impotence, decreased sex drive, fatigue, and weight gain.

Len Sperry, MD, PhD

See also: Depression; Obsessive-Compulsive Disorder (OCD); Serotonin; Tofranil (Imipramine)

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Androgyny

One way in which society defines men and women is in terms of how masculine or how feminine they are based on their appearance, personality, and mannerisms. Femininity is often associated with someone who is nurturing, warm, sympathetic, sensitive, affectionate, and emotional. Masculinity is associated with being aggressive, dominant, strong, competitive, and independent. However, men and women can also be viewed in terms of how androgynous they are. This third concept looks at how some people are a combination of masculinity and femininity, meaning that they have high levels of both masculine and feminine traits.

Definition

- **Androgyny** is the combination of personality traits that are both feminine and masculine. An androgynous individual is sometimes hard to identify as either distinctly male or female—whether it is in appearance, dressing, or behavior. This type of person is known as an androgyne.

Stereotypes about men and women have changed significantly over the past three to four decades. Most social scientists now believe that men are not completely masculine and women are not completely feminine. In fact, men and women both have traits of each. To a certain extent, this illustrates the concept of androgyny, meaning that a person possesses both masculine and feminine traits in varying degrees. Someone who exhibits high levels of both masculine and feminine traits would be defined as androgynous.

Androgyny can be a controversial issue. Some categorize it as a deviant form of sexuality, while others look at it as an idealized form of oneness. The term "androgynous" has also been used to describe a hermaphrodite, which is someone who is born with both male and female sex organs.

One of the leading researchers of androgyny was Sandra Bern who, in the 1970s, developed the Bern Sex-Role Inventory. It is among the most popular gender measurements with results classifying individuals into one of four gender orientations: masculine, feminine, androgynous, or undifferentiated.

Beginning in the 1970s and continuing to present day there has been an emergence of nontraditional males in pop culture that embodied more androgynous traits. Some of the most notable changes began in music with Robert Plant, Mick Jagger, Prince, Boy George, David Bowie, Dee Snider, Michael Jackson, and Marilyn Manson, to name a few.

Mindy Parsons, PhD

See also: Gender Identity Development; Sexual Identity

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Anger in Adults

"Anger" refers to the external behaviors and internal emotional, physiological, and cognitive processes a person experiences when feeling angry.

Description

Anger is one of the most common human emotions and is a combination of a person's thoughts, feelings, and behaviors in response to a stimulus. Anger serves the purpose of enabling an individual to recognize problems and take action.

Anger is considered an adaptive and constructive emotion when it is employed to maintain positive relationships, assert appropriate authority, or promote change. For example, if someone sees a student being bullied, the observer will first become aware of the problem by the emotional feelings, physical sensations, and thoughts associated with anger. The observer's heart rate increases and muscles tense; the observer may feel a sense of heat flushing his or her face. The observer has the thought of how unfair or hurtful the bullying is and that he or she must stop it. Emotionally the observer feels compassion and anger. This experience is often referred to as "righteous indignation." "Righteous indignation" refers to anger resulting from a perception of mistreatment, injustice, or malice. These feelings may lead to a behavioral response that is used to stop the bullying.

Causes and Symptoms

Physical sensations of anger included muscle tension such as fist clenching or teeth grinding, body temperature change, and sweating. When cartoon characters are depicted as angry, they turn red, steam begins shooting out of their ears, and they clench their fist and grimace. Although these depictions are cartoonish they do illustrate some of the physical body responses to anger. Common verbal expressions of anger include "it makes my blood boil,, "I wanted to explode," and "I went off on somebody."

Anger encompasses a wide range of emotional experiences from being mildly annoyed to intense rage. The emotional state of anger is highly associated with thoughts and behaviors. There are three components of anger that are used to determine if a person has an anger problem: frequency, intensity, and duration. Frequency refers to how often a person is angered, intensity refers to how angry a person becomes, and duration refers to how long the anger lasts.

Anger is considered dysfunctional when behaviors become malicious or spiteful and the individual seeks to hurt the offender or get revenge. Verbal abusiveness such as yelling, screaming, name-calling, and making threats are examples of verbal anger behaviors. Pushing, blocking, hitting, and breaking things are examples of physically abusive behaviors. Other anger behaviors include hand gestures, facial expressions, spitting, and other body language expressions. Functional or healthy anger expression is related to the psychological capacity of emotional regulation. Being able to regulate one's emotions is positively associated with health outcomes, relationships, academic performance, and successful problem solving.

How we think about an event determines how we feel about it. How we think about an event is called an "appraisal." Appraisals determine the initial intensity and general positive or negative functionality of the emotion. Repetitive or constant thinking about a negative event is called "rumination." People who ruminate can't "let it go"; they "stew over it" and are unable to "get over it." "Reappraisal" is actively changing the way in which one thinks about an event.

Researchers who study anger have determined that how a person appraises, or thinks about an event, determines the person's emotional response to the event. People who ruminate and do not change or modify how they think about the event stay angry or increase their anger and aggressive behaviors. People who reappraise events, thus changing how they think about the event, decrease both the intensity of the experience and the duration of the emotional upset.

Diagnosis and Prognosis

Because there is such a wide range of anger experience and expression, including appropriate expressions of anger such as frustration or annoyance, anger in and of itself is not a diagnosable disorder. Anger is included as a symptom in several disorders listed by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), including oppositional defiant,

post-traumatic stress, and some personality disorders. There is a recognized disorder titled "intermittent explosive disorder" in which the central feature is repeated behavioral anger-based aggressive outburst. Diagnosis is made depending on the intensity of the verbal and physical aggression and frequency of the aggressive outburst. These outbursts are impulsive (not planned) and are grossly out of proportion to the stressing event. The outbursts are recurrent and cause either considerable distress in the individual or significant problems at work and with his or her personal relationships. The core feature of the disorder is failure to control impulsive aggressive behaviors in response to events that would not typically result in aggressive outburst.

Individuals who have experienced physical and emotional trauma, alcoholism, and domestic violence while growing up are at increased risk for intermittent explosive disorder. Treatments are available, including individual and group talking therapies. Although there are no medications directly prescribed for anger control, some drug therapies have beneficial effects in treating underlying mood disorders.

Anger is one of the most common of human emotions. When unregulated, the emotional and behaviors components of anger can lead to significant problems in maintaining healthy relationships and social functioning. When managed by reappraisals, anger can become a healthy and productive emotion leading to positive relationships and social change.

Steven R. Vensel, PhD

See also: Aggressive and Antisocial Behavior in Youth; Conduct Disorder; Oppositional Defiant Disorder (ODD)

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Anger Management

Anger management describes the process of acquiring skills to recognize signs that one is becoming angry and take action to deal with the emotion in a productive, healthy way.

Description

"Anger management" refers to a set of psychological, therapeutic techniques and exercises that a person can use to deal with anger in an effective manner. This process involves recognizing triggers and calming oneself down before the situation escalates. Anger management is suggested for people who are unable to control their anger or manage anger appropriately once it surfaces. The purpose of an anger management strategy is to learn to deal with anger in a positive, healthy way. These skills can be taught to oneself through the use of books or other resources or be learned in an anger management class taught by a mental health professional.

Development

Anger is a natural human emotion. Everyone experiences anger at one time or another. Physical well-being can be negatively impacted by anger. Research indicates that anger can increase a person's chances of developing heart disease. This risk is higher for men than women. Anger is linked to other physical problems as well, such as insomnia, digestive issues, and headaches. However, anger can also have survival benefits—it serves as part of our brain's *fight or flight* response to perceived threat or harm. Anger should be expressed, though, in appropriate ways. An anger management approach teaches a person to cope with anger rather than suppress it. Acceptance, acknowledgment, and truth are an important part of an anger management approach. One must also be taught to recognize signs of anger. These include physical symptoms that signify that anger may be building. Examples may include increased heart rate, increased body temperature, reddening of the face, clenched fists, tightening of the jaw, and quickening of the breath. Identifying stressors is another integral piece in this process as stress can be caused by different factors such as work, family, or health.

A person may himself or herself recognize that he or she has anger management issues, or this may be suggested to the person by a family member or friend. In more severe cases, a person may be mandated to attend anger management classes by the legal system, often resulting from the inability to control one's anger in a previous situation. Anger management strategies can be practiced alone, one on one, in a small group, or in a class setting. These sessions are typically led by a psychologist or other trained mental health professional. Depending on a person's needs and the circumstances and severity of the problem, these sessions can last from weeks to months to even longer. If a person has other mental health issues, this can also adversely affect treatment. Some of these conditions include a history of substance abuse, depression, anxiety, and/or social disorders such as Asperger's syndrome. Other factors that can impact success are lack of self-care (nutrition, sleep, exercise) and stress. Common techniques employed in anger management training include relaxation, guided imagery, deep-breathing, stress management, problem solving, conflict resolution, cognitive behavior therapy, and solution-focused strategies.

Certain steps encompass most anger management programs. One, the participant learns his or her anger triggers and notes situations where these are likely to cause anger to arise. Two, the participant recognizes physical signs and symptoms that signify that anger is building. Three, the participant employs anger management strategies in order to calm down and control his or her anger. Last, the participant learns to deal with the situation in a positive, healthy way and express feelings and needs in order to solve the problem effectively.

Current Status

No anger disorders are listed in the DSM-5. Most research conducted on anger management surround its use with persons who suffer from anxiety and depression. These strategies are related to psychological treatment for these disorders. Effective interventions for anger management support a cognitive behavioral approach. Accepting personal responsibility and being conscious and in control of negative thought patters are key aspects of this type of therapy.

Melissa A. Mariani, PhD

See also: Anger in Adults; *Diagnostic and Statistical Manual of Mental Disorders* (DSM)

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Animal-Assisted Therapy

Animal-assisted therapy is a goal-directed therapy that involves the presence of or interaction with an animal as a fundamental part of a client's treatment.

Description

Animal-assisted therapy is used for a number of different conditions. These can range from problems involving emotional distress to anxiety-related symptoms and disorders. Therapy dogs are the most common although a wide variety of animals are now being used. Other animals involved in these types of interventions include horses and dolphins.

There are references in history to the therapeutic presence of animals for medical problems, especially psychological ones. After World War II, animal-assisted therapy began to be a subject of serious consideration, especially with medical professionals who were working with children. It was found that animals could serve as catalysts or mediators of human social interaction. It can expedite both the process of socialization and learning as well as helping with building rapport between patients and therapists.

There are two things that distinguish animal-assisted therapy from the simple presence of animals in therapy. First, the intervention involves the intentional presence or use of an animal and a psychological

or medical professional delivers the therapy. This professional is required to practice within the scope of his or her professional training and expertise. In order to be successful, animal-assisted therapy must be carefully directed and the animals must be carefully chosen and often trained to be able to participate in treatment.

Development

Ancient literature and tradition stated that being licked by a dog was curative. Since then the use of comfort or support animals has been recognized for some time. Florence Nightingale, for example, made the first mention of it in the 1800s. But it is only more recently that the value of such animal-assisted therapy for treatment of conditions like mental health disorders has been acknowledged.

Sigmund Freud, one of the fathers of psychology, noticed the calming effect his dog had on his patients when his dog was in the room during sessions. In modern times Boris Levinson introduced the practice of animal-assisted therapy and the first complete work in the field through his book. In 1977, Sam and Elizabeth Corson opened the first pet-assisted therapy program at a psychiatric unit at Ohio State University.

Alan Beck and Aaron Katcher began their work documenting the direct changes in the physical responses of patients in the presence of a friendly dog. They found that patient's breathing became more regular, heartbeat slowed, and muscles relaxed. These symptoms suggest lowering of the nervous system and therefore stress. Animal-assisted therapy began with dogs but has grown to popularly include equine, or horse, and dolphin-assisted therapies.

Current Status

The popularity of animal-assisted therapies is growing. New programs emerge frequently, and an increasing variety of animals are being used for this therapy. Use of therapy animals has highlighted the positive benefits of touch in counseling. Therapy animals provide a nonjudgmental space for individuals to work out their problems in a way that can include nonthreatening touch.

From a therapeutic perspective, there has been a lot of work done in order to agree on methodological standards and strategies that help establish the scientific evidence base for the efficacy of animal-assisted therapies. In the early 2000s handbooks and research articles began to be published on this topic. As best practices emerge, the practice of animal-assisted therapy has gained more credibility among other more traditional treatments in counseling and therapy.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Freud, Sigmund (1856–1939); Psychotherapy

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Anorexia Nervosa

Anorexia nervosa is a mental disorder characterized by refusal to maintain minimal normal body weight along with a fear of weight gain and a distorted body image.

Definitions

- **Binge eating** is a pattern of disordered eating consisting of episodes of uncontrolled intake of food.
- **Bulimia nervosa** is a mental disorder characterized by recurrent binge eating with loss of control over one's eating and compensation for eating.
- **Eating disorder** is a class of mental disorders that are characterized by difficulties with too much, too little, or unhealthy food intake, and may include distorted body image.

Description and Diagnosis

Anorexia nervosa is an eating disorder that is diagnosed when an individual displays a body weight significantly below what is normal or expected for the individual's current age and height. The individual is preoccupied with self-image and appears to be in denial regarding the severity of weight loss. The individual presents with distorted perceptions regarding his or her body (distorted body image). The individual believes he or she has "fat thighs" or a "fat stomach" when he or she actually lacks appropriate body mass, meaning that the individual is too thin. The extreme weight loss in anorexia nervosa is due to the individual's fear of gaining weight. The body mass index (BMI) is used to indicate the severity of the disorder with ranges from mild to extreme. There are two subtype patterns of anorexia nervosa; one is restricting food intake, while the other is bingeing and purging. The subtypes involve patterns of food restriction, and patterns of bingeing, that is, eating followed by purging through vomiting and/or use of laxatives. The binge eating/purging subtype can be distinguished from bulimia nervosa. While both engage in binge eating and purging, the bulimia nervosa maintains body weight that is minimally normal or above normal level (American Psychiatric Association, 2013).

Some facts about the prevalence (extent) of the disorder are as follows: Anorexia nervosa is more common in females with a 10 to 1 ratio. It is more common in economically advantaged countries like the United States, Australia, and Japan. It is less common in low- and middle-income countries. In the United States, the prevalence is lower among Latinos and African Americans (American Psychiatric Association, 2013). The disorder often presents in adolescence or young adulthood. The disorder is found more often in settings that value thinness, such as modeling, acting, cheerleading, and athletics.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they are significantly below normal levels in body weight, have an intense fear of gaining weight, and exhibit practices of food restriction. The diagnosis also depends on displaying undue preoccupation with body weight or denial of current low body weight. Anorexia nervosa can be either restricting type or binge eating/purging type. Severity of mild, moderate, severe, and extreme forms of this disorder can be specified based on body weight (American Psychiatric Association, 2013).

The causes and course of this disorder are many and complex. Anorexia nervosa runs in families and it takes a considerable toll on health requiring both medical and dental examinations to determine the level of biological treatment required. In addition, there are often significant neurological ramifications especially to an extended practice of anorexia nervosa. Social aspects of this disease involve consideration of the family dynamics and the role played by the anorexic individual in the family. Within this social context the anorexic develops psychological beliefs about perfectionism or the desire to remain a child. These beliefs are reflected in their everyday behavior, which focuses on excessive food restriction and preoccupation with their body image while largely ignoring other areas of life such as intimacy, work or school, and friendships. While anorexic individuals may initially be able to function adequately in school or work, cognitive performance deteriorates over time as a result of the disorder.

Treatment

Because of the multifaceted nature of this disorder, its clinical treatment must include medical, dental, and psychological evaluations and interventions. Because this is one of the few mental disorders that can be life threatening, medical evaluation and treatment are required for any individual presenting with an extremely low BMI. Time spent in states of semi-starvation results in loss of bone density, loss of menses (periods), digestion problems, and cardiac arrhythmia (abnormal heart rhythms). Depression and social relation issues as well as obsessive-compulsive behaviors around eating and exercise are also common. Individual and group therapy are common psychological interventions. Because suicide rates among anorexics are very high, assessment of suicidal thoughts and behaviors is essential (American Psychiatric Association, 2013).

Len Sperry, MD, PhD

See also: Binge Eating Disorder; Bulimia Nervosa

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Anosognosia

Anosognosia is a condition in which individuals have no awareness that they have a medical disease or disability.

Definitions

- **Bipolar disorder** is a mental health disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more depressive episodes.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Dementia** is a group of symptoms, including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of neurons (nerve cells) in the brain.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than external stimuli.
- **Hemiplegia** is a condition resulting from an illness, injury, or stroke that causes total or partial paralysis of one side of the body.
- **Schizophrenia** is a chronic and mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult.

Description

Anosognosia is described as a deficit of self-awareness of an impairment or medical condition. Individuals with anosognosia do not realize that they are ill. It can create a tremendous challenge for the individual, family members, and caregivers. Many individuals who are diagnosed with bipolar disorder, Alzheimer's disease, dementia, and schizophrenia have this condition. Having this lack of awareness increases the risk of treatment failure because many individuals are noncompliant with taking their medications. This may result in the reappearance of various symptoms including hallucinations and delusions. Other features of anosognosia include the failure to acknowledge one's hemiplegia or other disabilities, such as blindness or paralysis.

Anosognosia is not the same as denial of illness. Anosognosia has a biological basis. It is caused by damage to the right side of the brain. In contrast, there is more likely to be a psychological (mental) basis involved in those in denial of their medical condition. Nearly half of individuals with schizophrenia have moderate or severe impairment in their awareness of illness. It is particularly common for those with bipolar disorder to experience hallucinations and/or delusions. Yet nearly 40% of individuals with bipolar disorder also have impaired awareness of illness (American Psychiatric Association, 2013). Not surprisingly, anosognosia is one of the main reasons why those with schizophrenia and bipolar disorder do not take their medications.

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See also: Alzheimer's Disease; Bipolar Disorder; Dementia; Hallucinations; Schizophrenia

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Antabuse (Disulfiram)

Antabuse is a prescription medication used in the treatment of chronic alcoholism. Its generic name is disulfiram.

Description

Antabuse is used as a conditioning treatment for alcohol dependence. When taken with alcohol, Antabuse causes unwanted and unpleasant effects, and the fear of these effects negatively conditions the individual to avoid subsequent alcohol use. So how does Antabuse work? When alcohol is ingested, the body metabolizes or breaks it down into acetaldehyde, the toxic substance that causes the hangover symptoms experienced after heavy drinking. Normally, the body continues to break down acetaldehyde into acetic acid, a harmless substance. Antabuse interferes with this metabolic process by preventing the breakdown of acetaldehyde into acetic acid. The result is that acetaldehyde levels increase up to 10 times greater than normally occur when drinking alcohol. These very high levels of acetaldehyde cause reactions that range from mild to severe, depending on how much Antabuse and how much alcohol is consumed. In other words, Antabuse serves as physical and psychological deterrent to an individual trying to stop drinking. It does not reduce the individual's craving for alcohol, nor does it treat alcohol withdrawal symptoms. For these reasons, Antabuse should be used in conjunction with counseling and other treatment methods.

Precautions and Side Effects

Those with a history of diabetes, severe myocardial disease, coronary occlusion, or psychosis should not take Antabuse. Neither should those with advanced or severe liver disease take Antabuse. Those with a history of seizures, hypothyroidism, or nephritis need close monitoring if Antabuse is used. Besides avoiding alcohol, individuals should also avoid any products containing alcohol, such as cough and cold preparations and mouthwashes. They should also avoid topical preparations that contain alcohol, such as aftershave lotion and perfume.

The common mild side effects of Antabuse includes drowsiness and fatigue. Others include nausea, vomiting, sweating, flushing, throbbing in the head and neck, headache, thirst, chest pain, palpitations, dyspnea, hyperventilation, and confusion. More severe reactions include respiratory depression, cardiovascular collapse, heart attack, acute congestive heart failure, unconsciousness, arrhythmias, and convulsions. Antabuse is also associated with impotence.

Len Sperry, MD, PhD

See also: Addiction; Alcoholism; Substance Abuse Treatment

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Antianxiety Medications

Antianxiety medications are a class of central nervous system depressants that slow normal brain function. Also known as anxiolytics and sedatives, these drugs are prescribed to reduce anxiety and tension and to induce sleep. Prolonged use or abuse of these drugs can result in substance dependence and withdrawal symptoms. Antianxiety medications are among the most abused drugs in the United States, whether obtained legally by prescription or illegally through the black market.

Definitions

- **Anxiolytic** refers to a substance that relieves anxiety and any of a group of medications prescribed to induce a feeling of calm and relaxation and relieve anxiety; it is also called tranquilizers.
- **Benzodiazepines** is a group of central nervous system depressants that are used to relieve anxiety or to induce sleep.
- **Intoxication** is a state in which significant behavioral or psychological changes follow ingestion of a substance.
- **Sedative** is any medication that induces relaxation and sleep.
- **Substance abuse** is a milder form of addiction than substance dependence wherein the user does experience tolerance or withdrawal symptoms.
- **Substance dependence** is the state in which an individual requires the ongoing use of a particular substance to avoid withdrawal symptoms.
- **Tranquilizer** is another name for anxiolytic.
- **Withdrawal symptoms** are a group of physical and/or psychological symptoms that are experienced when a drug or other substance is discontinued after prolonged use.

Description

Antianxiety medications, or "anxiolytics," are powerful central nervous system depressants that are prescribed to reduce feelings of tension and anxiety, as well as to induce sleep. Antianxiety medications are usually taken orally, and although these drugs work differently, they all produce a pleasant drowsy or calming effect. When used over a prolonged period, tolerance develops. This means that larger doses are needed to achieve the initial effects. Continued use can lead to physical dependence, and withdrawal symptoms result when the dosage is reduced or stopped. When combined with other anxiolytics or other central nervous system depressants, such as alcohol, the effects are additive.

The drugs associated with this class of substance-related disorders are benzodiazepines that include Valium, Librium, Xanax, Halcion, and ProSom; barbiturates that include Seconal and Nembutal; and barbiturate-like substances that include Quaalude, Equanil, and Doriden. Each of these antianxiety drugs is capable of producing wakeful relief from tension or inducing sleep, depending on dosage. Other legal uses of antianxiety medications include medical treatment and prevention of seizures, and these antianxiety medications are used as muscle relaxants and anesthetics and to make other anesthetics work more effectively.

Precautions and Side Effects

Even when these depressants are prescribed for medical reasons, an individual taking central nervous system depressants usually feels sleepy and uncoordinated during the first few days of treatment. As the body adjusts to the effects of the drug, these feelings begin to disappear. If the medication is used long term, the body develops tolerance, and increasing doses are needed to obtain the desired effect of general calming or drowsiness.

The use of antianxiety medications can pose extreme danger when taken along with other medications that cause central nervous system depression, such as prescription pain medicines, some over-the-counter cold and allergy medications, and alcohol. Use of additional depressants can slow breathing and respiration and can lead to death. Withdrawal from antianxiety medications can be dangerous and should be done under medical supervision. The safest method of withdrawal involves a gradual reduction of dosage. Abrupt withdrawal from these medications can lead to seizures due to the sudden increase in brain activity.

Antianxiety Medication Addiction and Treatment

Abuse of antianxiety medication can develop with prolonged use, as tolerance grows relatively quickly. Increasing amounts of the drug are then needed to produce the initial effect. It is not uncommon for individuals to become addicted to antianxiety medications even when they are medically prescribed.

The most common pattern of abuse and dependence to antianxiety medications involves use among teens and young adults, which escalates to abuse or dependence. Dependence may begin with occasional use at social gatherings and then eventually to daily use and high levels of tolerance. A somewhat less common pattern of abuse and dependence to antianxiety medications involves individuals who initially obtain medications by prescription, usually for treatment of anxiety or insomnia. Though the vast majority of those who use medications as prescribed do not develop substance dependence problems, a significant number develop tolerance and withdrawal symptoms.

Substance dependence, the more severe form of addiction, involves various cognitive, behavioral, and physiological symptoms associated with continued use of the substance. It always includes both tolerance and withdrawal symptoms. Abuse is a less severe form of addiction that may involve risky behavior, such as driving while under the influence. For example, individuals with an abuse disorder may miss work or school or get into arguments with relatives or friends about their substance use. These problems can easily escalate into full-blown dependence. Progression to full-blown dependence begins with intoxication. Intoxication involves significant problematic behaviors or psychological changes, including inappropriate sexual or aggressive behavior, mood swings, impaired judgment, and impaired work functioning, that develop during or shortly after use of the antianxiety medication. As with alcohol dependence, these behaviors may be accompanied by slurred speech, unsteady gait, memory or attention problems, poor coordination, and stupor or coma. Memory impairment is not uncommon, especially anterograde amnesia where, like in an alcoholic blackout, the individual does not remember anything that occurs after use of the drug.

Withdrawal is a characteristic syndrome that develops when use of the antianxiety medication is significantly reduced or discontinued abruptly. Abrupt discontinuation of an anxiolytic is similar to the abrupt discontinuation or "going cold turkey" in to heavy alcohol use. Symptoms may include increased heart rate, respiratory rate, blood pressure and body temperature, sweating, hand tremor, insomnia, anxiety, nausea, and restlessness. Seizures are likely to occur in one out of four individuals undergoing untreated withdrawal. In the most severe forms of withdrawal, hallucinations and delirium can occur. Withdrawal symptoms are generally the opposite of the acute effects experienced by first-time users of the drugs. The length of time of the withdrawal period varies depending on the drug and may last as short as 10 hours or as long as three to four weeks. The longer the substance has been taken and the higher the dosage, the more likely that withdrawal will be severe and prolonged.

Successful treatment for antianxiety medication addiction typically incorporates several treatment modalities. Psychotherapy or counseling, particularly cognitive behavior therapy, focuses on helping addicted individuals identify and change the behaviors, attitudes, and beliefs that contributed to their drug usage. Combined with prescribed medications to make withdrawal safer and easier, therapy can help the addicted individual in making a full recovery. It may require multiple courses of treatment before full recovery can be achieved. Narcotics Anonymous is an important and necessary part of ongoing recovery support.

Len Sperry, MD, PhD

See also: Benzodiazepines; Substance-Related and Addictive Disorders

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Antidepressant Medications

Antidepressants are prescribed medications that are primarily used to treat depression and depressive disorders.

Definition

- **Depressive disorders** are medical conditions that interfere with daily life and normal functioning, and involve symptoms such as excessive sadness, altered sleep or eating patterns, and lack of energy. Common depressive disorders are major depression, dysthymic disorder, dysthymia, major depressive disorder, and bipolar disorder with periods of mania and depression.

Description

Antidepressant medications are used primarily to reduce symptoms of depression and in the treatment of anxiety disorders, seasonal affective disorder, some eating disorders, some pain syndromes, migraine headache, smoking cessation, fibromyalgia, and some sleep disorders. The type of antidepressant medication prescribed depends on the particular array of symptoms a patient displays or reports. There are several different types of antidepressant drugs. All of them work by altering the level or activity of neurotransmitters (chemical messengers) in the brain.

The main classes of antidepressant medications are tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and atypical antidepressants. Those who do not improve with one type of antidepressant drug may sometimes be helped by another type of antidepressant, because different classes of medication work somewhat differently.

Tricyclic antidepressants. These were the first class of medications found to be useful in treating depression and related conditions. These medications work by preventing neurons (nerve cells) from reabsorbing the neurotransmitters serotonin, dopamine, and norepinephrine after they are released. Tricyclic antidepressants tend to have more side effects than other types of antidepressants. Specific tricyclic antidepressants include Tofranil, Elavil, Anafranil, Sinequan, Norpramin, Pamelor, Vivactil, and Surmontil.

Monoamine oxidase inhibitors. Monoamine oxidase inhibitors (MAOIs) are medications that prevent neurotransmitters such as dopamine, serotonin, and norepinephrine from being broken down into inactive chemicals. This means that when MAOIs are used, more of these neurotransmitters are available to send messages in the brain. MAOIs can have potentially serious side effects since they prevent the tyramine (an amino acid) from being broken down. Tyramine is found in foods like aged cheese, smoked meats and fish, and raisins. If tyramine cannot be broken down, it can accumulate in the body, causing increased blood pressure and possibly stroke. Specific MAOIs include Marplan, Nardil, and Parnate.

Selective serotonin reuptake inhibitors. The selective serotonin reuptake inhibitors (SSRIs) are a class of antidepressants that work by preventing neurons from reabsorbing serotonin after it is released. The effect of serotonin on adjoining neurons is prolonged. The SSRIs include Celexa, Lexapro, Prozac, Luvox, Paxil, and Zoloft.

Serotonin-norepinephrine reuptake inhibitors. Serotonin-norepinephrine reuptake inhibitors are a class of antidepressants that work similar to SSRIs. But instead of blocking serotonin only, they block the absorption of both serotonin and norepinephrine. Effexor, Pristiq, and Cymbalta are commonly prescribed SNRIs.

Atypical antidepressants. The atypical antidepressants are a collection of medications with different chemical makeups than the other classes of antidepressants. Examples of atypical antidepressants include Wellbutrin, Remeron, and Desyrel.

Precautions and Side Effects

Use of antidepressant medications may increase suicidal thoughts in children, adolescents, and adults through the age of 24. Antidepressants can precipitate mania in those who are susceptible to bipolar disorder. Various medical conditions may affect the efficacy or risks of antidepressants. These conditions include headaches, epilepsy, recent heart attacks or stroke, kidney disease, and diabetes. The use of antidepressants in

pregnancy and breast-feeding can be problematic and if used must be done under close medical supervision. Those who abruptly stop taking most antidepressants may experience withdrawal symptoms.

Antidepressant use often involves side effects. Specific effects depend on the specific medication and the individual's characteristics. Possible side effects include dry mouth, constipation, nausea, bladder problems, sexual problems, blurred vision, dizziness, drowsiness, insomnia, increased heart rate, headache, nervousness, and agitation. Newer antidepressants, such as the SSRIs and SNRIs, are considered to have fewer and less troublesome side effects than the tricyclic antidepressants and the MAOIs. Antidepressants can interact with other medications, so individuals should inform their doctor about all medications and herbal supplements. Alcohol and recreational drugs can decrease the effectiveness of antidepressants and should not be combined with these medication.

Len Sperry, MD, PhD

See also: Depression

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Antipsychotic Medications

Antipsychotics are prescription medications used to treat psychotic disorders, including schizophrenia, schizoaffective disorder, and psychotic depression.

Definitions

- **Extrapyramidal symptoms** are side effects of certain antipsychotic drugs. They include repetitive, involuntary muscle movements, such as lip smacking, and the urge to move constantly.
- **Neuroleptic malignant syndrome** is a potentially fatal condition resulting from antipsychotic use characterized by severe muscle rigidity (stiffening), fever, sweating, high blood pressure, delirium, and sometimes coma.
- **Psychosis** is a severe mental condition in which an individual loses touch with reality. Symptoms include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.
- **Schizophrenia** is a mental disorder in which it is difficult to distinguish real from unreal experiences. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.
- **Schizoaffective disorder** is a severe mental disorder in which an individual exhibits signs of both schizophrenia and a mood disorder.
- **Tardive dyskinesia** are involuntary movements caused by certain antipsychotic medications. They include tongue thrusting, repetitive chewing, jaw swinging, and facial grimacing.

Description

Antipsychotic medications are used to treat psychotic disorders, ranging from schizophrenia, schizoaffective disorder, delusional disorder, brief psychotic disorder, substance-induced psychotic disorder, and psychotic depression. They are also used to treat the psychosis associated with other medical conditions, such as dementia. Antipsychotics are thought to work by blocking dopamine receptors in the brain and interfering with dopamine transmission.

There are two classes of antipsychotic medications: older or "typical" antipsychotics (also known as first-generation antipsychotics) and newer, "atypical" antipsychotics (also known as second-generation antipsychotics). The typical antipsychotics have been in use since the 1950s. They are effective in treating

"positive" symptoms of schizophrenia (abnormal thoughts and perceptions, such as delusions, hallucinations, or disordered thinking).

The "atypical" antipsychotics have been in use since the 1990s. They tend to be effective in treating both positive and "negative symptoms" (lack of speech, "flat" facial expressions, apathy, lack of pleasure in normally pleasurable activities). Clozaril was the first of this class. It proved to be effective in treating disorders that had not responded well to typical antipsychotics. Several other atypical antipsychotics were introduced after Clozaril. These include Risperdal, Zyprexa, Seroquel, and Geodon. There are side effects associated with each of these, but they are generally better tolerated than the conventional types of antipsychotics.

Precautions and Side Effects

The atypical antipsychotic medications have largely replaced the older medications, presumably because of lower risk of side effects. Choosing which class of antipsychotic medications to use is challenging for the prescriber. On one hand, atypical antipsychotics are more expensive and more likely to cause weight gain and diabetes. On the other hand, they may be more effective than older medications in treating psychotic symptoms.

The typical antipsychotics were believed to produce a number of unpleasant side effects, the worst of which were extrapyramidal symptoms, neuroleptic malignant syndrome, and tardive dyskinesia. In contrast, the risk of tardive dyskinesia was presumed to be lower with the atypical antipsychotics, particularly Clozaril. However, Clozaril can cause agranulocytosis (a loss of the white blood cells that fight infection). To avoid this, those taking Clozaril must have their white blood cell counts monitored every week or two. The inconvenience and cost of blood tests and the cost of the medication have made treatment with Clozaril difficult for many. This is unfortunate since Clozaril may be the most effective of all the antipsychotic medication. A major research study (the CATIE trial) suggests that the typical antipsychotics may be just as safe and as well tolerated as the atypicals. In the past, these older medications were often used at much higher doses than are used currently. This may explain why they appeared to cause more side effects.

Len Sperry, MD, PhD

See also: Clozaril (Clozapine); Schizoaffective Disorder; Schizophrenia

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Antisocial Personality Disorder

Antisocial personality disorder is a mental disorder characterized by a persistent pattern of disregarding and violating the rights of others.

Definitions

- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychopathic personality** is a mental disorder characterized as amoral behavior, inability to love and understand another's feelings (empathy), extreme self-centeredness, and failure to learn from experience. It is also known as psychopathy and psychopath.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

- **Sociopathic personality** is a mental disorder characterized by amoral and criminal behavior and lacks a sense of moral responsibility. It is also known as sociopathy and sociopath.

Description and Diagnosis

Antisocial personality disorder is a personality disorder characterized by a pattern of antisocial behavior. Such behavior begins in childhood or early adolescence and is characterized by aggressiveness, fighting, hyperactivity, poor peer relationships, irresponsibility, lying, theft, truancy, poor school performance, runaway behavior, and inappropriate sexual activity, as well as drug and alcohol abuse. As adults, assaultiveness, self-defeating impulsivity, hedonism, promiscuity, unreliability, and continued drug and alcohol abuse may be present. Criminality may be involved. These individuals fail at work, change jobs frequently, tend to receive dishonorable discharges from the military, are abusing parents and neglectful spouses, have difficulty maintaining intimate relationships, and may be convicted and spend time in prison. Antisocial behavior often peaks in late adolescence and early 20s and lessens in late 30s. This disorder is four times more common in males than in females.

In the past this disorder was known as psychopathic personality and sociopathic personality. While there are some similarities among these disorders and antisocial personality disorder, there are differences. The first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders* provided descriptions of the psychopathic personality or the sociopathic personality. However, starting with DSM-III, the designation "antisocial personality disorder" has been used along with specific diagnostic criteria.

The clinical presentation of the antisocial personality disorder can be described in terms of behavioral style, interpersonal style, thinking style, and feeling style. The behavioral style of this disorder is characterized by poor job performance, repeated substance abuse, irresponsible parenting, persistent lying, delinquency, truancy, and violations of others' rights. These individuals can also be impulsive, angry, hostile, and cunning. Even though they may engage in rule-breaking behavior, they can be successful in business, politics, and other professions. They are forceful individuals who regularly engage in risk-seeking and thrill-seeking behavior. Their interpersonal style is characterized by antagonism and belligerence. They also tend to be highly competitive and distrustful of others and thus poor losers. Their relationships may at times appear to be "slick" as well as calculating. Their relationships are characteristically shallow and superficial, and often involve no lasting emotional ties or commitments. Their thinking style tends to be impulsive and rigid or inflexible as well as externally oriented. Because they are contemptuous of authority, rules, and social expectations, they easily rationalize their own behavior. Their feeling style of this disorder is characterized by the avoidance of "softer" emotions such as warmth and intimacy because they regard these as signs of weakness. The need to be powerful and the fear of being abused and humiliated lead to a denial of the "softer" emotions as well as their uncooperativeness. Guilt is seldom, if ever, experienced. They also find it difficult to tolerate boredom, depression, or frustration and subsequently are sensation-seekers. In addition, they tend to be callous toward the pain and suffering of others, and show little shame for their own deviant actions.

The cause of the antisocial personality disorder is not well understood. The parenting style these individuals experienced growing up often was hostile, abusive, or neglectful. Their parents and siblings may have engaged in and modeled antisocial behavior. In addition, these individuals have a characteristic view of themselves, the world, and others, and a basic life strategy. They tend to view themselves as cunning and entitled to take whatever they want. They are also likely to view themselves as strong, competitive, energetic, and tough. They tend to view others as abusive and devious or as easy prey to be used and abused. They tend to view life as hostile and rules as keeping them from fulfilling their needs. Accordingly, their basic life strategy and pattern is to take what they want and break rules and defend themselves against efforts to be controlled or abused by others.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of disregarding and violating the rights of others. They disrespect and disregard laws and social

norms, and regularly engage in acts that are grounds for arrest. These individuals lie, are deceitful, and will take advantage of others for pleasure or for personal profit. They are impulsive and fail to plan ahead. They are also irritable and aggressive, which results in physical fights or assaults. It is not surprising that these individuals disregard the safety of others as well as themselves. Their irresponsibility is demonstrated by their failure to engage in consistent work behavior and failure to meet financial obligations. Furthermore, their lack of remorse is shown by their indifference in having hurt, mistreated, or stolen from others (American Psychiatric Association, 2013).

Treatment

Unlike other personality disorders in which psychotherapy can be effective, the antisocial personality disorder is less amenable to such treatment. Typically, these individuals are usually not interested in making life changes. When treatment is required by the courts, employers, or other agencies, these individuals are likely to resist treatment efforts. However, special residential treatment programs have shown some promise. There appears to be at least one exception to receptivity to psychotherapeutic treatment. When the antisocial personality disordered individual experiences a moderate degree of depression, he or she may be willing to engage in psychotherapy in order to reduce depressive symptoms.

Len Sperry, MD, PhD

See also: Personality Disorders; Psychopathic Personality; Psychotherapy

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Anxiety Disorders in Adults

Anxiety disorders in adults are a group of mental disorders characterized by anxiety as a central or core symptom.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Anxiety** is apprehension or worry about an imagined danger.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing automatic thoughts and maladaptive beliefs.
- **Exposure therapy** is a behavior therapy intervention (method) in which a client is exposed to a feared object or situation.
- **Fear** is an emotional response to a known danger.
- **Panic** is an intense sense of fear.
- **Panic attack** is an episode of sudden, intense, and debilitating sense of fear that is short lived.
- **Phobia** is an intense fear of a person, place, or thing that significantly exceeds the actual danger posed.
- **Selective mutism** is a mental disorder in which children or adolescents fail to speak in some social situations although they have the ability to talk normally at other times.
- **Separation anxiety disorder** is an anxiety disorder characterized by excessive anxiety resulting from separation from those to whom a child is attached.

Description and Presentation

This group of disorders includes specific phobia, social anxiety disorder, panic disorder, agoraphobia, and generalized anxiety disorder that are common in adults. It does not include anxiety disorder that is common in children or adolescents like separation anxiety disorder or selective mutism. Children and/or adolescents can also experience specific phobia. But since they are also common in adults, they are described here. Anxiety disorders in adults share the primary feature of anxiety, anxiety that is not caused by medication or recreational drugs. Adults typically refer to their experience of anxiety as fear, nervousness, worry, tension, or something similar. Many experience anxiety numerous times in their lives, but what separates anxiety disorders from normal experience is that symptoms last for at least six months. In addition, they must cause clinically significant distress or must disrupt the individual's daily functioning.

Certain characteristics have been associated with a risk of developing anxiety disorders in adulthood. First, there may be genetic factors that increase the likelihood of developing an anxiety disorder. Abuse or neglect in childhood may also be a risk factor in the development of anxiety disorders in adulthood.

Here is a brief description of five anxiety disorders commonly diagnosed in adults.

Specific phobia. Is a phobia related to a specific fear such as being a passenger on an airplane, blood, closed spaces, or spiders? What separates a specific phobia from a fear is that the experience of fear far exceeds the actual dangers posed, or they may experience anxiety. In addition, they are likely to avoid the feared object(s). Although this condition is primarily concerned with the fear evoked by the phobic object, there is often an element of anxiety leading up to an imminent or likely exposure to it.

Approximately 8% of the U.S. population has a specific phobia. Furthermore, like most of the anxiety disorders, they tend to occur twice as often in women than men (American Psychiatric Association, 2013). Depending on the circumstances, individuals may be prescribed antianxiety medication for situations in which they will have to endure their phobic object (e.g., for a plane flight). For long-term change, treatment for specific phobia most commonly includes exposure therapy. As the name suggests, individuals are gradually exposed to what they fear while maintaining a relaxed and calm state.

Social anxiety disorder. Also referred to as social phobia, this disorder is characterized by excessive fear of being critically evaluated by others in a social situation. Often, fear revolves around some sort of performance such as a presentation, dance, or speech. In more severe cases, simply attending a party or having a conversation with a stranger may be sufficient to induce significant fear. Infrequent anxiety or fear related to social circumstances is a common occurrence. What characterizes this disorder from normal social functioning is that the anxiety or fear almost always occurs as opposed to occasionally. Social anxiety can cause someone to become isolated or, in severe cases, unable to maintain relationships and/or be employed.

Approximately 7% of the U.S. population experiences this disorder. It is notable that this disorder is far less prevalent in some cultures than in the United States. Also, this tends to occur twice as often in women than men (American Psychiatric Association, 2013). This disorder is commonly treated with exposure therapy or cognitive therapy.

Panic disorder. Individuals with this disorder experience both recurring panic attacks and anxiety in regard to experiencing future attacks. These attacks may include physical symptoms such as heart palpitations (pounding heart), sweaty palms, shortness of breath, and tingling in the fingers. Individuals experiencing a panic attack may also sense that they are in some way detached from their experience (called derealization). In addition, they may have a sense that they are dying or going crazy.

An important component of panic attack is that there is no realistic, plausible cause of their acute fear. For example, an individual experiencing a panic attack may think that he or she will choke while having

no physical obstruction of the airway. It is important to note that this condition, like other anxiety disorders, is not caused by medication, drugs, or illness. Panic attack is also different from panic in that normal panic results from a realistic concern. Individuals who experience this disorder may also experience agoraphobia.

Panic disorder is less prevalent than other anxiety disorders. Approximately 2.5% of the U.S. population experiences panic disorder. Unlike the other anxiety disorders, it seems that panic disorder occurs in similar proportions to both sexes (American Psychiatric Association, 2013). This disorder is commonly treated with both drugs and behavior therapy. Antidepressant medications may be prescribed to reduce the anxiety about future attacks, while antianxiety medications may be used to reduce the intensity of the actual attack. Behavior therapy is used to reduce the fear and related anxiety and ultimately resolve the disorder. Treatment often begins with medications that are used only until the fear and anxiety responses are reduced with behavior therapy. Without treatment, this condition will likely become chronic.

Agoraphobia. Agoraphobia is a phobia in which individuals experience an intense fear of crowds, public places, open spaces, or places from which they believe that they cannot easily escape. Alternatively, the primary fear may also be embarrassment of being observed panicking by others in the public space. Like other phobias, individuals with this disorder commonly avoid exposure to what they fear. The likelihood of developing this disorder is approximately 1.7% in adolescence and adulthood. Also, it is likely to occur with panic disorder. Agoraphobia is usually treated the same as panic disorder and is treated and simultaneously with it (American Psychiatric Association, 2013).

Generalized anxiety disorder. Generalized anxiety disorder is a constant uncontrollable worry that both is excessive and causes individuals distress. The worries may focus on multiple concerns about their children, their health, or their job. Or, the worries may be very broad so that the individual literally worries about worrying. Those who experience this disorder often have sleeping difficulties and feel fatigued and/or irritable. Also, they may experience mild physical symptoms such as trembling, muscle tension, or sweating.

The likelihood that at individual will experience this disorder at some point in his or her lifetime is 9%. It occurs more frequently in those of European descent than non-European descent. Also, it occurs far more frequently in first-world nations than in the developing nations (American Psychiatric Association, 2013). Treatment includes a wide range of options, including antidepressants medication, antianxiety medications, cognitive therapies, and behavioral therapies.

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See also: Antianxiety Medications; Antidepressant Medications; Agoraphobia; Cognitive Therapies; Exposure Therapy; Generalized Anxiety Disorder; Panic Attack; Panic Disorder; Social Anxiety Disorder; Specific Phobia

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Anxiety Disorders in Youth

Anxiety disorders in youth describe conditions of excessive anxiety and worry that occur in children and manifest in different ways.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Anxiety disorders** cause people to feel excessively scared, distressed, and uneasy during situations in which others would not experience these symptoms.

Description

Anxiety disorders are the most common mental illnesses in America. Sometimes these disorders are often difficult to recognize because people attempt to hide them or they get confused for other issues. Anxiety disorders are especially common in children and adolescents. There are several disorders that fall under the category of anxiety disorders. Among the most common anxiety disorders for youth are phobias, panic disorders, obsessive-compulsive disorder, and post-traumatic stress disorder.

Phobias are a fear of something that poses little or no actual danger. The fear leads many to completely avoid objects or situations that can cause feelings of terror, dread, and panic. Phobias can substantially restrict a child's ability to socialize with others, go to school, or participate in family outings. Separation anxiety is a kind of phobia that is common among some children. This anxiety specifically presents when a child is removed from a person or object he or she is attached to. Children and adolescents with phobias or separation anxiety usually anticipate the worst and often complain of fatigue, tension, headaches, and nausea.

Panic disorder can often result in panic attacks. It is characterized by sudden feelings of terror that strike repeatedly and without warning. Physical symptoms can include chest pain, heart palpitations, shortness of breath, dizziness, abdominal discomfort, feelings of unreality, and fear of dying. Children and teens with this disorder may experience unrealistic worry, self-consciousness, and tension.

Obsessive-compulsive disorder describes those who have frequent, unwanted thoughts, behaviors, or feelings. Many times obsessive thoughts or worries lead youth to engage in a pattern of behavior they find difficult to control. Common compulsions may include counting, checking, organizing objects, and excessive hand washing.

Post-traumatic stress disorder: persistent symptoms of this disorder occur after a child or teen has experienced a trauma. This can include traumatic events such as physical or emotional abuse, natural disasters, or witnessing extreme violence. Usually these children experience nightmares, flashbacks, lack of feeling, sadness, rage, and difficulty focusing.

Causes and Symptoms

As with many other psychological disorders, it is still unclear whether the causes of anxiety disorder in young people are more biological or environmental. Some professionals consider anxiety disorders to have both neurological and environmental causes. Researchers indicate that children and adolescents are more likely to have anxiety disorders if their parents or caregivers also have anxiety issues.

Diagnosis and Prognosis

In order to properly identify anxiety disorders in youth, it is important to consider physical, cognitive, and emotional characteristics. Anxiety is part of a child's flight or fight response. Experiencing anxiety helps a child learn how to determine fighting for or fleeing a situation. This is part of normal development and is important to have for balance and mental health. Multiple assessments exist to try to prevent a mistaken diagnosis.

Mental health professionals must take into account the individual's general medical condition. Anxiety can often be associated with the experience of certain illnesses or as a side effect of medications. Left untreated, anxiety disorders can debilitate the lives of young people. How well any individual does with treatment depends on the severity of the condition.

Most patients can be helped through a combination of medication and therapy to gain a better quality of life.

Treatment

Among the range of effective treatments for anxiety disorders are medications, individual therapy, family therapy, or a combination of these. Cognitive behavior therapy in combination with medication is the most effective treatment for youth and adults with anxiety disorders. Therapy can help teach children and adolescents how to deal with their fears by modifying and practicing new behaviors, which can lead to positive change.

For parents and caregivers it is important to learn about anxiety disorders so that they can understand and help their child with an anxiety disorder. Psychoeducation, support groups, and seeking individual counseling can be helpful for parents who have a child with anxiety disorder. In providing treatment to the youth with anxiety disorders, parents and caregivers should involve the child or adolescent in the process of decision making and problem solving to enhance their success later in life.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Adverse Childhood Experiences; Antianxiety Drugs; Anxiety Disorders in Adults; Anxiety Reduction Techniques; Obsessive-Compulsive Disorder (OCD); Panic Attack; Panic Disorder; Phobias; Post-Traumatic Stress Disorder (PTSD) in Youth; Separation Anxiety Disorder

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Anxiety Reduction Techniques

Anxiety reduction techniques are skills that an individual can learn, which will help handle or overcome the causes, symptoms, and effects of anxiety, stress, and tension. These techniques are divided into two categories, physical and mental, because of the strong connection between the two for people dealing with anxiety.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Stress** is the pattern of specific and nonspecific responses to events that tax or exceed an individual's ability to cope.
- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description

Anxiety reduction techniques can be both physical and psychological and help those who suffer from anxiety, tension and stress. Usually the suffering is strong enough that individuals often find it difficult to engage in and enjoy daily living. Sometimes the symptoms are so severe that the person will do just about anything to find relief.

People who experience anxiety undergo psychological problems that create stress and tension. This mental stress is often related to physical problems as well and leads to chronic anxiety and stress. This long-term anxiety can lower the immune system, increase blood pressure, and increase muscle tension. All of these symptoms can eventually lead to serious life-threatening illnesses. Health-care professionals therefore have sought to treat the causes and symptoms of anxiety, stress, and tension in a variety of ways.

Medical interventions for anxiety reduction include the use of prescription drugs and have been used for decades. This approach, however, has some problems and can prevent effective long-term resolutions for the problem causing the stress. In addition to that stress, the medication could contribute to addictive behaviors and is a reality when using medication as treatment. Some individuals who use medication to relieve anxiety experience negative side effects and dependency, which leads to more stress and anxiety.

This vicious cycle led many health-care professionals to explore and begin using other anxiety reduction techniques. Some of these techniques include psychotherapy in the form of relaxation and cognitive behavioral strategies. Research also provides a rationale for the use of physical to reduce anxiety. Both of these techniques can be helpful for professionals working with individuals with anxiety so they can be taught through professional help and continue practicing these techniques outside of therapy.

Development

One of the first modern investigators of the effects of alternative methods on stress was Dr. Herbert Benson, who published the book *The Relaxation Response* (1975). His approach challenged the medication approach to encourage more psychological and physical activities that reduce stress. Since then the field has rapidly expanded with both traditional medical and alternative approaches multiplying over the years.

There are a variety of options available for relieving anxiety and stress. Among the most common are physical activities such as diaphragmatic breathing (as in yoga), massage, exercise and relaxation. Common mental relaxation techniques include visualization and imagery, hypnosis, and meditation.

The clinical basis for the success of these techniques lies in the fact that they stimulate the production of natural opiates in the brain. These brain chemicals have been found to block pain and to create a feeling of euphoria or a "high" much like the medications prescribed for anxiety. Through the natural release of this chemical, individuals with anxiety are less likely to utilize medication and experience side effects or dependence.

Current Status

Recently, the field of biofeedback to treat anxiety has been introduced. Biofeedback relies on the use of a machine that measures brain waves, cardiac rhythm, pulse, breathing, muscle tension, or conduction of electricity by the skin. It is a conditioning process. When a more internally tranquil state is recorded by the equipment, the patient is rewarded by a pleasant tone or colored light. The procedure then aims at helping the patient concentrate on maintaining the positive changes that have occurred in the body.

Other more recently popular anxiety reducing techniques include cognitive restructuring. This approach is based on becoming aware of the chronic stressors in life and learning how to reappraise them. This is a kind of cognitive restructuring activity that can lessen the stress of uncertainty and the anxiety about loss of control through identifying and practicing healthy coping mechanisms. In general, the work on optimistic thinking and positive psychology and cognitive restructuring attests to the power of the mind to promote health and well-being.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Anxiety Disorders in Adults; Anxiety Disorders in Youth; Mindfulness

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Anxious Personality Disorder

Anxious personality disorder is a personality disorder characterized by a persistent, continuous pattern of anxiety.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorder.
- **Characterological anxiety** is a persistent pattern or trait of anxiety which reflects an individual's general level of distress. It contrasts with state (situational) anxiety which reflects an individual's distress in a given situation.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Defense mechanisms** are strategies for self-protection against anxiety and other negative emotions that accompany stress.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure therapy** is an intervention (method) in which a client is exposed to a feared object or situation. It is also referred to as flooding.
- **Generalized anxiety disorder** is an anxiety disorder characterized by chronic anxiety and multiple exaggerated worries even when there is little or nothing to provoke it.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture. Personality disorder reflects an individual's unique personality structure.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.
- ***Psychodynamic Diagnostic Manual*** **(PDM)** is a diagnostic system based on psychoanalytic theory that is used by professionals to identify mental disorders with specific diagnostic criteria.

Description and Diagnosis

Anxious personality disorder is a personality disorder that overlaps considerably with the DSM-5 diagnosis of generalized anxiety disorder. While anxiety is the psychologically organizing experience in anxious personality disorder, it differs from the anxiety disorders. In most anxiety disorders, the anxieties involve specific objects or situations. For example, with a spider phobia, the anxiety involve spiders, which is a specific object. In contrast, anxious personality disorder involves characterological anxiety, which is a "free-floating" or global sense of anxiety with no object or situation.

Those with this disorder have failed to develop adequate coping strategies for dealing with the common stresses and fears of everyday life. They typically report having had a parent, who because of that parent's own anxiety could not adequately comfort them or provide a sense of security or support.

Two or more of the following types of anxiety are common among those with this personality disorder:

signal anxiety (emotional cues that a specific situation was previously considered dangerous), moral anxiety (dread of violating one's core values), separation anxiety (fear of loss of a relationship), and annihilation anxiety (terror of loss of a sense of self). This contrasts with the various anxiety disorders in which only one of these tends to predominate.

Many are surprised to learn that the anxious personality disorder is not included in DSM-5. However, it is described in the *Psychodynamic Diagnostic Manual* (PDM). According to the PDM (2006), the anxious personality disorder is diagnosable by the following criteria. Individuals exhibit an anxious or timid temperament (inborn personality characteristics). They are preoccupied with being safe amid perceived dangers. Their basic emotion is fear. Their basic belief or view of themselves is that they are in constant danger from unknown forces. Their basic belief or view of others is that others are the sources of either danger or protection. Furthermore, they are unable to adequately shield themselves from such danger because their defense mechanisms are inadequate.

Treatment

Treatment of the anxious personality disorder tends to be long term and challenging. Therapists do well to demonstrate an attitude of confidence in the individual's own capacities to tolerate and reduce anxiety. It is also important to develop and maintain a strong therapeutic relationship since these individuals tend to become discouraged because of their long-standing symptoms. Exposure therapy and mindfulness practices can be very useful in anxiety reduction. Other cognitive behavior therapy techniques can be helpful in understanding and mastering this disorder. Antianxiety medications can also be considered in reducing anxiety symptoms. However, because of the risk of addiction, these medications should be prescribed with caution for individuals with this personality disorder.

Len Sperry, MD, PhD

See also: Anxiety Disorders in Adults; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Exposure Therapy; Mindfulness; Personality Disorders; Psychoanalysis; *Psychodynamic Diagnostic Manual* (PDM)

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Apathy

Apathy is a state of emotional indifference; it is the absence of interest, concern, or enthusiasm in things most people enjoy about life.

Description

"Apathy" is a term used to describe an emotional state of indifference and lack of passion. It is most often a temporary feeling that is experienced by most people. Apathy is frequently a symptom of various psychological and emotional disorders. Apathy is a lack of passion and enthusiasm for life. There is a suppression of emotion or feelings. Apathetic people live with a lack of concern, excitement, or interest in relationships, current events, and meaning in life. They are numb to the excitement and wonder of life.

Apathy is described as a lack of motivation. It is characterized by a decrease in three key categories of functioning. There is a decrease in goal-oriented behavior in which there is a lack of effort to engage in activities or an overreliance on others to structure activities. There is also a decrease in goal-directed thinking characterized by a lack of interest in learning, a lack of interest in new experiences, and a lack of concern about one's personal problems. The third category is a decrease in emotion and emotional responsiveness.

Apathy is most often transient, meaning it is a phase that people go through but do not stay in. Apathy is not depression and is not considered a separate mental health disorder. People suffering from depression are debilitated or incapacitated in some fashion. Depressed people often lack the ability to fully function or engage in life. Apathetic individuals, who are not suffering from a mental health disorder, are able to fully function in life. They just do so with little enthusiasm and passion. A common phrase used by apathetic people is "Who cares?"

Current Status

Apathy is a common experience in medical and mental health conditions. Apathy is common in depression and in individuals suffering from adjustment disorder and other mood disorders such as persistent depressive disorder. Apathy is also associated with disorders such as Asperger's syndrome and Alzheimer's disease. It is also associated with some medical conditions such as hypothyroidism and hyperthyroidism. Because apathy is not a separate mental health disorder, there is no specific treatment for it. Periods of apathy are considered a normal part of life. When apathy persists over a longer period of time, the individual is more likely to be suffering from a medical or mental health condition.

Everyone experiences periods of apathy. Apathy is often a coping response after a highly emotional experience takes place. During these times emotional energy is spent and sometimes exhausted; people just run out of emotional energy. Apathy is the experience people have while they recharge or recover emotionally. For instance, consider a senior in high school who has worked very hard to get into a top college. The university has very competitive entrance requirements and the student has studied and worked very hard to get in. She has participated in extracurricular activities and has volunteered in service projects to enhance her chances of getting into this highly regarded university. She has also spent countless hours on the Internet exploring all of the facets of the school and city it is located in. She has followed its football games on television and has a sweatshirt with the school mascot on it. She worked hard on the application, received excellent recommendations from teachers, and submitted the application well before the deadline. But she didn't get in and is extremely disappointed. We can predict that she will go through a period of time where she doesn't seem to care about college or where she attends. Because of the intense emotional energy spent in the pursuit of the college, she feels numb and tells her best friend she "couldn't care less" about college. She declines an invitation to a party and stays home that weekend and mopes around the house. However, after a brief period of time she begins to recover and begins to think about other colleges. She remembers that her best friend talked about her favorite college and she decides to check it out on the Internet. She is back on track and is excited by the different options she has.

Apathy is an emotional state that most individuals experience in their lifetime. Short periods of apathy are not cause for alarm and are considered normal. When apathy is longer lasting, it may be a sign of emotional struggle and be of concern if the individual is not functioning well.

Steven R. Vensel, PhD

See also: Adjustment Disorder; Persistent Depressive Disorder

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Aphasia

Aphasia is the impaired ability to understand words, signs, or gestures caused by a brain injury or disease.

Definitions

- **Alzheimer's disease** is a medical and mental disorder that causes dementia particularly late in life. It is also referred to as Neurocognitive Disorder Due to Alzheimer's Disease.
- **Dementia** is a group of symptoms including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of neurons (nerve cells) in the brain.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life. It is not considered a disorder unless it significantly disrupts one's daily functioning.
- **Epilepsy** is a medical condition when seizures reoccur. It is also known as seizure disorder.

- **Seizure** is an episode of abnormal electrical activity in the brain that results in physical findings and changes in behavior.
- **Stroke** is a medical condition when there is deprivation of oxygen to the brain due to a lack of blood flow.

Description

Aphasia is an impairment or disturbance in the comprehension and expression of language. The degree of impairment can range from having difficulty remembering words to having the inability to speak, read, or write. Symptoms can be mild or severe. When the symptoms are severe, communication may be nearly impossible. Some signs and symptoms of aphasia include the inability to form words, inability to repeat a phrase, or inability to pronounce words. Other symptoms may involve the inability to comprehend language, persistent repetition of phrases, inability to name objects, and the inability to write sentences that make sense. Aphasia does not affect intelligence.

Individuals with cancer, seizures, epilepsy, Alzheimer's disease, or other brain diseases may experience aphasia. Those who have had a stroke or head injury are likely to experience severe aphasia. There are also progressive forms of aphasia that develop slowly. These types of aphasia include brain tumor, dementia, or infection. The more extensive the brain damage, the greater the likelihood of severe and lasting disability.

Aphasia can cause a number of problems in one's life due to lack of communication. Often, good quality of life is significantly reduced. Aphasia can also cause problems in relationships, jobs, education, and day-to-day functioning. It can also lead to depression, frustration, and humiliation. Some individuals with aphasia are very aware of their difficulties. Others are not so aware of when there is a breakdown in communication. Individuals with aphasia claim the worst part of their disorder is the rejection they receive from others who do not understand what aphasia is.

Len Sperry, MD, PhD, and Elizabeth Smith Kelsey, PhD

See also: Alzheimer's Disease; Dementia; Depression; Seizures; Stroke

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Applied Behavior Analysis

Applied behavior analysis is a science that aims to understand and improve human behavior.

Description

Applied behavior analysis (ABA) differs from other approaches to understanding behavior in its focus, goals, and methods. The focus of ABA is to understand behaviors you can observe. These are defined as specifically and objectively as possible. Treatment is then focused on improving the behaviors that are identified in a systematic way. It explores what environmental factors influence the way people act. The way ABA trained therapists do this is by gathering information and tracking data and by making sure that treatment is effective.

There are three major beliefs of ABA that originate from behavioral theory. The first is that behavioral philosophy is scientific. The next is that research and analyzing behavior is required for experimentation. Last, ABA requires the development of techniques and technology for the goal of improving behavior.

Therapists work with young children and older adults. Early intervention involves trained therapists directing treatment. There are a wide variety of techniques available in ABA. Usually it involves a structured environment but can be done in the home, school, or community. ABA sessions have historically focused on individual therapy between a behavior analyst and client. But group instruction using ABA techniques is useful as well.

Development

The field of psychology began with the study of conscious states. In the early 1900s a shift to focus on behavior started with John B. Watson. He wanted to focus psychology on observable events that can predict and control behavior. These experiments officially began with B.F. Skinner through research and publications. Skinner established the field of experimental analysis of behavior. He was able to provide a guideline for breaking down behaviors into smaller parts and understanding specific influences on behavior. He revolutionized the field of ABA and in some ways made it radical and controversial.

Another important figure in the development of ABA was Don Baer. He believed the key point of behaviorism is to understand what people do. He was known for being able to break down the process of behaviorism and ABA in a way that students and others could truly understand. He was also involved in studying the effects of punishment, escape, and avoidance on young children.

In 1959 one of the most important papers that established ABA was released, *The Psychiatric Nurse as a Behavioral Engineer*. The publication of this paper and others allowed professionals to start thinking of ABA beyond trained therapists. The principles of ABA began being used and published in schools, hospitals, and beyond. In the early 1960s and 1970s university programs began to offer programs in ABA. Then in 1968, an important year for ABA, the *Journal of Applied Behavior Analysis (JABA)* came into existence. In this first volume various psychologists, including Don Baer, published articles and helped several become known as the founding fathers of ABA.

Current Status

During the 1990s and 2000s the field of applied behavior analysis grew with the formation of organizations and publications of books and journals on the subject. On a practical level, ABA has helped many different kinds of learners to improve. These areas of improvement can range from academic to language to lifestyle. Today it is widely recognized as effective and safe for various conditions including developmental disorders like autism.

Effective ABA practices currently involve an individualized approach to each client. The therapist tailors treatment to the needs and abilities of the person he or she works with. The common elements of ABA therapy include a planning or assessment phase and then applying proven techniques.

In recent decades, the provision of a training program for those who can provide ABA therapy was established. The Behavior Analyst Certification Board was created to ensure that ABA therapy is being provided at a high standard of care. Those seeking to use behavior therapy or ABA should find a certified professional in the form of a Board Certified Behavior Analyst. These professionals are known as BCBA or BCaBA professionals.

Alexandra Cunningham, PhD

See also: Behavior Therapy; Behavior Therapy with Children; Skinner, B.F. (1904–1990); Watson, John B. (1878–1958)

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Archetypes and the Collective Unconscious, The (Book)

The Archetypes and the Collective Unconscious by Swiss psychiatrist Carl Gustav Jung was originally published in 1959. This book is Jung's explanation of a universal unconscious of mankind, which he believed was impersonal in nature and expressed as instinct. In the book, Jung states that the universal unconsciousness is not anything that has been blocked from our consciousness but instead is a preconscious experience that has always existed. As he explains it, "Thinking existed long before man was able to say, 'I am conscious of thinking.' "

Definitions

- **Anima** is the female image that is part of the male psyche.
- **Animus** is the male image that is part of the female psyche.
- **Archetype** is a pattern of behavior used to organize, understand, and interpret how we experience life. Archetypes can be fluid, meaning they can change over time.

Jung was a great influence on the field of psychology. Freud personally selected Jung in 1910 as the first president of the International Psychoanalytic Association. However, in 1914, Jung rejected Freud's theories and founded his own system of Analytical Psychology, which was based on archetypal and symbolic theory.

In his book, Jung introduces archetypes as symbols of preconscious thinking. He identifies the following archetypes: the anima in men, the animus in women, the persona, the self, the mother archetype, the child archetype, the hero, and the trickster. In addition to these conscious archetypes, there is an archetype for the unconscious, which Jung calls the shadow. The shadow is made up of what is suppressed from the consciousness and is at a more superficial level than the other archetypes. The shadow is considered a darker element, comprised of chaos, wildness, sex, and life instincts.

According to Jung, everyone's consciousness evolves in stages. When an agreement is reached between the universal (archetypical) unconscious and the individual ego (consciousness), a person reaches individuation. Both the reason of consciousness and the chaos of the unconscious should continue to be expressed, because this conflict and collaboration is what makes us human.

Throughout his career as a scientist and practicing clinician, Jung focused on religion and spirituality. He believed religion was important to the human psyche, and he chose to focus on it in the context of his work. He focused on Christianity and spirituality in his work, and in this book Jung examines the change in a person's psychic state as a result of Christianity. Jung looks at Christ as a symbol of wholeness, along with symbols from Gnosticism and alchemy. He also examines Gnostic symbols of self and how the Quaternity is used in alchemy as a way to organize wholeness.

Using a series of 24 mandalas, Jung describes both the history of our psychological development as humans and a patient's progress toward individuation. The mandala, a symbol from Tibetan Buddhism, was used by Jung to represent the totality of self. The mandala symbol helps reduce mental confusion and restore balance.

Jung explores the archetype of the self, representing the person as a whole. Jung saw the self as a psychological union of the conscious, or masculine, and the unconscious, or feminine. When the conscious and unconscious are together, they stand for psychic totality.

From Jung's work, many terms today are in common use, including archetype, introvert, extrovert, synchronicity, anima, and New Age spirituality. His work has influenced many fields, including psychology, medicine, art, religion, and literature. *The Archetypes and the Collective Unconscious* shows a unique insight into his efforts to combine Christian teachings with other examples of thought and expression.

Mindy Parsons, PhD

See also: Jung, Carl (1875–1961); Jungian Therapy

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Aricept (Donepezil)

Aricept is a prescribed medication used to treat Alzheimer's disease. Its generic name is donepezil.

Definitions

- **Acetylcholine** is a chemical messenger that transmits nerve impulses from cell to cell.

It causes blood vessels to dilate, lowers blood pressure, and slows the heartbeat. A sufficient level of acetylcholine is associated with mental focus and attention.

- **Alzheimer's disease** is a progressive neurodegenerative disease in which dementia results from the degeneration and death of brain cells because of low levels of acetylcholine, plaques, and neurofibrillary tangles.
- **Dementia** is a group of symptoms (syndrome) associated with a progressive loss of memory and other intellectual functions that interfere with one's ability to perform the tasks of daily life. It impairs memory and reasoning ability, causes disorientation, and alters personality.

Description

Aricept is used to treat symptoms of dementia associated with Alzheimer's disease. While it can result in small improvements in dementia for a short period of time, Aricept cannot stop the progression of Alzheimer's disease. Aricept is in a class of medications called cholinesterase inhibitors. Such medications prevent the breakdown of acetylcholine, a chemical messenger (neurotransmitter) that facilitates nerve impulses within the brain. An adequate level of acetylcholine is associated with mental focus and attention. As brain cells die, they can no longer transmit nerve impulses. In certain regions of the brain, cell death results in symptoms of dementia. By maintaining sufficient acetylcholine levels in the brain, Aricept facilitates the transmission of nerve impulses.

Precautions and Side Effects

Individuals with heart conditions, stomach ulcers, bladder obstruction, asthma, chronic obstructive lung disease, or a history of seizures should use Aricept only under close medical supervision. Aricept should not be used during pregnancy nor by nursing women unless the benefits outweigh the risks.

Side effects reported with the use of Aricept include sleep difficulties, dizziness, nausea, diarrhea, muscle cramps, and headache. These side effects are usually mild, short lived, and usually subside when Aricept is stopped. Other less common side effects include depression, drowsiness, fainting, loss of appetite, unusual dreams, weight loss, frequent urination, arthritis, and easy bruising.

Research has found that the effects of Aricept on Alzheimer's disease can be enhanced when Aricept is combined with Namenda, another Alzheimer's medication. Clinical trials have shown that the combination of Aricept and Namenda is more effective than the use of Aricept alone in the treatment of moderate to severe Alzheimer's disease. This combination appears to be safe as well as effective. Aricept does interact with some medications and can increase the side effects associated with use of Luvox, an antidepressant.

Len Sperry, MD, PhD

See also: Alzheimer's Disease; Namenda (Memantine)

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Art Therapy

Human expression through art dates back more than 40,000 years to Paleolithic cave paintings of hunting expeditions and large wild animals. Since prehistoric times, art expression has proven to be one of mankind's most powerful means of communicating experience. Through artistic expression there is much to be learned about ourselves and one another, especially in therapeutic settings. As a profession, art therapy, which emerged in the mid-20th century, is focused on better understanding the human condition and the inner workings of the psyche as revealed through art expression.

Definition

- **Art therapy** is a mental health specialty used by specially trained therapists working with clients using a variety of art media. The process of creating art is a form of therapy that helps clients to explore their feelings, improve personal insight, resolve emotional conflicts, and address a variety of challenges, including addictions, social skills, anxiety, and depression.

As a mental health area of specialization, art therapy is used in a variety of clinical settings and with a wide array of diverse populations. Art therapy is also used in nonclinical settings, including art studios and various workshops that focus on developing creativity. Art therapists require specific and extensive training to receive certification and use this form of therapy in working with clients of all ages, including children, adolescents, adults, and the elderly.

This form of therapy can be used by itself, or it can be used in combination with other forms of therapy, such as cognitive behavior therapy or group therapy. Art therapy can be used in working with individuals, couples, families, and groups and for a variety of mental health challenges, from post-traumatic stress disorder (PTSD) in war veterans to schizophrenia, and from depression to sexual abuse in childhood.

Art therapy is considered a form of expressive therapy in which a client can use a wide variety of art materials and mediums. This includes pottery, clay, chalk, paint, crayons, markers, collages, mandalas, and other art materials. Art therapy can also use digital media, such as painting and drawing programs on computers and tablets. Unlike like a typical art class that focuses on learning skills or techniques, art therapy sessions are looking at the client's inner experience—how he or she feels, perceives, and imagines.

One example of an art therapy technique is coloring a mandala, which has been proven to reduce anxiety because it induces a meditative state, which in turn lowers a person's blood pressure and pulse rate and slows breathing and metabolism. Famed psychoanalyst Carl Jung referred to mandalas as a representation of the unconscious self. The process of creating a mandala is both therapeutic and symbolic. Creating mandalas, like most art therapy, has little to do with the final product, but rather the therapeutic value in the journey of the process.

The use of art therapy is based on using the creative process for self-expression as a way for clients to resolve conflicts, solve problems, improve behavior, strengthen interpersonal skills, reduce stress and anxiety, improve self-esteem, and improve personal awareness. In short, this type of therapy uses the creative process to develop a better understanding and insight into the individual client, and it is backed by traditional psychotherapeutic theories and techniques. When those theories and techniques are combined with an in-depth understanding of the psychological forces that play into the creative process, the results can be highly therapeutic for the client. Around the mid-1900s, doctors started to notice people frequently used various forms of art to express their mental health challenges. This, in turn, led to therapists using the artwork as a way of healing. It can be used as part of their treatment or to assess clients—for example, having a client do a Kinetic Family Drawing or House-Tree-Person Test.

The research on art therapy continues to show a generally positive response for the therapeutic effects on a variety of populations. Art therapy has proven particularly effective with returning war veterans who suffer from PTSD, and it also has shown tremendous benefits both psychologically and physically with older adults who are confined to hospitals or nursing homes. Several studies focusing on institutionalized older adults reveal that art therapy increases creativity and generally improves the patient's level of happiness, peacefulness, and calmness, while reducing depression and sense of despair.

Art therapy works in a variety of populations by helping the individual verbalize his or her feelings and past experiences. Community mental health agencies, schools, private counseling offices, hospitals, and nursing homes are all potential settings where art therapy services may be available.

Becoming an art therapist requires training in both therapy and art, including studying psychology and human development. Art therapists often have a clinical practice of some kind and use art therapy as treatment for mental health issues. Through the art created by clients, art therapists discern nonverbal symbols and metaphors expressed through the art and the

creative process itself—information that may not otherwise be expressed verbally.

Mindy Parsons, PhD

See also: Expressive Arts Therapy; Figure Drawing; House-Tree-Person Test

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Organization

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Website: http://www.arttherapy.org/

The AATA states that its mission is "to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy." http://www.arttherapy.org/.

Asperger's Syndrome

Asperger's syndrome, also called Asperger's disorder, is a diagnosis on the autism spectrum where people have good verbal skills but noticeable social problems.

Definitions

- **Asperger's disorder** is a neurological condition marked by challenges in socializing and restricted interests or repetitive behaviors.
- **Autism spectrum disorders** are developmental disabilities that affect a person's ability to communicate, socialize, and behave like most others.

Description

Asperger's disorder or syndrome (AS) is commonly described as a high-functioning form of autism due to normal language development and intelligence. Those who are diagnosed with it exhibit difficulty interacting socially and behave differently than others. They usually have problems such as poor one-on-one conversations, obsessive interest in a limited range of subjects, and repetitive patterns of behavior.

The disorder is named after Dr. Hans Asperger (1906–1980), an Austrian physician, who first described the particular behaviors that mark people with this syndrome in a paper published in 1944. He observed a group of boys with good language skills but poor communication and motor skills. Dr. Asperger called the group of boys who had marked social problems but good language and cognitive skills the "little professors." Their limited and all-consuming interests led them to be highly verbal yet seemingly unaware of interest displayed by others. These boys also had awkward motor skills. He also noted that their fathers had experienced similar problems in their lives. A translation of Dr. Asperger's original paper is provided by Dr. Uta Frith in her book *Autism and Asperger Syndrome* (1991).

Although people with AS have good verbal skills, they do have trouble relating socially with the overall effectiveness of their communication. Because of this people with AS are often characterized by what is seen as weird behaviors and experience social isolation in childhood. They have difficulty with two-way and nonverbal communication. When you add in clumsiness with gross motor movement, they often find it difficult to establish common bonds with their peers. These characteristics can have an ongoing and lifelong impact on their ability to live independently and

to hold a job or on other important areas of daily life functioning.

Causes and Symptoms

Currently, there is not a single cause or group of causes for Asperger's syndrome nor any of the diagnoses on the autism spectrum. While no specific genes have been found to relate to Asperger's, some researchers have noted structural differences in specific areas of the brain that do not occur in unaffected children.

Although we are not sure of the reasons for this, Asperger's disorder does affect a greater number of males than females, sometimes estimated at four to one ratio. It has often been identified as occurring in families across generations which may indicate that environmental factors also play a role in its development. Those who manifest the characteristics of AS often are of normal to high intelligence. Their limited ability to exhibit age-appropriate social interaction often leads to overcompensation on their limited areas of intellectual interest. This misguided attempt to engage others is often seen as overwhelming them with facts and repetition, which can lead to rejection by their circle of acquaintances. Their inability to read the emotional reactions of others can result in poor judgments about the motives and intents of the people they encounter. The worst result is that they can be victimized and deceived by others.

People with AS often have impairments with theory of mind. Theory of mind is the mental ability of people to take the perspective of others. This can often lead to social confusion and awkwardness among those with AS and their peers.

Often teachers and adults responsible for educating and supporting individuals with AS are impressed by their intelligence and verbal skills and can forget or ignore the sometimes less obvious social skill difficulties. People with AS can often be overlooked because their deficits aren't as obvious as those with more moderate or severe autism spectrum disorders.

Diagnosis and Prognosis

Asperger's disorder is marked by four diagnostic criteria. This includes a limited ability to recognize and use social interaction skills and lack of success in building relationships with their peers. This is due to limited social turn taking and an overemphasis on their own restricted interests.

Repetitive patterns of behavior especially around an intense focus on one or a few areas of interest are also present for people with AS. A rigid adherence to routines and need for sameness is characteristic of the diagnosis. In addition, small or whole-body tics like finger flapping or hand twisting are commonly occurring. Many people with AS have ongoing preoccupations with aspects or parts of objects. In order to receive a diagnosis there should be no noticeable delay in language acquisition or learning skills. Yet significant challenges in interpersonal, work, and other areas of social relationships should be present.

Asperger's syndrome is considered a chronic or lifelong condition. The prognosis appears significantly better for those with AS than for many others on the autism spectrum. Researchers suggest that as they mature, many people can learn to be self-sufficient and are capable of high-level employment.

Treatment

While there is no cure for Asperger's disorder, there are many ways that people can progress. One way to do this involves recognizing and adjusting their behaviors to be more effective communicators in social situations. This can be done through individual and group therapy, behavior modification, and social skills training. People with AS commonly receive behavior, occupational, and language therapy. Education for parents, siblings, and close friends also helps them to limit those with Asperger's disorder and to recognize and limit any problematic behaviors.

Alexandra Cunningham, PhD

See also: Autism; Autism Spectrum Disorders; Pervasive Developmental Disorders

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Assertiveness Training

Assertiveness training (AT) is a therapeutic procedure designed to help people improve their sense of self-esteem as well as their ability to communicate more clearly with others.

Definition

- **Assertiveness** is the quality of being self-assured and confident without being aggressive.

Description

In the history of modern American self-help and personal development movements, AT became a popular intervention designed to promote self-respect and self-expression. Assertiveness has been seen not only as a way to express ourselves clearly and act in our own best interests but also as a means of combating social fears and discomfort by standing up for ourselves without undue anxiety. From the beginning assertiveness was identified as a key behavioral skill that could enhance self-esteem and which could be learned and improved through awareness and practice. AT also aims to help people overcome many socially debilitating conditions such as depression, social anxiety, and problems resulting from unexpressed anger. Because of this it came to be part of the teaching and therapeutic practice of many personal development experts, behavior therapists, and cognitive behavioral therapists.

Although they exhibit individual differences, the various ATs tend to have some objectives in common. Chief among them is to increase awareness of personal dignity and rights. As such, AT fit nicely into the 1960s and 1970s, a period that saw both the civil rights struggle and the rising demand for equal rights for women. Other commonalities among the trainings include the importance of making the distinction between the three key ideas of passivity, assertiveness, and aggressiveness, whether these are expressed verbally or nonverbally. Respect for personal boundaries has been another key concept.

Development

Assertiveness training was introduced by Andrew Salter in the early 1960s and popularized by Joseph Wolpe. The term and concept was popularized among the general public by books such as *Your Perfect Right: A Guide to Assertive Behavior* (1970) by Robert E. Alberti and *When I Say No, I Feel Guilty: How to Cope Using the Skills of Systematic Assertiveness Therapy* (1975) by Manuel J. Smith.

The heyday of AT in its initial forms came in the late 1970s and early 1980s. Some self-proclaimed gurus used extreme techniques in an effort to help people break through perceived social barriers. As a result some people acted out in socially inappropriate and obnoxious ways in the name of empowerment and assertiveness. When used poorly and with bad intentions, so-called assertiveness techniques could be psychological tools that led readily to psychological damage or abuse.

Current Status

Assertive behavior continues to be identified as especially valuable in several areas of psychological health. In health care, which remains a complex and confusing system often controlled by medical experts, it is good to know how to request clearly what you need. It is also important, especially for men, to learn how to be assertive emotionally and clear in their expressions of intimacy. Finally, it can be a great help in being able to know how to say "no" to peer pressures to use drugs or, especially in the case of children and adolescents, to resist unwanted sexual advances.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Social Skills Training

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Ativan (Lorazepam)

Ativan is a prescribed antianxiety medication used to treat anxiety disorders and anxiety associated with depression. Its generic name is lorazepam.

Definitions

- **Anterograde amnesia** is a type of memory problem (amnesia) in which new memories cannot be formed while existing memories remain intact.
- **Benzodiazepines** are a group of central nervous system depressants that are used to relieve anxiety or to induce sleep.
- **Sedative-hypnotics** are medications that induce calmness and sleep. Barbiturates and benzodiazepines are its main types. These are also called tranquilizers, sleeping pills, or sleepers.

Description

Ativan is a sedating (causes drowsiness) medication that is classified as a benzodiazepines. Like other benzodiazepines, Ativan is believed to work by increasing gamma-aminobutyric acid (GABA), a chemical messenger in the brain. GABA inhibits the transmission of nervous impulses in the brain and spinal cord and decreases symptoms associated with anxiety. Ativan's primary use is to treat anxiety disorders and anxiety associated with depression. Secondary uses include the management of nausea and vomiting, insomnia, and seizures. Ativan is also used prior to surgery to produce sedation, sleepiness, drowsiness, relief of anxiety, and a decreased ability to recall the events surrounding the surgery. Ativan differs from drugs such as Valium and Librium in that it is shorter acting and does not accumulate in the body after repeated doses.

Precautions and Side Effects

Ativan can cause physical and psychological dependence, so it should be used with caution in those with a history of drug abuse. Its dosage should not be changed nor should it be suddenly discontinued. Instead, when stopping this medication, the dosage should gradually be decreased and then discontinued. If Ativan is stopped abruptly, individuals may experience withdrawal symptoms such as agitation, irritability, difficulty sleeping, and convulsions. Those with narrow-angle glaucoma, severe uncontrolled pain, or severe low blood pressure should not take Ativan. It has been associated with birth defects when taken during the first three months of pregnancy. Women taking this drug should not breast-feed. Ativan has also been reported to cause anterograde amnesia.

Common side effects of Ativan include drowsiness and sleepiness. Because of this, individuals exercise caution in driving, operating machinery, or performing activities that require mental alertness. Less common side effects include dizziness, reduced sex drive, weakness, unsteadiness, disorientation, nausea, agitation. Some individuals experience headache, difficulty sleeping, rash, yellowing of the eyes, vision changes, and hallucinations.

Alcohol and other central nervous system depressants can increase the drowsiness associated with this medication. Herbal remedies kava kava and valerian may increase the effects of Ativan. Individuals should not drink alcohol when taking Ativan and for 24 to 48 hours before receiving an injection prior to surgery.

Len Sperry, MD, PhD

See also: Benzodiazepines; Sedative, Hypnotic, or Anxiolytic Use Disorder

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Attachment Styles

The theory behind attachment styles was first developed by John Bowlby (1907–1990), with significant contributions that later came from Mary Ainsworth (1913–1999). Attachment styles are generally classified as either secure or insecure attachments; however, there are three subtypes of insecure attachments that include anxious-ambivalent, avoidant, and disorganized-disoriented. Attachment styles are considered important because the ability to create secure or insecure attachments with others impacts an individual throughout his or her lifespan.

Definition

- **Attachment styles** refer to the way in which an individual cognitively and emotionally interacts with others. Attachment styles are important since human relationships are central and connect into all areas of a person's life.

Description

The development of attachment theory is credited to John Bowlby. Bowlby initially worked with the World Health Organization on the area of juvenile delinquency. His work with juvenile delinquents led to his discovery of attachment as an evolutionary adaptation. Bowlby believed that a child's attachment to his or her mother served as a model for the child's later relationships and, in part, determined his or her ability to be emotionally stable. Bowlby held that it was not the perceived relationship between a caregiver and child but the actual interactions that create the blueprint for how an individual relates to others throughout his or her lifetime.

In the 1960s, Mary Ainsworth joined with Bowlby and became a major theoretical contributor to attachment theory. She used a measurement technique called the Strange Situation Test to explore the different kinds of attachments infants have to their primary caregivers. Twelve-month-old babies and their mothers were brought into a room and the baby was subjected to a series of eight, three-minute episodes whereby there were changes to the social situation. Some of these episodes were likely to be stressful to the baby. Initially, the baby and mother were left alone in the room; then the mother and a stranger (one of the researchers) would enter and leave the room in varying patterns. The baby's reactions were recorded as well as the baby's exploration of the room and response to the return of the mother after she had left the room.

Ainsworth and her colleagues identified three patterns of response correlating to attachment styles and a fourth was added in later research. The four types of attachment styles are securely attached; anxious-ambivalent—insecurely attached; avoidant—insecurely attached; and disorganized-disoriented—insecurely attached. It is believed that attachment styles originate from the type of caregiving received in the baby's first year of life.

In studies on attachment, the majority of babies are found to be securely attached. These babies display distress when separated from their mother, which results in crying and attempts to go after her. Upon the return of the mother they greet her happily and will reach for her. Once they feel reassured by their mother's presence, they are comfortable in exploring the room. Ainsworth felt that babies in this category used their mother as a secure base. In Ainsworth's study, 65% of the babies showed this response style, and this figure has been replicated through many subsequent studies.

Babies identified as anxious-ambivalent—insecurely attached display high levels of anxiety, struggling to gain security even with the presence of their mother. These babies are often stressed and distressed when separated from their mother. The defining characteristic of these babies is that upon the return of the mother they greet her angrily and resist their mother or respond listlessly to her efforts to comfort the child. These babies rarely go off and explore the room after their mother's return. This style accounted for about 10% of the babies.

Avoidant babies account for about 20% of most samples. These babies fail to cry when separated from their mothers. They also avoid or ignore her when she returns. These babies often are unemotional during the separation and reunification with their mother. These babies will direct attention toward toys or other things present in the room. It has been suggested by

researchers that this is done as a way of defending themselves against anxiety.

Disorganized-disorientated babies account for about 5%. These babies were initially difficult to identify and categorize. These infants display contradictory behaviors. They show an inclination to approach their mother when stressed as well as avoid her when she approaches.

Attachment research initially looked at life disruptions but has since moved toward focusing on parent–child interactions. Research has found that those with insecure attachments have related to numerous difficulties later in life. Unresolved attachment can also be connected to past trauma and rejection. In childhood, the goal of attachment is protection given by the parent. In adulthood it is survival and emotional caregiving. When the needs are not met, there is an increase in anxiety and the person becomes dismissive and preoccupied or feels unresolved.

When a child is securely attached, he or she is able to be separate from parents, seek comfort from them when frightened, greet them with positive emotions, and prefer them to strangers. When an adult is securely attached, he or she is able to have trusting lasting relationships and higher self-esteem, is comfortable sharing his or her feelings with others, and seeks out social support.

When a child is ambivalently attached, he or she may be wary of strangers, may become greatly distressed when his or her parents leave, and does not appear to be comforted when they return. As adults, these children are reluctant to become close to others, worry that their partner doesn't love them, and become very distraught at the end of relationships. Children who are avoidant will avoid parents; they do not seek contact or comfort and show little to no preference for parents over strangers. As adults, they have problems with intimacy, invest little emotion into relationships, and are unwilling or unable to share their thoughts and feelings.

Mindy Parsons, PhD

See also: Insecure Attachment; Reactive Attachment Disorder; Secure Attachment

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Attention-Deficit Hyperactivity Disorder

Attention-deficit hyperactivity disorder (ADHD) is characterized by a persistent pattern of inattention and a compulsive activity level that is more severe than those exhibited by other individuals at a comparable level of psychological development.

Definition

- **Hyperactivity** means more active than is usual or desirable.

Description

Attention-deficit hyperactivity disorder is one of the most commonly identified, and misidentified, neurobehavioral disorders. The average age of ADHD onset is about seven years of age although it can continue or arise in adolescence and adulthood. Symptoms include problems staying focused and paying attention, difficulty controlling behavior, and being over active.

ADHD affects about 4.1% of American adults aged 18 years and older. It has been estimated that the disorder affects 9.0% of American children aged 13 to 18 years (National Institutes of Health). Men are four times more likely to exhibit signs of ADHD than women. While, as with those on the autism spectrum, studies show that the number of people being diagnosed with ADHD is increasing, it is still unclear how much of this increase is due to the existence of the label to describe dysfunctional behaviors that in the past would only have been seen

as deliberately annoying or impolite behaviors. In order to be classified as ADHD, the questionable behavior patterns that the individual exhibits must clearly interfere with social, academic and/or occupation functioning at the expected developmentally appropriate level.

Causes and Symptoms

As with many other conditions, research has not led to a clear conclusion as what causes ADHD, although many studies suggest that genes play a large role. Like many other disorders, ADHD probably results from a combination of factors. In addition to genetics, researchers are considering possible environmental factors as well as how brain injuries, nutrition, and the social environment might contribute to ADHD.

Recently, the idea that refined sugar causes ADHD or makes symptoms worse is popular, but ongoing research tends to discount this theory, not support it. Inattention, hyperactivity, and impulsivity are the key behaviors of ADHD. While it is normal for people to be inattentive, hyperactive, or impulsive at times, for those who suffer with ADHD, these behaviors are more severe and occur much more frequently. To be diagnosed with the disorder, a person must exhibit symptoms for six or more months and to a degree that is markedly greater than other people of the same age.

Recognizing ADHD symptoms and seeking help will lead to better outcomes for those affected children, their families, and/or their coworkers. Key symptoms are difficulty sustaining attention and the ability to persist in completing tasks; failure to give sufficient attention to details so that careless mistakes are common; appearing to be distracted or just not hearing instructions; frequent distractions and going from one activity to another without completing any one of them; difficulty organizing work, work space, schedules, or activities; and dislike for activities that demand sustained attention or effort and easy distraction by stimuli irrelevant to the task or activity at hand.

It is important to remember that other possible causes of these behaviors must be examined and dismissed before it is proper to consider a diagnosis of ADHD.

Diagnosis and Prognosis

Most people get distracted, act impulsively, and struggle to concentrate at one time or another. Sometimes, these normal factors may be mistaken for ADHD. Coming to the reasoned conclusion that a person has ADHD is a several-step process. There is no single test to diagnose ADHD, and many other problems, like anxiety, depression, and certain types of learning disabilities, can exhibit similar symptoms. It is important that the person be medically examined, including hearing and vision tests, to rule out other problems that have similar symptoms to ADHD. It can also be helpful to consult a checklist that rates ADHD symptoms and get a comprehensive picture of the person's circumstances and developmental history from family and acquaintances.

Treatment

Currently available treatments focus on reducing the symptoms of ADHD and improving functioning. Treatments include medication, various types of psychotherapy, education or training, or a combination of treatments. Treatments can relieve many of the disorder's symptoms, but there is no cure. With treatment, most people with ADHD can be successful at work and lead productive lives.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Attention-Deficit Hyperactivity Disorder in Youth

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Attention-Deficit Hyperactivity Disorder in Youth

Attention-deficit hyperactivity disorder (ADHD) in youth is when a child or adolescent has problems with controlling overactive behaviors and attending to and focusing on tasks.

Definition

- **Hyperactivity** means more active than is usual or desirable.

Description

While ADHD does affect about 4.1% of American adults aged 18 years and older, the rate is much higher in children. It has been estimated that the disorder affects 9.0% of American children aged 13 to 18 years. Boys are four times more likely to exhibit signs of ADHD than girls (Centers for Disease Control, 2012). ADHD is one of the most commonly identified neurobehavioral disorders that affect young children. The average age of ADHD onset is about seven years although it can continue or arise in adolescence and even into adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity.

Researchers and mental health professionals show that the number of children being diagnosed with ADHD is increasing. It is still unclear why this is occurring; in 1970 only 1% of children were diagnosed with ADHD. How much of this increase is due to the existence of the label to describe dysfunctional behaviors that in the past would only have been seen as deliberately annoying or impolite behaviors is unclear.

In order to be classified as ADHD, the questionable behavior patterns that the individual exhibits must clearly interfere with social, academic, and/or occupational functioning at the expected developmentally appropriate level. In the past few years there has often been a "rush to judgment" that a child may have ADHD where in given situations it may be some level of incompetency in the adult lead (such as a teacher) who is responsible by giving inconsistent, unclear, or contradictory information or instructions.

Causes and Symptoms

As with many other conditions, research has not led to a clear conclusion as what causes ADHD, although many studies suggest that genes play a large role. Like many other disorders, ADHD probably results from a combination of factors. In addition to genetics, researchers are considering possible environmental factors as well as how brain injuries, nutrition, and the social environment might contribute to ADHD. Recently, the idea that refined sugar causes ADHD or makes symptoms worse is popular, but ongoing research tends to discount this theory not support it.

Inattention, hyperactivity, and impulsivity are the key behaviors of ADHD. While it is normal for all children to be inattentive, hyperactive, or impulsive at times, for children with ADHD, these behaviors are more severe and occur much more frequently. To be diagnosed with the disorder, a child must exhibit symptoms for six or more months and to a degree that is markedly greater than other children of the same age.

Some children with ADHD also have other illnesses or conditions. For example, they may have one or more of the following: a learning disability, oppositional defiant disorder, conduct disorder, anxiety/depression, and bipolar disorder. ADHD also may coexist with sleep problems, bed-wetting, substance abuse, or other disorders or illnesses.

Recognizing ADHD symptoms and seeking help early will lead to better outcomes for both affected children and their families. Some key symptoms include difficulty sustaining attention and the ability to persist in completing tasks; failure to give sufficient attention to details so that careless mistakes are common; appearing to be distracted or just not hearing instructions; frequent distractions and going from one activity to another without completing any one of them; difficulty organizing work, work space, schedules, or activities; dislike for activities that demand sustained attention or effort and easy distraction by stimuli irrelevant to the task or activity at hand. It is important to remember that other possible causes of these behaviors must be examined and dismissed before it is proper to consider a diagnosis of ADHD.

Diagnosis and Prognosis

Children are diverse in development and personality; they mature at different rates and have different interests, temperaments, and energy levels. Most children get distracted, act impulsively, and struggle to concentrate at one time or another. Sometimes, these normal factors may be mistaken for ADHD.

ADHD symptoms can appear early in life, often between the ages of three and six, and because symptoms vary from child to child, the disorder can be hard to diagnose. Parents may first notice that their child loses interest in things sooner than other children or seems constantly "out of control." Often, teachers notice the symptoms first, when a child has trouble following rules or frequently "spaces out" in the classroom or on the playground.

Coming to the reasoned conclusion that a child has ADHD is a several-step process. There is no single test to diagnose ADHD, and many other problems, like anxiety, depression, and certain types of learning disabilities, can exhibit similar symptoms. It is important that the child be medically examined, including hearing and vision tests, to rule out other problems that have similar symptoms to ADHD. It can also be helpful to consult a checklist that rates ADHD symptoms and get a comprehensive picture of the child's developmental history from parents, teachers, and, sometimes, the child himself or herself. It is also important to remember that certain situations, events, or health conditions may cause temporary maturational delays in behavior in a child that seem like ADHD.

Treatment

Currently available treatments focus on reducing the symptoms of ADHD and improving functioning. Treatments include medication, various types of psychotherapy, education or training, or a combination of treatments. Treatments can relieve many of the disorder's symptoms, but there is no cure. With treatment, most people with ADHD can be successful in school and lead productive lives.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Attention-Deficit Hyperactivity Disorder

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Authentic Happiness (Book)

Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment is a best-selling book about the science of positive psychology and finding real happiness.

Definitions

- **Positive psychology** is the science about the best things in life with a focus on positive emotions, traits, and institutions.
- **Well-being** is the state of being happy, healthy, or successful.

Description

Martin P. Seligman (1942–) is the director of Positive Psychology Center at the University of Pennsylvania. He is a leading figure and founder of the Positive Psychology movement. He became world famous when he developed the theory of learned helplessness in the 1960s. His first best-selling book *Learned Optimism* was published in 1990. It is the first book about positive psychology. After receiving funding and conducting more research on positive psychology, Seligman published *Authentic Happiness* 2002.

In a departure from other psychological approaches, Seligman focuses on building positive emotions and strengths in therapy. He states that real, lasting

happiness comes from focusing on one's personal strengths to improve all aspects of one's life. Using practical exercises, brief tests, and a website program, Seligman shows readers how to identify their highest virtues and use them in ways they haven't yet considered. The book is divided into three sections: positive emotions, positive traits, and positive institutions.

The section on positive emotions is the longest section of the book and focuses on what psychologists know about positive emotions. Seligman uses the terms "happiness" and "well-being" as synonyms throughout the book. He discusses the positive results involved in nurturing positive emotions and experiencing life optimally. The scientific research to support the positive effects of positive emotions is highlighted in this section.

The second section describes character strengths and the idea of signature strengths, which are a person's primary positive traits. Seligman lists 24 strengths and virtues that people identify with. Some examples of signature strengths are to be curious, loving, kind, or spiritual. In order for a trait to become a signature strength, the person must own and enjoy it purposefully.

The last section of *Authentic Happiness* discusses the influence of positive institutions or "Mansions of Life." It discusses how the ideas of positive psychology apply to many systems in life, including work, family, and education. Seligman focuses on the importance that things in our environment have in influencing our psychological state. Therefore, places like schools and government agencies need to adopt the principles of optimism and positive emotions in order to generate psychologically healthy people.

As Seligman concludes this book, he recommends ways to achieve happiness or well-being. Achieving happiness is the desired goal in using positive psychology. Happiness and well-being can come by using signature strengths in work, relationships, and finding life's purpose. Seligman states that happiness is about experiencing life positively and optimistically to achieve this ultimate goal.

Impact (Psychological Influence)

The movement of positive psychology, led by Seligman and others, has created a shift in thinking about psychological well-being. The theories and techniques proposed by positive psychologists challenge the medical model of psychology, which tends to focus on illness and decreasing the negative. The proposition that counseling and therapy should shift from the mind-set of reducing bad symptoms to increasing positive traits and emotions was initially seen as radical.

Positive psychology has not only influenced clients seeking therapy to improve but has also been recommended for counselor well-being. Mental health professionals are vulnerable to burnout and compassion fatigue, which can lead to difficulties in providing effective counseling to clients. Researchers show that students, counselors, and therapists who utilize tools from positive psychology themselves can prevent early burnout and fatigue.

Since this new wave of psychology was introduced into the field, there has been extensive research and effort put forth. The research and practice of positive psychology has been supported through traditional methods for testing the effectiveness of therapy. The pursuit of authentic happiness and well-being through the use of positive psychology is now supported by mental health professionals around the world. The publication of *Authentic Happiness* and many other books since has impacted the field greatly with its presentation of a different and easily applicable way of approaching counseling.

Alexandra Cunningham, PhD

See also: Positive Psychology; Seligman, Martin (1942–); Well-Being; Well-Being Therapy

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Autism

Autism is a developmental disability that affects the brain's ability to help an individual socialize, communicate, and behave like most others.

Definitions

- **Autism spectrum disorders** are developmental disabilities that affect the brain and impact a person's ability to communicate, socialize, and behave like most others.
- **Asperger's syndrome,** also called Asperger's disorder, is a diagnosis on the autism spectrum where people have good verbal skills but noticeable social problems.

Description

Autism spectrum disorders (ASDs) include the diagnoses of autistic disorder, Asperger's disorder, and pervasive developmental disorder-not otherwise specified (PDD-NOS). Two other diagnoses that are sometimes considered in the category are Rett syndrome and childhood disintegrative disorder, which are rare, regressive genetic conditions.

In 1943 Leo Kanner, an American psychiatrist, was the first doctor in the world to publish a paper about children with ASDs. Dr. Kanner gave children the label of autism, based on the term created by Dr. Eugen Blueler in 1912 as he described patients who were trying to escape from reality. In Austria, Dr. Hans Asperger also identified children with high-functioning ASDs and worked with Dr. Kanner to write the first medical papers on the subject.

People with ASDs can be very mildly to severely disabled. In the United States, 1 in 88 children is diagnosed with an ASD. People with ASDs have problems with social, communication, and behavior skills. They can repeat behaviors and might not like change in their routines. These people have different ways of reacting to things, learning, and paying attention.

Causes and Symptoms

ASDs have no single cause. Some studies strongly suggest that people are predisposed to having ASDs. In some cases, parents and other family members show mild behaviors that can be linked to autism. Researchers believe that genes and factors in the environment contribute to the disorders.

There are several signs that help identify that a person might have an ASD. This includes problems with his or her speech. Individuals with ASD also have the ability and tendency to repeat things. There is likelihood they will avoid eye contact or have atypical facial expressions. People with autism appear to be unaware or uninterested in other people and have trouble understanding other's feelings. At a young age, children with autism don't tend to play pretend, such as acting like an animal or feeding a doll. They also don't typically point to show interest, which is a typical behavior of young children. Many times people with autism react unusually to sensory input, like the way things smell, taste, look, feel, or sound.

A few main challenges exist for people with ASD. These challenges are in social communication and behaving like their peers. There are ranges of abilities and challenges within these categories. For example, one person with ASD might not be able to talk at all, while another can talk too much without much purpose. Also, one person with ASD might have a few close friends, while another doesn't know how to socialize at all. Therefore, every person with ASD will act a little bit differently than the other. The most common diagnoses among the ASDs are autistic disorder, Asperger's disorder, and PDD-NOS.

Diagnosis and Prognosis

Autistic disorder is usually diagnosed between the ages of 18 and 36 months. This diagnosis includes speech delay or loss of speech during early childhood. It also includes challenges in self-care like using the toilet and keeping clean. In some cases, people with autistic disorder can have lower intellectual levels than other people. Because of these things, people with autistic disorder are more severely disabled than some other people with ASDs. Children diagnosed at an early age will benefit from therapy or intervention in order to help build their skills. If they learn to speak and behave with progress, they can be less disabled and considered high functioning.

Asperger's disorder and PDD-NOS is usually diagnosed between the ages of seven and eight years. People diagnosed with Asperger's disorder are always able to speak but might not do it well. This means they can communicate but usually not to get their needs met. They also have average or above-average intellect, meaning they are as smart as or smarter than most other people. Because of this, people diagnosed with Asperger's disorder or PDD-NOS are considered high functioning.

Treatment

Autism is a lifelong condition that can be helped but not cured. Some people with autism can lead normal or near-normal lives. The best-studied therapies include behavioral, educational, and medical treatments. These include, but are not limited to, applied behavior analysis, special education, and drug therapy. Counseling and educating families affected by autism can help them cope, get treatment, and find support. Therefore, parent and caregiver treatment and involvement is an essential part of treating the person with autism.

Alexandra Cunningham, PhD

See also: Asperger's Syndrome; Autism Spectrum Disorders; Pervasive Developmental Disorders

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Autism Spectrum Disorders

Autism spectrum disorders (ASD) are developmental disabilities that affect a person's ability to communicate, socialize, and behave like most others.

Definition

- **Behavior** is an observable action demonstrated by a human or animal caused by either internal or external occurrences.

Description

Autism spectrum disorders and related conditions impact the neurodevelopment of a person from a young age. Those diagnosed with ASD usually have social and behavioral challenges. These challenges range from mild to severe. In the mildest forms, a person can have trouble making friends and can hyperfocus on areas of interest that are considered odd to others. In severe forms of ASD a person might not be able to speak and might engage in behaviors that result in serious injury. Therefore, people with this diagnosis are different in how they seem to others but overall have problems socializing and acting like their same-aged peers.

In 1943 Leo Kanner, an American psychiatrist, was the first doctor in the world to publish a paper about children with ASDs. Dr. Kanner gave children the label of autism, based on the term created by Dr. Eugen Blueler in 1912 as he described patients who were trying to "escape from reality." In Austria, Dr. Hans Asperger also identified children with high-functioning ASDs and worked with Dr. Kanner to write the first medical papers on the subject.

Causes and Symptoms

Autism spectrum disorders have no single cause. Some studies strongly suggest that people are predisposed to having ASDs. In some cases, parents and other family members show mild behaviors that can be linked to autism. Researchers believe that genes and factors in the environment contribute to the disorders.

People with ASDs can be very mildly to severely disabled. In the United States, 1 in 88 children is diagnosed with an ASD. People with ASDs have problems with social, communication, and behavior skills. They can repeat behaviors and might not like change in their routines. These people have different ways of reacting to things, learning, and paying attention.

There are several signs that help identify that a person might have an ASD, including lack of or delay in speech; repeats things; avoids eye contact; appears to be unaware or uninterested in other people; has trouble understanding other's feelings; doesn't pretend play (act like an animal or feed a baby doll); doesn't gesture

or point to show interest; reacts unusually to the way things smell, taste, look, feel, or sound and has trouble expressing their needs.

Three main challenges exist for people with ASD. These challenges are in communicating, socializing, and behaving like most others. There are ranges of abilities and challenges within these three categories. For example, one person with ASD might not be able to talk at all, while another can talk too much without making sense. Also, one person with ASD might have many friends, while another doesn't know how to socialize at all. Therefore, every person with ASD will act a little bit differently than the other. The most common diagnoses among the ASDs are autistic disorder, Asperger's disorder, and pervasive developmental disorder-not otherwise specified (PDD-NOS).

Diagnosis and Prognosis

Currently ASD identifies people of different abilities on a range of mild, moderate, or severe. In past years, ASDs have included the diagnoses of autistic disorder, Asperger's disorder, and PDD-NOS. Two other diagnoses that are sometimes considered in the category are Rett syndrome and childhood disintegrative disorder, which are rare, regressive genetic conditions. These labels are no longer used medically but could still be used in common language.

Severe forms of ASD, like the former autistic disorder, are usually diagnosed between the ages of 18 and 36 months. This diagnosis includes a speech delay or loss of speech during early childhood. It also includes challenges in taking care of oneself, like using the toilet and keeping clean. In some cases, people with autistic disorder can have lower intellectual levels than other people. Because of these things, people with autistic disorder are more severely disabled than some other people with ASDs. Children diagnosed at an early age will benefit from therapy or intervention in order to help build their skills. If they learn to speak and behave with progress, they can be less disabled and considered high functioning.

Milder forms of ASD, the former Asperger's disorder and PDD-NOS, are usually diagnosed between the ages of seven and eight years. People diagnosed with Asperger's disorder are always able to speak but might not do it well. This means they can communicate but usually not to get their needs met. They also have average or above-average intellect, meaning they are as smart as or smarter than most other people. Because of this, people diagnosed with Asperger's disorder or PDD-NOS are considered high functioning.

Treatment

ASDs are lifelong conditions that can be helped but not cured. Some people with ASDs can lead normal or near-normal lives. The best-studied therapies include behavioral, educational, and medical treatments. These include, but are not limited to, applied behavior analysis, special education, and drugs. Many treatments for ASDs exist, but few are supported by scientific evidence. Counseling families affected by ASDs can help them cope, get treatment, and find support.

Alexandra Cunningham, PhD

See also: Asperger's Syndrome; Autism; Pervasive Developmental Disorders

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Aversion Therapy

Aversion therapy is used to deter people from engaging in certain behaviors by exposing them to negative consequences to those actions.

Definitions

- **Aversion therapy** is a treatment in which the patient is discouraged from a behavior being subjected to a punishing stimulus when he or she engages in that behavior.

- **Desensitization techniques** are behavior change methods for reducing an individual's oversensitivity to fearful situations by intentionally and gradually exposing the individual to various emotionally distressing events.

Description

The purpose of aversion therapy is to decrease or stop certain behaviors by having a client associate unpleasant or painful experiences with doing the activity. For example, a bad-tasting substance might be placed on the tips of a person's fingers to discourage nail-biting or skin-chewing behaviors. Aversion therapy is a form of behavioral conditioning as it influences actions or behaviors through punishment. For much of its history, aversion therapy was dependent on the use of either chemical reactions or electric shock.

Aversion therapy has been widely used to help people stop the use of alcohol or other addictive drugs, from cigarettes (nicotine) to heroin (opioids). A specific example of chemical aversion therapy was the use of drugs like lithium with alcoholic clients. These chemicals induce nausea in those abusing alcohol so that they would associate the drinking of alcoholic beverages with the negative experience of vomiting.

In the case of electric shock aversion therapy, a patient who exhibits violent behavior might be made to watch images of violent crime while some kind of electrical shock is administered. The aim is that the association of engaging in the behavior with the negative experience of the electrical shock will help prevent the violent behaviors. Many behaviorists believe that the use of chemicals, electric shock, and other aversion therapies should only be used when the behaviors are more dangerous than the use of the aversive techniques.

Development

Aversion therapy began to be used in the 1930s to treat alcohol and drug-addicted patients. Later, it was extended to purely psychological conditions, such as homosexuality under the idea that homosexuality was freely chosen. During these years homosexuality was clinically classified as a mental health disorder. Any psychologically deviant behavior, like homosexuality, was subject to change through aversion therapy.

Aversion therapy with its strong connection to discomfort, pain, and punishment began to fall out of favor in the 1970s. Its controversial use with psychiatric patients and people diagnosed with homosexuality created problems among helping professionals. In 1973 the American Psychiatric Association removed homosexuality from the list of disorders in its *Diagnostic and Statistical Manual of Mental Disorders*. After this, aversion therapy began to be rejected as a valid approach to the treatment of homosexuality although it still persists in certain isolated pockets of society. Its association with abusive treatment of homosexuality has especially led to its being discredited and rejected.

Current Status

Currently, aversion therapy is still used especially for drug and alcohol treatment and among certain behavioral specialists. Aversion therapy is an unpleasant experience, by design, and such methods have often been judged to fall into the category of cruel or unusual punishment. Therefore, today it is usually based on the use of the imagination and the association of unpleasant images or memories with the undesirable behavior. This approach is called desensitization.

Covert desensitization is an approach that was elaborated by American psychologist Joseph Cautela. Using visual imagery techniques, he paired images of undesirable behavior, like smoking, with vivid pictures of aversive stimuli, like vomiting. This system is designed to counteract the positive responses that had been associated with the patient's previous behavior.

Alexandra Cunningham, PhD

See also: Covert Sensitization

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Avoidant Personality Disorder

Avoidant personality disorder is a mental disorder characterized by a pattern of social withdrawal, feelings of inadequacy, and oversensitivity to negative evaluation.

Definitions

- **Assertiveness training** is a behavior change method for increasing self-esteem and self-expression in intimidating interpersonal situations.
- **Desensitization techniques** are behavior change methods for reducing an individual's oversensitivity to fearful situations by intentionally and gradually exposing the individual to various emotionally distressing events.
- ***Diagnostic and Statistical Manual of Mental Disorders*** **(DSM)** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

The avoidant personality disorder is a personality disorder characterized by a pervasive pattern of social isolation, fearfulness, nonassertiveness, feelings of inadequacy, social awkwardness, and extreme sensitivity to criticism and rejection. Because individuals with this disorder believe they are socially inept, unappealing, or inferior, they fear being embarrassed, criticized, or rejected. So, when faced with the prospect of making new social contacts, they predictably say a quick "no" to new work or social relationships that may threaten their otherwise safe and controlled life space. The only exception is when they are certain of being liked and accepted by another. Both the avoidant personality disorder and the schizoid personality disorder are socially isolative. However, unlike those with schizoid personality disorder, avoidant individuals actually crave relationships and often have some friends with whom they feel safe. Those with avoidant personalities share some features with the dependent personality disorder. These include feelings of inadequacy and a lack of assertiveness.

The avoidant personality disorder is characterized by the following behavioral style, interpersonal style, thinking style, and feeling style. The behavioral style of avoidant personalities is characterized by social withdrawal, shyness, distrustfulness, and aloofness. Their behavior and speech is both controlled and inactive, and they appear nervous and awkward. Interpersonally, they are overly sensitive to rejection. Even though they desire acceptance by others, they keep distance from others and require unconditional approval before being willing to "open up." They often "test" others to determine who can be trusted to like them. Their thinking style is one of heightened alertness and self-doubt as they scan their emotional environment searching for clues of potential criticalness or rejection. Their feeling style is marked by shyness and nervousness. Since they have often experienced criticism, disapproval, and nonacceptance by others, they often experience feelings of sadness, tenseness, and loneliness.

The cause of this disorder is not well understood. Avoidant personality disorder is strongly associated with anxiety disorders and is associated with actual or perceived rejection by parents or peers during childhood. Furthermore, these individuals tend to have characteristic view of themselves, the world, and others, and a basic life strategy. They view themselves as adequate and frightened of rejection. They tend to view the world as unfair, demanding, critical, and

rejecting. Accordingly, their basic life strategy and pattern is to be vigilant, demand reassurance, and fantasize and daydream about being involved in safe and affirming relationships. So, it is not surprising that those with avoidant personalities are attracted to virtual relationships in romance novels and soap operas.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of being socially inhibited, feeling inadequate, and overly sensitive to the negative evaluations of others. This is typically because they view themselves as socially inept, unappealing, or inferior to others. They consistently avoid work activities that require close interpersonal contact for fear of being criticized or rejected. They will not get involved with others unless they are certain of being accepted. Fearing they will be shamed or ridiculed, they are uncomfortable and act with restraint in intimate relationships. In anticipation of shame or ridicule, they are uncomfortable and are hesitant in intimate relationships. Similarly, they experience feelings of inadequacy and inhibition in new interpersonal situations. Commonly, these individuals will refuse to take personal risks or engage in activities that may prove embarrassing.

Treatment

The clinical treatment of this disorder usually involves psychotherapy. A primary goal of therapy is to desensitize the individual to the criticism of others. Desensitization techniques are useful and effective in this regard. A related goal is to increase the individual's self-esteem, self-confidence, and assertiveness. Assertiveness training can also be effective in reversing an individual's avoidant and isolative pattern.

Len Sperry, MD, PhD

See also: Dependent Personality Disorder; Personality Disorders; Psychotherapy; Schizoid Personality Disorder

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Avoidant/Restrictive Food Intake Disorder

Avoidant/restrictive food intake disorder is a mental disorder characterized by avoiding or restricting food intake.

Definitions

- **Anorexia nervosa** is n mental disorder characterized by refusal to maintain minimal normal body weight along with a fear of weight gain and a distorted body image.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive (faulty) behaviors.
- **Bulimia nervosa** is a mental disorder characterized by recurrent binge eating with loss of control over one's eating and compensation for eating.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Feeding and eating disorders** are a class of DSM-5 mental disorders characterized by a persistent disturbance of eating that significantly

impairs physical health or everyday functioning. They include anorexia nervosa and avoidant/restrictive food intake disorder.

- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.
- **Systemic desensitization** is a behavioral technique in which an individual is gradually exposed to an object, place, or event that triggers anxiety, while engaging in some type of relaxation at the same time to reduce the symptoms of anxiety.

Description and Diagnosis

Avoidant/restrictive food intake disorder is one of the DSM-5 feeding and eating disorders. It is characterized by avoiding or restricting food intake. Common symptoms include not being able to eat certain foods based on their texture or aroma. Some individuals with this disorder may only like hot or cold foods or hard or soft foods. Others will refuse foods based solely on color. For example, an individual may not eat strawberries because he or she does not like the color red. In some cases, individuals will refuse entire food groups like vegetables and fruits. Individuals with this disorder may even limit certain food types based on specific brands (e.g., store brand name of a cereal versus Kellogg's brand cereal). Other symptoms include unfavorable reactions to foods, such as vomiting or gagging. Infants with this disorder may show signs of irritability and difficulty consoling during feeding times, and may appear uninterested or withdrawn.

The name of this disorder was replaced in the DSM-5. It was previously known as "Feeding Disorder of Infancy or Early Childhood" in the previous edition (American Psychiatric Association, 2013). DSM-5 has expanded the disorder to include adults as well as infants and children.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if an individual is avoiding or restricting the intake of food and fail to meet the necessary requirements for nutrition or sufficient energy. One of the following criteria is also needed for the diagnosis. The criteria are significant loss of weight, significant deficiency in nutrition, dependence on oral supplements, use of a feeding tube, or noticeable interference with psychosocial functioning. The disturbance does not occur solely in anorexia nervosa or bulimia nervosa. The diagnosis cannot be made if symptoms are the result of a medical condition or another mental disorder. The diagnosis must include the specifier, "in remission" if none of the criteria have not been met for an extended period (American Psychiatric Association, 2013).

The occurrence of this disorder most commonly occurs in early infancy or early adolescence but may persist into adulthood. Furthermore, avoiding or restricting foods may be based on sensory characteristics of foods introduced in the first decade of life but may occur as well into adulthood. In some cases, parent–child interaction may contribute to the infant's and adolescents' feeding problems (American Psychiatric Association, 2013). For example, presenting food to the child inappropriately or a parent interpreting a child's behavior as an act of regression or rejection may contribute to this disorder. Inadequate nutritional intake may worsen irritability and developmental delays for infants, adolescents, and adults. If child abuse or neglect is suspected as a cause of this disorder, changing caregivers has been shown to improve this disorder. No matter the age of an individual with this disorder, social functioning tends to be negatively affected.

Treatment

Psychotherapy is often effective in the treatment of individuals with this disorder. Cognitive behavior therapy is particularly effective for adults with this disorder. Behavioral therapy, particularly systemic desensitization, is an effective form of treatment for children with this disorder. It can help a child and parent

overcome feeding problems and the dislike and avoidance of certain foods. By changing the texture of foods and the pace and timings of the feedings, individual can and do improve.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Anorexia Nervosa; Behavior Therapy; Bulimia Nervosa; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Psychotherapy; Systematic Desensitization

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B

Baby Boomers

The term "Baby boomer" is used to describe a person who was born in the post–World War II era (1946–1964) during the time when the annual birth rate increased exponentially. This generation became a countercultural phenomenon in the United States and Europe as it progressed through adolescence and adulthood, having a historical impact and influencing both the civil rights and feminist movements.

Description

The *Oxford English Dictionary* cites the first recorded use of the phrase "baby boomer" in 1970 in an article in *The Washington Post*. The term has since been used commonly to describe this counterculture. According to the U.S. Census Bureau, "baby boom" refers to a 19-year period following World War II that was marked by a noticeable increase in the birth rate. This cultural phenomenon was documented in North America and Europe. In Canada, this group is referred to as "Boomies," and in Great Britain the time period is termed "the bulge." Historians and authors differ regarding time limits for the era as well as the reasoning for this population spike. Some historians attribute the boom to a desire for normalcy and sense of hopefulness about the future following 16 years of depression and war. Attainment of "the American Dream" felt possible. Others argue that the Cold War campaign urged Americans to outnumber communists. The baby boomer generation is made up of two broadly defined cohorts, the leading-edge boomers and the trailing-edge or late boomers. The leading-edge boomers, encompassing more than half of the generation, are individuals born between 1946 and 1955. The trailing-edge or late boomers are individuals who were born between 1956 and 1964. Subsegments of the generation have also been identified and include the following monikers: "golden boomers," "generation Jones," "alpha boomers," "yuppies," "zoomers," and "cuspers."

Approximately 76 million babies were born in the United States alone during the baby boom, comprising 40% of the total population. Such a rapid increase in population requires nations to prepare for the shift. As a result of the baby boom, many industries and corporations grew more profitable, in particular those associated with housing, retail, and technology. Suburban communities also exploded.

Boomers came of age during the 1960s and 1970s, periods of dramatic social change. Conservative and liberal views clashed. Political controversies were at the forefront: opposition to the Vietnam War, the civil rights movement, and the feminist cause. Thus, baby boomers changed the political landscape of the United States to some extent. This generation has been since associated with qualities such as independent thinking, ingenuity, and resistance to tradition.

Impact (Psychological Influence)

The baby boomers were the most successful, active, and well-educated generation up to that time and among the first to grow up genuinely expecting the world to improve with time. Nearly 90% of boomers completed high school, and almost 30% went onto pursue a college degree or higher. By comparison, Generation X, those born between 1965 and 1980, has been nowhere near as populous or prosperous as their parents. In fact,

the birth rate among Americans has dropped dramatically from around 25 per 1,000 in 1957 to 14 per 1,000 in 2011.

With the current average life expectancy projected to be age 75 for males and age 80 for females, boomers will continue to be a dominant force in society for years to come. The first baby boomers reached the standard retirement age of 65 in 2011. According to the Pew Research Center, in January 2015, the millennial generation (aged 18 to 34 in 2015) is expected to grow to 75.3 million, overtaking the projected 74.9 million boomers (aged 51 to 69). By 2030, about one in five Americans will be older than 65, and some experts believe that this will place a strain on social welfare systems.

Melissa A. Mariani, PhD

See also: Millennials

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Bandura, Albert (1925–)

Albert Bandura is a Canadian American psychologist who is best known for his development of social learning theory and the concept of self-efficacy. He is also known for the controversial 1961 Bobo doll experiment. He is ranked as the fourth most eminent psychologist of the 20th century.

Description

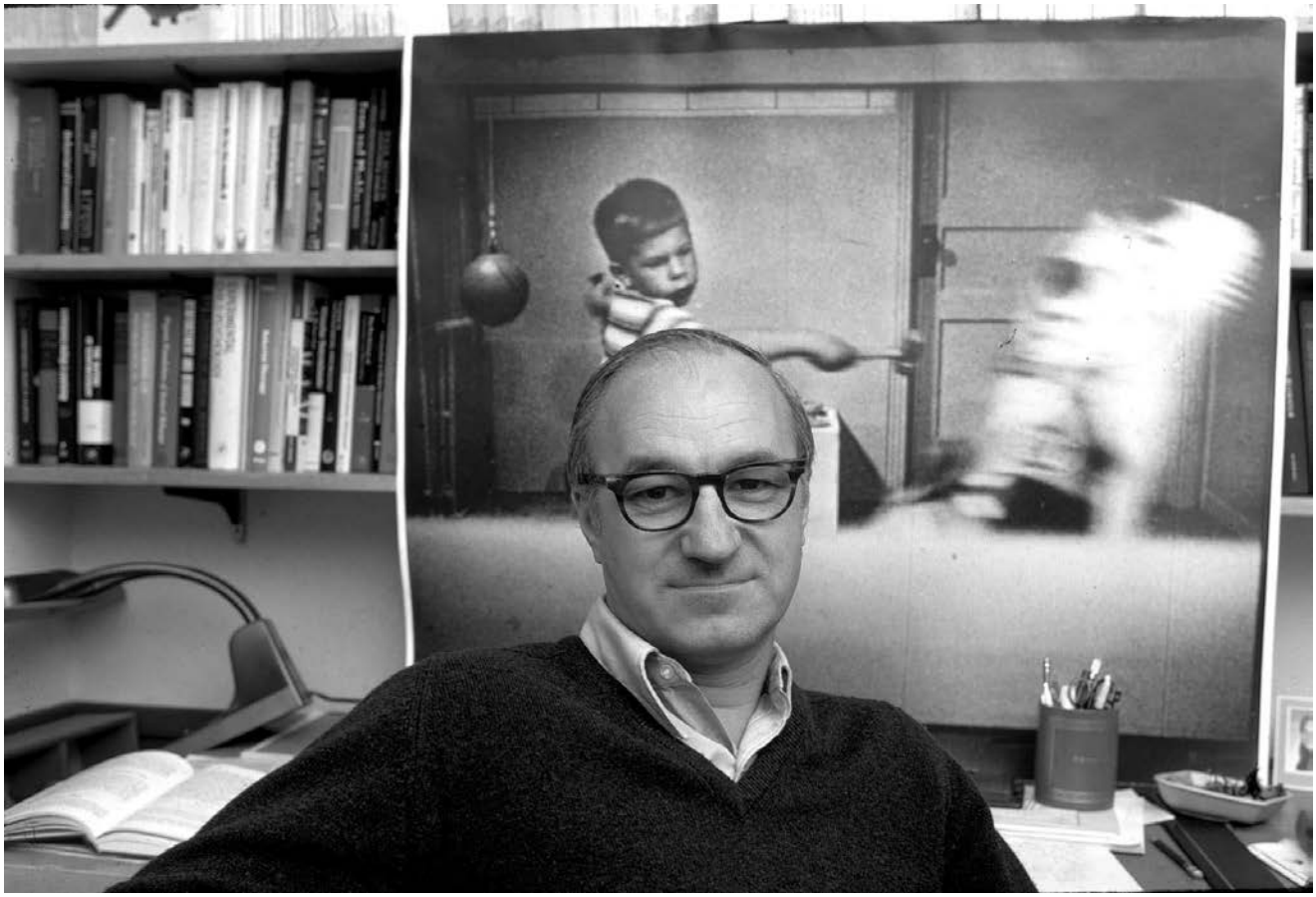
Albert Bandura was born in Mundare, Alberta, Canada, on December 4, 1925. He is of Ukrainian and Polish descent. He was the youngest of six children and the only male child. Mundare, Canada, was a remote town of fewer than 500 inhabitants with limited educational resources, and Bandura attended the one and only school. Due to a shortage of teachers and resources, learning was left to the student's own initiative and motivation. This early educational experience was to play a role in the development of Bandura's social learning theory.

After graduating from high school Bandura worked in the Yukon, repairing the Alaska Highway. Bandura found himself working alongside of criminals, draft dodgers, alcoholics, and other socially challenged individuals. Bandura credits this experience with his interest in psychopathology. Bandura enrolled at the University of British Columbia intending to study the biological sciences. After taking a psychology course just to fill a vacant time slot, he decided to pursue the subject for degree. He graduated in three years (1949) and received his first award: the Bolocan Award in psychology, given only to the top student in psychology. Bandura then attended the University of Iowa and in 1952 graduated with his PhD. Also in 1952 Bandura married Virginia Varns. The couple would have two children and were married for 59 years until Virginia's passing in 2011.

Impact (Psychological Influence)

After earning his doctorate degree Bandura was offered a position at Stanford University, where he continues to work to this day. Bandura began to investigate how family patterns lead to aggressive behavior in children. He discovered that children who behaved very aggressively had parents who had hostile and aggressive attitudes. Bandura concluded that children learned to be aggressive by observation and imitation. He called this process "social learning."

Bandura's early study into human behavior led to an experiment referred to as the "Bobo doll experiment." Using an inflatable doll one group of children was shown a film of a woman beating and yelling at the Bobo doll. Another group of children was not shown the film and another group shown a film of nonaggressive behavior toward the doll. After the film was watched, the children were allowed to play in a room that had a Bobo doll in it. The children who viewed the



Albert Bandura is a Canadian American psychologist, one of the most influential and distinguished of his time. Best known for his development of social learning theory and the concept of self-efficacy, he's also known for the controversial 1961 Bobo doll experiment, which observed aggressive behavior in children. (Jon Brenneis/Life Magazine/The LIFE Images Collection/ Getty Images)

film of aggressive behavior where much more likely to beat and yell at the doll, imitating the behavior they saw in the film. The other groups did not behave aggressively. The children who beat the Bobo doll did not receive any encouragement or incentives to do so. They did it on their own, simply by observing and then imitating the behavior they saw on the film. At the time most psychologists thought that all behavior had to be reinforced, or rewarded, before it was learned. Bandura's Bobo doll experiment demonstrated that behavior can be learned without being rewarded. This was a very new way of thinking about how people learn, develop, and behave as human beings. Although some people criticized the experiment for training children to act aggressively, the Bobo doll experiments are considered one of the great psychological experiments of the 20th century. In 1977 Bandura's book *Social Learning Theory* was published and had a significant impact on the direction of psychology during the 1980s.

Another significant contribution Bandura has made to the field of psychology is the development of the concept of self-efficacy. "Self-efficacy" refers to a person's attitude about himself or herself and belief in his or her own abilities to complete tasks and reach goals. Bandura demonstrated that people with high self-efficacy are able to accomplish their goals, are not overcome by obstacles, and are able to positively solve problems. People with low self-efficacy give up easily, feel helpless, and are unable to change situations to reach their goals.

Albert Bandura is one of the most influential and distinguished psychologists of the 20th and 21st

centuries. He has served on advisory boards, federal agencies, research panels, congressional committees, and commissions of the American Psychological Association. He has received more than 15 honorary university degrees recognizing his contributions to the field of psychology. He has received numerous awards for distinguished scientific contributions to the field of psychology and education. He is also the recipient of the Outstanding Lifetime Contribution to Psychology Award from the American Psychological Association.

Steven R. Vensel, PhD

See also: Social Learning Theory

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Barbiturates

Barbiturates are a class of prescribed drugs that slow the nervous system and are prescribed primarily for sedation, general anesthesia, and treating some types of epilepsy.

Definitions

- **Epilepsy** is a medical condition involving episodes of irregular electrical discharge within the brain that causes impairment or loss of consciousness, followed by convulsions.
- **Benzodiazepines** is a group of central nervous system depressants that are used to relieve anxiety or to induce sleep.
- **Seizure** is a sudden convulsion or uncontrolled discharge of nerve cells that may spread to other cells throughout the brain.
- **General anesthesia** is a drug-induced loss of consciousness and physical sensation.
- **Recreational drugs** refer to the use of a drug with the intention of creating a psychoactive or heightened psychological experience; typically, such use is illegal. These drugs are also called street drugs.

Description

The signature feature of barbiturates is their capacity to effectively depress the central nervous system and produce sedation. In the 1960s and 1970s barbiturates were commonly prescribed to treat anxiety and insomnia. However, because of their abuse potential, the prescription use of barbiturates has declined and the drug has been largely replaced by benzodiazepines. Today, barbiturates are used to sedate patients prior to surgery as well as to produce general anesthesia. They are also used to treat some forms of epilepsy. Barbiturates still in use include Fiorinal (generic name: butalbital) and Seconal (generic name: secobarbital) to treat insomnia and Nembutal (generic name: phenobarbital) to treat seizures.

These drugs are highly addictive and are often abused as recreational drugs. Although still commercially available, barbiturates are no longer routinely recommended for insomnia because of their ability to cause dependence, tolerance, and withdrawal. In general, barbiturates lose their efficacy when they are used to treat insomnia on a daily basis for more than two weeks. These drugs also have significant side effects when taken in large doses and can cause respiratory failure and death.

Precautions and Side Effects

Barbiturate abuse can occur when these drugs are taken for a prolonged period of time or in higher than prescribed doses. Long-term barbiturate use should be avoided unless there is a strong medical need, such as uncontrolled seizures. Women should not use barbiturates during pregnancy unless absolutely necessary. Those addicted to barbiturates while pregnant can give birth to addicted babies who may suffer withdrawal symptoms after birth. Women who are breast-feeding

should not take barbiturates because these drugs enter the breast milk and may cause serious side effects in the nursing baby. Children who are hyperactive should not receive phenobarbital or other barbiturates. Some children, paradoxically, become stimulated and hyperactive after receiving barbiturates. Elderly patients must be carefully monitored for confusion, agitation, delirium, and excitement if they take barbiturates. Barbiturates should be avoided in elderly patients who are receiving drugs for other mental disorders such as schizophrenia or depression. While taking barbiturates individuals should not drive, operate heavy equipment, or perform other activities requiring mental alertness.

The most common side effect of barbiturate use is drowsiness. Less common side effects include agitation, anxiety, breathing difficulties, clinical depression, constipation, confusion, dizziness, low blood pressure, nausea, decreased heart rate, nightmares, and vomiting. Rare side effects include fever, headache, anemia, allergic reactions, and liver damage. Overdosing on barbiturates or combining barbiturates with alcohol or other central nervous system depressants can cause unconsciousness and even death. Emergency medical treatment is needed for anyone who shows signs of an overdose or a reaction to combining barbiturates with alcohol or other drugs. Such signs include severe drowsiness, breathing problems, slurred speech, staggering, slow heartbeat, excessive confusion, and severe weakness.

Len Sperry, MD, PhD

See also: Seizures

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Beattie, Melody (1948–)

Born in 1948 in St. Paul, Minnesota, Melody Beattie rose to become a widely acclaimed self-help author, particularly among the addiction and recovery circles following the release of her international best seller, *Codependent No More*. The book was published in 1986 and has since sold more than 8 million copies and has been translated into several languages.

Description and History

Codependence is an unhealthy level of emotional or psychological dependence on a loved one whereby one or both individuals in the relationship need the other to feel fulfilled.

Beattie's firsthand knowledge of the difficulty of struggling with addictions began at an early age. After being abandoned by her father, kidnapped at age four, and later sexually abused by a neighbor, she began drinking while still in middle school. She became an alcoholic by the age of 13 and a drug addict by age 18. She started hanging out with a crowd that robbed pharmacies for drugs, and her criminal activity ultimately led her to enter a court-mandated treatment center.

Beattie is considered a beloved self-help author of more than two dozen books and is a household name in addiction and recovery circles. Through her international best seller and writing numerous other books, she has helped millions of followers by sharing her firsthand knowledge of addiction struggles. In addition to surviving abandonment, kidnapping, sexual abuse, and addiction, she has persevered through divorce and the death of a child. For many, her real-life experience gives her credibility and standing to tackle these difficult issues.

Beattie was motivated by her personal struggles of loving someone who suffers from addiction. She has been quoted as saying that there were many books out there about how to help an addict or an alcoholic, but no one was discussing how the addict impacts the lives of the people around him or her.

The concept that she writes about, codependency, is considered an integral part of the relationships among those with addiction or substance abuse issues. Beattie explains that codependent individuals frequently become obsessed with controlling the addict's behavior in an often futile attempt to keep that person from creating chaos and trouble.

Melody Beattie became a widely acclaimed self-help author, particularly among addiction and recovery circles, following the release of her international bestseller *Codependent No More* in 1986. She has since published several more books. (Michael Mauney/The LIFE Images Collection/Getty Images)

The term "codependence" emerged during the early 1980s and was often used to describe the spouse of an addicted individual. For example, a wife with an alcoholic husband focused her time and resources to making excuses to family and friends, buying alcohol, and keeping the peace within the family. Eventually, all of her activities began to revolve around her husband's drinking. A few of these codependent women founded Al-Anon in 1990, which offers support groups modeled after Alcoholics Anonymous as a way of supporting the needs of family members of alcoholics.

Mindy Parsons, PhD

See also: Addiction Counseling; Peer Groups; Psychoeducation; Psychoeducational Groups; Self-Help Groups

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Organizations

Al-Anon: Friends and families of problem drinkers find understanding and support at www.al-anon.org.

Al-Anon Family Group Headquarters, Inc.
1600 Corporate Landing Parkway

Virginia Beach, VA 23454-5617
Telephone: (757) 563-1600
Fax: (757) 563-1655

Co-Dependents Anonymous (known as CoDA) support groups and information for codependents are available at www.coda.org.

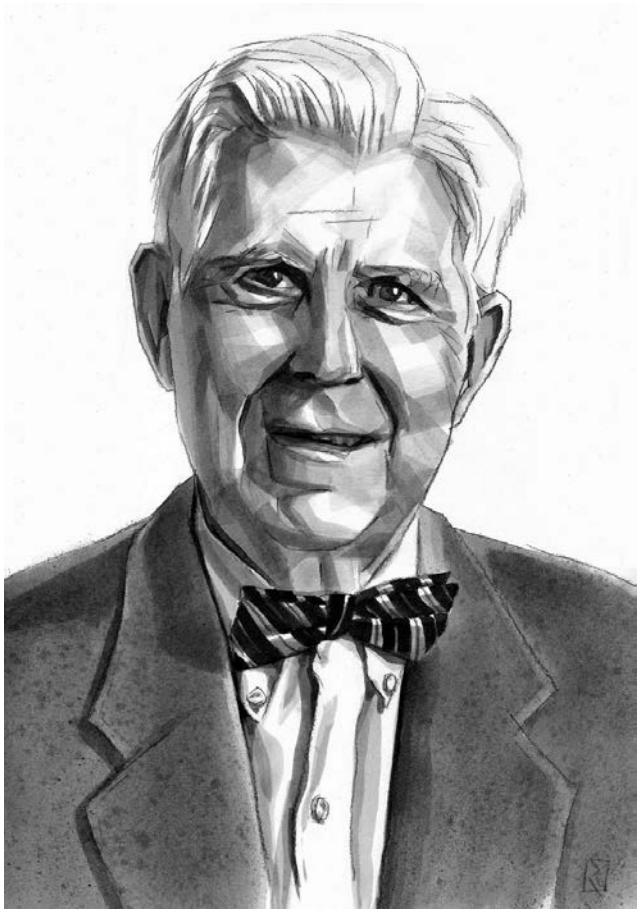
CoDA, Fellowship Services Office
PO Box 33577
Phoenix, AZ 85067-3577
Telephone: (602) 277-7991
Toll-free: (888) 444-2359

Beck, Aaron T. (1921–)

American psychiatrist, Aaron T. Beck, is credited as the "father of cognitive therapy" and is known for his extensive research into psychiatric illnesses and for developing various self-report measures to assess anxiety and depression.

Description

Aaron Temkin Beck, was born July 18, 1921, in Providence, Rhode Island, the third son to Russian Jewish immigrants, Elizabeth Temkin and Harry Beck. Two of Beck's siblings died before he was born. His early years were comfortable, growing up in a typical middle-class family and participating in Boy Scouts and athletics. However, at the age of eight he developed a serious staph infection, causing him to be hospitalized and drastically limiting his involvement in sports; he resorted to solitary activities like reading. This experience also resulted in Beck's overwhelming fear of blood, doctors, and hospitals, phobias he would later overcome by training himself to think rationally. Beck proved to be an exemplary student. He attended Brown University majoring in English and Political Science, was a member of the prestigious Phi Beta Kappa Society, served as an editor on *The Brown Daily Herald*, and received several accolades, including the Philo Sherman Bennett Essay Award Francis Wayland Scholarship, the William Gaston Prize for Excellence in Oratory, and the Francis Wayland Scholarship. He graduated magna cum laude from Brown University in 1942 and continued his education at Yale Medical School, completing his MD in 1946. He did his residency at the Rhode Island Hospital. During his schooling he was trained in the use of medication and psychoanalytic therapy, approaches that he came to believe lacked the ability to empower people to help themselves and take control of their psychological ailments. After graduation, he serviced in the U.S. military as assistant chief of neuropsychiatry at Valley Forge Army Hospital. Aaron married Phyllis in 1950 and the couple went on to have four children. In 1954, he joined the faculty at the University of Pennsylvania, where he later developed his approach



Aaron T. Beck is considered "the father of cognitive therapy" and known for his extensive research into psychiatric illnesses and for developing various self-report measures to assess anxiety and depression. (Jan Rieckhoff/ullstein bild via Getty Images)

while conducting multiple studies on patients suffering from chronic depreson. This approach, which he termed "cognitive therapy" (CT), is a type of talk therapy that employs problem-solving techniques by challenging clients' negative "automatic thoughts" in order to alter faulty thinking, instill hope, and restore a positive outlook on recovery. Cognitive therapy has proven effective in treating a variety of psychological disorders, including anxiety, depression, post-traumatic stress, substance abuse problems, eating disorders, schizophrenia, and suicidal ideation. CT is noted for its solid research support, and is also a cost-effective, time-conscious, and longer-lasting treatment.

Impact (Psychological Influence)

Dr. Beck and his daughter, Dr. Judith Beck, founded the *Beck Institute for Cognitive Behavior Therapy and Research* in Philadelphia in 1994, where he still serves as President Emeritus and his daughter as president. The institute continues to conduct research and provide training and therapy to professionals, educators, and clients from all over the world. He is also director of the *Aaron T. Beck Psychopathology Research Center* at the University of Pennsylvania. Beck has taught at Oxford, Temple, and the University of Medicine and Dentistry of New Jersey, in addition to his long-standing presence at Penn where he presently serves as Professor Emeritus of Psychiatry. He has received honorary degrees from the University of Pennsylvania, Yale University, Brown University, Philadelphia College of Osteopathic Medicine, and Assumption College. A variety of self-report measures to gauge anxiety and depression were developed by Dr. Beck, including the widely used Beck Depression Inventory, as well as the Beck Hopelessness Scale, Beck Scale for Suicidal Ideation, and Beck Anxiety Inventory. Beck has authored or coauthored over 600 professional journal articles and 25 books, some of which include *Cognitive Therapy and the Emotional Disorders, Depression: Causes and Treatment, Cognitive Therapy of Anxiety Disorders: Science and Practice*, and *Anxiety Disorders and Phobias: A Cognitive Perspective*. Dr. Beck's accomplishments are substantial, and he has been the recipient of many awards such as the Heinz Award in the Human Condition, Kennedy Community Mental Health Award, the Albert Lasker Clinical Medical Research Award, the Anna-Monika Prize, the Adolf Meyer Award, and the Morselli Medal for Lifetime of Research in the Field of Suicide. Cognitive therapy is the most widely used and rigorously studied psychotherapy approach to date. It has profoundly impacted the psychological health of millions of people worldwide so much so that *The American Psychologist* deemed Dr. Aaron T. Beck as "one of the five most influential psychotherapists of all time."

Melissa A. Mariani, PhD

See also: Anxiety Disorders in Adults; Cognitive Therapies; Depression

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Beck Depression Inventory

The Beck Depression Inventory is a widely used clinical measure (questionnaire) of depression.

Definitions

- **Cognitive therapy** is a psychological treatment that focuses on changing cognitive beliefs and thinking patterns to produce behavioral change.
- **Depression** is a mental condition characterized by sadness and loss of interest in life, sleep problems, loss of appetite, loss of concentration, and even thoughts of self-harm.
- **Dysthymic disorder** is a less severe but chronic (ongoing) form of depression.

Description

The Beck Depression Inventory (BDI) is a 21 multiple-choice questionnaire developed to measure the intensity, severity, and depth of depressive symptoms in individuals between the ages of 13 and 80 years. The BDI serves at least two purposes: first, to detect or screen for depression in mental health and primary care settings; and second, to assess and monitor for changes in depressive symptoms. The BDI usually takes between 5 and 10 minutes to complete as part of a psychological or medical examination. The paper and pencil or computer version is either filled out by an individual (self-report) or administered verbally by a trained professional. The BDI also helps measure symptoms related to depression such as fatigue, irritability, guilt, weight loss, and apathy. A shorter form is also available; it is composed of seven questions or items and is used primarily to screen for depression in primary care settings.

Developments and Current Status

The BDI was developed and published in 1961 by Aaron T. Beck, MD (1921–), the founder of cognitive therapy. It was adapted in the 1970s and copyrighted in 1978 (BDI-1A). A more recent version (BDI-II) was developed and published in 1996 by Beck, Robert A. Steer, and Gregory K. Brown. The BDI is divided into two subscales. The affective subscale consists of eight items that measure psychological, or mood, symptoms. These items include negative thoughts involving. pessimism, past failures, guilty feelings, punishment feelings, self-dislike, self-criticalness, suicidal thoughts, and worthlessness. The other subscale focuses on somatic or physical symptoms. It has 13 items, such as loss of energy, agitation, and indecisiveness.

The long form of the BDI is composed of 21 questions, each with four possible responses. Each response is assigned a score ranging from zero to three, indicating the severity of the symptom that the patient has experienced over the past two weeks. The sum of all BDI item scores indicates the severity of depression. The test is scored differently for the general population and for those who have been clinically diagnosed with depression. For the general population, a score of 21 or over represents depression. For those who were clinically diagnosed with depression, BDI-II scores from 0 to 13 represent minimal depressive symptoms, scores of 14 to 19 indicate mild depression, scores of 20 to 28 indicate moderate depression, and scores of 29 to 63 indicate severe depression. The BDI can distinguish between different subtypes of depressive disorders, such as major (severe) depression and dysthymic disorder.

The BDI has been shown to be valid and reliable, with results corresponding to clinician ratings of depression in more than 90% of all cases. Finally, it should be noted that the BDI is one of the most widely used assessment tests by medical and mental health professionals and researchers for measuring depressive symptoms.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Depression and Depressive Disorders; Persistent Depressive Disorder

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Behavior Therapy

Behavior therapy is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.

Definitions

- **Behavior modification** is the use of learning principles to increase the frequency of desired behaviors and decrease the frequency of problem behaviors.

- **Behavioral analysis** is a type of assessment that focuses on the observable and quantifiable aspects of behavior and excludes subjective phenomena such as emotions and motives.
- **Dialectical behavior therapy** is a type of cognitive behavior therapy that focuses on learning skills to cope with stress, regulate emotions, and improve relationships.
- **Mindfulness** refers to paying attention in a particular way that is intentional, in the present moment, and nonjudgmental.
- **Reinforcement** is a behavioral modification process in which certain consequences (effects) of behavior increase the probability that the behavior will occur again.
- **Shaping** is a behavioral modification process for reinforcing responses that come sufficiently closer to the desired response.

Description

Behavior therapy (BT) is a treatment approach based on the assumption that behavioral (including emotional) problems are learned responses to the environment and can be unlearned. Traditional BT focuses only on observable behavior and so ignores mental processes. Thus, instead of uncovering and understanding the unconscious processes that underlie maladaptive behavior, behavioral therapists assist clients in directly modifying the maladaptive behavior or developing a new, adaptive behavior. Basic to BT is the antecedent-behavior-consequence model of behavioral analysis, which describes the temporal sequence of a problematic behavior in terms of its "antecedents" (stimulus situation that cues or triggers behavior), "behaviors" (the problematic behavior itself), and "consequences" (the effects or outcomes that follow the behavior). Three types of behavior problems can be identified from this analysis: behavior excesses, deficits, or inappropriateness. Core concepts of BT include respondent and operant conditioning and positive and negative reinforcement.

Various strategies are utilized in traditional BT to promote the desired (new or modified) behavior. These include shaping the consequences (effects or outcomes) of a behavior so that a desired behavior is reinforced and the undesired ones are extinguished. The desired behavior is then rehearsed (practiced). In addition, therapeutic interventions such as skill training, exposure, response prevention, emotional processing, flooding, systematic desensitization, and homework are used to achieve specific therapeutic outcomes.

Developments and Current Status

BT has evolved over the years. A useful way of understanding this evolution is in terms of its "three waves." The first wave emphasized traditional BT, which focused on replacing problematic behaviors with constructive ones through classical conditioning and reinforcement techniques. Joseph Wolpe (1915–1997) pioneered classical conditioning, particularly systematic desensitization. Traditional BT was a technical, problem-focused, present-centered approach that contrasted with other therapy approaches. The second wave involved the incorporation of the cognitive therapies. These cognitively oriented approaches focused on changing problematic feelings and behaviors by changing the thoughts that cause and perpetuate them. CBT, which was an integration of both behavioral and cognitive techniques, emerged during this phase. The third wave involved the reformulation of conventional CBT approaches. Third-wave approaches were and are more experiential and indirect and utilizes techniques such as mindfulness, dialectics, acceptance, values, and spirituality. Unlike the first and second waves, third-wave approaches emphasize second-order change, that is, basic change in structure and/or function, and are based on contextual assumptions, including the primacy of the therapeutic relationship. Next is a description of CBT followed by descriptions of three common third-wave approaches.

Cognitive Behavior Therapy

Cognitive behavior therapy (CBT) is a psychotherapy approach that addresses maladaptive (faulty) behaviors, emotions, and thoughts with various goal-oriented,

explicit systematic interventions. The name refers to behavior therapy, to cognitive therapy, and to therapy based on a combination of basic behavioral and cognitive principles and research. Many therapists working with individuals dealing with anxiety and depression use a combination of cognitive and behavioral therapy. CBT acknowledges that there may be behaviors that cannot be controlled through rational thought. CBT is "problem focused" (undertaken for specific problems) and "action oriented" (therapist tries to assist the client in selecting specific strategies to help address those problems). CBT is thought to be effective for the treatment of a variety of conditions, including mood, anxiety, personality, eating, substance abuse, tic, and psychotic disorders. Many CBT treatment programs for specific disorders have been developed, evaluated for efficacy, and designated as evidence-based treatment. CBT is the most commonly practiced therapy approach in North America.

CBT was developed through an integration of cognitive therapies with behavior modification in the late 1970s. The term "cognitive-behavior modification" was first used by psychologist Donald Meichenbaum (1940–). The cognitive therapies include cognitive therapy, which was developed by Aaron Beck, and rational emotive behavior therapy, which was developed by Albert Ellis. While rooted in rather different theories, these two traditions have been characterized by a constant reference to experimental research to test hypotheses, at both clinical and basic levels. Common features of CBT include its focus on the present, the directive role of the therapist, structuring of the psychotherapy sessions, and on alleviating symptoms.

Dialectic Behavior Therapy

Dialectic behavior therapy (DBT) was developed for the treatment of borderline personality disorder by American psychologist, Marsha Linehan (1943–). More recently, it has been modified and extended for use with other personality disorders as well as Axis I or symptom disorders such as mood disorders, anxiety disorders, eating disorders, and substance disorders. DBT is an outgrowth of BT but is less cognitive than traditional CBT since DBT assumes that cognitions are less important than emotional regulation. Four primary modes of treatment are noted in DBT: individual therapy; skills training in a group, telephone contact, and therapist consultation.

Cognitive Behavior Analysis System of Psychotherapy

Cognitive behavior analysis system of psychotherapy (CBASP) is a form of CBT that was developed by the American psychologist James P. McCullough (1942–). Basic to this approach is a situational analysis that combines behavioral, cognitive, and interpersonal methods to help clients focus on the consequences of their behavior and to use problem solving for resolving both personal and interpersonal difficulties.

The goal of CBASP is to identify the discrepancy between what clients want to happen (the desired outcome) in a particular situation and what has happened or is actually happening (the actual outcome). Treatment consists of two phases: elicitation and remediation. Elicitation involves a detailed analysis of a specific situation. In remediation, behaviors and thoughts are therapeutically processed so that new behaviors and thoughts will result in their desired outcome.

Mindfulness-Based Cognitive Therapy

Based on the mindfulness teachings of Thich Nhat Hanh (1926–), psychologist Jon Kabat-Zinn (1944–) developed what he called mindfulness-based stress reduction in 1979. This method uses mindfulness techniques to reduce stress associated with various medical conditions. Based in part, on this method, psychologist Zindel Segal (1956–), and his colleagues Mark Williams and John Teasdale, developed mindfulness-based cognitive therapy (MBCT). It was first described in their book, *Mindfulness-Based Cognitive Therapy for Depression* in 2002. MBCT is an adjunctive (extra) or standalone form of treatment that emphasizes changing the awareness of, and relation to, thoughts, rather than changing thought content. It offers clients a different way of living with and experiencing emotional pain and distress. It fosters a detached attitude toward negative thinking and provides the skills to prevent escalation of negative thinking at times of potential relapse. Clients engage in various formal meditation practices

designed to increase moment-by-moment nonjudgmental awareness of physical sensations, thoughts, and feelings. Assigned homework includes practicing these exercises along with exercises designed to integrate application of awareness skills into daily life. Specific prevention strategies derived from traditional CBT methods are incorporated in the later weeks of the program.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Cognitive Therapies; Dialectical Behavior Therapy; Mindfulness; Mindfulness-Based Psychotherapies

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Behavior Therapy with Children

Behavior therapy with children uses techniques of behavior modification to replace bad habits with acceptable ones.

Definitions

- **Antecedent** is something that occurs before a behavior and includes places, people, and things involved in the environment.
- **Behavior** is an observable action demonstrated by a human being or an animal caused by either internal or external occurrences.
- **Consequence** is the result or outcome that occurs after a behavior is demonstrated.
- **Reinforcement** is the result of a behavior that will strengthen the likelihood of the behavior to happen again in the future.

Description

The aim of behavior therapy with children is to identify and foster the development of personal coping strategies that can replace negative behaviors. The most effective treatments involve the child, parents, teachers, and therapists. All those involved must be taught by a trained therapist about which behavioral interventions are most effective.

Behavior therapy with children focuses on three key elements, which are the antecedent, behavior, and consequence. In the field it is important to identify what happens right before, the antecedent, and after, the consequence, the behavior. This approach is referred to as the antecedent-behavior-consequence model of intervention. It is commonly used in behavior therapy with children to create effective programs at home, in school, and in the community.

One subtype of behavior therapy commonly used with children is applied behavior analysis (ABA). It is one of the most well-researched and supported types of behavior therapy with children. Its goal is to help teach children a variety of ways of responding to challenges in a more positive way. In order to begin behavior therapy, several observations and assessment of a situation have to occur to help identify the function or the purpose of the behavior. Within ABA there are clearly identified reasons why behavior occurs. Some of these include a child's need for attention, to escape, to gain access, and/or to satisfy a sense or physical response like pain. The goal of this therapy is to identify one or many of these reasons for behavior and replace negative behaviors with more positive ones. This occurs often through positive reinforcement, which helps to increase a desired behavior and decrease problem behavior.

Another subset of behavior therapy is cognitive behavior therapy (CBT), which focuses on helping children to identify and improve their thoughts and behaviors. CBT teaches children and teens how to recognize what might trigger undesirable responses and avoid those circumstances. This approach requires that a child have the ability to identify thoughts and consequences. Therefore, CBT can be most effectively used with older children and with parents who can be actively involved.

In behavior therapy for children, several strategies are used. Modeling, role-playing, rehearsal, and rewards are some of them. As an example, role-playing is used to practice interaction with others around real issues in structured situations. This is one example of how children can learn that positive behaviors work and negative behaviors will not result in the same rewards.

Development

One of the founders of behavior therapy with children is considered to be Dr. B.F. Skinner, who identified some of the basic theories of how we learn. Yet before him Dr. John B. Watson was one of the first clinicians to directly use behavior therapy with children in the 1920s. Dr. Watson studied the effects of behavioral conditioning on helping children with phobias or fears. In 1953, Skinner published his first influential book, *Science and Human Behavior*, which included his view on working with children.

Until the late 1970s, behavior therapy was mostly applied in treatment with severely problematic children. Gradually, the work began to be applied to children with different ranges of cognitive and emotional problems. One great success has been in work with children diagnosed with attention-deficit hyperactivity disorder, where behavior therapy can bring positive changes in social relationships and daily functioning.

Behavior therapy has also been used extensively with children on the autism spectrum with positive results. Many practitioners and researchers specifically refer to ABA therapy as one of the most effective treatments for autism. In all cases, when therapy is extended through training both parents and teachers, its benefits are seen in the entire family constellation as well as broadly in the school environment.

Current Status

Today, the field of behavior therapy, especially in the forms of ABA and CBT, is a major part of the treatment protocols for child and adolescent psychology and psychiatry. Ensuring that the child gets the help appropriate to his or her age and circumstances is important in behavior therapy. The younger the child when treatment begins, the greater the chances of behavior therapy being effective. Behavior therapy is proven to work on its own with several populations and groups of children with certain diagnoses. However, there are still cases where a combination of medication and therapy may help behavior changes occur more effectively.

The focus of behavior therapy should always be on treating the child with respect and positive regard. A current focus in behavior therapy is on positive behavior systems and supports. This has helped to put behavior therapy with children into a better position for its introduction into schools and parenting. Many children with different issues benefit from behavior therapy, and it is considered one of the most helpful and effective treatments for young children with a range of challenges.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Applied Behavior Analysis; Attention-Deficit Hyperactivity Disorder in Youth; Autism Spectrum Disorders; Cognitive Behavior Therapy; Skinner, B.F. (1904–1990)

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Behavioral Activation

Behavioral activation is a brief, structured treatment approach that activates those who are depressed so they can again experience pleasure and satisfaction.

Definitions

- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors.
- **Cognitive behavior therapy** is psychotherapy approach that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as cognitive behavioral therapy.

- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing distorted thinking patterns.
- **Depression** is an emotional state that is characterized by feelings of low self-worth, guilt, and a reduced ability to enjoy life.
- **Positive reinforcement** is a way of increasing the strength of a given response by rewarding it.

Description

Behavioral activation is a brief, behavioral treatment for depression that activates individuals in specific ways so they can again engage in pleasant activities. As a result they begin to reexperience pleasure and satisfaction and their depression lifts. Behavioral activation is based on a behavioral theory of depression. In this theory, as individuals become depressed, they increasingly withdraw from their environment, engage in escape behaviors, and disengage from their routines. Depression typically leads to withdrawal, avoidance, and inactivity. This prevents them from experiencing positive reinforcement that provides satisfaction and the desire to be active and involved. Over time, this avoidance exacerbates depressed mood, as individuals lose opportunities to be positively reinforced through pleasurable experiences and social activity, or experiences of mastery.

Behavioral activation treatment is a set of techniques for helping individuals to overcome this pattern. Therapists help their clients to set weekly goals, to identify possible sources of positive reinforcement, and to schedule and structure their activities. Clients are encouraged to develop a list of activities that they enjoy or need to engage in as part of their normal life. Then, beginning with the easiest activities on the list, the individual agrees to carry them out in a systematic way. This reinstates contact with the naturally occurring positive reinforcement of the given activity, which in turn helps overcome the depressed mood.

Developments and Current Status

In the mid-1970s, Peter M. Lewinsohn (1939–), an American psychologist, described a behavioral theory of depression. He speculated that depression reflects low levels of positive reinforcement and high levels of aversive (negative) control. These were due to problems in the environment or to underdeveloped coping skills. Accordingly, he developed a treatment to increase pleasant activities for depressed individuals. As they engaged in an increasing number of pleasant activities, their rate of positive reinforcement began to increase. As activation increased, their symptoms of depression decreased. Unfortunately, his theory and approach was overshadowed in the 1980s and 1990s by the development of Aaron T. Beck's (1921–), cognitive therapy (CT) approach for understanding and treating depression. CT and cognitive behavior therapy (CBT) became known as the most effective treatments for depression. However, in 1996, psychologist Neil S. Jacobson (1949–1999) reported research on the effectiveness of CBT for depression. It showed no differences in treatment outcome between CBT and behavioral activation. A subsequent study showed that behavioral activation was as effective as antidepressant medications for mild to moderate depression. These and subsequent studies have led more therapists to use behavioral activation. Behavioral activation is utilized as either a standalone treatment or an adjunctive (additional) treatment combined with CT, CBT, or other approaches.

Len Sperry, MD, PhD

See also: Behavior Therapy; Cognitive Behavior Therapy; Cognitive Therapies; Depression

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Behavioral Assessment

Behavioral assessment is a form of assessing an individual's behaviors in a specific problem situation.

Definitions

- **Assessment** is the measurement, observation, and systematic evaluation of an individual's thoughts, feelings, and behavior in the actual problem situation.
- **Traits** are patterns of behavior, thought, and emotion, which are stable over time, differ across individuals, and influence behavior.

Description

Behavioral assessment is an approach to assessment that focuses on overt behaviors and the identification of its antecedents (triggers) and consequences (effects) in a problematic situation. The purpose of this assessment is to devise a behavioral plan to correct the problem situation. Correctly identifying the antecedents and consequences points to the function or "why" of the behavior. Behavioral assessment involves observing or otherwise measuring an individual's actual behavior in the specific settings where the individual experiences a behavioral difficulty. Once the behavior is defined and measured, careful consideration is given to factors that may be reinforcing and maintaining the behavior. Specific measures are selected based on the behavior and its context in order to analyze the target behavior prior to, during, and after. This information is used in developing a detailed plan containing strategies for changing or replacing the behavior.

Behavioral assessment typically involves one or more behavioral interviews and observations, and includes direct observation and indirect methods. Direct observation focuses on a specific behavior: frequency (how often a behavior occurs), magnitude (how intense it is), and duration (how long it lasts). Direct observation often includes "anecdotal recording," which involves recording a pattern of behavior using an antecedent-behavior-consequence format. In doing an anecdotal observation, the observer records all behaviors observed, and what was observed to occur before and after the behaviors. For example, if a child is observed to slam the door to his or her bedroom, the observer should record "slammed bedroom door shut" rather than "child frustrated." Then the observations are arranged into a chart which specifies behaviors, antecedents (what happened prior to the behavior), and consequences (what happened as a result of the behavior). Also tracked are the times at which behaviors were observed. Indirect methods include checklists and rating scales. Examples of checklists and rating scales used with children include the Revised Behavior Problem Checklist, the Behavioral Assessment System for Children, and the Behavior Evaluation Scale.

Developments and Current Status

Behavioral assessment evolved from the field of behavior therapy as an alternative to traditional assessment approaches. Traditional assessment approaches were based on the trait model where inferred traits were used to explain and predict behavior of individuals across various contexts and situations. This model had limited utility for behavior therapists and researchers who viewed personality as the total of an individual's habit patterns and behavior. They valued observable phenomena and verifiability of observations and subsequently developed behavioral assessment.

There are two broad categories of behavioral assessment generally: clinical behavioral assessment and functional behavioral assessment (FBA). Clinical behavioral assessment is conducted for problem behaviors exhibited in home, school, work, or other settings, to provide a clear intervention plan for therapists, case managers, family members, or others who work with the individual being evaluated. FBA is an approach used with children who demonstrate chronic behavior problems. It focuses on patterns of behavior and the identification of their purpose or their function. For example, the function might be to avoid something, to get something, or to make something happen. The function is inferred from the carefully observed and analyzed sequence of behavior. FBAs are conducted by a school system when students with disabilities or suspected of having a disability are demonstrating

inappropriate behaviors. By federal law, school districts are required to perform FBAs as part of the Individuals with Disabilities Education Act.

Len Sperry, MD, PhD

See also: Diagnosis

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Behavioral Health

Behavioral health is a health-care specialty that focuses on behavior and its effect on mental and physical well-being. It is sometimes referred to as mental health.

Definitions

- **Behavioral health care** is the continuum of health-care services for individuals who suffer from, or are at risk of, mental, behavioral, or addictive disorders.
- **Behavioral medicine** is the interdisciplinary health-care specialty, which integrates knowledge and techniques from behavioral and biomedical science and applies this knowledge and techniques to the diagnosis, treatment, rehabilitation, and prevention of medical conditions.
- **Health Maintenance Organization** is an organization that provides or manages health-care delivery to control costs (managed care).
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Medical cost offset** is the cost savings that occurs when the use of medical services decreases as a result of mental or behavioral health interventions.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Behavioral health is specialty area of health care that addresses the influence and effect of behavior on mental and physical well-being. Over the past decade, the term "behavioral health" is gradually replacing the term "mental health." "Behavioral health" is a broad term that encompasses mental health, psychiatric, marriage and family counseling, and addiction treatment. It includes services provided by psychologists, counselors, psychiatrists, social workers, neurologists, and physicians.

Behavioral health promotes a philosophy of health that emphasizes individual responsibility in the application of behavioral and biomedical science, knowledge, and techniques to the maintenance of health and the prevention of illness and dysfunction with self-initiated, health-enhancing activities. These activities include healthy eating, exercising, no smoking, positive attitude, and limited use of alcohol. Behavioral health is a specialty area of behavioral medicine.

Developments and Current Status

Psychologist Joseph D. Matarazzo (1925–) first defined the health-care specialty of behavioral health in 1979. He distinguished it from the field of behavioral medicine, which was formally introduced in 1978 by the newly formed Society of Behavioral Medicine. Since then, much of the vision, training, clinical practice, and research on behavioral health and medical offset originated with psychologist Nicholas Cummings (1924–). Cummings is considered by many the father of behavioral health-care practice.

Given the changes already noted, it appears that behavioral health practice will become a dominant force in health care. To the extent that behavioral health practice becomes the norm, the practice of

psychotherapy and psychological treatments within an integrated health-care setting will be notably different. Shorter and more focused psychological and psychotherapeutic interventions will replace the traditional 50-minute psychotherapy hour. As reimbursement shifts to favor integrated health care, increasing numbers of psychotherapists will work in primary care settings, with smaller numbers in clinics, agencies, or private practice.

Len Sperry, MD, PhD

See also: Behavioral Medicine; Integrative Health; Psychotherapy

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Behavioral Medicine

Behavioral medicine is the interdisciplinary approach to understanding, preventing, diagnosing, and treating medical conditions with behavioral aspects.

Definitions

- **Behavioral** describes the way someone responds to his or her environment. It is also referred to as psychological.
- **Biomedical** is the involvement of biological, medical, and physical sciences.
- **Biopsychosocial** refers to biological, psychological, and social factors.
- **Cochrane Reviews** are evidence-based reviews of health care and health policy research that addresses prevention, treatment, and rehabilitation.
- **Interdisciplinary** is the integration of two or more scientific or educational areas of knowledge.
- **Rheumatic heart disease** is a heart condition caused by rheumatic fever, which is triggered by a preventable infection. The disease is more prevalent in impoverished countries and communities.

Description

Behavioral medicine is the field of medicine that integrates behavioral and biomedical scientific knowledge. It focuses on the role that behavioral factors play in the cause, treatment, and prevention of medical conditions. It also promotes the communication of theory and research, and its application, among the professional fields, particularly medicine and psychology.

The term "behavioral medicine" was first used in 1973 in the title of the book *Biofeedback: Behavioral Medicine* by psychiatrist Lee Birk (1936–2009). It was also used in the names of two organizations, Center for Behavioral Medicine and Study of Behavioral Medicine. The first definition of behavioral medicine was established in 1976 when psychologists Gary E. Schwartz (1944–) and Stephen Weiss held a conference at Yale University for a diverse group of behavioral and biomedical professionals. Together these scientists developed an interdisciplinary definition for the new field of behavioral medicine. They arrived at this definition: "Behavioral medicine is the field concerned with the development and integration of behavioral and biomedical science knowledge and techniques relevant to health and illness and the application of this knowledge and these techniques to prevention, diagnosis, treatment, and rehabilitation. Psychosis, neurosis and substance abuse are included only insofar as they contribute to physical disorders as an end point" (Schwartz and Weiss, 1977, 3). This definition focuses on health as well as illness. Schwartz and Weiss believed the integration of behavioral science and medicine would result in greater knowledge with broader application.

Two examples in which behavioral medicine is used to study and treat physical illness are high blood pressure (hypertension) and rheumatic heart disease.

Behavioral medicine research incorporates the impact of biological, psychological, behavioral, social, environmental, and cultural influences on the occurrence, pattern, treatment, and management of these diseases. Behavioral medicine does not include research on mental illness (i.e., psychosis and neurosis), substance abuse, mental retardation, and social welfare issues (see the previous paragraph).

The advent of behavioral medicine promoted the development of interdisciplinary scientific journals that offer a central venue for behavioral and biomedical researchers to publish scientific findings. It also promoted the development of interdisciplinary organizations that united researchers, practitioners, and educators from different fields. The National Institutes of Health created the Office of Behavioral and Social Sciences Research to coordinate research between the behavioral and social sciences. Finally, the Cochrane Collaboration acknowledged behavioral medicine as an evidence-based field and has included it in the resource database of the Cochrane Reviews.

As far back as 1936, researchers have made the argument that psychosocial factors impact physical health and illness (Suls and Davidson, 2010), namely that psychological stress affects the cardiovascular, respiratory, muscular, metabolic, immune, and central nervous systems. Continuous psychological stress on these systems results in physical changes, which can negatively impact a person's health.

The significance of psychological influences on physical illness and the effects of physical illness on psychological factors illustrate the reciprocal relationship between the mind and body. Behavioral medicine research has several implications for mental health practitioners. First, psychological factors such as anxiety, fear, stress, and self-efficacy impact physical health and behavior. Second an integrative approach from a biopsychosocial perspective is necessary to comprehensively assess, diagnose, and treat individuals. Third, socioeconomic status, race, and ethnicity impact health outcomes and must also be considered during assessment, diagnosis, and treatment.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Biopsychosocial Model; Biopsychosocial Therapy; Integrative Health

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Bender Gestalt Test

The Bender Gestalt Test is a widely used assessment tool for measuring cognitive abilities and assessing brain dysfunction. It is also known as the Bender Visual-Motor Gestalt Test.

Definitions

- **Alzheimer's disease** is a degenerative medical condition that adversely affects the brain and causes dementia within the later years of life.
- **Attention-deficit hyperactivity disorder** is a condition involving hyperactivity in children, characterized by an inability to concentrate and inappropriate or impulsive behaviors.
- **Autism** is a neurological condition that usually begins before the age of three years and develops with respect to disorders involving speech and language, interpretation of the world, social interactions and the formation of relationships, and reaction to stimuli. Repetitive behaviors are often seen within the condition.
- **Visuomotor** refers to visual and motor processes.

Description

The Bender Gestalt Test (BGT), also called the Bender Visual Motor Gestalt Test, is a psychological

assessment tool used to evaluate visual-motor functioning and visual perception skills in children and adults. The test requires fine motor skills, the ability to discriminate between varying elements of visual stimuli, the capacity to integrate visual skills with motor skills, and the ability to shift attention from the original design to what is being drawn. The test-taker is instructed to reproduce (copy) simple figures (geometric designs) on a blank piece of paper as well as he or she can. Usually it takes from 7 to 10 minutes to complete. Scores are based on accuracy of the resultant figures and other such relevant factors. The BGT can identify possible organic brain damage and the degree of maturation of the nervous system. It is used to evaluate visual-motor maturity and integration skills, style of responding, reaction to frustration, ability to correct mistakes, planning and organizational skills, and motivation. It is also used within inpatient psychiatric units to differentiate between serious mental disorders and brain impairment.

Developments and Current Status

The BGT was developed by Lauretta Bender, MD (1897–1987), an American child psychiatrist. Bender published the monograph *A Visual Motor Gestalt and Its Clinical Use* in 1935. The original test contains nine geometric figures drawn in black. These figures are presented to the test-taker one at a time, who is asked to copy the unique figure onto a blank sheet of paper with the card still in sight. They are allowed to erase but cannot use rulers or other aids.

The second edition of the Bender Visual-Motor Gestalt Test (Bender-Gestalt II) was published in 2003. It contains 16 figures and has a new recall procedure for visual-motor (visuomotor) memory that provides a more comprehensive assessment of these skills. It also includes supplemental tests of simple motor and perceptual ability to aid in identifying motor-visual deficits. Furthermore, new norms are provided for copy and recall procedures. The main test takes between 5 and 10 minutes to administer, with an additional 5 minutes to complete each of the supplemental visual and motor tests.

The Bender-Gestalt II is used to assess the maturation of visuomotor perceptions of children and adults from age 3 to 85 years. It is useful in assessing various neuropsychological psychological conditions such as Alzheimer's disease, attention-deficit hyperactivity disorder, autism, giftedness, and intellectual and learning disabilities. It is also useful in identifying cognitive decline in older adults. Overall, the Bender-Gestalt II remains a popular psychological test because it is simple to use, is brief to administer, and has proven effective for a wide range of ages.

Len Sperry, MD, PhD

See also: Alzheimer's Disease; Attention-Deficit Hyperactivity Disorder; Autism

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Benzodiazepines

Benzodiazepines are a class of drugs that slow the nervous system functioning and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms. They are highly addictive.

Definition

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.

Description

Benzodiazepines are a class of antianxiety medications that work by slowing the central nervous system functioning. Although anxiety is a normal response to stressful situations, some have elevated levels of anxiety that interfere with daily living. Benzodiazepines help reduce anxious feelings and also relieve other troubling symptoms of anxiety, such as increased heart rate, difficulty breathing, irritability, nausea, and faintness. Other uses of benzodiazepines are for muscle

spasms, epilepsy and other seizure disorders, phobias, panic disorder, withdrawal from alcohol, and sleeping problems. However, this medicine should not be used every day for sleep problems that last more than a few days. If used this way, the drug loses its effectiveness within a few weeks. The class of antianxiety drugs known as benzodiazepines includes Xanax, Librium, Valium, and Ativan. The antianxiety effect of this class of medications is experienced shortly after they are taken, typically within 15–60 minutes, depending on the specific medication.

Precautions and Side Effects

Some benzodiazepines increase the likelihood of birth defects, and their use during pregnancy can cause dependency and withdrawal symptoms in the infant. Because benzodiazepines may pass into breast milk, women who are breast-feeding should not use this class of medications without checking with their physicians. Benzodiazepines have considerable addictive potential, and long-term use of benzodiazepines may result in dependence and tolerance, so it is important that their use be monitored by the prescribing practitioner.

The most common side effects are dizziness, light-headedness, drowsiness, clumsiness, unsteadiness, and slurred speech. These problems commonly resolve as the body adjusts to the medication. They do not require medical treatment unless they persist or interfere with normal activities. More serious, but less common side effects include behavior changes, confusion, depression, difficulty concentrating, hallucinations, involuntary movements of the body, memory problems, seizures, or yellow skin or eyes. Medical attention should be sought if these appear. Those who have taken benzodiazepines for a prolonged period or at high doses may notice side effects for several weeks after they stop taking the drug. They should check with their physicians if the following symptoms occur: irritability, nervousness, or sleep problems.

Benzodiazepines interact with other central nervous system drugs and alcohol to further slow central nervous system functioning. These drugs include antihistamines, allergy medicine, cold medicine, muscle relaxants, seizure medications, sleep aids, and some pain relievers. They may also increase the effects of anesthetics, including those used for dental procedures. The combined effects of benzodiazepines and alcohol can result in unconsciousness or even death. Warning signs of this interaction include slurred speech or confusion, severe drowsiness, staggering, and profound weakness.

Len Sperry, MD, PhD

See also: Antianxiety Medications; Ativan (Lorazepam); Valium (Diazepam); Xanax (Alprazolam)

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Bereavement

Bereavement is an individual's emotional reaction to the loss (death) of a loved one.

Definitions

- **Bereavement counseling** is a type of counseling that assists individuals in coping with grief following the death of a loved one or any major life transition that results in grief. It is also called grief counseling.
- **Complicated grief** is the type of grief that is unresolved after an extended period of time and does not follow the typical progression that occurs in common grief reactions.
- **Derealization** is a perceptual reaction in which an individual becomes convinced that life or others are not real.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.

- **Five stages of grief** are the stages that individuals often experience after the death of a loved one or even after a non-death-related loss. The stages are denial, anger, bargaining, depression, and acceptance.
- **Grief** is a healthy emotional reaction to the loss of another person.
- **V-code** is a DSM-5 designation for a mental condition that is not a disease or injury but results in symptoms or distress that may require some form of intervention.

Description

Bereavement is an emotional response that can be triggered by news of another person's death. Bereavement can vary greatly from person to person, and grief also has a cultural influence. Typical reactions that occur during bereavement are sadness, difficulty concentrating, anger, guilt, temporary decline in daily functioning, derealization, isolation, and frequent crying. The DSM-5 identifies bereavement as a V-code. Resolution of bereavement-related symptoms occurs over a few months, but when symptoms persist, it is called complicated grief.

Bereavement reactions can also occur after a non-death type of loss, for example, a divorce, the loss of functioning of one's legs, or acute illness of a loved one. In 1969, psychiatrist Elisabeth Kübler-Ross (1926–2004) identified the "five stages of grief" in her book *On Death and Dying*. The stages are denial, anger, bargaining, depression, and acceptance. Her research examined the emotional reactions of patient facing terminal cancer or other illnesses, and she described the five stages based on her observations of her patients' experience of grief. Sometimes, individuals do not experience the stages in a linear fashion. Some switch between several stages multiple times, while others may not experience anger or bargaining at all.

Treatment

Bereavement counseling is helpful in dealing with bereavement when symptoms are sufficient to disrupt daily activities. This type of counseling aims to assist individuals in moving from bereavement symptoms to resolution or acceptance of the loss. It assists clients in processing their emotions and other reactions to the loss.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Bereavement Counseling; Grief; Grief Counseling; Kübler-Ross, Elisabeth (1926–2004)

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Bereavement Counseling

Bereavement counseling is a type of counseling that assists individuals in coping with grief following the death of a loved one or any major life transition that results in grief. It is also called grief counseling.

Definitions

- **Bereavement** is an individual's emotional reaction to the loss (death) of a loved one.
- **Complicated grief** is the type of grief that is unresolved after an extended period of time and does not follow the typical progression that occurs in common grief reactions.
- **Derealization** is a perceptual reaction in which an individual becomes convinced that life or others are not real.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **The five stages of grief** are the stages that individuals often experience after the death of a loved one or even after a non-death-related loss. The stages are denial, anger, bargaining, depression, and acceptance.

- **Grief** is a healthy emotional reaction to the loss of another person.
- **V-code** is a DSM-5 designation for a mental condition that is not a disease or injury but results in symptoms or distress that may require some form of intervention.

Description

Bereavement counseling is used with clients who have lost a person or animal due to death. It is often used when a person experiences grief-related behaviors or thoughts that are extremely distressing and are impacting his or her daily functioning. This type of counseling aims to assist individuals in moving from bereavement through resolution or acceptance of the loss. This process is typically done through counseling, by assisting the client in processing his or her emotions and other reactions to the loss. Some common grief presentations that are treated in bereavement counseling include sadness, difficulty concentrating, anger, guilt, temporary decline in daily functioning, derealization, isolation, and frequent crying. Resolution of bereavement-related symptoms typically occurs over a matter of a few months, but when symptoms persist, it is called complicated grief. Complicated grief can occur due to trauma, if the client has a personality disorder, or if the client lacks some of the coping skills or resources to manage grief. Typically bereavement counseling is done in a brief therapy setting, while complicated grief is often done in a long-term setting.

The DSM-5 only lists bereavement as a "condition for further study." Bereavement symptoms may mimic different depressive disorders, but they often pass within a few months and do not meet full criteria for a depressive disorder. When an individual experiences severe and enduring depressive symptoms during bereavement, he or she will be a likely candidate for bereavement counseling. In addition, individuals with a predisposition to depression are vulnerable to experiencing significant challenges with bereavement or major episodes of depression.

Bereavement counseling assists clients through the different stages of grief. One model that explains the grief process was created by psychiatrist Elisabeth Kübler-Ross (1926–2004). She identified the "five stages of grief" in her book *On Death and Dying*. The five stages are denial, anger, bargaining, depression, and acceptance. Her research examined the emotional reactions of clients facing terminal cancer or other illnesses. It is important to note that the individuals do not experience the stages in a linear fashion, as some individuals will switch between several stages multiple times, while others may not experience anger or bargaining at all. In bereavement counseling, the counselor will seek to assess the client's coping skills and symptoms, while aiming to work with the client in moving toward the acceptance stage of grief and at least improved daily functioning. Some clients may grieve for several months, while others may grieve for over a year. Others may grieve for many years with very little improvement.

Bereavement counseling may also be used when a client is aware that he or she or a loved one will likely experience death due to a terminal illness or severe injury. This type of grief is called anticipatory grief, which occurs when a client experiences grief before a loved one dies. Clients may seek counseling services shortly after news of a loved one's terminal illness and likely probability of death as a result.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Bereavement; Kübler-Ross, Elisabeth (1926–2004)

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Best Practices

Best practices are methods that have consistently shown results superior to those achieved with other means and that are used as benchmarks.

Definitions

- **Accountability** is the expectation or requirement to conduct evaluations and report performance information.
- **Benchmark** is a standard by which a product or clinical activity can be measured or evaluated.
- **Evidence-based practice** is a form of practice that is based on the integration of the best research evidence with clinical expertise and client values.
- **Health Maintenance Organization** is an organization that provides or arranges managed care.
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Practice** is a method or process used to accomplish a goal or objective.

Description

Best practices are methods, procedures, or processes that have been proven to be superior to other methods, procedures, or processes. Benchmarking is a means of comparing various methods and is essential in creating new best practices. Best practices come about when better ways of doing things are discovered. Regular use of best practices leads to consistent outcomes. Best practices improve the quality of a process, and consistency is improved through their use. While the term "best practices" begins in business settings, it is increasingly common in health and mental health settings.

Development and Current Status

The development of best practices in health and mental health care has its roots in managed care. In 1973, the U.S. Congress mandated changes in health care that led to the creation and adoption of best practices. The goal of best practices in business is to increase process efficiency and profit margins. In contrast, the goal of best practices in health and mental health care is to improve clinical outcomes and reduce costs.

Several changes in mental health and psychological services in the United States have occurred in the past two decades. Many of these changes are the result of the increasing expectation for accountability. Increasingly, medical and psychological practice has become more accountable and evidence based. In 2001, the Institute of Medicine defined evidence-based practice (EBP) in medicine as the integration of best research evidence with clinical expertise and patient values. In 2005, the American Psychological Association modified that definition by including client characteristics, culture, and preferences.

It should be noted that EBP is broader than the concept of best practices because it explicitly considers research evidence, client values, and clinician expertise, that is, utilizing clinical skills and past experience to rapidly identify the client's health status, diagnosis, risks and benefits, and personal values and expectations. The current status of best practice is directly related to EBP.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Evidence-Based Practice

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Beyond Freedom and Dignity (Book)

Beyond Freedom and Dignity is a book written by Dr. B. F. Skinner that highlights his ideas about human behavior and the process of changing human behavior.

Description

Beyond Freedom and Dignity is the name of a book written by American psychologist B.F. Skinner and was first published in 1971. The book challenges the concept of dignity, which Skinner refers to as free will and moral individuality. Instead of the traditional idea that based human choice and development on morality, he took a different approach. He used scientific methods to modify behavior for the purpose of building a happier and better-organized society.

Expanding on the ideas of John B. Watson, Skinner's research led him to believe that human beings are not independent of their physical, social, and cultural environment. He argued that human free will is both false and misleading. This is because Skinner demonstrated that human behavior could be manipulated through both negative and positive reinforcements. In the book he hopes to teach people that we are fooled if we think humans have freedom and free will. This teaching was based on the fact that he proved how actions are both predictable and controllable. Through scientific research he claimed that behavior is based on rewards or punishments.

Perhaps helped by a negative reaction to the freedom movement of the late 1960s, Skinner's ideas presented in *Beyond Freedom and Dignity* struck a chord with many people. This included psychologists, who believed that environment and genetics were important because they molded human decision making. The widespread popularity of the ideas Skinner wrote about in this book helped reinforce a behaviorist approach. This happened within the field of psychology but also in the fields of education and business. The importance of both positive and negative environments in shaping how decisions are made contradicted the concept of free will.

Current Status and Impact (Psychological Influence)

The central insight of behaviorism is the awareness that our activities and choices are heavily influenced by social and environmental factors. This includes things that are rewarding and discouraging. *Beyond Freedom and Dignity* helped popularize the concept, and its principles continue to be represented in higher education.

Although many disliked Skinner's approach, his ideas remain central to the way we understand human behavior. He was one of the first people to use applied behavior analysis to understand human development. He placed this in the context of Individual Psychology as it applies to the environment and people collectively. *Beyond Freedom and Dignity* portrayed these concepts and helped society become aware of human behavior and ways to be as productive as possible in changing it.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Applied Behavior Analysis; Behavior Therapy with Children; Skinner, B.F. (1904–1990)

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Bibliotherapy

Bibliotherapy is an adjunct to psychological treatment, particularly psychotherapy, which incorporates written materials that are read outside of treatment sessions.

Definitions

- **Adjunct** is a form of treatment that, while not required, can be helpful to the treatment process.
- **Agoraphobia** is anxiety about or avoidance of places or situations from which escape may be difficult or help might not be available in the event of having panic symptoms.
- **Cognitive behavioral therapy** is a form of psychotherapy that emphasizes the correction of distorted thinking patterns and change of maladaptive behaviors.
- **Psychoeducation** is a component of many psychological treatments in which patients are provided knowledge about their psychological condition, its causes, and how a particular treatment might reduce their symptoms and/or increase their functioning.

Description

Bibliotherapy is a form of treatment in which structured readings are used as an adjunct to psychological treatments, particularly psychotherapy. These readings, including biographies, workbooks, and short stories, are used to reinforce learning or insights gained in the therapy. They can also provide additional professional resources to foster personal growth and development. Bibliotherapy has been utilized in a variety of treatment settings for various psychological conditions, including eating disorders, depression, bipolar disorders, agoraphobia, alcohol and substance disorders, and stress-related health conditions.

The goal of bibliotherapy is to increase the patient's understanding of his or her condition or problem that requires treatment. The written materials are used to educate the patient about the condition itself and to increase the patient's acceptance of a proposed treatment. Commonly, reading about one's condition outside of the therapy sessions encourages more active participation in the treatment process and fosters personal responsibility for recovery. Many patients are relieved to learn that others have had the same condition or problem and have been able to successfully cope with or recover from it. Therapists who prescribe bibliotherapy often find that it accelerates treatment progress.

Commonly, bibliotherapy is used as an adjunct to conventional psychotherapy approaches. It is commonly used in cognitive behavior therapy in the developing individualized treatment plans and workbooks for specific disorders. For example, patients with eating disorders, especially bulimia nervosa, can benefit from reading educational information appropriate to their stage of recovery, such as books or articles about cultural biases regarding weight, attractiveness, and dieting. Such information can help patients better understand the rationale for their treatment. In this regard, bibliotherapy is similar to psychoeducation.

Developments and Current Status

For many, written material can reinforce their commitment to getting better. Those who lack the time or finances to participate in weekly psychotherapy sessions may often find that bibliotherapy can bridge the gap between less frequently scheduled appointments. For those experiencing agoraphobia or similar psychological conditions that can preclude in-office treatment, bibliotherapy can be most beneficial. Research indicates that it can be highly effective in helping individuals with agoraphobia better understand and cope with their symptoms.

As with any form of treatment, bibliotherapy is effective to the extent to which it actively engages the patient's desire and readiness for change. The use of bibliotherapy in the form of additional information and workbooks can greatly reinforce the patient's commitment to change.

Len Sperry, MD, PhD

See also: Agoraphobia; Cognitive Behavior Therapy; Psychoeducation; Psychotherapy

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Binge Drinking

Binge drinking is an irregular episode of heavy alcohol consumption.

Definitions

- **Alcohol abuse disorder** is a mental disorder involving a pattern of problematic alcohol use that leads to significant problems for the user.
- **Alcohol intoxication** is the impairment of ability following the ingestion of alcohol.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **Standard drink** is considered 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor.

Binge drinking describes episodes of excessive alcohol intoxication where a person reaches a blood alcohol concentration level of 0.08 g/dL. That typically means a person having five alcoholic drinks in two hours for men and four alcoholic drinks within two hours for women, according to the National Institute on Abuse of Alcohol and Alcoholism. (Andreaobzerova/Dreamstime.com)

Description

Binge drinking describes intermittent episodes of excessive drinking that result in alcohol intoxication. The amount of alcohol considered to be excessive in one episode is five standard drinks for men and four for women. Although individuals who binge drink may drink in excess regularly, usually this is not on a daily basis. In contrast, excessive drinking on a daily basis is likely to result in an alcohol abuse disorder or alcoholism.

Binge drinking is most common among young adults, particularly men rather than women. The likelihood of individuals' binge drinking increases if they are college students. This is especially true if they are involved with a fraternity or sorority. It follows that young adults who value "partying" in college also tend to binge drink more than those who do not. A large survey of college students (Courtney and Polich, 2009) found that 44% qualified as binge drinkers. In addition, there is a correlation between those who begin to drink in high school and those who binge drink in early adulthood.

Although this behavior may or may not qualify as alcohol abuse disorder, there are often significant consequences to binge drinking. One of the most likely outcomes is significant impairment of judgment. As a result, binge drinking individuals may act in unusual, harmful, or dangerous ways. For example, drunk driving and unprotected sex may be caused by alcohol intoxication and binge drinking. Furthermore, the consequences of binge drinking are considered to be the leading cause of injury and death in college students in the United States. These are most likely to occur because of car accidents.

Treatment

Binge drinking in itself is not considered a medical condition or mental disorder. Therefore, there is no formal treatment for binge drinking. However, on college campuses prevention programs are commonly

used to control this behavior. Another approach is to increase enforcement of the legal drinking age. These programs are generally ineffective.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Alcohol Use Disorder

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Binge Eating Disorder

Binge eating disorder is a mental disorder characterized by binge eating without subsequent purging episodes.

Definitions

- **Addiction** is a persistent, compulsive dependence on a substance or a behavior.
- **Anorexia nervosa** is an eating disorder characterized by refusal to maintain minimal normal body weight along with a fear of weight gain and a distorted body image.
- **Bariatric surgery** is a surgical procedure on the stomach and/or intestines to help those who are extremely obese lose weight. It is also called weight loss surgery.
- **Binge eating** is a pattern of disordered eating consisting of episodes of uncontrolled intake of food.
- **Cognitive behavior therapy** is a form of counseling or psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Eating disorder** is a class of mental disorders that are characterized by difficulties with too much, too little, or unhealthy food intake and may include distorted body image.
- **Obesity** is an excessive accumulation of body fat, usually 20% or more over an individual's ideal body weight.

Description and Diagnosis

Binge eating is central to this disorder, and it involves eating a large quantity of food in a short time. Individuals with binge eating disorder binge regularly for several months. They believe that they cannot control their eating at the time and feel unhappy and upset about it afterward. Binge episodes are experienced as a type of "out-of-body" or "trance-like" experience where the individuals with this disorder experience a loss of control. Individuals with this disorder seem to live from one diet to another and are preoccupied with the need to lose and maintain weight loss. They are often extremely embarrassed by weight gain and are likely to isolate themselves from others.

Binge eating is also central to another eating disorder called bulimia nervosa. But it differs in that those with binge eating disorder do not use purging methods like vomiting or laxatives. Typically, this disorder often leads to obesity. But it also occurs in normal-weight individuals. Obese individuals suffer significantly more medical challenges, such as hypertension (high blood pressure), stroke, heart disease, sleep problems, type 2 diabetes, colon cancer, and breast cancer. Individuals engaging in binge eating often look to diets to help control binge eating.

Binge eating disorder is more prevalent in females but occurs more often in males than do other eating disorders. It is common in individuals who seek treatment for weight loss. Often the client lacks awareness of the psychological or psychiatric components of the disorder. Binge eating is also seen in many seeking bariatric surgery. This disorder usually begins in adolescence and does tend to run in families.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pattern of consuming excessive amounts of food in a relatively short amount of time (two hours or less) and engage in this bingeing behavior one or more times per week for at least a three-month period of time. A binge is an isolated period of eating in which the

individual ingests enormous amounts of food, often at a rapid rate, eating to the point of physical discomfort. While it might be a common experience to witness one or two relatives engaging in binge eating at events like Thanksgiving dinner, the binge eating disorder involves engaging in this type of overeating from 1 to over 14 times per week. Individuals experience the binge as an "out of personal control" experience unrelated to the feeling of hunger. Bingeing often occurs in isolation due to embarrassment regarding the amount of food ingested and is usually accompanied by intense feelings of guilt. Binge eating is diagnosed if the binge occurs without purging and is not an active component of eating disorders like bulimia nervosa or anorexia nervosa. The degree of severity in binge eating ranges from mild with one to three episodes per week to extreme with 14 or more (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, it appears to run in families, which may suggest a genetic predisposition to addiction (American Psychiatric Association, 2013). Cultural attitudes about body shape and weight also appear to play a role. Long-term dieting as well as psychological issues appear to increase the risk of this disorder. More specifically, stress, anxiety, and depression can lead to binge eating.

Treatment

The goals for treatment for this disorder are to reduce eating binges, to improve emotional well-being, and, often, to lose weight. Because it typically involves shame, poor self-image, self-disgust, and other negative emotions, counseling is directed at addressing these and other psychological issues. Most commonly, cognitive behavior therapy (CBT), in individual and/or group sessions, is the mainstay of treatment. CBT typically focuses on the situations and issues that trigger binge eating episodes. These include negative feelings about one's body or a depressed mood. If obesity is involved, weight loss counseling is used in addition to CBT. Medication may also play a role in the treatment of this disorder. While no medication is specifically designed to treat binge eating disorder, antidepressants such as Prozac can reduce the urge to binge and treat associated symptoms like anxiety and depression. When bipolar disorder or a personality disorder is present, treatment is more challenging and may require hospitalization.

Len Sperry, MD, PhD

See also: Anorexia Nervosa; Bulimia Nervosa; Cognitive Behavior Therapy; Prozac (Fluoxetine)

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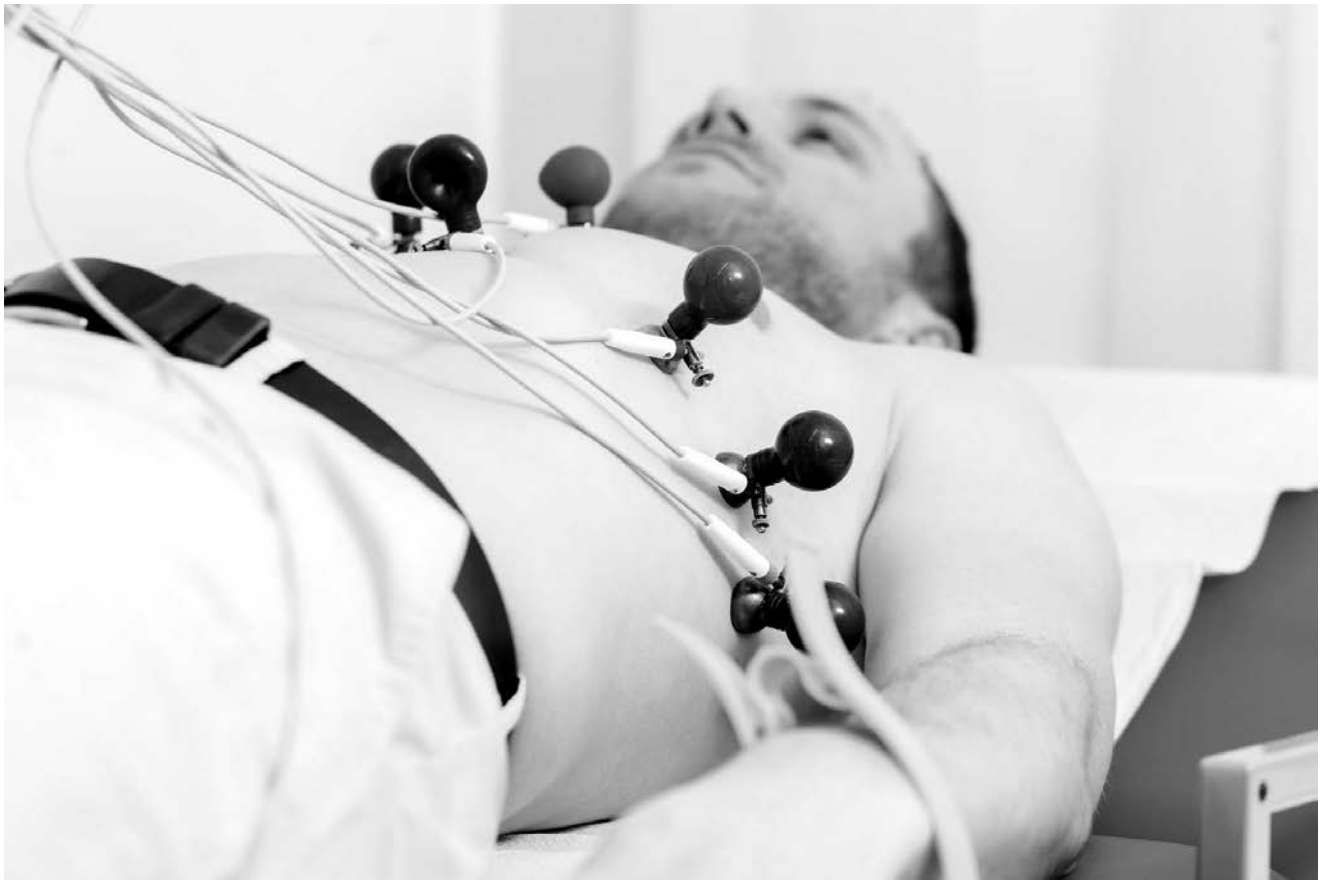
Biofeedback

Like any other skill, individuals can learn how to regulate certain unconscious reactions in their bodies. For example, any person—even children—can master how to regulate body temperature with his or her mind. In fact, with proper training, a person can learn how to regulate his or her breathing, muscle tension, heart rate, blood pressure, and even brain waves. To learn these mind–body skills, individuals require the proper instruction and minute-to-minute updates on their bodies' current status. Biofeedback provides this constant stream of information. These streaming updates are critical for a person to understand how his or her body reacts to certain stimuli.

Description

Biofeedback is both the process and device used to train individuals to regulate their own physiologic functions. By giving the individual constant, moment-to-moment updates on specific physiologic functions like heart rate and breathing, this therapy allows him or her to master control over what would otherwise be unconscious bodily reactions.



Biofeedback is both the process and device used to train individuals to regulate their own physiologic functions. Biofeedback instruments may include electrodermographs (EDG), capnometers, feedback thermometers, electrocardiographs (ECG), rheoencephalographs (REG), electroencephalograph (EEG) or "neurofeedback," and photoplethysmographs (PPG). (Arne9001/Dreamstime.com)

Biofeedback is a noninvasive therapy that allows a patient to take control of his or her own well-being. It sharpens the mind's hold over various reactions in the body. Through a series of specialized trainings, biofeedback allows an individual to recognize how certain thoughts, situations, or emotions may trigger unhealthy spikes in heart rate, stress levels, blood pressure, or surface temperature.

These biofeedback treatments (or trainings) are focused on the individual. Every patient is different and therefore learns at a different rate and responds to different stimuli. When undergoing biofeedback therapy, a patient is connected to specialized biofeedback equipment that gives the patient constant visual or auditory signals about bodily reactions. In other words, patients see and hear in real time how their bodies are reacting to various situations.

With this constant stream of information, patients can be trained to manage these reactions. Like physical therapy, patients are encouraged to train and practice at these sessions with a specialized therapist to control these reactions. Through constant repetition, almost anyone can master this type of training, which is why biofeedback is often compared to other trainable skills like learning a language or learning to catch a ball.

One of the most common forms of biofeedback is surface electromyography, which is used to treat many different conditions including chronic pain and joint dysfunction. Other biofeedback instruments

include electrodermographs, capnometers, feedback thermometers, electrocardiographs, rheoencephalographs, electroencephalograph or "neurofeedback," and photoplethysmographs, which treat a wide range of conditions.

Development and Current Status

Biofeedback has been extremely effective in helping patients overcome all kinds of disorders, injuries, and conditions. Various biofeedback treatments have been known to help improve patients' memory, sleeping, muscle pain, tension headaches, migraines, anxiety, stress levels, attention-deficit disorder, urinary incontinence, epilepsy, Raynaud's disease, and phantom limb pain, among others.

Studies have shown that biofeedback can assist with learning and other cognitive functions. For example, one study demonstrated how college students used biofeedback to improve their academic performance. Another study showed how a portable biofeedback device allowed a soldier to overcome his insomnia in the middle of a warzone. Other studies show that biofeedback allowed children with various mental handicaps to improve their IQs.

Other studies still show that biofeedback can help adults—and even possibly adolescents—overcome addictions to alcohol, opiates, or other illegal substances. Interestingly, in one study, biofeedback doubled the recovery rate of drug dependence, and it also improved test subjects' ability to process information and focus their attention.

Biofeedback both is noninvasive and poses no known risks to the individual. In fact, biofeedback is often used successfully when other treatments or medications have failed. It's also used on pregnant or nursing women who cannot take other medications.

One drawback to biofeedback is the expense. Biofeedback devices and treatment can be costly. However, as technology is improving, new lower-cost options are becoming available, including some portable biofeedback devices that patients can use at home.

As a modern practice, biofeedback dates back to the mid-20th century. The term "biofeedback" itself was coined in 1969—at the same conference where the Bio-Feedback Research Society first formed. However, some researchers maintain that biofeedback actually began over a century ago in India with certain ancient forms of Yoga and breathing exercises that mimic modern biofeedback.

Today, biofeedback continues to offer solutions for patients with many different conditions. At the same time, biofeedback also gives patients some measure of control over their own health and wellness.

Mindy Parsons, PhD

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Organizations

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10200 West 44th Avenue, Suite 304
Wheat Ridge, CO 80033
Telephone: (800) 477-8892 or (303) 422-8436
E-mail: info@aapb.org
Website: www.aapb.org

Biofeedback Certification International Alliance
5310 Ward Road, Suite 201
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Website: www.bcia.org

Biopsychosocial Model

Biopsychosocial model is a way of thinking about health and illness in terms of biological, psychological, and social factors rather than purely in biological terms.

Definitions

- **Biomedical** model of health and disease focuses primarily on biological factors and excludes psychological, environmental, and social influences.
- **Biochemical marker** is any substance in the urine, blood, or other bodily fluids that serves as an indicator of a medical condition.
- **Interdisciplinary** refers to the integration of two or more academic disciplines.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotions, which make distinguishing between real and unreal experiences difficult.

Description

Biopsychosocial model is a way of integrating biological, psychological, and social factors to better understand an individual's experience of disease and illness. This model is used in many fields such as psychiatry, clinical psychology, health psychology, counseling, medicine, nursing, sociology, and clinical social work.

The "biopsychosocial model" was originally developed in 1980 by American psychiatrist George L. Engel (1913–1999), who viewed people as "united, biopsychosocial persons" rather than "biomedical persons" (Dowling, 2005, 2039). Engel promoted the movement from a purely medical model of disease that focuses on biological factors to a biopsychosocial model that incorporates psychological and social factors as well as biological variables. Under the medical model, both physical disease (i.e., diabetes) and mental illness (i.e., schizophrenia) are attributed to the dysfunction of core physical processes. From a biological standpoint, laboratory tests can detect and confirm diabetes or schizophrenia in a person; however, that person may not be experiencing any symptoms and may be completely unaware of any problem. When symptoms begin and how they are physically expressed is influenced by the interaction of psychological, social, and cultural factors *with* biological factors. The severity of a disease is also impacted from a combination of these factors. Psychological and social factors influence when, or even if, a person seeks medical care. Proper medical treatment may manage or eliminate a disease or illness but may not necessarily restore health. In this case, psychological and social influences may be operating as obstacles to the achievement of health. Also affecting the achievement of health is the quality of the patient–doctor relationship and the patient's trust in the physician.

The biomedical model does not take into account variables that aid in the explanation and treatment of mental illness. Engel's biopsychosocial model provides a framework to understand what causes disease and illness, why it appears when it does, the severity of the disease or illness, and how to treat it. It also takes into account the role of the physician and the entire health-care structure. This model helps explain why two people diagnosed with the same disease (measured by biochemical markers) may experience two very different health outcomes. One individual may consider his or her condition to be severe and experience distressing symptoms, while the other may view his or her condition to be mild and experience little symptom distress.

The biopsychosocial model has implications for mental health practitioners and the entire health-care structure. First, it suggests that the treatment of disease and illness necessitates the collaboration of an interdisciplinary team of practitioners from both the medical and mental health fields. Second, the biopsychosocial approach requires practitioners from different fields to understand the interrelationship of physical, psychological, and social factors, and incorporate them throughout the treatment process. This model illustrates that physical and psychological factors may be indirectly affected through health behaviors (e.g., sedentary lifestyle, excessive alcohol use, poor nutrition) and biological factors (e.g., diabetes). Third, practitioners must keep in mind that a purely medical model approach could lead to misdiagnosis. For example, a biochemical measure, such as a blood test, may indicate normal sugar levels in a sick patient or abnormal sugar levels in a healthy patient. Finally, the biopsychosocial

model is the basis for behavioral medicine, which is the interdisciplinary approach to understanding, preventing, diagnosing, and treating medical conditions with behavioral aspects. Len Sperry (1943–), a physician and psychologist, has described a treatment approach based on this model called biopsychosocial therapy.

Christina Ladd, PhD, and Len Sperry, MD, PhD

See also: Biopsychosocial Therapy; Health Psychology; Mind–Body; Social Cognitive Theory

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Biopsychosocial Therapy

Biopsychosocial therapy is an integrative approach to planning and implementing psychological treatment when biological factors are present along with psychological and sociocultural factors.

Definitions

- **Biopsychosocial perspective** is a way of thinking about health and illness in terms of biological, psychological, and social factors rather than purely in biological terms. It is also referred to as the biopsychosocial model.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Vulnerability** refers to an individual's unique susceptibility to develop a medical or psychological condition or express symptoms based on the individual's genes and psychological history.

Description

Biopsychosocial therapy is an integrative approach to planning and implementing psychological treatment which attends to biological, psychological, and sociocultural factors. Rather than being a "new" treatment or psychotherapy approach, it is a set of strategies for planning and implementing effective treatment interventions within a biopsychosocial (BPS) perspective. It uses basic treatment strategies and treatment tactics to tailor (customize) treatment to the particular needs of clients. Because of its comprehensive and integrative emphasis, biopsychosocial therapy is particularly useful with "difficult," "treatment-resistant" situations or where a medical conation complicates psychiatric (mental) conditions. These include chronic medical conditions like asthma, diabetes, cancer, and chronic fatigue syndrome. It includes depression and anxiety disorders that have not responded to conventional treatment. Also included are comorbid (simultaneous presence) conditions such as substance disorders with an anxiety disorder or heart disease with clinical depression.

Biopsychosocial therapy is based on the BPS perspective. This perspective is an integrative and comprehensive way of thinking about and treating medical and psychological conditions. Since then, it has increasingly influenced the fields of medicine, psychiatry, psychology, social work, and counseling. This perspective emphasizes three sets of vulnerabilities and resources: the biological, the psychological, and the sociocultural domains. In this perspective, stressors, client vulnerabilities and resources, and levels of functioning or impairments are central factors. Four basic premises underlie this perspective. First, a client's problems are best understood in terms of multi-causation involving biological, psychological, and social factors rather than a single etiology. Second, a client's problems are best understood in terms of a client's biological, psychological, and social vulnerabilities. Third, a client's problems are best understood as manifestations of the client's attempts to cope with stressors (biological, psychological, interpersonal, or environmental) given his or her vulnerabilities and resources. Finally, multimodal interventions are used to effect change.

The treatment process includes four phases: engagement, assessment, intervention, and maintenance/

termination. Tailoring treatment to the individual's need is essential at each phase. First, the individual is engaged in the treatment process. Second, an assessment is made of the individual's symptoms and maladaptive pattern. Third, interventions focus on modifying maladaptive patterns and achieving some integration of the chronic illness within the patient's expanded self-conception, such that the illness becomes a part of the self but does not fully define the self. Finally, the focus shifts to maintaining the change and, when appropriate, reducing the individual's reliance on the treatment relationship.

Development and Current Status

The BPS perspective was first proposed by psychiatrist George L. Engel (1913–1999) in a 1977 article in *Science*, where he described the need for a new medical model or perspective. He argued that the biomedical model had proved inadequate in the effective treatment of many patients with medical and psychiatric conditions. Instead, he outlined the BPS model.

Biopsychosocial therapy was formally described and articulated by psychiatrist Len Sperry in 1988 in an article entitled "Biopsychosocial Therapy: An Integrative Approach for Tailoring Treatment." Subsequent articles and books have elaborated this approach and its clinical applications.

The BPS perspective assumes that treatment of medical and mental conditions requires that clinicians (physicians, nurses, psychotherapists) address the biological, psychological, and social influences on a patient's functioning. The reason is that the workings of the body can affect the mind, just as the workings of the mind can affect the body. This means both a direct interaction between mind and body and indirect effects through intermediate factors. A growing body of scientific research indicates that patients' perceptions of health and threat of disease influence the likelihood that they will engage in health-promoting or treatment behaviors. These include taking medication, eating healthy foods, and engaging in physical activity. Research also suggests that when clinicians frame treatment recommendations in a BPS perspective, patients are more likely to better understand and follow such recommendations.

A noticeable shift is under way from a strictly biomedical perspective to a BPS perspective. The trend in U.S. health care is toward integrative care, as mandated by the Affordable Care Act. This focus on integrative services means that clinicians will gather more BPS information from their patients. Integration of professional services through integrated health teams means that patients' psychological and sociocultural needs will be addressed in addition to their biological needs. Members of integrative health teams (nurses, nutritionists, health psychologists, social workers, and professional counselors) will address all three aspects of the BPS perspective. This will allow physicians to focus primarily on biological factors.

Len Sperry, MD, PhD

See also: Biopsychosocial Model; Depression; Psychotherapy

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Bipolar Disorder

Bipolar disorder is a mental disorder characterized by a history of manic or hypomanic episodes, usually with one or more major depressive episodes.

Definitions

- **Bipolar and related disorders** are a group of mental disorders characterized by changes in mood and in energy (e.g., being highly irritable and impulsive while not needing sleep). These disorders include bipolar I disorder, bipolar II disorder, and cyclothymic disorder.

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also called CBT.
- **Cyclothymic disorder** is a mental disorder characterized by alternating cycles of hypomanic and depressive periods with symptoms like those of bipolar disorder and major depressive disorder but of lesser severity.
- **Depression** is a sad mood or emotional state that is characterized by feelings of low self-worth or guilt and a reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts the individual's daily functioning.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily functioning. These disorders include major depressive disorder, persistent depressive disorder, disruptive mood dysregulation, and premenstrual dysphoric disorder.
- **Depressive phase** is a mental state characterized by sad mood, reduced ability to enjoy life, and decreased energy or activity seen during the course of a bipolar disorder.
- **Hypomania** is a mental state similar to mania but less intense.
- **Major depressive disorder** is a mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning. It is also referred to as clinical depression.
- **Mania** is a mental state of expansive, elevated, or irritable mood with increased energy or activity.
- **Manic phase** is a mental state characterized by expansive, elevated, or irritable mood with increased energy or activity seen during the course of a bipolar disorder.
- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.

Description and Diagnosis

Bipolar disorder is one of a group of bipolar and related disorders. It is characterized by manic or hypomanic episodes, usually with one or more major depressive episodes that cause clinically significant distress or disrupt everyday functioning. This disorder is often not recognized or is misdiagnosed as major depressive disorder by mental health professionals. Early in its course, bipolar disorder may masquerade as poor school or work performance or as alcohol or drug abuse problem. If left untreated, it tends to worsen and the individual experiences episodes of full-blown mania or depression. Bipolar disorder is a chronic condition. Research indicates that more than half of those diagnosed with this disorder had four or more episodes of mania and depression (Goodwin and Jamison, 1990). The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), describes two variants of this disorder: bipolar I disorder and bipolar II disorder. Each will be described separately along with its diagnostic features.

Bipolar I disorder. Individuals with this type of bipolar disorder experience periods of mania followed by periods of depression. During the manic phase, they display considerable enthusiasm, hopefulness, confidence, and expansive self-esteem, often to the point of grandiosity. They tend to act impulsively while their thinking is expansive and creative, but distracted. Their enthusiasm contributes to sleeplessness, pressured speech, and increased social participation and to extreme choices that would not be made during non-manic periods. These symptoms reflect the individual's efforts to overcome challenges and create feelings of worth and excitement. While these manic episodes appear to neutralize their underlying discouragement, they create other problems. Largely this is because of their failure to consider the consequences of their actions during these manic periods. This failure

later seems to contribute to intensified periods of hopelessness and despair and the inevitable depressive episode that follows.

According to the DSM-5, individuals can be diagnosed with this disorder if they exhibit episodes of persistently elevated, expansive, or irritable mood along with persistently increased goal-directed activity or energy. These episodes last for at least one week and are present most of the day. The mania itself includes elevated self-esteem and grandiosity, decreased need for sleep, increased talkativeness, flight of ideas or sense of racing thoughts, distractibility, and goal-directed behaviors and engagement in activities that have the potential for painful consequences. These symptoms must be significantly distressing and impair the individual's ability to function in important areas of life. Furthermore, these episodes cannot have been caused by substance use or a medical condition or another mental disorder (American Psychiatric Association, 2013).

Bipolar II disorder. The primary difference between bipolar I disorder and bipolar II disorder is the extent of the mania. Bipolar II is characterized by hypomania, which includes less extreme periods of manic features. Why do some individuals exhibit hypomania instead of mania? It may be that those with this bipolar II have a greater awareness of the potential consequences of their actions. This awareness may serve to inhibit the mania. Maybe their ambitions are not as lofty or self-contemptuous as those with a manic episode. It might be that their commitments to family and career serve to limit their mania. Or, the anticipated shame and guilt associated with the failure and disappointment associated with a manic episode serve to retard manic energy.

Unfortunately, there is little research to support these speculations. However, it may be that these are two very different disorders with very different origins. Clinical experience has shown that individuals diagnosed with major depressive disorder who also display hypomanic symptoms are quite different from those with only depressive symptoms. For one, they are likely to have more episodes of severe depressive symptoms, more impaired functioning, and other mental disorders. But even more important, over time these individuals are more likely to "convert" (meet the criteria) to bipolar I disorder.

According to the DSM-5, individuals can be diagnosed with this disorder if they exhibit one episode of major depression and at least one hypomanic episode. These individuals must never display a full manic episode nor any psychotic feature. For these individuals, the hypomania itself may not significantly contribute to problems in daily functioning. The more significant disruption emerges from the depressed symptoms. These symptoms must be significantly distressing and impair the individual's ability to function in important areas of life. Furthermore, these episodes cannot have been caused by substance use or a medical condition or another mental disorder (American Psychiatric Association, 2013).

The cause of both variants of this disorder is not well understood. However, there is some evidence for genetic and physiological factors as causes or triggers for it (American Psychiatric Association, 2013). Since this disorder runs in families, there appears to be a genetic basis for it. Major depressive disorder, bipolar disorder, and cyclothymic disorder often occur together in families. This occurrence suggests that these mood disorders share similar causes. Levels of the neurotransmitter (brain chemical) called norepinephrine seem to influence bipolar symptoms. Low levels of norepinephrine are associated with depression, while high levels are associated with mania. Imbalanced hormones may be involved in causing or triggering bipolar disorder. An imbalance in hormones may be involved in causing or triggering bipolar disorder. For example, hormone changes related to childbirth may result in bipolar disorder. Environmental factors may also be involved. Stress, significant loss, abuse, or other traumatic experiences may play a role in the development of this disorder. Whether causative or not, stressful life events and alcohol or drug abuse can make the treatment of bipolar disorder more difficult.

Treatment

Effective treatment usually involves psychotherapy and medication for both variants of this disorder.

However, in bipolar II, clinician will be more attentive to the depressed features rather than to the mania, which is a primary focus in the treatment of bipolar I. Psychotherapy, particularly cognitive behavior therapy (CBT), can be quite helpful in increasing emotional regulation. The challenge is to better manage daily life challenges. CBT helps those with this disorder in two ways. The first is to identify unhealthy, negative beliefs and behaviors and replace them with more healthy and positive ones. The second is to identify triggers to both hypomanic and depressive episodes and better cope with upsetting situations. Medication may be helpful in emotional regulation. Medications like Lithium, Depakote, and Tegretol are particularly useful in regulating and stabilizing mood.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Cyclothymic Disorder; Depression

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Birth Order

The term "birth order" refers to the rank or position of siblings by their age within a family unit.

Definitions

- **Middle child syndrome** is a phenomenon commonly used to refer to the psychological and emotional results, usually negative, that a person experiences when wedged between older and younger siblings (typically in a three-child family).
- **Nature versus nurture** refers to the ongoing debate among professionals as to which factors contribute more to differences in personality, intellect, and psychological development, biological/genetic (nature) or environmental/social (nurture) contributors.
- **Sibling rivalry** refers to fighting, resentment, or feelings of animosity felt or displayed among brothers and sisters within a family.

Description

Birth order defines the rank order of brothers and sisters by age within a family. For centuries, theorists and researchers have hypothesized about the impact birth order has on personality, IQ, self-esteem, and overall psychological development. While some evidence suggests that one's position within one's family of origin has a profound effect, there is also research to support the contrary. Factors including parenting style, gender, financial constraints, and health concerns can also influence family dynamics and increase the likelihood of sibling rivalry.

Austrian psychologist Alfred Adler (1870–1937) was the first theorist to propose that birth order could be linked to commonalities among various personality types. Adler, himself a middle child, posited that one's position within a family could have lasting effects on how one perceives situations and progresses through tasks related to work, family, and friends (Adler termed this "lifestyle"). Firstborn children are commonly viewed as reliable, structured, successful, competitive, high achieving, and conscientious. Those who are middle children are often described as flexible, even-tempered, people-pleasers, peacemakers, social, and sometimes rebellious. Lastborn children, also known as youngest children or babies, may be characterized as uncomplicated, fun-loving, pampered, attention seekers, manipulative, and outgoing. Finally, those who grow up as only children are described as mature, diligent, conscientious, leaders, and oftentimes perfectionists. Though these characteristics are

widely accepted, exceptions to these can and do exist. Likewise, variations in the traditional family structure can also result in distinctions, including situations that involve divorce, blended families, adoptions, and gap children (siblings who are separated by more than five years).

Current Status and Impact (Psychological Influence)

Research on birth order has been ongoing for decades, suggesting that this remains an area of interest to professionals in the fields of psychology, psychiatry, sociology, medicine, and education. Several of the studies, however, have lacked methodological rigor and adequate sample sizes. Findings, therefore, have been mixed, with some data pointing to the salience of familial rank while other results indicate that birth order does not necessarily leave an indelible mark on one's personality or behavior as was once believed. Family size, which determines birth order, is associated with certain social factors, including ethnicity, education level, and socioeconomic status. Recent evidence has linked birth order and IQ with data reporting that the more older siblings a person has, the lower that person's IQ is. Findings also indicate that birth order influences friendship and spousal choices with selections corresponding to similarities in personality. More rigorous studies are needed on this topic.

Melissa A. Mariani, PhD

See also: Adler, Alfred (1870–1937); Nature versus Nurture

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Blended Families

Blended families, commonly known as stepfamilies, describe familial structures consisting of children and parents who are not necessarily biologically related to one another.

Definitions

- **Nuclear family**, or elementary family, defines a traditional family unit made up of a mother, a father, and their children.
- **Stepfamily** is another term used to describe a blended family, or a family unit consisting of parents and children who are not biologically related but formed as a result of parental separation, divorce, and possible remarriage.

Description

Blended families, or stepfamilies, are prevalent in today's society, and the traditional nuclear family can no longer be considered the norm. The term "blended" describes family units where the parents and children are not all biologically related but have formed after the ending of a previous relationship. Families that are blended include one or both of the parents whom have children with prior partners that join together through marriage, civil union, or simply by cohabiting. If the couple marries, the parent may be referred to as a "stepmother" or "stepfather" and siblings as "stepsister" or "stepbrother." Stepparents, though they may assume some to all of the responsibilities associated with their new child, have no legal parental rights unless they legally adopt the child(ren). In the United States alone it is estimated that blended families make up approximately 40% of couples with children. Given that over 60% of all marriages now end in divorce, the number of blended families has increased substantially. Statistics further indicate that one-third of all marriages in the United States are remarriages.

Fortunately, a biological connection among family members is not necessary in order to form healthy, caring bonds. However, the transition process involved with blended families can be difficult. If the previous

Blended families include those families where one or both parents who have children with other partners join together, whether through marriage, civil unions, or living together. (Ajphotos/Dreamstime.com)

relationship ended negatively, both adults and children may be suffering emotionally, which could place strain on the new unit. Divorce situations can cause angst, particularly if children still have hopes of parents reuniting. Custody disputes can add an additional level of stress. Adjusting to the new family structure, including roles and responsibilities, may take time. Often children resist discipline from their "new" parent, exhibiting overt misbehavior and disrespect. Others internalize pain and engage in destructive patterns that are harder to recognize and address.

Impact (Psychological Influence)

Families today experience more transitions than families of the past. Frequent marriages, quicker divorces, and more short-term cohabiting relationships are common for children and parents. Changes in living arrangements, parenting styles, and familial environments can have a profound impact on child/adolescent well-being. Difficulty accepting the new relationship and adjusting to different home expectations, rules, settings, and schedules can further complicate the process. Loss of familial stability can effect children socially, emotionally, and psychologically. Some may have a hard time maintaining healthy relationships, resulting from lack of trust and support. Research suggests that children from divorced families are at greater risk for delinquency; they display violent behaviors, use alcohol and drugs, and engage in sexual activity at higher rates than youngsters from intact families. Academic achievement also appears to be affected by family structure, with children from intact families performing better in school. Studies indicate that children

from broken homes are more prone to hyperactivity, mood swings, anxiety, and depression than their counterparts. However, experts agree that regardless of the familial structure most children thrive in households that are stable, consistent, and caring.

Melissa A. Mariani, PhD

See also: Family Therapy and Family Counseling

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Body Dysmorphic Disorder

Body dysmorphic disorder is a mental disorder characterized by an excessive preoccupation with an imaginary or minor defect in a part of the body.

Definitions

- **Cognitive behavior therapy** is a form of counseling and psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Muscle dysmorphia** is the obsessive belief that one is not muscular enough.
- **Obsessive-compulsive disorder** is a mental disorder characterized by persistent thoughts and compulsive actions, such as cleaning, checking, counting, or hoarding.

Description and Diagnosis

Body dysmorphic disorder is one of the classes of obsessive and compulsive and related disorders in DSM-5. All of these disorders involve some kind of obsessive preoccupation and/or compulsion. Body dysmorphic disorder involves a persistent preoccupation with a part of the body—usually the face, skin, or hair—that is perceived as defective or problematic. Unfortunately for those diagnosed with this disorder, their perceived defect is not recognized by others. Repeated attempts to reduce or eliminate the disorder fail. They also mentally compare their personal appearance to that of others. The extent of the individual's preoccupation causes significant distress or impairment in occupational, social, and other areas of life. There are gender differences in how this disorder presents. Males with it tend to be preoccupied with either genital or muscle dysmorphia. In contrast, females tend to be preoccupied with a wide range of appearance-based concerns.

Typically, those diagnosed with this disorder are ashamed of how they look and embarrassed about the amount of focus that they must put on their appearance. They are convinced that others perceive them as they do themselves and also believe that others are mocking them for these perceived defects. Because of the shame they experience and the belief that others notice their perceived defects, they tend to introverted, quiet, and reserved. They seldom have close, intimate friendships because of their shame, low self-esteem, and related social anxiety. They also may incorrectly and negatively interpret the facial expressions of others, especially in situations where the social cues are vague.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pattern of fixation and concern about perceived imperfections and flaws in their physical appearance even though these defects go unrecognized or seem minor to others. Some individuals are specifically concerned with having a deficient body build or muscle mass. They also have developed and engaged in repeated patterns in response to their concerns about their appearance.

Such repeated behaviors might include mirror checking, extreme and unnecessary grooming, exercising, or picking at their skin. In addition, individuals will engage in approval-seeking behaviors about their appearance from others. Mental acts of comparing personal appearance to that of others are common. These repeated behavioral and mental acts cause enough distress to impact social, occupational, and other areas of functioning. Preoccupation with appearance cannot be related or attributed to concerns about weight or body fat in persons who have been diagnosed with an eating disorder. Persons with body dysmorphic disorder may differ in their level of insight. In addition, those diagnosed with this disorder may have problems with executive functioning and visual processing (American Psychiatric Association, 2013).

The cause of this disorder is not fully understood. However, it may be genetic in origin and tends to run in families where obsessive-compulsive disorder is diagnosed. It is often associated with childhood abuse and neglect. Individuals may have grown up with limited opportunities to deal with life's demands and may have never "fit in" within the family, the school, or other social settings. As children, they may have developed repetitive patterns of evasion in response to their parent's expectations. Psychologically, individuals are likely to value perfection and believe that appearances are important. They tend to view themselves as defective and unique but unable to be acceptable to others. They tend to view the world as unsafe and that others find them disgusting. Low self-esteem, few social connections, and limited personal responsibility are likely to have predisposed them to be self-absorbed and focused on appearance.

Treatment

The clinical treatment of this disorder is a combination of medications and counseling or psychotherapy. Those with this disorder respond reasonably well to antidepressant medications such as Prozac, Luvox, and Paxil. They tend to require higher dosages of these medications than those who are being treated for depression with these drugs. Cognitive behavior therapy (CBT) is an effective approach to psychotherapy with these individuals. Because the disorder involves inaccurate self-perceptions and beliefs about their appearance, the focus of CBT is to challenge these beliefs. Because of their perfectionism, those who seek cosmetic plastic surgery typically end up feeling the same or worse. For this reason, many plastic surgeons routinely refer those who seek cosmetic surgery for a psychological evaluation prior to surgery.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Luvox (Fluvoxamine); Obsessive-Compulsive Disorder; Paxil (Paroxetine); Prozac (Fluoxetine)

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Body Image

The term "body image" is often considered to be the way an individual views his or her body. However, body image also includes how a person thinks and feels about his or her body. Body image is influenced by how a person takes care of his or her body, the absence or presence of medical issues, and reactions from others. Negative thoughts about one's body image can lead to serious challenges, many of which are more common among women, including psychological distress, shame, anxiety, depression, low self-esteem, and even eating disorders.

Definition

Body image is a complex psychological concept that includes a subjective picture of one's own physical appearance that comes both from self-observation and from the reactions of others.

Body image can be negative when compared to unrealistic models for both men (muscular) and women

(thin). However, women tend to experience body dissatisfaction more often than men. Body image is influenced from birth. Individuals develop their body image through a combination of their own thoughts and ideas, as well as feedback from their family, friends, culture, and society. While many may not be happy with their body image, there are some who are so unhappy that it may become a component to developing an eating disorder or lead to other mental health challenges, such as anxiety or depression.

Body image is a mental picture that individuals have when they think of what they look like not only to themselves but also to others. However, these thoughts are merely perceptions and may be extremely accurate on one end of the spectrum or completely inaccurate on the other end.

Body image is an important psychological concept because distorted self-views are widespread among American women and those self-views influence an individual's behavior. It is important to note that men are affected by negative body image as well, but it is more readily discussed and recognized in women. Some have taken the position that body image often has a negative connotation to it. There has been an idealized perception of body image that women maintain a thin frame and men have a muscular frame.

Those suffering from a negative body image tend to either avoid their thoughts and emotions regarding their image or take steps toward improving their perceived flaws. At times, this approach can lead to lower self-esteem or disordered eating.

Children and adolescents who report having positive family relationships tend to have higher body image satisfaction. Children and adolescents who sense their parents have negative thoughts about their body image can often hold negative self-views of their bodies. Eating disorders, such as anorexia nervosa or bulimia, have been on the rise since the 1950s. One of the key diagnostic factors is associated with having a negative poor body image, which causes great mental distress. Those working in the field have been calling for the focus to be on wellness and not on weight.

Body image is a constant topic of discussion everywhere from news programs to media. Society especially focuses on the body image of celebrities and is quick to scrutinize when an A-lister gains weight, even during pregnancy. For example, when pop singing sensation Christina Aguilera gained weight and moved from being a tiny starlet to a curvaceous figure, the media and public were quick to criticize her harshly. However, Christina took the platform to encourage people to love their bodies regardless of shape or size.

Dove is a soap company that has been working hard to focus on real beauty and looks to improve women's body image. In its 2013 advertising campaign, the company hired an FBI sketch artist to draw seven women as they described themselves. The artist was not able to see the women and was only able to ask questions having them describe their appearance. Then, strangers were asked to describe these same women to the artist. In each of the sketches, the ones that came from the women's self-descriptions were far less attractive than those that came from a stranger's description. The message was clear for everyone that women are often critical of their appearance and the goal should be to love and find beauty in themselves.

Mindy Parsons, PhD

See also: Anorexia Nervosa; Body Dysmorphic Disorder; Bulimia Nervosa; Eating Disorders; Self-Esteem

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Body Integrity Identity Disorder

Body integrity identity disorder is a condition characterized by an intense desire to have a healthy body part amputated. It is also known as amputee identity disorder.

Definitions

- **Body dysmorphic disorder** is a mental disorder characterized by an excessive preoccupation with an imaginary or minor defect in a part of the body.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Gender identity disorder** is a mental disorder characterized by significant dysphoria (discontent) with one's biological sex or the gender roles associated with that sex. It is also called gender dysphoria.
- **Proprioception** is the body's internal sense of its position in space and of the location of body parts in relation to one another.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

Body integrity identity disorder is a mental disorder characterized by an intense desire, in a nonpsychotic individual, to have one or more body parts (usually limbs) removed by amputation. Usually, body part is healthy, functioning, and not deformed. Individuals with this disorder typically have an idealistic image or view of themselves as amputees and desire to have their body altered to conform to that image. They strongly believe that the body part is foreign or unwanted and will "feel complete" only when it is removed. They may use assistive devices (like crutches) in public in order to appear disabled. Almost always, they feel ashamed, embarrassed, or depressed.

The disorder was proposed for inclusion in DSM-5. But, because it is such a rare condition with very little research, it was not included as a separate disorder. However, it was considered as a possible subtype of body dysmorphic disorder. After serious review, researchers noted a basic difference between the two disorders. Those with body dysmorphic disorder are excessively concerned about perceived defects in one or more features of their body and want to improve that feature. In contrast, those with body integrity identity disorder want to amputate the defective feature. Actually, this disorder is more similar to gender identity disorder in that the individual believes that a body part is alien to his or her sense of self, similar to the way in which a person with gender identity disorder believes that biological sex is alien to his or her sense of self.

The cause of the disorder is as of yet unknown. It may be that there is damage to the brain involving proprioception. As a result, individuals with this disorder have brains that fail to "recognize" the body parts that they want amputated. Another explanation is that this disorder may be an extension of body alteration methods that are so common today. These include body piercing, breast implants, and other plastic surgery alterations for aesthetic purposes.

Treatment

There is no definitive treatment for this disorder. For some individuals, surgical removal of the body part has been beneficial. However, because such surgery poses significant ethical concerns, it is not the treatment of choice. For others, psychotherapy may be helpful to deal more effectively with other problems in their lives.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Body Dysmorphic Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Gender Identity Development; Psychotherapy

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Body Piercing

Acts of body piercing and tattooing are the two most common forms of what is known as body modification or body adornment. Although the history of body piercing dates back centuries, today's body piercing often has very different meanings and motivations. In fact, one's self-identity, a desire for beauty, and distinction from others are often the reasons cited for body piercing. However, there have been several studies that show individuals who engage in body piercing have higher incidence rates of sexual abuse, physical injury, and criminal history.

In addition, the body modification population shows tendencies for addictive behavior and often uses the piercings as a way to cope with trauma. Other studies have shown body piercings and tattoos to be strongly related to anger, substance abuse, eating disorders in adolescents, early sexual activity, and self-injury.

Body piercing has become increasingly more widespread in the United States, the United Kingdom, and Europe over the past 20 years. It falls under the category of body modification. This includes procedures that permanently alter a person's body, usually by puncturing the skin to insert a piece of jewelry. Body piercing and tattooing are the two most common forms of body modifications and are practiced by approximately 6.5% and 8.5% of the population, respectively. Piercings are commonly placed in the upper ear, nose, navel, lip, tongue, cheek, and uvula, and are most common among adolescents and young adults.

In history, body piercing was considered a form of cultural expression among a number of civilizations. It has been used to express religious, sexual, and cultural identities. Evidence shows that the Aztecs practiced ear piercing 4,000 years ago. Piercing of the nose has been common among Alaskan natives since the 19th century, tongue piercing was common among Mayan Indians, and genital piercing is mentioned in the *Kama Sutra*, which maintains evidence of penis piercings that included attaching jewelry.

Body piercing became increasingly common during the punk rock movement that began in the late 1970s in Europe. A counterculture was born in an effort to shock and provoke. This practice soon took root in the homosexual and sadomasochist population in the United States and Britain. Shortly thereafter, top music and film celebrities embraced body piercing. Emerging trends in body piercing also include brandings, which is scarring the body by applying heated materials to the skin.

Other forms of body piercing include cuttings, which are cuts in the skin using a sharp knife or blade, as well as implantations of three-dimensional objects placed under the skin to create a sculpture on the surface of the skin. Another form of body piercing is known as pocketing, which is a stapling of the flesh. Stretching or gauging is one form of piercing that is growing in popularity. It involves gradually expanding the ear lobe or any other part of the ear.

Significant medical risks are associated with body piercings. The risks vary in severity from infection and nerve damage to sterility and even death. The most common side effects are bleeding and bacterial and viral infections (e.g., viral hepatitis and HIV), as well as tissue damage and allergies.

Some social scientists believe that individuals who modify their bodies are motivated by rebellion and defiance. They believe that modifications of gauging, piercing, cutting, pocketing, tattoos, and so on, are a way of demonstrating their rejection of conformity to social standards and conventionality.

Mindy Parsons, PhD

See also: Stigma; Tattoos

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Body Work Therapies

Knowing the connection between mind and body, physiotherapists and other body work practitioners have developed physical treatments known as body work therapies to help reengage the mind's control over the body and heal or prevent other injuries to the body. A healthy mind has dominion over the body. Likewise, a person with an unhealthy mind or other injuries can lose control over his or her body.

Definition

- **Body work therapy** is a general term that refers to all physical and psychotherapy treatments involving movement or touch to heal the body. These body-based therapies are often designed to unite the body and the mind or heal other injuries in the body.

Description

Often classified as alternative medicine, body work can involve physical techniques, manipulative therapies, massage, and breath work. One goal of this type of therapy is to increase a person's awareness of his or her own body. This therapy can be used to improve posture, heal ongoing stress injuries (as in athletes or dancers), realign the body's structure, increase a person's movement, and even overcome emotional traumas like post-traumatic stress disorder. These body work therapies can take many forms. At times, it can involve deep-tissue work, while the patient lies in a passive state. At times, it can involve applying pressure on hypersensitive spots on the patient's body. At times, it can involve practicing Tai-Chi Chuan (Tai Chi) or other Zen relaxation techniques. At times, it can even involve talk therapy in conjunction with physical treatments.

Since each person is unique, body work therapies focus on addressing the individual. Body work practitioners stress the importance of empathy and intuition when working with new patients to address their specific needs. Examples of popular body work therapies include basic body awareness therapy (BBAT), the Alexander Technique, acupressure, Hellerwork, Shiatsu, Trigger Point Therapy, and Rolfing.

There are a few minor risks involved with body work therapy. For instance, anyone who has recently undergone surgery or suffered a serious injury should not begin body work therapy without first consulting his or her physician. Patients suffering from serious illnesses or infections should wait to start body work therapy. If patients are suffering from post-traumatic stress disorder, body work can trigger violent reactions, flashbacks, anxiety attacks, and feelings of rage. Also, some body work like Rolfing or Hellerwork can cause mild discomfort for new patients.

Development and Current Status

Interestingly, various forms of body work therapy have existed for centuries. One of the oldest forms of body work is Shiatsu, which was discovered in the early 20th century in Japan. However, Shiatsu evolved from an ancient form of Japanese massage that was practiced for centuries known as "Anma." Throughout the 20th and now 21st centuries, new body work practitioners, massage therapists, and physiotherapists have continued to develop new forms of body work therapies to treat all kinds of physical injuries, chronic pain, and emotional trauma. One of the most recent developments has been in using body work to treat mental illness. Scandinavian health services now regularly use a treatment known as BBAT to treat schizophrenia patients. Through various therapy sessions of movement, massage, Tai-Chi, and breathing, schizophrenic patients are often able to overcome or reduce the physical symptoms of schizophrenia like disembodiment, lack of mental awareness, loss of balance, loss of erect posture, or other bodily functions. After this therapy, schizophrenic patients also tended to have higher self-esteem, less anxiety, and an overall feeling that they have more ownership over their bodies.

The body–mind connection is extremely important in this type of therapy. Shiatsu specialists often work with post-traumatic stress disorder victims—including children—to help them overcome their recent emotional traumas. Specifically, Shiatsu has been known to help soldiers who have just returned from combat, children or other individuals who grew up in war zones, trauma victims with missing limbs, abuse victims who suffered from mental or physical abuse, and

those who recently experienced a death of a loved one. Body work therapy continues to thrive as a recognized medical practice in both Eastern and Western medicine.

Mindy Parsons, PhD

See also: Psychotherapy

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Borderline Personality Disorder

Borderline personality disorder is a mental disorder characterized by a pattern of instability in interpersonal relationships, self-image, affects, self-harm, and a high degree of impulsivity.

Definitions

- **Brief psychotic episode** is a period in which an individual experiences psychotic symptoms such as hearing voices (hallucinations), paranoid thoughts, depersonalization (feeling unreal), or disorganized speech. The episode is usually triggered by substances, medications, or extreme stress.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Dialectical behavior therapy** is a psychotherapy approach that focuses on coping with stress, regulating emotions, and improving relationships.
- **External locus of control** is the belief that one's life is controlled by forces outside the individual's control.
- **Idealizing** is the exaggeration of positive qualities and the minimization of negative qualities.
- **Mindfulness** is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Splitting** is the inability to synthesize (put together) contradictory qualities, such that the individual views others as either all good or all bad.

Description and Diagnosis

Borderline personality disorder is a personality disorder characterized by a pattern of unpredictability, impulsivity, troubled relationships, anger, mood swings, and self-destructive behavior. Individuals with borderline personalities present with a complex clinical picture, including diverse combinations of anger, anxiety, intense and labile affect, and brief disturbances of consciousness such as depersonalization and dissociation. In addition, their presentation includes chronic loneliness, a sense of emptiness, boredom, volatile interpersonal relations, identity confusion, and impulsive behavior that can include self-injury or self-mutilation. Stress can even precipitate a psychotic episode. Of all the personality disorders, they are more likely to have irregularities of circadian rhythms (physiological cycles), especially of the sleep–wake cycle. As a result, chronic insomnia is a common complaint.

The borderline personality in individuals is identified by the following: behavior style, interpersonal style, thinking style, and feeling style. Their behavioral style is characterized by physically self-damaging

acts such as suicide gestures, self-mutilation, or the provocation of fights. They tend to accomplish less in their careers and socially than their intelligence and talents would suggest. Their interpersonal style tends to fluctuate quickly between idealizing and clinging to another individual to devaluing and opposing that individual. They are overly sensitive to rejection and abandonment feelings following even slight stressors. Their relationships tend to develop rather quickly and intensely. They are typically intolerant of being alone. As a result they seek out the company of others in indiscriminate sexual affairs, late-night phone calls, or after-hours emergency room visits with vague medical or psychiatric complaints. Their thinking style is best described as inflexible and impulsive. They reason by analogy from past experiences and have difficulty reasoning logically and learning from past mistakes. Because they have an external locus of control, borderlines usually blame others when things go wrong. By accepting responsibility for their own failings, borderlines believe they would feel even more powerless to change circumstances. They often have difficulty recalling images and feeling states which could make sense of their situation and soothe them in times of turmoil. Their inflexibility and impulsivity are further noted in their tendency toward splitting and an inability to tolerate frustration. Finally, because of difficulty in focusing attention and subsequent loss of relevant data, borderlines also have a diminished capacity to process information. Finally, their feeling style is characterized by marked mood shifts from a normal mood to a depressed mood. In addition, inappropriate and intense anger and rage may easily be triggered. Other feelings can include emptiness, a deep "void," or boredom.

The cause of this disorder is not well understood. However, these individuals tend to have characteristic view of themselves, the world, and others and a basic life strategy. They tend to view themselves defective and needy. They tend to view their world as unpredictable and hurtful. Accordingly, their basic life strategy and pattern is to expect others to take care of them and make them happy. They will not likely commit to anything and will reverse roles and vacillate in their thinking and feelings when under actual or perceived attack.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of unstable relationships, emotional reactions, identity, and impulsivity. They engage in frantic efforts to avoid abandonment, whether it is real or imagined. Their interpersonal relationships are intense, unstable, and alternate between the extremes of idealization and devaluation. They have chronic identity issues and an unstable sense of self. Their impulsivity can result in self-damaging actions such as reckless driving or drug use, binge eating, or high-risk sex. These individuals engage in recurrent suicidal threats, gestures, acting out, or self-mutilating behavior. They can exhibit markedly reactive moods, chronic feelings of emptiness, emotional outbursts, and difficulty controlling their anger. They may also experience brief, stress-related paranoid thinking or brief psychotic episodes (American Psychiatric Association, 2013).

Treatment

The clinical treatment of this disorder typically involves psychotherapy and may include medication. Decisions about treatment goals and focus are best based on an assessment of the individuals for overall level of functioning. Higher-functioning borderlines have a greater probability for collaborating in psychotherapeutic treatment than the lower-functioning borderlines. Higher-functioning individuals with this disorder may be responsive to traditional psychotherapy that is focused on insight and solving problems of daily living. With lower-functioning individuals, treatment goals may be more limited. The focus of treatment is more likely to be on managing crises and achieving and maintaining more stable functioning. Dialectical behavior therapy (DBT) is one of the most effective treatment approaches with borderlines, particular with lower-functioning individuals. DBT incorporates four treatment components: individual therapy, skills training in a group, telephone contact, and therapist consultation. The rationale for the group component is that the intense interpersonal relationship that forms between the therapist and the client serves as the trigger for the client acting-out. Such acting-out is effectively reduced in a group format. Just as important, skills like emotion regulation and mindfulness are learned

in this treatment format. Medication can also be used with this disorder. It is aimed at target symptoms such as impulsivity, insomnia, depression, or anxiety. Such medications include antidepressants, antianxiety, and antipsychotic drugs.

Len Sperry, MD, PhD

See also: Dialectical Behavior Therapy; Personality Disorders; Psychotherapy

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Bowen Family Systems Theory

Bowen family systems theory was developed in the 1950s by Dr. Murray Bowen (1913–1990), a psychiatrist and professor who is considered a pioneer in family therapy. The foundation of his systems theory is the belief that a family is best understood as an interconnected emotional unit and thus any therapeutic intervention needs to address the complex interactions among various family members in the context of the entire family system.

This approach to family counseling is strongly grounded in theory and has provided a majority of the mainstream language utilized when exploring and discussing family systems and family therapy. Bowen introduced the majority of mainstream language in regard to family systems therapy, including ordinal birth position, genograms, and differentiation of self.

Murray Bowen was born in 1913 and was the oldest of five children. He earned his MD from the University of Tennessee Medical School in 1937 and interned at Bellevue Hospital in New York City. His psychiatric training began in 1946 in Kansas. Bowen was also part of a five-year research project through the National Institutes of Mental Health. His research focused on parents and family members of schizophrenic children who had been hospitalized for extended periods of time.

Bowen believed that his efficacy as a therapist was directly linked to his understanding of natural systems theory, something he used as a guide for working with both families and individual patients. He held strongly to the science of human behavior, asserting that there was a difference between what a person was and what he or she felt, imagined, or said. Although there were critics, many agree that family systems theory is among the most fully developed, theoretically grounded views of the family.

Bowen also adopted the idea of family constellation to look at sibling position. This looks at the fixed and ordinal birth positions. Bowen believed that using the ordinal approach he could identify the role the children would play in the emotional aspect of the family life.

In order to help assess these patterns, Bowen was the first therapist to use a genogram. This tool provides a map or diagram of multiple generations and the relationships among the members. This allows for a way of organizing the important information about the family expanding at least three generations. This tool allows for understanding from both the therapist and the family members who now have a visualization of their relationships and patterns. The genogram includes names of family members and dates of birth, marriage, divorce, and death as well as cultural and ethnic origins, religious affiliation, socioeconomic status, and type of relationships.

Bowen also utilized process questions to encourage clients to consider the roles they play in relating with members of their family. He encouraged participants to speak directly to him as opposed to each other during the session. The questions were circular as the focus of change is in relation to others who are viewed

as having an effect on functioning. Bowen also encouraged the use of I-positions, which are clear statements of personal opinion and belief that do not have emotional connections. This allows for members to communicate in a more rational manner.

Bowen therapists are concerned with changing individuals within the context of a system. Problems are viewed as stemming from relationship patterns in the family of origin. Therefore, the family of origin must be understood and patterns and relationships addressed.

Bowen therapists are central contributors to the American Association for Marriage and Family Therapy as well as to several current key academic journals such as *The Journal of Marital and Family Therapy*. This theory is actively taught and explored in graduate programs to future clinicians. Bowen's concept of a genogram has been adapted by several other theorists and actively used by many in the family therapy field.

Mindy Parsons, PhD

See also: Family Life Cycle; Family of Origin; Family Therapy and Family Counseling; Genograms; Identity and Identity Formation

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Organizations

American Association for Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314–3061
Telephone: (703) 838–9808
Website: www.aamft.org

American Counseling Association
5999 Stevenson Ave.
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Fax: (703) 823-0252
E-mail: info@aca.org
Website: http://www.counseling.org

The Bowen Center
4400 MacArthur Blvd. NW #103
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Website: www.thebowencenter.org

Brain

The brain is the organ at the center of the nervous system that controls all other organs and bodily functions.

Definitions

- **Autonomic** means involuntary or unconscious.
- **Central nervous system** is one of the two parts of the nervous system that contains the brain and the spinal cord.
- **Genes** are deoxyribonucleic acid or blueprints that create molecules called proteins. Genes determine heredity.
- **Glial cells** are cells in the central nervous system that provide support for surrounding neurons. Glial cells do not send electrical signals.
- **Homoeostasis** is the tendency of a system to regulate internal processes and maintain a stable and constant condition.
- **Magnetic resonance imaging** is a medical diagnostic test that uses magnetic fields to produce detailed images of the brain and internal organs. It is also referred to as MRI.
- **Nervous system** is the body's control system that is responsible for all voluntary and

involuntary actions. It regulates chemical processes and responds to internal and external stimuli. It is made up of the central nervous system and the peripheral nervous system.

- **Neurons** are brain cells that process and send information throughout the body via electrical signals.
- **Neurotransmitters** are chemicals in the brain that send messages across synapses from one neuron to another neuron.
- **Peripheral nervous system** is one of the two parts of the nervous system that connects the central nervous system to the organs, muscles, blood vessels, and glands.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

Description

The brain is the three-pound organ that controls everything an individual or animal does. It controls all conscious and unconscious processes. It initiates muscle activity and releases chemicals that allow a person or animal to quickly respond to environmental stimuli. In combination with the spinal cord and surrounding nerves, it makes up the central nervous system. The brain is considered in terms of two hemispheres. The right hemisphere is associated with abstract and creative functions and is responsible for induction, or reasoning from specific to general. The left hemisphere is associated with linear and rational functions and is responsible for deduction, or reasoning from general to specific. The brain is composed of three parts: the forebrain, the midbrain, and the hindbrain. The forebrain regulates sensory and information processing, instinctual functions, and voluntary functions. The midbrain regulates vision, hearing, motor control, temperature, sleep, and arousal. The hindbrain is the stem that connects the brain to the spinal cord. It regulates autonomic functions such as heart rate and breathing. It also helps maintain balance, provide movement coordination, and manage sensory information. One of the most important functions of the brain is homeostasis or the regulation of internal chemical processes to maintain a constant balance. The hypothalamus, located at the bottom of the forebrain, is primarily responsible for basic biological functions and homeostasis.

The brain regulates an individual's basic survival instincts and is the motivator that activates behavior to seek food, water, and shelter. It works on a reward-punishment system. When a behavior results in a positive consequence, the reward system produces chemical changes in the brain that cause that behavior to be repeated in similar situations. In contrast, when a behavior results in a negative consequence, the punishment system produces chemical changes in the brain that cause that behavior to be repressed or extinguished. The reward mechanism in the brain plays a significant role in drug and alcohol addiction.

The brain makes it possible for humans and other animals to learn from experiences and modify their behavior. In turn, modified behavior influences brain processes. Santiago Ramón y Cajal (1852–1934), a Spanish neuroscientist, claimed that when learning occurs, there are chemical changes that take place between neurons in the brain. It wasn't until 1971 that physical evidence was found by Terje Lomo (1930–) to support Cajal's claims.

The brain an individual is born with contains the majority of cells it will ever have. What determines brain growth after birth is how much or how little the connections between the brain cells develop. Genes produce proteins that work to connect brain cells. Although the genetics of a brain cannot be altered, the biochemical process within these proteins can. The brain contains two primary groups of cells, neurons and glial cells, which transmit signals to communicate between cells. The points of communication are called synapses. Neurotransmitters are released at synapses. Neurons work together to form a circuit. Circuits work together to form specialized brain systems. Different brain systems regulate functions such as language, perception, or decision making. Environmental influences have the capacity to activate or deactivate the chemical process between cells and impact brain development. Scientific research has shown that growth and development of the brain depends on both genes and experiences.

The debate on the relationship between the brain and mind was started by Rene Descartes (1596–1650) when he made the statement, "I think, therefore I am." The neural activity in the brain is necessary for language, cognitions, emotions, and overall existence of the mind. Researchers indicate that the mind is a complex function of the brain and when the brain is impaired, so is the mind. Similarly, problems with the mind (mental illness) can impair the brain's functioning. For example, depressive illnesses are disorders of the brain. Research studies using magnetic resonance imaging have shown that brains of depressed individuals appear different from individuals without depression. The brain functions that regulate mood, thoughts, behavior, the sleep–wake cycle, and appetite are affected by changes in serotonin levels. Antidepressant medication boosts neurotransmitter levels and assists in restoring homeostasis (balance). Medication in combination with psychotherapy usually results in the better outcome for many depressed individuals.

Christina Ladd, PhD, and Len Sperry, MD, PhD

See also: Depression; Split Brain

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Brain Imaging

Brain imaging is a set of medical diagnostic techniques for directly or indirectly imaging the structure and function of the brain. It is also known as neuroimaging.

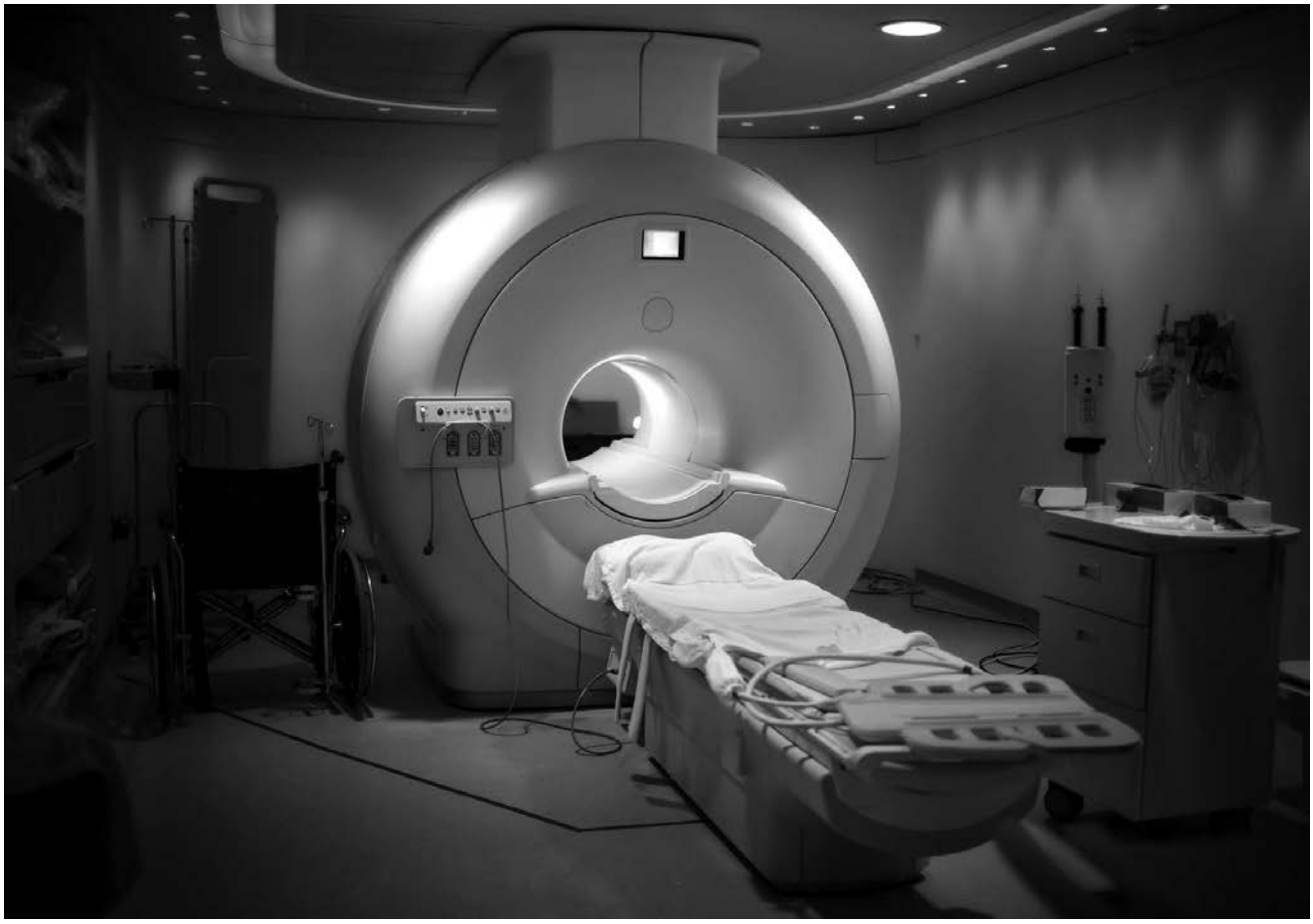
Definitions

- **Brain electrical activity mapping** (BEAM) is a quantitative version of the electroencephalogram (EEG) test, which produces a colored schematic map of the head.
- **Computed tomography** (CT) is a medical diagnostic test in which computer-processed X-rays produce tomographs (cross-sectional images) of body areas.
- **Electroencephalography** is a medical diagnostic test that records electrical activity on the scalp to evaluate various brain functions and psychological disorders.
- **Magnetic resonance imaging** (MRI) is a diagnostic imaging device that uses electromagnetic radiation and a strong magnetic field to produce images of soft tissues.
- **Positron emission tomography** (PET) is a diagnostic imaging technique that uses radioactive substances to produce three-dimensional colored images within the body.
- **Single-photon emission computed tomography** (SPECT) is a diagnostic imaging device that uses gamma rays to produces images of the body.

Description

Brain imaging is a set of medical diagnostic techniques that are useful in providing images (pictures) of the brain used in detecting injury or disease. These images directly or indirectly identify the brain structures and functioning. There are six common types of brain imaging techniques currently in use. They are the EEG, computerized axial tomography (CT), the single-photon emission computed tomography (SPECT), positron emission tomography (PET), magnetic resonance imaging (MRI), and its related functional MRI scan (fMRI).

The first actual neuroimaging technique was the EEG. It was the first effort to measure brain physiology. By taping tiny metal electrodes on the top and sides of a patient's head, the EEG measures neuron-generated evoked potentials (electrical currents) on the surface of the brain. These EEG-generated potentials are valuable in that they measure the functionality of sensory and neuromuscular pathways. Thus, this type of neuroimaging is most commonly used to diagnose epilepsy and sleep disorders. A quantitative version of the EEG,



Brain imaging is a set of medical diagnostic techniques that are useful in providing pictures of the brain and used in detecting injury or disease. Magnetic resonance imaging (MRI) is often used for neuroimaging. (Melissa Connors/Dreamstime.com)

called brain electrical activity mapping (BEAM), produces a brain map with electrical potentials identified with colors. This brain map is particularly useful in the diagnosis of Alzheimer's disease and mild closed-head injuries.

Computerized axial tomography scan (CT scan) involves X-rays that move in a small circular arc and penetrate the patient's head. The different intensities of the X-rays measure the location of and variant density of brain tissue and are used by a computer to construct a composite picture of the brain. This type of neuroimaging can be used to identify blockages, clots, and bleeding in the brain. These pathological changes are visually represented on a computer screen. While the CT is effective in displaying brain anatomy, it cannot measure brain functioning. However, the SPECT is an extension of CT scanning that can assess functioning. SPECT uses radioactive materials injected through a vein to generate high-resolution images. The SPECT scanner monitors the tracer's movement through body tissues. The rate of its radioactive decay allows the clinician to obtain three-dimensional images of blood flow in the heart or electrical activity in different areas of the brain. It can also scan for tumors or bone disease.

Positron emission tomography was the first neuroimaging device to create three-dimensional localization of brain function. PET requires patients to ingest (drink) or be injected with a radioactive substance. This substance emits positrons from which a computer image is generated as with CT scans. Tumors, lesions, and psychiatric abnormalities are visualized. In psychiatric conditions, PRT can identify metabolic activity in the brain. Low levels suggest conditions like

depression, while high levels suggest conditions such as schizophrenia.

Magnetic resonance imaging scan is the most popular type of neuroimaging. Because it uses magnetic fields rather than X-rays, it is safer than a CT scan. By placing electromagnets around a patient's head, the MRI works by generating a visual representation of the brain's functioning. MRI is used to identify tumors, tissue degeneration, and blood clots. Like the CT scan, MRI scan provide only anatomical but not physiological information. However, the fMRI scan can provide such physiological or functional information. It is able to measure rapidly changing physiology and generate three-dimensional images of the brain. More specifically, it can measure blood and oxygen flow.

Developments and Current Status

Starting in 1850, clinicians and researchers used invasive techniques to examine the brain. Cutting open a living patient's skull to identify specific brain anatomy and functioning was the only available technique in the pre-neuroimaging era. The obvious advantage of all the neuroimaging techniques that were to emerge in the 20th century was that clinicians and researchers had a noninvasive view of the brain's anatomy and physiology while the patient remained conscious. In the 1920s the ventricles (cavities or open spaces) of the brain and spinal cord were first visualized with X-rays, as were normal and abnormal blood vessels in and around the brain. It was in the early 1970s that CT scanning became available for diagnostic and research purposes. In the early 1980s, SPECT and PET of the brain were introduced. In the late 1980s, the BEAM emerged. It was derived from the EEG. Except for the CT scan, these other imagining techniques were primarily used for research purposes. About the same time, MRI was developed. About 1990 fMRI became available. However, it was not until the early 2000s that brain imaging for clinical purposes became feasible.

Len Sperry, MD, PhD

See also: Computed Tomography (CT); Electroencephalogram (Brain Electrical Activity Mapping); Magnetic Resonance Imaging (MRI); Positron Emission Tomography (PET); Single-Photon Emission Computed Tomography (SPECT)

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Breakfast Club, The (Movie)

The Breakfast Club (1985) was the second successful movie by writer and director John Hughes about the important, coming-of-age issues that face most teens in high school. The film is known for its accurate and believable dialogue and its realistic depiction of the problems that teenagers face.

Description

In this film, five teenagers are alienated not only from the adult world of their parents and teachers but also from each other because they come from different cliques or social groups in the school which makes them feel like they have nothing in common. All that ends on a long Saturday when the five end up being forced to spend an all-day detention together. The group starts with only a vague knowledge of one another which leads them to rely on stereotypes (classifications of other people by overly simplified conceptions, opinions, or images). Gradually, however, as the day wears on, the five t students open up to one another. The characters include John Bender, acted by Judd Nelson, who plays the "criminal"; Andrew Clark, played by Emilio Estevez, who is the "athlete"; Brian Johnson, played by Anthony Michael Hall, the "brain"; Allison Reynolds, played by Ally Sheedy, who is the "basket case"; and Claire Standish, played by Molly Ringwald, who is the "princess."

These five must remain together in the high school library for a period of 8 hours and 54 minutes: from

Although released thirty years ago, *The Breakfast Club* (1985), a film by writer-director John Hughes, still speaks to teenagers today. The movie shows teenagers who are alienated not only from the adult world of parents and teachers but also from each other because they come from different school cliques or social groups, making them feel that they have nothing in common. Left to right are Ally Sheedy, Judd Nelson (top), Anthony Michael Hall, Emilio Estevez, and front, Molly Ringwald. (Universal Pictures/Photofest)

exactly 7:06 a.m. to 4:00 p.m. They are instructed to write a 1,000-word essay, in which each student must write about who he or she thinks he or she is. Bender, who rejects authority, disregards the assignment and stirs up the other students.

The students spend the day fighting, talking, smoking marijuana, and dancing. Gradually they open up to each other and reveal their deepest personal secrets. They all discover that they have strained relationships with their parents and are afraid of making the same mistakes as the adults around them. As they grow more involved, they begin to fear that once detention is over they will return to their cliques and never speak to each other again.

Toward the end of the day, the other students ask Brian "the brain" to write the essay assigned earlier. But instead of writing about the given topic, Brian writes a letter objecting to the topic, stating that they have already been judged and labeled. Brian signs the essay on behalf of the group, "The Breakfast Club."

The theme that resonated with audiences was the sense of alienation not only from authority figures but between each of them as stereotyped teens. It is only when they realize how alike their struggles are, especially with their parents, that they become close. They discover that they are more alike than they are different.

Impact (Psychological Influence)

Similar to Hughes's earlier film *Sixteen Candles*, *The Breakfast Club* spoke to teenage problems and angst by taking its characters and their struggles seriously. It also directly addressed the cliques and stereotyping that is often typical of the teenage years, especially during high school. One of the main reasons why this film remains so influential and popular is its authenticity in portraying teenage issues, many of which transcend the time period of the movie.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Cliques; *Mean Girls* (Movie); *Sixteen Candles* (Movie)

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Brief Dynamic Psychotherapy

Brief dynamic psychotherapy is a psychological treatment approach that focuses on maladaptive interpersonal patterns that are treated by facilitating new experiences.

Definitions

- **Attachment** is the emotional bond between children and caregivers that can provide a secure (healthy) base from which children are able to safely explore their environment and relate to others.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Corrective emotional experience** is a treatment strategy in which a therapist provides a more supportive and new relational response as compared to the assumed expectations of the client.
- **Countertransference** is the unconscious redirection of feelings from the therapist to the client.
- **Cyclic maladaptive pattern** is the pattern (manner) in which a person relates to others and how it influences all aspects of an individual's life.
- **Insight** is the awareness that occurs when an individual attains a fuller understanding of self and others.
- **Interpretation** is a guess or hypothesis made by a therapist about the relationship between an individual's behaviors, thoughts, or emotions and his or her unconscious emotions or thoughts.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.
- **Psychodynamic therapy** is a form of psychotherapy that emphasizes unconscious (outside awareness) conflicts and focuses on an individual's early childhood and dreams.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Transference** is the unconscious redirection of feelings from the client to the therapist.

Description

Brief dynamic psychotherapy is a shortened form of psychodynamic therapy. The roots of this approach are in Sigmund Freud's (1856–1939) psychoanalytic theory. The healing process that occurs in long-term psychoanalytic therapy typically requires years of therapy, while brief dynamic therapy can occur in a relatively short amount of time. Given the emphasis on cost savings in health care today, individuals are often eligible for only a limited amount of therapy sessions. Psychologist Hans H. Strupp (1921–2006) developed such a time-limited approach which he called brief dynamic psychotherapy. This approach can effect change in a relatively few sessions, usually 20 or less. Of the several brief approaches to psychotherapy used in clinical practice today, time-limited dynamic psychotherapy is a commonly used and research-based approach.

The goal in brief dynamic therapy is to provide individuals with new experiences of themselves and others through corrective emotional experiences provided in session. Other brief dynamic therapy strategies include interpretation, resolving transference, and fostering insight. Further, therapists aim to assist clients in understanding themselves and developing insight into their relationships by exploring unmet needs that are associated with early attachment figures. The brief dynamic therapy model assumes that individuals' maladaptive interpersonal patterns are reenacted in therapy, and the practitioner will be influenced by the client's dynamics. The therapist's countertransference toward the client also provides information about the client's cyclical maladaptive pattern. Countertransference and transference issues are used in this approach to modify preexisting relational, emotional, and behavioral patterns through in-session processing of these dynamics.

Human suffering, such as depression, is conceptualized from this perspective by examining faulty relationship patterns with caregivers, and these faulty patterns are commonly reflected in presenting symptoms and interpersonal distress. The client's cyclical maladaptive pattern is at the heart of conceptualizing an individual's presenting issues. The four relational components to

assess are acts of self, expectations of others reactions, acts of others toward the self, and acts of the self toward the self. Acts of self include thoughts, feelings, wishes, motives, perceptions, and behaviors of the client. Expectations of others reactions include how the clients imagine others will react to them in response to their actions. Acts of others toward the self are the actual behaviors of others, as observed or perceived by the client. Finally, acts of the self toward the self are the clients' behaviors toward themselves and also their relationship with themselves.

Developments and Current Status

While Sigmund Freud's psychodynamic theories are a primary influence, more recent proponents of brief dynamic psychotherapy include Jeffrey L. Binder (1943–) and Hanna Levenson (1945–), who prefer the designation brief dynamic therapy. Both were mentored by Hans Strupp. A relatively small number of professional therapists exclusively use psychodynamic therapy in practice today. However, more therapists use elements of psychodynamic therapy to conceptualize their cases but implement cognitive behavior therapy techniques to treat their clients.

Len Sperry, MD, PhD, and Jon Sperry PhD

See also: Cognitive Behavior Therapy; Psychodynamic Psychotherapies; Psychotherapy

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Brief Psychotic Disorder

Brief psychotic disorder is a mental disorder characterized by psychotic symptoms with a sudden onset, short duration, and the full return of functioning. It is usually triggered by extreme stress. This disorder is also referred to as acute, transient, or reactive psychotic disorder.

Definitions

- **Antipsychotic medication drugs** are prescribed drugs that are intended to reduce psychotic symptoms. It is also known as neuroleptics.
- **Catatonia** is disorganized, limited, or complete absence of normal physical behavior.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Family therapy** is a type of psychotherapy for families that focuses on improving relationships and understanding between family members.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Psychotic symptoms** are a group of severe symptoms that include hallucinations, delusions, disordered thinking, or disorganized movement.
- **Schizophrenia spectrum and other psychotic disorders** are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, delusional disorder, and brief psychotic disorder.
- **Substance-induced psychotic disorder** is a mental disorder characterized by hallucinations or delusions caused by the use of or withdrawal from substance like alcohol or cocaine.

Description and Diagnosis

Brief psychotic disorder is one of the schizophrenia and other psychotic disorders. Individuals with this disorder are likely to present with acute psychotic symptoms that have appeared suddenly. It almost always follows an extreme stressor. Emergency hospitalization is common

because of their unexpected and extremely abnormal behavior. As with other psychosis, they are likely to experience hallucinations, particularly of the auditory type. Some individuals may present with various forms of catatonia, including stupor, physical rigidity, expressionlessness, or mutism (not speaking). They may also be experiencing delusions or paranoid thoughts. Approximately 9% of those presenting with a first episode of psychosis receive this diagnosis. Women are twice as likely as men to suffer from this disorder. The age of onset varies, but the average age is mid-30s. In addition, this disorder occurs more frequently in developing nations (American Psychiatric Association, 2013).

An important differentiator between brief psychotic disorder and other disorders is that individuals return to pre-onset functioning in a short time. This means that as their symptoms quickly recede, they regain their same level of abilities and functioning. While this disorder shares some psychotic features with substance-induced psychotic disorder, it is different. Brief psychotic disorder is not caused by substance use or withdrawal.

It is critical that a clinician ascertain the exact time frame involved in both onset and duration in order to make an accurate diagnosis. Brief psychotic disorder can last no longer than one month, or the diagnosis is not applicable. Should it last longer, another disorder from the schizophrenia spectrum and other psychotic disorders group should be considered. Usually, a very stressful event precedes the onset of this disorder. Therefore, it is important to not only ascertain if a stressor is related to the onset of the disorder, but it is imperative to assess for stress-related conditions such as post-traumatic stress disorder.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit the abrupt onset of symptoms of delusions, hallucinations, disorganized speech, or bizarre behavior and posture. The episode must last at least one day by less than one month with the eventual return to pre-onset level of functioning. Symptoms of this disorder must be distinguished from culturally sanctioned response patterns that may resemble such symptoms. The diagnosis is not given if there is evidence of the direct physiological effects of a medication, a drug of abuse, or a medical condition (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, individuals with a family history of bipolar disorder or depression are more likely to develop a psychotic disorder than those who do not. As already noted, extreme stressors often trigger this disorder. Substances, medications, and medical conditions can cause psychotic episodes. In addition to family history and stressors, substances, medications, and medical conditions can cause, complicate, or trigger psychotic disorders. Accordingly, detailed information about such factors should be identified.

Treatment

Depending on the severity of the symptoms, individuals may require hospitalization for the initial days following the onset of the disorder. During this time, a comprehensive assessment is undertaken to identify the causes and triggers of the disorder. The goal of treatment is to reduce symptoms and to return individuals to their previous level of functioning. Both medication and cognitive behavior therapy are common treatment interventions. Various antipsychotic medication such as Haldol, Risperdal, and Zyprexa are commonly used. In addition to treatment aimed at the reduction of symptoms, it is often recommended that individuals participate in psychoeducation (information sessions) programs aimed at helping them understand their condition. Also, family therapy is beneficial for individuals suffering from brief psychotic disorders. This form of therapy allows other family members to gain insight into the condition and understand how they might support the individual who is suffering in the family setting.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Delusions; Family Therapy and Family Counseling; Haldol (Haloperidol); Hallucinations; Psychosis; Risperdal (Risperidone); Schizophrenia; Schizophreniform Disorder; Substance-Induced Psychotic Disorders; Zyprexa (Olanzapine)

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Brief Therapy

Brief therapy is a form of therapy that can increase an individual's functioning in a relatively short amount of time.

Definitions

- **Acceptance and commitment therapy** is a psychological treatment approach that assists individuals to accept what is outside their control and commit to action that enriches their lives. It is also known as ACT.
- **Adlerian therapy** is a psychological treatment approach that uses encouragement to assist individuals to find constructive actions to deal with their problems while developing an enhanced sense of social interest.
- **Behavioral therapy** is a psychological treatment approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **Biopsychosocial therapy** is a psychological treatment approach that focuses on clients' biological, psychological, and social dynamics and focus interventions on those areas.
- **Brief dynamic psychotherapy** is a psychological treatment approach that focuses on maladaptive interpersonal patterns and unmet needs, which are treated by facilitating new experiences in therapy.
- **Brief reality therapy** is a psychological treatment approach that emphasizes problem solving in the here and now. It does not focus on mental illness, rather on the ability to choose and create a better future.
- **Cognitive behavior therapy** is a psychological treatment approach that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Cognitive behavior analysis system of psychotherapy** is a psychological approach that focuses on changing thoughts and behaviors by analyzing desired outcomes in contrast to actual outcomes. It is also called CBASP.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Solution-focused brief therapy** is a psychological treatment approach that focuses on strengths and problem solving, and examines an individual's past ability to cope effectively.

Description

Brief therapies are an assortment of psychotherapy approaches that can effect change in clients in a short amount of time. Some theories have therapeutic processes that can take years to achieve treatment goals, while brief therapy models utilize techniques that influence change rather quickly. Given the limitations of managed care, individuals are often eligible only for a limited amount of therapy sessions. Third-party payers typically expect therapy to be completed in very few sessions and the treatment provided to be effective and long-lasting. As a result of this, brief therapies have become the treatment of choice for many therapists. Brief therapy models are goal oriented and time-limited and focus treatment to address the individual's strengths and abilities. Rather than looking for the cause of the problem, brief therapies

work with clients to make changes in their lives and improve their functioning. Brief models seek to effect change with clients in as little as just one session. Various brief models have been articulated in the literature.

Some brief therapies include brief dynamic therapy, cognitive behavior therapy (CBT), biopsychosocial therapy, brief Adlerian therapy, acceptance commitment therapy (ACT), brief reality therapy, cognitive behavior analysis system of psychotherapy (CBASP), and solution-focused brief therapy. CBT and CBASP are psychological treatment approaches that help clients reduce and modify maladaptive behaviors and cognitions, while brief dynamic therapy works with individuals to examine relationship patterns and unmet needs by changing relational patterns toward a more adaptive approach. Brief Adlerian therapy effects change in clients by helping them implement constructive actions and increase their sense of belonging. ACT assists individuals to accept what is outside their control and commit to action that is in accordance with their goals and values. Solution-focused brief therapy focuses on strengths and problem solving, and examines an individual's past exceptions to when the problem was not a problem. While other brief models exist, the examples provided earlier utilize different therapeutic strategies and interventions to assist individuals who are seeking therapy services in a time-limited setting.

Developments and Current Status

Brief therapy models were developed by various theoretical proponents. Brief therapies are considered some of the most clinical useful and efficient therapy modalities. Research and application of brief therapy approaches continue to occur at an increasing rate. It is anticipated that brief therapies will outnumber the longer-term therapies.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Acceptance and Commitment Therapy (ACT); Adlerian therapy; Biopsychosocial Therapy; Brief Dynamic Psychotherapy; Cognitive Behavior Analysis System of Psychotherapy(CBASP); Cognitive Behavior Therapy; Grief Counseling; Motivational Interviewing; Positive Psychology

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Bulimia Nervosa

Bulimia nervosa is a mental disorder characterized by recurrent binge eating with loss of control over one's eating and compensation for eating.

Definitions

- **Anorexia nervosa** is an eating disorder characterized by refusal to maintain minimal normal body weight along with a fear of weight gain and a distorted body image.
- **Binge eating** is a pattern of disordered eating consisting of episodes of uncontrolled intake of food.
- **Binge eating disorder** is an eating disorder characterized by binge eating without subsequent purging episodes.
- **Cognitive behavior therapy** is a form of counseling or psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Eating disorder** is a class of mental disorders that are characterized by difficulties with too much, too little, or unhealthy food intake, and may include distorted body image.

Description and Diagnosis

Bulimia nervosa is an eating disorder with a characteristic pattern of recurrent binge eating followed by purging. Bulimics overeat because food gives them a feeling of comfort. However, overeating makes them feel out of control. Then, feeling ashamed, guilty, and afraid of gaining weight, they purge. Basically, this disorder represents a loss of control about overeating and the compensatory behavior of purging for the purpose of regaining a sense of control. Individuals with bulimia nervosa tend to be of normal weight and "low calorie" or "careful restrictive" eaters between episodes of bingeing and purging. About 1.0%–1.5% of females have this disorder, which begins in adolescence and remains a pattern through early adulthood. The female-to-male ratio is 10:0 (American Psychiatric Association, 2013).

This disorder must be distinguished from the binge/purge subtype of anorexia nervosa. Both bulimia nervosa and this subtype involve binge eating and purging. However, whereas the anorexic is unable to maintain even minimal weight, the bulimic contains purging sufficiently to maintain body weight that is minimally normal or above normal level (American Psychiatric Association, 2013). Bulimia nervosa can also be distinguished from binge eating disorder, where there is bingeing but no purging.

Purging typically involves self-induced vomiting, fasting, overexercising, or using medicines like laxatives to induce diarrhea and/or excessive bowel movements. The binge/purge experience is often hidden, occurring during the night or when alone, and bulimics become skilled at inducing vomiting and using diuretics and exercise. Purging can lead to serious and even life-threatening medical conditions. These include dental problems like tooth decay, gum disease, and loss of tooth enamel that result from acid in the mouth following vomiting. It can also lead to osteoporosis (bone thinning), kidney damage, and fatal cardiac arrhythmias (abnormal heart rhythms). Laxative dependence is a common complication of this disorder. Dentists and dental hygienists have a key role in identifying bulimia nervosa since they are often the first to recognize the dental damage caused by purging.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pattern of binge eating followed by methods of purging or compensating to avoid weight gain. It is not the same as the binge/purge pattern in anorexia nervosa. The purging and/or compensation often involves vomiting, the use of laxatives, diets, and/or fasting. In this disorder the individual is preoccupied with thoughts about appearance, shape, and weight. Depending on the number and duration of binge/purge episodes per week, the disorder is given a severity rating of mild, moderate, severe, or extreme. The disorder can range from mild (1–3 episodes of binge/purge per week) to extreme (14 or more episodes per week) based on the frequency and duration of the episodes of bingeing and purging (American Psychiatric Association, 2013).

The causes and course of this disorder are many and complex. Family history, social factors, and personality traits are usually involved. A family history of obesity or an eating disorder is not uncommon. Expectations for thinness, stressful work situations, divorce, relocation, or loss of a loved one may be involved. It is common in social settings or professions that involve a body performance such as sports, acting, and modeling. Preoccupation with external beauty and "looking good" are common among those with this disorder. Personality traits such as perfectionism, worry, or low self-esteem are common. This disorder may begin with efforts to find social acceptance, attention getting, and the need to please others or seek approval. Sometimes few of these factors are involved, and the disorder begins with the use of purging as a short-term strategy for losing weight.

Treatment

Clinical treatment of this disorder typically involves counseling and sometimes medications. Unlike anorexia nervosa, treatment of bulimia nervosa does not usually involve hospitalization. The goal of the treatment is to reduce bingeing and purging and to foster recovery from the disorder. Because individuals with this disorder are often diagnosed with mood disorders or substance disorders, particularly involving alcohol and/or stimulants, these conditions must be treated simultaneously. Counseling usually involves cognitive behavior therapy and

nutritional counseling to change certain behavior and thinking patterns. Antidepressant medicines like Prozac may be used to reduce the binge-purging and to treat related depression or anxiety. Treatment of this and related disorders tends to be long term.

Len Sperry, MD, PhD

See also: Anorexia Nervosa; Binge Eating Disorder; Cognitive Behavior Therapy; Prozac (Fluoxetine)

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Bullying and Peer Aggression

Bullying, or peer aggression, involves intentionally harmful, repeated acts of aggression toward a person, typically a peer, with lesser power.

Definitions

- **Bully**, the aggressor, victimizer, or perpetrator of bullying; a person who uses his or her power to intimidate, harass, or harm another person.
- **Bullycide** refers to a suicide where the victim's death has been attributed to the victim having been bullied either in person or online.
- **Bystander** is a person who is present at, observes, or witnesses a particular event or circumstance (such as bullying) but who does not have direct involvement.
- **Cyberbullying** refers to using technology (texting, e-mailing, chat rooms, social media sites, pictures, etc.) to repeatedly and intentionally degrade, threaten, or humiliate another person.
- **Mobbing** is defined as when an individual is bullied by a group of people in any context, including a family, school, social setting, or workplace.
- **Victim** is the person who has suffered or been harmed as a result of being the target of bullying behavior.

Description

Bullying, also referred to as peer aggression, is defined as repeated acts of aggression, abuse, or intimidation that are inflicted directly or indirectly over time by one or more dominant persons. This behavior involves the interaction among three parties: the bully (aggressor), the victim (target), and the bystander (witness). Generally, bullying is committed from peer to peer. When bullying is inflicted by a group rather than by one individual, it is termed "mobbing." Three essential components distinguish bullying from other forms of victimization: (1) *intentional* harm to the victim, (2) *repetition* of the harmful acts over time, and (3) the existence of a *power differential* (physically, chronologically, socially, emotionally, psychologically) between bully and victim. There are various types of bullying, including physical, verbal, relational, and cyberbullying. Physical bullying entails behaviors like hitting, slapping, punching, pushing, kicking, tripping, spitting, and damaging another person's property. Insults, name-calling, slurs, threats, and spreading rumors/gossip are forms of verbal bullying. Relational bullying is described as when one uses one's social influence or popularity to isolate, ignore, exclude, or reject another person. Cyberbullying is a more recent phenomenon whereby aggressors use technological means (texting, pictures, social sites, e-mail, etc.) to bully their victims.

Students in grades 6–10 are most likely to be involved in bullying incidents, though bullying has been observed in children as young as three. There are also notable peaks in bullying behavior during the transition years from elementary to middle school and again from middle to high school, pointing to the value of early intervention. Early reports indicated that boys were more likely to engage in physical types of bullying while girls more readily displayed relational bullying. However, recent trends suggest that both boys and girls are

involved in relational types of aggression, with a drastic increase noted in recent times in rates of cyberbullying for both genders. The prevalence of technology in today's society has greatly contributed to increased incidents of cyberbullying. Accessibility to technology and anonymity issues further complicates this problem.

Victims of peer aggression may be targeted for differences in their appearance, race, ethnicity, gender, sexual orientation, personality, reputation, or ability. Experts have sought to establish a pattern of behavior for bullies, though no definitive profile exists. It was once believed that bullies harass and torment due to low self-esteem, but this is now considered a myth. Rather, aggressors are attracted to the attention and sense of power they get from putting others down.

The word "bully" can be traced back to the mid-16th century when it was first used as a term of endearment, likened to the word "sweetheart" or "lover" (Dutch/German origin). It was not until the 17th century that the term began to have more of a negative connotation. Reference to the current meaning of "bully" or "bullying" increased around the 1970s–1980s and became more commonplace in everyday vernacular in the late 1990s and early 2000s. The popular book, *Queen Bees and Wannabees* (2009), written by Rosalind Wiseman, exposed the true realities of bullying and relational aggression in girl world. The continued success of the pop culture film, *Mean Girls* (2004), based on Wiseman's book, further points to society's interest in the bullying phenomenon. Wiseman later went on to publish *Masterminds and Wingmen* (2013), addressing relational bullying from a boy's perspective.

As awareness about bullying has increased, more attention has been placed on approaches, policies, and strategies to prevent and combat it. Several have been attempted, ranging in level of effectiveness from zero-tolerance policies, restorative-justice approaches, education and identification training, and punitive measures. Norwegian psychologist Daniel Olweus is considered the pioneer of bullying research. He was the first to examine the prevalence of this problem among school-aged children back in the 1970s. His findings led him to develop a comprehensive approach for addressing bullying school-wide, the *Olweus Bullying Prevention Program*, which focuses on fostering positive peer relationships and creating safe environments where students can learn and develop. This program remains a popular evidence-based approach used today. Recent research supports the effectiveness of social-emotional learning programs that also work to create an overall positive school climate.

Current Status and Impact (Psychological Influence)

Studies have linked experiences with bullying to a wide range of negative consequences (physical, behavioral, academic, social, emotional, and psychological). Victims commonly report headaches, sleep problems, nightmares, and bed-wetting. They also report fear and anxiety about attending school and other social events. Bystanders indicate similar concerns. Being victimized also results in lower self-esteem and an increased risk of experiencing depression. "Bullycide," a term used to describe suicide resulting from peer aggression, is of further concern, as is homicide. There is evidence to support that several school-shooting cases can be traced back to victimization. Success in school can also be affected by bullying. Researchers have tied victimization to increased tardy, absentee, and dropout rates; poorer grades; and more academic struggles. Bullies also experience distinct consequences. Future involvement in spousal abuse, child abuse, and sexual harassment incidents is also more probable for those identified as bullies. In addition, aggressors exhibit lower frustration tolerance, have quicker tempers, and display more impulsive behaviors, which greatly contribute to struggles in school. Poorer grades; increased absentee and dropout rates; substance abuse problems; and high rates of depression, suicide, and self-injurious behaviors have also been noted.

Estimates suggest that some 30%–40% of youngsters, about one out of every four kids, report some level of involvement with bullying on a regular basis. However, these numbers are thought to be grossly underestimated as bullying often goes unrecognized and unreported. Most incidents occur in unsupervised locations such as playgrounds, bathrooms, and hallways, so the true severity of this problem remains unknown. Secrecy also plays a large role, as many victims are scared to report incidents out of fear of retaliation. Bystanders may also be hesitant to report out of concerns that the bully may turn on them next.

Presently, 49 states have anti-bullying laws (all except Montana). Georgia was the first to pass legislation back in 1999. Legislation varies by state according to reporting procedures and guidelines, requirements, and punishments. Educators, researchers, law enforcement officers, psychologists, counselors, parents, and young people remain interested in investigating and remedying the bullying problem.

Melissa A. Mariani, PhD

See also: Cyberbullying; *Mean Girls* (Movie); Mobbing; Peer Groups

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Bystander Effect

The bystander effect, also known as bystander apathy, is a highly researched social psychological phenomenon that occurs when an individual or individuals, who witness dangerous or harmful situations, stand by without offering assistance to the victim or victims.

Definitions

- **Bystander** is a person who is present at, observes, or witnesses a particular event or circumstance (such as bullying) but who does not have direct involvement.
- **Diffusion of responsibility** suggests that bystanders rationalize their hesitance, reluctance, or lack of intervening on a victim's behalf due to a belief that others present will take responsibility.

Description

When dangerous, harmful events or emergency situations occur and an onlooker or onlookers do nothing to intervene, stop, or assist the victim(s), this is referred to as "the bystander effect." This phenomenon has also been termed "bystander apathy," describing what appears to be relative disregard or lack of empathy for what the victim is experiencing. The probability of intervening also appears to decrease as the number of bystanders present increases. Various aspects of this effect have been researched and identified by social psychologists that help explain why the effect occurs. These variables include situational ambiguity, familiarity with the environment, sense of social responsibility, level of group cohesiveness, and diffusion of responsibility.

Development

Sociologists and psychologists have been researching the bystander effect for decades beginning with the groundbreaking study conducted by Bibb Latané and John Darley in 1968. Their interest was piqued following the publicized brutal rape and murder of "Kitty" Genovese by Winston Moseley on March 13, 1964, in Queens, New York. Though it was determined during trial proceedings that a dozen or so people had witnessed various pieces of the attack, media reports initially indicated much higher numbers (36–38), which resulted in public outrage and increasing concerns regarding bystander responsibility. (It was also later publicized that, during the Genovese attack, one person did call the police and one woman rushed to Genovese's side after the attack.) Latané and Darley proceeded with a series of experiments to investigate bystander behavior. Essentially, these studies consisted of staged events whereby a participant or group of participants were placed in emergency and nonemergency situations and observed to see whether they would intervene as well as how long it would take them to act.

Diffusion of responsibility, or the reluctance of observers to initiate assistance or involve themselves when others are around, was suggested as one possible explanation of the phenomenon. Witnesses often believe that someone else, perhaps an individual more qualified, will step up. Others may prefer not to get involved due to fear or intimidation.

Current Status and Results

Research on the bystander effect suggests that whether onlookers perceive the situation as an emergency or not matters. The more serious a situation is viewed, the faster the bystander reacts. An additional finding shows that when a person is alone, rather than with one or more people, he or she also tends to react more swiftly. Degree of connection to the victim is also a contributing factor. Bystanders with some relationship or tie to the victim are more likely to assist. Several examples of the bystander effect have been recorded throughout history. Recent interest in this phenomenon has focused on youth's hesitance to intervene in bullying situations, with experts recommending school violence-prevention programs that address bystander interventions in order to produce lasting change.

Melissa A. Mariani, PhD

See also: Bullying and Peer Aggression; Cliques; Mobbing; Obedience Studies

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CACREP

See Council for Accreditation of Counseling and Related Educational Programs

Caffeine-Related Disorders

Caffeine-related disorders are a group of disorders characterized by excessive consumption of caffeine. The disorders in this group include caffeine intoxication and caffeine withdrawal.

Definitions

- **Addictive** refers to a persistent, compulsive dependence on a substance or a behavior.
- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics and tranquilizers.
- **Caffeine** is a naturally occurring stimulant that is derived from plants, which may be addictive or cause withdrawal symptoms.
- **Caffeine-induced anxiety disorder** is an anxiety disorder characterized by state of panic (intense fear of a known danger) or anxiety (intense worry or an imagined danger) as a result of the consumption of caffeine.
- **Caffeine-induced sleep disorder** is a sleep disorder characterized by disturbed sleep as a result of the consumption of caffeine.
- **Substance-related disorders** are a group of mental disorders that are characterized by the problematic use of substances.
- **Withdrawal symptoms** are the symptoms (nervousness, headaches, insomnia, etc.) that occur when an individual who is addicted to a substance (drugs or alcohol) stops using the substance.

Description and Diagnosis

Caffeine-related disorders represent a group of mental disorders that result from excessive consumption of caffeine. This group is part of the substance-related disorders. The two primary disorders of this category are caffeine intoxication and caffeine withdrawal. Because they differ from this group in the severity of symptoms, caffeine-induced anxiety disorder and caffeine-induced sleep disorder are not included.

Caffeine consumption is common and widespread in many cultures. Typically, it is found in coffee, tea, energy drinks, and soda. But it is also in chocolate, in many over-the-counter medicines, and in weight loss supplements. In the United States, it has been estimated that 85% of the population consume caffeine frequently (American Psychiatric Association, 2013). Consequently, these disorders affect people in significant numbers. It is therefore important that clinicians are able to recognize these disorders as well as rule out other similar disorders and treat accordingly.

Here is a brief description of the two most common disorders.

Caffeine related disorders (caffeine intoxication and caffeine withdrawal) represent mental disorders that result from excessive consumption of caffeine, and are part of substance-related disorders. (Richard Nelson/Dreamstime.com)

Caffeine intoxication. Caffeine intoxication is a disorder that results from the consumption of large amounts of caffeine. Individuals diagnosed with this disorder have often consumed 250 mg of caffeine or more, roughly equivalent to 2.5 cups of coffee. To be given this diagnosis individuals must exhibit symptoms that may include agitation, apprehension, excitability, rapid heartbeat, flushed face, frequent urination, and difficulty sleeping. Such symptoms must be distressing to the individual or disrupt daily functioning.

Both children and older adults may be more sensitive to the effects of caffeine than middle-aged adults. It is estimated that 7% of the population may experience many of the earlier-mentioned symptoms every year (American Psychiatric Association, 2013). Treatment of this disorder may include the administration of antianxiety medication to reduce symptoms and laxatives to flush out the caffeine. If the caffeine was ingested recently, activated carbon (a substance that readily absorbs chemicals) may also be administered. Intense symptoms typically last four to six hours and then stop. This means that most individuals will recover fully even without treatment.

Caffeine withdrawal. Caffeine withdrawal is a disorder that results from the abrupt termination of caffeine consumption after having consumed the substance for an extended period of time. Symptoms of this disorder often include migraine (most common), inability to concentrate, moodiness, or symptoms similar to the flu. Typically, symptoms occur within two days following the last ingestion of caffeine. It is estimated that this disorder affects roughly half of those who stop caffeine after extended use (American Psychiatric Association, 2013). One of the most effective ways to reduce caffeine withdrawal symptoms is to provide the individual a small dose of caffeine. Since headaches are the most common withdrawal symptom, individuals may be encouraged to take an over-the-counter headache remedy (like Bayer aspirin) which contains caffeine.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Antianxiety Medications

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Cancer, Psychological Aspects

The psychological aspects of cancer include symptoms of anxiety, depression, and post-traumatic stress, as well as spiritual–existential issues. These may be experienced by the individual with cancer or caregivers.

Definitions

- **Adjustment disorder** is a mental disorder characterized by emotional or behavioral symptoms in response to an identifiable

stressor that is significantly distressing or causes impairment.

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Chronic disease** is a disease entity which usually does not have a single cause, a specific onset, nor a stable set of symptoms. While cure may be possible, it is unlikely for advanced levels of the disease process. It is also referred to as chronic medical conditions.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.
- **DSM-5** stands for *the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Post-traumatic stress disorder** is a mental disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. It is also referred to as PTSD.
- **Psychological factors affecting other medical conditions** is a mental disorder characterized by emotional factors that worsen a medical condition.
- **Relapse** is the recurrence of symptoms after a period of improvement or recovery.

Description

While some may consider cancer only a medical condition, there are many psychological aspects that result from this chronic disease. A cancer diagnosis and cancer treatment can result in significant psychological distress. The extent of distress depends on the type of cancer, time since diagnosis, degree of physical and social impairment, and prognosis. Some individuals may not develop symptoms severe enough to qualify for a diagnosis but may still experience psychological problems. Feelings of anger, guilt, sadness, and fear are common in those living with chronic disease. Others may qualify for a mental health disorder diagnosis. These include adjustment disorders or disorders of depression and anxiety.

Common psychological problems faced by individuals with cancer are anxiety, post-traumatic stress, depression, spiritual–existential issues, and interpersonal (relationship) issues. Individuals with cancer may experience anxiety for a number of reasons. These include fears about the cancer progressing or returning after remission (relapse). They may also be due to financial problems resulting from medical expenses, inability to perform previous duties at work or with family, or fears about dying. Experiencing a life-threatening medical condition is one criterion for a diagnosis of post-traumatic stress disorder according to the DSM-5. Depression may be brought on by the loss of familiar routines in daily life. Hopelessness, low self-esteem, and feelings of vulnerability that are associated with cancer may add to this. Individuals may also experience spiritual and existential issues. These involve loss of faith, conflicts in their relationship with God, and finding meaning in their illness. The psychological aspects of cancer impact family members and caregivers as well. Fears of losing a loved one and the stress associated with caring for an individual with cancer can lead to symptoms. Some individuals may develop mental health disorders like post-traumatic stress disorder themselves. This is particularly true for parents of children with cancer. Such stress can lead to a decline in care and increased distress for the individual with cancer.

The psychological problems associated with cancer can also lead to worsening physical symptoms. The DSM-5 diagnosis, psychological factors affecting other medical conditions, describes this relationship. Stress can cause tumors to grow and spread and increase feelings of helplessness. The relationship between psychological factors and cancer can be positive as well, however. Those who are able to manage stress tend to have better outcomes. Exercise, meditation, social support, and counseling are examples of activities

used to cope with the psychological problems associated with cancer.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Adjustment Disorder; Anxiety; Chronic Illness; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Post-Traumatic Stress Disorder (PTSD); Psychological Factors Affecting Other Medical Conditions; Re lapse and Relapse Prevention

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Cannabis Use Disorder

Cannabis use disorder is a mental disorder characterized by cannabis (marijuana) use, which leads to significant problems for the user.

Definitions

- **Addiction** is a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Executive functions** are high-level cognitive abilities such as planning, organizing, reasoning, decision making, and problem solving that influence more basic abilities such as attention, memory, and motor skills.
- **Motivational interviewing** is a counseling strategy for helping individuals to discover and resolve their ambivalence to change. It is also referred to as MI.
- **Narcotics Anonymous** is a self-help and support group for those addicted to drugs to help them learn how to live without the use of mind- and mood-altering chemicals. It is a Twelve-Step Program.
- **Psychoactive** is a drug or substance that has a significant effect on mental processes. There are five groups of psychoactive drugs: opioids, stimulants, depressants, hallucinogens, and cannabis.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions and compulsions based on a plan called the Twelve Steps.

Description and Diagnosis

Cannabis use disorder is one of the substance-related and addictive disorders. It is characterized by a problematic pattern of cannabis use which leads to significant distress or disrupted daily functioning. Problematic use of marijuana includes short-term physical and mental effects. Physical effects include mild sedation, impaired eye–hand coordination, increased appetite ("munchies"), and enhancement of senses. For example, food tends to taste and smell better and with increased appetite can lead to overeating. Mental effects include confusion, drowsiness, difficulty concentrating, exaggerated mood and personality, short-term memory difficulties, and time distortion. Mental effects can also include distortions of sound and color and possible hallucinations. The effects can be unique to the individual. So, while most users will be relaxed, some will be energized by marijuana use. Some may use it only for a specific purpose, such as to be more

Cannabis use disorder is a substance-related and addictive disorder. It is characterized by a problematic pattern of cannabis (marijuana) use, leading to significant distress or disrupted daily functioning. (Petr Zamecnik/Dreamstime.com)

sociable or to hear music more deeply or differently, while others use it daily. Cannabis is probably the most widely used illicit psychoactive drug in the world. It is used by approximately 5% of adults in the United States, with more males than female users (American Psychiatric Association, 2013).

Long-term effects include respiratory problems, immune system impact, and acute mental effects. Although there is not a direct cancer relationship between long-term marijuana use and cancer such as there is with nicotine use, other respiratory problems include acute and chronic bronchitis and lung tissue damage. Some individuals will experience a great deal of anxiety and paranoia while using marijuana that persists after usage. While not common, cannabis use can precipitate psychosis in those with a predisposition toward it.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a problematic pattern of cannabis use, which leads to significant impairment or distress. This must occur within a 12-month period. This includes taking the substance in larger amounts or for longer than intended. It means wanting to cut down or stop using the substance but not achieving this goal. It involves spending much time getting, using, or recovering from use of the substance. This disorder also involves cravings and urges to use the substance, and continuing to use, even when it causes problems in relationships. It involves failure to meet obligations at home, work, or school because of substance use. It also means reducing or stopping important social, work, or recreational activities because of substance use. This disorder involves repeated substance use even when it is physically dangerous. Despite knowing the risks of the physical and psychological problems that are caused or made worse by the substance, use of it continues. It means tolerance develops (needing more of

it to get the desired effect). Finally, it involves withdrawal symptoms, which can be relieved by taking more of the substance (American Psychiatric Association, 2013).

This disorder has many of the same root causes as other substance disorders. The desire for a "high" along with the belief that marijuana is harmless often leads to experimentation during adolescence. However, regular cannabis users typically experience withdrawal symptoms, including stomach pain, aggression, anxiety, and irritability. Many frequent cannabis users are believed to continue using in order to avoid these unpleasant symptoms. Early use of this drug is associated with pervasive cognitive, social, and work-related problems in later life. Long-term use leads to comprised brain activity, particularly cognitive and executive functions (American Psychiatric Association, 2013). Easy availability, higher potency, and lower price for cannabis may all contribute to the increase in cannabis-related disorders.

Treatment

Treatment for this disorder is similar to the treatment of other substance disorders. The goal of treatment is abstinence. Treatment approaches range from inpatient hospitalization and drug rehabilitation centers for detoxification to outpatient programs. Motivational interviewing is useful in identifying reasons to stop using cannabis and to increase motivation and readiness for treatment. Then, cognitive behavior therapy can be used to identify the beliefs, behaviors, and situations that trigger use and cravings. From these clinicians can develop a plan to reduce the likelihood of relapse. Because cannabis addiction is considered a chronic condition, long-term treatment to maintain sobriety and prevent relapse is necessary. This often includes continuing in therapy and/or a Twelve-Step Program like Narcotics Anonymous. For heavy users suffering from withdrawal symptoms, treatment with antianxiety and antidepressant medication may be used.

Len Sperry, MD, PhD

See also: Addiction; Cognitive Behavior Therapy; Motivational Interviewing; Twelve-Step Programs

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Capgras Syndrome

Capgras syndrome is a mental disorder characterized by the delusion that someone to whom one is close has been replaced by an imposter. It is also called Capgras delusion.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing automatic thoughts and maladaptive beliefs, including delusional beliefs.
- **Delusional disorder** is a mental disorder characterized by delusions. Previously this disorder was referred to as paranoia or paranoid disorder.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Dementia** is a group of symptoms including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of neurons (nerve cells) in the brain.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.

Capgras syndrome is a rare mental disorder characterized by the delusion that someone to whom one is close has been replaced by an imposter. It is also called Capgras delusion. (Bowie15/Dreamstime.com)

- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.
- **Schizophrenia spectrum and other psychotic disorders** are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, schizophreniform disorder, schizoaffective disorder, and schizotypal personality disorder, and delusional disorder.

Description

Capgras syndrome is a specific delusion in which an individual believes that one's friend, family member, or spouse has been replaced by an imposter who is identical in appearance. This belief may be of a short duration or chronic. This disorder is named for the French psychiatrist Joseph Capgras (1873–1950), who was the first clinician to recognize and write about the disorder. It is also known as Capgras delusion and delusion misidentification.

The occurrence of Capgras syndrome is unknown but is considered to be rare. This disorder is not a specific diagnosis outlined in the DSM-5. However, it

does qualify as a symptom of the schizophrenia spectrum and other psychotic disorders, including delusional disorder and schizophrenia, which it is most commonly associated with. It follows that individuals who experience Capgras syndrome may be diagnosable with one of the previously mentioned disorders.

The specific cause of this disorder is unknown. For individuals who have a primary diagnosis that includes delusional components, the cause is most likely related to the same origin of the primary diagnosis. For those who do not have a delusional disorder, it has been theorized that brain dysfunction caused by illness (e.g., dementia) or brain injury can cause this disorder to manifest. As it pertains to brain injury, it has been suggested that damage to the brain in the areas related to emotional response may be to blame. An individual may see the familiar face of a loved one and be able to recognize it but not experience the emotional response typically associated with that person. Consequently, the individual forms the belief that this person is not the person he or she once knew.

Treatment

Treatment of Capgras syndrome in someone with a primary diagnosis of schizophrenia spectrum and other psychotic disorders is usually the same as the primary diagnosis. Many of the methods employed in these psychotic disorders are effective in treating the characteristic delusion of this syndrome. Specific therapies may include cognitive therapy and antipsychotic medications.

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See also: Antipsychotic Medications; Cognitive Therapies; Delusional Disorder; Delusions; Dementia; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Schizophrenia; Schizophrenia Spectrum and Other Psychotic Disorders

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Career Assessment

The purpose of career assessment is to obtain information about a person's interests, abilities, talents, and capacity for growth related to his or her aspirations. In using career assessment tools, a trained practitioner, such as a career counselor or advisor, guides the client toward appropriate placement in hopes of helping the person pursue his or her work-related goals.

Definitions

- **Career counselor,** or vocational counselor, is a counseling professional who has received specialized coursework, training, and certification in career-related guidance in order to provide advisement to persons seeking assistance in this area.
- **Interest inventory** is a type of career assessment that gauges what a person likes or is interested in.
- **Self-assessment (career)** is a self-reporting instrument used to gather information about a person's values, personality, interests, skills, and abilities.

Description

Career assessment describes the process of using tools, tests, questionnaires, and inventories to determine a person's abilities and skills related to work. They are used to identify strengths and weaknesses to help guide possible job choices. Career assessments refer to the specific tests that are used to acquire knowledge about a person's career options. Both quantitative and

qualitative information are generated from these tests. Counselors who have been schooled in career or vocational guidance typically conduct them. However, other professionals who have been trained in this type of assessment, including mental health practitioners and educational advisors, may also perform these tests.

There are various types of career assessments, and each uses a different type of criteria to gather information. Interest inventories gauge what one's likes, preferences, or activities one is drawn to. Other tools assess a person's values or what criteria are most important to a person in terms of the person's career. For example, one may value flexibility in work schedule over salary. Aptitude and skills tests seek to determine what a person is best suited for in terms of natural talents or skill sets. Personality inventories place individuals in various type categories and attempt to link these to different careers known to be rewarding for those types.

Development

The foundation for career assessment was laid several decades ago in the early part of the 20th century. A growing need to find proper job placements for soldiers returning from war as well as a new emphasis on math and science preparation in the field of education spawned the career guidance counseling movement. From this came many changes including the development of career assessment tools, such as the Myers–Briggs Type Indicator (MBTI), the Strong-Interest Inventory, and Holland's Codes.

The Myers–Briggs Type Indicator assessment is a psychometric questionnaire that was developed by Katharine Cook Briggs and her daughter Isabel Briggs Myers in 1962. The MBTI measures a person's perceptions of the world and decision-making process. The theoretical basis for the assessment is the principle of typology. Carl Jung was the first psychologist to propose the idea of types back in the 1920s. He theorized that there were four main ways that people experience the world, through sensation, intuition, feeling, or thinking. The MBTI emphasizes the value of personal preferences and how these guide our interests, values, needs, and motivation.

Another career assessment tool is the Holland Codes. Psychologist John Holland developed these codes based on six personality types: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional, each reflective of how a person approaches life. Individuals are categorized based on their top three types. Occupations are also classified and then matches are based on what personality types fit those careers best.

The Strong Interest Inventory (SII), developed by psychologist E. K. Strong, Jr., in 1927, is one of the most popular career assessments. The most recent version (2004) is based on the Holland Codes and is used readily in by career advisors and guidance counselors. The goal of the SII is to determine a person's top interest and use that information to decide on an appropriate career choice.

Current Status and Results

Career assessment tools have been criticized for their lack of validity and reliability. Though these types of tests can be valuable in obtaining useful information, they should be interpreted only by trained professionals and should not be viewed as an end-all determinant. Many of these tools gauge how a person reports feeling, thinking, behaving, or preferring at a given time, which arguably is likely to change over time. However, research trends indicate that a person will change careers at least once in his or her lifetime so career assessments are useful vehicles to guide this process and help a person determine the best suitable job options.

Melissa A. Mariani, PhD

See also: Career Counseling; Career Development

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Career Counseling

Career counseling is a collaborative process in which a counselor or advisor works with a person to help

identify personal interests, abilities, and goals so the person can make wise career-related decisions.

Definition

- **Career counselor,** or vocational counselor, is a counseling professional who has received specialized coursework, training, and certification in career-related guidance in order to provide advisement to persons seeking assistance in this area.

Description

Career counseling describes a process in which a counselor and counselee form a collaborative relationship focused on identifying and acting on career-related goals. A career counselor employs various techniques that may include individual or group-based discussion, as well as the use of self-assessments, including interest inventories, personality tests, and aptitude tests. By uncovering a person's interests and abilities, the career counselor seeks to expose the counselee to various job possibilities that may be suitable. Goals of a career counseling session may be to bring about self-awareness, identify personal strengths and weaknesses, develop short- and long-term goals, accept responsibility for one's actions, and maintain the proper level of motivation.

Counseling focused on career-related areas can be provided to people of any age and at any stage of their career path. Topics do not have to focus solely on possible job or career changes but may also surround workplace frustrations, decisions about pursuing further education, and/or how to balance personal and professional life. People seeking career counseling services can meet with counselors in a one-on-one setting or in small groups. Though these are the most common settings, career counseling activities may also be presented to larger groups in a classroom or workshop environment. Small group sessions may last anywhere from four to six sessions. An initial or intake career counseling session may entail the use of assessments that will help determine the person's interests, aptitude, and skill sets.

Development (History and Application)

The practice of career counseling has its foundation in career counseling theory. Career counseling theories are different from career theories in that career theories provide possible explanations for how people experience their careers and work environments along with how they make job-related decisions. On the other hand, career counseling theories attempt to provide possible approaches to assist a person along his or her career development path. Several types of career counseling theories exist and can determine the approach, techniques, activities, and assessment tools that a career counselor chooses to employ with a client.

Career counseling services began at the turn of the 20th century with Frank Parsons and the vocational guidance movement. Parsons outlined a career decision-making process whereby people could identify their aptitudes and interests and align them to a fitting career choice. Current theorists, such as John Holland, refer to this concept as "person-environment-fit."

Career counselors typically receive specialized education, training, and/or certification. Most hold a master's level degree in counseling with a specific focus on career assessment, development, theory, and advisement techniques. Professional school counselors, or guidance counselors, obtain coursework and training pertaining to career counseling topics for students in grade prekindergarten through 12th.

Current Status

Career counseling takes place in different settings. Career counseling centers may be free standing or located in educational settings including community colleges and universities. Recent mandates require that career domains be covered in the kindergarten through 12th-grade curriculum. However, how educational systems go about this can vary according to state, district, and school setting. Professional school counselors have been charged with covering career development in their guidance and counseling curriculums. Furthermore, the American School Counselor Association National Model mandates that career standards be incorporated into comprehensive developmental guidance

programs. School counseling curriculums may cover career domains in a variety of direct counseling services, including classroom guidance, small group counseling, and individual counseling. Again, the delivery system may also vary according to grade level. For example, high school students may require more individualized career guidance services, so one-on-one advising may occur more often at this level.

Melissa A. Mariani, PhD

See also: Career Assessment; Career Development

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Career Development

Career development refers to an ongoing, lifelong process of learning about oneself and developing new skills in relation to work. This process can be influenced by several factors including psychological, educational, physical, economical, and sociological.

Description

Career development refers to how people relate to the world of work and their role in it. This ongoing process involves managing one's career either within an organization or between organizations for the purpose of attaining specific career goals and aspirations. Several factors contribute to the development and success of a career over the lifespan, including personality and trait factors, developmental factors, and systemic factors. These factors have been outlined as the basis of different career development theories.

Career development can be defined within two separate contexts: organizational and personal. When defining the term from an organizational perspective, career development refers to how one manages one's career within an organization or between organizations. It also includes how these organizations structure advancement within the company (i.e., how one progresses in career goals). From a personal perspective, career development is defined as the combination of physical, psychological, sociological, educational, and economic factors that influence the nature and significance of work for a person over his or her lifetime. These factors can also impact one's career patters, decision-making style, sense of self, and personal values.

Prior to the late 1960s, the term "career development" was more commonly referred to as vocational development and its practice as career guidance or vocational guidance. The more recent term, "career development," emerged in the later part of the 20th century and has continued to evolve in the 21st century. Career development derived from the vocational guidance movement. Demographic, economic, and societal changes in the United States during this time urged leaders to respond to growing demands in educational and career domains. Pressure to compete with other nations thus resulted in a need for career guidance and career development practices. The purpose of career development then was to help determine a person's aptitude and ability and properly place the person in a fitting career.

Frank Parsons, the father of the vocational guidance movement, offered a three-step model for counselors to use to guide people through the career development process. He proposed that first, one should have a clear understanding of oneself and one's interests, abilities, talents, and limitations. Second, the person should be educated on what careers are out there that would be a good match for his or her aptitudes, and furthermore, the person should have a working knowledge of the requirements needed in order to be successful in that line of work. With this comes the practical knowledge related to advantages and disadvantages of those career paths. Third, one must have a reasonable ability to incorporate what was learned in the first two steps in order to make the best decision possible.

Current Status and Impact (Psychological Influence)

A person should be introduced to career development early on in life in school if not at home. Though career development has been a focal point of education in elementary and secondary schools since the mid-1900s, specific standards were not outlined in curriculum until much later. The American School Counselor Association's first set of National Standards, developed in 1995, outlined three domain areas that should be the focus of guidance and counseling standards for all students in K-12 settings. These three domains are academic, personal/social, and career development. Career decision making remains an integral part of a student's future success in the world of work.

Melissa A. Mariani, PhD

See also: Career Assessment; Career Counseling

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Caregivers

Caregivers are those who help others who by reason of age, illness, or disability are unable to live self-sufficiently.

Description

A caregiver is a person designated as responsible for the care of someone else who suffers from poor mental health or physical disability or whose health is impaired by sickness or old age. The general term "caregiver" refers to both professional health-care workers and untrained, semiskilled relatives or friends of disabled people. Professional caregivers include graduate school–educated nurses, postsecondary trained assistants, and high school graduates. These professionals also include registered nurses, personal care assistants, or respite care workers. Duties involved in these professional roles range from the provision of medical care to self-help skills and beyond.

Family members, friends, and other relatives of people with disabilities or illnesses also serve as caregivers. Usually these informal caregivers are unpaid and are expected to help the individuals they care for with their daily living activities such as cleaning, cooking, and paying bills. In recent years however, the range of duties has increased to include some traditionally performed only by nursing staff. These duties include administering prescribed medications, dealing as intermediary with doctors and nurses on behalf of the one they care for, and helping the patient with intimate activities such as bathing or dressing, as well as activities such as exercise or physiotherapy. Often caregivers perform these activities over many years and with increasing difficulty as the patient's or relative's condition worsens. Caregivers themselves age and encounter their own physical, psychological, and mental limitations.

Current Status and Impact (Psychological Influence)

In 2009 it was estimated that there were over 60 million people in the United States who were acting as caregivers for others in some capacity. Almost 75% of these people were female and most were between 35 and 59 years of age. With an aging population and limited societal services for individuals who cannot live self-sufficiently, the role of caregiver has become a very common and necessary function in modern society. Caregivers are especially necessary in the beginning stages of debilitating conditions like dementia, Alzheimer's, and Parkinson's. When these patients require assistance mostly to cope with normal daily activities, it is usually relatives or friends who provide the necessary help.

Many nonprofessional caregivers face great challenges in adjusting to their role and its physical and psychological demands. They are often in relationships of familial intimacy with the patients for whom they are responsible. Even though they often say that they find the opportunity to provide care for a loved

A caregiver is responsible for the care of someone else who suffers from poor mental health or physical disability, or whose health is impaired by sickness or old age. A good caregiver can be crucial to those who suffer from mental health issues. (Jean Paul Chassenet/Dreamstime.com)

one rewarding, it is also true that stress and burnout characterize many caregivers especially after what may be years of continuous responsibility. This condition of exhaustion or discouragement is often referred to as caregiver syndrome.

It is clear that taking care of the caregiver is a challenge for society. Caregivers must have support themselves in order to do their jobs effectively and efficiently. One of the best supports is for the caregiver to get a temporary but regular break from the demands of caregiving for a patient or family member. Psychoeducation and support activities, such as support groups, for caregivers are crucial in the coming years if they are to fulfill their critical duties.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Psychoeducation; Support Groups

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Case Conceptualization

Case conceptualizations provide psychotherapists with an explanation and strategy for planning and focusing treatment interventions to increase the likelihood of achieving treatment goals.

Definitions

- **Diagnostic and Statistical Manual of Mental Disorders (DSM)** is a diagnostic classification framework that characterizes mental disorders with specific diagnostic criteria. It is used by clinicians to diagnose mental disorders. The most current version is DSM-5.
- **Maladaptive pattern** refers to a pattern that is dysfunctional or unhealthy.
- **Pattern** is a description of an individual's characteristic way of perceiving, thinking, and acting.

Description

A case conceptualization is a clinical strategy for obtaining and organizing information about a client, explaining the client's situation and maladaptive pattern, guiding and focusing treatment, anticipating challenges and roadblocks, and preparing for successful termination. While many therapists develop conceptualizations to guide their practice, not all therapists explicitly articulate these conceptualizations because they are not sufficiently confident with this competency. There are a number of internal and external reasons for developing and articulating a case conceptualization. The most important internal reason is that a case conceptualization enables therapists to experience a sense of confidence in their work. This confidence is then communicated to the client, which strengthens the client's trust in the therapist and belief that therapy can and will make a difference.

Developments and Current Status

Since at least 2005, case conceptualizations, previously called case formulations, were a requisite for the effective provision of psychotherapy. There are at least three external reasons for this trend. The first reason is the accountability demand by third-party payers that counselors and therapists justify their treatment with clients. Receiving authorization and payment to treat a client requires documentation of a compelling rationale for treatment. The second reason is the movement toward empirically supported treatment, which emphasizes the use of case conceptualizations. The third reason is that the diagnostic manuals, such as DSM-5, are largely descriptive and do not provide explanation for causes, precipitants, maintaining factors, or treatment interventions. In contrast, a case conceptualization provides a rationale for all these factors and a link between diagnosis and treatment.

A case conceptualization is essentially a summary statement consisting of four components. The first is a diagnostic formulation that provides a description of the client's presenting situation and its perpetuants or triggering factors. It answers the "What happened?" question and usually includes a DSM-5 diagnosis. The second is a clinical formulation that provides a compelling explanation of the client's presenting symptoms, issues, and maladaptive pattern. It answers the "Why did it happen?" question. The third is the cultural formulation that provides a cultural explanation of the client's presentation and the impact of cultural factors on the client's personality. It answers the "What role does culture play?" question. The fourth is the treatment formulation that provides an explicit blueprint for intervention planning. It answers the "How can it be changed?" questions, contains treatment goals and specific interventions, and anticipates challenges in achieving these goals.

Len Sperry, MD, PhD

See also: Psychotherapy; Psychotherapy Skills and Competency

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Case Management

Case management is a collaborative process between a case manager and an individual and his or her family to assess, plan, coordinate, evaluate, and advocate for the individual's health needs.

Definitions

- **Case managers** are health-care professionals who work with individuals and families to

plan, coordinate, and monitor the outcomes of health-care services.

- **Evidence-based practice** is a form of practice that is based on the integration of the best research evidence with clinical expertise and client values.
- **Health Maintenance Organization** is an organization that provides or arranges managed care.
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Case management has two functions (purposes). The first is to advocate for the client after determining health and mental health needs. The second is to coordinate resources and ensure that the client's needs are satisfied. Case managers are an integral part of case management. Their job is to assess the client's needs to determine the appropriate services to fulfill those needs. They then develop a detailed plan, which includes the services of health-care providers, psychiatrists, psychotherapists, psychological evaluation, substance abuse programs, and life skills counseling. Case manager also works with other agencies and professionals to ensure that clients' needs, including living arrangements, are met.

Case management involves a case-by-case evaluation of clients' need for services. The need is compared to the cost of services and available funding for services. Case management attempts to ethically match appropriate health-care services with client needs. It assists in managing health problems as well as life care planning. First and foremost, the measure of the effectiveness of case management is its advocacy for the client.

While case management and psychotherapy appear to be similar, they are actually quite different. The primary focus of psychotherapy is to develop a therapeutic alliance (relationship) with a client and then work collaboratively to effect a basic change in the client's personality and pattern of functioning. In contrast, while a good working relationship and collaboration with a client are essential for case management to be effective, the goal is not to effect basic changes in the client's personality and pattern of functioning. Rather, it is to coordinate the services of all providers involved with the client, including psychotherapists. It should be noted, however, that occasionally, a psychotherapist may function briefly in the case management role when a client does not have a designated case manager.

Development and Current Status

Case management has its roots in managed care and Health Maintenance Organizations. Managed care was established to increase the efficiency and cost effectiveness of health care. Case management can and does have a critical role in managed care. This is particularly the case when a client has serious, complex, or long-standing health problems that require the coordination of many health providers and services. In this respect, case management has a unique role on the health-care team.

Over the years, case management has become a recognized health-care profession. The Case Management Society of America began in 1990. It was established to assist in defining and promoting the profession of case management. Since 1993, the Commission on Case Manager Certification has awarded the Certified Case Manager designation to professionals who meet certification standards.

Case management systems range in size, bureaucracy, and the number of cases to be managed. Some case management systems are overloaded with clients. The effectiveness of case management is directly related to the amount of time spent with a client. Most frequently, case management is utilized with the elderly, disabled, or chronically ill. Finally, it should be noted that changes to the health-care system in the United States have increasingly impacted the practice of case management.

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See also: Case Manager; Empirically Supported Treatment; Evidence-Based Practice

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Case Manager

Case managers are health-care professionals who work together with individuals and families to assess, plan, coordinate, evaluate, and advocate for the individual's health needs.

Definitions

- **Case management** is a collaborative process between a case manager and an individual and his or her family to assess, plan, coordinate, evaluate, and advocate for the individual's health needs.
- **Evidence-based practice** is a form of practice that is based on integration of the best research evidence with clinical experience and client values.
- **Health Maintenance Organization** (HMO) is an organization that provides or arranges managed care.
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Case managers have two essential functions (job purposes). The first is to manage advocacy efforts for clients' health and mental health needs. This advocacy occurs after the case manager works to determine what a client's health needs are. The second function includes the coordination of resources necessary to meet those needs. It also includes working with other agencies and professionals to ensure that client needs are thoroughly evaluated, monitored, and treated. Case managers evaluate clients' need for services on a case-by-case basis. They strive to make the most ethical decisions possible regarding matching health services with clients' needs, while considering cost of treatment and available funding. Highly effective case managers successfully advocate and efficiently coordinate services for their clients.

While case managers' and psychotherapists' functions appear to be similar, they are actually quite different. Psychotherapists focus primarily on developing a therapeutic alliance (relationship) with a client and then collaboratively work to effect basic changes in the client's personality and pattern of functioning. In contrast, while effective case managers establish a good working relationship, the purpose of their job is not to effect basic changes in the client's personality and pattern of functioning. Rather, case managers coordinate with all providers of health services required by clients' needs, which often include psychotherapists. However, when a client does not have a case manager, his or her psychotherapist can function briefly in the case management role. Case managers, on the other hand, are not typically trained to function as a psychotherapist.

Development and Current Status

The coordination of health services has evolved throughout the years and has been the responsibility

of various health-care professionals. The modern case manager, described earlier, has its roots in managed care and HMOs. Managed care was established to increase the efficiency and cost effectiveness of health care in the 1970s. In 1990, the Case Management Society of America (CMSA) was founded. CMSA assisted in defining and promoting professional case managers. Since 1993, the Commission of Case Manager Certification has awarded the Certified Case Manager designation to professionals who meet certification standards.

Layven Reguero, MEd, and
Len Sperry, MD, PhD

See also: Case Management; Empirically Supported Treatment; Evidence-Based Practice; Managed Care

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Catatonic Disorders

Catatonic disorders are mental disorders characterized by catatonia or disturbances in muscle movement often involving rigid body postures.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are also referred to as neuroleptics or antipsychotics.
- **Bipolar disorder** is a mental disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more major depressive episodes.
- **Catatonia** is a condition of immobility with muscle rigidity or inflexibility and, at times, overactivity and excitability.
- **Delirium** is sudden and severe confusion due to changes in brain function that occur in mental and physical illness.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily routine.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Electroconvulsive therapy** is a procedure in which electric currents are passed through the brain, intentionally triggering a brief seizure in order to quickly reverse symptoms of certain mental illnesses. It is also referred to as ECT.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than external stimuli.
- **Psychotic disorder** is a severe mental disorder characterized by psychotic features.
- **Psychotic features** are symptoms characteristic of psychotic disorders. They include delusions, hallucinations, and negative symptoms (lack of initiative and diminished emotional expression).
- **Schizophrenia spectrum and other psychotic disorders** are a group of DSM-5 mental disorders characterized by psychotic features. They include schizophrenia, delusional disorder, and catatonic disorders.
- **Specifier** is an extension to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Catatonic disorders are classified with the DSM-5 schizophrenia spectrum and other psychotic disorders. Basic to all catatonic disorders is catatonia. It is characterized by a psychomotor (mental processes and physical movement) disturbance that may involve decreased motor activity, dismissiveness during an interview or physical examination, or excessive or strange motor activity. The psychomotor disturbance in an individual may range from being unresponsive to agitated. Motor immobility and dismissiveness may be severe or moderate. Excessive and strange motor behaviors may be simple or complex. The most common presentation is maintaining stiffened and rigid body postures for long periods. In some cases, an individual may alternate between decreased and excessive motor activity. Individuals exhibiting severe stages of catatonia may need supervision from a caretaker to avoid harming themselves or others. Furthermore, catatonia has potential risks, which include exhaustion, malnutrition, extreme fever, and self-harm.

Catatonia is a condition that can occur in several disorders, including neurodevelopmental, psychotic, bipolar, and depressive disorders, and other medical conditions. While catatonia is not a specific disorder in DSM-5, DSM-5 does recognize catatonia associated with other mental disorders (e.g., psychotic disorders, neurodevelopmental disorders, bipolar disorders, depressive disorders, or other mental disorders). There are three types of catatonic disorders in DSM-5. They include catatonia associated with another mental disorder (catatonia specifier), catatonic disorder due to another medical condition, and unspecified catatonia. Following are brief descriptions of each of these disorders.

Catatonia associated with another mental disorder (catatonia specifier). Catatonia associated with another mental disorder (catatonia specifier) may be applied when criteria are met for catatonia during the course of psychotic, neurological, depressive, bipolar, or other mental health disorders. The catatonia specifier is appropriate to use when an individual has characteristics of psychomotor disturbance and involves at least 3 of the 12 diagnostic features indicated in the DSM-5. Some of the diagnostic features include not actively relating to the environment, motionlessness maintained over a long period, resistance to positioning by the examiner, opposition to instructions, and inappropriate posture maintained over a long period. Individuals with this disorder may also exhibit a detailed caricature of normal actions, repetitive movements, agitation, disapproving facial expressions, and mimicking another individual's speech and movements. The majority of catatonia cases involve individuals with bipolar and depressive disorders. However, up to 35% of individuals with catatonia have schizophrenia and are usually diagnosed in inpatient settings (American Psychiatric Association, 2013). Catatonia can occur as a side effect of medications. Before any of the disorders related to the catatonia specifier can be diagnosed, a variety of other medical conditions need to be excluded.

Catatonic disorder due to another medical condition. Catatonic disorder due to another medical condition is the presence of catatonia that is found to be caused by the psychological effects of another medical condition. Catatonia is diagnosed when at least 3 of the 12 clinical features indicated in the DSM-5 are present. The diagnostic features of this disorder are exactly the same as the one's listed earlier in catatonia associated with another mental disorder (catatonia specifier). There must be evidence from a physical examination, an individual's history, or laboratory results that the disturbance is the direct result of another medical condition. This diagnosis is not given if it is better accounted for by another disorder (e.g., depressive episode) or if it takes place solely during the course of a delirium. The disturbance (catatonia) must cause significant impairment and distress in an individual's occupational, social, or other important areas of life. A number of medical conditions may cause catatonia, particularly neurological conditions, such as head trauma, inflammation of the brain, and disease of blood vessels in the brain (American Psychiatric Association, 2013).

Unspecified catatonia. Unspecified catatonia is a category that applies to the appearance of symptoms that are characteristic of catatonia and cause significant impairment or distress in occupational, social, or other important areas of an individual's life. The essential features of the primary mental disorder or other medical condition are not clear. Furthermore, the full criteria for catatonia as indicated in the DSM-5 are not met, and there is not sufficient information to make a more specific diagnosis (American Psychiatric Association, 2013).

Treatment

The clinical treatment of catatonic symptoms involved medication management and electroconvulsive therapy (ECT). Antipsychotics are effective in treating symptoms of catatonia. However, there are concerns with these medications since they can cause or worsen catatonia in some individuals. Still, because they are effective with most individuals with these disorders, they continue to be used. ECT is another form of treatment for catatonia. It involves administering electric shock to the brain, which precipitates a seizure in order to quickly reverse symptoms of catatonia. If an individual does not positively react to medication therapy, ECT has been shown to be the second choice of treatment. ECT has been found to be an effective and safe treatment approach.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Benzodiazepines; Bipolar Disorder; Brain; Delirium; Delusions; Depression and Depressive Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Electroconvulsive Therapy (ECT); Hallucinations

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CBT

See Cognitive Behavior Therapy

Celexa (Citalopram)

Celexa is a prescription antidepressant medication for the treatment of depression and various anxiety disorders. Its generic name is citalopram.

Description

Celexa is one of the selective serotonin reuptake inhibitor (SSRI) antidepressants. Its main use is for the treatment of depression. Other uses include treatment of alcoholism, eating disorders, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, premenstrual dysphoric disorder, and social anxiety disorder. Serotonin is a neurotransmitter or brain chemical that carries nerve impulses from one nerve cell to another. It is believed that depression and certain mental disorders are caused by insufficient serotonin in the brain. Like the other SSRI antidepressants, Prozac, Zoloft, and Paxil, Celexa increases the level of brain serotonin. Increased serotonin levels in the brain appear to be beneficial in relieving symptoms associated with depression, anxiety, alcoholism, headaches, and premenstrual tension and mood swings.

Precautions and Side Effects

Individuals who are allergic to other SSRI medications should not be prescribed Celexa. Those with liver problems and those over the age of 65 are best treated with lower doses of the drug. Those with histories of mania, suicide attempts, or seizure disorders should start Celexa with caution and only under close physician supervision. Children and young adults are at higher risk of developing suicidal thoughts and actions. Generally, those under 18 years of age should not take Celexa. Because it interacts with monoamine oxidase inhibitors, like Parnate, an antidepressant, or Buspirone, an antianxiety medication, Celexa should not be used in combination with these medications. Similarly, certain herbal supplements, like Ginkgo and St. John's wort, should not be taken together with Celexa.

Nausea, dry mouth, and insomnia are among the most common side effect of Celexa. Other side effects include anxiety, agitation, headaches, dizziness, restlessness, sedation, tremor, and yawning. Decreased sex drive in women and difficulty ejaculating in men have been reported, while weight gain or loss is not common. In some patients these sexual side effects never resolve. If sexual side effects continue, the dose may be reduced or a switch made to another antidepressant.

Len Sperry, MD, PhD

See also: Antidepressant Medications

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Certified Addictions Professional (CAP)

Certified Addictions Professional is a credential for individuals who provide treatment services for addictions. It is also known as CAP.

Definitions

- **Addiction** is a chronic disease of the brain that involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **Ambivalence** is a human phenomenon that occurs when a client has opposing opinions about behavioral change.
- **Case management** is a process that involves linking clients to community resources that may enhance or promote their well-being or daily functioning.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **Motivational interviewing** is a counseling approach that is used to assist individuals in considering behavioral change, that is, to stop using alcohol and seek alternative coping strategies.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

Description

Certified Addictions Professional (CAP) is a credential that requires training, supervision, and passing a standardized exam. This designation allows clinicians to provide assessment and treatment among individuals living with substance-related and addictive disorders. Individuals with this credential are certified through their state's addictions certification board. This certification requires a minimum of a bachelor's degree and specific education in addictions. Other requirements include supervised work experience with substance abusers and passing a state certification exam. Specific training is required in the following areas: clinical evaluation, case management, counseling, treatment planning, professional documentation, ethical and professional issues, theory and treatment of addictions, client and community education, and application to practice. Training in these content areas can be obtained online or in face-to-face training settings.

Certified Addictions Professionals provide assessment and psychotherapeutic treatment, create treatment plans, and provide case management to individuals living with substance use disorders. Services that CAPs offer include addiction prevention, intervention, and continuing care services. Specific interventions include substance abuse counseling among individuals, couples, families, communities, and group therapy contexts. Substance abuse counseling includes talk therapy interventions such as relapse prevention, learning new coping skills, learning triggers, and cognitive and behavioral replacement strategies. CAPs are trained in working with clients who

may be court ordered for treatment or who are not motivated to stop using substances.

Since many clients who enter drug treatment are ambivalent about changing, motivational interviewing is often used. It can assist clients in examining their behaviors and ambivalence in a nonjudgmental and supportive environment. CAPs often utilize this approach to form an alliance with the client but also assist the client in resolving his or her ambivalence about abstaining from substance use and eventually assist him or her in committing to therapy and self-improvement.

Maintenance of the CAP credential requires ongoing continuing education that can be attained from approved providers. Continuing education is required to ensure that clinicians are learning and practicing empirically supported treatments. CAP holders are responsible for obtaining required continuing education through approved or accredited training providers.

The CAP credential is affiliated with the International Certification & Reciprocity Consortium (IC&RC), which monitors the international standards of practice in addiction counseling and other tasks that CAPs engage in. In addition, the IC&RC recognizes the minimum standards to provide reciprocity to professors across state borders. The certification board monitors the code of ethics to ensure quality assurance in the prevention and treatment of individuals living with addictions. Individuals applying for the CAP also take an international exam from the IC&RC.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Addiction; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Motivational Interviewing; Substance-Related and Addictive Disorders

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Certified Rehabilitation Counselor (CRC)

A Certified Rehabilitation Counselor is a professionally trained therapist who works to help people with various disabilities. It is also known as a CRC.

Definitions

- **Certification** is a formal procedure by which an accredited or authorized person or agency assesses and verifies that a person has the knowledge and skills to perform certain activities.
- **Rehabilitation counseling** is a type of counseling that focuses on helping individuals who have disabilities in order to achieve their career, personal, and independent living goals.

Description

Specific qualifications are required in order to become a Certified Rehabilitation Counselor (CRC). This includes specialized education, training, and field work prior to passing a national exam. Once a person successfully completes these steps, he or she is able to apply to become a CRC. The education and training that CRCs receive focus on understanding the medical and psychosocial aspects of various disabilities.

Those students seeking a master's degree in rehabilitation counseling have undergraduate degrees in rehabilitation services, psychology, sociology, or other human services–related fields. As a master's degree is required at a minimum, rehabilitation counselors are trained at the graduate level. Most earn a master's degree, with a few continuing on to the doctoral level. The Council on Rehabilitation Education accredits programs at universities, but not all programs meet accreditation requirements. This limitation prohibits some graduates from professional certification/licensure.

The primary purpose of rehabilitation counselors is to value a client's rights to be as independent as possible. This includes independent living, promoting advocacy, and empowering the client to be socially included. There are several areas of specialty among

rehabilitation counselors. These include specializations in employee assistance, job coaching, substance abuse, life and medical care planning, and mental health counseling. CRCs should also be knowledgeable about assistive technology and devices that can help people overcome obstacles. A CRC is also involved in case management and assessing a client's abilities and strengths to help him or her get jobs.

Current Status and Impact (Psychological Influence)

Although policies vary from state to state, rehabilitation counselors who work in the federal and state systems typically must hold a master's degree in rehabilitation counseling, special education, or a related field, and are required to be certified or be eligible to sit for the certification examination. People accepting employment in government-run vocational rehabilitation programs are required to meet these qualifications by a specific date in order to keep their jobs.

Alexandra Cunningham, PhD

See also: Commission on Rehabilitation Counselor Certification (CRCC); Rehabilitation Counseling; Vocational Counseling

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Chamomile

Chamomile is an herb that has been used to alleviate anxiety and stress, to produce mild sedation, to reduce restlessness and irritability, and to ease depression.

Description

The chamomile flower has been harvested for centuries for various medicinal purposes. Today, various preparations are available. It is commercially available in prepackaged tea bags, in capsule form, as an oil, and as a liquid extract. Chamomile has both internal and external use. It has been used internally for a wide variety of conditions to remove intestinal parasites, to prevent or to reduce inflammation, and to control infection. Chamomile has also been used to relieve intestinal cramping, digestive disorders, menstrual cramps, premenstrual syndrome, headache, and other stress-related disorders. In addition, it is used a sedative, often in the form of tea, to treat anxiety and insomnia. External uses of chamomile include blending its oil with lavender or rose for scenting perfumes, candles, creams, and for other aromatherapy products intended to calm or relax the user's mind and body and reduce anxiety.

Does chamomile actually work? A randomized, double-blind, placebo-controlled study found chamomile extract helped reduce symptoms of mild to moderate generalized anxiety disorder (GAD). Because this is the first controlled clinical trial of chamomile extract for GAD and involved a small sample, additional studies are needed to support its findings. Unlike prescription medications, the U.S. Food and Drug Administration does not evaluate chamomile with regard to its effectiveness, purity, or safety.

Precautions and Side Effects

Generally, chamomile is considered safe. However, it can cause side effects such as allergic reactions in people who are sensitive to ragweed and other substances. Chamomile should not be taken two weeks before or after surgery. Women who are pregnant or could become pregnant should not use chamomile, since its use may increase the risk of miscarriage. Similarly, it should not be used by mothers who are breast-feeding infants. Chamomile can increase the effects of anticoagulant medications and the effects of benzodiazepines. It could also adversely interact with sedatives, antiplatelet drugs, aspirin, and nonsteroidal anti-inflammatory drugs. Individuals prescribed such medications should talk with their doctor before using chamomile. In addition, chamomile can interact with supplements such as ginkgo biloba, garlic, saw palmetto, St. John's wort, and valerian.

Len Sperry, MD, PhD

See also: Ginkgo biloba; St. John's Wort; Valerian

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Chicken Soup for the Soul (Book)

Chicken Soup for the Soul is a *New York Times* best-selling book that was first released on June 28, 1993. Since this first publication, 200 variations on the title and translations into 40 different languages have followed. Over 112 million copies have been sold in the United States and Canada alone.

Description

The popular book series, *Chicken Soup for the Soul*, written by Mark Victor Hansen and Jack Canfield, has seen much success grossing over $2 billion to date. The authors both had previous careers as motivational speakers and knew how storytelling could be used to inspire others. For the original book, published in 1993, they gathered 101 of the most powerful stories from ordinary people all over the nation. The book's title came from Canfield's memory of his grandmother and how she always said that her chicken soup could cure any ailment; they applied this same concept to hurts of the soul.

Chicken Soup for the Soul did not gain initial popularity from media attention but rather through simple word of mouth. By September 1994, it was on every major best-seller list in the United States and Canada. It soon received coverage on television shows like *The Oprah Winfrey Show* and *The Today Show* and major sitcoms such as *Friends* and *Everybody Loves Raymond*. In 1995, the book won the prestigious American Booksellers' Book of the Year Award. In 1996, it was honored "Non-Fiction Literacy Award" by the American Family Institute. *Chicken Soup for the Soul* set a record in 1998 when it had seven books from the series on the *New York Times* best-seller list at one time.

Impact (Psychological Influence)

The next two decades saw continued growth for the brand. In 2007, *USA Today* honored *Chicken Soup for the Soul* as one of the five most memorable and affecting books in the last quarter century. In April 2008, the authors sold a large portion of the company to a multimedia group headed by Internet executive, Bill Rouhana, hoping to expand the book's impact further. The newest titles in the series are now distributed through Simon & Schuster, Inc. Over 112 million books have been sold to date, and titles have been translated into more than 40 languages. The *Chicken Soup for the Soul* name is one of the most well known; 88.7% of people recognize it and know what it is (Harris Poll). The company is hoping to expand into other media outlets and is currently working on the development of television shows and Internet sites devoted to providing people with comfort, support, and overall wellness.

Melissa A. Mariani, PhD

See also: Self-Esteem

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Child Abuse

Child abuse and neglect impacts more children in the United States than all other serious diseases. Every year more than 3 million reports of child abuse that involve more than 6 million children are made in the United States. According to the nonprofit organization Child Help, there is a report of child abuse approximately every 10 seconds, and according to the Centers for Disease Control (CDC), more than four children die every day as a result of abuse.

Description

The Centers for Disease Control defines "child abuse" as the physical, sexual, or emotional maltreatment or neglect of a child or children. It includes any act or series of acts of commission or omission by a parent or caregiver that results in harm, potential for harm, or threat of harm to a child.

Child abuse can occur in multiple different forms of either physical, emotional, or sexual abuse or neglect. Neglect can be physical, educational, emotional, or medical. Physical neglect includes abandonment or lack of supervision as well as failure to provide for the child's safety or physical needs. Educational neglect includes not enrolling the child in school or allowing for frequent truancy. Emotional neglect includes a lack of affection or attention or psychological care for a child's needs. Medical neglect includes delay or withholding medical care, including due to religious beliefs. However, not all states will prosecute in relation to religious beliefs.

Indicators of neglect can include poor hygiene, unsuitable clothing, untreated injury, lack of immunizations, and indicators of prolonged exposure to elements such as extreme heat or cold as well as height and weight significantly below healthy age levels.

Physical abuse is generally the most obvious form of abuse as there can be marks left on the child. This could include everything from punching, beating, burning to shaking of a baby or child. Indicators of physical abuse are recurrent injuries that have either unexplained or inconsistent explanations. The child may be hesitant to show certain parts of his or her body, for instance, not wanting to dress out for physical education classes. The child may also act out aggressively toward others.

Fetal abuse is the result of the parent consuming drugs or alcohol while pregnant. This can result in the child being born addicted. It can also result in premature birth, miscarriage, or developmental delays.

Sexual abuse involves a child in sexual activities. There can be non-touching sexual abuse, which would include an adult exposing himself or herself to the child. Touching sexual abuse would include fondling, making the child touch an adult's sexual organs, or penetration of a child by adult or object. Sexual exploitation includes using the child for prostitution or for pornography. Indicators of sexual abuse include sexually acting out, bruises or bleeding in the genitalia, bed-wetting, excessive bathing, fire setting, aggressive or withdrawn behaviors, or substance abuse. Child sexual abuse is for the benefit of the abuser with lack of regard for the child. Ninety percent of child sexual abuse cases go unreported due to the child being afraid to tell anyone what happened.

Emotional abuse can greatly negatively impact a child's development and self-concept. This is generally the hardest to identify due to lack of physical evidence. This can be done by rejecting the child and humiliating or shaming the child, as well as isolating the child. Indicators of emotional abuse can be seen by the child hiding his or her eyes or avoiding eye contact as well as defensiveness, low self-esteem, regression, difficulty with relationships, depression, or alcohol and drug use.

Children at risk for abuse can come from a family where violence within the intimate partners is present, or are younger than four years. Another risk factor comes from living in communities with high level of violence or in families with great stress, substance abuse, poverty, or chronic illness. However, abuse can happen anywhere. The perpetrator generally has low levels of empathy and low levels of self-esteem.

Current Status and Impact (Psychological Influence)

Each year in the United States more than 3 million reports of child abuse involving over 6 million children are made. Each state in the country has a state-run department that investigates these reports and takes actions to help protect and assist in maintaining and assuring family safety. Regardless of the type of abuse, mental health symptoms such as depression or aggression are common after experiencing a form of abuse.

Research has shown that with a history of sexual abuse in childhood there are a multitude of mental health and behavioral problems in adult life. There is generally a strong link with depressive symptoms as well as post-traumatic stress disorder. Adults with drug and/or alcohol addiction also demonstrate high frequencies of reports of sexual abuse in their childhood. In fact adults with a history of childhood sexual abuse have significantly higher rates of an axis 1 disorder from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR).

Child abuse clearly can have long-lasting effects on development of children causing emotional difficulties and aggressive behaviors. There is also strong evidence that children who have been abused or neglected struggle with social relationships and interactions with peers. Children who have been abused or neglected are

also at increased risk for juvenile delinquency, substance abuse, and self-destructive behaviors.

Mindy Parsons, PhD

See also: Adverse Childhood Experiences; Child Protective Services; Domestic Violence; Foster Care; Neglect

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Child Onset Fluency Disorder

Child onset fluency disorder is a condition that disrupts a child's speech. It is also called stuttering.

Definitions

- **Fluency** is the ability to speak correctly and easily.
- **Stuttering** is talking with continued involuntary repetition of sounds, especially initial consonants.

Description

Child onset fluency disorder affects how fluently a child speaks and is therefore understood by others. It usually begins at an early age and lasts throughout someone's life to some degree. This condition disrupts the sounds produced from a child and creates a stutter. At some point in time, almost everyone experiences difficulty communicating. In child onset fluency disorder, a child's speech is significantly challenged and creates problems in daily communication.

These problems in daily communication can impact a child's ability to communicate under stressful circumstances. For example, if the home or classroom is a stressful environment, a child will have more disruptions in speech. This can occur commonly when talking on the telephone or in public speaking when speech is relied on heavily for effective communication. For some children their stuttering can occur across environments and situations. This can cause isolation and removal from certain activities that children want to be involved with. Many children with this condition will try to hide their speech problems by using words they can rely on using well or by claiming to forget what they were trying to say or simply my remaining silent.

Child onset fluency disorder usually presents itself around the age of two to four years. In some cases, stuttering will start during later elementary school years but this is rare. It is more common for males to be diagnosed with this condition. Young children who are diagnosed are usually not aware of their speech problems. But children develop, they become aware that they are different from others and notice other people's reactions to their speech.

There are different levels of stuttering that vary across the children who are diagnosed. For some children, speech problems are significant and can persist for days, weeks, and months. Some other children will develop minor speech issues and improve fairly quickly from the first signs of stuttering. Child onset fluency disorder can also improve under certain circumstances and vary daily. This can make it seem like the condition goes away completely and then reappears later. When a child becomes a teenager and later an adult, his or her speech issues tend to stabilize and does not tend to get better or worse with age although under stressful circumstances stuttering tends to worsen.

Causes and Symptoms

The cause of child onset fluency disorder is not known. Research suggests that genetics influences a child's likelihood to be diagnosed with the disorder. When family members inherit stuttering from their family, it directly impacts their ability to speak fluently. But not everyone who is genetically prone to the condition will develop it.

For many people diagnosed with stuttering, stressful life events can often initiate their speech problems. When children are young, their speech issues might be creating more mature sentences. This can occur when a child is attempting to develop from two- or three-word sentences into longer, more complicated statements. Therefore, it may appear that a child does not stutter when he or she uses fewer words and then later speech problems appear. A child who is frustrated by speech is more likely to become physically tense, and this can affect the child's ease of communicating. Other children can make fun of their peers, and this can worsen the symptoms of stuttering. Many diagnosed with this condition experience feelings of anxiety and shame.

Symptoms of the disorder are repeating words or parts of words in addition to lengthening words. Children and adults with the condition might appear to be nervous or out of breath. People with the disorder make a serious effort to complete a word and try not to get stuck on words.

Diagnosis and Prognosis

The accurate diagnosis of child onset fluency disorder should be done by an evaluation by a certified speech-language pathologist (SLP). It might seem easy for others to identify stuttering in some, but not easy in others. SLPs will be able to identify the types of issues that a child presents with and can identify stressors in the environment that impact the speech disorder. Formal assessments, observations, and parent or teacher interviews are typically used during diagnosis and interpreted by the SLP.

After a comprehensive assessment, the results should include when stuttering is most likely to occur. There are specific pieces of information that are important to consider including family history, if the speech problems have occurred for at least six months and if the child is concerned or scared of speaking. When these characteristics are present, a diagnosis of child onset fluency disorder is probably appropriate.

Over half of the children diagnosed between two and four years who stutter will improve and no longer have speech problems. Usually this occurs within a few months of the diagnosis. For others, stuttering will last for years and have periods of supposed improvements with some periods of regression. It is unclear why some children continue stuttering while others do not. Most children who recover from the condition have received speech therapy, but there are some who never receive treatment and also recover. More research needs to be done on this to help determine what helps children become more fluent.

Treatment

Speech-language pathologists (SLPs) are involved in the delivery of speech therapy for children who are diagnosed with stuttering. Many treatment programs are behavioral in nature and focus on teaching the person new skills to improve speech. SLPs who treat these clients use techniques such as monitoring speech pace and relaxation. Learning to control the rate or pace of speech is one of the most effective methods for managing stuttering. This helps people speak more easily and fluidly over time and can create more natural language development and fluency.

Treatment of children during their preschool years is controversial for some SLPs. This is because it is hard to determine whether some children outgrow their issues and many are concerned that treatment could bring damaging awareness to a child who is not able to cope well. In order to prevent this, therapists will recommend a wait-and-see approach in order to give the child time to develop and improve on his or her own. If after a determined period of time therapists, teachers, and parents do not see improvements, individual therapy is warranted.

Parents and other caregivers who are able to interact with children can model fluent speech. Involving the parents and teachers whom the child is exposed to the most has proven helpful in eliminating symptoms

in young children. The use of devices and technology has also shown to help children with speech issues. One such way these devices can be used is by recording fluent speech from the child and playing this back to the child.

Support and treatment groups for people with stuttering issues are widely available. These groups are usually self-help in nature and bring together groups of people who face the same problem. People who participate in support groups claim that their experiences in the group give them an opportunity to use techniques they've learned in therapy. They can help each other cope with everyday problems and serve as support. Many of these groups exist in the United States and the world.

Alexandra Cunningham, PhD

See also: Speech-Language Pathology

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Child Protective Services

"Child Protective Services" (CPS) is the name, in many states, of the governmental agency that is responsible for responding to and investigating reports of child abuse and/or neglect. Other states have similar agencies but use other names.

Description

Child Protective Services is a state agency partly funded by the federal government and partly by state and local sources, which handles reports of suspected child abuse or neglect. Each state has its own laws that define abuse and neglect, obligations for reporting, protocol to follow, and penalties for abusers. State agencies receive guidance and structure from the national agency, the Administration for Children and Families, also referred to as the Children's Bureau, which falls under the U.S. Department of Health and Human Services. Depending on the state, the child protective services agency may also be known as the Department of Children and Families, the Department of Children and Family Services, or the Department of Social Services. As the name denotes, the main objectives of this department are to ensure the welfare of minors and provide social services to families. The agency is responsible for a wide range of services, including assisting families with proper care and safety in order to remain together, foster care placement, youth and young adult transition programs out of foster care, and adoption procedures. Personnel work in conjunction with community agencies, tribes, schools, local law enforcement, and the courts.

The law prohibits child maltreatment and Child Protective Services (CPS) may respond to abusive acts by forcefully removing the child from an unsafe home. Any person who suspects child abuse or neglect should promptly report it to CPS. As of August 2012, approximately 18 states and Puerto Rico have issued statutes that require this. Several professionals are classified as "mandatory reporters" including doctors, teachers, and childcare providers, and they are responsible for most of the reports made. Once a report is made, CPS staff may initiate an investigation to determine if the child is at risk and whether the environment is safe for the child to remain in. Initial calls are either "screened out" or "screened in" depending on whether there is sufficient information to warrant an investigation. If a report is screened out, the CPS staff member may refer the reporter to other local agencies or to local law enforcement for help. However, if the report is screened in, then the CPS caseworker must respond to the report in a timely manner, anywhere from a few hours to a few days. This depends on the information provided, including the type of abuse, potential severity of the situation, and the requirements under state law. An investigation will include questioning of the child, the child's parents/guardians, and other people who are in regular contact with the child. If the child is believed to be in imminent danger, then he or she may be removed from the home immediately and placed in the care of a relative or friend or in foster care while court proceedings take place. Depending on the state, additional steps may also be taken to help remediate and support

the family in order for them to reconcile. Once the investigation is complete, the CPS caseworker makes one of two findings, either unsubstantiated (unfounded) or substantiated (founded). If unsubstantiated, then the case is filed and essentially dropped; if substantiated, the CPS agency then initiates the authority of the court to determine what actions, if any, are necessary to keep the child safe. The court may then issue order to place the child in the care of another entity, require services be sought, or order that the abuser have no contact with the child. CPS claims that its preferred course of action is to rehabilitate and reunite families; however, this is often not the case. Evidence has also shown that disregard for following proper protocol, delay in the timeliness of responding to reports, and lack of communication between members has contributed to negative perceptions of CPS.

Dating back to 1825, states began enacting laws giving child welfare agencies the authority to remove abused and neglected children from their homes and place them in proper care. In 1874, the first case of child abuse to be prosecuted in the United States, referred to as "the case of Mary Ellen," spurred public outrage and subsequent response from the federal government, including President Roosevelt's public funding of volunteer organizations dedicated to child welfare. The Children's Bureau was established in 1912 by President Taft to coordinate efforts on a national level. The Social Security Act of 1930 outlined further funding toward child maltreatment intervention. C. Henry Kempe referred to "battered child syndrome" in articles published in 1961–1962, raising concerns over the long-lasting effects of abuse. This led to 49 states passing mandatory child abuse reporting laws by the mid-1960s. In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was passed bringing further national attention to the issue. In addition to providing federal funding toward prevention efforts and treatment, the CAPTA supported research and data collection activities. The CAPTA was recently amended and reauthorized on December 10, 2010. The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272), considered the first piece of comprehensive legislation on the problem, promoted state economic incentives for decreasing the length and number of minors placed in foster care. Other similar legislation followed, including the Adoption Assistance Act, the Child Abuse Prevention, Adoption, and Family Services Act of 1988, and the Child Abuse, Domestic Violence, Adoption, and Family Services Act of 1992. All focused on easing the adoption process to promote family permanency for children. In 1997, the Adoption and Safe Families Act was passed, introducing the idea of "concurrent planning" where caseworkers first attempt to reunify families but, in conjunction, work an alternative plan so as not to delay permanency for the child. Current practice is based on this model.

Impact (Psychological Influence)

Child abuse and neglect remains a public concern. According to a 2010 report issued by the National Child Abuse and Neglect Data System, a nationally estimated 754,000 duplicate (repeated victims) and 695,000 unique (first-time reports) number of children were found to be victims of child maltreatment. Based on the unique number of victims, an estimated 78% suffered neglect, 18% were physically abused, 9% were sexually abused, 8% were psychologically abused, and 2% were medically neglected. Recent statistics issued by the U.S. Department of Health and Human Services in 2012 reported that an overwhelming 676,569 children were victims of abuse or neglect (Child Welfare Information Gateway, 2013). Victims of childhood maltreatment suffer from physical, emotional, and psychological distress and are more prone to develop depression, anxiety, and social and behavioral problems. Of further concern are incidents of recidivism, as the cycle of abuse is likely to repeat itself. Prevention efforts should focus on counseling; skill development and remediation; and practical support for victims, perpetrators, and their families.

Melissa A. Mariani, PhD

See also: Child Abuse; Foster Care; Neglect

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Childhood Disintegrative Disorder

Childhood disintegrative disorder (CDD) is a condition where after healthy development up to the age of approximately 2 but before a child turns 10 years of age, there is loss in many areas of functioning.

Description

Childhood disintegrative disorder, also known as Heller's syndrome, is often considered part of a larger category of developmental disorders. The latest edition of the *Diagnostic and Statistics Manual* places it clearly within the definition of autism spectrum disorder (American Psychiatric Association, 2013). However, unlike others who exhibit autism, those with CDD show severe and abrupt regression following several years of normal development. It is characterized as a more dramatic loss of skills than in other children, and many develop the disorder later than is typical with autism. History and data on this condition is limited, and it may often be misdiagnosed. From the data collected, it seems that the condition occurs in only 2 out of 100,000 children and that most are boys.

Causes and Symptoms

In the absence of brain injury or trauma, science has not determined the characteristic causes for CDD. It is difficult to determine why some children who had previously been on a normal developmental curve begin to lose skills and abilities that they had already acquired. Some research suggests that a combination of genetic issues, including autoimmune factors, and prenatal and environmental stress may explain brain differences for those with CDD. Some scientists have discovered higher-than-normal protein deposits in the brain that can disrupt synaptic transmission.

Symptoms are varied but distinct. In studies at the Yale Child Study Center, it is noted that children with CDD tend to undergo rapid and severe regression. In addition to loss of skills, 70% of these children have episodes of behavior problems before regression. For children between the ages of three and four, some other symptoms of the possible presence of CDD may be increased activity, irritability, or anxiety, which precedes a marked decrease or loss in speaking ability, social skills, and/or motor skills. These motor issues include bladder and/or bowel control problems. Additional symptoms may include difficulty in making the transition from sleep to waking, poor social interactions, tantrums, or withdrawal from peers, as well as poor coordination and awkwardness in walking.

Diagnosis and Prognosis

It is important to note that although some children go through periods of limited regression during normal development, these temporary setbacks are not long lasting. These do not match the severity or lasting impact of the deficits that mark CDD. CDD is characterized by sharp, significant, and often permanent losses of abilities. Although some symptoms may parallel those that occur in autism spectrum disorder and Rett's disorder, clinical analysis will help determine whether the symptoms actually indicate that CDD is the proper diagnosis. In most cases of CDD, the loss of skills reaches a plateau, which unfortunately may last a lifetime. There are some cases when the loss of skills is progressive and leads to early death.

Treatment

There are no medications specific for CDD, although individual symptoms may be addressed with drugs. Therapeutic behavioral interventions are commonly used, such as applied behavior analysis. This treatment is an attempt to slow down the child's deterioration and help stabilize and improve the child's communication, self-help, and social skills.

Alexandra Cunningham, PhD

See also: Autism Spectrum Disorder; Behavior Therapy with Children; Pervasive Developmental Disorders

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Children's Apperception Test (CAT)

The Children's Apperception Test (CAT) is a projective test used to assess personality traits, maturity level, and overall psychological well-being in children 3 to 10 years of age.

Definitions

- **Apperception** is the process of understanding something through associating it with a previous experience.
- **Projective test** is a type of psychological assessment that seeks to assess a person's true feelings, thoughts, and attitudes based on responses to ambiguous stimuli.
- **Rorschach test**, also known as the "Inkblot Test," was developed by Hermann Rorschach in 1921 and is the most widely used psychological projective assessment. Respondents, ages three and up, are shown a series of inkblot cards and asked a series of questions in order to reveal information about their personality, preferences, and possible internal/external conflicts.

Description

The Children's Apperception Test is a projective personality test for children. Sigmund Freud used the term "projection" to describe how a person may unconsciously project his or her inner feelings onto the external world and vice versa. Projective assessment tools are used to encourage one to openly express what one thinks and feels. General impressions and insights are derived about the person from the answers given. Another commonly used projective assessment is the Rorschach Inkblot test.

The CAT is based on the Thematic Apperception Test (TAT), which was created by psychologist Henry A. Murray for use with people aged 10 years and older. The TAT is comprised of a series of 31 picture cards depicting humans in common social and relational situations. Respondents are asked to develop their own stories based on the scenes on the cards. Answers are believed to reveal underlying themes, emotions, and conflicts about the person's inner world and interpersonal relationships. The CAT follows the same process of assessment as the TAT but is meant to be used with children under the age of ten. The child is presented a series of picture cards and asked to describe what's happening in the situations to the examiner. When this test is used correctly, it is believed to reveal significant aspects of a child's personality. There are three versions of the CAT: the CAT-A (pictures of animals), the CAT-H (pictures of humans), and the CAT-S (pictures of children in typical family situations). Administration of the CAT takes approximately 20 to 45 minutes. However, there is no set time limit. There are no right or wrong answers, and no numerical score are given on the CAT.

Development

The original CAT was developed by psychiatrist Leopold Bellak and psychologist Sonya Sorel Bellak. First published in 1949, it was used to assess personality in

children aged 3 to 10. This first version of the CAT, the CAT-A, used animal figures instead of human beings because the authors believed that younger children would identify more easily with pictures of animals. This CAT-A consisted of 10 cards showing animal figures in human social settings. The CAT-H was later developed in 1965 to depict humans. A supplement, the CAT-S, was also added, which included pictures of children in typical family situations. The most recent version of the CAT was published in 1993. Again, the purpose of these tests was to elicit personal identification with what was happening in the picture card scenes.

Current Status and Results

The CAT should be administered only by a trained professional (psychiatrist, psychologist, licensed counselor, social worker, or teacher with specific training in this type of assessment). The results of the CAT alone should never be used to diagnose. Rather, it should be given as part of a larger battery of tests and include an in-depth interview with both the child and his or her parents/guardians. A thorough medical history should also be obtained. This way the assessor has a comprehensive picture of the child's overall psychological functioning.

The Children's Apperception Test is not considered a reliable or valid assessment. There is no clear evidence to support that this test measures what it seeks to or that it measures those constructs consistently from child to child. In addition, because this is a subjective type of assessment based mostly on the opinions and impressions of the examiner, findings are subject to bias and error.

Melissa A. Mariani, PhD

See also: Personality Tests; Rorschach Inkblot Test

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Children's Depression Inventory

The Children's Depression Inventory (CDI) is an assessment that is used to evaluate the symptoms of depression in children and adolescents.

Definition

- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.

Description

In its long form the CDI is a list of 27 questions that rates the symptoms of depression in children and teens aged 7 to 17. It measures five different factors. Those are negative mood, self-esteem, interpersonal problems, lack of pleasure, and ineffectiveness. This instrument or tool has a revised version that provides an option for teachers and parents to rate the children they have or are working with.

The CDI is also available in a short, 10-question format. Today, it is highly recommended that the long-form CDI be used, which includes sections for teachers and parents. When CDI results are combined with adult observation and input, they can help provide an accurate description of the child's situation. It helps with early identification of depression and getting treatment to those who need it as quickly as possible.

Development (Purpose and History)

Children can experience mood swings as they develop. But some children suffer from true clinical depression which can be dangerous since self-harm and suicide are possible results. During the 1970s and 1980s childhood depression started to be recognized, and several instruments like the CDI were created.

Maria Kovacs, PhD, was the developer of the CDI. Dr. Kovacs began practicing cognitive therapy in the 1970s as a treatment that was effective for depression, even more so than traditional drugs. For many years Dr. Kovacs worked with Aaron T. Beck, MD, who developed a popular depression inventory instrument, the Beck Depression Inventory (BDI). The BDI was created for adults and based on Dr. Beck's clinical experience with depressed patients. Dr. Kovacs collaborated with him to research and develop the CDI, which was published in 1979.

Current Status and Results

Since it was first published, the CDI has been used in the United States and internationally as a way to identify depression in children and adolescents. The CDI has been validated statistically as a predictor of depressive disorders in children. It is also used to show a distinction between its results for depression and anxiety disorder or conduct disorders.

The CDI does face some criticism as an accurate instrument. One is that it provides too many false negatives, which means that the test shows no depression when depression really exists. Another is that it may identify children who have a general emotional disturbance rather than depression.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Depression in Youth

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Chronic Illness

Chronic illness is the subjective experience of a chronic disease.

Definitions

- **Acute disease** is a medical condition with a single cause, a specific onset, and identifiable symptoms which is often treatable with medication or surgery and is usually curable.
- **Chronic disease** is a disease entity that usually does not have a single cause, a specific onset, nor a stable set of symptoms. While cure may be possible, it is unlikely for advanced levels of the disease process. It is also referred to as chronic medical conditions.
- **Disease** is an objective medical condition that can be acute or chronic.
- **Illness** is the subjective experience of a disease.
- **Well-being** is the state of being happy, healthy, prosperous, or successful.

Description

Chronic diseases are medical conditions that are prolonged in duration and do not resolve spontaneously. They are seldom cured completely. Common examples are heart disease, cancer, stroke, diabetes, and arthritis. The Centers for Disease Control and Prevention (CDC) considers chronic diseases to be the most common and costly of all health problems. Nearly 50% of American adults (133 million) live with at least one chronic disease. They account for 70% of all deaths. These diseases account for more than 75% of health-care costs. Chronic medical conditions are three types more common than psychiatric conditions. The reality is that they are preventable. CDC points to four modifiable health behaviors that are responsible for most disability and premature deaths related to chronic diseases. These are tobacco use, inadequate physical activity, poor food choices, and overuse of alcohol. With the average life span now extending in the 80s, the reality is that most individuals can expect to contend with chronic illness in themselves or in the lives of those close to them.

While many use the terms chronic disease and chronic illness interchangeably, they have somewhat different meanings. While disease represents an objective process, illness is a subjective process. As such,

chronic illness is experienced differently from individual to individual. Unfortunately, the health-care system has let to offer those with chronic diseases in contrast to those with acute diseases. Largely, this is because medical research and the training of health-care providers has emphasized acute diseases. Furthermore, for treatment to be effective, providers must be sufficiently competent in tailoring treatment that is responsive to multiple factors. These include the individual's unique personality, coping resources, culture, and the type and phase of his or her illness.

There are four main types of chronic diseases. The first is the life-threatening medical conditions such as fast-growing cancers, stroke, and heart attacks. A second type includes the manageable medical conditions such type 2 diabetes, hypertension (high blood pressure), obesity, and chronic sinusitis. While they may become serious, they are seldom life threatening. The third type includes progressively disabling diseases such as Parkinson's disease, lupus, rheumatoid arthritis, and multiple sclerosis. The fourth type includes those that are not life threatening but have a waxing and waning course. Sometimes, but not always, this type can be debilitating. Chronic fatigue syndrome and fibromyalgia are examples.

There are also four phases of chronic illness. These have been described by Patricia Fennell (2003). They are based on her clinical research with several hundred individuals with various types of chronic medical conditions.

Phase One: Crisis. The basic task of this phase is to deal with the immediate symptoms, pain, or traumas associated with this new experience of illness.

Phase Two: Stabilization. The basic task of this phase is to stabilize and restructure life patterns and perceptions.

Phase Three: Resolution. The basic task of this phase is to develop a new self and to seek a personally meaningful philosophy of life and spirituality consistent with it.

Phase Four: Integration. The basic task of this phase is to achieve the highest level of well-being possible despite compromised or failing health status.

It should be noted that not all individuals with a chronic illness proceed through all four phases. In fact, many chronically ill individuals get caught in a recurring loop of cycling between phase one and phase two. This means that each crisis produces new wounding and destabilization. Such crises are likely to be followed by a brief period of stabilization. But without intervention, a new crises will invariably destabilize the individual again. Only when health providers help these chronically ill individuals to break this recurring cycle can they move to phases three and four.

Len Sperry, MD, PhD

See also: Alcohol Use Disorder; Obesity; Tobacco Use Disorder

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Chronic Pain Syndrome

Chronic pain syndrome is a medical condition characterized by the experience of long-standing pain. It is also known as chronic pain.

Definitions

- **Acute pain** is pain that comes on quickly and may be severe but is experienced for a relatively short time (less than six months). It is the opposite of chronic pain.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Fibromyalgia** is a medical condition characterized by widespread, unexplained pain as well as sensitivity to pressure or touch in specific areas of the body.

- **ICD-10** stands for the *International Statistical Classification and Related Health Problems, 10th edition*. It is published by the World Health Organization and lists all known medical and psychological conditions affecting human beings worldwide.
- **Mindfulness-based stress reduction** is a form of cognitive behavior therapy that utilizes meditation and yoga to change the way an individual perceives and reacts to bodily sensations.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Pain** is an unpleasant sensation occurring in varying degrees of severity as a result of injury, disease, or emotional distress.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Rheumatology** is the field of medicine concerned with the painful disorders of the skin, joints, nerves, and bones.

Description and Diagnosis

"Chronic pain syndrome" is a general term and medical condition. In contrast to acute pain, it does not disappear when the underlying cause of pain has been treated or has healed. Chronic pain lasts longer than six months. It is described in the ICD-10 as the experience of ongoing pain that may or may not have a known physiological (related to the body) cause. There is no specific set of symptoms that accurately describes all individuals who suffer from chronic pain syndrome. Symptoms may include dull back pain, severe headaches, and widespread painful sensation of the skin layer. One of the most widely known forms of chronic pain syndrome is fibromyalgia. Although fibromyalgia is considered to be a specific medical diagnosis, the cause is still unknown. Chronic pain syndrome is not described in the DSM-5.

There is no agreement as to what causes chronic pain syndrome. Although this condition is poorly understood, it is relatively common. Estimates of the occurrence of this disorder exceed 25% of U.S. population.

Treatment

Chronic pain syndrome is treated differently depending on the types of symptoms described by the individual as well as the type of clinician seen. Common treatment may include over-the-counter nonsteroidal anti-inflammatory drugs such as Advil (ibuprofen) or Aleve (naproxen-sodium). Corticosteroid injections and narcotic pain medications may also be prescribed by a physician, often one specializing in rheumatology. Although this condition is considered to be physiological in nature, certain forms of psychotherapy have been shown to be effective in reducing pain. The forms of psychotherapy that are most notable are those that involve mindfulness practice such as mindfulness-based stress reduction. Unfortunately, there are no known treatments considered to be completely curative.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Fibromyalgia; International Classification of Diseases; Mindfulness; Psychotherapy

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Circadian Rhythm Sleep–Wake Disorder

Circadian rhythm sleep–wake disorder is a mental disorder that is characterized by irregular patterns of sleep.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Circadian rhythm** is the approximately 24-hour cycle of physiological and psychological regulation of bodily rhythms such as sleeping and waking. It is commonly referred to as the "internal bodily clock."
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Light therapy** is a medical treatment in which doses of bright light are administered to normalize the body's internal clock and treat depression. It is also called phototherapy.
- **Sleep hygiene** refers to the habits, practices, and nonmedical treatments for insomnia, which improve the quality of sleep.
- **Sleep–wake disorders** are a group of mental disorders that are characterized by various sleeping disturbances including circadian rhythm sleep–wake disorder.

Description and Diagnosis

Circadian rhythm sleep–wake disorder is one of the Sleep–Wake Disorders in DSM-5. It is characterized by a sleep pattern that is out of sync with normal circadian rhythms. Individuals with this disorder have trouble sleeping during the times that others typically sleep. Those with this disorder may not follow the typical circadian rhythms of others, but if allowed to follow their particular patterns, they can experience sufficient and otherwise normal sleep.

To be diagnosed with this disorder, the individual must have recurrent difficulty adapting sleeping patterns to his or her environmental requirements such as job or social demands. In addition, the incongruence of his or her sleeping pattern with these demands must cause sleeplessness, sleepiness, or both. Individuals may be genetically predisposed to this disorder. Also, atypical light exposure (such as living in northern climates where there is limited daylight) may also be a contributing factor.

DSM-5 identifies five subtypes of circadian rhythm sleep–wake disorder. A brief description of each follows:

Delayed sleep phase type. The delay sleep phase type is characterized by the inability to fall asleep for at least two hours after the preferred sleep time. Individuals with this disorder may also have difficulty waking at the preferred time as a result of a short sleep period. Consequently, individuals may experience sleepiness throughout the day, especially in the morning. Although this disorder affects approximately 17% of the adult population, it is common in adolescence where upward of 7% may experience this type. This diagnosis in adolescence is differentiated from normal sleeping pattern difficulty in that the symptoms typically persist for greater than three months (American Psychiatric Association, 2013). Without treatment, some may experience this disorder intermittently for their entire lives, while for others, symptoms are reduced with age.

Advanced sleep phase type. This type is characterized by earlier than normal sleep–wake times, typically of at least two hours. Also, if an individual delays sleep until the conventional time, he or she will still wake early, thereby causing excessive daytime sleepiness. This type affects approximately 1% of the adult population. Although onset can occur at any age, it is more common in middle-aged and older adults (American Psychiatric Association, 2013). It is important to note that advanced sleep times are common in older adults but are differentiated by adverse symptoms such as daytime sleepiness or shorter than preferred sleep periods.

Irregular sleep–wake type. This type is characterized by fragmented sleep throughout a 24-hour period. An individual with this type does not experience a major sleep period. The individual may experience sleeplessness for long periods of the night and nap excessively during the day. The prevalence of this subtype is not known (American Psychiatric Association, 2013).

Non-24-hour sleep–wake type. This type is characterized by irregular duration of the entire sleep–wake

cycle that is out of sync with the normal light–dark 24-hour cycle. Unlike the other types, individuals with this type do not follow a 24-hour pattern of sleeping. They may sleep too much or too little in any given 24-hour period. This type is common in the blind, affecting approximately 50%, but is rare in sighted individuals (American Psychiatric Association, 2013).

Shift work type. This type is characterized by job-related obligation that occur during normal sleeping periods (i.e., at night), thereby causing excessive sleepiness while on the job and sleeplessness while at home. For the diagnosis to apply, both symptoms must be present. Individuals who suffer from this type are more prone to accidents or lowered performance on the job than if they experienced normal, restful sleep. This type is relatively common in night workers, affecting approximately 7.5%. Individuals who are middle aged or older are more prone to this type (American Psychiatric Association, 2013).

Treatment

The treatments for this disorder may include behavior therapy, education on optimal sleep hygiene, and light therapy. The common goal of these therapies is to help the individual in adapting his or her environmental cues to support optimal sleep. Also, individuals may be prescribed sleep aids such as Lunesta or Ambien to help them fall asleep at a conventional or preferred time. Medication may be used as a standalone treatment or in conjunction with therapy.

Len Sperry, MD, PhD

See also: Ambien (Zolpidem); Behavior Therapy; Lunesta; Sleep Disorders

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Clinical Health Psychology

Clinical health psychology is a form of psychology that is informed by the biopsychosocial model of health and emphasizes behavioral medicine interventions.

Definitions

- **Behavioral medicine** is an interdisciplinary form of modern medicine that integrates the behavioral, biomedical, and social sciences.
- **Behavioral psychology** is a form of psychology whose aim is to study behavioral adaptation to an environment and its stimuli.
- **Biopsychosocial model** is a way of conceptualizing (thinking about) health and illness in terms of biological, psychological, and social factors rather than purely in biological terms. It is also referred to as the biopsychosocial perspective.
- **Clinical psychology** is a form of psychology that integrates science, theory, and practice to increase the knowledge of the psyche and its function. It is also concerned with predicting, assessing, diagnosing, and alleviating psychological problems and related disability.
- **Cognitive psychology** is a form of psychology whose aim is to study thought and distorted patterns of thinking.
- **Humanistic psychology** is an experiential form of psychology developed from the work of Abraham Maslow and Carl Rogers, which emphasizes a client's capacity for self-actualization and unique positive personal growth.
- **Psychoanalytic psychology** is the form of psychology largely developed by the work of Sigmund Freud, which emphasizes the conflicts

and compromises between the unconscious and conscious mind.

- **Psychometric assessment** is the direct or indirect measurement of psychological differences.
- **Psychosomatic model** is a way of conceptualizing (thinking about) certain medical conditions as caused by or resulting from psychological factors.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Clinical health psychology is a form of clinical psychology that is informed by the biopsychosocial model of health. This contrasts with conventional clinical psychology, which tends to focus on the psychosocial model (psychological and social factors explain health and illness), and conventional medicine, which focuses on the biomedical model (biological factors sufficiently explain health and illness). Clinical health psychology emphasizes the clinical and scientific contributions of behavioral medicine in predicting, assessing, diagnosing, and alleviating psychological problems and related disability. Often the root cause of psychological dysfunction is not isolated to a single contributing factor. Instead, it is usually best explained through the integration of biological, psychological, and social systems contributing factors. For example, behavioral psychology, cognitive psychology, humanistic psychology, psychoanalytic psychology, and biomedical model all have different ways to explain and treat a single psychopathology. It honors the contributions of all applicable biological, psychological, and sociological conceptual models.

Clinical health psychology is a system of psychological subspecialties rather than a separate psychological specialty. As an integrative system, it emphasizes the partnership between psychology and medicine. Such collaborative efforts between clinical health psychologists and other medical and health professionals have markedly contributed to the understanding of psychopathology (dysfunctional thoughts and behavior). These efforts have also furthered the team-based practice of integrative medical and psychotherapeutic interventions. The inclusion of behavioral medicine allows clinical health psychology to expand its focus to include all physiological and psychological factors related to illness. Clinical health psychologists are professionals with a doctoral degree in psychology, specialized training in health, and licensure as a psychologist. They are involved in the treatment of chronic pain, headaches, cessation of cigarette smoking, substance abuse, and management of obesity. Some are also involved in the treatment of heart disease and many other chronic medical conditions. Accordingly, they practice primarily in clinics, hospitals, and other health-care settings.

Development and Current Status

The relationship of the mind and body have been the subject of intense discussion over the centuries. The early Greek philosophers, such as Hippocrates, documented the collaboration between mind, especially with regard to psychology, and body, particularly with regard to medicine. Later influences, including western religion's view of human nature, resulted in a lead to a philosophy of mind–body dualism. Mind–body dualism views illness as either a medical condition caused by biological dysfunction, such as an infection, or a psychological dysfunction caused by trauma or evil spirits. However, in the 19th and 20th centuries, Sigmund Freud (1856–1939) and others developed the foundation for a science of the mind and mind–body interaction. At the same time, Lightner Witmer (1867–1956) established the first psychological clinic at the University of Pennsylvania in 1896. He first used the term "clinical psychology" in 1907 in the journal *The Psychological Clinic*.

Clinical psychology evolved largely from both psychometric assessment and psychoanalytic psychology. The first university programs leading to the doctor of philosophy (PhD) degree were established in 1946 and were accredited by the American Psychological Association (APA). The APA was established in 1892 but did not develop a section devoted to clinical psychology until 1919. This section was revised in 1945

to become APA's Division 12, The Society of Clinical Psychology. Division 12 of the APA is one of the most influential psychological organizations to date. The Veteran's Administration and APA influenced the integration of psychotherapy into graduate training programs in clinical psychology. This integration of scientific research and psychotherapeutic practice in training programs is known as the scientist-practitioner model. It is also known as the "Boulder Model" because Boulder, Colorado, was the location of the professional conference at which the model was accepted by representatives of the profession. It was not until 1973 that the doctor of psychology (PsyD) was accepted by the APA and recognized by the profession. These alternative training programs are known as practitioner-scholar models or the "Vail Model."

Starting in the 1940s, many psychiatrists and clinical psychologists working at the interface of psychology and medicine adopted the psychosomatic model. Franz Alexander (1891–1964), a Hungarian American physician and psychoanalyst, was a main force in advocating for psychosomatic viewpoint. It was largely a psychological explanation that emphasized the power of the mind over the body. For example, duodenal (stomach) ulcers were believed to be caused by frustration and emotional stress. The psychosomatic model began to wane as research determined that there was, in fact, both biological *and* psychological factors involved. Research identified an infection with the *Helicobacter pylori* (*H. pylori*) bacteria along with psychological stress as causative factors in ulcers. Prior to this discovery, the psychiatrist George L. Engel (1913–1999) wrote about the need for a new medical model in a landmark article in *Science* in 1977. Engel proposed the biopsychosocial model, which could integrate the psychosomatic model with the biomedical model.

As the biopsychosocial model has become increasingly accepted in health-care settings, clinical health psychologists have become indispensable team members in behavioral medicine and the health-care system. The cost of health care in the United States has also been a factor in the utilization of clinical health psychologists. Clinical health psychology has made the case that psychologists with specialty training in health psychology and behavioral medicine are invaluable in reducing the financial burden of managing preventable illnesses.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Clinical Psychology; Mind–Body Medicine; Psychosomatic-Psychosomatic Medicine; Somatopsychic

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Clinical Mental Health Counseling

Clinical mental health counseling is a distinct helping profession with national standards for education, training, and clinical practice.

Description

Mental health counselors (MHCs) provide a variety of mental health services including psychotherapy; assessment and diagnosis of mental health disorders; substance abuse treatment; crisis management; treatment planning; psychoeducation, prevention programs; and evidence-based therapies. MHCs provide services in a variety of settings, including agency-based services; substance abuse treatment centers; and hospitals, employee assistance programs, private practice and managed health-care organizations. MHCs provide services to individuals of all ages, families, and couples.

Development

Clinical mental health counseling takes place within a wellness model, meaning the goal of counseling is to help the person move toward higher levels of wellness

rather than to cure an illness. Personal and emotional issues are understood from within a human growth and development perspective, which is a holistically focused approach to helping. Prevention is also a key value of clinical mental health professionals. The goal of counseling is to empower and assist clients in solving problems independently. Counseling is considered a collaborative and transitory process through which clients increase their problem-solving skills and self-understanding.

Current Status

Clinical MHCs are highly trained professionals. MHCs earn a master's or doctoral degree from a counselor education or closely related program. Education programs are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and range from 48 to 60 semester hours depending on the area of specialization. The core areas of mental health education programs approved by the CACREP include diagnosis and psychopathology, psychotherapy, psychological testing and assessment, professional orientation, research and program evaluation, group counseling, human growth and development, counseling theory, social and cultural foundations, lifestyle and career development, and supervised practicum and internship. Licensure requirements for clinical MHCs are equivalent to two other disciplines (clinical social worker and marriage and family therapist) that require a master's degree for independent practice. A licensed clinical MHC has the following professional qualifications: an earned master's degree in counseling or a closely related mental health discipline, completed a minimum of two-year postgraduate clinical work under the supervision of a licensed or certified mental health professional, and passed a state or national licensure or certification examination.

Clinical MHCs adhere to a rigorous code of ethics and professional practice standards. The American Counselors Association code of ethics consists of eight sectional headings addressing counseling issues: the counseling relationship; confidentiality; professional responsibility; relationship with other professionals; evaluation, assessment, and interpretation; teaching, training, and supervision; research and publications; and resolving ethical issues.

Clinical mental health counseling is a distinct helping profession with a unique focus on wellness, prevention, and empowerment.

Steven R. Vensel, PhD

See also: Mental Health Counselor

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Clinical Psychology

Clinical psychology is the branch of psychology involved with the assessment and treatment of mental illness, abnormal behavior, and psychiatric conditions.

Definitions

- **Behavioral psychology** is a form of psychology whose aim is to study behavioral adaptation to an environment and its stimuli.
- **Cognitive behavior therapy** is a form of psychotherapy that addresses maladaptive thought distortions that lead to unwanted emotional and behavioral symptoms.
- **Cognitive psychology** is a form of psychology whose aim is to study thought and distorted patterns of thinking.
- **Humanistic psychology** is an experiential form of psychology developed out of the work of Abraham Maslow and Carl Rogers, which emphasizes a client's capacity for self-actualization and unique positive personal growth.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychoanalytic psychology** is the form of psychology largely developed by the work of Sigmund Freud, which emphasizes the conflicts

and compromises between the unconscious and conscious mind.

- **Psychometric assessment** is the direct or indirect measurement of psychological differences.
- **Psychopathology** is a maladaptive experience of suffering or aspect of a psychological condition incorporating cause, development, structure, and consequences.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Clinical psychology is the branch of psychology that involves the assessment, diagnosis, and treatment of psychological disorders and behavioral conditions. It integrates knowledge from scientific research and professional practice. The goal of this integration is to enhance the ability to predict, assess, diagnose, and alleviate psychological problems and related dysfunction. Traditionally, there are three major theoretical perspectives in the practice of clinical psychology and psychotherapy. They are the psychoanalytic, cognitive behavioral, and humanistic traditions. More recently, systems theory has been incorporated into many aspects of clinical psychology. Theoretical orientations such as these guide clinical psychologists' research interests or work with clients. Clinical psychology is a system of subspecialties more than it is a single psychological specialty. There is so much diversity in clinical psychology. This leads to the establishment of many sub-specializations within clinical psychology. In addition, the profession undergoes rapid developmental changes as new information is acquired via science and practice. However, clinical psychologists tend to specialize as scientific researchers, clinical practitioners, or some combination of the two. Clinical psychology researchers are primarily interested in empirical study and the publication of novel scientific findings. Research in clinical psychology influences diverse areas of society, including education, medicine, and public policy. Practitioners of clinical psychology utilize the research findings to inform their work with persons suffering from some form of psychopathology. Clinical psychology practice often utilizes psychometric assessment and psychotherapeutic intervention.

Development and Current Status

Lightner Witmer (1867–1956) established the first psychological clinic at the University of Pennsylvania in 1896. Witmer published the term "clinical psychology" in a professional journal he established in 1907, titled *The Psychological Clinic*. Clinical psychology was developed out of psychometric and psychoanalytic forms of psychology. This history is most clearly evidenced by the development and military use of intelligence tests by the United States during World War I. These psychometric assessments, named *Army Alpha* and *Army Beta*, were used to determine how military enlistees would be utilized in the war effort. The United States' Veterans Administration became aware that many veterans returning from the war required treatment related to psychological trauma. After World War II there were increasing numbers of veterans with psychological trauma from "shell shock." As a result, the Veteran's Administration underwrote the development of university doctoral programs in clinical psychology.

The first university programs leading to the doctor of philosophy (PhD) degree were established in 1946 and were accredited by the American Psychological Association (APA). The APA was established in 1892 but did not develop a section devoted to clinical psychology until 1919. This section was revised in 1945 to become APA's Division 12, The Society of Clinical Psychology. Division 12 of the APA is one of the most influential psychological organizations to date. The Veteran's Administration and APA influenced the integration of psychotherapy into graduate training programs in clinical psychology. This integration of scientific research and psychotherapeutic practice in training programs is known as the scientist-practitioner model. It is also known as the "Boulder Model" because Boulder, Colorado, was the location of the professional conference at which the model was accepted by representatives of the profession. It was not until 1793 that the doctor of psychology (PsyD) was accepted by the APA and recognized by the profession.

These alternative training programs are known as practitioner-scholar models or the "Vail Model."

Layven Reguero, MEd, and Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Counseling and Counseling Psychology; Psychotherapy

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Clinical Trial

A clinical trial is a research study for comparing a new medication or treatment with an existing medication or treatment to determine its efficacy and safety. It is also known as clinical research trials.

Definitions

- **Effectiveness** refers to how well a treatment works (produce a beneficial effect) in the clinical practice of medicine.
- **Efficacy** refers to how well a treatment works (produce a beneficial effect) in clinical trials.
- **Food and Drug Administration** is the federal agency responsible for ensuring the safety and effectiveness of all drugs, vaccines, and medical devices.
- **National Institutes of Health** is a federal agency that conducts or supports biomedical research, including sponsoring clinical trials.
- **Placebo** is an inactive form of treatment (often a sugar pill) that has no treatment value.
- **Randomized controlled trial** is a research design in which participants are assigned randomly (by chance) to an experimental treatment or one that receives a comparison treatment or placebo. It is also referred to as randomized clinical trial.
- **Recruiting** is the time frame that a clinical trial has to identify and enroll participants in the trial.

Description

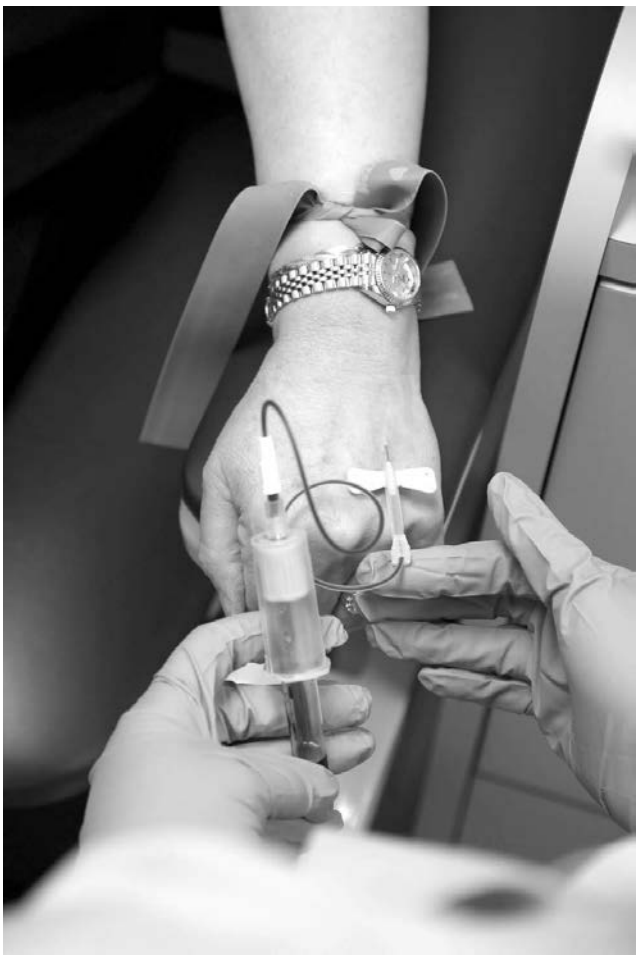
Clinical trials are research studies that utilize medical tests to determine the indications, efficacy, and safety of a new medication or treatment intervention. Such trials involve the monitoring of the various effects on large groups of individuals. They are used to assess the efficacy and effectiveness of a new treatment in comparison with the current standard of care or an existing treatment for a disease or disorder. In the United States, new medical treatments or devices must be approved by the U.S. Food and Drug Administration before they can be released for widespread use. Such approval requires rigorous testing in randomized controlled trials to determine whether it is effective in treating the medical condition. This testing is also used to determine the type and extent of side effects that may result.

Clinical trials are conducted by researchers affiliated with government health agencies such as the National Institutes of Health (NIH), a medical center, medical school, independent researchers, or private industry. Participants are recruited, as either volunteers or paid research subjects. Usually, participants are divided into two or more groups, including a control group that does not receive the experimental treatment, receives a placebo (inactive substance) instead, or receives a conventional treatment for comparison purposes.

For some individuals, clinical trials provide an opportunity for receiving new treatments that are not otherwise available. Those with difficult-to-treat or incurable medical conditions, like AIDS and certain cancers, can participate in clinical trials if standard therapies are not effective.

Developments and Current Status

Clinical trials have a rather long and rich history. About 605 BC what appears to be the first documented clinical trial is recounted in the book of Daniel. In it King Nebuchadnezzar ordered that children of royal blood



Clinical trials are research studies that use medical tests—often involving blood samples—to determine the indications, usefulness, and safety of a new medication or treatment intervention. Such trials involve the monitoring of the various effects on large groups of individuals. (Jim West/Alamy)

were to eat only meat and wine. Daniel requested an exemption for himself and three other men to eat only bread and water. It wo that the enforced consequences, for example uld be an experiment trial for 10 days in which one group would eat the king's diet and the other group would eat only bread and water. After the trial Daniel and the three children were noticeably healthier. Since this first trial, conducting clinical trials has been greatly refined. In 1747 James Lind conducted the first controlled clinical trial on sailors suffering from scurvy. All sailors were placed on the same diet, but one group was also given cider and vinegar, while the other group was given lemon juice. The group who had the lemon juice supplement recovered from scurvy in just six days. Placebos were used in clinical trials for the first time in 1863. Since then there have been several refinements in how clinical trials have been designed and run.

There are various types of clinical trials: The most common is treatment trials. These trials test the relative effectiveness of new drugs or treatments or combinations of drugs and treatments. A second type of clinical trial is prevention trials. These trials are used to research ways for preventing a disease in individuals who have not previously had it. They are also used to prevent its return in those who were diagnosed and were then successfully treated. A third type of clinical trial is diagnostic trials. These trials seek to find better ways to diagnose a disorder or illness. A fourth type of clinical trial is screening trials to determine the best way to detect a disease or disorder. A fifth type of clinical trial is the quality-of-life trial. These trials are used to investigate how to increase quality of life (making life easier or more normal) for those diagnosed with a chronic illness.

Clinical trials usually have four phases. Each phase has a different purpose within the trial. Phase I trials involve a small group of participants (20 to 80). It focuses on evaluating the safety and potential side effects of a drug or treatment. It also helps in determining a recommended dosage. In Phase II, the treatment or drug is tested in more participants (100 to 300) to determine its efficacy, effectiveness, and safety. In Phase III, even more participants (1,000 to 3,000) are involved. In this phase the intervention is compared to standard treatments, and further information is collected about its safety and side effects. In Phase IV, post-marketing studies are carried out when the drug or intervention is widely available. The purpose of this phase is to collect additional data on the optimal use of the treatment and to further evaluate its side effects.

The research hospital of the NIH conducts ongoing clinical trials on medical treatments, medications, and therapies for various medical conditions. It continually recruits volunteers in many of these clinical trials. To find out more about medical research studies, various clinical trials, and availability in participating in a clinical trial with NIH, contact the Patient Recruitment and Public Liaison Office at 1-800-411-1222 or visit its website: http://www.cc.nih.gov.ezproxy.fau.edu/participate.shtml.

Len Sperry, MD, PhD

See also: Cancer, Psychological Aspects; HIV/AIDS

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Cliques

Cliques are small groups of friends with shared values, characteristics, and interests, who usually prefer to socialize exclusively with one another.

Definitions

- **Peer groups** are informal associations of people that arise from similarities in age, background, social status, and interests.
- **Peer pressure** describes the positive or negative influence one's peer group, or clique, has on one's attitudes, values, and behaviors.

Description

The term "clique" is derived from the 18th-century Old French term *cliquer*, meaning to "make a noise," and its later derivative, the English term "claque," referring to a group of people hired to applaud or publicly support someone. In the modern sense, the word "clique" describes a small, tight-knit group of people with similar qualities, values, interests, and behaviors. Generally, "cliques" refer to groups of adolescents who hang out primarily with one another. Both males and females form and join cliques. Those who are associated with adolescent cliques generally look, dress, think, and act the same. Some commonly used terms that refer to cliques that may exist in a present-day school include nerds, jocks, preps, Goths, emos, punks, surfers, skaters, gamers, and the "popular" group, or "in crowd." Subgroups have also been identified within these groups (e.g., "band geeks," "football jocks," "Honors kids").

These informal associations of people have positive and negative characteristics, though a prevailing negative connotation of the word "clique" does exist in mainstream culture. On the positive side, cliques can provide a sense of connectedness, belonging, and safety helping members feel important, valued, wanted, and included. In addition, members of cliques often stick up for one another or have one another's back—a quality of particular importance in the adolescent world. On the other hand, cliques can have negative consequences. Cliques, by definition, are exclusionary, so those who are not members may feel judged, undervalued, or rejected. Even those associated with the clique can struggle. Members may experience acting differently when they are in their clique than when they are not with them. Peer pressure is heightened in this type of social environment as well, which can cause the individual to behave in ways that conflict with his or her personal sense of self, values, and feelings. This issue of conformity versus nonconformity is profound in cliques as there is often a set of both spoken and unspoken rules that govern the group's cohesion. Under these circumstances, cliques may engage in bulling behavior—as power and social dominance play a key role in maintaining group dynamics. The book *Queen Bees and Wannabees* articulates this phenomenon from the adolescent girl's perspective. Thus, cliques have established hierarchies both within the group itself and among varying groups within the given setting (i.e., a school), and these levels of power are often made known to members and nonmembers alike.

Impact (Psychological Influence)

Social status among peers and between peer groups has been an area of interest for educators, psychologists, counselors, and sociologists for decades. The peer group one associates with can have an indelible influence on how that person thinks, feels, and acts, essentially affecting the person's overall growth and development. Group association can impact academic performance, behavior, self-esteem, and self-worth, which are critical

in determining one's future trajectory and long-term success. Research indicates that an individual's rank in a clique is associated with both the social behaviors the individual uses within the group and the degree of likability by friends and peers. Findings also suggest that, good or bad, the most dominant group members get rewarded. However, there is increasing evidence to support that the range of accepted cliques is on the rise. Furthermore, traditionally deemed "popular" groups no longer have the influence they once had. Though dominant groups may still exist, most young people seek and are often successful in finding a social circle that fits them as individuals. Providing opportunities for youth to engage, including group projects and extracurricular activities, may remedy clique formation and rivalry.

Melissa A. Mariani, PhD

See also: Gangs; *Mean Girls* (Movie); Peer Groups

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Clockwork Orange, A (Movie)

A Clockwork Orange is a film directed and released by Stanley Kubrick in 1971, which depicts the isolation and violence among rebellious youth in Britain.

Description

The issue of how society could react to control the growing alienation and violence among young people became a prominent and popular theme, especially because of the social revolutions of the 1960s. Stanley Kubrick's 1971 film *A Clockwork Orange* is an adaptation of Anthony Burgess's 1962 novel of the same name. It employs disturbingly violent images to comment on psychiatry, juvenile delinquency, youth gangs, and other social, political, and economic subjects pertinent to the United Kingdom at that time.

The story depicts the main character, Alex, leading a gang of teenagers who go on the rampage every night, beating, raping, and murdering helpless victims. Eventually Alex is arrested and charged for his crimes. While in jail, he volunteers as a subject for aversion therapy in an effort to shorten his sentence. This kind of therapy is a treatment in which the patient is discouraged from a behavior by being subjected to a punishing stimulus when engaged in that behavior. The aversion therapy itself is violent. When Alex is eventually released from jail because he is cured, he initially hates violence. Eventually the people he meets and interacts with treat him so violently that inevitably he returns to a life of violence and sadism. So while after aversion therapy, Alex behaves for a while as if he were a good member of society, his new behavior does not really result from his own free choice. His goodness is involuntary. In the end he has become the clockwork orange of the title, organic on the outside, mechanical on the inside.

The film's central moral question, as in the book from which the movie was derived, is the definition of goodness. It asks whether it makes sense to use aversion therapy to stop immoral behavior. It is likened to the age-old question of whether a good end can justify evil means. The film raises several interesting questions without resolving them. What is goodness? Is it acceptable to use violent means in an attempt to stop violent behavior? Is aversion therapy effective?

Stanley Kubrick, the director of the movie, described the film in this way: "A social satire dealing with the question of whether behavioral psychology and psychological conditioning are dangerous new weapons for a totalitarian government to use to impose vast controls on its citizens and turn them into little more than robots." He also wrote: "It is a story of the dubious redemption of a teenage delinquent by condition-reflex therapy. It is, at the same time, a running lecture on free-will" (Houston, 1971, 43).

A scene from *A Clockwork Orange*, a classic film from 1971 directed and produced by Stanley Kubrick, shows Alex (Malcolm McDowell), an imprisoned gang leader, being subjected to painful aversion shock therapy in an attempt to reduce his love of physical and sexual violence. (Warner Bros./Photofest)

Impact (Psychological Influence)

The movie is a clear depiction of the dilemma that arises as a result of classical conditioning where the first step is pairing a behavior with a stimulus. In this movie, Alex is conditioned to associate violence with nausea. There is a possible second step, where there is an extinction of the pairing, whether intentional or not, but it is important to know that in the movie it is unintentional. This happens when the person discovers that the enforced consequences, for example, nausea because of drugs not because of violence, are shown to no longer have an effect. Since the change in behavior was artificial, or forced, the subject is then free to resume the original behavior without feeling any further negative consequences. In much less dramatic and dangerous forms, aversion therapy has been tried many times to limit or eliminate habits judged to be negative such as homosexuality and addictions to drugs and alcohol with limited or damaging effect.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Aversion therapy

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Clozaril (Clozapine)

Clozaril is an atypical antipsychotic medication used to alleviate the symptoms and signs of schizophrenia,

particularly for those who have not responded to any other antipsychotic drug. Its generic name is clozapine.

Definitions

- **Atypical antipsychotic** is a class of newer-generation antipsychotic medications that are useful in treating schizophrenia and other psychotic disorders.
- **Extrapyramidal symptoms** are side effects caused by certain antipsychotic medications. They include repetitive, involuntary muscle movements, such as lip smacking, and the urge to be moving constantly.
- **Tardive dyskinesia** is a disorder involving involuntary and repetitive body movements that can develop after long-term use of certain antipsychotic medications.

Description

Clozaril is considered an atypical antipsychotic medication that differs from typical antipsychotics in its effectiveness in treating schizophrenia and its profile of side effects. It was the first atypical antipsychotic drug to be developed. Clozaril may reduce the signs and symptoms of schizophrenia in a large proportion of patients with treatment-resistant schizophrenia who have not responded to typical antipsychotics. It is intended for use in those with severe schizophrenia who have not responded to any other antipsychotic drug or who have experienced intolerable side effects. It is estimated that as many as 20%–60% of those with schizophrenia are treatment resistant. Clozaril is believed to work by blocking the neurotransmitters dopamine and serotonin in the limbic system, a region of the brain involved with emotions and motivation.

As an atypical antipsychotic it is to less likely to cause tardive dyskinesia and other extrapyramidal (pertaining to a neural network in the brain) side effects. Tardive dyskinesia involves involuntary movements of the tongue, jaw, mouth, or face or other groups of skeletal muscles. The incidence of tardive dyskinesia increases with increasing age and with increasing dosage. It may also appear after the use of the antipsychotic has stopped. Women are at greater risk than men for developing tardive dyskinesia. There is no known effective treatment for this syndrome, although gradual (but rarely complete) improvement may occur over a long period.

Precautions and Side Effects

Clozaril can cause agranulocytosis, a life-threatening depletion of white blood cells. It can cause epileptic seizures in about 5% of those taking Clozaril. Because seizures are dose related, that is, increasing as the dose of the drug is increased, Clozaril should be discontinued or the dose reduce to stop the seizures. Clozaril should be used in pregnant women only when strictly necessary. Infants born of mothers on Clozaril show extrapyramidal symptoms and symptoms of withdrawal, including agitation, trouble breathing, and difficulty feeding. Clozaril may also be secreted in breast milk, so breast-feeding is not advisable. Clozaril can cause sedation and may interfere with driving and other tasks requiring alertness. The drug may increase the effects of alcohol and sedatives.

Clozaril can cause a number of side effects, including decreases of blood pressure, rapid heart rate, changes in heart rhythm, sedation, increased appetite, excessive salivation, nausea, constipation, abnormal liver tests, elevated blood sugar, blurred vision, dry mouth, nasal congestion, decreased sweating, difficulty urinating, skin rash, weight gain, and fever.

Len Sperry, MD, PhD

See also: Psychosis; Tardive Dyskinesia

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Clueless (Movie)

The movie *Clueless*, released in 1995, was a popular teen comedy based loosely on the novel *Emma* directed by Amy Heckerling and starring newcomer Alicia Silverstone.

Description

Clueless is a teen-pop culture film that was released in the United States on July 19, 1995. It was written and directed by Amy Heckerling and produced by Scott Rudin. The comedy is very loosely based on Jane Austen's 1815 novel *Emma*. Alicia Silverstone stars as the lead character, Cher Horowitz. Other actors in the film include Stacey Dash (Dionne Davenport), Paul Rudd (Josh), and Brittany Murphy (Tai Frasier).

The movie is set in Beverly Hills and follows Cher's life as she navigates the social scene in high school. Cher is attractive, popular, wealthy, and fashion-obsessed. Her downfall is that she is also extremely superficial. She lives in a mansion with her father Mel (Dan Hedaya), a powerful litigator in town. Her mother died after suffering complications from a liposuction surgery. Cher is the envy of her peers. Her best friend Dionne is also rich, pretty, and popular. One of the only people to find fault with Cher is her socially conscious ex-stepbrother Josh, who is home visiting on break from college. Cher and Josh verbally spar about one another's shortcomings, though never maliciously. In an effort to prove her selflessness, Cher sets out on several "community service projects." First, Cher decides to play matchmaker to two of her teachers in an attempt to have them soften up on their grading so she can improve her report card. They find happiness and Cher decides that she enjoys helping others, so she moves onto her next project. So she befriends the new, unhip girl at school, Tai, in hopes of turning her popular. This plan backfires when Tai rises to top social status and eventually turns her sights on Josh. It is then that Cher realizes her true feelings for Josh and humbles herself in an effort to win his heart. She allows Tai to be her true self and pursue her feelings for another love interest. In the end, Cher and Josh find love once Cher abandons her selfish ways and begins to appreciate the people in her life.

The movie *Clueless*, released in 1995, is a teen comedy based loosely on the Jane Austen novel *Emma*. Directed by Amy Heckerling and starring newcomer Alicia Silverstone, it covers themes of superficiality, kindness, and admitting mistakes. (Paramount Pictures/Photofest)

Impact (Psychological Influence)

Clueless became a surprise sleeper hit when it grossed over $11 million on its opening weekend, finishing no. 2 behind the movie *Apollo 13*. In its box office run it grossed $55 million, the 32nd highest-grossing film of 1995. It catapulted Alicia Silverstone to international star status. Critics have also rated the film favorably. In 2008, *Entertainment Weekly* ranked it 42nd out of 100 "New Classics" released between 1983 and 2008. The magazine also named it the 19th best comedy of the past 25 years. The movie spun off to a television sitcom and a series of books. Much of the pop-culture lingo from the movie is still used by youth

today, including phrases like "Whatever," "As-if," and, the movie's title, "Clueless."

Melissa A. Mariani, PhD

See also: Bullying and Peer Aggression; Cliques; Peer Groups

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Coaching

Coaching is a developmental process in which a coach enables an individual to meet his or her goals for improved performance, personal growth, or career enhancement.

Definitions

- **Business coaching** is a form of coaching in which a coach works with an employee (below the level of executive) to enhance the employee's awareness and behavior in order to better achieve the business objectives of both the employee and his or her organization.
- **Executive coaching** is a form of coaching in which a coach works collaboratively with an executive to accomplish specific goals and objectives involving the executive's productivity and well-being. It is short term and focuses on increasing skills and performance or on personal and professional development.
- **Executive consultation** is a form of consultation in which a consultant functions as a sounding board and expert advisor to address a broad range of professional and personal issues of concern to the executive. It is often an ongoing and long-term process.
- **Personal coaching** is a form of coaching in which a coach works to improve the quality of his or her client's life, by offering advice on a broach array of personal and professional matters, including career, health, and personal relationships. It is also known as life coaching.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

When hearing or seeing the word "coaching" many think of sports coaching. In sports, a coach gives directions, instruction, and training of the on-field operations of an athletic team or of individual athletes. Today, many other forms of coaching have developed, in which coaches have different goals and roles than sports coaches. Increasingly, newer forms of coaching are regularly utilized and sought by a broad array of organizations and individuals who are not sports teams nor athletes. A common misconception is that coaching is the same as psychotherapy or therapeutic counseling. In fact they are quite different. The goal of psychotherapy is to assist individuals to recover from emotional or other psychological disorders such as anxiety, depression, or grief. In contrast, the goal of coaching is to assist normal, healthy individuals to achieve personal goals such as clarity on career objectives, increased well-being, or improved work–life balance.

Developments and Current Status

These newer forms of coaching include business coaching, personal coaching, and executive coaching. These forms of coaching focus on one of two objectives. The first is to increase the individual's personal development. The second is to increase the individual's professional performance. It is interesting to note that the original meaning of the word "coaching" is derived from the word "carriage," which in the English language means to convey an individual from where he or she is to where he or she wants to be. The assumption is that focusing on the individual's overall development

will lead to increased professional effectiveness and job performance. Those who practice personal coaching, also called life coaching, emphasize this objective. On the other hand, those who view that the purpose of coaching is primarily to improve professional performance enhancement and secondarily personal development are more likely to practice business coaching. If the employee is an executive, it is called executive coaching.

Executive coaching is similar but different from executive consultation. Executive consultation addresses a broader range of professional and personal concern than are typically addressed in executive coaching. Issues in executive consultation can range from complex financial and personnel decisions to delicate personal health issues. Accordingly, it requires a seasoned consultant with an encyclopedic knowledge and broader experience base than is required of executive coaches. The signature characteristic of this form of consultation is that the consultant serves a sounding board and expert advisor who can quickly and effective assess the personal and organizational dynamics influencing the executive's concerns. In executive coaching, the coach also works collaboratively with an executive but with a different focus. The focus of such coaching is on increasing specific skills, performance, or development. It is usually directed at communicating vision and acting strategically, understanding individual and organizational dynamics, building relationships and mobilizing commitment facilitating team performance, or improving specific corporate results. Unless it is part of an ongoing leadership development program, executive coaching tends to be fairly focused and of short duration.

Len Sperry, MD, PhD

See also: Psychotherapy

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Cobain, Kurt (1967–1994)

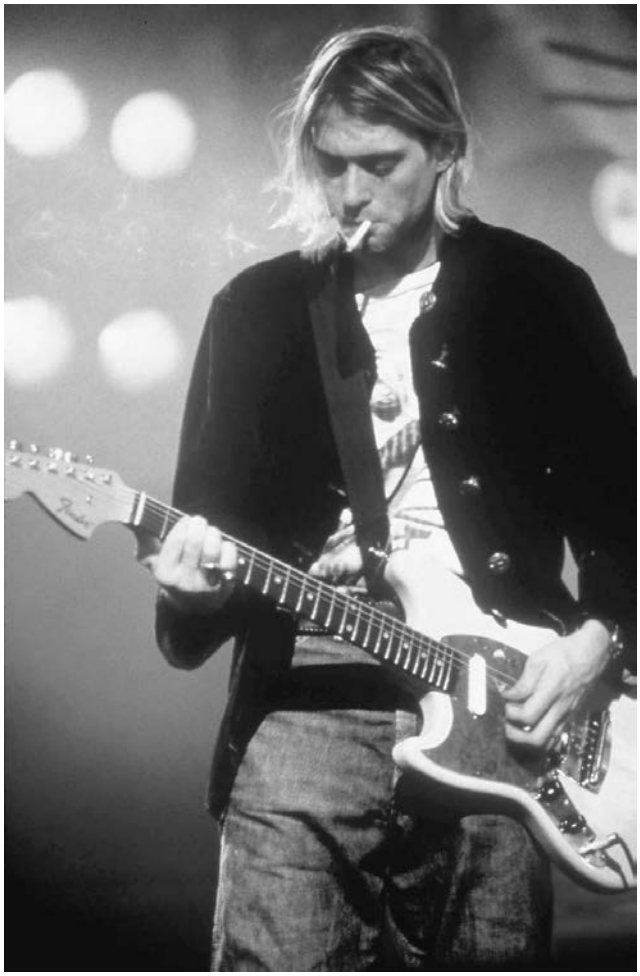
Kurt Cobain was the lead singer, guitarist, and songwriter of the pop-culture grunge band, Nirvana. His rise to musical fame in the 1990s is well noted along with his tumultuous relationship with girlfriend and later wife, Courtney Love, and ongoing struggles with drug addiction.

Description

Kurt Donald Cobain was born on February 20, 1967, in Aberdeen, Washington, to his parents, Wendy Elizabeth (Fradenburg) and Donald Leland Cobain, a waitress and automotive mechanic. Kurt had one sibling, younger sister, Kimberly. Cobain's family was filled with artistic and musical influences. His grandmother, Iris Cobain, was a professional artist. Kurt began drawing at an early age and his bedroom was often described as an art studio filled with drawings of his favorite cartoon characters. Musical talent was also present in the family. His Uncle Chuck Fradenburg was in the band The Beachcombers, his Aunt Mari Earle played guitar, and his great-uncle Delbert was an Irish tenor singer who made an appearance in the 1930 film *King of Jazz*. Kurt began singing and playing musical instruments at an early age. His Uncle Chuck gave him his first guitar, a prized gift.

Kurt's parents officially divorced when he was nine years old. This experience had a profound effect as he grew more sullen, withdrawn, and defiant. Though his parents both found new partners, neither household was well received by Kurt. He did not get the level of attention he was used to in his father's, and his mother was involved in a domestic violence situation. After seeking therapy for Kurt, his parents were advised that a single-family environment would be most beneficial, so on June 28, 1979, Cobain's mother granted full custody to his father.

Cobain spent his high school years back and forth between his parents and other family members. His behavior problems continued as well. He dropped out



Kurt Cobain, a brilliant American musician best known as the lead singer, guitarist, and primary songwriter of the rock band Nirvana. Cobain struggled with depression and addiction for a number of years, and at the age of 27 ended his life with a shotgun. (AP Photo)

of Aberdeen High School just two weeks shy of graduation after realizing he did not have adequate credits to graduate. His time was then spent at odd jobs, oftentimes unemployed, and following favored punk bands from concert to concert. A few years later he persuaded a fellow devotee, Krist Novoselic, to partner up with him to form the beginnings of Nirvana. The band struggled initially with its first album *Bleach*, trying out a few different drummers and finally settling on Dave Grohl, with whom they found their greatest success. In 1991, their major label debut album, *Nevermind*, was released.

The lead single, "Smells Like Teen Spirit" from that album, was the platform the band needed to catapult into mainstream, rising to the top of the alternative rock/grunge movement. Since the debut of *Nevermind* (1991), Nirvana has sold over 25 million albums in the United States and over 50 million worldwide. Despite this success, Cobain was always uncomfortable with the spotlight and felt misinterpreted by the media. The band released its third album, *In Utero*, in 1993.

Though his professional life was on the rise, Cobain's personal life remained tumultuous. On January 12, 1990, in a Portland nightclub, Kurt Cobain met Courtney Love, the head of the rock band Hole. The two began dating and found common ground in their drug addictions. After dating a short while, Courtney revealed that she was pregnant and the couple subsequently married on Waikiki Beach in Hawaii on February 24, 1992. The couple's daughter, Frances Bean Cobain, was born on August 18, 1992. Tabloid reports then surfaced speculating about Courtney's drug use during her pregnancy. A judge ordered the couple to give up custody and leave Frances in the care of Courtney's sister Jamie. After months of legal battles and conceding to regular drug testing and visits from a social worker, Courtney and Kurt were eventually granted back full custody.

Though Cobain suffered from bouts of depression and drug abuse throughout his life, it was his addiction to heroine that eventually led him to his first stint in rehab in 1992. His recovery did not last long and he ended up overdosing in 1993. He overdosed again in early March 1994, though this incident has been noted as his first suicide attempt. On March 25, 1994, Love staged an intervention and Cobain agreed to enter rehab again but walked out after only 2 days. He returned to his home in Seattle though reports from family and close friends cannot account for his whereabouts during those few days. On April 8, 1994, Cobain's body was discovered at his home in Lake Washington. The coroner's report indicated he suffered one gunshot wound to the head and traces of heroin and diazepam were in his system. A suicide note was also found.

Impact (Psychological Influence)

Cobain's posthumous album "Nirvana: MTV Unplugged" earned him and his band a 1995 Grammy Award. In 2003, *Rolling Stone* magazine named Cobain

the 12th greatest guitarist of all time. Dying at the age of 27, he is considered a member of the "27 Club," a group of prominent musicians who all died at the age of 27. Other members include Jimi Hendrix, Janis Joplin, Jim Morrison, and Amy Winehouse. Kurt Cobain is remembered as one of the most iconic alternative rock musicians of contemporary time. Fascination with his life and the struggles he faced continue, as does the popularity that his musical and artistic talents created.

Melissa A. Mariani, PhD

See also: Love, Courtney (1964–)

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Cocaine

Cocaine is a stimulant drug that is extracted from the leaves of the coca plant. It produces feelings of euphoria and is highly addictive.

Definition

- **Stimulant** is a drug that increases brain activity and produces a sense of alertness, euphoria, endurance and productivity, or suppress appetite. Examples are cocaine, amphetamines, and Ritalin.

Description

Cocaine is one of the oldest-known psychoactive drugs. Extracted from coca leaves, cocaine was used by the Incas and others in the Andean region of South America for thousands of years as a stimulant. It was also used to depress appetite and to treat high-altitude sickness. It is a substance that can be processed into many forms for use as an illegal drug of abuse. In its most common form, cocaine is a whitish crystalline powder, which is known by such street names as "coke," "blow," "C," "flake," "snow," and "toot." It is most commonly inhaled or snorted. It may also be dissolved in water and injected. Cocaine produces feelings of euphoria or intense happiness. It also produces hypervigilance, increased sensitivity, irritability or anger, impaired judgment, and anxiety. Because it is highly addictive, the Federal Drug Administration classifies cocaine as a Schedule II drug, which means it has restricted medical usage. For example, a licensed physician can use it as a local anesthetic for certain eye and ear problems and in some kinds of surgery.

Crack is a form of cocaine that can be smoked and produces an immediate, more intense, and more short-lived high than the powder form. Crack comes in chunks, which are off-white in color, and called "rocks." Besides their standalone use, both cocaine and crack are often mixed with other substances. Cocaine may be mixed with methcathinone to create a "wildcat." Cigars may be hollowed out and filled with a mixture of crack and marijuana. Either cocaine or crack used in conjunction with heroin is called a "speedball." Cocaine used together with alcohol represents the most common fatal two-drug combination.

Cocaine Abuse

The patterns of cocaine abuse in the United States have changed much over the past 30 years. In the annual study, cocaine use among high school seniors was found to have declined from 13.1% in 1985 to 3.1% in 1992. The rate of cocaine use began to rise again and peaked at 5.5% in 1997 (Leshner, 2010). However, use among all ages declined over the same time period, which was attributed in part to education about the risks of cocaine abuse. The incidence of new crack cocaine users has also decreased. A 1997 study by the National Institute on Drug Abuse indicates that among outpatients who abuse substances, 55% abuse cocaine. The lifetime rate of cocaine abuse was reported as 0.2%. More recently, the National Survey on Drug Use and Health reports that in 2009, 4.8 million Americans aged 12 and older had abused cocaine in any form. It also found that adults 18 to 25 years of age had a higher rate of cocaine use than any other age group.

Cocaine abuse affects both genders and various populations across the United States. Males are up to

two times more likely to abuse cocaine than females. Cocaine began as a drug of the upper classes in the 1970s, but since then the socioeconomic status of cocaine users has shifted. Cocaine is more likely to be abused by the economically disadvantaged because it is easy for them to get and it is inexpensive. These factors have led to increased violence as those who are cocaine dependent may become involved in illegal activity, like drug dealing to fund their habit. It has also been associated with higher rates of HIV/AIDS among disadvantaged populations.

Len Sperry, MD, PhD

See also: Addiction; Addictive Personality

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Codependency

Codependency is a psychological concept referring to an excessive dependency on others and the thinking, feeling, and behavioral patterns that affect a person's ability to experience healthy relationships.

Description

Codependency is a concept that originally developed in the field of substance abuse recovery. The prefix "co" is Latin for "together." Originally codependency described how family members enable a substance abuser's addictive behaviors (alcohol or drugs use). Enabling is a dysfunctional behavior that is intended to help the substance abuser but actually reinforces the dependency. Enabling behaviors include taking the blame or making excuses for the substance abuser's addiction. For example, the codependent wife of an alcoholic calls the husband's workplace telling the employer that her husband is "sick" and can't come in to work when in fact he is hung-over and shouldn't drive or operate machinery. She believes she is helping him by protecting his employment and reputation, and her financial security, but in fact this enables his alcoholism. Her "helping him" shields him from the consequences of his behaviors and keeps him from being accountable or taking responsibility for his substance abuse. Thus, she is "co" dependent, or with him, in his alcoholism even though she does not drink.

Codependency is not a specific diagnosable mental health condition but it is a term that is used in a variety of situations. The definition of codependency has broadened since it was first identified in the field of addictions. In the fields of counseling and psychology, codependency has come to describe a person's overdependence on and control of another person to feel good about himself or herself. It has been described as "relationship addiction" in which the relationship is more important than the individual. Individuals who are codependent have an underdeveloped sense of self-esteem and only feel good when others are perceived to need them. As a result codependents have poor boundaries; they try to control the relationship by overly caring for the individual. They do more than their fair share of work; they often feel the martyr and have a need for recognition but are embarrassed when they receive it. How they act, feel, and think goes far beyond normal self-sacrifice and caregiving. They feel guilty if they have to assert themselves, fear being rejected, and have difficulty making decisions for fear that others will disapprove of the decision. Codependents believe that others' opinions are of more value than their own. They have difficulty admitting mistakes and go to great lengths to appear right in the eyes of the other, even if that means lying. Codependents are most comfortable when they feel needed. As a result they can be controlling, overly nurturing, or overly compliant depending on the nature of the relationship.

Current Status and Impact (Psychological Influence)

Although codependency is not an officially recognized mental health disorder, it is recognized by most mental health professionals as being a condition that affects a person's ability to have healthy and fulfilling relationships. There is general consensus that codependency develops in childhood as a result of growing up in a dysfunctional family. As such, it is believed that codependent behaviors are learned and can be changed. Individual psychotherapy and couples counseling can be helpful in changing the thoughts, feelings, and behaviors associated with codependency. There are also many books, support groups, website, and online support organizations that address codependency and offer instruction and help to codependents.

Steven R. Vensel, PhD

See also: Addiction Counseling; Beattie, Melody (1948–); Peer Groups; Psychoeducation; Psychoeducational Groups; Self-Help Groups

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Cognitive Behavior Analysis System of Psychotherapy (CBASP)

Cognitive behavior analysis system of psychotherapy is a psychotherapy approach that focuses on identifying and changing hurtful thoughts and behaviors with more helpful ones. It is also referred to as CBASP.

Definitions

- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive (problematic) behaviors.
- **Behavioral analysis** is a type of assessment that focuses on the observable and quantifiable aspects of behavior and excludes subjective phenomena such as emotions and motives.
- **Cognitive therapy** is psychotherapy approach that focuses on identifying and modifying maladaptive (faulty) thoughts.
- **Dialectical behavior therapy** is a type of cognitive behavior therapy that focuses on learning skills to cope with stress, regulate emotions, and improve relationships.
- **Interpersonal psychotherapy** is a psychotherapy approach that focuses on interpersonal relationships and their context and on building interpersonal skills.
- **Psychodynamic psychotherapy** is a psychotherapy approach that assumes dysfunctional behavior is caused by unconscious, internal conflicts and focuses on gaining insight into these conflicts.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Situational analysis** is a type of behavioral analysis in which interpretations (thoughts) and related behaviors in a specific situation are identified.

Description

Cognitive behavior analysis system of psychotherapy (CBASP) is a psychotherapy approach that combines situational analysis with behavioral, cognitive, and interpersonal methods. It works by helping individuals focus on the consequences of their behavior and to use problem solving to resolve personal and interpersonal difficulties. The basic premise of CBASP is that personal and relational problems or symptoms result from a mismatch between what an individual desires or wants and what actually occurs. The focus of therapy is helping clients discover why they did not

obtain a desired outcome by evaluating and modifying their limiting or hurtful interpretations (thoughts) and behaviors. In this approach individuals are helped to discover why they did not obtain a desired outcome by evaluating their problematic thoughts and behaviors. They identify the discrepancy between what they want to happen in a particular situation and what has happened or is actually happening.

There are two phases in CBASP treatment: elicitation and remediation. The elicitation phase consists of a detailed situational analysis. This analysis focuses on specific questions: How would you describe the situation? How did you interpret the situation? Specifically, what did you do and what did you say? What did you want to get out of the situation, that is, what was your desired outcome? What was the actual outcome of this situation? And, finally, did you get what you wanted? During the remediation phase, behaviors and interpretations are targeted for change. Then, the individual is helped to select alternative thoughts and behaviors that are more likely to achieve his or her desired outcome. First, each interpretation of the situation is assessed to determine whether it helped or hindered the achievement of the desired outcome. Next, each of the client's behaviors is similarly analyzed to determine whether it helped or hindered in the attainment of the desired outcome.

Developments and Current Status

CBASP is a form of behavior therapy that was developed by the American psychologist James P. McCullough (1942–). It combines methods from behavior therapy, cognitive therapy, interpersonal psychotherapy, and psychodynamic psychotherapy. McCullough sought to find an effective treatment for chronic depression. Since many chronically depressed individuals engage in emotional thinking and do not learn from previous experience, they remain trapped in life. He developed CBASP to help such individuals to move beyond emotional thinking and learn from their experience. Teaching such individuals to learn from their experience and use problem-solving techniques makes it possible for them to become perceptually aware of behavioral consequences. When individuals are able to identify the link between their interpretations and behavior and their consequences, they are then able—often for the first time—to use problem-solving methods to resolve both personal and interpersonal difficulties.

Even though CBASP was initially developed for the treatment of clients with chronic depression, it has extended to mental disorders. These include the various personality disorders, eating disorders, and the anxiety disorder (panic, social anxiety, and general anxiety disorder). It has been said that CBASP can be helpful with nearly all mental disorders except dementia and active psychotic states. It also includes conditions such as anger management, couples issues, parent–child issues, and social skills deficits. It can be used in individual and group formats. CBASP is both a standalone and adjunctive intervention method.

Research has shown that CBASP is a highly effective treatment approach. A national study involving more than 600 chronically depressed individuals showed that CBASP was more effective than either an antidepressant alone or cognitive behavior therapy alone. However, the when CBASP was combined with the antidepressant, 85% achieved an improvement (50% reduction in symptoms) while 42% achieved remission (elimination of all depressive symptoms) (McCullough, 2000).

Len Sperry, MD, PhD

See also: Behavior Therapy; Cognitive Behavior Therapy

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Cognitive Behavior Therapy

Cognitive behavior therapy is a form of counseling or psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT and cognitive behavioral therapy.

Definitions

- **Automatic thoughts** are thoughts that spontaneously come to mind when a particular situation occurs.
- **Behavior modification** is the use of learning principles to increase the frequency of desired behaviors and decrease the frequency of problem behaviors.
- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors.
- **Cognitive restructuring** is a psychotherapy technique for replacing maladaptive thought patterns with constructive thoughts and beliefs.
- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing distorted thinking patterns.
- **Dialectical behavior therapy** is a type of cognitive behavior therapy that focuses on learning skills to cope with stress, regulate emotions, and improve relationships.
- **Psychodynamic therapy** is a psychotherapy approach that assumes dysfunctional behavior is caused by unconscious, internal conflicts and focuses on gaining insight into these conflicts.
- **Rational emotive behavior therapy** is a type of cognitive behavior therapy that focuses on identifying and disputing irrational beliefs.
- **Schema therapy** is a type of cognitive behavior therapy that focuses on identifying and changing maladaptive schemas.
- **Schemas** are core beliefs or assumptions about one's self and the world.

Description

Cognitive behavior therapy (CBT) is a psychotherapy approach that addresses maladaptive (faulty) behaviors, emotions, and thoughts with various cognitive and behavioral interventions. CBT integrates the cognitive restructuring approach of cognitive therapy with the behavioral modification techniques of behavior therapy. The therapist works with the individual to identify thoughts and behaviors that are causing distress, and then to change those thoughts in order to readjust the behavior. Where individuals have schemas which are flawed and require change, CBT can be employed. Unlike other psychotherapy approaches that focus on insight (understanding), such as the psychodynamic psychotherapy, CBT is "problem focused" (focuses on specific problems) and "action oriented" (strategies that focus on changing actions or behaviors). CBT is time-limited, which means treatment is typically completed in 6 to 20 one-hour sessions.

CBT can be used with adults, adolescents, and children. It is thought to be effective for the treatment of a variety of psychological conditions. These include mood disorders, personality disorders, social phobia, obsessive-compulsive disorder, panic disorder, and agoraphobia. CBT has also been found to be effective with eating disorders, substance abuse, post-traumatic stress disorder, chronic pain, and attention-deficit hyperactivity disorder.

There are several approaches to CBT, including cognitive therapy, behavior therapy, schema therapy, and dialectical behavior therapy. While there are differences among these approaches, they all share a number of common characteristics. These are discussed here.

Focus on cognitive and behavioral factors. A basic premise of CBT is that individuals' emotions and behaviors are influenced by their beliefs or thoughts. Because most emotional and behavioral reactions are learned, the goal of therapy is to help individuals unlearn unwanted responses and to learn a new way of responding. The process begins with assessing

maladaptive behaviors and thoughts, including automatic thoughts. By assessing, challenging, and modifying maladaptive beliefs and behaviors, individuals are able to gain control over problems previously believed to be insurmountable.

Direct session activity. CBT is a directive approach in which therapists typically direct session activity by setting an agenda, decide, plan what will be discussed prior to the session, and actively direct discussion of specific topics and tasks. Cognitive behavior therapists also endeavor to stimulate and engage individuals in the treatment process and these decisions.

Teach skills. Because CBT is also a psychoeducational approach, cognitive behavior therapists teach individuals skills to help them cope more effectively with problematic situations. Dealing directly with skill deficits and excesses is central to individuals achieving and maintaining treatment gains.

Provide information. Cognitive behavior therapists also discuss the explicit rationale for their treatment and the specific techniques being used. They may provide individuals with detailed information, for example, books or handouts, to orient individuals to the treatment process, to increase their confidence in treatment, and to enhance their ability to cope with problematic situations.

Use homework and between-session activities. Homework and between-session activities are a central feature of CBT. Such activities provide individuals the opportunity to practice skills learned in sessions and transfer gains made in treatment to their everyday life. Such activities can also foster and maintain symptom reduction.

Emphasize present and future experiences. CBT focuses on the impact individuals' present maladaptive thoughts have on their current and future functioning. In addition, skills learned in therapy are designed to promote more effective future functioning.

Developments and Current Status

The term "cognitive behavior therapy" came into usage in the past 40 years or so. It evolved from both the cognitive therapy and behavior therapy traditions in psychotherapy. Behavior therapy in America was pioneered by psychologist Joseph Wolpe (1915–1997). Cognitively oriented therapies in America were pioneered by psychiatrist Aaron T. Beck (1921–), the developer of cognitive therapy, and by psychologist Albert Ellis (1913–2007), the developer of rational emotive behavior therapy. A useful way of understanding this evolution of CBT is in terms of what has been called the "three waves" of behavior therapy.

First wave. The first wave emphasized traditional behavior therapy, which focused on replacing problematic behaviors with constructive ones through classical conditioning and reinforcement techniques. Joseph Wolpe pioneered classical conditioning, particularly systematic desensitization. Traditional behavior therapy was a technical, problem-focused, present-centered approach that was markedly different than psychoanalysis, individual-centered therapy, and similar approaches of that era that emphasized the therapeutic relationship and the feelings and inner world of the individual.

Second wave. The second wave involved the incorporation of the cognitive therapies which focused on modifying problematic feelings and behaviors by changing the thoughts that cause and perpetuate them. The incorporation of cognitive and behavioral therapies in the 1970s was not initially a cordial or conflict-free union, but today most cognitive therapists incorporate key behavioral interventions while most behavior therapists recognize the role of individuals' beliefs about the consequences of their behaviors The fact that both were problem focused and scientifically based therapies has helped foster this union, resulting in CBT becoming the most commonly practiced treatment method in the United States since the late 1980s.

Third wave. The third wave involved the reformulation of conventional CBT approaches which were based on a modernist paradigm or perspective. In contrast, third wave approaches tend to be more influenced by the postmodern perspective. Accordingly, treatment tends to be more experiential and indirect and utilizes techniques such as mindfulness, dialectics, acceptance, values, and spirituality. Unlike the first and second wave, third wave approaches emphasize second-order change, that is, basic change in structure and/or function, and are based on contextual

assumptions, including the primacy of the therapeutic relationship.

Len Sperry, MD, PhD

See also: Behavior Therapy; Cognitive Therapies; Dialectical Behavior Therapy (DBT); Schema-Focused Therapy

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Cognitive Behavioral Modification

Cognitive behavioral modification (CBM) is a psychotherapy approach that focuses on identifying dysfunctional self-talk in order to change unwanted behaviors.

Definitions

- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing faulty behaviors, emotions, and thoughts. It is also known as CBT and cognitive behavioral therapy.
- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing automatic thoughts and maladaptive beliefs.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Rational emotive therapy** is a form of psychotherapy based on the idea that problems are caused by irrational thoughts, beliefs, and expectations. It was developed by Albert Ellis and is also known as RET. In the 1990s Ellis incorporated the dimension of "behavior" and changed the name to REBT.
- **Self-talk** is one's constant internal conversation which can either be encouraging and motivating or discouraging and self-critical.

Description

Cognitive behavioral modification is a combination of cognitive therapy and behavior therapy techniques for fostering healthy thoughts and behaviors. It focuses on identifying dysfunctional (faulty) self-talk in order to change unwanted behaviors. The assumption is that behavior is the result of one's thoughts and self-talk. The goal of CBM is to teach individuals to observe their own self-talk and behavior and replace it with new, healthier self-talk and behavior.

There are three phases in the CBM process. The first phase involves self-observation. This involves individuals closely listening to their own self-talk and observing their behaviors. Individuals need to be particularly aware of any negative statements they make about themselves as this will likely contribute to symptoms of anxiety and panic. The second phase involves new self-talk. Once an individual recognizes he or she is engaging in negative self-talk, he or she can begin to change it. When an individual catches himself or herself in negative thought patterns, he or she can re-create new positive self-talk. For example, an individual may say "I can't take this exam, and I will fail. I am just not smart enough." A new and healthier self-talk might be: "I know this exam is going to be difficult, but I am going to study and prepare as best as I can." When an individual makes new self-statements, he or she is guided to new behaviors. This leads to better coping skills, and as each small success builds upon another, an individual can make significant gains in his or her recovery. The third phase of CBM involves learning new skills. Each time an individual can identify his or her negative self-talk, modify it, and change his or her behaviors, he or she is learning new skills. When

individuals are controlled by negative thoughts, it becomes difficult to control behaviors in unpleasant situations. CBM can help an individual change negative thoughts to positive thoughts, and as a result, the individual will begin to behave and act more effectively.

Psychologist Donald Meichenbaum (1940–) developed CBM in the 1970s. Meichenbaum was greatly influenced by rational emotive therapy. He was one of the first to advocate for combining behavior therapy with cognitive therapy. As a result, he is recognized as one of the founders of cognitive behavior therapy.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Behavior Therapy; Cognitive Behavior Therapy; Cognitive Therapies; Psychotherapy; Rational Emotive Behavior Therapy (REBT)

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Cognitive Complexity

Cognitive complexity is an indicator of the degree of complexity (intricacy) or simplicity of an individual's thinking and perceptual skills.

Definitions

- **Cognitive development** is the ability of individuals to think, perceive, and gain an understanding of their world.
- **Cognitive model** refers to how concepts are related. Such models help one to know, understand, or reproduce the idea they represent.
- **Cognitive system** is an interrelated system of beliefs, ideas, assumptions, and knowledge.
- **Concept** is an idea that represents a class of objects or their properties such as "truck" or "green."
- **Construct** is a type of schema which is a cognitive model for understanding meaning.
- **Domain** is a field of personal knowledge.
- **Perceptual skill** is the ability to develop a mental image or awareness of the elements of the environment.
- **Schema** is a cognitive model through which an individual understands or assigns meaning to his or her world. A schema is also referred to as a construct.

Description

Cognitive complexity is described as the level of differentiation and integration in an individual's cognitive system. Differentiation is the number of available constructs in an individual's cognitive system about a particular domain. Integration is the ability to recognize relationships among cognitive constructs (schemas) in a particular domain. The degree of cognitive complexity helps to predict an individual's social and clinical judgment (decisions).

Those who are high in cognitive complexity tend to perceive nuances and subtle differences. Therefore, they are more likely to engage in "both-and" thinking. In contrast, those who are low in cognitive complexity tend not to perceive such nuances and subtle differences. As a result, they are more likely to engage in "black and white" and "either-or" thinking.

Cognitive complexity is also known as a schema, which is an indicator of how individuals structure their world. An individual's level of cognitive complexity relates to an individual's level of cognitive development. The higher the level of an individual's cognitive development, the higher his or her level of cognitive complexity. For example, increasing the growth and thinking process can lead to higher levels of cognitive complexity. Individuals develop constructs as internal ideas of reality of the world around them. These constructs are based on interpretations of an individual's observations and experiences. Complexity of cognition

is a result of childhood development and not a personality trait. Parental, familial, and social interactions in early childhood influence the development of the constructs. To the extent that individuals are able to learn from their mistakes and past experiences, their cognitive complexity increases.

Cognitive complexity is particularly important for counselors and therapists. It is often difficult to understand individuals' needs, particularly in counseling, because often times their situations are very complex. An individual's level of cognitive complexity can vary from topic to topic. Given the connection between cognitive complexity and the development of expertise in counseling, programs that train counselors and therapists would do well to integrate cognitive components into their training. Some concrete techniques for integrating cognitive complexity into training curricula include (a) attending to and seeking information about oneself, others, and relationships; (b) organizing and integrating information into conceptual models; and (c) planning, guiding, and evaluating interventions.

Len Sperry, MD, PhD, and Elizabeth Smith Kelsey, PhD

See also: Schemas and Maladaptive Schemas

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Cognitive Deficits

"Cognitive deficit" is a medical term used to describe a variety of brain function impairments.

Description

The word "cognitive" is used to describe any number of mental processes including perception, memory, judgment, and reasoning. Language and communication are also considered cognitive processes. The term "cognitive deficit" is used to describe a variety of conditions pertaining to problems in a person's mental process. Cognitive deficits include intellectual impairment, speech and communication impairment, memory impairment, and perceptual impairment.

Causes and Symptoms

Cognitive deficits are caused by a number of events and occur in children and adults. Children can be born with cognitive deficits, which can occur as a result of genetic abnormalities, infections, exposure to drugs taken by the mother during pregnancy, and lack of oxygen during birth or in many other ways. Cognitive deficits can occur as a result of acquired brain injuries such as a severe blow to the head, oxygen deprivation from choking or drowning, and brain damage caused by drug use or poisoning. Medical conditions such as strokes or aging-related diseases such as Alzheimer's disease can cause cognitive deficits.

Prognosis

Although there is not a cure for cognitive deficits, they can be treated. Cognitive remediation and cognitive rehabilitation are two types of interventions used to reduce cognitive deficits.

Steven R. Vensel, PhD

See also: Cognitive Remediation; Intellectual Disability

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Cognitive Dissonance

Cognitive dissonance is the emotional discomfort people feel as a result of conflicting beliefs, thoughts, attitudes, and behaviors.

Description

Cognitive dissonance theory is a well-established and highly researched social psychology theory originally proposed by Leon Festinger (1919–1989) in the 1950s. Leon Festinger, one of the top 100 most eminent psychologists of the 20th century, coined the term "cognitive dissonance." He first used the phrase in his 1956 book *When Prophecy Fails*, which looked at what happens in the minds of UFO cult members when their beliefs of a prophecy (a UFO landing and the destruction of the earth) failed to come true. In 1957, Festinger explained cognitive dissonance theory and its importance to social psychology in his book *A Theory of Cognitive Dissonance*. Cognitive dissonance is one of the most highly studied phenomena in the history of psychology.

Cognitive dissonance is the psychological and emotional state produced when someone holds conflicting beliefs, thoughts, attitudes, or values and behaves in ways that are incongruent to those cognitions. The perception of an inconsistency creates a negative internal state of discomfort or dissonance. There are many emotions that may be associated with cognitive dissonance, including anxiety, fear, anger, frustration, and embarrassment.

According to cognitive dissonance theory, people are highly motivated to reduce their cognitive dissonance. Individuals employ several strategies in order to reduce the discomfort. They can modify existing cognitions, that is, change of belief; add new cognitions, that is, add a new belief; or reduce the importance of one of the components of the conflict, that is, change a perception. For example, imagine two separate high school students who aspire to become Olympic athletes. They know that in order to reach their dream they must be dedicated and train several hours each day. Cognitive dissonance would occur when they consider skipping practice for a day at the beach with their friends. They both feel guilty and anxious about missing a day of practice. It is uncomfortable and something must occur in order to reduce the negative feeling. There is a dissonance between their belief of "I want to become an Olympic athlete" and "I want to go to the beach with my friends." One of them thinks "missing one day of training could make the difference between becoming an Olympian and not making it; besides, I don't really like the beach that much" and that person attends practice. The other athlete thinks "I've been working so hard I deserve a break; missing one day of training can't make that big of a difference," and skips practice. Both were in a state of cognitive dissonance. They were conflicted between their goal of becoming Olympic athletes and going to the beach, a behavior that was in opposition to their goal. One of the students changed her belief by justifying (I deserve a break) and rationalizing (it won't make a difference) the behavior (a day at the beach). The other student reduced the cognitive dissonance by adding a new belief (one day of training could make a difference) and reducing the importance of one of the components (I don't like the beach that much), choosing to attend practice.

Current Status and Impact (Psychological Influence)

A tremendous amount of research has been conducted in examining key components of cognitive dissonance theory in adults and children. The concepts of beliefs, attitudes, and motivational systems; psychological and emotional discomfort; compliance dynamics; use of justification and rationalization; and decision making have been studied.

Cognitive dissonance theory continues to be one of the most studied concepts in psychology. It has been used to examine a multitude of social and psychological problems such as eating disorders, mood and behavior disorders, and substance abuse disorders. It has also been used in studies of relationships, parenting, moral beliefs, racism, prejudice, happiness, attitudes, decision making, motivation, self-perception, and in hundreds of other personal applications. In addition to the social psychology fields, cognitive dissonance research has been conducted in virtually every professional field, including, education, nursing, marketing, economics, finance, law, communication, advertising, and medicine.

Cognitive dissonance theory is a concept that has provided insight into human behavior and functioning. Over the past 60 years studies investigating a wide variety of confusing human behaviors have been conducted. These studies have consistently led to the development of helpful interventions and treatments for a

wide variety of problems. Cognitive dissonance theory is sure to continue to offer meaningful insight and understanding into the human condition.

Steven R. Vensel, PhD

See also: Schemas and Maladaptive Schemas

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Cognitive Problem-Solving Skills Training (CPSST)

Cognitive problem-solving skills training (CPSST) focuses on decreasing inappropriate and disruptive behaviors in children and adolescents by teaching them constructive ways to solve problems.

Description

CPSST was developed to help reduce significant conduct and behavioral problems in children and adolescents at home, at school, and in the social environment. It focuses on helping children and adolescents learn to manage the thoughts and feelings that often provoke or create the problems to begin with. Dysfunctional behaviors include impulsive, disruptive, annoying, and defiant behaviors; aggressive behaviors; and behaviors that infringe upon the rights of others.

The goal of CPSST is to decrease dysfunctional behaviors by increasing an individual's choice in how to respond to social situations. A central precept of CPSST is that children and adolescents are limited in how they interact and respond socially. These limits are often imposed by the family systems of the child. The individual maturity level of the child also imposes limits to his or her response to problems. The early focus is on discovering irrational interpretations and assumptions that lead to dysfunctional behaviors and acting out. For instance, a child who acts out aggressively in a classroom may have wrongly interpreted that someone is laughing at him or her when in fact it is not so.

CPSST consists primarily of individual sessions although group treatment sessions can be utilized. Sessions typically last for 45 to 60 minutes and usually occur weekly but can occur more frequently. CPSST uses a cognitive behavioral approach to managing interpersonal conflict and social relationships. An essential component to early treatment is helping the child or adolescent understand how thoughts, feelings, and behaviors work together to form responses to problems. One of the first goals of CPSST is to address the cognitive aspects of the individual's behavior. How an individual thinks about situations and interprets the actions and behaviors of others is crucial to developing new ways of thinking that lead to new ways of feeling and behaving. Another central aspect of CPSST is helping children gain insight into how they are often a part of the conflict or problem. CPSST then teaches children different skills and techniques in managing thoughts and feelings and in responding appropriately to stressful situations.

CPSST is a collaborative and interactive process between the client and the therapist. Learning new behaviors through modeling and role-playing is key behavioral elements of CPSST. Teaching alternative ways of responding and affirming new skills are also important behavioral components of CPSST. Homework is often assigned in order for the individual to practice the new skills and new ways of thinking. Homework and events during the week are discussed and evaluated in order to reinforce successful problem solving or correct areas of weakness.

Successful CPSST results in children being able to be more flexible in social conflicts and less likely to act impulsively. As CPSST progresses, children become more skilled at generating and implementing alternative solutions to conflicts. Another aspect of successful CPSST is an understanding and anticipation of the social consequences of the child's behaviors on self and others.

Development and Current Status

CPSST continues to be studied and has been found to be effective in changing problem behaviors in children and adolescents. Alan Kazdin, director of Yale Parenting Center, has conducted extensive research into child conduct problems and is the most cited researcher of CPSST. Kazdin's clinical research team has studied child-rearing practices, parenting, and ways in which parenting can be altered to improve child functioning at home, at school, and in the community. The team has also examined child and adolescent treatment practices in use in the mental health professions, the clinical and research bases of these practices, and the implications for mental health services. The result of this extensive research has been the development of the "Kazdin Method" of parenting, which uses a combination of cognitive problem solving and parent training. The Kazdin Method has been examined in controlled studies and found to be effective in reducing conduct problems in children and adolescents aged 2 to 17. It has also been found to be effective across diverse ethnic groups.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy

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Cognitive Remediation

Cognitive remediation is a type of treatment that assists individuals suffering from psychiatric disorders improve their cognitive skills and increase their social functioning.

Description

Cognitive remediation is a psychological treatment approach focused on the improvement of cognitive deficits and problems in living for individuals suffering from psychiatric disorders such as schizophrenia and attention-deficit hyperactivity disorder. The goal of cognitive remediation is to improve skills most closely tied to living independently, such as holding a job and developing meaningful relationships. Cognitive remediation is used in conjunction with other medical and psychotherapeutic treatments. It has been shown to be effective in the treatment of some psychotic disorders, attention disorders, mood disorders, and eating disorders.

Cognitive remediation and cognitive retraining use similar techniques but have distinct goals. Cognitive retraining focuses on restoring or compensating for cognitive losses after a brain injury. The goal of cognitive remediation is to develop new abilities and skills in individuals suffering from psychiatric disorders.

Development

Cognitive remediation therapy was originally developed at Kings College in London to improve social functioning of patients suffering from psychological and neuropsychological conditions such as schizophrenia. Cognitive remediation uses exercises and tasks to train the brain and improve neuropsychological function. There are two main techniques used to train brain functions. One is to strengthen the deficit function by targeting the specific impairment in order to increase functioning. The second is to target cognitive strengths and develop strategies to compensate for the impaired function. Assisting patients to think more abstractly, increase attention span, organize increasingly complex problems, and develop skills in problem solving and logic are examples of identified treatment goals. Most frequently, the exercises and tasks in cognitive remediation therapy are administered via computer and often take the form of games. Repetition is an important factor in cognitive remediation. Some examples of task used in cognitive remediation therapy include sentence completion exercises; remembering list of numbers, words, or figures; organizing sequences of numbers, letters, or symbols; and other exercises.

Conditions and disorders that have symptoms of attention and concentration issues, memory impairment, and organizational problems include attention-deficit disorders and schizophrenia. Other conditions that have symptoms of cognitive impairment include depression and anorexia. For instance, people suffering from depression often report feeling that their "head is in a cloud" and they are unable to think clearly. Individuals suffering from an eating disorder such as anorexia have very rigid thought patterns when it comes to food.

Current Status

There are numerous studies indicating the effectiveness of cognitive remediation in assisting individuals suffering from a variety of psychological disorders. There are over 100 clinical trials involving more than 2,000 people with schizophrenia indicating cognitive remediation to be effective in improving abilities associated with essential living skills.

In 2010, Til Wykes, professor of clinical psychology and rehabilitation at the Institute of Psychiatry, King's College London, called for greater focus in the research of cognitive remediation therapy. He suggested that all researchers adopt and use no more than 10 standardized measures of performance and categorize study participants into meaningful subgroups, such as age or ways of learning. He also called for researchers to investigate more precisely how cognitive changes are brought about and how significantly they affect a person's life. Further research is currently being conducted investigating the usefulness of this promising technique with other types of conditions in which cognitive impairments are observed.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy; Cognitive Deficits; Cognitive Retraining

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Cognitive Retraining

Cognitive retraining is a form of neuropsychological treatment, which assists brain injury patients restore, or compensate for loss of, cognitive abilities due to a brain injury.

Description

The purpose of cognitive retraining is to assist brain injury patients recover impaired brain functions and improve their quality of life. Cognitive retraining is a rehabilitative technique used by a variety of professionals to improve or restore function to impaired attention, memory, organization, reasoning, understanding, and problem-solving cognitive functions. Assisting brain injury patients improve their awareness of the impact of the injury, accepting their limitations, and adapting to the changes brought about by the injury are important components of cognitive retraining. Developing a sense of well-being within a realistic understanding of the neurobiological changes is an overarching goal of cognitive retraining. Neuropsychologists, counselors, psychologists, psychiatrists, occupational therapists, and speech therapists, among others, can be trained to provide cognitive retraining treatments.

Development

Cognitive retraining is a psychoeducational approach characterized by the therapist's efforts to improve the patient's awareness, acceptance, and realism about

his or her injury-related strengths and challenges. Patients are taught to recognize how their neurological strengths and difficulties impact life at home, work, and school and in the environment. There are two categories of cognitive retraining: restorative and compensatory. Restorative retraining helps injured individuals recover functions that have been impaired by injury, stroke, or hypoxia. Compensatory training focuses on assisting patients to cope with and compensate for permanent impairment.

Cognitive retraining begins with a comprehensive neuropsychological assessment of the injured individual. The goal of the assessment is to determine the extent of the injury. It is not uncommon for brain injury patients to be unaware of the extent of their functional impairments, so a complete assessment is essential in planning a course of treatment interventions. The assessment tailors the cognitive retraining to the specific needs of the individual. Studies have indicated that patient buy-in and the ability to "see the big picture" is important to successful outcomes. When patients were able to clearly see the purpose and application of the skills being taught, they were more likely to develop those skills. The relationship between the patient and therapist is also a key factor in positive recovery. A positive working alliance with the therapist, in which there is agreement on therapeutic goals and open and collaborative communication between patient and staff, maximizes treatment potential. Developing a positive working alliance with brain injury patients promotes patient buy-in, fosters positive adaptations, assists in the development of realistic treatment goals, and results in an increase in productivity and quality of life.

Patients receiving cognitive retraining are required to perform a variety of repetitive exercises. Repetition is a key component of cognitive retraining in order for the retrained skill to become automatic. Computers are often used in the cognitive retraining process. Cognitive exercises that target multiple cognitive processes are frequently employed in cognitive retraining. For instance, the "Matching Shapes" exercise addresses functions of memory, motor speed, focused attention, and visual scanning. In the matching shapes exercise, the patient is shown, at random, one of 15 cards depicting one of four shapes. The patient is required to match the shape on the card by pointing to the correct shape on a picture, which contains 13 different shapes. The patient's score is the time required to match all 15 shapes correctly. Another example of a cognitive exercise is the "block design" exercise which targets attention/concentration skills, motor dexterity, visual scanning, and visual spatial perception. In the block design exercise, the patient is shown 1 of 10 different drawings of colored squares in differing arrangements. The patient is required to construct a matching structure using colored blocks. The patient is scored by cumulative total time it takes to complete 10 structures.

Cognitive retraining is an important therapeutic strategy in the recovery and rehabilitation process for individuals suffering from brain injuries. Whether from stoke, injury, or accident, across all ages, cognitive retraining assists individuals in the development of skills needed to live productive, hopeful, and meaningful lives.

Steven R. Vensel, PhD

See also: Cognitive Deficits; Cognitive Remediation

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Cognitive Therapies

Cognitive therapies are a group of psychotherapies that emphasize distorted cognitions and treatment that aims at correcting them. Rational emotive behavior therapy, cognitive therapy, and schema therapy are three common cognitive therapies.

Definitions

- **Automatic thoughts** are thoughts that spontaneously come to mind when a particular situation occurs.
- **Cognitive restructuring** is psychotherapy technique for replacing maladaptive thought patterns with constructive thoughts and beliefs.
- **Cognitive revolution** refers to the shift from a focus on a purely behavioral approach to an acceptance of the role of cognitions as necessary for a fuller understanding of human behavior.
- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing automatic thoughts and maladaptive beliefs.
- **Irrational beliefs** are distorted and/or self-defeating beliefs that are firmly held despite contradictory evidence. It is also known as maladaptive beliefs.
- **Psychoanalysis and the psychoanalytic therapies** are a group of psychotherapy approaches that assumes dysfunctional behavior is caused by unconscious, internal conflicts and focuses on gaining insight into these conflicts.
- **Rational emotive behavior therapy** is a type of cognitive behavior therapy that focuses on identifying and disputing irrational beliefs.
- **Schema therapy** is a type of cognitive behavior therapy that focuses on identifying and changing maladaptive (problematic) schemas.
- **Schemas** are core beliefs or assumptions about one's self and the world.

Description

Cognitive therapies are a group of psychotherapy approaches for which psychological symptoms and conditions are understood to be caused by distorted thinking or thought processes and which can be corrected by changing them. They differ in theory and practice from the psychoanalytic therapies and the behavioral therapies. Three cognitive therapy approaches include rational emotive behavior therapy (REBT), cognitive therapy (CT), and schema therapy (ST). The cognitive therapies view emotional difficulties as rooted in the clients' irrational beliefs—REBT, automatic thoughts and maladaptive beliefs—CT, or maladaptive schemas—ST. Cognitive therapists foster change in clients by assisting them to be more aware of their irrational or maladaptive thoughts and beliefs and their problematic impact, and to replace these problematic thoughts with more adaptive ones. A variety of interventions are utilized in the cognitive therapies, particularly cognitive restructuring which is a broad method, including disputation, guided discovery, Socratic questioning, examining the evidence, reattribution, and cognitive rehearsal.

Developments and Current Status

The cognitive therapies arose as a response to the perceived shortcomings of the psychodynamic therapies and of behavioral therapy. Some of the pioneers in the development of the cognitive therapies had psychoanalytic training. These included psychologist Albert Ellis (1913–2007), the developer of REBT, and psychiatrist Aaron T. Beck (1921–), the developer of CT. Others had training in behavior therapy and other approaches, like psychologist Jeffrey Young (1950–), the developer of ST. The "cognitive revolution" of the 1970s was a turning point in the rapid evolution, acceptance, and legitimacy of the cognitive therapies. Historical precursors of the cognitive therapies have been identified in various ancient philosophical traditions, particularly Stoicism. For example, both Ellis and Beck cite the influence of the Stoic philosophers. One of these, Epictetus, said: "Men are disturbed not by things, but by the view which they take of them." More recent influences on the cognitive therapies include Alfred Adler (1870–1937), who said: "I am convinced that a person's behavior springs from his ideas." Adler developed Individual Psychology in which the cognitive dimension is a central component.

Rational Emotive Behavior Therapy

In 1953, Ellis broke with psychoanalysis and began calling himself a rational therapist. Thereafter, he referred to his approach as rational therapy. His book *How to Live with a Neurotic* published in 1960 elaborated his new method. As he began to emphasize that emotions followed from thoughts, the approach was renamed rational emotive therapy. Later, as cognitive behavior therapy was becoming the dominant therapeutic approach, he renamed his approach rational emotive behavior therapy to reflect its utilization of behavioral methods.

REBT employs the ABCD framework, where "A" is the activating event, "B" is the individual's belief about the event, "C" is the cognitive, emotional, or behavioral consequences of one's beliefs, and "D" is disputation of the irrational belief. In this approach, personal and relational problems as well as symptoms are viewed as resulting from self-defeating thought processes. These thought processes include self- and other-deprecation, catastrophizing, overgeneralizing, and personalizing. The goal of REBT is to change irrational beliefs and self-defeating thought processes into rational beliefs and adaptive thought processes. The focus of treatment is to identify and change the irrational beliefs that underlie disturbed feelings and self-defeating behavior through various cognitive restructuring methods, particularly disputation.

Cognitive Therapy

Like Ellis, Beck also broke with the psychoanalysis in the 1960s. Beck's approach was first articulated in his book *Depression: Clinical, Experimental, and Theoretical Aspects* published in 1967. Soon after, his approach was criticized by behavioral therapists who denied that there was a cognitive cause for mental conditions. Fortunately, as a result of the "cognitive revolution," soon behavior therapy techniques and CT techniques became joined together, giving rise to cognitive behavior therapy. However, even though CT had typically included some behavioral methods, Beck and his associates sought to maintain and establish its integrity as a distinct, clearly standardized therapy.

Theoretically, CT emphasizes the role of cognitive processing in emotion and behavior. It views personality as shaped by central values or superordinate schemas. Psychological distress is influenced by a number of factors, including biochemical predispositions, different learning history, and cognition reaction style. However, presenting problems and symptoms are understood to result from faulty beliefs and/or maladaptive schemas. The focus of treatment is to become aware of limiting automatic thoughts and confront faulty beliefs with contradictory evidence and develop more adaptive beliefs.

Instead of listing specific maladaptive beliefs like Ellis, Beck emphasized that individuals operate from automatic thoughts and core schemas. For example, a woman comes to therapy who is depressed about failing to meet a deadline at her job. Her view of self or self-schema is "I'm worthless and can never do anything right." Strongly believing, this schema tends to activate automatic thoughts like "Things never work our" and "I'm going to get fired." These beliefs further worsen her mood. This is intensified if she reacts by avoiding activities that served to confirm her belief that she is worthless. In therapy, the therapist and client would work together to change this and related automatic beliefs. This is done by addressing the way she thinks and behaves in response to similar situations and by developing more flexible ways to think and respond.

Schema Therapy

Schema therapy is a derivation of CT. Young originally developed it primarily for personality-disordered clients who failed to respond adequately to CT. It was formalized in Young's 1990 book *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach*. Schema therapy is a broad, integrative model that shares some commonalities with object relations therapy, experiential therapy, dialectical behavior therapy, and interpersonal therapy as well as CT and other forms of cognitive behavior therapy. Despite these similarities, ST differs from these approaches with regard to the nature of the therapy relationship, the general style and stance of the therapist, and the degree of therapist activity and directiveness.

Basic to ST are early maladaptive schemas which emerge from aversive childhood experiences such as abuse, neglect, and trauma in early life and lead to maladaptive or unhealthy life patterns. The basic goals of

ST are the following: to identify early maladaptive schemas, to validate the client's unmet emotional needs, to change maladaptive schemas to more functional ones, to promote more functional life patterns and coping styles, and to provide an environment for learning adaptive skills. ST requires considerable training and experience to practice it appropriately and effectively.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Psychoanalysis; Schema-Focused Behavior Therapy

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College Counseling

College counseling centers offer a range of services to parents and students about higher education application, admission, and successful completion.

Definitions

- **College advising** is the process of providing students with the information they need to decide on what postsecondary options are right for them, including application, admittance requirements, coursework progression, and financial aid options.
- **College advisor** is a professional who offers parents and students with information about preparing for college readiness and future success.
- **College readiness counseling** is a type of counseling provided individually, in small groups, or in classroom settings to students prior to postsecondary entrance in an effort to boost preparedness and eventual completion.
- **Professional school counselors** are counseling practitioners employed in various educational settings who collaborate with parents and teachers to help students develop across academic, social, and career domains.

Description

"College counseling" refers to the process of providing parents and students with information about application, entrance, coursework, and financial aid for college. College counseling can be provided in various settings and can differ in terms of size, set up, and level of service.

In the high school setting, college counseling may be provided by a guidance counselor or professional school counselor to students on an individual, small group, or classroom basis. Professional school counselors have a master's degree and hold specialized certification or licensure. These professionals are skilled in the practice of guidance and counseling students.

College counseling can also be provided to students at the postsecondary level. College counselors have credentials similar to professional school counselors. However, college advisors, sometimes confused with "college counselors," do not necessarily have backgrounds in counseling. Advisors, rather, have specialized knowledge about the institution or program they service. Many faculty members serve as advisors in higher education settings.

College counseling is an ongoing process. The goal is not reached at admittance into college but continues as the student succeeds throughout his or her college experience and ends ultimately on completion. Students beginning their postsecondary careers need college counselors to provide them with recommendations about how to navigate college successfully. This may include guidance about choosing an appropriate major, outlining a program of study, and providing information about support services.

Development

College counseling practice first appeared in the early 1900s when it was noted that students were struggling to navigate higher education without proper guidance. At this time faculty members and university presidents were providing these types of services. After 1945, veterans returning from war were in particular need of assistance. This spawned an increase in postsecondary educational and vocational counseling, and expansion in the field continued through the 1970s. During the 1990s and on into the early 21st century, college counseling centers became stable fixtures on campuses.

Current Status

In 1991, the American College Counseling Association (ACCA), a division of the American Counseling Association, was established. The mission of the ACCA is to support counselors working in higher education so they can foster student success. The organization serves professionals from various disciplines working in college counseling centers, community colleges, and university settings. Most college counseling centers follow the ethical guidelines, standards, and practices outlined by the ACCA. Though challenges and obstacles related to the practice of college counseling continue to arise, the field itself continues to grow due to the high value placed on obtaining a postsecondary degree.

Melissa A. Mariani, PhD

See also: Counseling and Counseling Psychology; Guidance Counselor

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Columbine Shooting

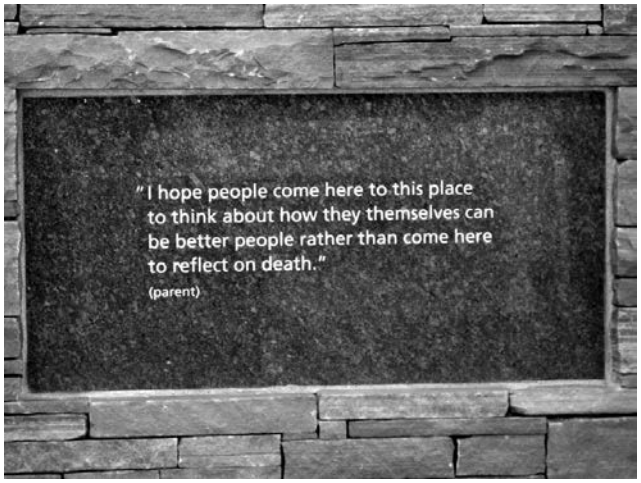
The Columbine shooting is the school rampage shooting that took the lives of 12 students and 1 teacher and injured 24 others.

Definitions

- **Biopsychosocial** is the integration of biological, psychological (thoughts, feelings, and behaviors), and social (environmental and cultural) factors to understand and explain human behavior.
- **School rampage shooting** refers to the act of a student or former student attacking a school with a gun with the initial intent to shoot a specific target but injures or kills at least one other person. It is differentiated from other forms of schools violence and from workplace violence.
- **Sociocultural** refers to the combination of social and cultural factors.

Description

The Columbine shooting is the rampage shooting committed by two seniors at Columbine High School in Columbine, Colorado. On April 20, 1999, these students executed a complex attack on the school that involved guns, bombs, and explosive devices. The perpetrators, Eric Harris (1981–1999) and Dylan Klebold (1981–1999), also took their own lives at the end of their terror attack. In 1996, Harris created a private website where he posted a blog on gaming. Eventually the blog became a place for the troubled teenager to post his negative feelings toward society and instructions on how to make bombs and explosives. The two high school seniors wrote in their personal journals that they wanted to replicate the Oklahoma City Bombing. The bombing of the Alfred P. Murrah Federal Building occurred on April 19, 1995, and killed 168 people



One of the many memorial plaques at Columbine High School in Littleton, Colorado, reflecting on the aftermath of the school rampage shooting that took the lives of 12 students and 1 teacher and injured 24 others. (Bruce Cotler/Globe Photos/ZUMAPRESS.com/Alamy)

and injured at least 680 people. Since their intention was to kill as many people as possible, they placed bombs and explosives in the school cafeteria during the busiest lunch period. However, the cafeteria bombs failed to detonate. Then, Harris and Klebold began randomly shooting people in their path until they entered the library where students and staff were hiding. Here they proceeded to shoot more people until law enforcement officials arrived. At that point, they took their own lives by shooting themselves.

The Columbine shootings have cultural significance. First, the amount of news media coverage it received was only second to the O. J. Simpson murder trial (during the 1990s). Second, at that time, it was the most violent act against a school that killed the most people. Third, the two students used the Internet to create websites to post violent acts committed, bomb-building instructions, hit lists, death threats, and videos. Fourth, after the shootings, many schools installed security measures and adopted a zero tolerance policy toward threats of violence. Finally, the Columbine shootings prompted other individuals who felt victimized, bullied, or somehow marginalized to copy Harris and Klebold's rampage shootings. Harris and Klebold posted their strategies on the Internet and provided others with specific plans on how to carry out an attack. These postings inspired others to imitate the Columbine shooting and seek revenge on people who they felt wronged them. Furthermore, many subsequent shooters attempted to exceed the death toll of the Columbine shooting.

A sociocultural perspective is taken to understand and make sense of school shootings. The factors considered to have influenced the behavior of Harris and Klebold include bullying, mental illness, video game violence, social climate, Goth subculture, and music. To date, the primary underlying issue for these young men is believed to have been their pain and anger associated with the loss of a place among their peers, in the school community, and in society. An interdisciplinary team effort and a biopsychosocial perspective are both necessary to understand and explain the causes of violence. This team effort includes teachers, school administrators, policy makers, parents, and health-care workers.

Christina Ladd, PhD, and Len Sperry, MD, PhD

See also: Bullying and Peer Aggression; Mass Shootings

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Combined Treatment

Combined treatment is the combination of psychotherapy and medication to treat mental conditions.

Definitions

- **Biopsychosocial** refers to biological, psychological, and social factors and their interaction.
- **Pharmacological** means it relates to pharmacology or the scientific study of drug reactions.
- **Pharmacology** is the study of drugs, how they react, and their use in medicine.

- **Psychopharmacology** is the study of psychotropic drugs and their chemical interactions with the brain.
- **Psychosocial** refers to psychological and social factors and their interaction.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

Description

Combined treatment is the use of psychological treatment with pharmacological treatment. The objective of combined treatment is to improve an individual's social functioning, quality of life, and treatment outcome. The combination of psychotherapy and medication results in better treatment outcomes for the individual than medication alone. Usually, two clinicians, such as a psychotherapist and a psychiatrist, work collaboratively to develop and implement treatment.

Combined treatment may work better in the prevention and delay of illness onset than either psychotherapy or medication treatment only. Psychotherapy may increase medication compliance and medication compliance may enhance client focus and engagement in the treatment process. Combined treatment is necessary when one type of treatment, either psychotherapy alone or medication alone, is insufficient to decrease or alleviate symptoms.

The term "combined treatment" was originally used by psychiatrist Gerald Klerman (1928–1992) in 1991 in the book entitled *Integrating Pharmacotherapy and Psychotherapy*. Klerman asserted that combined treatment is more efficacious than either medication or psychotherapy alone because it (1) helps to achieve illness remission faster, (2) improves the probability that treatment will commence, (3) decreases or eliminates the probability of relapse, (4) simultaneously treats the client's problems while aiding in the reduction of stress among family members, (5) increases medication compliance, (6) develops and/or improves psychosocial skills, and (7) speeds up the psychotherapy process (Beitman and Klerman, 1991, 3–19). Psychotherapy in combination with medication is better than medication alone for the treatment of depression, bipolar disorder, schizophrenia, attention-deficit hyperactivity disorder, bulimia, sleep disorders, and post-traumatic stress disorder.

The appropriate combination of treatments is determined from a biopsychosocial approach. An individual's genetic attributes and predispositions, psychological factors, and sociocultural context are considered in the choice of medication and treatment modality (i.e., individual, family, and/or group therapy). From a biopsychosocial perspective, a diagnostic map must be constructed to understand and explain the individual's problems. Then, measurable treatment goals must be identified and assessed throughout the psychotherapy process. Medication, if prescribed, must be monitored and adjusted as necessary. Health practitioners must work collaboratively to determine the sequence and type of combined treatment necessary depending on the diagnosis and its severity. For example, an individual with schizophrenia might receive medication treatment first, followed by individual and family psychotherapy. An individual suffering with psychosis may not be able to take part in any modality of psychotherapy until he or she is properly medicated and psychotic symptoms are managed. Conversely, for individuals with personality disorders, it may be better to begin the combined treatment process with psychotherapy and then include medication to treat symptoms of depression, anxiety, hallucinations, and delusions. Which type of treatment comes first is based on a thorough assessment, professional clinical judgment, and the type and severity of the problem at hand. In addition, clients collaborate with the practitioner in deciding which treatment should be administered and when.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Multimodal Therapy; Psychopharmacology; Psychotherapy

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Commission on Rehabilitation Counselor Certification (CRCC)

The Commission on Rehabilitation Counselor Certification (CRCC) is a not-for-profit organization that sets the standard for quality rehabilitation counseling services through a certification program.

Definitions

- **Certification** is a formal procedure by which an accredited or authorized person or agency assesses and verifies that a person has the knowledge and skills to perform certain activities.
- **Rehabilitation counseling** is a type of counseling that focuses on helping individuals who have disabilities in order to achieve their career, personal, and independent living goals.

Description

The Commission on Rehabilitation Counselor Certification ensures that rehabilitation professionals are accountable for the work they do. Rehabilitation counselors work with people with disabilities to provide vocational services. The skills and training required to do this work vary and can be intensive. The work of these counselors may include interviewing and analyzing a client's disability level to help him or her obtain work and medical and social services. The counselor works to determine what kind of work is appropriate, given the level of disability. When the disabilities are of a catastrophic nature, the rehabilitation counselor may be involved in the full range of life planning for the client.

Development

As the field of rehabilitation counseling grew, it became important to ensure that the counselors had adequate education and skills. The CRCC was founded by two other rehabilitation organizations as a not-for-profit organization established to set standards of quality rehabilitation counseling services. It does this through a standardized certification process for rehab counselors as well as by serving as a lobbying group for the rights of people with disabilities.

The need to ensure quality counselors was reinforced by the passing of the Americans with Disabilities Act in 1990. The CRCC has continued to identify guidelines for conduct and ethical behavior. This is necessary because the field of rehabilitation counseling has grown exponentially in recent years.

Inevitably many ethical questions and issues arise in the course of rehabilitation counseling. Rehabilitation counselors have available training in a Code of Professional Ethics for Rehabilitation Counselors in addition to decision-making models to help them resolve ethical dilemmas. CRCC has also been a lobbying group to ensure the support of rehabilitation efforts and standards of practice.

Impact (Psychological Influence)

Rehabilitation counseling was identified as one of the fastest-growing health professions in the United States in 2011. The CRCC has become the world's largest rehabilitation counseling organization, with over 16,000 professionals currently certified. Since its start the CRCC has certified over 35,000 rehabilitation counselors.

CRCC standards are always in need of review and updating. This includes revising the tests for certification in order to reflect current understanding and best practices of the rehabilitation counselor role and functions. One of the roles of the CRCC is to receive, review, and act on ethical complaints and violations. In the 13 years between 1993 and 2006, 113 complaints were reviewed, of which only 36 resulted in action.

There will continue to be a significant role for CRCC in the rehabilitation field. Among many other

challenges is an increasingly diverse patient population. This requires changes in laws and guidelines in health care and insurance that are important for people with disabilities. It is also important for the CRCC to be involved in addressing the many ethical challenges for rehabilitation counselors and provide ways to make sure they are providing the best care for their clients.

Alexandra Cunningham, PhD

See also: American Rehabilitation Counseling Association (ARCA); Rehabilitation Counseling

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Common Factors in Psychotherapy

Common factors in psychotherapy are basic elements that do not depend on a specific theory or psychotherapy approach.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Dodo Bird Verdict** is the claim that all psychotherapies are equally effective regardless of their components.
- **Psychoanalysis** is a theory of human behavior and a form of therapy based on psychoanalytic theory. In psychoanalysis, clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams. It was initially developed by Sigmund Freud.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Common factors in psychotherapy are basic elements that do not depend on a specific theory or treatment. Throughout history, the followers of different theories have attempted to prove that their theory was superior to others. They argued that their theory led to better outcomes in therapy. For example, those who practice psychoanalysis believed that exploring the past and unconscious drives is necessary for clients to change. Those who practice behavior therapy, however, did not consider these things important and instead focused on behaviors in the present. Currently, there are over 250 different therapeutic approaches. Research has attempted to show which of them is more effective than the others to settle this debate. However, no clear consensus has been reached.

Several factors are common in most psychotherapy approaches. Many of these factors influence the outcomes of psychotherapy. In 1936, psychologist Saul Rosenzweig (1907–2004) published the first paper outlining common factors in psychotherapy. He concluded that all types of therapy could be effective if therapists had these factors. This was also referred to as the Dodo Bird Verdict in reference to a character's quote in Alice in Wonderland ("Everybody has won and all must have prizes"). Rosenzweig's factors included the therapist's personality and theoretical consistency. Psychologist Carl Rogers (1902–1987) later described the "necessary and sufficient" conditions of therapeutic change in 1957. These were empathy, respect, and genuineness. Rogers argued that therapy was effective simply if these elements were present (sufficient). Psychiatrist Jerome Frank (1909–2005) examined many different types of healing practices ranging from traditional psychotherapy to religion. He found four features shared by all effective therapies. These were a confiding relationship with a therapist, a healing setting, a clear explanation for symptoms and the solution, and a collaborative process or ritual to restore the patient's health.

More recent research has continued the investigation into common factors. Psychologist Michael Lambert (1944–) and others reviewed therapeutic outcomes studies. They found that certain factors were responsible for change across different theories and diagnoses and were not connected to a specific theory. They are client variables, the therapeutic relationship, placebo effects, and technique. "Client variables" refer to the qualities that clients themselves possess and bring to therapy. These include such factors as motivation for change, social support, and inner strengths. This is sometimes referred to as "extratherapeutic" change because it is separate from the therapy. According to Lambert's analysis, client variables account for 40% of therapy outcome. The therapeutic relationship factor included variables like empathy, respect, and genuineness previously identified by others. This factor takes place between the therapist and the client, also called the therapeutic alliance. Lambert found that this accounted for 30% of the therapy outcome. Placebo effects refer to clients' degree of hope and expectations for change. Those who believe that positive change will happen are more likely to meet this expectation. Placebo effects account for 15% of therapy outcome according to Lambert. The final common factor is technique. This encompasses features unique to specific theories, such as interpretations or feedback. According to this analysis, 70% of the outcome in therapy is decided by client variables and the therapeutic relationship alone (Lambert, 1992). In other words, therapy will be successful if a client is motivated for change and the therapist has established a strong bond. This formula excludes the specific techniques and theories many thought to be important. Common factors research has led to the development of integrative therapy approaches.

Len Sperry, MD, PhD, and George Stoupas, MS

See also: Behavior Therapy; Dodo Bird Verdict; Psychotherapy; Rogers, Carl R. (1902–1987)

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Community Mental Health

"Community mental health" refers to the delivery of community-based mental health and addictions services to at-risk and underserved populations suffering from mental health conditions and substance use disorders.

Description

The U.S. Department of Health and Human Services (DHHS) is the government agency that provides funding and resources for essential services to underserved populations suffering from mental health conditions and substance use disorders. The Substance Abuse and Mental Health Services Administration (SAMHSA) is an operating division of the DHHS and is tasked with improving the quality and availability of substance abuse prevention, addiction treatment, and mental health services. SAMHSA provides grants and funding to states for substance abuse and mental health services and programs. A major goal of SAMHSA is to improve access and reduce barrier to programs and services for individuals who suffer from, or are at risk for, substance use disorders or mental health disorders.

Development

President John F. Kennedy signed the Community Mental Health Act (CMHA) into law in 1963. The CMHA made a significant impact on the delivery of mental health services and led to the establishment of comprehensive community mental health centers throughout the United States. Prior to the enactment of the CMHA people suffering from chronic mental health conditions were frequently "warehoused" in psychiatric hospitals and institutions. These individuals received little, if any, effective treatment, suffered

from poor living conditions with little freedom, and could remain in these institutions for years with little hope of reentering their communities as productive citizens. With advances in psychotropic medications and the development of new approaches to psychotherapy, community-based care became a viable solution to the warehousing of those suffering from chronic mental health disorders.

As treatment of mental illness became more diverse and comprehensive, it became evident that those suffering from addictions also needed services. The combination of mental health interventions and interventions directed at recovery from addiction disorders became known as "behavioral health care." The provision of comprehensive mental health and addiction services is the goal of community-based behavioral health organizations.

Current Status

Community mental health organizations offer a wide variety of support and services to people with mental illnesses and substance use disorders. Examples of services to communities include 24-hour crisis response and suicide preventing training; community reentry support to released prisoners; educational support to organizations in new mental health and addictions therapies; provision and funding of community-based substance use treatment centers; school-based substance intervention educational programs; domestic violence prevention; child and elder abuse prevention and recovery training; and school and gang violence interventions and programs.

According to the National Council for Behavioral Health (National Council), there are approximately 8 million adults and children in the United States living with mental illness and substance use conditions who have severely limited or no access to behavioral health services. The National Council is an example of how the DHHS and SAMHSA provide help to the citizens of the United States. The National Council, funded by DHHS and SAMHSA, represents over 2,000-member organizations that employ over 750,000 people providing care to at-risk individuals and families. The National Council advocates for policies to ensure that people with mental health and addictions disorders have access to comprehensive, high-quality care in order to provide the opportunity for recovery and full participation in community life. The National Council coordinates the Mental Health First Aid (MHFA) program, a national mental health initiative.

In response to gun violence, President Obama called for Mental Health First Aid training across the United States. MHFA is a public education program that teaches community members how to recognize and respond to signs of mental illness and substance use disorders before they become a crisis. MHFA has both youth and adult courses. MHFA consists of eight hours of instruction that introduces participants to the risks factors and warning signs of mental health concerns and links them to local mental health resources, national organizations, support groups and professionals, and online tools. MHFA promotes early detection of specific illnesses such as anxiety, depression, bipolar disorder, psychosis, eating disorder, and addictions. MHFA training is provided to any concerned citizen or group. The National Council seeks to make Youth Mental Health First Aid available in every one of the 4,197 colleges and 13,809 school districts in the United States.

Steven R. Vensel, PhD

See also: Behavioral Health; Mental Health Laws; Substance Abuse and Mental Health Services Administration (SAMHSA)

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Community Reinforcement Approach (CRA)

Community reinforcement approach is a treatment that rearranges an individual's life so that abstinence and sobriety are more rewarding than substance use. It is also called CRA.

Definitions

- **Abstinence** is the choice not to engage in certain behaviors or give in to desires such as alcohol or drug use.
- **Aversion therapy** uses principles from behavioral psychology to help reduce or eliminate unwanted behaviors.
- **Confrontational counseling** is an intervention used by counselors to promote wellness in an individual by promoting insight, reducing resistance, promoting open communication, and increasing conformity between an individual's goals and behaviors.
- **Family therapy** is a type of psychotherapy approach that is used to help family members resolve conflicts and improve their communication skills.
- **Group therapy** is a type of psychotherapy approach in which a small group of individuals meet regularly with a therapist.
- **Motivational interviewing** is a counseling strategy for helping individuals to discover and resolve their ambivalence to change.
- **Positive reinforcement** is the addition of a reinforcer (reward) following a desired behavior that increases the likelihood that the behavior will reoccur.
- **Recovery** is a series of steps individuals take to improve their wellness and health, while living a self-directed (responsible) life and striving to reach their highest potential.
- **Sobriety** is the condition of complete abstinence from all mind-altering substances as well as increased mental, physical, and spiritual health.
- **Social support system** is feedback and a sense of belonging provided by friends and peers.
- **Substance use disorder** is a mental disorder in which one or more mind-altering substances lead to clinically significant distress or impairment in an individual.

Description

Community reinforcement approach (CRA) is a substance treatment approach for individuals with substance use disorders. It provides individuals with incentives to stop using by eliminating positive reinforcement for using substances and enhancing positive reinforcement for sobriety. The basic premise is that positive reinforcement has a powerful role in encouraging and discouraging substance use. CRA was developed in the early 1970s by psychologist Nathan Azrin (1930–2013). Azrin stressed the interaction between an individual's behavior and his or her environment, particularly the positive reinforcement of an individual's social support system or community. He believed CRA could help individuals decrease their addiction and better enjoy life. CRA uses recreational, social, vocational, and familial reinforcers to help individuals in the recovery process.

CRA integrates several treatment elements into its program. It helps build motivation to stop drinking and using drugs. It assists in analyzing substance abuse patterns and increasing positive reinforcement for an individual to stop using. It involves learning new coping behaviors and involving friends and family members in the recovery process. These elements can be modified to an individual's needs in order to achieve the best treatment outcome. In addition, CRA has been successfully integrated with other treatment approaches. Some of these approaches include motivational interviewing, family therapy, group therapy, aversion therapies, and confrontational counseling. The goal of these various approaches is skills training and improving communication and problem solving.

However, what is unique about CRA is its emphasis on community reinforcement and social support. Individuals with substance use problems, therapists, and friends and family all work together to increase abstinence and sobriety. Having a healthy social support system is a key part of this approach. CRA can be as effective as or more effective than traditional approaches.

Len Sperry, MD, PhD, and Elizabeth Smith Kelsey, PhD

See also: Aversion Therapy; Family Therapy and Family Counseling; Group Therapy; Motivational Interviewing

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Comorbidity

Comorbidity is the presence of an additional mental disorder or medical condition that occurs alongside a mental disorder. It is also referred to as co-occurring illness and dual diagnosis.

Definitions

- **Differential diagnosis** refers to the presentation of symptoms that appear to meet the criteria of multiple diagnoses and the process of ruling out diagnostic alternatives.
- **Dual diagnosis** is the presence of a mental disorder and an addiction to alcohol or drugs.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Personality disorder** is a type of mental disorders characterized by deeply ingrained maladaptive (problematic) patterns of thinking and acting.
- **Predisposing factors** refer to all the possible factors that account for and explain the client's characteristic way of perceiving, thinking, and responding.

Description

Comorbidity is the occurrence of one or more mental or medical disorders (conditions) along with a primary mental disorder. Usually, these co-occurring pathologies have similar structure, development, or cause. For example, depression is a common comorbidity following a myocardial infarction (heart attack). However, in medicine "comorbidity" can indicate the simultaneous existence of two or more medical conditions that have different causes, structures, or development. This can lead to confusion about the nature of the multiple diagnoses. For treatment purposes, the interrelationship among the multiple conditions must be taken into account. The reason is that individuals with a diagnosed mental disorder have an increased risk of other diagnoses.

Several factors foster comorbidity. These include genetic predisposition, family history, environment, and a history of trauma. It is also possible that different unrelated predisposing factors are operative, leading to different unrelated diagnoses. Finally, it is often the case that the symptoms associated with one mental disorder operate as the predisposing factors of one or more other disorders or physical illnesses. Such differing factors that foster comorbidity may exist in isolation or coexist within the same individual. In brief, comorbidity is having more than one diagnosis at any given time.

Mental health professionals also use the term "comorbidity" when referring to the coexistence of multiple symptoms. This is especially true when a single diagnosis will not account for all client symptoms. The personality of the client is also a factor in comorbidity. Personality traits and coping styles influence the risks associated with developing comorbid mental health disorders. Personality disorder also has a tendency to coexist. It is not uncommon for a client

diagnosed with a personality disorder to have features of another personality disorder. In fact, more than half of individuals with personality disorders will be diagnosed with a comorbid personality disorder. Mood disorders and anxiety disorders also have a high rate of comorbidity. The substance disorders often have comorbid mental disorders and/or physical illnesses. The term "dual diagnosis" is especially common when indicating the coexistence of substance-related disorders and other mental disorders. For example, depression is common in individuals with alcohol dependence.

Current research indicates inconsistent use of the term "comorbidity." The primary importance is for the clinician to account for all of the client's problems. It is possible to exclude some of the client's problems if the clinician focuses on only one diagnosis. In this case, comorbidity is related to the term "differential diagnosis." Where the determination of differential diagnosis or process of diagnostic elimination cannot be fully made, the possibility of comorbidity increases.

Development and Current Status

Alvin Feinstein (1925–2001) introduced the term "comorbidity" to medicine in 1970. In the 1990s, researchers identified two major types of comorbidity. "Homotypic comorbidity" refers to the coexistence of two or more diagnoses of the same diagnostic category. "Heterotypic comorbidity" refers to the coexistence of two or more diagnoses of different diagnostic categories. As researchers began to investigate comorbidity, questions arose as to the nature of the relationship between or among coexisting pathologies. A theory of a direct causal relationship was proposed, such that the presence of one disorder causes the presence of another disorder or illness. Another theory of the relationship between comorbid disorders that developed is the theory of the indirect causal relationship. The indirect causal relationship indicates that the presence of one diagnosis increases the likelihood of a second diagnosis. A third theory that developed out of the research on comorbidity is that of common factors. The comorbidity theory of common factors indicates that multiple diagnoses have the same set of predisposing factors.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Depression; Dual Diagnosis; Substance-Related and Addictive Disorders

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Compassion Fatigue

"Compassion fatigue" refers to the emotional strain and stress experienced by a variety of health-care professionals working with victims of traumatic events.

Description

Compassion fatigue, also known as secondary traumatic stress, is a stress condition that some helping professionals experience after working with people who have experienced traumatic events. It is the result of the accumulated emotional and psychological impact of repeated exposure to the traumatic experiences of others. It has been referred to as the "cost of caring" and is experienced by a wide variety of health-care professionals, including counselors, psychologists, social workers, nurses, doctors, emergency room workers, and other care providers. It has also been found to affect clergy, lawyers, firefighters, and other emergency responders. It is estimated that between 16% and 85% of care providers experience compassion fatigue. Compassion fatigue was first recognized in the 1990s and continues to be the focus of research and investigation across professional fields. Charles Figley is recognized for his extensive research and publications concerning compassion fatigue.

Causes and Symptoms

Caregivers who treat trauma victims and listen to repeated stories of tragedy, violence, sorrow, pain, sadness, fear, terror, loss, and death experience compassion fatigue, also referred to as vicarious traumatization. These repeated stories begin to have an affect on the caregiver, and the caregiver experiences what is referred to as secondary traumatic stress.

The effects of compassion fatigue impact helping professionals' emotions, thoughts, and behaviors. They may begin to remember their client's stories during their nonwork hours and may visualize the stories in their mind's eye. Sometimes these images are intrusive and caregivers can't seem to stop thinking about the events even though they did not have the experience themselves. They may experience some of the feelings associated with their client's story. They may become sad or depressed, emotionally detached, anxious, or fearful or experience other feelings their clients or patients experienced. Caregivers may experience physical difficulties such as difficulty sleeping, headaches, or stomach problems. Professionals working with victims of violent crime may become obsessed with fears of their own safety and may avoid places that remind them of the client's experience. Caregivers who work with children may become overprotective of their own children. It is not uncommon for compassion fatigue to result in a change in worldview and beliefs. Caregivers suffering from compassion fatigue may begin to question the meaning of life, question their own religious beliefs, become skeptical, or feel anger toward God.

Diagnosis and Prognosis

Research indicates that certain risk factors exist for the development of compassion fatigue. Exposure is a significant factor. Caregivers who are exposed to traumatic stories on a daily basis are at greater risk of secondary trauma than are those who are exposed less often. It has also been found that those who are more empathic are at greater risk for compassion fatigue. Other risk factors include ability to self-care, coping abilities and stress management, work and peer support, and spirituality.

Compassion fatigue is preventable and treatable. Perhaps the most important strategy to prevent secondary traumatic stress is self-care, which begins with awareness. Professionals who understand compassion fatigue are more likely to recognize the signs of fatigue before they become problematic. Self-care practices such as pursuing enjoyable activities like sports or hobbies, regular exercise, and social activities apart from work are important to a balanced lifestyle that can provide recovery and perspective when working with traumatized clients. It is very important that professionals debrief and talk with other professionals in a supportive role. When compassion fatigue becomes debilitative, psychotherapy has been shown to be effective in the recovery process.

Steven R. Vensel, PhD

See also: Trauma; Trauma Counseling

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Competency and Competencies

Within the context of health care, competency is the ability to integrate knowledge, skills, and attitudes to provide high-quality care. Competencies are the specific knowledge, skill, and attitudes by which competency can be evaluated.

Definitions

- **American Counseling Association** is a not-for-profit, professional, and educational organization that is dedicated to the growth and enhancement of the counseling profession. It is also referred to as the ACA.
- **American Psychological Association** is the largest professional organization in the United States and Canada. It publishes the

Publication Manual of the American Psychological Association and is also referred to as the APA.

- **Counseling** refers to professional guidance of an individual by assisting him or her in resolving personal, social, or psychological problems and difficulties.
- **Countertransference** is the redirection of a therapist's feelings toward a client and more generally as a therapist becomes emotionally entangled with a client.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.
- **Transference** is a phenomenon characterized by unconscious redirection of feelings from one individual to another.

Description

Competency in the field of counseling is the judicious and continuous use of skills, knowledge, emotions, values, clinical reasoning, and reflection in health care. This includes counseling and psychotherapy. The term "competency" was coined by an American psychologist, R. W. White (1904–2001), in 1959. It involves a wide range of professional and personal capacities related to an external standard or requirement. For example, the capacity for analysis, critical thinking, and professional judgment in evaluating a situation and making clinical decisions is based on the competence of a counselor. Because the issues that individuals bring to counseling are often complex, it can be difficult for counselors to effectively treat them. Thus, counselors with a high level of competency are more likely to be effective and successful than those with less competency. It is not surprising that both the American Counseling Association and the American Psychological Association expect competency of its members.

"Competencies" refer to specific knowledge, skill, attitudes, and their integration. Competency can be evaluated in terms of specific competencies. The American psychologist David McClelland (1917–1998) is considered to be the father of the competency movement. There has been a shift in professional training from a core curriculum model to a core competency model of learning (Sperry, 2010). Sperry has identified and described six core competencies in counseling and psychotherapy. These competencies include having a conceptual foundation, relationship building and maintenance, intervention planning, intervention implementation, intervention evaluation and termination, and being culturally and ethically sensitive in practice (Sperry, 2010).

The conceptual foundation provides a conceptual map that will help guide a therapist in determining which clinical data to observe and elicit and how to understand the data. Competent therapy also requires a strong therapeutic relationship between the therapist (counselor) and the client. A strong therapeutic relationship is important because it promotes a bond of trust between the therapist and client and encourages an agreement about the goals for the treatment process. There are two competencies in relationship building. They include establishing a therapeutic alliance and the ability to encourage treatment-promoting behaviors. There are three competencies included in maintaining a therapeutic relationship. One involves being aware of and resolving resistance and having mixed feelings (ambivalence) about something. In addition, being aware of and resolving therapeutic tensions and being aware of and fixing transference and countertransference issues are another aspect to maintaining a therapeutic relationship. Implementation of the intervention process is a part of the core competency model of learning. Therapists who use techniques that focus on intended goals are likely to become proficient in this competency. Intervention planning is a part of the core competency model. It includes accomplishing a comprehensive diagnostic assessment, assigning a DSM-V diagnosis, creating a successful case formulation and treatment plan, and combining a clinical case report. Implementation of an intervention is performed by using modalities and techniques that focus on intended goals that will be helpful in becoming proficient in this competency. Competent counseling requires the capacity for assessing treatment and getting ready for terminating a client. Continually observing a client is vital in order to assess the treatment progress. Lastly,

competent therapy insists that the therapist practice in an ethically and culturally sensitive way. Furthermore, cultural competence may help to promote a strong therapeutic alliance.

Len Sperry, MD, PhD, and Elizabeth Smith Kelsey, PhD

See also: American Counseling Association (ACA); American Psychological Association (APA); Counseling and Counseling Psychology; Psychotherapy

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Compliance

Compliance is the extent to which an individual follows a prescribed treatment regimen. A related term is "adherence."

Definitions

- **Adherence** involves taking an active role in collaborating with a health provider and treatment regimen.
- **Noncompliance** is the failure, in whole or part, to follow a prescribed treatment regimen.
- **Treatment regimen** is a specified course of treatment for a medical or psychological condition.

Description

"Compliance" is defined as the extent to which an individual's behavior, such as taking medications, keeping scheduled medical appointments, or making lifestyle changes, coincides with his or her prescribed treatment regimen. Patient treatment noncompliance is one of the most vexing challenges facing health-care providers. Noncompliance with medical treatment is very common, ranging from 50% to 75% (Brown and Bussell, 2011). Estimates are that only one-fourth of individuals with hypertension (high blood pressure) are getting medical treatment. Of those, about one-half of those have normal blood pressure readings because only two-thirds use medication as prescribed. In 2006 it was reported that more than 125,000 patients with treatable ailments die each year in the United States because of failure to take their medication properly (American College of Preventive Medicine, 2011). The reality is that most patients find it difficult to take medications as prescribed or make major lifestyle changes consistently over long periods of time.

Compliance and adherence are often used synonymously, but they are different. Compliance literally means complying with (following) the health-care provider's recommended treatment regimen. Compliance implies a paternalistic role for the provider and a passive role for the patient. In contrast, adherence means that the patient is adhering to the treatment regimen. Adherence implies that the patient is empowered to take a reasonable degree of responsibility for his or her own health. It also implies that the patient and provider collaborate to improve the patient's health by integrating the provider's professional opinion with the patient's lifestyle, values, and preferences for care. More specifically, adherence depends not only on patient's acceptance of information about the health condition itself but also on the provider's ability to persuade the patient that the prescribed treatment is worthwhile. It also depends on the individual's perception of the provider's credibility, empathy, interest, and concern.

Developments and Current Status

A medical dictum is particularly relevant to any discussion of compliance. "Drugs don't work in patients who don't take them." So why don't patients comply or adhere? Early research on compliance emphasized the treatment regimen and health provider instructions, and later focused on client perception of his or her illness and expectations of treatment. In the 1990s the focus of adherence research was on the

patient–provider relationship and how to improve it. Today, efforts have shifted to increasing the family's influence on compliance.

Len Sperry, MD, PhD

See also: Psychotherapy

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Compulsions

Compulsions are habitual behaviors, practices, or rituals that are impulsively engaged in to defend against perceived threats, to reduce fears or otherwise minimize distress.

Definitions

- **Comorbidity** is the existence of one or more mental disorders or physical illnesses that occur with a primary psychiatric illness. It is also referred to as dual diagnosis.
- **Evidence-based practice** is a form of practice that is based on integration of the best research evidence with clinical experience and client values.
- **Obsessions** are persistent, intrusive, inappropriate, and unwanted thoughts, impulses, or images that result in anxiety or distress.
- **Obsessive-compulsive disorder** is a mental disorder that is distressful to the individual and is characterized by unreasonable obsessions or compulsions that are inappropriately time consuming or cause marked distress or impairment.
- **Obsessive-compulsive personality disorder** is a personality disorder that is defined by a pervasive pattern of preoccupation with control, perfectionism, and meticulousness at the expense of flexibility, openness, and efficiency.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Theoretical integration** is the assimilation of two or more theories of psychotherapy.

Description

Compulsions are habitual behaviors, practices, or rituals that are intended to defend against distress. Obtaining pleasure or gratification is not the primary function of compulsions. A client suffering from compulsivity feels compelled to execute the compulsion. The client feels driven to defend themselves against perceived threats, driven to reduce their anxiety, or driven to minimize their distress. Common compulsive behaviors are hand washing, ordering, checking, hoarding, and requesting or demanding reassurance. Common compulsive mental practices or rituals include praying, counting, and the silent repetition of a word or phrase. Individuals suffering from compulsions are constantly doing and undoing. Compulsions are born out of an individual's desire to avoid the "out-of-control" feeling created by anxieties, perceived threats, and other forms of distress. Compulsions are typically related to an individual's reactive

and unwanted emotional response toward an authority that he or she feels forced to be submissive to. The client's reactive emotions are often connected with rebellion, aggression, greed, destructiveness, or disorderliness. Because these emotions are believed by the individual to be unacceptable or dangerous, he or she unwittingly develops compulsions to protect against feeling the reactive emotions. Compulsions are protective psychological defensive mechanisms that prevent unwanted feeling states.

Clients performing defensive compulsions are aware of the fact that their compulsions are excessive or unreasonable. Further, the habitual behavior, practice, or ritual is clearly inappropriate. In fact, compulsions are not at all rationally associated with the perceived threat, anxiety, or distress they are designed to inhibit. Compulsions persist as a result of the tremendous anxiety or distress that is generated through attempts to resist engaging in the compulsion. Clients find relief in yielding to the compulsion and attempt to integrate them into their daily lifestyles. This lifestyle integration may be relatively successful and of little consequence to the individual. In this case compulsions are not pathological. However, it is probable that compulsions will lead to marked distress and require psychotherapy to overcome. Pathological compulsions can be very time consuming and significantly interfere with the client's desired lifestyle. Clients' routines may be interrupted by compulsions. Compulsions may interfere with occupational or academic functioning and impede upon social activities and engagement in meaningful relationships.

Development and Current Status

The *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association has differentiated obsessive-compulsive disorder (OCD) from obsessive-compulsive personality disorder (OCPD) since its third revision (DSM-III). Subsequent editions, including DSM-III-R, DSM-IV, DSM-IV-TR, and DSM-5, maintain the important distinctions between OCD and OCPD. These two distinct mental disorders are rarely comorbid (occurring together). OCD and OCPD are not variations of the same disorder. Compulsions are a feature of OCD but are not of OCPD.

However, the history of term compulsion does not begin with the DSM-III. Medical practitioners in the medieval period utilized the Latin term *compulsio* to talk about compulsions. Many years later, Jean Etienne Dominique Esquirol (1782–1840) opened a clinic for the treatment of involuntary, irresistible, and instinctive activity. In the 1850s French psychiatrists were calling compulsions "insanity with insight" (*folie avec conscience*) and deemed the condition a weakness of willpower. Bénédict Augustin Morel (1809–1873) reclassified OCD from a form of insanity to a disease of the emotions (neurosis). Morel's contribution to OCD laid the groundwork for the modern DSM definition. Freud (1856–1939) also recognized OCD but described it as essentially the same disorder as the OCPD. Needless to say, Freud created unnecessary confusion, which persists even today among some clinicians. Psychological conceptualizations of (ways of thinking about) compulsions evolved from volitional to emotive to intellectual. Until the publication of the DSM-III there was a common belief that pathological personality dynamics caused or triggered compulsions. As noted previously, OCPD was officially distinguished from OCD in 1980.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Evidence-Based Practice; Exposure Therapy; Motivational Interviewing; Self-Efficacy

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Computed Tomography (CT)

Computed tomography (CT) is a medical diagnostic test in which computer-processed X-rays produce tomographs (cross-sectional images) of body areas. It is also referred to as X-ray computed tomography and computed axial tomography (CAT scan).

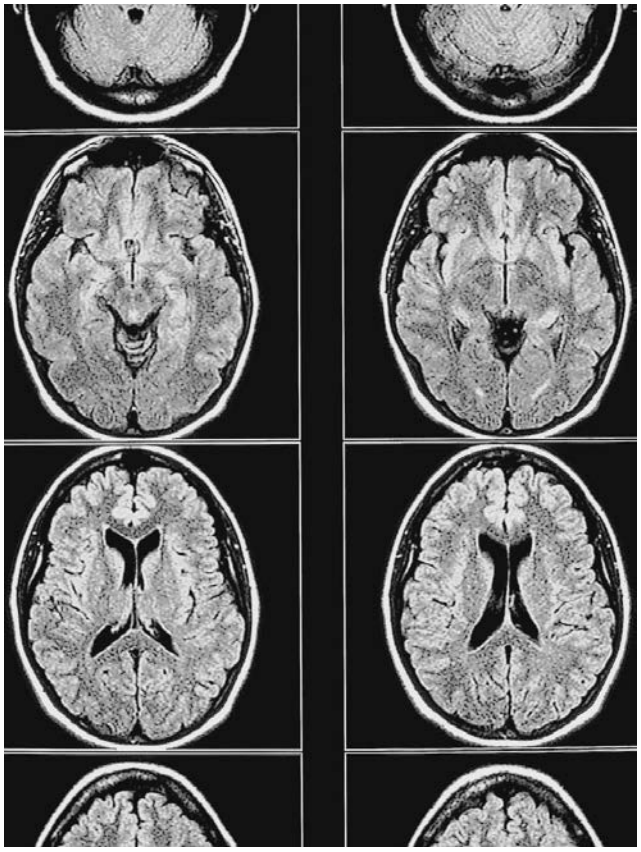
Definitions

- **Magnetic resonance imaging** is a diagnostic imaging device that uses electromagnetic radiation and a strong magnetic field to produce images of soft tissues.
- **Positron emission tomography** is a diagnostic imaging technique that uses radioactive substances to produce three-dimensional colored images within the body.

Description

Computed tomography (CT scan) is a medical imaging procedure that utilizes computer-processed X-rays to produce tomographic images ("slices") of specific areas of the body. These cross-sectional images are used for diagnostic and therapeutic purposes in various medical disciplines. Digital geometry processing (computer software) is used to generate a three-dimensional image of the inside of an object from a large series of two-dimensional X-ray images.

CT scans are relatively inexpensive compared to magnetic resonance imaging scans and positron emission tomography. CT is a commonly used diagnostic tool that supplements some standard X-ray studies, like the chest X-ray, while it has replaced others. For example, the CT is used to identify tumors, cysts, or infections that may be suspected on a chest X-ray. CT scans of the abdomen are useful in defining body organ anatomy, including visualizing the liver, gallbladder, pancreas, spleen, aorta, kidneys, uterus, and ovaries. Such scans can verify the presence or absence of tumors, infection, abnormal anatomy, or changes caused by trauma.



Computed tomography (CT) is a medical diagnostic test in which computer-processed x-rays produce tomographs (cross-sectional images) of body areas, including the brain. (Dave Bredeson/Dreamstime.com)

Developments and Current Status

The CT was invented by Sir Godfrey Hounsfield in England at EMI Central Research Laboratories using X-rays. It was originally known as the "EMI scan" because it was developed at a research branch of EMI. However, EMI is more widely known today for its music and recording business. The first EMI brain scan was done in October, 1971. Soon after, it became known as computed axial tomography and body section röentgenography. Only much later did it become known as the CT scan.

CT produces considerable diagnostic data that can be formatted, through a process known as "windowing," to demonstrate various bodily structures based on their ability to block the X-ray beam. In the past, CT images were represented only in the axial (vertical) or transverse (horizontal) plane. Now, CT

images can be represented in various planes, including a volumetric (three-dimensional) representation of body structures.

CT scans have greatly improved the ability of physicians to diagnose many medical conditions earlier in their course and with much less risk than previous diagnostic methods. Further refinements in CT scan technology promise even better picture quality and patient safety. CT scans known as "spiral" or "helical" CT scans are able to provide more rapid and accurate visualization of internal organs. For instance, many trauma centers are using these scans to more rapidly diagnose internal injuries after serious body trauma. High-resolution CT scans are used to accurately assess the lungs for inflammation and scarring. CT angiography is a newer technique that allows noninvasive imaging of the coronary arteries.

Len Sperry, MD, PhD

See also: Magnetic Resonance Imaging (MRI); Positron Emission Tomography (PET)

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Computer-Based Testing

Computers play such an integral role in society that it should come as no surprise that clinicians and psychologists rely heavily on computer-based testing in their evaluation, analysis, and research. In particular, psychologists and researchers alike use computer-based testing programs to standardize testing for personality and actuarial studies. Such computer-based testing also determines an individual's strengths in terms of academics and provides statistical analysis that may lead to indications of a mental health diagnosis.

Definition

- **Computer-based testing** is a form of automated psychological assessment that uses computer software programs to interpret, analyze, and even administer testing procedures. A broader definition of computer-based testing can also include Internet-based assessments, whereby subjects respond through an online medium.

Description

Computer-based testing is not a new phenomenon. Mental health professionals have been using computers for psychological assessment for more than 50 years. Interestingly, computer-based testing as a whole has not changed significantly since the Mayo Clinic released its first computer-based psychological assessment in 1962.

Today, computer-based testing is used in countless psychological studies. Clinicians use this form of testing in nearly every type of personality test. Popular psychological assessments include the Minnesota Multiphasic Personality Inventory-2 (or "MMPI-2"), the MMPI-2-RF, and Wechsler Adult Intelligence Scale.

This type of computer-based testing provides many advantages, including the fact that it's more cost effective than traditional testing methods of paper and pencil. It's also easier to score when a computer evaluates test results. In addition, computer-based testing allows for broad-based statistical analysis of the results once the test is completed. Perhaps, most important, as society becomes more computer literate, clinicians are finding that test subjects prefer to use computer-based testing than the traditional pencil and paper tests.

Studies indicate that test subjects are more open, honest, and forthcoming when answering personality and other questions through a computer-based test compared to a test with paper and pencil. They have also found that test subjects are more likely to respond candidly to sensitive questions in computer-based testing

as opposed to traditional, clinician-administered testing methods.

Certain computer-based testing has also evolved to adapt to the individual taking the test. This gives a more precise evaluation of a person's abilities when the computer-based test is tailored to his or her level of knowledge and expertise. While there are many benefits to these computer-based tests, psychologists also warn there are potential disadvantages.

Impact (Psychological Influence)

One of the main issues with these automated tests is their validity. Researchers and psychologists are concerned that such tests may exhibit a certain bias—based on the person administering the test and his or her level of expertise. Another potential disadvantage is the collaboration between the clinician and the computer programmer who designs the test. Some clinicians are concerned that a lack of communication can lead to errors in the programming. However, expert clinicians have called for certain guidelines and standards for computer-based testing to help address these issues. As a whole, clinicians and researchers embrace computer-based testing. By all accounts, this type of testing will be even more critical in the years to come.

Mindy Parsons, PhD

See also: Behavioral Assessment

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Conditioned Reflexes: An Investigation of the Physiological Activity of the Cerebral Cortex (Book)

Conditioned Reflexes is a book about how behavior is influenced by the brain. It was written by Ivan Pavlov and discusses his experiments on dogs. It was first published in 1927.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Classical conditioning** is a process in which a previously neutral stimulus comes to evoke a specific response by being repeatedly paired with another stimulus that evokes the response. In Pavlov's experiments, food was the unconditioned stimulus that produced salivation in the dog—called a reflex or unconditioned response. The bell was the conditioned stimulus, which eventually produced salivation in the absence of food. This salivation was the conditioned response.
- **Conditioning** is a process of changing behavior with a reward or punishment each time an action is performed.
- **Reflex** is the name Pavlov gave to the unconditioned response.
- **Stimulus** is something that triggers a physical or psychological response. The plural is stimuli.

Description

Ivan Pavlov (1849–1936) wrote the book *Conditioned Reflexes: An Investigation of the Physiological Activity of the Cerebral Cortex*. He was a Russian physiologist who studied animals. His research focused on the brain and how it influenced behavior. Pavlov initially believed that animals and humans were simply machines who responded to their environment in predicable

ways. His early experiments involved exposing dogs to different stimuli before giving them food and measured the quantity of their saliva. The stimuli ranged from sounds to pictures and touch. When the food was removed, Pavlov found that the dogs still salivated when exposed to the stimulus. They had been conditioned to respond to the stimulus as if it were food. He concluded that the connection between the brain and behavior could be manipulated. This manipulation came to be called classical conditioning. The popular image of Pavlov's dogs drooling to the ringing of a bell comes from ideas introduced in this book.

Pavlov concluded that there are two types of reflexes. *Unconditioned* reflexes happen naturally, such as when a dog sees food and salivates. *Conditioned* reflexes are created through learning, such as when a dog salivates to nonfood stimuli. He discovered that the cerebral cortex (outer part of the brain) was responsible for this. He concluded that nerve pathways within this part of the brain can be changed through learning. It is as if learning "rewires" the brain. Pavlov also found that there were limits to this conditioning. If the brain was given too much to process, it would not change. In addition, new behaviors sometimes wore off over time if they were not reinforced.

Pavlov wrote in this book that all living things respond to their environments through this process of learning in the brain. More advanced organisms like human beings have more complex ways of learning. He viewed humans as different from other animals because they have more conditioned responses than natural ones. Pavlov believed that human civilization was created as a way to manage reflexes. For example, individuals are trained and educated by going to school. They learn about the world around them, how to follow rules, and how to appropriately interact with others. Pavlov also viewed conditioning as changeable. His research had a significant influence on the psychology, in general, and behavior therapy, in particular.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Behavior Therapy

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Conduct Disorder

Dating back centuries, parents and professionals alike have agonized over how to help children who are seemingly out of control, making conduct disorder among the oldest diagnostic categories currently used by modern-day child psychiatry.

In the early 1900s, one of the pioneers who found success in working with conduct disordered children was August Aichhorn, who left his teaching career at the age of 44 and went to study psychoanalysis under Sigmund Freud. Aichhorn felt that children who had stalled in their development were at risk for later antisocial behavior. He also believed that the cause of these challenges could frequently be traced back to difficulties in the parent–child relationship. Studies suggest that many children diagnosed with conduct disorder later go on to develop antisocial personality disorder.

With support and encouragement from Anna Freud, August Aichhorn is considered among the first to have worked successfully with troubled adolescents. His success came from making modifications to Sigmund Freud's psychoanalytic approach with neurotics. Aichhorn used psychoanalysis in combination with his keen understanding of personality to find positive results in working with juvenile delinquents.

Definition

- **Conduct disorder** is a psychological disorder described in the DSM 5 as having pervasive patterns of behavior that infringe on the rights of others or that violate social norms. These include aggressive, rule breaking, rebellion, and other destructive behaviors. The majority of individuals diagnosed with conduct disorder previously were first diagnosed with oppositional defiant disorder. Conduct disorder is believed to be a precursor to antisocial personality disorder. There are also links to ADHD, substance use, and learning disabilities, which commonly are present

in a child or adolescent diagnosed with conduct disorder.

There are two distinct subtypes of conduct disorder, including one with onset in childhood with at least one of the criteria being met before the age of 10 and the second being an onset in adolescence, which requires an absence of any criteria being present before the age of 10. The childhood onset type of conduct disorder includes children who frequently display higher levels of ADHD (attention-deficit hyperactivity disorder) symptoms, family problems, and academic challenges, as well as more aggressive behavior. The adolescent onset type usually has a better long-term prognosis compared to the childhood onset type.

Notably, there seems to be a link between oppositional defiant disorder, conduct disorder, and antisocial personality disorder. Specifically, it has been found that the majority of children who have been diagnosed with conduct disorder were previously diagnosed with oppositional defiant disorder. Moreover, a fair number of individuals who have been diagnosed with conduct disorder later go on to be diagnosed with antisocial personality disorder.

Some of the criteria for conduct disorder include aggression to people and animals (e.g., bullying, fighting, or cruelty to people or animals), destruction of property (e.g., fire setting, damage to property), deceitfulness or theft (e.g., breaking into someone's home or car, or lying), and disregard for rules (staying out late, running away, skipping school). Several risk factors have been identified for conduct disorder, including smoking during pregnancy, low socioeconomic status or poverty, parental misbehavior (drug use, criminal behavior), a poor family environment (unstable, single-parent homes), and exposure to physical or sexual abuse. Treatment of conduct disorder usually requires family therapy, behavior management, and pharmacotherapy.

Mindy Parsons, PhD

See also: American Academy of Child and Adolescent Psychiatry (AACAP); Antisocial Personality Disorder; Attention-Deficit Hyperactivity Disorder; Economic and Financial Stress; Juvenile Offenders; Oppositional Defiant Disorder (ODD); Poverty and Mental Illness

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Conflict Resolution

Conflict resolution, sometimes used interchangeably with "dispute resolution," describes a peaceful process or approach that is used to settle disputes, arguments, or conflicts between two opposing parties.

Definitions

- **Compromise** defines when opposing parties move toward one another, finding common ground in order to come to some resolution, understanding, or agreed-upon solution.
- **Conflict management** describes an ongoing process of mediating disputes between

two parties where a resolution, though sought after, may not be reached.

- **Mediation** is a process in which one objective party facilitates agreement, understanding, or resolution between two opposing parties.
- **Reconciliation,** a term that often has a religious connotation, describes the act of bringing back together two conflicting parties once agreement has been reached and often after some form of retribution has been made.

Description

Conflict resolution is a process used to facilitate peace or understanding between two or more social entities (individuals, groups, organizations, nations). Win–win solutions in which both sides feel that they have been heard and understood, and that their concerns have been addressed, are sought. Conflict resolution utilizes specific communication skills, including active listening, expression of feelings, empathic responding, open-ended questioning, and problem-solving techniques.

Conflict is an inevitable part of everyday human interaction that can arise from differences in perceptions, feelings, perspectives, interests, or approaches. It is centered in the belief that if one party gets what it wants, then the other party will not be able to do so. When conflict is not dealt with effectively, it can result in feelings of resentment and hurt or damage to relationships. However, when conflict is dealt with in a positive, respectful way, it can alleviate stress, foster acceptance, and even strengthen a relationship. Ownership for resolving conflict is the responsibility of both parties equally. Both need to find common ground, come together, hear one another out, increase understanding, and agree to concede on certain points.

Conflict resolution as a method, though it may vary in language and sequence, has some basic essential components. An initial component required, which can help alleviate tension for those involved, is for each person to recognize, acknowledge, and be able to regulate their emotions. In addition, both parties should have a clear understanding of their own needs. Further progress can be made if the parties are able to effectively communicate their needs to the one another. One must pay attention to what is communicated both verbally and nonverbally. Those involved should remain calm and refrain from attacking one another with either words or actions. Respecting differing backgrounds, perspectives, and views is key. If these components are incorporated, then each person is more likely to be willing to compromise, with the ultimate goal being to find some common ground.

Development

Conflict resolution arose as a defined field of study in the 1950s and 1960s during the Cold War era when fear of nuclear threat was a dominant theme. Scientists began to study conflict and apply similar principles to global problems and national relations, as well as to specific tensions between communities, groups, and individuals. Relations between national superpowers improved during the 1980s and 1990s with the downfall of the Soviet Union. However, tensions between the United States and Middle East have been ongoing since the turn of the century and continue to be of concern. Wars, movements, and threats have all resulted from conflict with varying outcomes. Often conflict between nations, organizations, and groups can result in an increased sense of unity among members of each particular groups. Foundational theorist in the field, Morton Deustch, was the first to define between what he termed "constructive" and "destructive" types of conflict. Other influential writers on the topic, Kenneth Thomas and Ralph Kilman, identified five styles of dealing with conflict during the 1970s: competitive, collaborative, compromising, accommodating, and avoiding. They argued that most people have a preferred conflict resolution style but can learn to respond with differing styles depending on varying situations. Several other models, theories, and approaches have followed with similar terminology, sequences, and themes.

Current Status

The study of conflict resolution is an expanding field both from a scientific perspective and in terms of professional practice. This topic has been studied among

countries, government agencies, educational institutions, communities, families, and between individual people. A new area of focus has been on understanding the particular worldviews of each party, remaining multiculturally sensitive and respectful to both. This approach can resolve conflicts more efficiently and effectively.

Melissa A. Mariani, PhD

See also: Coaching

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Conjoint Family Therapy

Conjoint family therapy is a form of psychotherapy developed by Virginia Satir (1916–1988), who is affectionately referred to as the mother of family therapy. Conjoint family therapy uses a comprehensive approach to working with families as a whole system as opposed to working with individuals within the family.

In conjoint family therapy, all family members are seen simultaneously. There must be an alliance between not only the therapist but also within the family unit as well to have a successful outcome. Family members must agree on treatment goals and be willing to work together and confront each other when necessary. Satir believed that oftentimes the presenting issue was not the core problem within a family system but rather the family's way of coping with the underlying problem.

Definition

- **Conjoint family therapy** is a family counseling theory in which a therapist sees a family and addresses the issues and problems raised by the family members as a system rather than addressing the problems being experienced by individual members of the family.

Description

Satir believed that maintaining self-esteem is a primary motivation of individuals and she believed that low self-esteem could lead to significant challenges in interpersonal relationships. Therefore, a family can achieve homeostasis of roles from efforts from each individual to maintain self-esteem. A change in an individual must also incorporate changes from each family member. This is accomplished through conjoint interviews.

In conjoint family therapy, the therapist examines the family rules, roles, and communication. The therapist focuses on group or subgroup actions within the family as opposed to just one individual in the family. Focus on an individual within the family could occur as part of this approach, but it had to be tied back into the context of the family.

Family therapy can be difficult if each member disagrees about what the problem is, what the treatment goals are, or the purpose of therapy. For there to be a successful outcome, each member must be an active participant and invest in the process and each other. The conjoint family therapy model also requires family members to be willing to take risks with each other. To achieve this, therapists must not only be building the therapeutic alliance but also the working alliance between the family members.

It is important that the therapist be in tune with potential ruptures within the family unit and the working alliance as a whole. Ruptures within conjoint family therapy are more complex. They can occur if one family member attempts to force another to participate making that person more likely to resent treatment as a whole. The therapist has to be sure he or she does not show any preferential treatment toward one family

member over another. There must be a balance of alliances to work toward successful outcomes.

Development and Current Status

Clinical observation and treatment of the whole family emerged in the 20th century. Interest in the family unit developed from working with individuals and seeing potential connections and impacts. The person who initially sought treatment, or rather the identified patient, was not necessarily the only one affected by problems within the family.

In the mid-1900s there was an emergence of three major forms of family therapy. Conjoint family therapy was the third one, which at the time was growing in popularity. One of the most important contributions of conjoint family therapy was that it led to looking at the family group as a system rather than just a single member of the family who was singled out as the identified patient.

As with any form of therapy, the working alliance is a key component. Virginia Satir played a key role in the development of family therapy and in working within family systems. One of her most well-known books is *Conjoint Family Therapy: A Guide to Theory and Technique*, as well as *Peoplemaking*.

Mindy Parsons, PhD

See also: Family Therapy; Satir, Virginia (1916–1988)

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Conjoint Sexual Therapy

Conjoint sexual therapy is a treatment conducted together for relationship partners, which focuses on aspects of their sexual issues and problems.

Definition

- **Sexual dysfunctions disorders** are a group of mental disorders characterized by significant difficulty in the ability to respond sexually or to experience sexual pleasure. Disorders include delayed ejaculation, female orgasmic disorder, and genito-pelvic pain/penetration disorder.

Description

The term and practice of conjoint sexual therapy came out of the research conducted by Masters and Johnson and published in their 1970 book *Human Sexual Inadequacy*. Conjoint therapy, in general, is behavior-based psychological treatment conducted with individuals together and in the same session. The goal is to help them deal with issues that negatively impact them. Behavior based in this context means that the therapy is not aimed at discovering why the problem exists but rather at dealing with its effects and consequences. For conjoint sexual therapy, sexual exercises and behaviors are often recommended as part of treatment.

In conjoint sexual therapy for sexual partners, the sexual issues or dysfunctions are treated as a separate entity. These include sexual dysfunction disorders such as arousal and orgasmic conditions. The belief is that the sexual problems themselves are the client. This means that issues are seen not as separate problems or individual, his or her, problems. Instead, they are viewed as part of the dynamic of the relationship that both partners share. This is true when the issues may have been problems like erectile dysfunction for the man or painful vaginal experience during intercourse for the woman. In this view, all sexual experiences are shared between partners and they must be worked on in that context for the treatment to be successful.

Development

While there is no question that Masters and Johnson were pioneers in conjoint sexual therapy, the treatment methods and approaches they used were ones that had been available for many years. Techniques described as sensate focus exercises were the basis of their treatment approach. Their aim was to broaden the sexual experience, to reduce anxiety around sexual performance, and to enable couples to enjoy the sexual experience. In all of this they were groundbreaking because they treated men and women as equal in their ability to enter into and enjoy the sexual experience.

Another important researcher in conjoint sexual therapy was Dr. Helen Singer Kaplan. She found that success in an outpatient setting required a slightly different approach. She added psychodynamic therapy and other approaches to increase the likelihood of success for her clients. Both Masters and Johnson and Kaplan were controversial in aspects of their suggestions, which included interventions such as sexual desensitization, masturbation, and sexual surrogates.

Current Status

Although there are many individual success stories from conjoint sexual therapy, it has remained difficult to show consistent experimental results. This makes sense because similar sexual problems may have a variety of physical and psychological causes. It is still a challenge to decide which approach is best for which clients and under what circumstances.

Nevertheless, conjoint sexual therapy remains a treatment of choice for couples who struggle with sexual relationship problems. Most therapists employ a variety of interventions to reduce fear around sexuality, enhance communication and enjoyment, and help people in general to have improved relationships. The aim in current therapeutic approaches is not just to improve sexual functioning but to enhance the partners in their relationship with one another.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Everything You Always Wanted to Know about Sex (*but Were Afraid to Ask*) (Book and Movie); Female Sexual Interest/Arousal Disorder; Male Hypoactive Sexual Desire Disorder; Sexual Dysfunctions

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Conners Rating Scales

Conners Rating Scales (CRS) are normed behavior rating scales used by mental health professionals to screen and assist in diagnosing attention-deficit hyperactivity disorder (ADHD) in children.

Definitions

- **Attention-deficit hyperactivity disorder (ADHD)**, according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), is a behavioral diagnosis used to describe a combination of problems, including difficulty sustaining attention, hyperactivity, and impulsivity.
- **Rating scales** are semi-objective assessment tools that require individuals completing them to assign a quantitative judgment to their observations of certain behaviors.

Description

Conners Rating Scales are rating forms, completed by parents, teachers, and sometimes self, to determine the presence of behavior issues specifically related to inattention, hyperactivity, and impulsivity. These general screening tools were initially developed to assist in the identification of these types of problems in children; however, they have recently been expanded to use with adults. The most recent version advertises use with ages 6 to 18 (parent and teacher). Psychologist C. Keith Conners published

the first of these rating scales in 1964, with follow-up editions in 1989 (Conners Rating Scales-CSR), 1997 (Conners Rating Scales-Revised—CSR-R), and 2008 (Conners 3—C3).

Both long and short versions of the CRS are easy to administer and score. They can be scored by hand or with the accompanying computer software. Number of items vary from version to version, with the most recent, the Conners 3, containing the following: Teacher (long-115; short-39), Parent (long-110; short-43), Self (long-59; short-39). Short version use is recommended for progress monitoring purposes, when one is planning multiple administrations over a period of time. Administration takes approximately 20 minutes for the long version and 10 minutes for the short, but there is no time limit. The Parent and Teacher surveys are written on a fifth-grade reading level and the Self-Report on a third-grade reading level. Both English and Spanish translations are available. The Conners 3 is comprised of six scales: Hyperactivity/Impulsivity, Executive Functioning, Learning Problems, Aggression, Peer Relations, and Family Relations.

The forms are multipaged, carbon copies. Responses circled on the front or back are automatically transferred to a middle section for use by the scorer. The scorer transfers the circled scores into appropriate scales on the middle form and totals each scale at the bottom of the page. After transferring the raw scores to the various scales and totaling them, the total of each scale (A–N) is transferred to another form which represents the findings graphically. The scorer must be careful to transpose the raw scores to the correct age group column within each major scale. Each of these column scores can then be converted to a T-score and then to percentile scores as needed. T-scores above 60 are cause for concern and have interpretive value. Interpretable scores range from a low T-score of 61 (mildly atypical) to above 70 (markedly atypical).

Development

The Conners Rating Scales were initially designed as a comprehensive checklist to identify common behavior problems in children. In the late 1990s, a restandardization of the scales took place, attempting to focus more narrowly on behaviors associated with ADHD. This revision, the CRS-R, was also empirically based and normed on a large, representative sample of North American children. The most recently published version, the Conners 3, includes normative data for 1,200 parents, 1,200 teachers, and 1,000 self-report raters and is matched to the 2000 U.S. Census information on ethnicity/race, gender, and parent education level. Separate norms are provided for males and females in one-year intervals.

Current Status and Results

Debate over the reliability and validity of these assessment tools has been an issue. Therefore, CRS should be used only as part of comprehensive psychoeducational evaluation. They should not be used in isolation to diagnose ADHD symptomatology as there is risk of obtaining false positives (diagnosing when criteria are not present) or false negatives (not diagnosing when the criteria are present). Though theses scales are easy to administer and score, they should be interpreted only by a trained professional. Early versions on the CRS were also criticized for the disparity between results obtained by different ethnic groups, but this has been addressed in the latest revisions.

Melissa A. Mariani, PhD

See also: Attention-Deficit Hyperactivity Disorder

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Contemplative Neuroscience

Contemplative neuroscience is the study of how contemplative practices such as meditation affect the brain and the nervous system.

Definitions

- **Contemplation** is studying or observing something carefully or thinking deeply about it.
- **Contemplative practices** are activities that foster contemplation, such as meditation, reflection, prayer, journaling, and worship.
- M**editation** is the concentrated focus on a sound, the breath, object, or attention itself to increase awareness of the present moment. Its purpose is to reduce stress, promote relaxation, or increase spiritual growth.
- **Mind–brain relationship** is the interaction of the mind (consciousness) and brain (nerve cells) summed up in the saying "minds are what brains do."
- **Mindfulness** is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.
- **Neuroplasticity** is the brain's capacity to restructure itself after training or practice allowing personal growth and development to occur.
- **Neuroscience** is the scientific study of the nervous system, particularly the functioning of the brain.

Description

Contemplative neuroscience is the scientific study of how the brain and nervous system are affected by contemplative practices. Over the past three decades, researchers have discovered how deeply the human brain is influenced by both human experience and the environment. This influence begins early in life and extends throughout the lifespan. This new understanding of the brain's capacity to change and develop, called *neuroplasticity*, provides insight into personal growth transformation (development) that once seemed impossible. This increasing awareness of the brain's plasticity means that the goal of decreasing or eliminating mental and nervous illness may be possible. It also means that mental and emotional health can be greatly increased. Contemplative neuroscience is one method for accomplishing these goals.

Developments and Current Status

Thich Nhat Hanh (1926–), a Zen Buddhist monk and teacher, conducted a retreat on mindfulness in the United States. One of the attendees was the American psychologist Jon Kabat-Zinn (1944–). In 1979, Kabat-Zinn adapted Hanh's teachings on mindfulness into his eight-week Mindfulness-Based Stress Reduction course. This course and its emphasis on mindfulness has since spread throughout North America and to other western countries. At about the same time, the American psychologists Daniel Goleman and Richard Davidson were researching and writing about neuroscience and emotions. In the 1980s, Davidson began a collaboration with the Dalai Lama, Buddhist monk and spiritual leader. As a result, Davidson became increasing involved in practicing and researching meditation. Throughout the next decade of research, he, and several other researchers, extensively studied mindfulness and meditation. Since the early 2000s the terms "contemplative science" and "contemplative neuroscience" emerged, reflecting basic research and applications in clinical and educational settings.

The research on neuroplasticity shows that specific kinds of mental training can influence how the brain functions. More specifically, it shows how emotional and mental well-being can be cultivated through various disciplines, including contemplative practices such as meditation and mindfulness. An individual's emotional set-points can be shifted toward higher levels of well-being. In contrast, conventional psychiatry focuses treatment on reducing symptoms

and discomfort with medications, without necessarily addressing the deeper causal issues behind the symptoms and distress. While medication may have a role in treatment of symptoms, it is incapable of teaching the brain new and healthy neurological habits. Contemplative training and meditation, however, can change such habits. Unlike conventional psychiatry, contemplative neuroscience assumes that brain and mind interactions are bidirectional. That means that mind can influence and change the brain, just as the brain can influence and change the mind.

A general goal of contemplative neuroscience is to empower individuals to become the masters of their own minds so they can experience more wholeness, more joy, and more peace. More specifically, loving kindness and compassion can be cultivated and hard-wired (made permanent) in the brain. In short, contemplative neuroscience offers a scientific worldview capable of radically changing what individuals believe is possible for their lives and the lives of future generations.

Len Sperry, MD, PhD

See also: Mindfulness; Mindfulness-Based Psychotherapies

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Conversion Disorder

Conversion disorder is a mental health condition characterized by paralysis, seizures, or other neurologic symptoms that cannot be explained by medical evaluation. It is also known as functional neurological symptom disorder and hysteria.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Dissociation** is a detachment from reality. Daydreaming is a non-pathological form of dissociation, while depersonalization (a sense that the self is unreal) is a pathological form of dissociation.
- **Dissociative disorders** are a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness which cause disrupted life functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Malingering** is the practice of intentionally exaggerating or faking physical or psychological symptoms for personal gain. It is also referred to as fictitious illness.
- **Mindfulness practices** are intentional activities that foster living in the present moment and an awareness that is nonjudgmental and accepting.
- **Somatic symptom and related disorders** are a group of DSM-5 mental disorders characterized by prominent somatic symptoms and significant distress and impairment. They include somatic symptom disorder, factitious disorder, and conversion disorder. Previously they were known as somatoform disorders.
- **Somatoform disorders** are a group of mental disorders characterized by physical symptoms that cannot be explained by a medical condition. DSM-5 calls them somatic symptom and related disorders.

- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description and Diagnosis

Conversion disorder is a dissociative disorder that was named to describe a health concern that begins as a psychological stressor or trauma but then "converts" to physical symptoms. Such symptoms appear suddenly and affect individuals' basic senses and movement such as their ability to see, hear, swallow, or walk. While individuals may describe their symptoms in detail, they often show little concern or indifference about symptoms. Historically, this disorder has been referred to as *La Belle Indifference* (American Psychiatric Association, 2013). This indifference can be a useful clue in distinguishing conversion disorder from the medical condition it may mimic. Symptoms can be severe at first. Fortunately for many individuals with this disorder, symptoms tend to improve within a short time.

Conversion disorder is more often diagnosed in women than men. Often these individuals are not psychologically minded (insightful) and they are likely to have an early history of abuse, particularly sexual abuse. The tendency toward dissociation is commonly seen with these individuals. This means they deal with stressors by removing themselves psychologically from these situations as a way of safeguarding themselves. In this way, they pay little or no attention to certain events and so they are less likely to remember or be concerned about them.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience symptoms of voluntary motor function or of sensory function such as weakness or paralysis of a limb or reduced ability to see or hear. What makes these symptoms problematic is that clinical findings cannot explain why these symptoms are occurring, or if there is a neurological disorder present, the symptoms cannot be accounted for by such illness. However, these symptoms contribute to significant disruption in work, relationships, or family life. The symptoms cannot be explained by another medical or mental condition (American Psychiatric Association, 2013).

The cause of this disorder is not well understood, but it appears that it is triggered by a stressful event, a relational conflict, or another mental disorder, such as depression. Individual personality dynamics appear to be involved, particularly feeling avoidance. A careful development history often reveals a pattern of feeling avoidance and confusion of physical sensations with feelings. As children, these individuals seldom experienced empathy or validation of their wishes, thoughts, and feelings. Instead they learned to value logic over feelings. They learned to discount not only their feelings but their bodily sensations as well. As they got older, they may have appeared to others to be healthy on the outside when in fact they were not. For instance, measures of heart rhythms or blood pressure could be clearly abnormal while they appear calm on the outside. In short, because their wishes, thoughts, and feelings were often discouraged or punished, they stopped paying attention to them. These experiences also contribute to a lack of psychological mindedness (insight), which is commonly seen in conversion disorders.

Treatment

For most individuals, symptoms of this disorder resolve (get better) without treatment, often,the reassurance of a health professional that there is no serious medical condition underlying the conversion symptoms. For others, counseling or psychotherapy can be helpful in treating symptoms and preventing their reoccurrence. However, psychotherapy may be necessary if anxiety, depression, or other mental health issues are present. Allowing such individuals to talk about the stressor that triggers their symptoms in a safe environment can be very therapeutic. Cognitive behavior therapy can be particularly helpful in recognizing and distinguishing feelings from somatic (bodily) sensations. Teaching stress management techniques and mindfulness practices can further increase awareness and reduce stress and anxiety.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Mindfulness; Somatic Symptom Disorder; Stress Management

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Coping

Coping is a psychological concept and is defined as the internal mental efforts and the external behavioral efforts a person makes in order to manage and respond to difficult, demanding, and stressful events.

Description

Stress is a part of the human experience and how people cope with stress can influence their lives in significant ways. Stress is defined as the relationship between a person and the environment that is judged by the person as difficult or exceeding his or her ability to experience physical, social, emotional, or psychological well-being.

Richard Lazarus, one of the top 100 most eminent psychologists of the 20th century, was instrumental in developing a theory of stress and coping. Lazarus found that when coping was effective, stress is controlled. When coping is ineffective, stress increases leading to physical and/or emotional difficulties and impaired social functioning. Lazarus used the phrase "cognitive appraisal" to refer to how a person thinks about and evaluates stressful events. There are two cognitive appraisals that take place in a person's mind when faced with stressful events: primary and secondary. Primary appraisals evaluate the impact of an event. Secondary appraisals evaluate what can be done to manage and cope with, or respond to, the event. Each of these appraisals interacts with each other to determine how much stress is experienced. For instance, imagine that there is a major paper due in class on Monday. This paper will have a significant impact on the grade for the course. Also imagine that there is an all-day music festival on Saturday and everyone will be there. How a student spends Saturday, that is his or her behavior, will be determined by his or her primary cognitive appraisal of the importance of the grade (what is at stake) and his or her secondary cognitive appraisal of what he or she needs to do to receive a good grade. One student has already written a complete and thorough draft and only needs to proofread the paper before turning it in. This student attends the festival with little or no stress about the assignment. The student's primary appraisal is that attending the music festival will have no impact on his or her grade. The student's secondary appraisal of what he or she needs to do to receive a good grade (a final proofread that is easily accomplished on Sunday) allows him or her to attend the festival. Another student, however, has put off the assignment and has written very little. The student's primary appraisal is that he or she will fail the class if he or she does not receive a good grade on the assignment. The student is very stressed, that is, the student is anxious and worried about the final grade. The student's secondary appraisal is that if he or she attends the festival, he or she will not have the time to produce a good paper. Another secondary cognitive appraisal is that there will be other music festivals to attend but only one chance to do well on the paper. The student copes with the stress of the assignment by choosing to stay home and work hard on the paper (his or her behavior), which decreases stress (anxiety).

Current Status

Lazarus's theory of stress, appraisal, and coping provided a gold standard model that is widely utilized in many helping techniques, methods, and theories of counseling.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy; Cognitive Therapies; Motivation

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Corrective Emotional Experience

A corrective emotional experience is a novel, positive reexperiencing of a past negative emotional event or pattern.

Definitions

- **Psychodynamic theory** is a broad category of psychological theories that view thoughts, feelings, and behaviors as the result of unconscious process.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Therapeutic alliance** is the moment-to-moment, interactive relationship between an individual and a therapist that should include mutual trust, respect, and collaboration. It is also called a therapeutic relationship.

Description

Corrective emotional experience is a treatment strategy by which an individual experiences a previously negative pattern of thinking, acting, or relating in an unexpected new and healthier way. This change occurs because the individual is better able to tolerate the past negative experience under more favorable circumstances. Such a positive reexperience can contribute significantly to positive outcomes in psychotherapy. Typically, the event or pattern that is reexperienced is related to the presenting issue or focus of psychotherapy and is facilitated by the therapist. The corrective experience helps the individual to reshape his or her understanding of the "self" (who the individual thinks he or she is) in relationship to others. That is to say that the individual is able to redefine who he or she is by experiencing an interaction with another, in this case a therapist, differently than ever before. It is different from insight, whereby an individual gains a purely intellectual understanding of an issue. Insight alone is not necessarily sufficient for significant growth and healing. This experience may occur during a therapy session, or it can occur outside of therapy as a result of the interactions that took place within the session.

There are two different interpretations of this general term. In the past, this term was most closely associated with psychodynamic theories. Consequently, the original interpretation refers to positive consequences that result from the difference between how a therapist reacts to the individual and how the individual expected the therapist to react. This discrepancy causes the individual to have a new and different interpretation of a relationship with another, thereby causing a corrective emotional experience. Today, the broader term "corrective experience" is used to reflect other perspectives besides psychodynamic theory. This more contemporary interpretation refers to any aspect of the interaction between the individual and therapist that results in the individual having a new and unexpected corrective experience.

There are four types of corrective experiences: emotional, relational, cognitive, and behavioral. Each type represents a differing mechanism of initiating the corrective experience. But all involve an emotional response as the individual learns new ways of responding or experiencing as compared to their previous patterns. An emotional type represents the original understanding of corrective emotional experience whereby the individual experiences a new and different emotional reaction to an unsettled past event. A more specific type is the relational, whereby the individual has a transformational experience as consequence of a new way of interacting with a therapist or another. The cognitive type represents an experience of a new mental process (way of thinking) about a past event. Lastly,

the behavioral type represents a new way of acting in response to something or someone.

For a corrective experience to occur, the individual must be engaged in the interaction and must be willing to take risks. It follows that the individual must feel as if the therapeutic environment is safe enough to be sufficiently vulnerable. It is therefore unlikely, if not impossible, that an individual will be able to feel and act in such a way if there is not sufficient trust, respect, and collaboration between the therapist and the individual; this is referred to as the therapeutic alliance or relationship. It is the relationship, not a specific intervention (therapeutic technique), which is of primary importance in creating the opportunity for the corrective experience.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Psychodynamic Theory; Psychotherapy; Therapeutic Alliance

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Council for Accreditation of Counseling and Related Educational Programs (CACREP)

Council for Accreditation of Counseling and Related Educational Programs is the accrediting agency for counseling profession. It is also known as CACREP.

Description

CACREP is a counseling-specific accrediting organization that is recognized by the Council for Higher Education Accreditation. CACREP was created in 1981 by the American Personnel and Guidance Association, which was the predecessor of the American Counseling Association. CACREP was created for the purpose of being the accrediting body for the counseling profession.

More than 30 years ago, leaders in the field of counseling donated their time, expertise, and vision to create an accrediting body that would hold the profession to a higher standard of training and education of graduate students. This includes students at both master's and doctoral levels, although doctoral accreditation came a few years later, but still dates back more than 25 years. It was hoped that by creating these standards of education and training it would, in turn, increase the level of competency of graduating professional counselors entering the field.

Within the U.S. higher education system, accreditation can be achieved in two distinct ways. One is through the university or college and the other is through a specific education program within the university or college. CACREP offers the latter, a specialized accreditation that looks solely at the preparation of graduate students within the counseling profession. However, CACREP has a fairly wide scope of accreditation, including program areas of addiction counseling; career counseling; clinical mental health counseling; marriage, couple, and family counseling; school counseling; student affairs and college counseling; and counselor education and supervision.

The accreditation process can take several years to apply (or reapply) and involves a team of CACREP counselor educators visiting the university to review its programs and ensure that it meets eight core areas of national standards in counseling, including the helping relationship, human growth and development, appraisal, research, professional orientation, social and cultural foundations, and group counseling.

Impact (Psychological Influence)

The most important factor in a counseling program is the proper preparation of students to enter the field as competent professionals who can practice independently. To achieve this, proper gatekeeping policies and procedures must be in place, as well as standards of education and training, since inadequate training can lead to psychological harm to clients, mistrust of the profession, or even ethical misconduct on behalf of the counselor. This is where CACREP standards come in. The current standards being used were updated in

2009. New revisions are being made to these standards, with an update expected in 2016.

According to several studies, the impact of accreditation can be seen in the fact that counselors who receive their training at CACREP-accredited institutions have significantly fewer ethics violations compared to non-CACREP-accredited program graduates. In addition, CACREP program graduates have been found to score higher on their licensure exams, suggesting that they are more knowledgeable in ethics and professional conduct than their non-CACREP-accredited counterparts. Notably, it has also been suggested that CACREP-accredited programs attract and retain higher-caliber students, which could also explain their compliance with ethical codes, higher scores on licensure exams, and holding to higher professional standards. This, in turn, leads to an overall higher level of competency for graduates of CACREP-accredited programs.

Mindy Parsons, PhD

See also: American Counseling Association (ACA)

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Organizations

Council for Accreditation of Counseling and Related Educational Programs (CACREP)
1001 North Fairfax Street, Suite 510
Alexandria, VA 22314
Telephone: (703) 535-5990
Fax: (703) 739-6209
Website: www.cacrep.org

The Council for Rehabilitation Education (CORE), which accredits graduate programs that provide academic preparation for a variety of professional rehabilitation counseling positions.
Council on Rehabilitation Education
1699 E. Woodfield Road, Suite 300
Schaumburg, IL 60173
Website: http://www.core-rehab.org/

Counseling and Counseling Psychology

Counseling and counseling psychology are mental health professions that prevent and treat mental conditions, as well as advocate for optimal human development.

Definitions

- **Behavioral psychology** is a form of psychology whose aim is to study behavioral adaptation to an environment and its stimuli.
- **Biopsychosocial model** is a way of conceptualizing (thinking about) health and illness in terms of biological, psychological, and social factors rather than purely in biological terms. It is also referred to as the biopsychosocial perspective.
- **Clinical health psychology** is the branch of psychology informed by the biopsychosocial model of health and emphasizes behavioral medicine interventions in working with psychological problems and related disability.
- **Clinical psychology** is the branch of psychology that emphasizes the diagnosis and treatment of mental disorders.
- **Cognitive behavior therapy** is a form of psychotherapy that addresses maladaptive thought distortions that lead to unwanted emotional and behavioral symptoms.

- **Cognitive psychology** is a form of psychology whose aim is to study thought and distorted patterns of thinking.
- **Evidence-based treatments** are therapeutic interventions (techniques) that scientific research demonstrates to be effective in facilitating therapeutic change. It is also known as empirically supported treatments.
- **Humanistic psychology** is an experiential form of psychology developed out of the work of Abraham Maslow and Carl Rogers, which emphasizes a client's capacity for self-actualization and unique positive personal growth.
- **Psychiatry** is the branch of medicine and form of psychology that emphasizes the medical management of psychological problems and related disability.
- **Psychoanalytic psychology** is the form of psychology largely developed by the work of Sigmund Freud, which emphasizes the conflicts and compromises between the unconscious and conscious mind.
- **Psychopathology** is a maladaptive experience of suffering or aspect of a psychological condition incorporating cause, development, structure, and consequences.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Counseling and counseling psychology are two closely related fields within the mental health profession. There are significant similarities and differences between counseling and counseling psychology. The major similarity between counselors and counseling psychologists is that they both primarily practice psychotherapy. The focus of their practice is to treat as well as to prevent psychopathology and related disability. They also help clients resolve hindrances to optimal growth and development. Counselors and counseling psychologists utilize evidence-based psychotherapeutic interventions to reduce the suffering or consequences associated with psychopathology and related disability. Highly effective counselors and counseling psychologists, however, do more than reduce symptoms. For example, they are more likely to focus on solutions rather than on symptom and psychopathology. They may also assist clients in increasing their level of functioning and psychological well-being. In counseling and counseling psychology therapy sessions, the present moment almost always includes an interpersonal interaction between a trained therapist and client(s). The therapeutic relationship is the primary method for remediating the consequences of a client's mental disorder, problem, or complaint.

Counseling and counseling psychology, like clinical psychology and clinical health psychology, are informed by the biopsychosocial perspective of health and illness. Clinical health psychology emphasizes behavioral medicine in working with psychological problems and related disability. Counseling and counseling psychology, in contrast, emphasize psychotherapy or therapeutic counseling. Most counselors and counseling psychologists are integrative and value a team-based approach to mental health. They will refer clients to other mental health specialists, such as psychiatrists, for adjunctive (supportive/secondary) treatment. This holistic approach to mental health enhances the ability to predict, assess, diagnose, and alleviate psychological problems and related dysfunction.

Counseling and counseling psychology share three major traditional theoretical perspectives. These are the psychoanalytic, cognitive behavioral, and humanistic traditions. More recently, systems theory has been incorporated into many aspects of counseling. Theoretical orientations such as these, in addition to client preference, guide psychotherapeutic intervention. Counseling and counseling psychology is a system of subspecialties more than it is a single specialty within the mental health profession. The system of subspecialties continues to be developed and refined as new information is acquired via science and practice. This leads to increasing diversity in ways of conceptualizing

(thinking about) client presentations and related psychotherapeutic interventions.

Development and Current Status

The terms "counselor," "psychotherapist," and "therapist" are still used interchangeably. One of the major distinctions between counseling and counseling psychology is the educational requirements necessary to become a counselor versus a counseling psychologist. The term "psychologist" in counseling psychologist has been regulated by law and is limited to use by those who have undergone specialized training. Counseling psychologists have earned a doctor of philosophy (PhD) degree or doctor of psychology (PsyD) degree in psychology and have been licensed in the state(s) in which they intend on practicing. On the other hand, counselors at least earn a master's degree in counseling and have been certified nationally or licensed by the state(s) in which they intend on practicing. These educational requirements are governed by two major professional affiliations. While highly favorable, a degree from an accredited educational program is not required for certification or licensure. The most highly acclaimed educational programs in counseling psychology are accredited by the American Psychological Association (APA). The APA was established in 1892. In 1945, APA established Division 17, the Division of Personnel and Guidance Psychologists. It was renamed the Division of Counseling Psychology in 1951. Division 17 of the APA is not as influential as it once was. For example, counseling psychologists were first utilized to give vocational guidance and advice. Today, vocational guidance is often given by non-licensed career advisors and career coaches, although some counselors and counseling psychologists still practice career counseling. When developing a career in counseling, the most prestigious counseling degrees are governed by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). CACREP was established in 1981. The creation of CACREP occurred only eight years after the PsyD degree was accepted by the APA. The PsyD practitioner-scholar model, otherwise known as the Vail Model, was a departure from the PhD scientist-practitioner model, otherwise known as the Boulder Model. As counseling training programs increasingly deviated from an emphasis on research, a new field of Counselor Education was born. CACREP is gaining much legislative influence and significantly contributing to the development of the counseling profession. This trend may continue because counselors are more cost effective than counseling psychologists. Historically, however, counseling and counseling psychology have shared many similarities. The word "counselor" comes from the Latin word *consulere*, which means to consult, advise, or deliberate. Counselors and counseling psychologists tend to focus on treating clients who are from a "normal" population. In other words, counselors and counseling psychologists make themselves available to work with clients who are without serious or chronic mental illnesses. Counselors and counseling psychologists tend to treat problems of living and concerns related to individual development across the lifespan, including most mental disorders. Chronic and debilitating mental disorders and related disabilities are better treated by clinical psychologists, neuropsychologists, and the medical community.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Clinical Psychology; Mental Health Counselor; Psychiatrist; Psychotherapy

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Counterdependent Personality Disorder

Counterdependent personality disorder is a mental disorder characterized by denial of dependency on others and an unwillingness to ask for help when in need.

Definitions

- **Avoidant personality disorder** is a mental disorder characterized by a pattern of social withdrawal, feelings of inadequacy, and oversensitivity to negative evaluation.
- **Codependent** is an emotional and behavioral condition that affects an individual's ability to have a healthy relationship because he or she often forms or maintains relationships that are one-sided, emotionally destructive, and often abusive.
- **Depression** is an emotional state characterized by feelings of sadness, guilt, or reduced ability to enjoy life. It is recognized as a mental disorder when it becomes significantly distressing and disrupts daily life.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Narcissistic personality disorder** is a mental disorder characterized by a pattern of grandiosity, lack of empathy, and need to be admired by others.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behaviors, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **PDM** stands for the *Psychodynamic Diagnostic Manual* and is a diagnostic framework that characterizes individuals in terms of their psychodynamics (forces that determine personality).
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also referred to as therapeutic counseling.

Description and Diagnosis

Counterdependent personality disorder is a personality disorder characterized by difficulty being close to others, a strong need to be right all of the time, self-centeredness, resistance in asking for help, and expectations of perfection in self and others. Individuals with this disorder have extreme discomfort when appearing weak or vulnerable and have difficulty relaxing. They are often addicted to several activities (e.g., constantly engaged in work or exercise). They tend to act strong while pushing others away, and exhibit extreme grandiose behaviors, which is a feature of narcissistic personality disorder. They often avoid contact with others (e.g., avoidant personality disorder), particularly out of fear of being crowded, and this can lead to emotional isolation and depression. The counterdependent male may take pride in himself not needing warmth, affection, or support in any relationship. He takes pleasure in being tough and independent. The counterdependent female may take on the attributes of a false self or male persona (image). The independent behavior of the counterdependent individual can act as a powerful lure for a codependent. An individual who is codependent exhibits symptoms of having low self-esteem and poor boundaries (limits), and is a people pleaser and caretaker. As a couple, codependent and counterdependent individuals can often switch roles.

In 1993, Robert Bornstein (1948–) described that there is a continuum from maladaptive dependency (submissiveness) through healthy interdependency (connectedness) to inflexible independence (unconnected detachment). Some individuals at the inflexibility end of the spectrum have powerful dependent longings that they keep out of awareness by denial and reaction formation. Essentially, this develops into having a personality disorder concealed by pseudo-independence. They define themselves in relationships as the individual whom others depend on and take pleasure for being able to take care of themselves. Individuals with this disorder may look skeptically at expressions of need and may regard evidence of emotional vulnerability in themselves or others with contempt. Often, these individuals have some secret of dependency (e.g., addiction to a substance, a partner, an ideology). Some individuals have a tendency toward illness or injury that gives them a justifiable reason to be cared for by others.

According to the *Psychodynamic Diagnostic Manual*, the psychopathic personality disorder is

diagnosable by the following criteria. Individuals are possibly more aggressive than openly dependent individuals. They are preoccupied with demonstrating a lack of dependence (e.g., shameful dependence). Individuals exhibit contempt for others and are in denial of weaker emotions, such as sadness, fear, longing, and envy. Their basic belief is that they do not need anyone. Their view of others is that everyone needs and depends on them and requires them in their lives in order to be strong and succeed. Furthermore, these individuals defend themselves through denial (PDM Task Force, 2006).

Treatment

Treatment for individuals with this disorder tends to be challenging. Counterdependent individuals rarely seek psychotherapy in order to avoid the possibility of regression. By eluding psychotherapy, an individual with this disorder can avoid discussing feelings as well as attempting to control the therapist in order to maintain his or her sense of independence. However, if an individual has a partner who is likely feeling a lack of true intimacy, the partner may be forced or given an ultimatum in participating in psychotherapy. While in treatment, individuals with this disorder need assistance in accepting their dependent desires as a natural part of being human before they can develop a healthy balance between separateness and connectedness. Progress in therapy can occur only when the individual can reflect on and mourn his or her early unmet dependency needs and become less defensive (PDM Task Force, 2006).

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Avoidant Personality Disorder; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Narcissistic Personality Disorder; Personality Disorders; *Psychodynamic Diagnostic Manual* (PDM); Psychotherapy

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Counterphobic Personality Disorder

Counterphobic personality disorder is a mental disorder characterized by actively seeking out that which is feared.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about imagined danger.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Obsessive-compulsive disorder** is a mental disorder characterized by unwanted and repeated thoughts and feelings (obsessions), or behaviors that one feels driven to perform (compulsions). It is commonly referred to as OCD.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **PDM** stands for the *Psychodynamic Diagnostic Manual* and is a diagnostic framework that characterizes individuals in terms of their psychodynamics.

- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also referred to as therapeutic counseling.

Description and Diagnosis

Counterphobic personality disorder is an uncommon personality disorder. It is characterized by actively seeking out fearful objects and situations. Those with this disorder are attracted to dangerous situations, thrive on taking risks, and have a reputation for intimidating others when exposed to immediate danger. They tend to put themselves in dangerous situations that are so irresistible and forceful that they cannot resist dangerous opportunities to reveal their fearlessness. They may also exhibit magical thinking. For example, they may believe that thinking or wishing for something can cause it to occur. Remarkably, individuals with this disorder have great confidence that they are safe no matter what danger they encounter.

Some children and adolescents appear to have a high threshold for stimulation and the need to deny any fear. Therapists describe these individuals as those who cannot swim yet will jump into the deep end of a swimming pool. Adolescents with this disorder often engage in reckless driving, take drugs on occasion, and engage in high-risk sexual behavior. Younger children with this disorder are often faced with a sense of powerlessness or fear of being lifeless. On the more adaptive (functional) end of the spectrum, children and adolescents become involved in risky activities but in a more controlled way. At the maladaptive (dysfunctional) end of the spectrum, children and adolescents with this disorder tease with the idea of potentially suicidal behavior (PDM Task Force, 2006).

According to the *Psychodynamic Diagnostic Manual*, counterphobic personality disorder is diagnosable by the following criteria. Individuals are preoccupied with safety and danger. Their contributing maturational patterns are unknown. Their main affects or feelings are contempt for others and denial of fear. They view themselves as fearless and able to face anything without fear. They tend to view others as easily frightened and that others admire their courage. Often, those with this disorder defend themselves through denial, through projection (e.g., making a prediction on known evidence or observations), and by means of defensiveness (PDM Task Force, 2006).

Treatment

Treatment for individuals with this disorder tends to be challenging. Individuals with counterphobic personality disorder rarely seek psychotherapy. However, they may participate in psychotherapy to address symptomatic problems such as depression and obsessive-compulsive disorder. Treatment is also difficult because of their need to deny ordinary anxieties and their tendency to present themselves with a sense of boldness that makes talking with a therapist about any feelings difficult. Therapists may experience anxiety when these individuals talk about their risk-taking behaviors and irritation when they describe their sense of having unlimited power (PDM Task Force, 2006).

Len Sperry, MD, PhD, and
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See also: Anxiety Disorders in Adults; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Obsessive-Compulsive Disorder (OCD); Personality Disorders; *Psychodynamic Diagnostic Manual* (PDM); Psychotherapy

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Couples Therapy

Couples therapy is a form of psychotherapy that focuses on strengthening the relationship bond and resolving conflicts between couples of all types.

Definitions

- **Atheoretical** refers to untested treatments that are not based on theory.
- **Cohabitation** is to live together with someone in a marriage, or marriage like, sexual relationship.
- **Conjoint therapy** takes place when both relationship partners are present in a therapy session.
- **Couples** refer to two people in an established married or unmarried partnership and may include, lesbian, gay, bisexual, transgender, and heterosexual couples.
- **Infidelity** is the act of having a romantic or sexual relationship with someone other than a wife, husband, or committed partner; it is also referred to as cheating, adultery, or having an affair.
- **In-laws** are the people you become related to through marriage, that is, the mother of a wife is referred to as the husband's mother-in-law.
- **LGBT** is an abbreviation for lesbian, gay, bisexual, and transgender couples.
- **Marriage and family therapist** is a protected professional title that designates an individual as meeting the educational standards set forth by the Commission on Accreditation for Marriage and Family Therapy Education.
- **Marriage counseling** is another term for couples counseling.
- **Psychotherapy** is a general term referring to a variety of talking treatments aimed at strengthening mental health, emotional, or relational problems.
- **Theory** refers to a body of knowledge, or set of principles, that explains the phenomenon in question.

Description

Couples therapy (CT) is a form of psychotherapy provided to all types of couples, including lesbian, gay, bisexual, transgender, and heterosexual couples. Historically referred to as "marital" or "marriage" counseling, the term "couples therapy" is increasingly becoming the preferred term. The use of the term "couples" recognizes that many couples cohabitate together while remaining unmarried.

The American Association for Marriage and Family Therapy (AAMFT) is the professional association, which represents over 25,000 marriage and family therapists. The AAMFT also serves as the accrediting organization for graduate training education in marriage and family counseling. Licensure as a marriage and family therapist is regulated by individual states.

Trained therapists provide CT, with most states requiring a graduate mental health degree and state license in order to provide CT. Therapist includes clinical psychologist, mental health counselors, clinical social workers, marriage and family therapist, and pastoral counselors. Couples counseling aims to assist couples strengthen their bond, resolve conflicts, and improve their relationship. CT is usually short term consisting of 12 to 20 sessions. There are a variety of therapeutic approaches and techniques to CT. Couples seek counseling for a variety of reasons, including relationship distress, improve relationship satisfaction, strengthen communication and problem-solving skills, working through issues related to infidelity, sexual difficulties and compatibilities, financial stresses, conflicts, parenting, and in-law issues.

Four phases in the development of CT have been identified, with each phase significantly influencing the expansion of methods and understanding of couples. Phase one (1930 to 1963), the "Atheoretical Marriage Counseling Formation" phase, was the pioneering phase of modern-day CT. Counseling was not based on any theories or scientific understanding of couples. Interventions consisted mostly of advice giving, extoling the virtues of family life, and educating couples on their legal and social obligations.

Phase two (1931–1966), the "Psychoanalytic Experimentation" phase, began to question the effectiveness of a traditional psychoanalytic approach in which partners were seen individually with the hope that as they each progressed through psychoanalysis, their stress would decrease and the relationship would benefit. Psychoanalysis was grounded in the belief that

psychological and social dysfunctions were due solely to problems within the individual. Couples who were seen individually rarely, if ever, described a shared event, such as a conflict, in the same way. At the time no theories existed that addressed how to understand multiple perspectives and help multiple people at the same time in a therapy session. This led to conjoint marital therapy in which two individuals are seen at the same time. Conjoint therapy was revolutionary from a psychoanalytic perspective. Phase two was a time of tremendous growth and theoretical development in understanding couples and how to help them. In 1942, the American Association of Marriage Counselors was formed and later renamed as the American Association for Marriage and Family Therapy.

Phase three (1963–1985) is the "Family Therapy Incorporation" stage. Theorists were no longer limited to a psychoanalytic perspective and began to focus on family dynamics. During this time, family therapy became the predominate focus of developing psychotherapies and marital counseling was largely absorbed into the family therapy movement. There was a tremendous increase in the development of theories during this time that focused on understanding the complex interactions and behaviors of families. The years 1975 to 1985 are considered the golden age of family therapy and several groundbreaking theories were developed. Four highly influential clinical family theorists include Don Jackson (Family Rules: Marital Quid Pro Quo), Virginia Satir (Family Therapy: Concepts and Methods), Murray Bowen (Family Systems Theory and Practice), and Jay Haley (Strategic Family Therapy). These, and many other theorists, incorporated ideas into how couples behaved in the family, and toward each other, and what impact the marital relationship had on healthy family functioning.

Phase four (1986–present) is the "Refinement, Extension, Diversification, and Integration" phase. Emerging out of the family therapy movement, CT reasserted its existence in the mid-1980s. Continuing to the present CT theory, research and the development of practical psychotherapies to helping couples have become increasingly refined and integrated with other forms of psychotherapy. For instance, emotion focused couple therapy and behavioral couple therapy are well-established forms of CT first developed in the 1980s and further refined through substantial research support. CT has also been integrated with psychotherapies originally developed as individual therapies such as solution focused therapy.

Couples therapy, in all its forms, has been shown to be effective. Research has consistently established that couples who receive any form of CT are better off after treatment than couples who received no treatment. Although there are numerous types of CT, few studies have examined which models are more effective when compared against each other.

Steven R. Vensel, PhD

See also: Bowen Family Systems Theory; Conjoint Family Therapy; Conjoint Sexual Therapy; Marriage and Family Therapist; Satir, Virginia (1916–1988)

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Covert Sensitization

Covert sensitization is a therapeutic technique in which an undesirable behavior is associated with an unpleasant image in order to try to control or eliminate the undesirable behavior.

Description

Covert sensitization is used in behavior and cognitive behavior therapy (CBT). By using this technique, the therapist helps the client identify the problem and then uses negative images or experiences to prevent it from

happening in the future. The hallmark of covert sensitization is that it happens in the imagination, which makes it covert. Examples of such techniques would be things like vomiting due to overeating or excessive consumption of alcohol in order to reduce addictive behaviors. During treatment, the client is encouraged to imagine the undesirable behavior and then associate it with an unpleasant or disgusting consequence.

The aim in covert sensitization is for the client to move away from his or her present thoughts and behaviors. For example, a client believes what he or she is doing is wrong or undesirable. Then the goal is for the client to shift his or her beliefs about the experience through feeling different unpleasant physical effects. A client who wants to quit smoking may be encouraged to imagine puffing on a cigarette and then associate it with a picture of black and decaying lung tissue. The aversive images are only powerful when they are based on things that the client finds truly negative. This is a form of imaged aversion therapy, and it is based on the idea that behavior is learned and can therefore be changed.

Development

In the 1960s psychologist Joseph Cautela was the first to outline a procedure for covert sensitization. He and his colleague Albert Kearney later published *The Covert Conditioning Handbook* in 1986. This handbook discussed the technique based on research investigations and case studies.

Because it does not require drugs and is relatively simple to implement, covert sensitization has been applied over the years. The technique has been used with many problematic and undesirable behaviors. Among them are alcoholism, smoking, gambling, obesity, and various sexual dysfunctions. Many programs using covert sensitization have had positive clinical results.

Prior to 1974, homosexuality was still identified as a mental illness. During that time covert sensitization was one of the approaches used to try to change or convert sexual orientation. Even though the majority of mental health professionals have changed their stance on this, there are still sexual reorientation or reparation programs that target the homosexual population. Covert sensitization is still used by fundamentalist religious groups, for example, who adhere to the belief that nonheterosexual orientation is a mental illness and continue to use this as a therapeutic technique.

Current Status

Covert sensitization continues to be applied both in therapy and in other fields. This includes people who experience a wide variety of psychosocial problems, from smoking cessation to sexual impulse control, even to drug addiction. One of its appeals is that it avoids the risks involved in drug and pharmacological interventions by using visualization and imagery. Covert sensitization has been used in the treatment of alcoholism, but the results remain controversial.

One critique of covert sensitization is that it does not concern itself with the roots of undesirable behaviors. Many believe that because of this, underlying psychological motivation can persist and therefore real change does not occur. The concern then is that problem thoughts and behaviors can resurface leading to a renewal of problems when and if the aversive imagery loses its power.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Aversion Therapy; Behavior Therapy; Cognitive Behavior Therapy

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Crisis Housing

"Crisis housing" refers to programs that provide short-term housing or residential assistance to people suffering from emergencies or serious mental health issues.

Definition

- **Crisis** is an event, or series of events, in a person's life marked by danger, instability, and chaos that negatively impacts his or her life.

Description

Within the mental health community, crisis housing is a temporary residence or institution for the treatment of people suffering from a recent crisis. Although sometimes referred to as crisis group homes, they differ from therapeutic group homes in their intent, focus, and duration of stay. In many communities, crisis housing has been therapeutically successful. It has also been found to be a cost-effective alternative to expensive psychiatric inpatient hospitalization. The provision of crisis housing has led to a reduction in the number of people who need to be admitted to more traditional clinical settings.

Development

Crisis housing began as a service to help people who were not able to find safe or healthy shelter. Based on emergency situations, crisis housing applies to victims of man-made and natural disasters. But crisis housing has also been important as a response to social, familial, and personal problems for some. It can provide a safe environment for those who are threatened by other people, like abusers, or by their own internal psychological problems, like psychosis.

Beginning in the 1980s, many local communities and governments began to provide crisis housing and case management services as an alternative to psychiatric hospitalization. Crisis housing has taken many forms, from conversion of hotels to refitted private homes. Although not without issues, crisis housing has proved effective in providing space and opportunity for treatment.

One example of a program that uses crisis housing is the Assertive Community Treatment program. This serves as an intervention program that treats people with serious mental illness in a comprehensive, multidisciplinary setting outside of a clinical or hospital setting. The model originated in the late 1970s with the Program of Assertive Community Treatment in Madison, Wisconsin. It grew out of the need to find community-based services as deinstitutionalization, or removal from clinical hospital settings, became the norm. Assertive Community Treatment is often referred to as a hospital without walls.

Current Status

Studies have shown that patients who have the opportunity to live in crisis housing tend to engage in treatment more effectively and have better outcomes. Crisis housing has been publicly supported in many states for patients with mental health issues. This is because it reduces the cost of treatment by avoiding expensive hospital or inpatient programs. Crisis housing can provide clients with the opportunity for a comprehensive approach to treatment.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Deinstitutionalization; Hospitalization

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Crisis Intervention

Crisis intervention is a fast assessment and response to help people involved in a crisis situation cope and move toward physical and emotional resolution.

Definition

- **Crisis** is an event, or series of events, in a person's life marked by danger, instability, and chaos that negatively impacts his or her life.

Description

Crisis intervention usually occurs when an individual's or group of people's ability to cope has been exhausted or destroyed. Generally, crises usually require outside support where physical, psychological, and social resources are needed to help people overcome intolerable situations. The crisis could be an individual trauma, like suicide, or a natural disaster, like a tornado, or a man-made disaster, such as terrorism. An example of a crisis is the Japanese tsunami of 2011. This natural event caused personal, civic, and regional crises that affected the people directly and the country itself could not address alone. They needed help from others to restore calm and order and even provide both basic and long-term social needs for those in the disaster or crisis zone.

The simplest approach to crisis intervention is the so-called ABC method. A is establishing and maintaining contact, B is identifying the problem clearly, and C is developing coping mechanisms. For health-care professionals the more common situations that demand crisis intervention are based around individual and family issues, horrific events such as death, sexual assault, or other violent crimes. These events shake people so deeply that they are robbed of their usual ability to assess and respond on their own. In this situation crisis intervention is often called crisis counseling and is to be conducted only by those specifically trained to provide this kind of treatment.

Development

There are individual organizations, such as the Red Cross, that have long helped people in disaster situations. The history of crisis intervention as a distinct concept dates back to the 1942 Boston Cocoanut Grove nightclub fire. The fire killed almost 500 people and plunged the community into a traumatic state. Eric Lindemann and Gerald Caplan, known as the fathers of crisis intervention, formed modern crisis intervention based on the response to that experience.

In 1963 federal law mandated the creation of community mental health centers to assist people in crisis. But the early success of these efforts was limited. It was in the late 1970s that the Federal Emergency Management Agency (FEMA) was established by the government. FEMA was created to plan, coordinate, and deliver emergency assistance in cases of widespread social need.

While there are different approaches to crisis intervention, the ACT process created by Albert Roberts, PhD, has been widely used. It has been applied to significant crisis events such as the response to the 9/11 terror attacks. Roberts recommends that those professionals who intervene should take specific steps when intervening to help with a crisis. The first step is to assess the deadly danger or lethality of the situation and the mental state of those involved. The next step is to establish rapport with and get the attention of those impacted by the crisis in order to connect with them. After this it is important to identify the major issues involved and spend time processing and dealing with the feelings of those affected. Next, professionals should apply some immediate emotional coping mechanisms and temporary or partial responses to the event. Once these short-term solutions are put in place, the next step is to develop a long-term action plan, including decisions about when the intervention should end and what will be done to follow up.

Crisis or critical incident debriefing is widely implemented immediately after a disaster. It was used in the crisis event of the mass shooting at a school in Columbine, Colorado, in 1999. Although helpful in the short-term, crisis intervention has been critiqued for being insufficient for long-term problems. This is especially true for those who have symptoms of post-traumatic stress disorder, which may show up only months after a traumatic event occurs.

Current Status

As the world continues to change politically, socially, and environmentally, crises will continue to occur. There is no doubt that crisis intervention skills will continue to be needed on many levels. Although key elements of response by professionals include critical incident debriefing and stabilization, longer-term interventions may also be needed to service those more severely or even chronically affected.

The success of crisis intervention efforts depends on three things. It is important that the intervention

be provided in a timely, effective, and well-trained fashion. This should involve not only mental health professionals but police, hot-line operators, clergy, government workers, and more. Crisis prevention and intervention is an important focus for those professionals dealing with people engaging in risky behavior. Often in the workplace, the skills of professionals in human resources are only brought to bear after a traumatic event has occurred.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Crisis housing

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Cults

"Cults" refer to religious and social fringe groups regarded by the majority culture as engaging in sinister, strange, exploitive, and psychologically harmful beliefs and practices.

Description

The term "cults" has been widely used in popular culture in describing destructive fringe religious and social groups. Religious researchers prefer to use the phrase "new religious movement" (NRM), recognizing that not all NRMs are harmful to their followers. Here "cult" will be used to refer to intense groups, frequently religious but not rooted in a mainstream religion, formed around a controlling and manipulative charismatic leader, which demand unwavering devotion, and pose a physical, psychological, or exploitive danger to their followers.

Impact (Psychological Influence)

Thousands of different cults exist. Destructive cults include apocalyptic groups such as "Heaven's Gate" in which 38 followers committed mass suicide after the UFO that was to usher in the end of world failed to arrive. Other cults have political, social and religious, motivations, such as the "People's Temple" infamous for the 1978 "Jonestown Massacre" in which over 900 followers committed "revolutionary suicide" by drinking poisoned drink mix at the urging of the Reverend Jim Jones. Although "Flavor Aid" was the actual drink brand used in the poisonings, the phrase "Don't drink the Kool-Aid" became culturally iconic when referring to unquestioned beliefs related to political or religious agendas.

Cult members use a variety of techniques to control and manipulate potential followers. Cults are usually isolated and exert considerable control over communication with the outside world. They use intense indoctrination techniques often referred to by the popular culture as "brain washing" or "mind control." They employ intense and cunning emotional manipulation; use guilt, shame, and fear tactics; subject recruits to emotionally charged meetings and rituals lasting for hours; and use sleep deprivation and other forms of influence to convert recruits. Cults dictate and control how followers should think, act, and feel. These practices are so effective that followers give up all they have and all they are to the cult.

Cults most frequently target young adults for recruitment. This is a stage in life when young adults are seeking their own self and spiritual identity distinct from that of their parents. This leaves them especially vulnerable to charismatic leaders who "have all the answers" and "know the one way." Young adults are emotionally manipulated and made to feel especially understood, accepted, and cared for increasing their vulnerability to recruitment and eventual conversion.

Cults are powerful and destructive social phenomenon, and awareness of their tactics is especially important for young adults. Becoming knowledgeable of the beliefs and practices of any religious group, or NRM, before becoming involved is an essential safeguard of one's spiritual and psychological well-being.

Steven R. Vensel, PhD

See also: Identity and Identity Formation; Spiritual Identity

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Cultural Competence

Cultural competence is the ability to interact effectively with individuals from other cultures. It is also known as multicultural competence and intercultural competence.

Definitions

- **Cultural competence** is the capacity to recognize, respect, and respond with appropriate words and actions to the needs and concerns of individuals from different ethnicities, social classes, genders, ages, or religions.
- **Cultural encapsulation** is a way of relating to another from one's own biased worldview and perspective.
- **Cultural incompetence** refers to acting from one's culturally encapsulated perspective and failing to consider the other's worldview.
- **Culture** refers to the values, norms, and traditions that affect how individuals of a particular group perceive, think, act, interact, and make judgments about their world.
- **Multicultural counseling** is an approach to counseling clients that is responsive to their cultural beliefs and the effect these beliefs can have on their treatment.
- **Worldview** refers to basic assumptions that individuals and groups have about other people and the world. It defines one's cultural perspective.

Description

Cultural competence is increasingly important in the helping professions of counseling and psychotherapy. It is the capacity to recognize and respond appropriately to the needs and concerns of individuals from other cultures. There are four dimensions of cultural competence: cultural knowledge, cultural awareness, cultural sensitivity, and cultural action. Briefly, cultural knowledge is acquaintance with facts about ethnicity, social class, acculturation, religion, gender, and age. Cultural awareness builds on cultural knowledge. It includes the capacity to recognize a cultural problem or issue in a specific client situation. Cultural sensitivity is an extension of cultural awareness. It also involves the capacity to anticipate likely consequences of a particular cultural problem or issue and to respond empathically. Cultural action follows from cultural sensitivity. It is the capacity to translate cultural sensitivity into action that results in an effective outcome. The higher one's level of culturally competence increases the more likely one will make appropriate decisions and take effective cultural action in a given situation.

Possessing only basic cultural knowledge, awareness, sensitivity and skillful, actions is insufficient to function effectively in a multicultural world. A low level of cultural competence is evident when one demonstrates deficits in these requisite components, is unable to perceive the need to apply them, or is unable to do so. In contrast, a high level of cultural competence is evident when one knows, recognizes, respects, accepts and welcomes, and takes effective and appropriate skillful action with regard to another's culture. In other words, cultural competence requires both sufficiency of its basic components and the proficiency to implement them.

Individuals vary in their capacity for demonstrating cultural competence. In fact, cultural competence has been conceptualized as a continuum ranging from a very low level of cultural competence at one end to a very high level of cultural competence at the other end. For example, a low level of cultural competence is called cultural incompetence. It reflects a lack of or minimal acquaintance and recognition of cultural knowledge and cultural awareness. Because there is

a lack of cultural sensitivity, one's cultural decisions and actions are likely to be inappropriate, ineffective, or even harmful or destructive. Individuals are likely to be culturally encapsulated. Besides a failure to understand the worldview and cultural identity of another, it is the failure to incorporate whatever cultural knowledge one might have of the other into interactions with others. In contrast, a high level of cultural competence reflects more cultural knowledge and awareness, and there is no indication of cultural encapsulation.

Developments and Current Status

Awareness of cultural factors in mental health is the basis of what is called the multicultural movement in counseling. In 1962, psychologist Gilbert Wrenn (1902–2001) described the culturally encapsulated counselor and how such counselors negatively impacted culturally different or minority clients. The movement gained momentum with psychologist Stanley Sue's (n.d.) 1977 article in which he indicated that minority clients received unequal and poor mental health services. In 1978 psychologist Derald Wing Sue (n.d.) described the term "worldview" and its influence on counseling. Soon after, the first edition of Derald Sue's book *Counseling the Culturally Different* appeared in 1981. It provided background on several different minority groups and became the model for similar books. Sue's book is now in its sixth edition. It has the distinction of being the most frequently cited publication in multicultural psychology. This book is estimated to be used in nearly 50% of the graduate counseling and psychology courses. In 1992, Darryl Sue and colleagues identified 31 standards of cultural competence arranged in three categories: awareness of one's own worldview, knowledge of the worldviews of culturally different clients, and skills needed to work with such clients. In a recent series of articles and book chapters, psychiatrist and psychologist Len Sperry (1943–) distinguished the four components of cultural competency: cultural knowledge, cultural awareness, cultural sensitivity, and cultural action.

Len Sperry, MD, PhD

See also: Acculturation and Assimilation; Culturally Sensitive Treatment; Culture

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Culturally Sensitive Treatment

Culturally sensitive treatment is a medical or psychotherapeutic treatment that is sensitive to the client's culture.

Definitions

- **Acculturation** is the degree to which individuals integrate new cultural patterns into their original cultural patterns.
- **Clinician credibility** is the culturally diverse individual's perception that the practitioner is effective and trustworthy based on how the practitioner instills faith, trust, and confidence in the client for the treatment process and outcomes.
- **Cultural identity** is an individual's self-identification and perceived sense of belonging to a particular culture or place of origin.
- **Cultural sensitivity** refers to practitioners' awareness of cultural variables in themselves and in their clients that may affect the professional relationship and treatment process.
- **Culture** refers to the values, norms, and traditions that affect how individuals of a particular group perceive, think, act, interact, and make judgments about their world.

Description

Even though most practitioners believe that culturally sensitive treatments are important in providing effective care to culturally diverse clients, very few practitioners actually provide such treatment. The most common reason for this omission is that few have had formal training and experience with these competencies. Such treatments include cultural intervention, culturally sensitive therapy, and culturally sensitive interventions.

Developments and Current Status

A cultural intervention is an intervention that is useful in effecting a specified change because it is consistent with the individual's belief system regarding healing. Examples include healing circles, healing prayer, exorcism, and involvement of traditional healers from that client's culture.

Culturally sensitive therapy is a psychotherapeutic intervention that directly focuses on the individual's cultural beliefs, customs, and attitudes. Since this therapy utilizes traditional healing methods, such approaches are appealing to certain clients. Examples include "cuento therapy," which focuses on "familismo" and "personalismo" through the use of folk tales ("cuentos"). "Morita therapy" is a therapy used for various disorders ranging from shyness to schizophrenia and is particularly effective in those with lower levels of acculturation.

A culturally sensitive intervention is a psychotherapeutic intervention that has been adapted or modified to be responsive to the cultural characteristics of a particular client. Cognitive behavior therapy is the most common of such intervention because it is structured, educationally focused, and easily modified to be culturally sensitive. For example, disputation and cognitive restructuring are not effective with individuals with lower levels of acculturation. However, culturally sensitive problem solving, skills training, and cognitive replacement interventions are more appropriate and effective.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Cultural Competence; Culture

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Culture

"Culture" refers to the values, norms, and traditions that affect how individuals of a particular group perceive, think, act, interact, and make judgments about their world.

Definitions

- **Acculturation** is the degree to which individuals integrate new cultural patterns into their original cultural patterns.
- **Acculturative stress** is the stress experienced when struggling to adapt to a new culture psychologically and socially and its impact on health status.
- **Clinician credibility** is the culturally diverse individual's perception that the practitioner is effective and trustworthy based on how the practitioner instills faith, trust, and confidence in the client for the treatment process and outcomes.
- **Cultural competence** is the capacity to recognize, respect, and respond with appropriate words and actions to the needs and concerns of individuals from different ethnicities, social classes, genders, ages, or religions.
- **Cultural diversity** is the presence of a number of diverse or different cultures within a society. It is also known as cultural pluralism.
- **Cultural identity** is an individual's self-identification and perceived sense of

belonging to a particular culture or place of origin.

- **Cultural sensitivity** is the practitioners' awareness of cultural variables in themselves and in their clients that may affect the professional relationship and treatment process.
- **Culture-bound syndromes** are recurrent, patterned, and problematic behaviors or experiences that are specific to a geographical region or culture.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Indigenous medicine** is a cultural system of practicing medicine that was developed prior to modern medicine and is part of a cultural heritage. It is also known as folk medicine and traditional medicine.
- **Multicultural counseling** is a form of psychotherapy in which the therapist and client (individual, couple, or family) who are of different cultural backgrounds collaborate in a psychotherapeutic relationship.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Culture is frequently conceptualized (thought about) as a way of categorizing different approaches to living. Cultural differences include heritage, customs, language, values, and beliefs. They also include ethnicities, races, and religious beliefs. Furthermore, cultural differences exist between social classes, gender identities, sexual orientations, and age groups. Artifacts or objects that are distinct to a group of people are also part of culture. For example, particular food, clothing, and housing norms may differ from group to group. These are the various ways in which culture is defined.

Cultural identity is the sense of belonging to a particular cultural group or place of origin. Cultural identity affects one's psychological experience of living. As a result, the mental health professions have integrated cultural sensitivity into their work. Cultural sensitivity is an ethical requirement of the profession. Cultural sensitivity requires basic knowledge and awareness of cultural factors and how they impact individuals. A culturally competent psychotherapist is aware of, knowledgeable about, and sensitive to a range of diverse human behaviors and experiences. This cultural competence is especially relevant to multicultural counseling. In the United States, the therapist and client are often members of different cultural groups. Effective psychotherapy accommodates cultural factors. Cultural factors influence the ways in which a client's presenting problem is expressed and understood. Psychotherapeutic interventions that are culturally sensitive lead to better treatment outcomes. Culturally sensitive psychotherapy includes an assessment of acculturation. Acculturative stress occurs when an immigrant experiences difficulty integrating new cultural patterns with his or her original cultural patterns. In addition, clients from cultures with histories of being oppressed may have difficulty trusting a therapist from cultural groups other than their own.

Development and Current Status

Nearly every cultural group throughout history has practiced the art and science of restoring health. Contemporary mental health practices are informed by this ancient heritage. Practitioners of indigenous medicine are more likely to work on healing physical, psychological, social, or spiritual ailments. In contrast, modern health-care professionals have become increasingly specialized in the practice of medicine. At the end of the 19th century, psychology established itself as a distinct profession. However, cultural considerations in the mental health professions were largely ignored until the middle of the 20th century. At that time the third major mental health reform was under way. The third major mental health reform was called the Community Mental Health Movement. The Community Mental Health Movement was a backlash against institutionalization and led to greater social integration.

Alexander H. Leighton (1908–2007) and Dorothea C. Leighton (1908–1989) were pioneers in culturally sensitive mental health research and practice. Their observations of indigenous healers illuminated similarities and differences between many traditional and modern health-care practices.

One of the major differences between indigenous and mainstream American culture is culture-bound syndromes. Until 1967 they were considered peculiar psychiatric disorders. Today, these syndromes are considered to be illnesses or afflictions that are specific to a given culture. The first culture-bound syndrome identified is amok and is associated with Malaysian culture. *Amok* describes a period of brooding followed by assaultive or murderous behavior. It is usually precipitated by a perceived insult or slight. Often, culture-bound syndromes are believed by the cultural group to be caused by evil spirits. There are many culture-bound syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders*.

The mental health professions have become increasingly sensitive to the impact of culture on psychotherapy since the 1950s. Culturally sensitive and evidence-based mental health practices have become more common. The surgeon general of the United States reported on the contributions of such research efforts in 2001. However, in the same report the surgeon general noted that major insufficiencies in cultural knowledge still existed. Mental health care for populations of cultural minorities is still not sufficiently evidence based. Modern science allows contemporary multicultural interventions to study the integration of traditional and modern treatments. Evidence-based treatments have been proven to produce therapeutic change in the controlled contexts of scientific research. However, the majority of evidence-based psychotherapy research does not emphasize cultural sensitivity. Counseling research has largely been based on white male middle-class American culture. The results of these scientific studies and resultant treatments might not be generalizable to members of cultural minority groups. Interventions that were invented in one culture may not be applicable across cultural barriers. The increasing diversity in the United States requires that evidence-based treatments be reevaluated for use with various cultural groups. Insensitivity to cultural factors in psychotherapy can lead to misunderstanding, conflict, oppression, and a minimization of positive outcomes. Common cultural differences leading to therapeutic obstacles include social class, gender, and sexual orientation. It is not surprising that dropout rates in psychotherapy are higher for culturally diverse clients than for clients in the cultural majority. Culturally sensitive therapeutic approaches have been developed to better serve the needs of culturally diverse clients.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Cultural Competence; Culturally Sensitive Treatment; Multicultural Counseling

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Custody and Custody Evaluations

Custody explores the rights of the parent or guardian over children. The primary purpose of an evaluation is to assess the best psychological interest of the child. In separation or divorce, custody evaluations review who has residential or primary care of the child or children as well as identify visitation rights and expectations. Custody evaluations are conducted to help determine which parent or caregiver best meets the child's needs and are generally conducted by a child psychologist appointed by the court or guardian ad litem (GAL).

Description

Custody evaluations have not always been as complicated and challenging as they currently are. Prior to the turn of the 20th century, children were automatically put into the care of their fathers as it was believed the fathers could care for children better financially. However, the industrial revolution brought to light the mother's role in child care. This led to a belief that younger children were better in their mother's care, resulting in a switch toward favoring mothers in custody disputes.

The 1960s to current day has brought attention to focusing on the best interest of the child as opposed to the gender of the parent. The 1970s introduced the Uniform Marriage and Divorce Act, which was adopted by the majority of states. This act focused on the best interest of the child and identified several factors that should be considered. These factors include parental preference regarding custody, the desire of the child, interactions and relationships of the child with the parent as well as siblings and any other person who could be involved in the adjustment of the child, and the mental and physical health of the parents as well as any other relevant factors. However, in the two decades mothers still predominately receive primary custody of the children in custody agreements.

Anyone the child resides with or who is responsible for caring for the child is a part of the child custody evaluation. This includes both natural parents and significant others such as stepparents, live-in partners, grandparents, and live-in help. The process includes interviews and observations, as well as cognitive and personality functioning tests. Information is obtained from school records, medical records, and legal and court records as well as from any relevant party involved. For instance, teachers may be interviewed for their perception of interactions and parental investment.

The purpose of the evaluation is the fitness of the parent. The evaluator and courts are looking at the emotional, financial, and residential stability. Any psychiatric hospitalizations and use of psychotropic medication, as well as the reasons for therapy can all be assessed. Any drug- or alcohol-related problems will also be evaluated. The evaluator will also look at what parents can best support the child academically as well as for needs of daily living. Cooperation both with the other parent and the courts is assessed as well as behavior during meetings. The parent's social skills and judgment are also explored, as well as the interaction between the child and parent and their ability to communicate openly. These factors are all incorporated into the Ackerman-Schoendorf Scales for Parent Evaluation of Custody (ASPECT and ASPECT-SF).

The evaluation is generally completed by a child psychologist and may work in collaboration with an adult psychologist. Ideally it should be a single professional completing the evaluation. The evaluator should have a doctorate in psychology and be licensed in that state. Traditionally both parents would hire an expert to evaluate them separately. Due to the cost and time of this, there has been a shift to court-appointed evaluators who serve both parents. Some states, however, still use the traditional method. It is common now that the evaluator be appointed either by the court or by a GAL. The evaluator works as a team member with the GAL as they are obligated to make recommendations based on best interest of the child.

Current Status

Currently child custody evaluations have a purpose of assessing the best psychological interest of the child as well as the child's well-being. There is a focus on the developing needs of the child as well and the ability of the parent to meet those needs.

Mindy Parsons, PhD

See also: Divorce; Family Therapy and Family Counseling

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Cutting

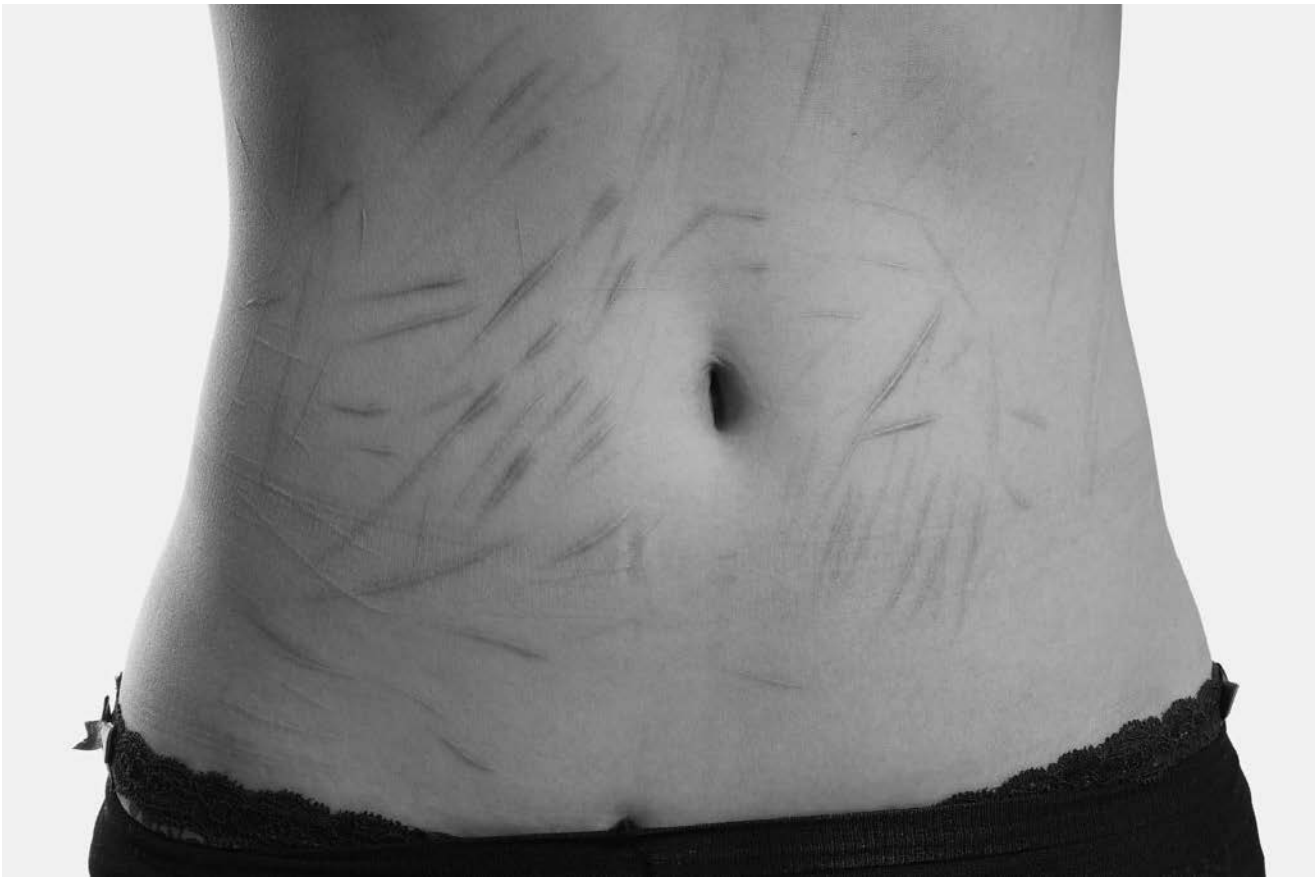
Cutting is a form of self-injury whereby one makes cuts on his or her body, usually on the arms or legs, without attempting to commit suicide.

Definitions

- **Deliberate self-harm,** or self-inflicted injury, refers to acts of harming oneself with non-suicidal intent.
- **Self-inflicted injury** is a term used to refer to a range of behaviors that encompass self-harm where one deliberately injures oneself but without suicidal intentions.
- **Self-injury,** also referred to as self-harm, is the act of intentionally harming one's own body (by cutting or burning), without the intention of committing suicide.

Description

Cutting is considered a type of deliberate self-harm or self-injury. A person who engages in cutting behavior intends to hurt himself or herself but does not do it with the intention of committing suicide. Rather, this type of self-harm is used as an unhealthy way to cope with emotional pain, anger, or frustration. However, as with any form of self-inflicted injury, there is the possibility of more serious and even fatal consequences.



Cutting is a form of self-injury whereby an individual makes cuts on his or her body with sharp objects such as razor blades, usually on the arms or legs. Cutting is not a suicide attempt but is rather a maladaptive coping mechanism for dealing with stress, anxiety, or other negative emotions. (Axel Bueckert/Dreamstime.com)

When a person cuts, he or she usually makes small, shallow incisions, using a razor or other sharp object, on his or her legs or arms. Typically these cuts are made in places that are not readily visible to family or friends. Cutting behavior is associated with an inability to cope and regulate one's impulses. It has been linked to a variety of mental disorders, including depression, anxiety, eating disorders, bipolar disorder, schizophrenia, and borderline personality disorder. Perfectionistic tendencies among some cutters have also been noted. People who self-injure have often experienced some form of abuse, physical, verbal, emotional, and/or sexual.

Cutters report that the act helps them to get rid of negative emotions, release endorphins, and/or gain some sense of control. Though feelings of calm or an easing of tension may result immediately on cutting oneself, this is often replaced later by feelings of guilt or shame. Oftentimes, cutting behaviors are associated with long-term psychological issues such as anxiety and depression. People who cut are also more likely to have experienced some form of abuse, physical, emotional, and/or sexual, in their past. Cutting behavior is a behavioral sign of deeper, underlying problems, and thus, treatment for this type of behavior should be sought out immediately. Consultation with a pediatrician or health-care provider may be the first step. Follow-up treatment may include working on behavior and proper coping skills with a counselor or therapist and/or medication.

Impact (Psychological Influence)

Research estimates that adolescents and young adults, ranging in age from 12 years to early 30s, report cutting behaviors most often. Children as young as nine years have reported cutting. Females are more likely to be cutters than males. Cutting and other forms of self-injurious behavior have been identified across all cultures and socioeconomic statuses. Though the practice of cutting may have existed in secrecy for some time, recent media attention has caused a rise in the number of young people who engage in this form of self-injury. To further complicate the matter, there have been relatively few research studies done on cutting which makes definitive statistics on the subject hard to come by.

Melissa A. Mariani, PhD

See also: Self-Mutilation/Self-Harm

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Cyberbullying

"Cyberbullying" refers to using electronic technology (cell phones, computers, tablets, gaming devices) to repeatedly and intentionally degrade, threaten, or humiliate another person.

Definitions

- **Bullycide** refers to a suicide where the victim's death has been attributed to his or her having been bullied either in person or online.
- **Bullying** describes deliberate, repeated acts of aggression that are inflicted directly or indirectly over time by one or more dominant persons.
- **Mobbing** defines when an individual is bullied by a group of people in any context, including a family, school, social setting, or workplace.

Description

Using technology and electronic communication as a means to threaten, harm, humiliate, or intimidate another person is known as cyberbullying. Cyberbullying is a distinct type of bullying or peer aggression. Technology devices such as computers, cell phones, tablets, or gaming devices can be used as vehicles for bullying behavior. Those who cyberbully may do so through calling, texting, e-mailing, instant messaging, posting comments, making

"Cyberbullying" refers to using electronic technology (e.g., cell phones, computers, and tablets) to repeatedly and intentionally degrade, threaten, or humiliate another person. It can have devastating psychological consequences for the victims and may even lead them to commit suicide. (Ian Allenden/Dreamstime.com)

verbal/written threats on social media and gaming sites, or taking pictures and transmitting them electronically. Canadian educator and anti-bullying activist, Bill Belsey, is credited with coining the term "cyberbullying."

Certain characteristics of cyberbullying make it more difficult to identify and report, given that the incidents do not happen in person as is the case with other forms including physical, verbal, or relational bullying. Anonymity is an issue as there is no way to be certain of the true identity of the aggressor. Temporary e-mail accounts, using pseudonames, anonymous postings, or sending messages from another person's phone or computer can be accomplished nowadays with little trouble. Another characteristic that contributes to the ease of cyberbullying is lack of supervision. While teachers, administrators, and staff can deter bullying from occurring in schools simply by their presence, close monitoring of electronic devices and proper Internet usage during personal time is more complicated. In addition, parents may not be as technologically savvy as their children, making it more difficult for them to adequately supervise their usage. Furthermore, the simplicity of accessing mobile devices, particularly smartphones with Internet capabilities, has made cyberbullying an around-the-clock issue. Homes are no longer safe havens, and aggressors can target their victims anywhere and anytime. The level of impact in terms of the number of people that can be reached through cyberbullying also makes it distinct from other types of bullying. Mobbing, or bullying by a group of people rather than an individual, can be accomplished almost effortlessly through group messages, chat rooms, and social networking sites. These factors also contribute to the lasting impact this type of harassment can have on an individual's emotional and psychological well-being.

Cyberbullying can result in serious consequences. Victims often report higher levels of fear, anxiety, and stress. In addition, those who have been cyberbullied have lower self-esteem, may become socially withdrawn/isolated, and are at greater risk for depression and suicide. The term "bullycide" has been used to refer to suicides where bullying was determined to be a primary contributing factor. Cases such as that of Ryan Halligan (2003), Megan Meier (2006), Pheobe Prince (2010), and Tyler Clementi (2010) brought media attention to the detrimental effects of cyberbullying specifically.

Current Status and Impact (Psychological Influence)

Since the 1990s there has been a rise in reported incidents of cyberbullying as society's reliance on technology has increased. Recent reports indicate that the majority of teens aged 12 to 17, approximately 95%, access the Internet on a regular basis. Smartphones, which have become an increasingly popular vehicle used for social interactions, permit users to go online from any location at any time of the day. Research has

found that most parents are concerned with what information their child may access or share online. Given this fact and the relative ease with which cyberbullying occurs, certain measures should be taken to help combat this growing problem. Experts agree that close monitoring can prevent and reduce cyberbullying. They recommend that parents discuss online etiquette and what constitutes appropriate sharing of information with their children and that they educate them about cyberbullying and its consequences as well as what to do if they see this behavior occurring. Parents are also encouraged to require their children to keep computers, tablets, and other devices in a centrally located, open room in the house to deter youngsters from engaging in negative interactions themselves or hiding the inappropriate behaviors of others.

Melissa A. Mariani, PhD

See also: Bullying and Peer Aggression; Peer Groups; Mobbing

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Cyclothymic Disorder

Cyclothymic disorder is a mental disorder characterized by alternating cycles of hypomanic and depressive symptoms.

Definitions

- **Bipolar and related disorders** are a group of mental disorders characterized by changes in mood and in energy (e.g., being highly irritable and impulsive while not needing sleep). These disorders include bipolar I disorder, bipolar II disorder, and cyclothymic disorder.
- **Bipolar disorders** is a mental disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more major depressive episodes.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also called CBT.
- **Depression** is a sad mood or emotional state that is characterized by feelings of low self-worth or guilt and a reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts the individual's daily functioning.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily functioning. These disorders include major depressive disorder, persistent depressive disorder, disruptive mood dysregulation, and premenstrual dysphoric disorder.
- **Hypomania** is a mental state similar to mania but less intense.
- **Major depressive disorder** is a mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning. It is also referred to as clinical depression.
- **Mania** is a mental state of expansive, elevated, or irritable mood with increased energy or activity.

- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.

Description and Diagnosis

Cyclothymic disorder is one of a group of depressive disorders. It is characterized by a chronic fluctuating mood with distinct periods of hypomanic symptoms and distinct periods of depressive symptoms. The symptoms are like those of bipolar disorder and major depressive disorder but of lesser severity. Cyclothymic disorder is similar to bipolar II disorder. It is seen in individuals unable to regulate their emotions effectively. They may lack the willingness to think beyond themselves, consider their impact on others, and take the initiative in meeting their responsibilities. This disorder usually begins early in life. It appears to be equally common in men and women although women are more likely to seek treatment for it than men (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pattern of chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and periods of depressive symptoms. These fluctuating depressive and hypomanic symptoms must be distinct from one another and have lasted at least two years. The hypomania and depression is not sufficient to warrant either a bipolar I or II diagnosis, yet sufficient to disrupts one's ability to function efficiently (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, there is some evidence for genetic and physiological factors as causes or triggers for it (American Psychiatric Association, 2013). Since this disorder runs in families, there appears to be a genetic basis for it. Major depressive disorder, bipolar disorder, and cyclothymic disorder often occur together in families. This suggests that these mood disorders share similar causes. These individuals also tend to have skill deficits in emotion regulation.

Treatment

Effective treatment of this disorder usually involves psychotherapy and medication. Psychotherapy, particularly cognitive behavior therapy (CBT), can be quite helpful in increasing emotional regulation. The challenge is to better manage daily life challenges. CBT helps those with this disorder in three ways. The first is develop better emotion regulation skills. The second is to identify unhealthy, negative beliefs and behaviors and replace them with more healthy and positive ones. The third is to identify triggers to both hypomanic and depressive episodes and better cope with upsetting situations. Medication may be helpful in emotional regulation. Medications like Lithium, Depakote, and Tegretol are particularly useful in regulating and stabilizing mood.

Len Sperry, MD, PhD

See also: Bipolar Disorder; Cognitive Behavior Therapy; Depakote (Divalproex Sodium); Depression; Lithium; Major Depressive Disorder; Tegretol (Carbamazepine)

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Cymbalta (Duloxetine)

Cymbalta is a prescribed medication used to treat depression and neuropathic pain. Its generic name is duloxetine.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat

depression and depressive disorders. They are known as antidepressants.

- **Neuropathic pain** is pain generated by the nervous system. It is also called neurogenic pain.
- **Selective serotonin norepinephrine reuptake inhibitors (SSNRI)** are medications that act on and increase the levels of serotonin and norepinephrine in the brain that influences mood. They differ from selective serotonin reuptake inhibitors, which act only on serotonin.
- **Serotonin discontinuation syndrome** is a condition caused by abrupt discontinuation of an SNRI resulting in withdrawal symptoms. These include flu-like symptoms, anxiety, agitation, vivid or bizarre dreams, insomnia, nausea, diarrhea, dizziness, headache, numbness and tingling of the extremities. This syndrome can be avoided by dose reduction over time.
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. It occurs when a number of medications that increase serotonin are taken together. Symptoms include high blood pressure, high fever, headache, delirium, shock, and coma.

Description

Cymbalta belongs to a class of antidepressant medications known as selective serotonin norepinephrine reuptake inhibitors (SSNRI). It is used to treat various disorders, including clinical depression, generalized anxiety disorder, and neuropathic pain associated with diabetic peripheral neuropathy and fibromyalgia. SSNRIs specifically act on two chemicals called serotonin and norepinephrine. It is believed that a decrease in serotonin and norepinephrine contributes to depression, anxiety, and pain. SSNRIs work by counteracting this by increasing the actions of both neurotransmitters. An increase of serotonin and norepinephrine in the brain is believed to reduce depressive symptoms, while an increase of both in the spinal cord reduces pain associated with diabetic neuropathy or fibromyalgia. Cymbalta has a high success rate in treating depression and is often the first SSNRI to be prescribed. Cymbalta can be used alone or in combination with other medications depending on the medical condition and the individual's health history.

Precautions and Side Effects

Antidepressant drugs, including Cymbalta, have been associated with an increased risk of suicidal thoughts and behaviors in children and adults up to age 24. Any patient taking an antidepressant drug should be monitored for changes in behavior and worsening depression. If treatment with Cymbalta is ceased, it should be slowly discontinued to avoid the development of SNRI discontinuation syndrome. Close medical monitoring is needed if Cymbalta is used with those with liver or kidney function impairment, seizure disorder, bleeding disorders, glaucoma, dehydration, and history of alcohol abuse and in patients younger than 25 years of age or those over 60 years. Cymbalta should be used only for a short time and with careful monitoring in those with bipolar disorder as it can induce mania. The safety of Cymbalta use during pregnancy and breast-feeding is unknown, so its use is not recommended.

Because SSNRIs have fewer side effects than SSRIs and tricyclic antidepressants, they tend to be the drug of choice in treating depression. Nevertheless, side effects may still occur. The most common are nausea, headache, dizziness, constipation, sexual dysfunction, diarrhea, sweating, dry mouth, shakiness, loss of appetite, hot flashes, high blood pressure, yawning, anxiety, and insomnia. Rare but serious side effects include mania, worsened depression and suicidality, seizures, serotonin syndrome, SNRI discontinuation syndrome, electrolyte imbalances, urinary retention, skin reactions, abnormal bleeding, liver damage, and glaucoma.

To reduce the likelihood of serotonin syndrome, Cymbalta should not be combined with antipsychotics like Thorazine or Prolixin or herbal supplements such as Yohimbine, ginkgo biloba, and St. John's wort. Drug interactions may occur when alcohol, Haldol, or NSAIDs are taken with Cymbalta. Other medications that can cause drug interactions with Cymbalta include Tagamet, Lithium, Inderal, and anticoagulant medicines. Others include diuretics (water pills), diet pills

such as Meridia, caffeine, antibiotics such as Cipro, mood stabilizers such as Lithium, antipsychotics such as Haldol and Clozaril, and antiseizure medications like Dilantin. There is increased risk of internal bleeding when Cymbalta is used with anticoagulant drugs such as aspirin and warfarin, and large doses of the herbal supplements red clover, ginkgo biloba, feverfew, or green tea.

Len Sperry, MD, PhD

See also: Antidepressant Medications; Depression

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Dahmer, Jeffrey (1960–1994)

Jeffrey Dahmer was a sexual predator and serial killer notorious for cannibalizing, that is, eating, many of his victims. He killed 17 males between 1978 and 1991, and was sentenced to 15 consecutive life terms in 1992. On November 28, 1994, he was murdered by a prison inmate.

Description and History

Dahmer was born in Milwaukee, Wisconsin, on May 21, 1960, to Lionel and Joyce Dahmer. His early upbringing was unremarkable until age 6, when he underwent minor surgery to correct a double hernia, and his brother was born. He is said to have become socially withdrawn and less self-confident. After high school, he enrolled in college but dropped out after one-quarter because of drinking and failure to attend class. Then he enlisted in the army but was dishonorably discharged because of his alcoholism. When his army superior berated him and said he would never amount to anything, Dahmer is reported to have said, "Just wait and see, someday everyone will know me."

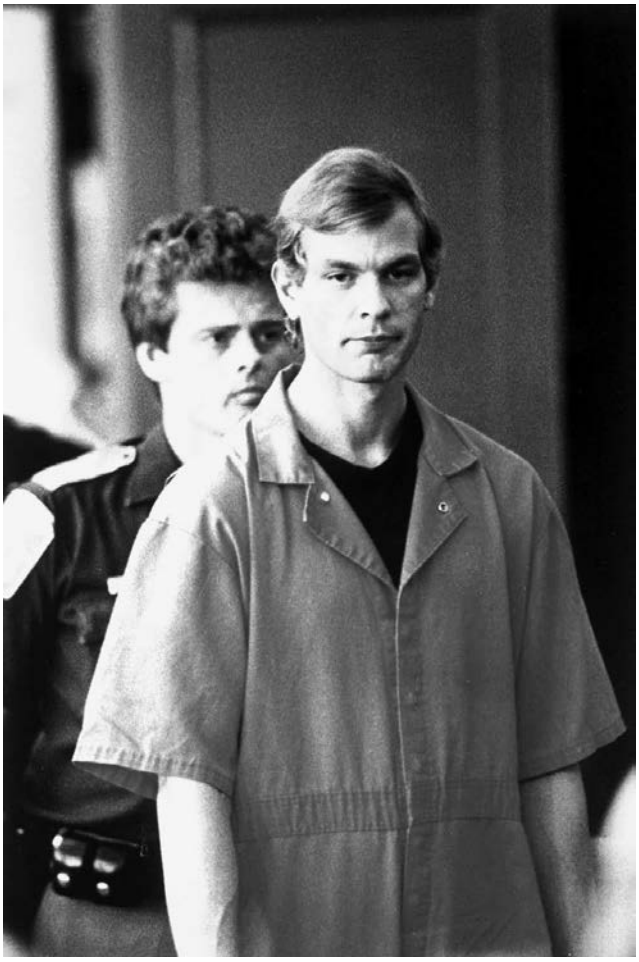
As an adult, Dahmer appeared to blend in easily in the middle-class neighborhood in which he lived. He was described as a quiet but likeable young man who held a job. At that same time he was a killer and sexual predator who murdered men and boys—most of whom were of African or Asian descent. Dahmer's murders were particularly gruesome because they involving rape, torture, dismemberment, necrophilia, and cannibalism. By the summer of 1991, Dahmer was murdering approximately one person each week and probably would have continued had he not finally been arrested after police searched his apartment.

Impact (Psychological Influence)

The story of Dahmer's arrest and the inventory in his apartment quickly gained national and international attention. Many were shocked to learn that several corpses were stored in acid-filled vats, and materials for an altar of candles and human skulls were found in his closet. Seven skulls were found in the apartment and a human heart was recovered from his freezer. Like many facile psychopaths, Dahmer had managed to avoid detection for years because of his uncanny ability to deceive police, parole personnel, and even mental health professionals with highly plausible stories and explanations.

He would entice victims to his apartment where he would drug them, strangle them, and then engage in various deviant sexual behaviors with the corpse prior to dismembering and eating it, at least parts of it. The key to this deadly sequence was drugging his victims, usually with benzodiazepines like Valium and Ativan or sleep-inducing medications like Ambien. Dahmer would grind the pills and mix them with coffee which he persuaded his victims to drink. The source of these pills were various physicians, including some psychiatrists with extensive training in forensics. He would complain of difficulty with anxiety and sleeplessness and convince these doctors that he really needed these medications. The fact that he had a long history of chronic alcoholism, dating from his high school and army days, should have been a contraindication to prescribing such medications. Nevertheless, he was consistently successful in conning physicians to provide him with the means to kill his next victims.

High-visibility psychopaths and serial killers seem to arise in every generation, but few have been as



Jeffrey Dahmer was a serial killer and sexual predator who murdered men and boys—most of whom were of African or Asian descent. Dahmer's murders were particularly gruesome because they involved rape, torture, dismemberment, necrophilia, and cannibalism. (AP Photo/Eugene Garcia)

gruesome and evil as to strangle, kill, sexually abuse, and cannibalize their victims like Dahmer. Jeffrey Dahmer appears to have made good on his promise to his army superior that "someday everyone will know about me."

Len Sperry, MD, PhD

See also: Lies and Deceit; Mass Shootings; Psychopathic Personality Disorder; Sexual Predator

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Dance Therapy

Dance therapy is the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual. It has been shown to be an effective therapeutic treatment by improving the well-being of those with social, physical, and/or psychological challenges.

Description

Dance therapy has been utilized as a healing ritual for thousands of years. Although dance therapy finds its roots among indigenous people, it wasn't formalized into a specific treatment modality until the 20th century. Thus, dance therapy is considered to be a relatively new practice; however, it has already been shown to be a viable treatment for a wide variety of mental and physical challenges.

For example, dance therapy has been studied as a treatment for dementia, depression, alcoholism, heart disease, diabetes, and many more mental and physical ailments—often with statistically significant positive results. It is important to note that there has long been a connection between therapy and dance; however, as a formal discipline, it remains a fairly new approach.

With the growing development of counseling theories and techniques, new ways of treating mental health challenges are being identified. Dance therapy, depending on the theoretical perspective of the therapist, is conducted either individually or in a group format. Regardless of perspective, the participant's dance identity must be considered. Dance therapy has been identified as an alternative medicine by the National Institute of Mental Health as it is an expression of the mind and body. Movement reflects personality and has an advantage over traditional talk therapy since it includes assessment of the nonverbal body movements. Dance therapy is considered to have a positive impact on a person's well-being.

There are two models that tend to be the most commonly utilized by practitioners. The first is Dance/Movement Therapy, which was developed in the United States during the 1940s. This model has been widely accepted by dance therapists in the United States. This model has its roots in modern dance tradition and encourages movement without any form of limitation. Here, the emphasis is on body-self, body weight, knowledge of the body, and creation of a safe space. This therapy is conducted either individually or in a group format.

The other model is Expression Primitive, which originated in France in 1984. This model came from the French Society of Dance Therapy. The view of this model is that dance therapy is ritualistic and present in every aspect of life. Dance is conducted in a group format with the individual following verbal or physical directives given by the therapist.

These two models are distinct from one another, and those in the field tend to choose the model they identify with and often question the effectiveness of the other. One large difference between the two is that The American perspective is that dance occurs under special conditions. The focus of disagreement between the two models is also focused on the differences in the forms of dance.

Current Status

Dance therapy is currently a supported form of alternative medicine by the National Institute of Mental Health. It has also been accepted by the Association for Creativity in Counseling, which is a recognized division of the American Counseling Association. Current research has found support for its effectiveness with specific disorders, such as eating disorders and alcoholism.

Mindy Parsons, PhD

See also: Eating Disorders; Expressive Arts Therapy; Substance-Related and Addictive Disorders

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Organizations

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Darkness Visible: A Memoir of Madness (Book)

Darkness Visible: A Memoir of Madness was written by William Styron (1925–2006) and published in 1990. Although an abridged version of the book was originally published in 1989 in the magazine *Vanity Fair*, the origins can be traced back to a lecture the author gave on affective disorders at the Department of Psychiatry at Johns Hopkins University's School of Medicine. This first-person account of his near-fatal descent into depression is considered one of the most vivid and insightful, even after more than 25 years since it was first published. The title of Styron's book is highly symbolic; it was taken from John Milton's description of hell in *Paradise Lost*.

William Styron was considered among the greatest American writers of his time following the release of his first novel, *Lie Down in Darkness*, published in 1952 when he was just 26 years old. He won a Pulitzer Prize for his second novel, *The Confessions of Nat Turner*, and his 1979 novel *Sophie's Choice* was made into an Academy Award–nominated movie in 1982 and an opera in 2002. However, he may be best known for his 1990 personal memoir of depression, *Darkness Visible: A Memoir of Madness*, which became a national best seller in 1990.

The impact of *Darkness Visible* has yet to wane, even though decades have passed since its original publishing. Although just 85 pages, the clarity of Styron's description of his depressive condition led to the book being embraced by both critics and mental health professionals alike. At the time, the memoir was considered groundbreaking in that it served to greatly increase knowledge about major depressive disorders and the often-accompanying act of suicide. It also helped to decrease the stigma and shame associated with depression that had long been kept silent among its sufferers.

Prominent American author William Styron's 1990 memoir, *Darkness Visible*, chronicled his terrible struggles with depression. (ZUMA Press, Inc./Alamy)

Styron chronicles the rapid onset of his depression and blames the abrupt end to years of alcohol abuse in combination with a prescription of Halcion (triazolam). Although he never attempted suicide, he painfully shares his intense suicidal ideation that kept him bedridden for months and ultimately led to his hospitalization.

One of the most valuable contributions of Styron's memoir is that it was the first book to help break the silence surrounding depression and refuted the idea that depression was suffered mainly by weak-minded individuals, especially those who attempted or completed suicide. However, perhaps the greatest impact of *Darkness Visible* is the message that no matter how severe depression may get, hope and even redemption is possible through perseverance.

Mindy Parsons, PhD

See also: Major Depressive Disorder; Suicide

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Date Rape

The term "date rape" refers to an act of sexual assault perpetrated by a person with whom the victim has been acquainted with (not a stranger). It is also referred to as "acquaintance rape."

Definitions

- **Consent** is an act of voluntary willingness.
- **Rape** occurs when sexual intercourse (vagina, anus, or mouth) is not consensual, or the perpetrator forces himself on the victim sexually against the victim's will.
- **Sexual assault** is an involuntary sexual act whereby a person is forced to engage in any type of sexual activity (touching, kissing, sexual penetration) against his or her will; it is used in legal terminology to refer to a statutory offense.

Description

"Date rape" refers to an act of nonconsensual sexual intercourse that is committed by a person the victim knows, usually a friend or acquaintance. It is also referred to as "acquaintance rape" or "drug-induced sexual assault." Date rape is distinguished from rape in that the victim knows the attacker socially. The victim may even have been involved in a romantic relationship with the attacker. Both men and women can be victims of date rape. Incidents of date rape oftentimes occur when the victim is under the influence of alcohol or drugs. Rohypnol and gamma-hydroxybutyrate are considered "date rape drugs" and have been linked to these cases of sexual assault. Date rape is a serious crime and is classified as a felony offense. Victims of date rape suffer from physical and emotional abuse.

Impact (Psychological Influence)

Date rape is much more common than incidents of rape perpetrated by a stranger. Estimates suggest that 80%–85% of all reported rapes can be classified as date rape. However, instances of date rape are also underreported as victims may not recognize these acts as a crime. Feelings of guilt over not knowing what happened, perhaps due to drugs or alcohol, are also contributing factors. The United States Bureau of Justice indicated that 38% of reported rapes were perpetrated by a friend or acquaintance, and in 28% of cases, the attacker was considered "an intimate," while in 7% of the cases the attacker was "a relative" (Rape Statistics, 2012).

Melissa A. Mariani, PhD

The term "date rape" refers to an act of sexual assault perpetrated by a person with whom the victim is acquainted (rather than a stranger). Incidents of date rape oftentimes occur when the victim is under the influence of alcohol or drugs. All forms of rape can have profound psychological consequences, including depression, anxiety, feelings of shame, and post-traumatic stress disorder (PTSD). (Innovatedcaptures/Dreamstime.com)

See also: Sexual Abuse; Sexual Predator

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Dating and Flirting

Dating is social courting done by two people who each want to see if the other is a possible intimate relationship partner or spouse. Flirting includes verbal and nonverbal communication by one person to another that suggests an interest in a physical or romantic relationship with the other person.

Description

Social rules regarding dating vary according to variables such as country, social class, religion, age, sexual orientation, and gender. Behavior patterns of dating and flirting are generally unwritten and constantly changing. There are considerable differences between social and personal values. Each culture has particular patterns that determine flirting and dating norms. These include choices such as whether the man asks the woman out and where people might meet. Other questions include whether kissing is acceptable on a first date and who should pay for meals or entertainment. Depending on where you live and who you are, the social choices and questions involved are complex.

The term "dating" most commonly refers to a trial period in which two people explore each other. Dating can also refer to the time when people are physically together in public as opposed to the earlier time period in which people are arranging the date, perhaps through corresponding by e-mail or text or phone. Another meaning of the term "dating" is to describe a stage in a person's life when he or she is actively pursuing romantic relationships with different people.

One of the main purposes of dating is for two or more people to evaluate one another's suitability as a possible long-term companion or spouse. Often physical characteristics, personality, financial status, and other aspects are judged and as a result feelings can be hurt and confidence shaken. Dating can be stressful for those involved because of the uncertainty of the future, the desire to be acceptable to the other person, and the possibility of rejection. Dating often lets those involved get a chance to decide where to take the relationship. If the dating experience is positive, two people usually move into a more permanent or committed relationship.

Flirting requires several different skills that involve body language, empathy, and creativity. Flirting can be used either in trying to find someone to date or in trying to get a desired object or outcome in a situation. Research has been conducted on flirting techniques used in bars, malls, and other places where young people go to meet each other. Results of this research indicate that it is not the most physically appealing people who get approached but the ones who send specific signs. These people signal their availability and confidence through basic techniques like eye contact and smiles. Signaling your interest in someone gets you halfway there, whether you're a man or a woman.

Two types of flirting exist and are fairly universal. Smiling and eye contact indicate flirting and are effective in most places and for most people. But an even more effective flirting technique is touch. Research has been done to identify which types of touching are flirting, such as touching the shoulder, waist, forearm, and, most intimately, the face. Flirting can be done to let another person know you're interested in him or her romantically or sexually. It usually occurs before and during the dating process. Touching that is gentle and informal, and that occurs face-to-face or involves hugging, lets someone else know that the person intends to continue pursuing the relationship.

Impact (Psychological Influence)

There are some identifiable differences in the ways that men and women in heterosexual relationships date and flirt. Research suggests that men prefer women who seem to be flexible and admired. Men also tend

to date younger women with subordinate jobs such as assistants rather than executive women. Online dating patterns suggest that men are more likely to initiate online exchanges. It also indicates that men are less picky than women and seek younger partners and tend to cast a wider net in the pool of women they choose. The stereotype for heterosexual women is that they seek well-educated men who are usually older and have high-paying jobs. Much of the research suggests that women are the pickier of the genders and that is linked to reproductive decision making.

Alexandra Cunningham, PhD

See also: Self-Esteem; Shyness

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de Shazer, Steve (1940–2005)

Steve de Shazer was a psychotherapist who, along with his wife Insoo Kim Berg, developed solution-focused brief therapy.

Description

Steve de Shazer (1940–2005) and his wife, Insoo Kim Berg (1934–2007), had both been trained in traditional psychoanalytic or Freudian therapy. They were frustrated because they found that it often didn't work to help clients resolve their issues. In fact they felt it was harmful and led to an endless cycle of investigating the origins of the client's issues. Because of these concerns, de Shazer and Kim Berg developed a new form of therapy called solution-focused.

Solution-focused brief therapy (SFBT) differs from other approaches to the treatment of psychological problems. The couple based SFBT on the concept that although causes of problems may be extremely complex, their solutions do not necessarily need to be. Their therapeutic approach decided to focus on simple, doable solutions. Together de Shazer and Kim Berg founded the Brief Family Therapy Center in Milwaukee, Wisconsin, during the 1980s.

SFBT, as a therapy model, does not put emphasis on the need to examine past problems. The approach focuses on the clients' assessment of how their lives or experiences might be different if they didn't exist at all. From this focus, the therapist builds approaches based on the clients' own strengths and previous successes. SFBT is based on solution building rather than problem solving.

Steve de Shazer and his wife were able to help clients build those solutions from insights and responses to what they called "the Miracle Question." The miracle question was an intervention; it asked the client to think differently by responding to this question: "If you woke up tomorrow and a miracle occurred and the problem had completely disappeared, even though you didn't know why, what small changes would tell you that it had been solved?" By asking their clients to describe how they would know the problem was resolved, and to evaluate how important the symptoms of improvement were, they could work with them to create change.

Impact (Psychological Influence)

SFBT has been widely practiced and accepted in the therapeutic community. Its hallmark is to focus on creating solutions rather than rehashing problems. de Shazer was specifically in charge of researching the approach, which helped solidify SFBT not only as a foundational theory but also as a practice that could be taught to future practitioners. The small, positive changes that are based on the client's perspective make it appealing to both professionals and their clients.

The SFBT approach is criticized for some weaknesses such as not allowing for exploration of family history and patterns as well as the limited applicability to those experiencing chronic or severe disorders. Steve de Shazer and Kim Berg admitted that their approach would not be effective in about 20% of client cases. But it has been adapted for use in a variety of different environments. This includes clinical therapy

groups, schools, and hospital nursing staffs. Clinical and research results indicate that SFBT makes a positive difference and Steve de Shazer helped to validate and make this approach known among mental health professionals.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Solution-Focused Brief Therapy (SFBT)

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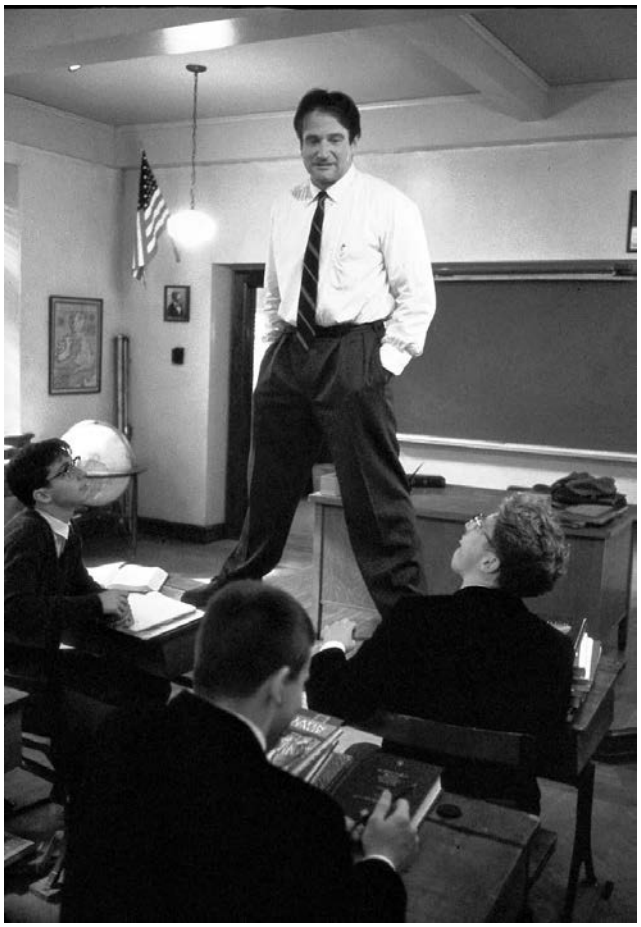
Dead Poets Society (Movie)

Dead Poets Society is a 1989 American-period film directed by Peter Weir and starring Robin Williams.

Description

In the movie *Dead Poets Society*, Robin Williams (1951–2014) portrays an inspiring English teacher at an exclusive Vermont private boys' academy in 1959. *Dead Poets Society* is perhaps best known for several iconic scenes in which Williams's character, John Keating, dramatically and idealistically inspires his students. Central themes include individualism, freethinking, self-empowerment, and living significant, meaningful lives in light of issues of mortality and death.

Set in 1959 the movie follows a class of students at the Welton Academy, a conservative prep school for boys. The story focuses on the impact a new and unconventional English teacher, John Keating, has on their lives. Keating, a former student at Welton, exposes the students to classic poetry in ways that are controversial and unorthodox for the time and setting. For instance, finding the mathematical formula to rate poetry absurd, Keating has students rip out the introduction of the poetry textbook. In another scene, Keating has students stand on their desks in order to see life from a different perspective. In perhaps the most iconic scene, Keating gathers his students in front of a trophy case with pictures of alumni from years long past. Quoting from a poem by Robert Herrick "Gather ye rosebuds while ye may," Keating tells the boys that the meaning of the poem is about "carpe diem," which means "seize the day." Keating tells his students "Because we are food for worms, lads. Cause believe it or not each and every one of us in this room is one day going to stop breathing, turn cold, and die. Therefore, seize the day, boys. Make your lives extraordinary" (Internet Movie Database, 2013).



Dead Poets Society portrays an inspiring English teacher (played by Robin Williams) at an exclusive Vermont private boys' academy in 1959. The film has been used to illustrate concepts such as empowerment and individuality. (Buena Vista/Photofest)

The students are both captivated and inspired by Keating's ideals. Keating encourages the students to revive the "Dead Poets Society," which meets secretly in a cave where they may reflect on how to "suck the marrow out of life," pursue their dreams, and find their voice. The movie follows several of the students' personal difficulties, challenges, and triumphs as they are changed by what they are leaning. For one student, Neil, his quest to find his own voice leads him to pursue acting and perform in a local play. This is in defiance of the plans his controlling authoritarian father has for him to become a medical doctor. Neil turns to Keating who encourages Neil to speak with his father to help him understand how he feels. Neil attempts to confront his father but is bullied and threatened with military school. Unable to reason with his father, Neil commits suicide.

An investigation is launched, and Keating is accused of abusing his authority, inciting rebellion, and encouraging Neil to defy his father. After being betrayed by one of the students, Keating is made a scapegoat for Neil's death and is fired. Entering the classroom one last time to retrieve his personal belongings, Keating is honored by the students standing on their desks in defiance of the headmaster.

Impact (Psychological Influence)

Dead Poets Society was well received by the viewing public and maintains an 85% Rotten Tomatoes rating. The film was nominated for four Academy Awards and won for best Original Screenplay (Tom Schulman). It is recognized as one of Robin Williams's best roles and performances.

Dead Poets Society is used as a teaching film in a wide range of topics, including innovative teaching techniques, teacher/student relationships, mentoring, and lessons on empowerment and individualism. More recently, *Dead Poets Society* has been criticized for whether the main character, John Keating, is a positive or negative example for a teacher. Was he inspiring students to love poetry or to love him; to think for themselves or to think like him? The film also called into question the ethical responsibilities teachers have when instructing and mentoring impressionable students. How responsible was Keating in Neil's death?

Dead Poets Society is a highly popular and highly rated American film that explores issues of self-empowerment and meaning in life. The movie remains one of the most popular Robin Williams films and continues to be used in a wide range of educational settings.

Steven R. Vensel, PhD

See also: Self-Identity

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Death, Denial of

The denial of death is when someone refuses to accept the concept of mortality for either himself or herself or someone else. Death is something that all living creatures experience at some point in their lives. It is an inevitable part of life that affects everyone. Many struggle to come to terms with the inevitable end of their own life or the loss of another.

Description

Within the United States the discussion of death is often considered a taboo topic of conversation. There are many implications with dealing with grief and loss for the loss or pending loss of a loved one or demise of one's self. Denial of death can occur for those who are terminally ill and seeing the end of their own life coming or for those who are anticipating the loss of a loved one or have already lost that person.

The loss of a loved one can lead a person to experience shock, increase his or her desire to connect with others, or bring on sadness, regret, and other mixed emotions. It is important to note that there are different attitudes toward death among various cultures. These variations can play a role in how an individual deals with death.

Humans have always contemplated the meaning of life and mortality. Regardless of how hard someone tries to ignore the awareness of the loss, symptoms will present through stressors, depressing thoughts, anxieties, or conflicts. Unfortunately, to be focused on the denial or fear of death can prevent people from living fully because so much energy is spent on the denial and avoidance of death. Freud argued that denial and fear of death is universal and a biological inheritance; however, therapists can help clients move past this fear or denial of death by working on acceptance.

Current Status

In the time of grief and loss or when someone is struggling with the acceptance of the end of life, therapists may be called on to assist with the transition. Tragic or unexpected loss can be very difficult for a person to come to terms with, especially the loss of a loved one. In 2012 and 2013, U.S. citizens experienced several large-scale tragedies, the Sandy Hook Elementary school shooting in Newtown, the Colorado movie theater shootings, devastating tornados in Oklahoma, the Boston Marathon bombing, and a plant explosion in Texas, all which cost many their lives. Agencies such as the Red Cross and other disaster reliefs are now including therapists and licensed practitioners as part of the first responders to meet the mental and emotional needs of those dealing with the loss of a loved one.

Mindy Parsons, PhD

See also: Grief; Palliative Care; Psychological Factors Affecting Other Medical Conditions; Terminal Illness, Psychological Factors

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Defense Mechanisms

Defense mechanisms are unconscious psychological processes by which individuals unknowingly attempt to reduce anxiety or conflict. These can be either healthy or detrimental for the individual.

Definitions

- **Coping strategy** is a conscious process employed by an individual to reduce anxiety or resolve a conflict or problem.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. This is the original theory of Sigmund Freud.
- **Unconscious** is an aspect of the mind which operates without awareness and over which one does not have active control. In contrast, the subconscious mind lies just below consciousness (awareness), and it is easily accessible if attention is paid to it.

Description

Defense mechanisms are psychological processes by which an unconscious drive that is incompatible with the world or one's sense of self is resolved. This process can also serve to protect an individual from the experience of fear, anxiety, and guilt. It can occur without the individual being initially aware that it is happening. Defense mechanisms are sometimes confused with coping strategies. The difference is that coping strategies are conscious efforts for dealing with conflicts. In contrast, defense mechanisms are unconscious efforts.

Defense mechanisms date back to the work of Sigmund Freud, the originator of psychoanalytic theory. Originally called "ego defense mechanisms," Freud

suggested that drives associated with the id (unconscious and primitive instincts) conflicted with the superego (moral part of self) representing societal rules and ideas of fairness. The reason it was called ego defense mechanism is that he believed the ego was the part of the self that resolved the conflict between the id and the superego. Although his model of ego is no longer used, his work served as the basis of contemporary defense mechanisms.

Defense mechanisms are numerous and unique. Here are descriptions of some of the more common defense mechanism.

- **Denial** is the defense mechanism whereby the consequences, implication, or a disturbing event is blocked or denied, as if they have never happened. For example, an individual who is on the verge of bankruptcy may continue unsustainable spending when it is otherwise obvious that he or she should change spending habits. Individuals may completely deny an obvious fact, or they may also acknowledge that fact but deny the consequences. This is similar to repression except for in repression it is disturbing thoughts, not a physical reality that is denied.
- **Displacement** is the unconscious refocusing of negative feelings or impulses on to a different object, usually one that has less power to retaliate or threaten. For example, an employer, someone who is very difficult to retaliate against, may unfairly reprimand an individual. Instead of responding to the employer, the employee unknowing takes his or her aggression out on the family pet on returning home. This is similar to sublimation, except for in sublimation the transmutation of the impulse of thought is typically more acceptable.
- **Intellectualization** is characterized by unknowingly denying the emotional or meaningful content of thoughts or events. Instead, the individual considers the event in a removed or overly objective manner. That is to say that they deal with the event intellectually and not emotionally. For example, a parent may be unable to knowingly accept the death of a child and subsequently may act robotic and unemotional toward spouse or others.
- **Projection** is a mechanism in which individuals extend some thought or quality about themselves on to another. For example, an individual may be unconsciously unwilling to accept that he or she has not achieved a high level of success and project this notion on to others. Subsequently, the individual may see or accuse others of being lazy or not achieving their potential.
- **Rationalization** is the most commonplace of defense mechanisms. This is characterized by explaining unacceptable events or thoughts with a logical argument while not acknowledging an apparent truth. For example, a student who receives a poor grade on a test may blame a professor for poor teaching when, in fact, the student did not study sufficiently.
- **Reaction formation** is the mechanism whereby an individual acts in a way contrary or opposite to his or her true sentiments. For example, if a man is attracted to a woman but unconsciously fears rejection, he may act cold and uninterested even if the woman acts as if she may be interested.
- **Regression** is characterized by a reaction to a disturbing event that is indicative of a less mature level of development. For example, an adult may experience significant financial hardship and revert to a childlike dependency on friends or parents.
- **Repression** is characterized by the unconscious blocking of disturbing thoughts from conscious awareness. An individual unknowingly represses difficult or unacceptable thoughts to such an extent that he or she is completely unaware of the disturbing thought having ever taken place. For example, an individual may have been exposed to abuse and acknowledge that it happened but be consciously unaware of any feelings about the event. This is similar to

denial, but different in with denial is the event itself that is blocked, not thoughts.

- **Sublimation** is a defense mechanism whereby an individual transfers the energy of a disturbing event or thought and expresses it in a more acceptable form. For example, someone who experienced a great deal of pain in childhood made unknowingly express his or her pain in art of exercise. This mechanism is similar to displacement except for in displacement the energy is transferred in to another object and is not necessarily dealt with in a more acceptable manner.

Defense mechanisms are no longer listed in DSM-5; however, they were listed in the previous DSM-4 as an area to be studied further. Although they are not listed in the current DSM, they are nonetheless useful to a clinician in assessing clients and understanding their behavior.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM)

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Deinstitutionalization

Deinstitutionalization is the release of a person with mental or physical disabilities from a hospital, asylum, or other medical institution, usually with the intention of providing treatment, support, or rehabilitation through outpatient community resources.

Description

Until the 1960s, American citizens who were diagnosed with severe mental illnesses, like schizophrenia, were institutionalized in government-run mental hospitals. These people were deemed to require long-term or permanent professional care and institutions were often called asylums for the insane. Government policy beginning in the 1960s refocused the concept of care for those with severe mental illnesses. In the movement of deinstitutionalization, the government decided to transfer responsibility for mental health care from state government to local care centers that would be funded largely by the federal government.

The deinstitutionalization of mental health care was made possible by several factors. The first was a change in the way society viewed the need and benefit of institutionalizing people with mental health issues. Mental health professionals began to feel that the large-scale institutionalization of people made them more dependent. Many believed that it accustomed patients to being passive recipients of care without encouraging them to change their circumstances or return to the outside world. Overall, people began to develop new attitudes toward those with mental health issues. People began seeing them no longer as patients for life but rather as people with treatable problems. Many believed that their issues could be resolved better within society rather than by removing them from society.

The second factor that promoted this movement was the possibility of controlling thinking and behavior through drug treatment. With patients whose symptoms indicated they were doing well and whose medication was managed, it was deemed that they could once again participate in normal society. And, finally, the last factor that made deinstitutionalization possible was the shift of financial support of these facilities from states to federal budgets. This process began in the United States and soon spread to Europe.

Current Status and Impact (Psychological Influence)

Among most people deinstitutionalization was considered a success in terms of reducing the number of mental health patients in hospitals by 75% between 1955 and 1980. But there have been criticisms of the movement. One is that there is a high cost in terms of the poorer quality of patient care that may be available in community service settings. Some say that hospitalization programs provide better quality care. Another factor that many believe credible is that some patients

who would have been cared for in psychiatric institutions are now in prisons. This likely includes people who suffer from paranoid delusions or types of dementia. Those disorders may lead them to refuse help because they either believe that people are trying to hurt them or that they do not need the help. Many people experiencing psychosis break the law and end up in the prison system instead of in medical treatment.

Inpatient hospital treatment does still exist in the United States and internationally. Most of these institutions, however, are privately owned and operated. Several privately run mental institutions provide services to patients who have broken the law but have been deemed mentally unfit and therefore instead of prison sentences they are ordered to seek inpatient hospital treatment. For these patients, their stays can range in time from a few months to decades.

The shift from hospitalization to community-based treatment has resulted in some concerns. From some perspectives, community-based services are not always adequate to the task of meeting the complex needs of all patients. This could lead to a portion of those with mental health issues who are living homeless, jobless, or with limited social connections. Today, many families are forced to provide care that once would have been more widely available from state institutions. Deinstitutionalization by itself is not the simple solution to a difficult and long-term mental health-care problem. But it has given people with mental illness or disabilities the opportunity to have access to the community and gain as much independence as possible.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Crisis Housing; Homelessness; Hospitalization

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Delayed Ejaculation

Delayed ejaculation is a mental disorder characterized by a male's delay, difficulty, or inability to reach sexual orgasm. It is also referred to as male orgasmic disorder.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Orgasm** is the peak of sexual excitation characterized by extremely pleasurable sensations.
- **Sensate focus exercises** are series of touching *exercises* designed to increase intimacy in a relationship. It is also called sensate focusing.
- **Sexual dysfunctions disorders** are a group of mental disorders characterized by significant difficulty in the ability to respond sexually or to experience sexual pleasure. Disorders include female organismic disorder and delayed ejaculation.
- **Sexual orgasm** is orgasm attained through sexual intercourse instead of self-stimulation or oral stimulation.
- **Systematic desensitization** is a form of cognitive behavior therapy that gradually exposes individuals to their phobia, while remaining calm and relaxed.

Description and Diagnosis

Delayed ejaculation disorder is one of the DSM-5 sexual dysfunction disorders. It is characterized by delay, difficulty, or complete absence of sexual orgasm in males during otherwise normal sexual activity. Some with this disorder indicate that they avoid sex because

of it. There is no consensus on what constitutes a delay in ejaculation. For this reason, the male's self-report is the basis for making the diagnosis. Delayed ejaculation is relatively rare, affecting less than 1% of men (American Psychiatric Association, 2013). However, this disorder is more likely to occur after the age of 50.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, this diagnosis requires the following criteria to be met. First, the male must experience a delay or absence of sexual orgasm in 75% or more occasions of sexual activity with his partner. This delay must be present for at least six months and cannot be attributable to relationship stress, use of medications, another disorder, or a medical condition. In addition, it must cause the male considerable distress. Some individuals may experience this disorder for their entire lives or may develop symptoms following a period of otherwise normal sexual functioning. Also, symptoms may be present in certain situations or may always be present. The condition is further specified (diagnosed) as mild, moderate, or severe.

The cause of this disorder is not well understood. However, it is believed to be associated with relationship or partner issues, a history of sexual abuse, and stress. Cultural factors, religious issues, and social factors can also cause or complicate the disorder.

Treatment

The goal of treatment is to restore normal sexual functioning. The first step in the treatment of this disorder is to identify and treat any physical cause or mental disorder. Like female orgasmic disorder, this dysfunction may have numerous cultural or social factors that must be considered. Therefore, treatment must be focused not only on the physical aspects of the disorder but also on the individual's beliefs and personal history. Treatment most commonly includes psychotherapy. Typically, this involves cognitive behavior therapy and specifically sensate focus exercises and systematic desensitization. Involving the spouse or sexual partner may be necessary if relational issues are present or sensate focusing is used. It is not uncommon for the partner to believe that he is no longer attracted to her because of his inability to reach climax. This and other concerns can lead to additional complications unless they are addressed in treatment. Specific medications are sometimes used in the treatment of this disorder.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Female Orgasmic Disorder; Sexual Dysfunctions; Systematic Desensitization

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Deliberate Practice

Deliberate practice is the intentional effort to achieve a level of expertise that is just beyond an individual's level of proficiency. It is also known as purposeful practice.

Definitions

- **Deliberate practice** is the intentional effort in striving to attain increased expertise just beyond an individual's level of proficiency.
- **Expertise** is the special knowledge or skills in a particular subject or area learned from experience or training and a high level of proficiency in utilizing that knowledge or skills.
- **Feedback** is information about how well or badly an individual is performing a task and is intended to help the individual perform it better.
- **Practice** is the act of rehearsing or engaging in an activity repeatedly in order to improve performance.
- **Self-reflection** is the process of examining one's own thoughts, feelings, and motivations in order to grow and change.

Description

Expertise is a lifelong process of continued development extending over several years of professional practice. More specifically, it requires years of professional training, professional experience, and challenges to be confronted and overcome on the path to expertise. It also requires an awareness of one's limitations, which motivates the individual to continue learning and developing throughout his or her career. Research suggests that it takes a minimum of 10 years for a high level of expertise to be achieved. This means 10 years of progressively increasing expertise, rather than 1 year of limited expertise that is repeated 10 times. The difference between the two is deliberate practice.

Deliberate practice differs considerably from practice. The key difference is intentional, stretching beyond one's current level of proficiency. Deliberate practice involves setting a stretch goal for performance, using specific interventions to master a specified task, seeking and using feedback, and engaging in self-reflection to optimize performance and increase expertise. In learning new skills, deliberate practice involves engaging in increasingly difficult elements of the skill. Setbacks and frustration are inevitable, and persistence and learning through failure, although unpleasant, are also necessary. Seeking ongoing feedback can greatly enhance deliberate practice. Then, it means using the feedback to alter the course or direction of treatment. Being open to feedback is part of deliberate practice. Finally, deliberate practice is fostered by the use of self-reflection.

Developments and Current Status

In 1980, two researchers, Stuart Dreyfus (n.d.) and Hubert Dreyfus (1929–), proposed that a learner passes through five distinct stages of developing expertise. These two brothers named the stages: novice, competence, proficiency, expertise, and mastery. Since then, the scientific study of expertise has expanded rapidly. Initially, this research focused on athletes, musicians, and chess players. Studies by psychologist K. Anders Ericsson (1948–) found that at least 10,000 hours of deliberate practice spread over at least 10 years was necessary to develop expertise. Now, this research has extended to physicians, psychotherapists, and elementary school students.

Len Sperry, MD, PhD

See also: Evidence-Based Practice; Psychotherapy

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Delirium

Delirium is a mental disorder characterized by rapid onset of extreme disorientation and confusion.

Definitions

- **Dementia** is the deterioration or loss of mental processes, particularly memory and confusion.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neurocognitive disorders** are a group of disorders in DSM-5 that are characterized by a decline from a previous level of neurocognitive (mental) function.

Description and Diagnosis

Delirium is one of the neurocognitive disorders of the DSM-5. It is characterized by severe disorientation and confusion. Individuals who experience delirium

appear to be bewildered and are unable to comprehend attempts to communicate. While this condition is most often acute, it can be chronic for some, particularly the elderly. Since the symptoms of delirium and dementia can be similar, it is essential that an accurate diagnosis be made by a trained physician or clinician.

This disorder is relatively rare in the population as a whole, affecting between 1% and 2%. However, over the course of an individual's lifetime it is not unlikely that the individual may experience delirium at some point. With increasing age, the chances of experiencing delirium increase significantly, especially in hospital and nursing facilities. In fact, delirium occurs in 15%–53% of individuals after a surgery and approximately 80% of those in intensive care. In addition, 83% of individuals experience delirium as they are dying (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience difficulty in focusing their attention and awareness, and are disoriented. These symptoms must have developed over a short time period and tend to fluctuate in severity. Also, the symptoms must be accompanied by some limitation in memory, coordination, or ability to communicate. Finally, there must be evidence that the disturbance has been caused by a substance, medication, or a medical condition or exposure to a toxic substance (American Psychiatric Association, 2013).

Unlike most mental disorders, the cause of delirium is well understood. It usually results from medical conditions that deprive the brain of oxygen or induce chemical imbalances. Most commonly these are dehydration or infections such as pneumonia, urinary tract infection, and abdominal infections. Other causes include alcohol or drug intoxication or withdrawal, exposure to a poison or toxic substance, and surgery. Some medications, like allergy medications, or combinations of medications can trigger delirium.

Treatment

The primary focus of treatment is to address the underlying cause or causes. Usually this means treating an infection, giving oxygen, or stopping the use of the medication or substance. Treatment then focuses on calming the brain and reducing disorientation using reorientation techniques. These include memory cues such as a calendar and clocks, and making the environment stable, quiet, and well-lighted. In many cases, the condition will resolve without the use of drugs or treatment.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Dementia; Alzheimer's Disease

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Delusional Disorder

Delusional disorder is a mental disorder characterized by delusions. Previously this disorder was referred to as paranoia or paranoid disorder.

Definitions

- **Antipsychotics** are prescription medications used to treat psychotic disorders, including schizophrenia, schizoaffective disorder, and psychotic depression.
- **Delusions** are fixed false beliefs that persist despite contrary evidence. The can be bizarre or non-bizarre (could occur in real life, such as being followed or conspired against).
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Psychoeducation** is a psychological treatment method that provides individuals with knowledge about the condition as well as advice and skills for reducing their symptoms and improving their functioning.

- **Psychosis (psychotic disorder)** is a mental disorder characterized by a loss of touch with reality and psychotic features.
- **Psychotic features** are characteristics of psychotic disorders: delusions, hallucinations, disorganized thinking and speech, grossly disorganized or abnormal motor behavior, and negative symptoms, for example, lack of initiative and diminished emotional expression.
- **Schizophrenia spectrum and other psychotic disorders** are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, schizophreniform disorder, schizoaffective disorder, and schizotypal personality disorder, and delusional disorder.

Description and Diagnosis

Delusional disorder is one of the schizophrenic spectrum and other psychotic disorders. It is characterized by non-bizarre delusions, which is the signature feature of this disorder. This diagnosis requires the presence of persistent, non-bizarre delusions, without the other psychotic features characteristic of other schizophrenia disorders. In fact, most with the disorder can be sociable and appear quite normal as long as their delusions are not triggered in conversation. But, when triggered, these individuals are likely to express their strange beliefs. Because their psychosis is limited and contained, these individuals are able to function reasonably well in other areas of their life. That means that professionals like physicians, lawyers, and teachers who are delusional can otherwise function in their jobs and personal lives. However, there are some who become so preoccupied with their delusion that their lives become disrupted.

Several types of delusional disorders can be specified, each of which reflects a dominant delusional theme. These include the *Erotomanic Type*, with the theme that someone of a higher status is in love with the individual. In the *Grandiose Type*, the theme involves inflated power or a special relationship to a deity or famous individual. In the *Jealous Type*, the theme involves the unfaithful of the individual's sexual partner. In the *Persecutory Type*, the theme involves being abused or treated malevolently. In the *Somatic Type*, the theme involves having a physical defect or medical condition. Delusional disorder is a rare disorder and is found in approximately 0.2% of adults. The jealous type is more common in females, while the persecutory type is more common in males (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit one or more delusions. Such delusions are manifest for at least one month. In addition, there are no positive symptoms of schizophrenia such as hallucinations. If hallucinations are present, they are related to the theme of the delusions. Functioning at work or in relationships is not significantly impaired. Nor is the individual's behavior considered odd, bizarre, or eccentric. If a major depressive episode or a manic episode has occurred concurrently, these episodes have been relatively brief. The symptoms of this disorder must develop during or within one month of intoxication by or withdrawal from the substance. Finally, the disorder cannot be caused by a substance, a medical condition, or another mental disorder (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, genetic, biochemical, and environmental factors may play a significant role in its development. There is a strong family link with this disorder and both schizophrenia and schizotypal personality disorders, suggesting a genetic basis (American Psychiatric Association, 2013). Biochemically, those with this disorder may have an imbalance in neurotransmitters (brain chemicals) that accounts for their symptoms. Also, environmental factors such as social isolation, drug abuse, excessive stress, and recent immigration may increase the risk of developing this disorder.

Treatment Considerations

By definition, delusional beliefs are resistant to compelling contrary evidence and rational disputation. Individuals with this disorder are convinced that their delusional beliefs are correct and that there is no need to change them. Accordingly, treatment of this disorder

can be extraordinarily difficult. The longer the symptoms have been present, the more refractory they are to simple treatments such as psychoeducation, psychotherapy, or medication. When those with this disorder agree to psychotherapy, it should be initiated in such a way that its benefits outweigh their reluctance to discuss their beliefs. Accordingly, early therapy sessions should emphasize developing a trusting relationship with a neutral and accepting therapist. Cognitive behavior therapy can be useful in changing delusional behavior. Antipsychotic medication can be also effective with this disorder. Such medication can take the "edge" off delusions and facilitate psychotherapy. However, those with this disorder are often resistant to taking medication.

Len Sperry, MD, PhD

See also: Antipsychotic Medication; Cognitive Behavior Therapy; Delusions; Hallucinations; Schizophrenia; Schizotypal Personality Disorder

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Delusions

Delusions are fixed, false beliefs that persist despite contrary evidence.

Definitions

- **Antipsychotic medications** are prescription medications used to treat psychotic disorders, including schizophrenia, schizoaffective disorder, and delusional disorder.
- **Delusional disorder** is a mental disorder characterized by delusions. Previously this disorder was referred to as paranoia or paranoid disorder.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Paranoia** is an unfounded or exaggerated distrust or suspiciousness of others.
- **Psychosis (psychotic disorder)** is a mental disorder characterized by a loss of touch with reality and psychotic features.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description

Delusions are unshakeable false beliefs. They are irrational, defy normal reasoning, and remain firm even in the face of overwhelming proof to the contrary. These beliefs are not accepted by others in the individual's culture or subculture (American Psychiatric Association, 2013). They are psychotic symptoms that are often accompanied by hallucinations or paranoia which act to strengthen the delusions. Delusions must be distinguished from overvalued or unreasonable ideas. With such ideas individuals usually have some doubt about the validity of their ideas. In contrast, delusional individuals are absolutely convinced that their delusions are valid.

Delusions are categorized as either bizarre or non-bizarre. Bizarre delusions are false beliefs that could never occur in real life, such as the belief that president is an alien. Non-bizarre delusions are false beliefs that could occur in real life, such as being followed or conspired against. Delusions can be symptoms of many physical and mental disorders, as well as reactions to some medications. They are most common in schizophrenia and delusional disorder. Delusional disorder is a rare disorder and is found in approximately 0.2% of adults. Jealous delusions are more

common in females, while persecutory delusions are more common in males (American Psychiatric Association, 2013). Other common disorders that may involve delusions include depression, bipolar disorder, and some types of alcohol and drug abuse. Many with Alzheimer's disease eventually develop delusions.

There are several types of delusions. The most common are described here.

Persecutory delusions. Individuals with this delusion falsely believe that they are being followed, cheated, drugged, conspired against, spied on, attacked, or obstructed in their pursuit of a goal. This type of delusion can be so broad and complex that it can appear to explain everything that happens to an individual. This is the most common type of delusions.

Jealous delusions. Individuals with this delusion falsely believe that their romantic partner is having an affair. Those with this belief may try to restrict their partner's activities or gather "evidence" and confront the partner about the nonexistent affair. This type of delusion is most likely to be associated with violent behavior. It is the second most common type of delusions.

Erotomanic delusions. Individuals with this delusion falsely believe that a famous individual or someone of higher status is in love with them. Usually, they attempt to contact the other through phone calls, letters, or gifts. Sometimes this delusion leads to stalking or violence against that individual or a perceived romantic rival.

Grandiose delusions. Individuals with this delusion falsely believe that they have special talents, powers, or abilities. They may even believe that they are famous or that they have a special mission in life. For example, they may believe they are a rock star or sent by God to save the world. More often, they believe that they have made a significant contribution for which they have not gotten sufficient recognition.

Somatic delusions. Individuals with this delusion falsely believe that their body is somehow diseased, deformed, or infested. For example, they may believe that their body is infested with parasites. Often this delusion leads to excessive and irrational concerns about their body so that they continually seek medical treatment for their imagined condition.

Delusion of reference. Individuals with this delusion falsely believe that insignificant remarks, events, or objects in their environment have personal meaning for them. They may believe that they are receiving special messages from a newspaper story or a television announcement. Often, the meaning assigned to such messages is negative.

While delusions of reference may be bizarre, most persecutory, somatic, erotomanic, grandiose, and jealous delusions are considered non-bizarre.

While delusions are usually caused by an underlying medical condition, other mental disorders, or drug reaction, the exact cause is unknown. Genetics, neurotransmitter (brain chemicals) abnormalities, and psychological factors may also play a role. Delusions can be caused by drugs such as amphetamines, cocaine, and phencyclidine. Delusions can occur both during use and withdrawal from drugs or alcohol. Some prescription drugs, including stimulants, steroids, and medications for Parkinson's disease, can cause delusions.

Treatment

Individuals with delusions often resist diagnosis and treatment. Because of their firm convictions in their delusions, they believe that there is nothing about them that needs to change. Treatment depends on the underlying cause of the delusions. Antipsychotic medications and psychotherapy, particularly cognitive behavior therapy, are commonly used. The prognosis for delusions depends on the underlying cause. Those caused by schizophrenia usually disappear within a few weeks of starting antipsychotic medication. With appropriate treatment, even those with diagnoses of delusional disorder can experience some relief of symptoms.

Len Sperry, MD, PhD

See also: Antipsychotic Medication; Cognitive Behavior Therapy; Delusional Disorder; Hallucinations; Schizophrenia

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Dementia

Dementia is the deterioration or loss of mental processes, particularly memory.

Definitions

- **Alzheimer's disease** is a medical and mental disorder that causes dementia, particularly late in life. It is also referred to as Neurocognitive Disorder Due to Alzheimer's Disease.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **Neurocognitive disorders** are a group of disorders in DSM-5 that are characterized by a decline from a previous level of neurocognitive (mental) function.

Description and Diagnosis

Dementia is a group of symptoms including loss of memory, judgment, language, and other cognitive (mental) function caused by the death of neurons (nerve cells) in the brain. It may also include changes in behavior, personality, and motor functions. There is commonly a loss of memory and the skills. The changes can be severe enough to seriously disrupt the individual's ability to carry out activities of daily living. These changes can be due to medical conditions such as Alzheimer's disease or a stroke (vascular dementia) or because of repeated blows to the head (in football players and boxers). Of the various types of dementia, Alzheimer's disease causes the most complications.

Dementia involves more than memory loss. It also involves decline in intellectual function, including difficulties with language, simple calculations, planning and judgment, and abstract reasoning. While dementia is not caused by aging, it is quite common in older individuals. It results from infections, brain diseases, tumors, and injuries to or biochemical changes within the brain. It should be noted that the term "dementia" has been replaced by "neurocognitive disorder" in DSM-5. The reason is that while dementia is most associated with cognitive impairment in the elderly, the term "neurocognitive disorder" is widely used and often preferred for conditions affecting younger individuals, such as impairment due to traumatic brain injury or HIV infection (American Psychiatric Association, 2013).

There are several types of dementia. Following are brief descriptions of the more common types.

Alzheimer's disease. Alzheimer's disease is the sixth leading cause of death in the United States and the fifth leading cause of death for persons 65 years of age and older. Between 60% and 90% and more of dementias are estimated to be of this type. Before the age of 70, about 10% of adults are diagnosed with the disorder. That figure rises to at least 25% after ago 70. Women are more likely than are men to develop this disease, in part because they tend to live longer (American Psychiatric Association, 2013).

Vascular dementia. This type is also called multi-infarct dementia because it involves changes in blood vessels in the brain. It is the second most common cause of dementia after Alzheimer's disease. Within three months following a stroke, between 20% and 30% of individuals are diagnosed with this type. It is more common in men than in women (American Psychiatric Association, 2013). Risk factors for it include high blood pressure, diabetes, a history of smoking, and heart disease.

Dementia with Lewy bodies. Dementia with Lewy bodies is probably the next most common form of dementia after vascular dementia. Lewy bodies are chemical substances in damaged nerve cells in the brain that cause or complicate dementia. Because the relationship between Lewy bodies in various types of dementia is not well understood, exact statistics for this type are unclear. Yet it is estimated that up to 30.5% of all dementias are of this type (American Psychiatric Association, 2013).

Other dementias. There are several other less common types of dementia. These include frontal lobe dementia, Pick's disease, Huntington disease,

Parkinson's disease, HIV infection, and head trauma. Repeated head trauma in those playing contact sports in high school and college is now considered a risk factor for developing dementia in later life. These other dementias may account for about 10% of all dementias.

Treatment

The primary goals of treating dementias are to preserve functioning and independence, and maintain quality of life, as much as possible. Specific treatment of dementia is based on its type and the particular case. In some types, cognitive function can be improved but not corrected. In some cases, dementia respond better to treatment than others. For example, treating high blood pressure in someone with the vascular dementia type can lead to considerable improvement in memory and cognitive functioning. In contrast, those in the advanced-stage Alzheimer's type may experience little or no improvement. However, in all cases, appropriate care and support is always helpful and should be extended. Medication and cognitive behavior therapy interventions are additional interventions.

Medications that target the symptoms of dementia include Cognex, Aricept, Exelon, Reminyl, and Namenda. Cognitive behavior therapy (CBT) interventions may be used to reduce the frequency or severity of problem behaviors such as aggression or socially inappropriate behavior. CBT is particularly useful in identifying and modifying the situations that trigger problem behaviors, which can be effective.

Len Sperry, MD, PhD

See also: Aricept (Donepezil); Cognitive Behavior Therapy; Dementia; Namenda (Memantine)

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Depakote (Divalproex Sodium)

Depakote is a prescribed medication for the treatment and prevention of seizures. Its generic name is divalproex sodium.

Definitions

- **Absence seizures** are ones characterized by abrupt, short-term lack of conscious activity along with behaviors such as eye rolls, blank stares, and lip movements. It is also referred to as petit mal seizures.
- **Antiseizure medications** are a group of prescription drugs used to treat epilepsy as well as burning, stabbing, and shooting pain. It is also called anticonvulsant medications.
- **Epilepsy** is a medical condition involving episodes of irregular electrical discharge within the brain that causes impairment or loss of consciousness, followed by convulsions.
- **Seizure** is a sudden convulsion or uncontrolled discharge of nerve cells that may spread to other cells throughout the brain.
- **Tonic-clonic seizures** are ones that involve the entire body and are accompanied by muscle contractions, rigidity, and unconsciousness. It is also referred to as grand mal or generalized seizures.
- **Trigeminal neuralgia** is a disorder of the trigeminal nerve which causes severe facial pain.

Description

Depakote is one of the antiseizure medications. It is effective in the treatment of epilepsy, particularly in preventing simple and complex absence seizures and

tonic-clonic seizures. Depakote is also used to treat the manic phase of bipolar disorder in adults, to prevent migraines in adults, and to reduce the pain of trigeminal neuralgia. It is effective in the treatment of epilepsy and in preventing absence seizures, mixed, and tonic-clonic (grand mal) seizures. Depakote is also used to treat the manic phase of bipolar disorder in adults, to prevent migraines in adults, and to reduce the pain of trigeminal neuralgia.

Its generic names are divalproex sodium, sodium valproate, and valproic acid. Depakote contains the same medication as Depakene except that it is coated to reduce some of its gastrointestinal side effects. Depakote is believed to work by increasing the levels of gamma-aminobutyric acid (GABA), which is an inhibitory neurotransmitter. That means that as GABA levels increase in the brain neurons or nerve cells, these cells are less likely to become activated or fire. The results are that seizure activity decreases, manic behavior is curbed, and the frequency of migraine headache is decreased.

Precautions and Side Effects

Because Depakote can interfere with blood clotting, blood tests should be done before starting the medication and at intervals throughout its use. Depakote use can increase the risk of birth defects when taken during pregnancy. Women who take Depakote should not breast-feed, since it can pass into the breast milk. Depakote causes drowsiness and impairs alertness in some individuals, so care must be taken in driving and using machinery until they determine how the drug affects them. The sedative effects are increased in the presence of alcohol, so it should be avoided when taking Depakote.

Common side effects of Depakote are mild stomach cramps, change in menstrual cycle, diarrhea, loss of hair, indigestion, change in appetite, nausea and vomiting, and trembling in the hands and arms. Such side effects tend to resolve with time. Another common side effect is weight gain. Those taking Depakote should be on a balanced, low-fat diet coupled with an increase in physical activity to counter this side effect.

Len Sperry, MD, PhD

See also: Bipolar Disorder; Seizures

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Dependent Personality Disorder

Dependent personality disorder is a mental disorder characterized by a pattern of submissiveness, a lack of self-confidence, and an excessive need to be taken care of by others.

Definitions

- **Assertiveness training** is a behavior change method for increasing self-esteem and self-expression in intimidating interpersonal situations.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

The dependent personality disorder is a personality disorder characterized by a pervasive pattern of dependent and submissive behaviors. Individuals with this disorder are excessively passive, insecure, and

isolated, and become overly dependent on others. Because of their fear of rejection and abandonment, they go to great lengths to secure and maintain relationships. Individuals with this disorder see themselves as inadequate and helpless. As a result they relinquish personal responsibility and put their fate in the hands of others to protect and take care of them. While at first acceptable, this dependent behavior can become controlling and may even appear hostile. This disorder is more common in females (2:1 females to males). In females, the dependent style often takes the form of submissiveness. In males, the dependent style is more likely to be autocratic, so that the husband and boss depends on his wife and secretary to perform basic tasks which he himself cannot accomplish. Whatever the case, this disorder can lead to anxiety and depression when the dependent relationship is threatened.

The clinical presentation of the dependent personality disorder is characterized by the following: behavioral style, interpersonal style, thinking style, and feeling style. Individuals' behavioral and interpersonal styles are characterized by docility, passivity, and non-assertiveness. In interpersonal relations, they tend to be pleasing, self-sacrificing, clinging, and constantly requiring others' reassurance. Their reliance on others leads to a subtle demand that others assume responsibility for major areas of their lives. Their thinking style of dependent personalities is characterized by suggestibility. Also, they tend to minimize difficulties, and because of their naiveté are easily persuadable and easily taken advantage of. Their feeling style is characterized by insecurity and anxiousness. Because they lack self-confidence, they may experience considerable discomfort at being alone. They may be preoccupied with the fear of abandonment and disapproval of others. Their mood tends to be one of anxiety or fearfulness.

The cause of this disorder is not well understood. However, these individuals tend to have characteristic view of themselves, the world, and others, and a basic life strategy. They view themselves as inadequate and self-effacing. They tend to view the world and others as caretakers since they do not believe they can care for themselves. Accordingly, their basic life strategy and pattern is to cling and rely on others to care for them. In turn, they respond by being pleasing and willing to do whatever others want.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive need to be cared for and cling to others because of their fear of separation. They constantly seek the advice and reassurance of others when making decisions. More than anything, they want others to take responsibility for most major areas of their lives. Not surprisingly, they seldom express disagreement with others for fear they will lose their support and approval. Because they lack confidence in their own judgment and ability, they have difficulty starting projects and doing things on their own. These individuals will even engage in actions that are difficult and unpleasant in order to receive support and caring from others. Because of unrealistic fears of being unable to take care of themselves, they feel helpless or uncomfortable when faced with being alone. When a close relationship is about to end, they immediately seek out another caring and supportive relationship. Finally, they become preoccupied with fears of being left to take care of themselves (American Psychiatric Association, 2013).

Treatment

The clinical treatment of this disorder usually involves psychotherapy. In general, the long-range goal of psychotherapy with a dependent personality is to increase the individual's sense of independence and ability to function interdependently. At other times, the therapist may need to settle for a more modest goal, that is, helping the individual become a "healthier" dependent personality. Treatment strategies typically include challenging the individual's limiting beliefs about personal inadequacy and learning ways in which to increase assertiveness in communicating with others. Assertiveness training is commonly used to achieve this. A variety of methods can be used to increase self-reliance. Among these are providing these individuals with directives and opportunities for making decisions, being alone, and taking responsibility for their own well-being.

Len Sperry, MD, PhD

See also: Personality Disorders; Psychotherapy

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Depersonalization/Derealization Disorder

Depersonalization/derealization disorder is a mental disorder characterized by symptoms of depersonalization, derealization, or both.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Antidepressants** are prescription medications used to treat depression and depressive symptoms.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also called CBT.
- **Depersonalization** is a mental state of detachment or a sense of being "outside" oneself or body and observing one's actions or thoughts.
- **Derealization** is a mental state characterized by a sense that one is out of touch with one's surroundings, as if in a dream.
- **Dissociative disorders** are a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness and which cause impaired functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.

Description and Diagnosis

Depersonalization/derealization disorder is one of the dissociative disorders in DSM-5. It is characterized by the experience of being out of touch with oneself and/or one's immediate surroundings. The symptom of depersonalization relates to an individual's perceptions about his or her physical body or mind, while derealization relates to an individual's surroundings. Individuals presenting with this disorder may express that they feel as if they are in a dream, that things around them seem as if they are artificial, that they are having an out-of-body experience, or that they feel as if they are an automated robot. It is also likely that an individual may have difficulty describing his or her symptoms. This disorder was previously called "depersonalization disorder" but was changed to include the symptom of derealization as it is now considered to result from the same cause.

Many individuals will experience short-term (from hours to several days) depersonalization or derealization symptoms sometime during their lifetime. Most common is daydreaming. However, longer-term manifestation that is diagnosable as this disorder is rare, affecting less than 2% of the population. This disorder occurs equally as often in both males and females. In most cases, the cause of this disorder is not known. However, childhood trauma, severe stress, and the ingestion of hallucinogenic drugs are known to cause this disorder. Typically, this disorder manifests around age 16 and almost always prior to age 25 (American Psychiatric Association, 2013).

To be diagnosed with this disorder, individuals must experience persistent or recurrent depersonalization and/or derealization. Individuals must still be able to think logically about what is in fact reality and what is only a thought or perception; this is called reality testing. If they cannot discern what is real and what is not, then clinicians must consider the psychotic disorders for diagnosis. In addition, if an individual is over age 40, medical conditions must be carefully ruled out as it is extremely rare for such late onset. For some who experience this disorder, it may have a sudden onset with continuous symptoms while others may have only intermittent episodes (American Psychiatric Association, 2013).

The exact cause of this disorder is not well understood. Nevertheless, it is believed to be linked to an imbalance of neurotransmitters (brain chemicals) that make a brain vulnerable to fear and severe stress. Other likely causes include experiencing abuse or observing violence toward a family member. It might also include severe stress or trauma associated with a car accident.

Treatment

Treatment for depersonalization/derealization disorder may include both medications and psychotherapy. Commonly used medications include both antianxiety medication and antidepressants. Various psychotherapy approaches can be used. The most is cognitive behavior therapy.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Antianxiety Medication; Antidepressant Medications; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Dissociative Disorders; Psychotherapy; Schizophrenia

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Deplin (Methyl Folate)

Deplin is a prescription remedy that is usually taken with a prescription antidepressant medication to more effectively treat symptoms of depression. Its generic name is methyl folate.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Blood–brain barrier** is a specialized layer of cells around the blood vessels of the brain controlling which substances can pass from the circulatory system into the brain.
- **Folate** is a B vitamin which is needed to maintain cell growth and brain function. Deficiencies are associated with depression and result from diet, illness, aging, and some medications. The synthetic form of it is called folic acid.
- **Genetic variations** (single nucleotide polymorphisms) can predict an individual's response to certain drugs, susceptibility to environmental factors such as toxins, and risk of developing particular diseases.
- **Medical food** is a therapeutic substance administered under the supervision of a physician. It is intended for the specific dietary management of a medical condition, such as depression.
- **Methyl folate** is the active form of folate which helps in producing mood-regulating neurotransmitters. The risk of depression is higher in those with genetic variations that reduce the ability to make L-methyl folate.
- **Personalized medicine** is medical practice that uses information about an individual's

unique genetic makeup and environment to customize medical care to the individual's unique needs.

Description

Deplin is a prescribed medical food (remedy) containing methyl folate, the active form of folate, which is a B vitamin. Unlike folic acid, methyl folate crosses the blood–brain barrier where it helps balance the neurotransmitters (chemical messengers) that affect mood (serotonin, norepinephrine, and dopamine). Deplin provides the necessary nutritional support so the brain can produce sufficient levels of the needed neurotransmitters to balance mood. In this novel form of treatment, Deplin is used in addition to (augmentation) an antidepressant. The way in which Deplin works differs from that of antidepressants. For example, a selective serotonin reuptake inhibitor (SSRI) antidepressant like Paxil works by slowing the "reuptake" of serotonin, making it available longer to the brain. But this SSRI may not work for long, or at all, if the brain is not producing sufficient quantities of serotonin (or other neurotransmitters) in the first place. This may explain why only 30% of those prescribed their first antidepressant get well (achieve remission) and why up to 50% of all those taking antidepressants never reach remission of their depression. Research shows that those with low levels of methyl folate are six times as likely to fail to respond to antidepressants only as those with normal levels. The reason for this appears to be genetic variations that reduce the individual's ability to make methyl folate. Taking folic acid does not have the same effect since only methyl folate crosses the blood–brain barrier. Initial research showed that an SSRI antidepressant augmented with Deplin more than doubled the response rates of an SSRI antidepressant augmented by a placebo (14.6% vs. 32.3%). Deplin reflects a shift that is beginning to occur in the practice of medicine. Customizing medication and other medical and preventive care is the basis for what is being called "personalized medicine."

Precautions and Side Effects

The rate of side effects reported by those who were given Deplin with an antidepressant at the beginning of therapy was similar to the rate of side effects reported by those who took only an antidepressant. But only a half of those who were on Deplin and an antidepressant stopped their therapy due to side effects. This means that those on Deplin and an antidepressant responded to the "main effects" (their depression improved) while "side effects" were not present or less bothersome. In terms of side effects, Deplin was not linked to weight gain, insomnia (difficulty sleeping), or sexual dysfunction. Since Deplin is relatively new, research on it is currently limited.

Len Sperry, MD, PhD

See also: Depression; Personalized Medicine; Serotonin

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Depression and Depressive Disorders

Depression is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts the individual's daily functioning.

Definitions

- **Bipolar disorders** are a group of mental disorders characterized by changes in mood and in energy (e.g., being highly irritable and impulsive while not needing sleep). These include bipolar I disorder, bipolar II disorder, and cyclothymic disorder.

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily functioning. It includes major depressive disorder, persistent depressive disorder, disruptive mood dysregulation, and premenstrual dysphoric disorder.
- **Premenstrual syndrome** is a medical condition in which cramps, breast tenderness, bloating, irritability, and depression occur prior to a woman's menstrual period and subside after it.
- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain resulting in symptom reduction.

Description

"Depression" is the general name for a group of mental conditions known as depressive disorders. Most individuals experience depressive symptoms (feeling down or blue) at some point in their lives. When these symptoms are mild and short lived, they are considered a normal emotional reaction. However, when they are more severe and significantly affect daily functioning, they are considered a depressive disorder. Depressive disorders are mental conditions that require medical and psychological treatment.

Depressive disorders are widespread and are a leading cause of disability in the world. Commonly recognized symptoms of the various types of depressive disorders are recurring feelings of sadness and guilt, sleep problems, changes in appetite, decreased energy, irritability, poor concentration, hopelessness, and thoughts of death or suicide. If only these "down" symptoms are experienced, the diagnosis is likely to be a (unipolar) depressive disorder. But if the depressed periods alternate with extreme "up" periods, the individual may have a bipolar disorder.

Depression is one of the leading causes of disability in the United States. According to National Institute of Mental Health, approximately 9.5% of adult Americans have some type of depressive disorder. One out of every four college students has some type of diagnosable mental illness. Even elementary school students have been diagnosed with depressive symptoms. Women experience depression at a rate of nearly twice that of men. Internationally, depression is estimated to become the second most common health problem in the world by 2020.

The following depressive disorders are briefly described here. They are major depressive disorder, persistent depressive disorder, disruptive mood dysregulation, and premenstrual dysphoric disorder.

Major Depressive Disorder

Major depressive disorder is also called major depression. In this disorder individuals experience episodes of sad mood or anhedonia (loss of interest or pleasure) that last longer than two weeks. These episodes are marked with five or more symptoms, and they significantly disrupt their everyday function (American Psychiatric Association, 2013). Individuals may also have thoughts of self-harm. This disorder is quite different from bereavement or a grief reaction associated with the death of a loved one. Some with this disorder may experience a single episode of severe depression in their lifetimes. For many others, recurrent episodes of such depression will occur throughout their lives.

Persistent Depressive Disorder

Persistent depressive disorder was previously called dysthymic disorder. It is a new diagnosis in DSM-5 that consolidates major depressive disorder and dysthymic disorder (American Psychiatric Association, 2013). Persistent depressive disorder is characterized by a depressed mood that lasts for at least two years and other depressive symptoms. While the symptoms tend to be less severe than those in major depressive disorder, they cause significant disruptions in the individual

daily functioning. For many individuals, this disorder is a lifelong condition.

Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder is a diagnosis for children between the ages of 6 and 18 years. It is characterized by severe and persistent irritability resulting in temper tantrums and persistent anger or irritability between the tantrums. Both interfere with children's ability to function at home, in school, or with their friends. Prior to DSM-5, many with this symptom pattern were likely to be labeled as "bipolar children." Some of these children were diagnosed with bipolar disorder even though they seldom met all the symptoms and criteria. In fact, few will go on to develop bipolar disorder as adults. Rather, children with chronic irritability are more likely to develop depressive and/or anxiety disorders when they become adults (American Psychiatric Association, 2013).

Premenstrual Dysphoric Disorder

Premenstrual dysphoric disorder is a severe form of premenstrual syndrome in which mood swings, depression, irritability, or anxiety significantly disrupts everyday functioning. Both premenstrual syndrome and premenstrual dysphoric disorder have physical and emotional symptoms. However, premenstrual dysphoric disorder causes extreme mood shifts that can disrupt the individual's work and relationships. In both the syndrome and disorder, symptoms typically begin 7 to 10 days before the menstrual period starts and continue for the first few days of the period. Both can cause fatigue, bloating, breast tenderness, and changes in sleep and eating patterns. However, in the disorder at least one of the following emotional or behavioral symptoms stands out: extreme moodiness, marked irritability or anger, overwhelming sadness or hopelessness, or extreme anxiety or tension.

The cause of these depressive disorders is not clearly understood. Yet they appear to have some genetic, biochemical, and environmental factors that cause or worsen these disorders. Genetic imbalances in neurotransmitters (brain chemicals) and hormones are likely causes. There are also various environmental factors that are involved. These include stressful environments, certain medical conditions, and precipitating events such as the loss of a job or relationship. Alcohol and drug use and prescribed medications that alter brain chemistry can also be causes.

Treatment

Treatment of these depressive disorders depends on the type of disorder and the specific case. Those with mild forms of a disorder may respond fully to cognitive behavior therapy (CBT) or other form of psychotherapy and not require medication. Others with moderate or severe forms of a disorder may require the combination of antidepressant medication like the SSRIs and therapy. Medication can provide relatively rapid relief from the symptoms of depression. CBT can help by changing the individual's patterns of thinking or behaving that resulted in the depressive episode.

Len Sperry, MD, PhD

See also: Bipolar Disorders; Cognitive Behavior Therapy; Disruptive Mood Dysregulation Disorder; Major Depressive Disorder; Persistent Depressive Disorder; Premenstrual Dysphoric Disorder

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Depression in Youth

Depression in youth can significantly interfere with a child's or teen's mood and behavior often resulting in sadness, loneliness, and inactivity.

Definition

- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.

Description

Depression in children and adolescents is classified as an internalizing disorder. This means that it takes place largely within the child's mind and doesn't produce external behaviors such as hyperactivity or aggression. Clinical depression in youth can be differentiated from the more normal phases of sadness and anxiety associated with development, especially in the teenage years. Unfortunately, it is often not recognized because it can be difficult to identify. If depression in children and teens is left untreated, it can lead to self-destructive behaviors, such as cutting or even suicide.

It has been estimated that as many as 2%–8% of youth may experience major depressive disorder. Researchers tend to think that the numbers for teens are higher than that. Some research says as many as 20% of adolescents may experience major depression at some point before the end of high school.

Causes and Symptoms

The causes of depression in children and teens are varied. Studies have indicated that everything from genetics to environmental factors can play a role. It is generally agreed that there is a strong link between the presence of stressors and the development of depression. Sadly, there can be a cycle of stressful events that happen to a child who experiences depression. Life stressors lead to depression and depression leads to even more feelings of stress. But some children handle their experiences of stress more easily, while others suffer from depression.

Without dismissing biological causes and genetics, it is clear that depression is often a multigenerational reaction to stressors. In other words, in some instances it is a learned behavior or a set of problematic reactions to stimuli in the lives of the depressed person. Problematic personal judgments in combination with negative social interactions can set the framework for depression in youth.

The symptoms of depression in youth are similar to those of depression in general. They include emotional issues such as intense feelings of sadness, low expression of emotion, and irritability. Other symptoms to look for as signs of depression are lack of sleep, unhealthy eating habits, and risky or injurious behaviors. Symptom includes talking about or acting on suicidal thoughts. In addition to these symptoms, others include a child having low self-esteem, focusing on negative or bad things, and distancing from friends and others.

Diagnosis and Prognosis

Traditionally, the diagnosis of depression in young people depends on the observations of parents and teachers. However, beginning in the late 1970s several self-reporting tools were developed. These tests refined the ability to detect depression based on a child's own reporting of his or her symptoms. The success of these tools, examples of which are the Children's Depression Inventory and the Kids Schedule for Affective Disorders and Schizophrenia in School-Age Children, highlights the importance of educating children and teens on how to recognize the symptoms and seek help for depression.

With early treatment for depression in youth, the prognosis is positive. This is usually most successful with counseling that involves the family and, in some cases, medication to help alleviate symptoms in children with depression. The longer treatment is delayed, the more challenging it will be to provide effective interventions.

Treatment

Cognitive behavior therapy is a preferred method of treatment for depression in youth. It contains a range

of activities and approaches, including related therapies like rational-emotive therapy, attribution retraining, learned optimism, and journal writing. Some of these are ways of beginning to reframe the emotional issues for children and teens. This helps them to learn new ways of understanding and counteract their depressive thoughts and behaviors. Getting involved in positive and fun activities, especially ones that involve physical movement, is another effective method for combatting depression.

In some cases, psychiatric drugs are used for children and teens who suffer from depression. Medication to help treat depression in youth can be used either as a temporary measure or on a long-term basis. The combination of psychotherapy and medication is a common approach to treatment.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Children's Depression Inventory; Depression and Depressive Disorders

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Depressive Personality Disorder

Depressive personality disorder is a mental disorder characterized by a persistent and lifelong pattern of pessimism, unhappiness, low self-esteem, and guilt. It is also known as melancholic personality disorder.

Definitions

- **Antidepressants** are prescribed medications that are primarily used to treat depression and depressive disorders and sometimes depressive personality disorder.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also called CBT.
- **Depression** is a sad mood or emotional state that is characterized by feelings of low self-worth or guilt and a reduced ability to enjoy life. Unless it greatly disrupts an individual's daily functioning, it is not considered a mental disorder.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt an individual's daily functioning. These disorders include major depressive disorder and persistent depressive disorder.
- **Hypomanic personality disorder** is a mental disorder characterized by an enduring pattern of hypomania that shapes cognition, attitudes, and identity. This pattern predictably shapes such individuals' behavior and relationships with others.
- **Persistent depressive disorder** is a depressive disorder characterized by a chronic, depressed mood lasting for more than two years. It was previously called dysthymic disorder.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.

Description and Diagnosis

Depressive personality disorder is a persistent and pervasive pattern of pessimism, unhappiness, low self-esteem, and guilt that begins in early adulthood and occurs in a variety of contexts. Depressive personality disorder occurs before, during, and after other depressive disorders, making it a distinct diagnosis. Individuals with this disorder are marked by

characteristic pessimism. They appear depressed, dejected, and joyless which can be disheartening to others. While they can suffer from mood swings, they are more often unhappy and melancholic. They are also overly critical and judgmental of others and constantly feel guilty and worthless.

Depressive personality disorder is listed among the personality disorders in the *Psychodynamic Diagnostic Manual*. It is described as the converse or polar opposite of the hypomanic personality disorder. Interestingly, depressive personality disorder was not listed with the other personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR). Nevertheless, it was listed in its Appendix B as a diagnosis worthy of further study, along with research criteria.

The DSM-IV-TR provides the following research criteria for depressive personality disorder. The moods of individuals with this disorder tend to be dominated by dejection, gloominess, cheerlessness, joylessness, and unhappiness. Their self-view is that of inadequacy, worthlessness, and low self-esteem. They tend to be critical, blaming and self-derogatory, brooding, and given to worry. They are also pessimistic and prone to feelings of guilt and remorse. In addition, they are negative, critical, and judgmental toward others.

As with most other personality disorders, there is no known cause for the depressive personality disorder. However, a variety of factors may be causative. These include inherited traits, early childhood experiences, and a predisposition toward pessimism. It appears that individuals with this disorder are more likely to develop persistent depressive disorder than those with other personality disorders or depressive disorders.

Treatment

Treatment depends on the severity of the condition. Psychotherapy, particularly, cognitive behavior therapy, appears to be beneficial in treating mild and moderate forms of this disorder. Medications, particularly antidepressants, may be helpful in treating the symptoms of depression of this disorder. Medication may be combined with psychotherapy for moderate to severe forms of the disorder.

Len Sperry, MD, PhD

See also: Antidepressant Medications; Cognitive Behavior Therapy; Depressive Disorders; Hypomanic Personality Disorder

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Detoxification

Detoxification is the process of safely removing addictive drugs from an individual's body.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about imagined danger.
- **Benzodiazepines** are a class of drugs that slow the nervous system and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms. They are highly addictive.
- **Recovery** is a series of steps an individual takes to improve his or her wellness and health while living a self-directed life and striving to reach his or her highest potential.
- **Seizure** is an episode of abnormal electrical activity in the brain that results in changes in the brain and in behavior.

Description

Detoxification is the process of removing toxic substances (e.g., drugs, alcohol, mind-altering chemicals)

from an individual's body, usually, under the care of a physician. Individuals who use drugs or alcohol can develop a physical dependence over time. Abruptly stopping the use of alcohol and drugs can result in significant withdrawal symptoms. It is extremely important for an individual with an addiction who is going through the detoxification process to be observed and treated by a health-care professional, as several drugs can result in life-threatening situations. For example, an individual who consumes alcohol or benzodiazepines on a daily basis can have a seizure if the individual abruptly stops using the substance on his or her own. Often, an individual will be prescribed a medication while being treated for detoxification so that he or she is more comfortable and also that he or she does not experience a seizure.

When an individual becomes physically dependent on drugs or alcohol, the individual may experience severe withdrawal symptoms when he or she stops using. Depending on the drug being abused, symptoms will vary. For example, an individual who is withdrawing (detoxifying) from heavy use of alcohol may experience increased heart rate, difficulty sleeping, anxiety, shaking, and seizures. An individual who is withdrawing from benzodiazepines may experience difficulty sleeping, muscle cramps, irritability, restlessness, seizures, and even death. The first step to recovery for individuals with addiction is detoxification.

Treatment

Treatment for detoxification is designed to remove toxins that are left in the body. An individual can go through the process of detoxification at several facilities (e.g., private clinics, addiction clinics, and mental health centers). An individual can also participate in an inpatient or outpatient treatment program for detoxification. This option is very beneficial because medical staff closely observes individuals. Furthermore, individuals are more likely prevented from using alcohol or drugs in an inpatient or outpatient program. Typically, the detoxification process can take less time when participating in an inpatient or outpatient treatment program.

Elizabeth Smith Kelsey, PhD, and Len Sperry, MD, PhD

See also: Addiction; Benzodiazepines; Detoxification Interventions; Recovery; Seizures

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Detoxification Interventions

Detoxification interventions are of three types: medical, social, and a blending of the medical and social models of detoxification.

Definitions

- **Detoxification** is the process of safely removing addictive drugs from an individual's body.
- **Methadone** is a drug that reduces symptoms of withdrawal for people addicted to other drugs.
- **Recovery** is a series of steps an individual takes to improve his or her wellness and health while living a self-directed life and striving to reach his or her highest potential.
- **Withdrawal** is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of certain drugs after prolonged regular use.

Description

When a person suffers from physical or mental impairment because of ingesting substances that are in the long term poisonous to the body, detoxification may be necessary before any other means can be used that will help improve his or her life situation. Everyone is exposed to toxic or poisonous elements during his

or her life. Through the lymph, circulatory and digestive systems, particularly the liver, kidneys, and stomach, the body naturally detoxifies itself. Urination and bowel movements are two ways in which this naturally occurs. Special detoxification treatments become necessary when the body's natural processes can no longer handle the amount of dangerous substances in the body and become overwhelmed.

In substance abuse treatment settings, detoxification is seen as a necessary precursor to other courses of treatment. It is considered the first step in recovery. Until the patient has removed the effects of toxic substances from his or her body, it is considered difficult, if not impossible, to deal with the psychological and psychosocial aspects of his or her problems. Medically supervised detoxification from drugs and alcohol is the safest way to achieve this goal. But this approach is relatively recent. It was not until 1958 that the American Medical Association (AMA) declared alcoholism was a disease. Until then, alcoholism and drug addictions were considered a moral or legal problem. They were not considered valid medical conditions that required medical intervention. By the 1970s more humane treatment of people with addictions was becoming the norm, for those suffering not only from alcoholism but also from drug addiction and other activities deemed chronic if not lethal.

There are two traditional models of detoxification: a medical model and a social model. The major differences between the two are that the medical model uses physicians, nursing staff, and medication to assist people through the sometimes fatal and painful withdrawal stages of detoxification. Those who prefer the social model do not see the need for medication or routine medical care. They choose to conduct detoxification in a nonmedical setting that relies on the presence of caring people, professional and otherwise, to help the person through the difficult process of detoxification.

Detoxification interventions are usually the first step in treating substance disorders. (Ivaylo Sarayski/Dreamstime.com)

Today a blend of these two intervention models is often used, with nonmedical people monitoring psychological withdrawal symptoms and professional medical people addressing the symptoms of physical withdrawal and detoxification. Inpatient treatment protocols have become more sophisticated and complex often involving the use of multiple drugs, such as methadone, to aid in the process. Three of the most dangerous drugs to detox from are heroin, benzodiazepines, and alcohol. These drugs are currently considered the most dangerous due to detox side effects, including seizures, strokes, and even death.

Most medical professionals working with substance-dependent clients discourage detoxification without medical supervision. The AMA continues to maintain that substance dependence is a disease, and it encourages physicians and other clinicians, health organizations, and policy makers to base all their activities on this premise. For mental health professionals, reliance on detoxification remains a necessary first step toward effective psychological treatment.

Alexandra Cunningham, PhD

See also: Addiction Counseling; Detoxification

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Developmental Coordination Disorder

Developmental coordination disorder (DCD) is defined as a significant impairment in the development of motor coordination that interferes with the ability to learn or to conduct the activities of daily life.

Definition

- **Developmental** relates to growth and the ability to learn new things, especially in regard to the gradual learning and maturing process in children.

Description

Although it is clear that children develop at different rates, poor motor coordination is recognized as a developmental problem. Sometimes children exhibit clumsiness or delays in activities such as crawling, walking, or dressing themselves. The term "developmental coordination disorder" refers to the difficulty in movement skills affecting children that is not due to intellectual, sensory, or neurological impairment. A key feature of DCD is difficulty in learning and performing everyday tasks at home, school, and play environments. It can affect as many as 6% of children who are between 5 and 11 years of age (National Institutes of Health, 2014). Occasionally, lack of coordination persists through adolescence and adulthood. This affects such things as handwriting or fine motor skills required for assembling puzzles or playing ball.

There has been confusion in the area of DCD because experts like pediatricians, neurologists, educators, and occupational and physical therapists saw the condition from their own points of view and found it hard to find a unified perspective. The condition was often called developmental dyspraxia, apraxia, or ataxia. By 1994 there was general agreement on the name "developmental coordination disorder." It describes a condition of significant problems in the development of motor coordination. The motor issues need to be distinct from medical conditions such as cerebral palsy or muscular dystrophy or even pervasive developmental disorder.

Causes and Symptoms

It is suspected that children with a history of prenatal or perinatal difficulties exhibit a higher incidence of developmental coordination disorder. The problems experienced by children with DCD are usually a result of problems in the brain's receptor system due to physical damage. Children with DCD may have a wide range of dysfunctions. These dysfunctions are often grouped into the areas of gross motor, fine motor, and psychosocial. Recently, the systems model has suggested a

complex interaction among various levels of the central nervous system. This usually results in impairments in such related areas as proprioception, motor programming, and the sequencing of muscle activities. These can appear in children as clumsiness walking, problems with their peers, or issues with handwriting. These problems can affect the ability to learn and to manage daily activities.

Diagnosis and Prognosis

In diagnosing DCD, it is important to distinguish it from problems or disorders that may have overlapping or similar symptoms. These disorders include cerebral palsy, mental retardation, pervasive developmental disorder, and attention-deficit hyperactivity disorder. Those children who score below the 15th percentile on standardized tests of motor skills and having an IQ score above 69 would qualify for a diagnosis of DCD (National Institutes of Health, 2014). Research in DCD has emphasized the motor and academic outcomes of children rather than the long-term emotional and behavioral consequences of the disorder.

There are two schools of thought on the persistence of DCD. One view holds that DCD is largely confined to childhood and that most children eventually learn or outgrow it. This approach may take longer and much more effort to acquire sufficient motor skills but it usually happens. Another view is that improvement of DCD symptoms is not simply a matter of aging and that it continues to be a motor and a social problem in adolescence. Evidence of its effects can also be found in some adults who suffered from DCD.

Treatment

Current treatment focuses on helping children improve their motor and psychosocial challenges. Task-specific intervention is one of many approaches designed to improve the motor performance of children and young adults with motor learning difficulties. Among them are physical therapy, sensory integration, the process-oriented treatment approach, and perceptual motor training. It should be noted that there are studies which show that children who have received perceptual motor training have demonstrated motor improvements equal to or greater than those of children who have received either sensory integration therapy or process-oriented treatment.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Developmental Disabilities; Specific Learning Disorder

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Developmental Disabilities

Developmental disabilities are conditions that restrict normal growth and activities whether physically, psychologically, educationally, or emotionally.

Definitions

- **Developmental** relates to growth and the ability to learn new things, especially in regard to the gradual learning and maturing process in children.
- **Disability** means a physical or mental condition that limits a person's movement, sense perception, or participation in normal physical or mental activities.

Description

Developmental disabilities usually begin during pregnancy, childbirth, or early infancy. The term also includes disabilities that may happen later due to injury, infection, or a variety of other factors. Whatever the source, they often impact daily functioning and therefore can become a challenge that may last a lifetime.

Not surprisingly many disabilities are overlapping; for example, a person with attention-deficit hyperactivity disorder may not do well in school, while a deaf person may experience specific emotional challenges in social interactions. "Developmental disabilities" is an umbrella term that describes a broad range of impairments that affect the growth and abilities of individuals in physical, learning, language, or behavior areas.

Developmental disabilities occur fairly evenly among all racial, ethnic, and socioeconomic groups. Despite this even distribution, some factors for increased risk and poorer prognosis are associated with the resources, education, and cultural norms of the parents. Recent estimates in the United States show that about one in six, or around 15% of children aged 3 through 17 years have one or more developmental disabilities, although levels of severity differ greatly (Centers for Disease Control and Prevention, 2013). According to the Centers for Disease Control, developmental disabilities include autism spectrum disorders, cerebral palsy, hearing/vision loss or impairment, intellectual disability, and learning disability.

Causes and Symptoms

Most developmental disabilities seem to be caused by a complex mix of factors. Some of the key factors include genetics, parental health, and other behaviors. These include smoking and drinking during pregnancy, complications during the birthing process, infections the mother might have during pregnancy or the baby might develop very early in life, and exposure of the mother or child to high levels of environmental toxins. An example of such toxins is lead. For some developmental disabilities, the cause is easy to pinpoint, but for many other conditions, the causes are not clear.

At least 25% of hearing loss among babies is due to maternal infections during pregnancy, complications after birth, and head trauma. Some of the most common known causes of intellectual disability include fetal alcohol syndrome and genetic and chromosomal conditions, such as Down syndrome and Fragile X syndrome. In certain cases infections during pregnancy, such as an infection passed from animals to humans, can cause a developmental disability. Children who have a sibling or parent with an autism spectrum disorder are at a higher risk of also having an autism spectrum disorder. Low birth weight, premature birth, multiple births, and infections during pregnancy are associated with an increased risk for many developmental disabilities. Untreated newborn jaundice can cause a type of brain damage known as kernicterus. Children with this brain damage are more likely to have cerebral palsy, hearing and vision problems, and problems with their teeth. Early detection and treatment of newborn jaundice can prevent brain damage.

Diagnosis and Prognosis

Parents are normally the best monitors and observers of the development of their children. If certain expected developmental milestones like smiling, interacting, talking, and walking are not reached within the expected range, then medical advice should be sought. Often the medical professional will join the parents in monitoring any perceived developmental delays or problems. If problems persist, the child should undergo developmental screening and evaluations to determine if the child's skills and abilities are on track, delayed, or not present. The earlier the diagnosis is made, the greater the opportunity for help and improvement.

Treatment

If a child exhibits developmental delays, it is important to get help as soon as possible. Early identification and intervention can have a significant impact on a child's ability to learn new skills. In addition, early intervention can reduce the need for later more costly interventions over a longer period of time.

People with developmental disabilities have physical, educational, or emotional deficits that require attention and help. Federal and state laws protect all those who are formally identified as having developmental disorders from discrimination. It is important for children and adults with disabilities to have access to health care and health programs in order to live as fully as they can, to stay well, and to be socially active.

Health-care professionals are aware that conditions such as asthma, gastrointestinal symptoms, eczema and skin allergies, and migraine headaches have been found to be more common among children with

developmental disabilities. Thus, it is especially important for children with developmental disabilities to see a health-care provider regularly. Many communities have independent living centers that are nonprofit, community-based agencies that help people with disabilities achieve and maintain self-sufficient lives within the community. Services offered include advocacy, information and referral, independent living skills training, and peer counseling.

Alexandra Cunningham, PhD

See also: Autism Spectrum Disorders; Down Syndrome

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Dexedrine (Dextroamphetamine)

Dexedrine is a prescription medication used to treat attention-deficit hyperactivity disorder (ADHD) and narcolepsy. Its generic name is dextroamphetamine.

Definitions

- **Attention-deficit hyperactivity disorder** is a disorder characterized by significant problems with attention, hyperactivity, or acting impulsively that are not appropriate for an individual's age.
- **Narcolepsy** is a condition of daytime sleepiness in which uncontrollable sleep attacks interfere with normal functioning.
- **Stimulants** are a class of drugs that increase brain activity and produce a sense of alertness, euphoria, endurance, and productivity or suppress appetite. Examples are cocaine, amphetamines, and Ritalin.
- **Tourette's syndrome** is an inherited disorder characterized by tics (involuntary movements or vocalizations). Tics are preceded by a felt tension that is relieved after the tic is performed.

Description

Dexedrine belongs to the class of medications known as stimulants. Dexedrine is used to treat poor concentration and impulse control problems common in ADHD, and to treat narcolepsy. ADHD is believed to be caused by a decrease in norepinephrine levels. Dexedrine appears to work by increasing norepinephrine and dopamine levels in the brain. The result in an increase in attention, concentration, appetite, energy level, judgment, memory, and impulse control. Dexedrine is also a standard treatment for narcolepsy. Dexedrine is available in a combination pill with the drug amphetamine (Adderall). The choice of using Dexedrine alone or in combination with other medications depends on the individual's health history.

Precautions and Side Effects

Dexedrine can be a habit-forming medication and should not be used for long periods or at higher doses than prescribed. It should not be used in those with a history of alcohol or substance abuse. Since it can lower seizure threshold, it is not appropriate for use by those with a seizure disorder. Dexedrine should not be used by those with glaucoma (high pressure in the eye), Tourette's syndrome, or a family history of Tourette's since it can worsen tics. Similarly, it should not be used by those taking or have taken a monoamine oxidase inhibitor (MAOI) within the past 14 days. It must be used with caution by those with hyperthyroidism, high blood pressure, liver function impairment, kidney function impairment, and heart conditions, and by those with bipolar disorder since it can trigger mania. Dexedrine causes a withdrawal syndrome when stopped abruptly, so it should be tapered off gradually when discontinuing it. Dexedrine may be unsafe for

use during pregnancy and breast-feeding, and its use is not recommended.

Common side effects of Dexedrine include stomach pain, nausea, loss of appetite, dizziness, insomnia, anxiety, restlessness, euphoria, headache, weight loss, changes in blood pressure and heart rate, palpitations, tremor, dry mouth, unpleasant taste, diarrhea or constipation, visual disturbances, impotence, and sexual dysfunction. Growth retardation in children can occur with prolonged use. Side effects that need medical attention include suicidal thoughts, confusion, chest pain, or heart palpitations, shortness of breath, restlessness, hallucinations (seeing or hearing, things that are not really there), fainting, tics, and seizures.

Dexedrine can increase, decrease, or alter the effects of other medications taken with it. Such interacting medications include antidepressant medications such as MAOIs, selective serotonin reuptake inhibitors like Prozac and Paxil, and tricyclics such as Tofranil. Effexor can cause greater-than-expected weight loss when used with Dexedrine. Antacids and the glaucoma and diuretic drug acetazolamide decrease the excretion of Dexedrine from the body and may cause toxic levels to accumulate. Many herbal supplements may also interact with Dexedrine and cause toxicity, including ginseng and green tea.

Len Sperry, MD, PhD

See also: Attention-Deficit Hyperactivity Disorder; Bipolar Disorder; Tourette's Syndrome

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DHEA (Dehydroepiandrosterone)

DHEA is a hormone used for increasing cognitive functioning and slowing the progression of Alzheimer's disease and some medical conditions. Its technical name is dehydroepiandrosterone.

Definitions

- **Adrenal insufficiency** exits when the adrenal glands do not produce sufficient epinephrine, norepinephrine, cortisol, aldosterone, and corticosterone. Addison's disease can result from it.
- **Hormone** is a chemical messenger that regulates such bodily functions as growth, development, metabolism, reproduction, and mood.

Description

DHEA is produced naturally by the adrenal glands. It has a number of uses, including increasing cognitive performance; slowing the progression of Parkinson's disease and Alzheimer's disease, adrenal insufficiency, depression, systemic lupus erythematosus (lupus), and erectile dysfunction; and improving sexuality and well-being. DHEA is also used to increase muscle mass, strength, and energy, but it is banned by the National Collegiate Athletic Association. The body converts DHEA into male and female sex hormones, such as estrogen and testosterone.

DHEA is also available as a nutritional supplement made from a substance found in soy and wild yams. Because of concerns about false claims, these supplements were taken off the U.S. market in 1985. But it was reintroduced after the Dietary Supplement Health and Education Act was passed in 1994. DHEA levels in the body begin to decrease after age 30 and may be low in those with anorexia, end-stage kidney disease, type 2 diabetes, AIDS, and adrenal insufficiency, and in the critically ill. DHEA levels may also be depleted by a number of medications, including insulin, corticosteroids, opiates, and Danocrine. While evidence supports the short-term use of DHEA in the treatment of adrenal insufficiency, depression, and lupus, there is concern about its long-term use. Because DHEA can elevate levels of androgens and estrogens in the body, it could increase the risk of prostate, breast, ovarian, and other hormone-sensitive cancers. Therefore, it is not recommended for regular use without medical supervision. DHEA is being investigated and may eventually be

approved by the Food and Drug Administration as a prescription drug for treating systemic lupus erythematosus and improving bone mineral density in women with lupus who are taking steroid drugs for treatment. Clinical trials are being conducted on DHEA with anxiety disorder, schizophrenia, and schizoaffective disorder. Information on participation in a clinical trial is available at the website of the NIH Clinical center, http://www.cc.nih.gov.ezproxy.fau.edu/participate.

Precautions and Side Effects

Because DHEA is a hormone it should be used under medical supervision, particularly those with or at risk for mood and psychotic disorders. Children and pregnant or breast-feeding women should not use it. Since it may alter liver function, those with liver disease should not use it. DHEA supplements may alter the levels estrogen and testosterone, which can increase the risk of hormone-sensitive cancers such as breast, prostate, and ovarian cancer. Those taking DHEA supplements may develop blood clots, so people with clotting disorders, heart disease, and a history of stroke should avoid DHEA supplements. DHEA supplements can affect the levels of other hormones, such as insulin and thyroid hormone, and also affect cholesterol levels. Those with diabetes, high cholesterol, thyroid disorders, Cushing's disease, and other hormonal disorders should be particularly cautious.

Common side effects of DHEA supplements include acne, insomnia, fatigue, oily skin, abdominal pain, hair loss, nasal congestion, irregular heartbeats, and heart palpitations. Since DHEA supplements may influence the production of male and female hormones, facial hair growth and a deepening of the voice may occur in women. Men may develop male pattern baldness, aggressiveness, high blood pressure, breast enlargement, and shrinkage of the testicles.

DHEA supplements may interfere with the effectiveness of antipsychotic medications such as Thorazine and Compazine. It may increase the effects of AZT (HIV medication), barbiturates, oral contraceptives, and benzodiazepines, such as Halcion, Xanax, and Valium.

Len Sperry, MD, PhD

See also: Alzheimer's Disease

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Diagnosis

Diagnosis is the process of identifying and labeling a medical or psychiatric disorder.

Definitions

- **Case conceptualization** is a method and strategy for obtaining and organizing information, understanding and explaining maladaptive patterns, focusing treatment, anticipating challenges, and preparing for termination.
- **Clinical assessment** is the formal process of collecting clinical data to establish a diagnosis, to develop a case conceptualization, and to plan treatment.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Mental status examination** is a clinical evaluation of an individual's appearance, orientation, behavior, mood and affect, speech, thinking, perception, cognition, insight, and judgment.
- **Psychiatric diagnosis** is a form of diagnosis based on the identification and labeling of mental disorder based on meeting diagnostic criteria matching a particular disorder.

Description

Diagnosis is a form of clinical assessment for the identification and labeling of a medical or psychiatric condition or disorder based on its signs and symptoms.

Clinical assessment has at least three goals. The first is to establish a psychiatric diagnosis based on *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria. The second is to develop a case conceptualization. The third is to plan treatment based on the diagnosis and case conceptualization. Of these three, establishing a psychiatric diagnosis is the first and, some would say, the most important step in clinical assessment.

Developments and Current Status

A psychiatric diagnosis is arrived at by comparing specific symptoms and impairment against the criteria for a given clinical disorder. Psychiatrists, psychologists, and mental health counselors diagnose psychiatric (mental) disorders using the criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is a reference work consulted by these and other clinicians, including social workers, couples and family therapists, medical and nursing students, and pastoral counselors.

The psychiatric diagnosis is based on a psychiatric evaluation (clinical assessment) that includes both psychiatric interview and observational data. Typically, a psychiatric interview includes questioning the individual about the reason for the diagnostic evaluation (clinical assessment); history of the present illness including symptoms, severity, and length of time involved; past psychiatric history; and developmental, psychosocial, and educational history. Additional data often includes information about health history and use of prescribed medications, alcohol, and street drugs. If the individual is unable or unwilling to provide such information, collateral information is sought. Information to better understand the individual's present condition and past history comes from relatives, friends, or available medical and psychiatric records.

An essential element of the psychiatric evaluation is a mental status examination, which is an assessment of the individual's overall level of functioning at the time of the evaluation. Psychological tests that the examiner thinks are necessary to establish or rule out a specific diagnosis may be undertaken.

A diagnosis is used to establish a prognosis (prediction of response to treatment) for the individual and to foster communication among health-care professionals involved in the individual's care. Furthermore, a formal DSM diagnosis may be required by insurers to pay for treatment services.

Len Sperry, MD, PhD

See also: Behavioral Assessment; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Mental Status Examination

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Diagnostic and Statistical Manual of Mental Disorders (DSM)

The *Diagnostic and Statistical Manual of Mental Disorders* is a diagnostic classification framework that characterizes mental disorders with specific diagnostic criteria.

Definitions

- **Mental disorder** is a mental or behavioral pattern or anomaly that causes either distress or an impaired ability to function in daily life. It is also known as a mental illness or psychiatric disorder.
- **Phenomenological** refers to a method of classification that emphasizes externally observable phenomena and descriptions rather than their underlying nature or origin.

Description

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) provides a common language and standard criteria for the classification of mental disorders.

The DSM is used in the United States as well as in other countries. It is used by clinicians, researchers, drug regulation agencies, insurance companies, the pharmaceutical industry, and policy makers. DSM is published by the American Psychiatric Association. Two other diagnostic manuals are the *International Statistical Classification of Diseases and Related Health Problems* (ICD) published by the World Health Organization and the *Psychodynamic Diagnostic Manual* published by the Alliance of Psychoanalytic Organizations. The stated purpose of the DSM is threefold: to provide a useful guide to clinical practice, to facilitate research and improve communication among clinicians and researchers, and to serve as an educational tool for teaching psychopathology.

Developments and Current Status

The origins of the DSM are in census and psychiatric hospital statistics, and from a United States Army and Veterans Administration (VA) manual. The DSM was substantially revised in 1980. The six revisions since its first publication in 1952 incrementally added to the number of mental disorders while removing those no longer considered to be mental disorders. The last major revision is DSM-5 in 2013. While the DSM is the official diagnostic system for mental disorders in the United States, it is also used widely in Europe and other parts of the world. Throughout its history, the DSM coding system is designed to correspond with the codes used in the ICD, although not all codes may match at all times because the two publications are not revised synchronously. The following is a brief description of all the DSM manuals from the beginning through DSM-5.

DSM-I. In 1952 DSM was published by the American Psychiatric Association. It listed 106 diagnostic categories and was merely 130 pages long. In 1949, the World Health Organization published the sixth revision of the *International Statistical Classification of Diseases* (ICD), which included a section on mental disorders for the first time. Soon afterward, the APA Committee on Nomenclature and Statistics was tasked with developing a diagnostic manual for use in the United States. It based this manual on the structure and conceptual framework of "Medical 203" of the VA system and ICD nomenclature. Many passages of text were identical to those in Medical 203. DSM-I included several categories of personality disturbance, neurosis, psychosis, and acute and psychophysiological reactions.

DSM-II. In 1968 DSM-II was published and listed 182 diagnostic categories. It was 134 pages long. It was remarkably similar to the DSM-I. It appeared prior to ICD-9, which was published in 1975. While the designation "reaction" was dropped, the term "neurosis" was retained. Both the DSM-I and the DSM-II reflected the predominant psychodynamic view. However, both included biological perspectives and concepts from a descriptive system of classification. Symptoms were not specified in detail for specific disorders. Many were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis (roughly, anxiety/depression broadly in touch with reality, or hallucinations/delusions appearing disconnected from reality). Sociological and biological knowledge was incorporated, in a model that did not emphasize a clear boundary between normality and abnormality. The idea that personality disorders did not involve emotional distress was discarded.

DSM-III. In 1980 DSM-III was published and listed 265 diagnostic categories. The original purpose of this revision was to make the DSM nomenclature consistent with the then current version of ICD. Another purpose was to improve the uniformity and validity of psychiatric diagnosis, and to standardize diagnostic practices. The establishment of these criteria was an attempt to facilitate the pharmaceutical regulatory process. The psychodynamic view was abandoned, in favor of a phenomenological (descriptive) model. Mental disorders were conceptualized as a clinically significant behavioral or psychological syndrome. The personality disorders were placed on axis II along with mental retardation. Besides the expansion of diagnostic categories, the most notable difference that would greatly impact clinical practice was the addition of a multiaxial system. This means an individual is evaluated on five axes or dimensions, each representing a different aspect of functioning. Axes I and II refer to types of psychological or psychiatric disorders, while Axes III through V represent general medical conditions, psychosocial and environmental problems, and a global assessment of functioning, respectively.

DSM-III-R. In 1987 the DSM-III-R was published as a revision of DSM-III. Six categories were deleted while others were added. Controversial diagnoses such as premenstrual dysphoric disorder and masochistic personality disorder were considered and discarded. "Sexual orientation disturbance" was also removed and was largely subsumed under "sexual disorder not otherwise specified," which can include "persistent and marked distress about one's sexual orientation." Altogether, DSM-III-R contained 292 diagnoses and was 567 pages long. Further efforts were made for the diagnoses to be purely descriptive.

DSM-IV. In 1994, DSM-IV was published with 297 disorders. Revisions were based on research reviewed by work groups and results from multicenter field trials relating diagnoses to clinical practice. A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Some personality disorder diagnoses were deleted or moved to the appendix.

DSM-IV-TR. In 2000, a text revision of the DSM-IV, known as the DSM-IV-TR, was published. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged. The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes to maintain consistency with the ICD.

DSM-5. In 2013, DSM-5 was published. It includes the same number of disorders as in DSM-IV. A number of changes in structure as well as content were made since the last edition. The most obvious is that the multiaxial system has been removed. The five Axes (I, II, III, IV, V) had been the focal point of DSM since it was introduced in 1978 with DSM-III. DSM-5 now documents diagnoses in a nonaxial manner, which combines the former Axes I, II, and III with separate notations for psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V). Other changes involve the addition of some new diagnoses, the removal of others, and revision of criteria for several disorders. These changes will align DSM-5 with the World Health Organization's International Classification of Diseases, eleventh edition (ICD-11). They are expected to foster improved communication and common use of diagnoses across disorders. DSM-5 is comprised of three sections. The first section describes how to use the updated manual. The second section describes the diagnostic categories. The third section includes cultural formulations and diagnostic conditions that are yet considered formal disorders.

Overall, three main changes are evident in the various editions of DSM. First, there has been a clear shift from defining mental disorders by their causes toward defining disorders as clusters of symptoms. Second, there is a coordination of diagnoses with the ICD. Third, there has been increased use of field trials and statistical analysis in evaluating the adequacy of diagnostic terms and criteria.

Len Sperry, MD, PhD

See also: Psychodynamic Diagnostic Manual (PDM)

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Dialectical Behavior Therapy (DBT)

Dialectical behavior therapy is a type of cognitive behavior therapy (CBT) which focuses on coping with stress, regulating emotions, and improving relationships. It is also known as DBT.

Definitions

- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors.

- **Cognitive behavior therapy** is a psychotherapy approach that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Cognitive restructuring** is psychotherapy technique for replacing maladaptive thought patterns with more constructive thoughts and beliefs.
- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing distorted thinking patterns.
- **Dialectic** is a form of discussion that resolves differences between two views rather than concluding that only one is true.
- **Schemas** are core beliefs or assumptions about one's self and the world.
- **Schema therapy** is a type of cognitive behavior therapy that focuses on identifying and changing maladaptive schemas.

Description

Dialectical behavior therapy (DBT) is a type of CBT that focuses on learning skills to cope with stress, regulate emotions, and improve relationships. DBT is an outgrowth of behavior therapy in that both focus on behavioral deficits and emotional excesses (inability to regulate emotions). Like CBT, DBT emphasizes a collaborative relationship between client and therapist. Both utilize learning principles, analyze triggers and environmental prompts, explore schemas and emotions, and utilize homework. In addition, recognize the importance of empathic responding.

Unlike traditional CBT, DBT emphasizes emotion regulation more than maladaptive (problematic) beliefs and schemas. Cognitively oriented CBT insists that dysfunctional feelings and behaviors are due to maladaptive beliefs and schemas that produce consistently biased judgments and cognitive errors. Instead, DBT focuses on how maladaptive schemas are initially formed. It explores schemas and the underlying dialectic conflicts that produced them rather than using cognitive restructuring to change them. DBT therapists attempt to connect clients' maladaptive beliefs to underlying affect and need, and then assist them to reinterpret their belief systems based on greater awareness of their feelings and needs.

The core strategies in DBT are "validation" and "problem solving." DBT attempts to validate clients' behavior and demonstrate an understanding of their difficulties and suffering. Problem solving focuses on the establishment of necessary skills. DBT has four primary treatment modes: individual therapy, skills training in a group, telephone contact, and therapist consultation. Following an initial period of pretreatment involving assessment, commitment, and orientation to therapy, DBT focused on the specific targets for that stage, which are arranged in a definite hierarchy of relative importance. These include decreasing suicidal behaviors, decreasing therapy-interfering behaviors, decreasing behaviors that interfere with the quality of life, increasing behavioral skills, decreasing behaviors related to post-traumatic stress, improving self-esteem, and attaining individual targets negotiated with the client.

Developments and Current Status

DBT was developed for the treatment of borderline personality disorder by American psychologist Marsha Linehan (1943–). Linehan developed this approach after finding that traditional psychotherapeutic approaches were ineffective in treating suicidal individuals with borderline personality disorder. She focused her approach on skills training because these individuals had considerable skill deficits. She also found that skills training was best accomplished in weekly didactic groups. These groups use a step-by-step format to teach four sets of skills. These skill sets are core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.

Core mindfulness. This is the ability to take control of one's mind rather than being controlled by it. Mindfulness focuses one's attention by a process of observing, describing, and participating from a nonjudgmental perspective. This allows for more objective, effective, and meaningful experiences in the present moment.

Interpersonal effectiveness. This is the ability to communicate and express oneself effectively while

understanding and remaining committed to one's goals and self-respect. It includes being able to ask for what one needs, say no, and cope with interpersonal conflict. Skills training includes assertive communication, interpersonal problem solving, and negotiation.

Emotion regulation. This is the ability to regulate your emotions by understanding the relationship between thoughts, feelings, body sensations, and behaviors. It also includes awareness of one's vulnerabilities and how they affect one's emotional states. These include inadequate sleep, misuse of medications, lack of exercise, and not incorporating positive experiences in daily life.

Distress tolerance. This is the ability to get through a difficult time without making the situation worse. Being able to tolerate distress (painful emotions) reduces the likelihood of engaging in self-destructive behaviors. Distress tolerance teaches the use of distraction, radical acceptance, and evaluating pros/cons as alternatives.

Research indicates that DBT is most effectively accomplished in an inpatient, partial hospitalization or residential treatment setting rather than in outpatient and private practice. DBT is best implemented with a treatment team in which one therapist provides skills training and another provides individual therapy. This is best accomplished when other therapists can provide a consultation function and when all therapists have access to a therapist consultation group for support.

More recently, DBT has been modified and extended for use with other personality disorders as well as Axis I or symptom disorders such as mood disorders, anxiety disorders, eating disorders, and substance disorders. DBT is an outgrowth of behavior therapy but is less cognitive than traditional CBT since DBT assumes that cognitions are less important than affect regulation. DBT has been adapted for private practice settings. It is recommended that the skill training component be best provided by another therapist; it is not absolutely necessary. Also, private practice clinicians using DBT would do well to have access to a psychotherapy consultant if involvement in a therapist consultation group is not possible.

Len Sperry, MD, PhD

See also: Behavior Therapy; Cognitive Behavior Therapy; Cognitive Therapy; Schema-Focused Therapy

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Dictionary of Occupational Titles (Book)

This book source was created in 1939 by the U.S. Department of Labor as a reference list of occupations for use by those interested in or seeking job placement.

Definitions

- **Occupational information** describes useful vocational data and facts, including career descriptions, requirements, benefits, and possible compensation for students, job seekers, and business/industry professionals to assist them in navigating the world of work.
- **Occupational Information Network (O*NET)** is the online occupational website that was created in 1991 to replace the *Dictionary of Occupational Titles* (DOT) print publication.

Description

The *Dictionary of Occupational Titles* (DOT) was published by the U.S. Department of Labor in 1939 to offer job seekers, employers, and career advisors with a comprehensive list of occupations and facts related to those. Containing over 17,000 vocational titles and descriptions, this first edition categorized jobs as skilled, semiskilled, or unskilled. The first edition of the DOT was also used to properly place World War II veterans in careers commensurate with their skills on their return. Second, third, and fourth editions of the DOT were published in 1949, 1965, and 1977, respectively.

Supplements to the fourth edition followed periodically to update the list of job categories and modify the skills required (e.g., technology related) and to notify readers of changes in workforce demand. A final update occurred in 1991. Soon after, the DOT was replaced by an online source, the Occupational Information Network, or O*NET. This website provides a comprehensive, up-to-date guide for students, trainees, workers, and employers to gather vocational information. Though it now contains only 13,000 job categories, fewer than the DOT had in 1939, these categories are now organized under occupational umbrellas, making it easier for searchers to scan through related fields of interest. The O*NET system houses a variety of useful sources, including the *Dictionary of Occupational Titles*, the *Directory of Occupational Titles*, and the *Occupational Job Outlook*. There are multiple ways to search the O*NET system, including sorting by job category, description, skills, interests, and/or work values.

Impact (Psychological Influence)

O*NET is readily used by career counselors and advisors as a valuable reference tool to help assess client's work values, interests, and aptitudes and assist in finding proper placement. Given O*NET's wide range of search capabilities and the vast amount of information it contains, it is a popular site for those seeking employment or those looking to attract good employees. The system is updated on a biannual basis to allow for the most current information to be obtained by users.

Melissa A. Mariani, PhD

See also: Career Assessment; Career Counseling; Career Development; Occupational Information

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Disability and Disability Evaluation

Disability is a physical or mental impairment that substantially limits one or more of the major life activities of an individual. Disability evaluation is a formal determination of the degree of a physical, mental, or emotional disability.

Definitions

- **Americans with Disabilities Act (ADA)** is a civil rights law intended to protect against discrimination based on disability. It was originally signed in 1990 and amended in 2008.
- **Disability** is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
- **Handicap** is a disadvantage for a given individual that limits or prevents the fulfillment of a role that is normal.
- **Impairment** is any loss or abnormality of psychological, physiological, or anatomical structure or function.

Description

In the United States disability has been legally defined in the Americans with Disabilities Act. Disability is a physical or mental impairment that substantially limits one or more of the major life activities of an individual. Major life activities include self-care, full range of movement, communication, vision, hearing, working, learning, and social relating. Disability can be caused by congenital (birth related), traumatic (accidental), or other factors, and vary widely in severity. They may be temporary or permanent, correctable, or irreversible. Physical disabilities include blindness, deafness, deformity, muscular and nervous disorders, paralysis, and loss of limbs. Mental disabilities are of two types: mental illness and mental retardation.

The terms "impairment," "disability," and "handicap" are often used synonymously. However, there are technical distinctions and different meanings for these terms. The most commonly accepted definitions are those of the World Health Organization in "The International Classification of Impairments, Disabilities, and Health." Basically, "impairment" refers to a problem with a structure or organ of the body, whereas "disability" is a functional limitation with regard to a particular activity. In contrast, "handicap" refers to a disadvantage in filling a role in life related to an individual's peer group. As already noted, disabilities can be correctable. Thus, an individual may not be able to walk because of an impairment of mobility (movement) such as paralysis. However, if this individual uses a wheelchair and is able to perform daily activities, then the impairment is presumably limited.

Developments and Current Status

The presence or absence of diagnosis of disability is essential in determining whether an individual meets the eligibility criteria for Social Security. It is also used to determine eligibility for benefits and income under disability insurance and for workmen's compensation benefits. A disability evaluation is the formal assessment procedure used in making this determination.

A mental disability evaluation examination is usually performed by a psychologist or psychiatrist. Intelligence testing and/or memory testing is commonly used when the alleged disability is due to learning disabilities, inability to read or write, a stroke, organic brain disorders, accident, or mental retardation A psychiatric evaluation and mental status examination is used when the alleged disability is due to personality disorder, an anxiety or mood disorder, or schizophrenia.

The physician or psychologist who performs the examination sends a written report to a specified Social Security board, a disability insurer, or a workman's compensation board. The report contains an opinion about the examinee's capacity to remember and understand instructions and to deal with supervisors and coworkers, and with work and life stresses. Based on this input, the board or insurer determines the disability and its extent.

Len Sperry, MD, PhD

See also: Americans with Disabilities Act (ADA)

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Disinhibited Social Engagement Disorder

Disinhibited social engagement disorder is a mental disorder in children characterized by an overly familiar and culturally inappropriate behavior with strangers.

Definitions

- **Attachment** is the emotional bond between children and caregivers that provides a secure (healthy) base from which children are able to safely explore their environment and relate to others.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Fetal alcohol syndrome** is a medical condition characterized by birth defects and learning and behavioral problems in children resulting from the mother's alcohol use during pregnancy.
- **Post-traumatic stress disorder** is a mental disorder characterized by nightmares, emotional numbing, and recurrent flashbacks of a

traumatic event that an individual experienced or witnessed.

- **Reactive attachment disorder** is a mental disorder characterized by disturbed and developmentally inappropriate social relatedness.
- **Trauma- and stressor-related disorders** are a group of mental disorders characterized by exposure to a traumatic or stressful event. These include post-traumatic stress disorder, reactive attachment disorder, and disinhibited social engagement disorder.

Description and Diagnosis

Disinhibited social engagement disorder is one of the trauma- and stressor-related disorders. This disorder is characterized by a pattern of behavior that is culturally inappropriate and overly familiar with relative strangers. Such behavior violates ordinary social customs and cultural boundaries. In some ways, this disorder is the mirror opposite of reactive attachment disorder. Whereas children with reactive attachment disorder cannot easily relate to individuals they know, those with disinhibited social engagement disorder relate indiscriminately to individuals they do not know. They show little anxiety and no distrust of those strangers as they engage in culturally inappropriate physical contact and displays of affection. These children tend to be happy and affectionate around strangers. They may or may not be this way with their parents or caregivers. Strangers may view these children as clingy. However, they are likely to become emotionally sensitive and anxious if strangers seem to reject their affection.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, children can be diagnosed with this disorder if they exhibit a pattern of behavior in which they seek out attention and contact with unfamiliar adults. They show a noticeable and concerning familiarity with strangers, such as inappropriate verbal and physical interactions. They may go off with strangers without hesitation. They may also not be aware of their caregiver in these unfamiliar settings. Their pattern of social neglect is evident by repeated changes in the primary caregiver or limited opportunities to form developmentally appropriate connections with caregivers. Finally, this diagnosis can be made if the child is at least nine months of age (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, social neglect is often present in the first few months of life in children diagnosed with this disorder (American Psychiatric Association, 2013). Children may respond to such limited displays of caring by actively seeking other sources of security and nurture. Then, having learned that parents or caretakers cannot be depended upon to care for and protect them, they look for others who might meet their needs and attempt to engage them in a friendly or overly friendly manner. Besides such neglect, repeated changes in the primary caregiver and limited opportunities to form appropriate connections and secure (healthy) attachments with caregivers may also be factors that contribute to the development of this disorder. There may also be a biological bases for this disorder. The indiscriminate social behavior seen in disinhibited social engagement disorder is also noted in some other disorders. These include cases of fetal alcohol syndrome even where there is no history of social neglect.

Treatment

The treatment of this disorder usually involves psychological interventions. The active involvement of the child's primary caregiver is essential. Establishing a sense of safety and security between the child and the caregiver is the first goal of treatment. Once such trust and consistency is formed, the child is less likely to seek comfort from strangers. Caregivers are then taught how to help their child set interpersonal boundaries. Cognitive behavior therapy can help in reducing stress and negative emotions associated with caring for a child with this disorder.

Len Sperry, MD, PhD

See also: Attachment Styles; Cognitive Behavior Therapy; Reactive Attachment Disorder

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Disruptive, Impulse-Control, and Conduct Disorders

Disruptive, impulse-control, and conduct disorders are a group of mental disorders characterized by a lack of self-control.

Definitions

- **Attention-deficit/hyperactivity disorder** is a mental disorder characterized by difficulty focusing as well as being overly active. It is commonly referred to as ADHD.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Family therapy** is a method of therapy that seeks to create change by improving the relationships and rules of the family.
- **Personality disorders** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Disruptive, impulse-control, and conduct disorders are a category of mental disorders that are characterized by the inability to regulate one's behavior, emotional responses, or both. This group of disorders includes oppositional defiant disorder, intermittent explosive disorder, and conduct disorder. A key factor that differentiates this group of disorders from disorders is that individuals with this group of disorders act in a way that violates the rights of others or social rules. The prevalence of these disorders varies, but as a rule, they tend to affect males more frequently than females (American Psychiatric Association, 2013). It is important to note that many of the symptoms of these disorders appear in the course of normal childhood development. Therefore, the occasional occurrence of some symptoms does not necessarily mean that an individual has, or will develop, one of these disorders. This group of disorders also includes antisocial personality disorder. However, that disorder is listed primarily as a personality disorder in DSM-5. A brief description of these DSM-5 disorders follows.

Conduct disorder. It is characterized by a pattern of behavior that violates the rights of others. This disorder represents a pattern of symptoms that is dominated by a lack of behavioral regulation. This disorder is one of the most severe of this category. Individuals with this disorder may exhibit a pattern of hurting other people and animals, and destroying property. Some individuals with this disorder may also lack guilt about their actions or empathy toward others. To be diagnosed with this disorder, an individual must exhibit a number of symptoms that may include fighting (with or without a weapon), bullying, torturing animals, sexual assault, purposefully destroying property, breaking into someone's home or vehicle, theft, sneaking out of his or her home, and skipping school. Prevalence of this disorder is estimated to be approximately 4% of the population (American Psychiatric Association, 2013). For some, this disorder manifests in childhood; for others, it may manifest in adolescence or adulthood. For those who develop this disorder as a child, their outcome is often worse than for those who develop it later. Treatment for this disorder may include psychotherapy, family therapy, and medication.

Kleptomania. It is characterized by impulsive stealing. The principal difference between kleptomania and thievery is that individuals with this disorder steal because they are excited by it or feel tension that is released when stealing, whereas thievery involves stealing for monetary gain. The prevalence if this disorder is rare, affecting less than 1% of the population (American Psychiatric Association, 2013). However,

this disorder is associated with up to 25% of individuals who shoplift. For an individual to be diagnosed with this disorder, he or she must demonstrate a pattern of stealing that is not for monetary gain. The individual must experience a tension that is released by stealing followed by pleasure (American Psychiatric Association, 2013). Treatment for this disorder typically involves psychotherapy.

Intermittent explosive disorder. It is characterized by a pattern of behavioral outburst cause by an inability to regulate one's emotions and impulses. This disorder represents a pattern of symptoms that are not dominated by either an inability to regulate one's behavior or emptions but approximately divided between the two. One of the common features of this disorder is aggression toward others. This aggression may be physical or verbal and far exceeds that which is normal for the individual's age or the situation where it is expressed. Most often, there is little or no provocation preceding the outburst. For this diagnosis to apply, the individual must exhibit a pattern of aggression that does not result in harm to others or property, which occurs at least twice a week for three consecutive months. However, if the consequences of the individual's actions are more severe and others or property is harmed, only three outbursts in a given year are required. Also, the individual must be at least six years of age and the aggression cannot have been preplanned and excessive. The prevalence of this disorder is estimated to be 2.7% (American Psychiatric Association, 2013). This disorder usually begins in late childhood but may affect people well into middle age. Treatment for this disorder may include psychotherapy, family therapy, and medication.

Oppositional defiant disorder. It is characterized by a pattern of irritability, moodiness, or defiance. This disorder represents a pattern of symptoms dominated by a lack of emotional regulation. This disorder is not to be confused with the otherwise normal childhood mood fluctuations or argumentativeness. The key differentiator is that these symptoms are persistent. For this diagnosis to apply, the individual must exhibit a number of symptoms to suggest that he or she is angry, temperamental, purposefully annoying, blaming, argumentative, or spiteful. Most important, the individual must demonstrate this with someone who is not a sibling and for at least six months. In addition, the individual must demonstrate these symptoms at least once a week or more, depending on age (American Psychiatric Association, 2013). Like all disorders, the social and cultural setting of the child is important to consider when making a diagnosis. The prevalence of this disorder is estimated to be 3.3% (American Psychiatric Association, 2013). The disorder is most likely to manifest prior to grade school. Individuals who experience this disorder may later develop conduct disorder and may be a greater risk for developing other mental disorders. Also, it is common for individuals suffering from this disorder to also have ADHD. Treatment for this disorder may include psychotherapy, family therapy, and medication.

Pyromania. It is characterized by multiple episodes of starting fires. Individuals who experience this disorder not only set fires but also are obsessed or fascinated by fire. The prevalence of this disorder as a standalone diagnosis is very rare, affecting less than one-third of 1% of the population (American Psychiatric Association, 2013). However, it does co-occur more frequently with other disorders. For someone to be diagnosable with this disorder, the individual must intentionally set multiple fires. The individual must experience emotional excitement, relief, or pleasure associated with setting the fire and the aftermath. Also, the individual must not have a cause or motive to set fires aside from his or her own interest or fascination in fire itself, such as in the case of criminal arson (American Psychiatric Association, 2013). As this disorder is often one of multiple disorders that occur in an individual, treatment varies depending on the other diagnosis but will typically involve psychotherapy aimed at changing the beliefs and behaviors surrounding fire.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Antisocial Personality Disorder; Attention-Deficit Hyperactivity Disorder; Conduct Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Family Therapy; Intermittent Explosive Disorder; Kleptomania; Oppositional Defiant Disorder (ODD); Personality Disorders; Psychotherapy; Pyromania

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Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder is a mental disorder in children characterized by a severe and frequent temper tantrums that interfere with daily functioning.

Definitions

- **Bipolar and related Disorders** are a group of mental disorders characterized by changes in mood and in energy (e.g., being highly irritable and impulsive while not needing sleep). These disorders include bipolar I disorder, bipolar II disorder, and cyclothymic disorder.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily functioning. These disorders include major depressive disorder, persistent depressive disorder, disruptive mood dysregulation, and premenstrual dysphoric disorder.
- **Dysregulation** is a problem with the control of physical or emotional functions.
- **Temper tantrums** are disruptive behaviors or emotional outbursts displayed in response to unmet needs or desires.

Description and Diagnosis

Disruptive mood dysregulation disorder is one of a group of depressive disorders. It is characterized by severe and persistent irritability resulting in temper tantrums and persistent anger or irritability between the tantrums. Both interfere with children's ability to function at home, in school, or with their friends. Prior to DSM-5, many with this symptom pattern were likely to be labeled as "bipolar children." Some of these children were diagnosed with bipolar disorder even though they seldom met all the symptoms and criteria. Research suggests that most will not go on to develop bipolar disorder as adults. Instead, children with chronic irritability are more likely to develop depressive and/or anxiety disorders when they become adults (American Psychiatric Association, 2013).

In terms of mood symptoms, children with this disorder can be irritable, upset, or moody from time to time. They may switch rapidly from irritable, easily annoyed, and angry mood states to silly, goofy, and giddy states of elation. They can experience periods of sadness almost every day. During adolescence this may be demonstrated by suicidal thoughts and behaviors. Often these children are very bright and capable but are greatly challenged by this disorder.

Occasional temper tantrums are a normal part of growing up. However, when children are continually irritable or angry or when temper tantrums are frequent, intense, and ongoing, it may suggest this depressive disorder. Such individuals (6 to 18 years of age) are probably fighting off depression or at least fighting to overcome imagined burdens. While anxiety reflects the individual's awareness of a burden to overcome, expressed frustration, irritability, and anger reflect the individual's efforts to react against and reach some resolution.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit chronic irritability that contributes to recurrent frustrations and temper outbursts. These outbursts occur more than three times per week and their moods between temper outbursts are persistently irritable or angry. The symptoms have been present for at least a year and the irritability and temper has been expressed across at least two settings, such as at home, school, or work, and contribute to significant functional disruption in those environments. This diagnosis can be given only to those between the ages of 6 and 18. Finally, this

disorder cannot have been caused by a substance, medication, or a medical condition or other mental disorder (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. It may be that genetic, environmental, and temperamental (personality) factors are operative (American Psychiatric Association, 2013). Because it is a mood disorder it is likely that it could result from a combination of biological predispositions and environmental conditions. It can run in families suggesting a genetic basis, or it can be a result of stressful environments in which the child lives. It may also be that a recent death in the family, a divorce, or relocation is a factor. Some children have neurological disorders like migraine headaches that may account for their persistent irritability. Or, their mood dysregulation may be associated with early psychological trauma and abuse.

As with other mood and conduct disorders in children, diagnosis is often delayed or mistaken for other conditions. Before a correct diagnosis is made, other diagnoses can be given. These include attention-deficit hyperactivity disorder, obsessive-compulsive disorder, depression, separation anxiety disorder, oppositional defiant disorder, and other conduct disorders. Even after the disruptive mood dysregulation disorder diagnosis is given, many children continue to be diagnosed with one or more of these diagnoses as well. Therefore, children with it and other diagnoses should be comprehensively evaluated and treated for these issues.

Treatment

Effective treatment of this disorder is individualized to the needs of the particular child and family. It usually includes individual therapy. Consulting with the child's family and school are usually necessary and helpful. Parents of children with this disorder need to fully understand it. For this reason, the therapist might meet with parents and assist them in dealing more effectively with their child or adolescent. Parents and teachers are helped to analyze the triggers and the purpose of their tantrums. They learn that when these disruptions longer serve a useful purpose, children can learn alternative ways of getting their needs met and relating in a healthier way with peer and family members. It may also be necessary for family therapy to address the family behaviors that promote the disruptive behaviors. Depending on the age of the child, medication may be prescribed. Medication, such as Ritalin and Risperdal, has been used to reduce impulsivity and irritability.

Len Sperry, MD, PhD, and
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See also: Bipolar Disorder; Conduct Disorder; Depression; Oppositional Defiant Disorder (ODD); Risperdal (Risperidone); Ritalin (Methylphenidate)

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Dissociative Amnesia

Dissociative amnesia is a dissociative disorder characterized by the inability to remember important personal information beyond what could be explained by normal forgetfulness. It is also known as psychogenic amnesia.

Definitions

- **Amnesia** is the inability to recall past events or retain new information. It usually occurs as a result of physical or psychological trauma.
- **Depersonalization** is a mental state of detachment or a sense of being "outside" oneself and observing one's actions or thoughts.

- **Dissociation** is a psychological process in which individuals experience being disconnected from their sensory experience, sense of self (identity), or personal history.
- **Dissociative disorders** are a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness and which cause impaired functioning.
- **Dissociative fugue** is a dissociative disorder characterized by a temporary loss of personal identity, moving to a new location, and assuming a new identity.
- **Dissociative identity disorder** is a dissociative disorder characterized by having more than one distinct identity. Previously it was referred as multiple personality disorder.
- **Post-traumatic stress disorder** is a mental disorder characterized by unwanted recollections or a reexperiencing of a traumatic event with arousal symptoms.

Description and Diagnosis

Dissociative amnesia is a dissociative disorder in which the characteristic feature is the sudden and temporary loss of ability to recall important personal information. This disorder is usually a reaction to experiencing or witnessing a traumatic event or violent crime. The loss of memory can involve information about a specific topic or memories of the immediate or distant past. It is too extensive to be explained by ordinary forgetfulness, and it cannot be due to a head injury, alcohol-induced blackouts, seizure disorder, or electroconvulsive therapy. Unlike the common portrayal of amnesia in television shows and movies, dissociative amnesia rarely involves a total loss of recall.

A hallmark of this disorder is its rapid onset and rapid recovery. In contrast, recovery of amnesia from organic or medical causes is gradual and is rarely complete. These memories are not actually lost. Rather, they are buried but are not readily accessible. However, they can resurface spontaneously or be accessed in psychotherapy. Individuals with dissociative amnesia may develop depersonalization as part of the disorder, but do not experience a change in identity, which is characteristic of dissociative fugue disorder. The incidence of dissociative amnesia increases during stressful or traumatic times, such as during a war or after a natural disaster. The likelihood of developing this disorder is quite rare in the United States. It is found in only 1.0% of American adult males and 2.6% of adult females (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they are unable to recall important information that is autobiographical in nature. This loss of memory can involve information about a specific topic or memories from the immediate or distant past such as traumatic or stressful events. It can include a loss of knowledge about one's identity or loss of previous knowledge about the world. Besides displaying such symptoms, the individual's functioning is also greatly affected in job, social, or other areas of life. This memory loss cannot be due to substance use, seizures, head injury, or other mental disorders like post-traumatic stress disorder, dissociative identity disorder, or neurological disorder (American Psychiatric Association, 2013).

The cause of this disorder is exposure to an overwhelming stressor such as combat, sexual assault, accidents, natural disasters, and extreme conflict or emotional stress (American Psychiatric Association, 2013). Genetics may also have a role since this disorder tends to run in families.

Treatment

Treatment begins with a comprehensive assessment of the triggering event, current stressors, medical history, psychiatric history and treatment, history of alcohol and substance use, and history of trauma and abuse. Referral for a medical evaluation may be needed to rule out physical trauma, neurological conditions, and drug-induced causes. Treatment of amnesia depends on the root cause of amnesia. Psychotherapy can be helpful for amnesia caused by emotional trauma. The goal is to safely express and process painful lost memories. It may also involve developing new coping skills, improving relationships, and restoring functioning.

Providing a supportive environment may be sufficient for spontaneous resolution to occur.

Len Sperry, MD, PhD

See also: Amnesia; Dissociation; Dissociative Identity Disorder; Post-Traumatic Stress Disorder (PTSD)

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Dissociative Disorders

Dissociative disorders are a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness and which cause impaired functioning.

Definitions

- **Antianxiety** medications are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Antidepressants** are prescription medications used to treat depression and depressive symptoms.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also called CBT.
- **Dissociation** is a psychological process in which individuals experience being disconnected or detached from their sensory experience, sense of self (identity), or personal history.
- **Dissociative fugue** is a dissociative disorder characterized by a temporary loss of personal identity, moving to a new location, and assuming a new identity.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hypnotherapy** is the use of hypnosis to help an individual change his or her beliefs, attitudes, or patterns through suggestion while the individual is in an altered state (hypnotized).
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.

Description

Dissociative disorders are a group of DSM-5 mental disorders that includes dissociative identity disorders, dissociative amnesia, depersonalization/derealization disorder, and other specified dissociative disorder. The central features of these disorders are relatively severe dissociative symptoms and impairment of functioning. Dissociation is a detachment from reality. When individuals suffer from dissociative symptoms, they experience being removed or detached from reality. Dissociative symptoms are numerous and vary significantly in severity. Daydreaming is a non-pathological form of it, while depersonalization (sense that the self is unreal) is a pathological form of dissociation.

Mild dissociation experiences include dreaming or being mad at one's dog when he or she has had a bad day at work. These experiences are not nearly as severe as the experience of one of the dissociative disorders. In addition, these symptoms usually have a rapid onset and are distressing. It is important to note that the dissociative disorders are different from the psychotic disorders whereby individuals can no longer separate what is real and what is not, as in the case of

hallucinations. What follows is a brief description of the four DSM-5 dissociative disorders.

Dissociative identity disorder. This disorder is characterized by an individual having two or more distinct personalities or identities. Often, an individual suffering from this disorder functions as if each identity was a completely different, independent person. When one identity is being expressed, the individual will often not recall what the alternate identity has done. Some who suffer from this disorder maintain a "possessed" personality where a demon or spirit overtakes them. There is variance in the obviousness of the change in personality. For some, there is a dramatic shift between personalities; for others, the change is subtle. Prevalence of this disorder is estimated to be 1.5% and to affect slightly more males than females (American Psychiatric Association, 2013). One of the most important aspects of this disorder is that individuals suffering from it have a very high probability of suicide. Abuse and traumatic events in childhood are associated with the manifestation of this disorder. The vast majority of cases do not resolve on their own and need highly skilled treatment. Treatment of this disorder requires some form of psychotherapy. This disorder was formerly called multiple personality disorder.

Dissociative amnesia. Dissociative amnesia is a dissociative disorder characterized by the inability to remember important personal information beyond what could be explained by normal forgetfulness. The information that cannot be recalled may be isolated to a specific period of time. Often, the event that cannot be recalled is of a stressful or traumatic nature. In other cases, individuals may suffer a complete loss of life history. This disorder is sometimes accompanied by dissociative fugue. It is found in only 1.0% of adult males and less than 3% of adult females (American Psychiatric Association, 2013). Treatment for this disorder will most likely incorporate psychotherapy, as there are no medications shown to be effective with this disorder. In addition, hypnotherapy may be used. This disorder is also known as psychogenic amnesia.

Depersonalization/derealization disorder. Depersonalization/derealization disorder is a dissociative disorder characterized by a symptom of either detachment, a sense of being "outside" oneself or observing one's actions or thoughts (depersonalization), detachment from a sense of one's surroundings, or both (derealization). Although relatively severe depersonalization/derealization is represented as a disorder, mild symptoms such as daydreams may manifest in otherwise normal-functioning individuals for short durations. The principal difference between normal experience and a qualifying disorder is the distress experienced by the individual and the duration of the symptoms. This disorder is most often caused by medical conditions or the ingestions of illicit drugs but may also be caused by extreme stress and trauma. It is relatively rare, occurring in less than 2% of the population (American Psychiatric Association, 2013). Treatment for this disorder may include both medications and psychotherapy.

Other specified dissociative disorder. This disorder is characterized by dissociative symptoms that cause substantial distress or impairment but do not fit the necessary criteria of the preceding disorders. This disorder is best understood as a grouping of four specific subtypes. These subtypes include chronic but relatively mild dissociative symptoms related to one's identity, loss of identity due to intense and prolonged coercion such as that which takes place in a cult. Others are short-term dissociative symptoms lasting less than one month as a result of a traumatic event, and significant and unusual loss of awareness related to one's environment. The prevalence of this disorder is unknown as it represents a newly established disorder in the DSM-5 (American Psychiatric Association, 2013). Like the other dissociative disorders, treatment may include both medication and psychotherapy. However, the psychotherapy of each subtype will be focused in the particular subtype.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Antianxiety Medication; Antidepressant Medications; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Dissociation; Dissociative Fugue; Dissociative Identity Disorder; Psychotherapy; Psychotic Disorders

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Dissociative Identity Disorder

Dissociative identity disorder is a mental disorder characterized by having more than one distinct identity or personality. Previously this disorder was known as multiple personality disorder.

Definitions

- **Amnesia** is the inability to recall past events or retain new information. It usually occurs as a result of physical or psychological trauma.
- **Borderline personality disorder** is a mental disorder characterized by a pattern of instability in interpersonal relationships, self-image, affects, self-harm, and a high degree of impulsivity.
- **Dissociate and dissociation** is a detachment from reality. Daydreaming is a non-pathological form of it, while depersonalization (a sense that the self is unreal) and dissociative identity disorder are pathological forms of dissociation.
- **Dissociative disorders** are a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness and which cause impaired functioning.

Description and Diagnosis

Dissociative identity disorder is one of the class of dissociative disorders characterized by the presence of two or more distinct alter egos (identities) within the same individual. Each alter ego is dominant at a particular time. Each alter helps the individual to cope with and meet the individual's needs. Because there can be 10 or more alters within the individual, it can be difficult to detect and diagnose the disorder early in its course. It may take six or more years of psychological treatment before the proper diagnosis of dissociative identity disorder is made. Because of the waxing and waning character of this disorder and the innumerable permutations of symptoms, the individual may present differently on different occasions. Accordingly, such individuals may receive many diagnoses.

Those with this disorder usually enter psychotherapy for various concerns ranging from anxiety to sleep disorders. In the course of treatment these individuals may complain of new concerns like the sudden onset of dizziness, difficulty finding their parked car, indecision about small matters, or denial of actions that were observed by others. On further investigation, a different alter ego emerges or is discovered in the course of treatment. Other symptoms of this disorder include auditory hallucinations, amnesia, and sudden mood swings. In fact, depression is one the most common of this disorder. The diagnosis of borderline personality disorder is also common, particularly in those who are lower functioning and engage in self-harmful behaviors.

This disorder usually begins in early childhood, although it is usually diagnosed between the ages of late adolescence and early middle age. In their late 50s, many with this disorder identify with one of their more resilient alters. The likelihood of developing dissociative identity disorder is small among adults in the United States, with 1.6% being males and 1.4% females (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a disruption of identity, which involves the presence of two or more distinct identities. As a result of this disruption the individual experiences altered affect, behavior, memory, consciousness, sensory motor functioning, or overall perception. These symptoms may be reported by the individual or observed by others. Memory impairment regarding important personal information, recall of daily events, and recall of traumatic events also occur in this disorder. Besides the individual displaying such symptoms, the individual's functioning is also greatly affected, including job, relationships,

or other areas of life. Furthermore, the disorder cannot be caused by a medication, substance use, or medical condition, such as seizures. Lastly, the disturbance is also not a part of any cultural or religious practices (American Psychiatric Association, 2013).

The cause of this disorder is usually severe and repeated trauma in childhood. It may involve severe emotional, physical, or sexual abuse, neglect, natural disaster, terrorism, war, or the loss of a parent. To survive extreme stress, these individuals dissociate (separate) the thoughts, feelings, and memories of this traumatic experiences from conscious awareness. Approximately 90% of clients living with this disorder have experienced a repeated and severe history of physical and/or sexual abuse as children (American Psychiatric Association, 2013).

Treatment

The ultimate goal of treatment of this disorder is the integration of all alters into a single personality. While this disorder is not very common, some with this disorder experience an integration of their various alters without treatment. For the rest, focused psychotherapy is the primary treatment strategy. The treatment of this disorder tends to be long, demanding, and painful. The initial goal is to establish a trusting relationship, while the intermediate goal is to maximize the individual's functioning. However, some degree of conflict-free collaboration among the various alters may be the only realistic goal for some individuals. Currently, treatment places less emphasis on processing past trauma and more emphasis on improving functioning and helping individuals live more meaningful lives. Generally, medications have limited value in treating this disorder. But they can useful in treating symptoms such as depression, insomnia, and panic.

Len Sperry, MD, PhD

See also: Amnesia; Borderline Personality Disorder; Dissociation

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Dissociative Personality Disorder

Dissociative personality disorder is mental disorder characterized by dissociation as a central personality trait.

Definitions

- **Dissociation** is a psychological process in which individuals experience being disconnected from their sensory experience, sense of self (identity), or personal history.
- **Dissociative disorders** are a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness and which cause impaired functioning.
- **Dissociative identity disorder** is a mental disorder characterized by having more than one distinct identity or personality. Previously, it was known as multiple personality disorder.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hypnosis** is a trancelike state that resembles sleep but is induced by another's suggestions that are readily accepted by the individual.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture. Personality disorder reflects an individual's unique personality structure.

- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.
- **Psychoanalytic therapy** is a form of psychotherapy that emphasizes unconscious (outside awareness) conflicts and focuses on an individual's early childhood and dreams.
- ***Psychodynamic Diagnostic Manual* (PDM)** is a diagnostic system based on psychoanalytic theory that is used by professionals to identify mental disorders with specific diagnostic criteria.
- **Self-hypnosis** is the act of hypnotizing oneself.

Description and Diagnosis

Dissociative personality disorder is a personality disorder in which an individual's dominant pattern involves dissociation. This characteristic may be expressed in many ways. For some, it may be confusion or the inability to recall a memory, while others may forget entire periods of their life. In the most severe cases, individuals may take on completely new identities or experience multiple identities. It is believed that this personality type results from early abuse by their primary caregiver.

While dissociative personality is not a diagnosis in DSM-5, it does share some characteristics of dissociative identity disorder. However, dissociative personality disorder is described in the *Psychodynamic Diagnostic Manual* (PDM). According to the PDM (2006), the dissociative personality disorder is diagnosable by the following criteria. Individuals are preoccupied with denying traumatic events. Their basic emotion is fear or anger. Their basic belief or view of themselves is that they are fragile or susceptible to frequent suffering. Their basic belief or view of others is that others are the dangerous, exploitive, oppressive, or saviors. Accordingly, they protect themselves from their belief about the world by dissociating their experience.

The exact cause of this personality disorder is not well understood. However, a variety of factors may be causative. According to the *Psychodynamic Diagnostic Manual* (2006), this disorder is commonly associated with an early history of severe and repeated physical or sexual trauma. These individuals tend to be easily hypnotized and have the capacity for self-hypnosis. Their primary way of defending themselves is to dissociate.

Treatment

Prior to treating dissociative personality disorder, it is imperative that a clinician first assess the individual for suicide risk, as individuals suffering from this disorder are prone to suicide. Psychoanalytic therapy is commonly used. Generally, treatment for this disorder is long term and relatively difficult.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Dissociative Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Personality Disorders; Psychoanalytic Theory; *Psychodynamic Diagnostic Manual* (PDM)

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Divided Self, The (Book)

The Divided Self: *An Existential Study in Sanity and Madness*, published in 1960, is a book written by psychiatrist and psychoanalyst Ronald D. Laing about people with psychotic disorders.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Psychotic** features are characteristics of psychotic disorders: delusions, hallucinations, disorganized thinking and speech, grossly disorganized or abnormal motor behavior, and

negative symptoms, for example, lack of initiative and diminished emotional expression.

- **Psychotic disorder** is a severe mental disorder in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

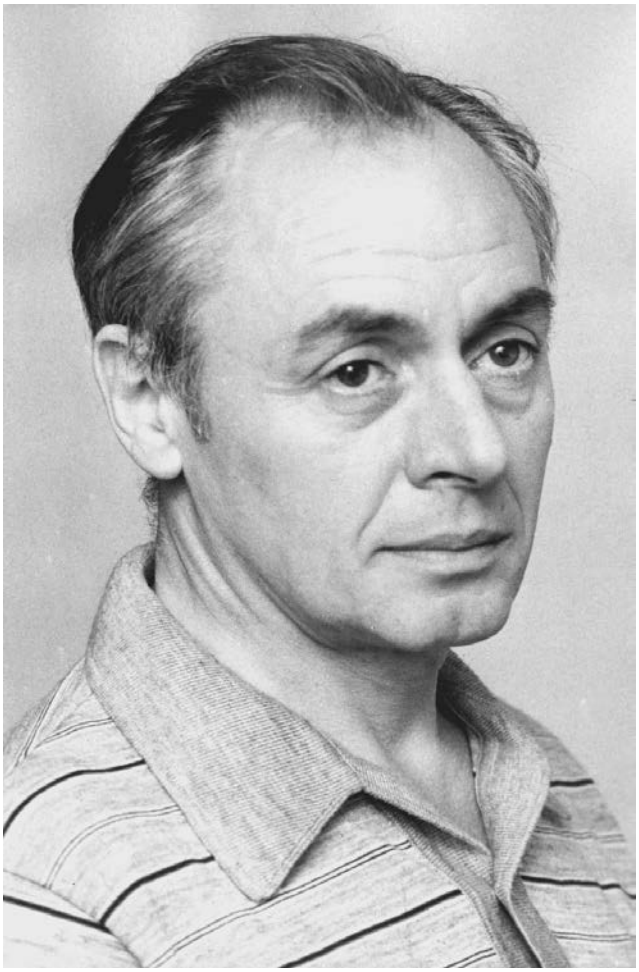
Description

Scottish psychiatrist Ronald D. Laing (1927–1989) was one of the most prominent figures in the antipsychiatry movement of the 1960s and 1970s. His observations led him to be very critical of the way the psychiatric community described and diagnosed insanity, especially in regard to schizophrenia. His critique called into question whether there is a clear diagnostic line between madness and sanity. In *The Divided Self*, Laing focuses specifically on schizophrenia. He claims that the disorder is largely an artificial creation of the psychiatric community that only served to label socially undesirable and misunderstood behavior. He questioned the value of antipsychotic drugs and argued that they were not the best or only treatment option for people with schizophrenia. He believed that the unreal world of schizophrenics was not simply a delusion. He described psychosis as the way that people with mental problems protect themselves from what they believe is threatening them.

Laing's insights were very heavily influenced by an existential approach to the observation of mental illness, based largely on the work of Jean Paul Sartre. His own psychological difficulties may have led him to see schizophrenia from the inside out, not just as an external observer. Laing established a therapeutic community near London to implement his ideas about how the mentally ill should be treated. In this community, drugs, or antipsychotics, were not a part of the treatment regimen. He continued to try to find ways to appreciate and learn from the world of psychotic individuals while still helping them to live at peace with the rest of society.

Impact (Psychological Influence)

Laing rose to prominence and fame quickly. He published a series of books and was criticized by the press because it believed his distinctions between the mentally ill and the sane were in many cases arbitrary, prejudiced, and potentially harmful. Partially because of



Psychiatrist and psychoanalyst Ronald D. Laing (1927–1989) discussed psychotic disorders in *The Divided Self: An Existential Study in Sanity and Madness*, published in 1960. (Ray Moreton/Keystone/Getty Images)

these criticisms and his own personal issues, his influence was short lived.

In his later work, Laing argued that psychotic individuals were sometimes more sane than other people and that psychotic experiences could have a healing dimension. With these claims he undermined his credibility with the scientific community and alienated many who thought he had gone too far. At the same time he was engaging in his own interests such as eastern spirituality and other health areas like birthing techniques. This led him farther away from psychiatry. His abuse of alcohol, from which he died in 1989, was the cause of him losing his medical license.

Recently, there has been a renewed interest in his ideas as society struggles with how to offer treatment to those suffering from psychosis. An effort to provide treatment while respecting clients' rights, their experiences, and their dignity is important to many in the psychological community. Laing's early work including *The Divided Self* is still used to challenge the health-care community to be honest and clear about treatment of psychosis in a mental health context. This important book reminds readers that caring for the mentally ill should not mean excluding them from society simply on the basis of a diagnosis or label.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Antipsychotics; Brief Psychotic Disorder; Psychosis; Schizophrenia; Shared Psychotic Disorder; Substance-Induced Psychotic Disorder

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Divorce

Divorce is the dissolution or termination of a marital union.

Description

More than one-half of all American first marriages end in divorce and over a million children a year are impacted by their parent's marital breakup. The effects of divorce on children have been highly investigated by social researchers as they attempt to better understand how to help children adjust to the challenges related to divorce.

Research indicates that children of divorce (COD) are more at risk for certain psychological problems when compared to children from continuously married parents (CCMP). Possible consequences include a decline in academic achievement, increases in anger, acting out or delinquent behaviors, higher rates of depression and anxiety, decrease in psychological well-being and self-esteem, decreased quality of family functioning, feelings of being caught between parents, and decreased coping capacity. Research also indicates that compared to CCMP, adult COD are at risk for lower self-esteem and less satisfaction with life, and have more symptoms of depression and anxiety. Adult COD also report less marital happiness, more marital discord, and more thoughts of divorce, and are more likely to get divorced.

Consequences of divorce should be viewed as risk factors more so than predictions as the magnitude, or effect, of divorce is relatively moderate. Scientifically rigorous research has shown that 90% of COD reach adulthood with comparable levels of psychological well-being (levels of self-esteem, life satisfaction, happiness, and psychiatric symptoms) as CCMP. Although some children are more vulnerable and at greater risk than others, most COD adjust to divorce within a few years of the marital breakup.

Researchers have identified two factors that particularly impact the effects of divorce on psychological well-being. COD who come from high marital discord families (e.g., yelling, screaming, and violence) actually have higher post-divorce well-being when compared to CCMP. This indicates that children exposed to high levels of conflict and discord may benefit from divorce. When parents reported low levels of discord, COD were worse off than CCMP. It may be that when parents outwardly get along a divorce is more shocking and difficult to adjust to for children. The other factor

Divorce, the legal dissolution or termination of a marital union, has become common in America and many other Western nations. Divorce can have a major psychological impact on everyone involved, particularly young children. (Zimmytws/Dreamstime.com)

that impacts the effect of divorce is the number of remarriages and re-divorce transitions of the parents. COD whose parents did not remarry had levels of psychological well-being comparable to that of CCMP. This suggests that the negative impact of divorce may be more associated with post-divorce remarriages.

Current Status

Because of the prevalence of divorce and the large numbers of children impacted by it, a substantial body of research exist. There is an increase call for investigation into the buffering effects and resiliency factors in children. Current research continues on the development of after-school programs to assist COD, and further research into impact of remarriage is needed.

Steven R. Vensel, PhD

See also: Single-Parent Families

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Dodo Bird Verdict

The Dodo bird verdict is the claim that all psychotherapies are equally effective regardless of their components.

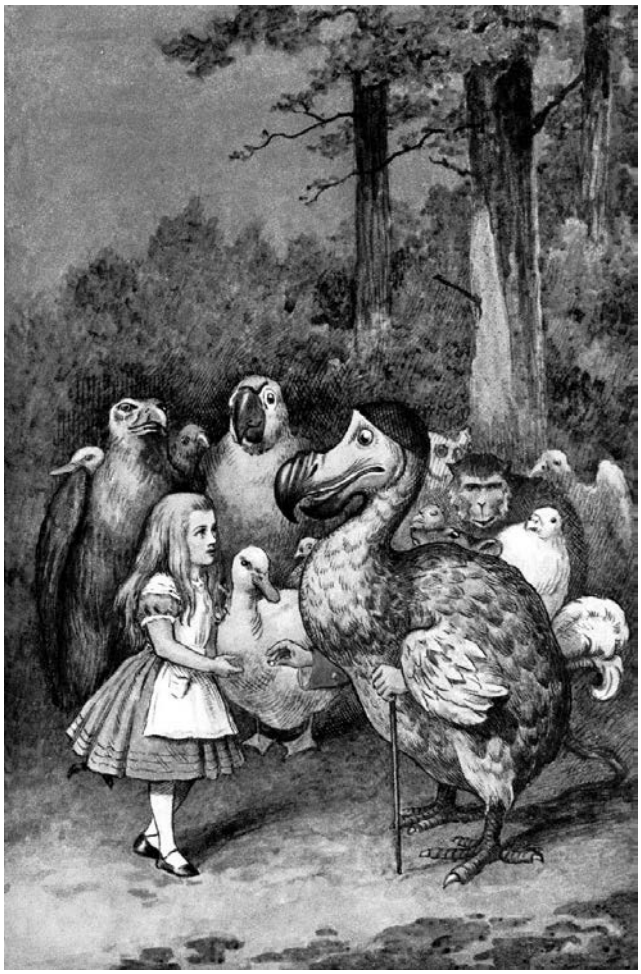
Definitions

- **Anxiety disorders** are a group of mental health disorders characterized by anxiety which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorders.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Common factors** is the viewpoint that psychotherapy has common components or factors and that these effect change more than specific factors or techniques.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. Psychotherapy is also called therapeutic counseling.
- **Therapeutic alliance** is a helping relationship between a psychotherapist and an individual in which they work together to effect change for the individual seeking help.

Description

The "Dodo bird verdict" is the name given to an ongoing debate in psychology. It is a controversial topic that claims that all psychotherapies produce equal outcomes regardless of their specific components. Psychologist Saul Rosenzweig (1907–2004) named the Dodo bird verdict in a 1936 article about common factors underlying competing approaches to psychotherapy. He argued that all therapy approaches were equally effective because of common factors. Rosenzweig used an illustration from Lewis Carroll's *Alice's Adventures in Wonderland* (1865) to describe the verdict. Several characters became wet and the Dodo bird has them run around the lake until they are dry. In time all get dry and he says, "Everyone has won, so all must have prizes." Rosenzweig's point is that common factors (e.g., everyone running around the lake) were more important than specific technical differences (e.g., how long or how far everyone had to run). He argued that all therapies are winners; they all produce equally effective outcomes (e.g., everyone became dry in the end).

In his 1975 review of psychotherapy research, psychologist Lester Luborsky (1920–2009) reported that there were few significant differences in the outcomes among the different psychotherapy approaches. Since then there have been several other studies that both support and oppose the verdict. Supporters of it claim that only common factors really effect change, particularly the therapeutic alliance. This is the means by



The Dodo bird verdict is the name given to an ongoing debate in psychology. Saul Rosenzweig used an illustration from Lewis Carroll's *Alice's Adventures in Wonderland* (1865) to make the point that common factors (e.g., everyone running around the lake) were more important than specific technical differences (e.g., how long or how far everyone had to run). He argued that all therapies can be equally effective, regardless of their specifics. (istockphoto.com/duncan1890)

which a therapist and an individual engage with each other and effect positive change in the individual. According to supporters, the more positive the therapeutic alliance, the better chance of improvement, regardless of the techniques used.

Critics of the Dodo bird verdict contend that specific techniques used in different therapies are more important and result in effective outcomes. Their most compelling argument is the research on cognitive behavior therapy (CBT) for anxiety disorders. CBT techniques are very effective in changing the individual's maladaptive (faulty) thoughts and behavioral patterns. The change effected results in reduction of anxiety symptoms.

Len Sperry, MD, PhD, and Elizabeth Smith Kelsey, PhD

See also: Anxiety Disorders; Cognitive Behavior Therapy; Psychotherapy

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Domestic Violence

Domestic violence takes many forms and is known by many different names, including spousal abuse, intimate partner violence, domestic abuse, domestic battery, family violence, and dating abuse. It is defined as a pattern of behavior involving abuse by one partner against the other in a relationship where it is used to gain or maintain power or control over the other. This can include physical abuse, threats, sexual abuse, emotional abuse, patterns of control, intimidation, or stalking. It can also involve endangerment of the other partner, such as kidnapping or harassment.

Description

The abused partner is referred to as the victim or survivor. Using this terminology must come with caution as it must match the mind-set of the person. For instance, a person coming for therapy or assistance may react with strong negativity to specific terms, so it is important to use the appropriate terminology. Academically there is a push toward the term "survivor" as it is found to encompass the notion of empowerment and resiliency.

Domestic violence encompasses a pattern of psychological, physical, emotional, economic, or sexual harm or threat of harm from one partner to another. This form of abuse can be a learned behavior or attitude of entitlement that can stem from a culturally supported environment. Those typically victim to this abuse are generally women and their children. However, it must be acknowledged that violence can occur in heterosexual and homosexual relationships, as well as with either a male or a female as the perpetrator or victim.

Separating from a violent relationship is often complicated for the victim and can take months or even years. This can be connected to concerns over financial safety or over fear of being alone or experiencing further harm due to past threats. The abused partner may feel trapped and may also experience denial that it won't happen again. The abused partner may also blame himself or herself for the acts of violence feeling he or she caused it by saying or acting in certain ways to upset his or her partner.

In the 1970s, Lenore Walker identified the cycle of abuse. This theory helps to explain patterns of behavior in abusive relationships. The theory focuses on the notion that once an abusive relationship is established, it is characterized by predictable patterns of abuse. This concept has been widely used and accepted in the field of domestic violence programs, education, and advocacy programs.

The cycle has four phases, and these repeat until the conflict has stopped generally by the victim or survivor leaving the relationship. The tension-building phase occurs prior to an abusive act and is generally

Domestic violence takes many forms and is known by many different names, including spousal abuse, intimate partner violence, domestic abuse, domestic battery, family violence, and dating abuse. In addition to potential physical harm, domestic abuse can lead victims to feel anxious, depressed, fearful, and helpless. (Godfer/Dreamstime.com)

identified by poor communication, passive aggressive behavior, and tension between the partners as well as fear of causing an outburst. The abused partner may make attempts to modify his or her behavior at this point to try and avoid triggering his or her partner. The next phase is acting out, which is where there is an active abusive incident. Following this is the reconciliation or honeymoon phase, where the abuser apologizes, ignores the incident, or gives an overabundance of affection. There are promises that it will never happen again. The abuser may make statements of desire to harm himself or herself to gain sympathy from his or her partner. The fourth part to the cycle is the calm phase where things seem to be peaceful. However, this will eventually lead back to difficulties and to the tension-building phase triggering the cycle to begin again.

There are four major types of intimate partner violence that are supported by research. The first is common couple violence where it occurs in a single argument and one or both partners physically attack each other. Intimate terrorism involves emotional and psychological abuse.

Violent resistance or self-defense occurs when the victim commits an act against the abusive partner. Finally, mutual violent control is a rare occurrence where both partners battle for control utilizing violent behaviors and actions.

Incidents of domestic violence can turn deadly especially when the abused partner attempts to leave the relationship. In certain cultures "honor killings" occur when it is felt that a family member has "shamed" the family. For instance, in some Middle Eastern cultures women are to adhere to certain standards such as being accompanied by male family members. If the women were to act against this notion of honor (including leaving an abusive relationship), the family's response to the perceived shame could result in that woman's death.

Current Status

Currently, one in every four women will experience domestic violence in her lifetime. It is estimated that 85% of domestic violence victims are women. Females between the ages of 20 and 24 are currently at the greatest risk of intimate partner violence. There are over 18.5 million mental health visits made each year as a result of domestic violence. However, despite these large numbers, most cases are never reported to the police.

Mindy Parsons, PhD

See also: Abuse; Child Abuse

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Organization

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Dopamine

Dopamine is a chemical messenger in the brain that regulates attention, affect, pleasure, and coping with stress. It is involved in disorders such as addictions, depression, and schizophrenia.

Definitions

- **Blood–brain barrier** is a specialized layer of cells around the blood vessels of the brain controlling which substances can pass from the circulatory system into the brain.
- **D1–D5** are the five dopamine receptor proteins responsible for receiving the dopamine transmission or signal for a cell.
- **Mesolimbic pathway** is the "reward pathway" of the brain.
- **Nucleus accumbens** is part of the brain involved in the mesolimbic reward pathway, which receives dopamine signaling from the ventral tegmental area.
- **Parkinson's disease** is a degenerative nervous disease characterized by shuffling gain, tremors, and muscle stiffness.
- **Ventral tegmental area** produces dopamine and signals to the nucleus accumbens and the rest of the striatum.

Description

Dopamine is a neurotransmitter (chemical messenger) in the brain that transmits nerve impulses that regulates attention, concentration, movement, impulse control, affect and mood, sleep, motivation, pleasure, and coping with stress. Pleasurable experiences are associated with high dopamine levels while stress is associated with lower levels. Altered levels of dopamine can cause a range of symptoms and problems, including depression, attention-deficit hyperactivity disorder (ADHD), addictions, and schizophrenia. It also plays a prominent role in the manifestations of Parkinson's disease.

Dopamine is part of the dopamine family of neurotransmitters, which includes adrenaline and noradrenaline. All are monoamines, which means that their chemical structure includes an amino group linked with an aromatic ring. Dopamine is made from the amino acid tyrosine (its precursor) in three brain areas: the substantia nigra, the ventral tegmentum, and the arcuate nucleus. The first two areas are implicated in many mental disorders. Because dopamine cannot cross the blood–brain barrier, medical professionals cannot just give dopamine directly. Instead, they give its precursor, tyrosine, which can cross the barrier so that the brain can make dopamine on its own. There are five dopamine receptors (D1–D5) which recognize the dopamine molecule, bind to it, and transmit its signal to other cells.

A decline in dopamine (D2 receptors in the substantia nigra) is linked with Parkinson's disease. Low levels of dopamine can also result in symptoms of depression, such as a loss of pleasure or motivation. Low levels of dopamine binding to other D2 receptor are associated with social anxiety, while high levels are linked to the hypersocial behavior of those experiencing the manic phase of bipolar disorder. ADHD is also associated with problems in dopamine transmission.

In contrast, schizophrenia is linked with high dopamine levels (in the ventral tegmentum) and the symptoms of hallucinations and disturbed thinking. Interestingly, those with Parkinson's disease who take medication that raises dopamine levels too high can develop

symptoms of schizophrenia, while those with schizophrenia who take medication that lowers dopamine levels can experience symptoms of Parkinson's disease.

Precautions and Side Effects

Side effects from medications that act on dopamine have been reported. More common ones are nausea, vomiting, and headache. Less common are irregular or rapid heartbeat, chest pain, dizziness, and trouble breathing.

Medications act on various dopamine receptors and increase or decrease dopamine levels. L-dopa is medication (antiparkinsonian) used in treating Parkinson's disease. It is a dopamine precursor that is synthesized into dopamine in the brain and reverses the effects of low dopamine levels. Monoamine oxidase inhibitors (MAOIs) block the activity of the enzyme that breaks down dopamine. As a result, MAOIs like Nardil and Parnate are antidepressants that increase dopamine levels. Antipsychotics are divided into two classes: typical and atypical antipsychotics that target different types of dopamine receptors. Clozaril is an atypical antipsychotic that targets the D4 receptor more strongly than the D2 receptor, while Parlodel targets D2 and is a partial inhibitor of D1. Abilify is a partial dopamine agonist (mimic), and Symmetrel is also a dopamine agonist.

Len Sperry, MD, PhD

See also: Abilify (Aripiprazole); Addictions; Depression; Schizophrenia

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Down Syndrome

Down syndrome is a chromosomal disorder that results in impairments of mental and physical development.

Description

Down syndrome (DS) is the most commonly occurring chromosomal condition in which children exhibit atypical physical features such as upward slanted eyes, small stature, and a deep crease in the palm of the hands. Although he was not the first to describe it, the syndrome was named after Dr. John Langdon Down, who published a detailed analysis of the condition in 1866. People with Down syndrome demonstrate a range of physical and mental impairments. According to the Centers for Disease Control, approximately 1 out of 691 children born in the United States is diagnosed with Down syndrome. Many people with DS have an intellectual deficit, or mental retardation, on a range from mild to severe. According to the National Down Syndrome Society, the average IQ score of a young adult with DS is approximately 50 while the national average is 100.

Through genetic testing, it is possible to identify Down syndrome at birth or before birth through prenatal testing such as amniocentesis. Prenatal testing can often lead to a decision on the part of the parents to terminate the pregnancy. The ability to identify the syndrome prenatally and terminate pregnancy is a controversial issue among the DS community.

Causes and Symptoms

Down syndrome is the most common chromosome abnormality in humans. Typically, human beings have cells that contain 23 pairs of chromosomes, half from each parent. When a person's cells show the presence of all or part of a third copy of chromosome 21, he or she has DS.

People with Down syndrome can be recognized due to certain abnormal physical characteristics. These include a short and wide physique, weak muscles, an upward slant to the eyes, and a deep crease across the center of the palm. These physical features vary from person to person. Individuals with DS can also experience conditions such as heart disease, celiac disease, and orthopedic conditions, which require medical supervision and care.

In childhood it is typical for individuals with Down syndrome to have a delay in speech development.

People with DS often demonstrate some degree of mental retardation. Often fine motor skills are also slow to develop. The development of gross motor skills affects some children who might not master walking until the age of four years.

Diagnosis and Prognosis

Genetic testing allows physicians to diagnose Down syndrome prenatally and at birth. Down syndrome is diagnosed through genetic tests that identify an extra copy of chromosome 21. Due to prenatal testing, many pregnancies end in early termination.

Decades ago the life expectancy for those with DS was nine years old. Over the last several decades, medical and educational interventions have substantially increased the prognosis for people with DS. Today people with DS typically live to 50 years of age or more.

People with Down syndrome have an elevated risk of developing several medical conditions. Commonly occurring medical diagnosis include heart disease, immune system problems, and seizure disorders. Complications with DS and these conditions increase the risk of premature death for these individuals. Regular checkups with a physician are highly recommended for people with DS.

Treatment

Treatment for Down syndrome is based on an analysis of each person's physical and intellectual challenges. Early childhood intervention through therapy and educational program is proven most effective. Preschool programs for children with Down syndrome will typically address all aspects of physical, occupational and speech therapies.

It is not only early childhood interventions and education which help. Also important is continued screening for physical and psychological issues that could affect life expectancy. Seeking appropriate medical treatment is important. In addition to medical interventions, it is helpful for people with Down syndrome to live in a supportive family or residential environment. The opportunity for vocational training can add immeasurably to the productivity, length, and quality of life for people with DS.

In the past, children with Down syndrome often received only basic, home-based education. Currently many DS children are integrated into the regular educational curriculum. For those who are not placed in regular education, specialized educational opportunities are available. Some students with DS graduate from high school and some go to college.

It has been found that education and opportunities to learn increase independence and self-care and improve quality of life. In the United States, there are increasing opportunities for participating in postsecondary education. Many adults with Down syndrome are able to work in the community, while others require a more sheltered work environment.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Developmental Disabilities; Mental Retardation

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Dreams and Dream Interpretations

Dreams can range from the absurd and disjointed to exciting or even terrifying. But figuring out what dreams mean is often subject to intense debate. Still, the interpretation of dreams has long been used in therapy for promoting personal change. It is defined as the process of assigning meaning to dreams and is used broadly across many theoretical orientations. It is a therapeutic approach that offers considerable flexibility in integrating theory and techniques to interpret a client's dreams.

Dream interpretation is thought to offer insight into a person's innermost longings, ability to problem solve, ability to adapt, and overall approach to creative

self-expression. Many believe that the content of a person's dreams is directly correlated to his or her waking life, as well as the level of psychological functioning. Dreams offer a therapist insightful information about a client's personality traits, as well as potential clinical challenges.

Sigmund Freud, who wrote *The Interpretation of Dreams*, was among the first to show a strong interest in interpreting the dreams of his patients. He suggested that dreams were related to wish fulfillment. He also believed that the content of the dream is connected to the unconscious wishes of the dreamer.

Freud identified four elements to dream interpretation, which he referred to as "dream work." The four elements include condensation, displacement, symbolization, and secondary revision. Condensation represents the multitude of ideas and concepts that are represented in a single dream and the information is condensed into a single thought or image. Displacement is the element that disguises the emotional meaning of the content. Symbolization censors the repressed ideas contained in the dream by including objects that are symbols of the content. Secondary revision is the final stage of the process. Freud suggested that strange elements are reorganized to make the dream understandable.

Carl Jung agreed with some points made by Freud. However, Jung did not share Freud's view that dreams are an expression of wish fulfillment. Jung instead believed that dreams were a way of revealing the personal and collective unconscious. He suggested that dreams were a way of compensating for less developed aspects of a person's psyche. Later research showed that personality that a person possesses in waking life is the same or similar to those expressed in dreams.

Dream interpretation as part of therapy is approached in a four-step process. It starts by reviewing all the images that were part of the dream. The client narrates the dream completely prior to the therapist asking any questions. The next step includes the therapist asking clarifying questions about the dream, including the client's affect, what the client saw, heard, or touched. Mining for this type of information helps uncover the feelings and sensations that were part of the dream. The third step attempts to revive the dream and the associate feelings by placing the client in a relaxed state. The therapist then helps the client relive the experiences of his or her dream. The key of this third step is to narrow in on any images that were particularly vivid for the dreamer. The fourth and final stage of dream interpretation has the therapist linking the experiences of the dream to other areas of the client's life and then integrating the experiences with the client's history and present life experiences.

Dream interpretation, however, lacks a unified and established methodology. The science and scientific support of dream interpretation is lacking. For instance, if one were to search what dreaming of fire means, one source indicates it represents a cleansing or punishment, whereas another source says it is connected with anger or a new beginning. While there are some similarities, these ideas are vague and differ enough that there is conflicting support of the meaning of this dream.

Dream interpretation has grown in popularity since the 1970s. Today, many bookstores have a wide collection of books available about the meaning of dreams, including dream dictionaries, symbol guides, and tips for interpreting and understanding dreams. However, the popularity tends to be more with the general public than with researchers in the mental health field. In fact, some researchers feel that dream interpretation is a neglected technique in contemporary treatment; however, others argue that there is not enough evidence to support using this as a treatment modality.

Mindy Parsons, PhD

See also: Freud, Sigmund (1856–1939); Jung, Carl (1875–1961); Jungian Therapy; Psychoanalysis

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Dreikurs, Rudolf (1897–1972)

Rudolf Dreikurs, MD, was an American psychiatrist and educator known for advancing Adlerian psychology through his writings and professional publications.

Description

Rudolf Dreikurs, MD (1897–1972), was an American psychiatrist and educator who advanced the theory and practice of Adlerian psychology, created by Alfred Adler (1870–1937). This approach to psychology understands individuals as social beings with a need to belong and strive for significance. It is also known as Individual Psychology. Dreikurs was a student and eventually close colleague of Alfred Adler. After Adler's death in 1937, Dreikurs went on to promote the use of Individual Psychology around the world.

Among his many contributions to the theory of Individual Psychology, he described a model of misbehavior and suggested that children "act out" when they experience a lack of belonging to a particular group or in their family. When a child misbehaves, he or she is acting from one of four "mistaken goals": attention seeking, power, revenge, or assumed inadequacy. Attention seeking is when a child keeps others busy through various behaviors to seek attention. The power goal is when a child seeks power to feel in control and a sense of belonging. The revenge goal is when a child seeks to get even or to retaliate for a previously perceived wrong doing of another person. The assumed inadequacy goal is when a child gives up to be left alone so that others will expect little from the child. Dreikurs worked with children by helping them enhance their cooperation and belonging skills by empowering them feel that they are valuable contributors to a classroom or family.

In 1952, Dreikurs founded the North American Society of Adlerian Psychology, of which he was an active leader of the society up until his death in 1972. He wrote many books that expanded the theory and practice of Adlerian psychology. He also founded the Alfred Adler Institute in 1952, which is now called Adler University, in Chicago, Illinois.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Early Recollections; Individual Psychology; Lifestyle and Lifestyle Convictions

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Drug Culture

Drug culture is a description for those people, groups, or communities where the use of drugs is a key element of daily life and social relationships.

Definitions

- **Alcohol use disorder** is a mental disorder involving a pattern of alcohol use which leads to significant problems for the user.
- **Benzodiazepines** are a class of drugs that slow the nervous system and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms. They are highly addictive.
- **Opioids** are a group of drugs that reduce pain. They are highly addictive and include both prescription drugs like Percocet and illegal drugs like heroin.
- **Psychoactive** is a drug or substance that has a significant effect on mental processes. There are five groups of psychoactive drugs: opioids, stimulants, depressants, hallucinogens, and cannabis.
- **Psychotropic medications** are prescribed drugs that affect thinking, feeling, and behavior. They include antipsychotic, antianxiety, antidepressant, and antimanic medications.

- **Stimulant** is a drug that increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity, or suppresses appetite. Examples are cocaine, amphetamines, and Ritalin.
- **Substance abuse** involves the use of substances (drugs or alcohol) in amounts or with methods that are harmful.

Description

Drugs, which can be defined as behavior-altering chemicals, have played a part in the history of most civilizations. There are several kinds of drugs, including alcohol, stimulants, opioids, benzodiazepines, cannabis, and psychoactives. Over time drugs have been used as parts of religious rituals, as well as for medicinal purposes and entertainment, escape, or recreation.

Culture can be defined as learned behavior based on a combination of shared customs, language, and beliefs. Subcultures share traits with the dominant culture but distinguish themselves with different customs, ideas, and practices. Some subcultures form as a result of a positive response to problems in the larger culture, and some are negative reactions against the values of the dominant culture. The drug culture can be viewed as a result of both negative and positive responses to the issues in the larger culture.

Drug cultures are examples of subcultures built around the idea that drugs, especially illegal drugs, are an important part of the human experience. Drug cultures are often associated with other sociological minority classifications such as race, poverty, or youth. Since society at large ostracizes and punishes the use of illegal drugs, the basis for conflict between the larger society and the drug culture is inevitable.

Current Status and Impact (Psychological Influence)

Drugs cause internal chemical changes in the body whether the intention of their use is medically beneficial or recreationally damaging. The dilemma that society and the medical community face is how to draw a sensible line between medically beneficial and dangerous drugs. In addition to this issue, many people are concerned about the overuse and dependence both of medically beneficial and of dangerous drugs for those who use them.

Not all drugs are illegal. Legal drugs include alcohol, prescription medications, and some mood-altering drugs depending on location. In the United States approximately two-thirds of the population drink alcohol. It is worth noting that for a decade in the 1920s, America tried to outlaw alcohol as an illegal drug during a period called prohibition. Prohibition had negative social and legal implications but was an attempt to prohibit the use of this addictive substance.

Another legal drug is nicotine. About 20% of people in the United States report using nicotine regularly, and it is a highly addictive drug. Other highly addictive drugs that people are dependent on are legally prescribed medications traditionally used to treat disorders such as depression or anxiety. The variety of mood-altering drugs that are available from multiple sources grows each year. The demand in the market for these products, distributed both legally and illegally, contributes to this growth.

Even though legal drugs cause both social and health problems, the appeal of the drug culture has always been illegal drugs. It is estimated that about 10% of people in the United States use illegal drugs regularly and many more have experimented with them at some point in their lives. It is estimated that millions of Americans are dependent on the use of illegal drugs such as heroin and cocaine.

Perhaps nothing illustrates the mystique surrounding illegal drugs better than two famous works of art. The first is a novel and later film written by Hunter S. Thompson in 1971, called *Fear and Loathing in Las Vegas*. The film's subtitle is *A Savage Journey to the Heart of the American Dream* and gave the sense of the love/hate relationship that Americans have with illegal drugs and the glamorization of their role. Another, more recent portrayal of drug culture is the Martin Scorsese film *The Wolf of Wall Street*. In this film, the presence of illegal drugs highlights the drug culture of the wealthy and successful. The use of high-class drugs and partying was a large part of the financial and social status of the characters in this film and is

a reflection of the drug culture for the rich during the 1980s and beyond.

The government and society in general are unsure of how to handle drugs and the drug culture. It seems clear that the issue is important, but it does not seem to have a simple solution. Legalization or decriminalization of drug use is gaining government clearance for substances such as cannabis in many locations across the globe. But some have cited both health and moral problems with the legalization of formerly illegal drugs. It is reported that as many as 25% of adolescents, between the ages of 16 and 17, are estimated to have used marijuana. The use of medical and recreational marijuana was first made legal in states like California, Colorado, and Washington. Many expect that this trend will grow, with more states legalizing its use.

Drug campaigns, such as the "Just Say No" approach of the 1980s, have not been effective in reducing the use of drugs or formation of drug subcultures. Many issues still exist, such as how to distinguish between medical and recreational use of drugs or decriminalizing possession of drugs for private use. Prevention programs such as improving substance abuse education and treatments have been in place for decades with varied impact. The drug culture is in frequent conflict with policy makers and authorities, like the Drug Enforcement Authority. Despite efforts to eradicate legal and illegal drug use and abuse, drug cultures persist and provide opportunities for those who engage or believe in the use of personal or medical drug use.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Prescription Drug Abuse; Psychedelic Drugs

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Drug Dependence

Drug dependence is a mental condition characterized by physical dependence. It is similar to but different from addiction.

Definitions

- **Addiction** is a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcohol use disorder** is a mental disorder involving a pattern of alcohol use which leads to significant problems for the user.
- **Cannabis use disorder** is a mental disorder characterized by cannabis (marijuana) use which leads to significant problems for the user.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Physical dependence** refers to physical changes in the body that result in tolerance and withdrawal symptoms when drug use is discontinued.
- **Psychological dependence** refers to the loss of control over the intense urges to use a substance at the expense of adverse (harmful) consequences.
- **Stimulant use disorder** is a mental disorder that is characterized by the use of stimulants, which leads to significant problems for the user. It includes amphetamine and cocaine.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

- **Tolerance** is the phenomenon in which the body requires increased amounts of the substance to achieve the desired effect.
- **Withdrawal** is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of certain drugs after prolonged regular use.

Description

Drug dependence is a mental condition characterized by the symptoms of physical dependence (tolerance and withdrawal) following the use of a drug or alcohol. In everyday language, the term "drug dependence" is used interchangeably with addiction. While both share some common features, there are also significant differences. Their technical meaning tends to differentiate them. For instance, the term "dependence" is used by many researchers and professionals to describe physical dependence following use of drugs or alcohol. Physical dependence is also observed with certain prescribed medications, such as antidepressants. On the other hand, addiction is characterized by psychological dependence, although there may also be some physical dependence. However, the physical changes associated with drug withdrawal are distinct from the loss of control over the intense urges that is associated with addiction. In short, psychological dependence refers to impaired control over drinking or drug use, while physical dependence refers to tolerance and withdrawal symptoms.

Until recently, the *Diagnostic and Statistical Manual of Mental Disorders* has added to the confusion by its inconsistent use of the terms "addiction" and "dependence" to describe alcohol and drug problems. DSM-5 resolved that confusion by eliminating the category of drug (substance) dependence entirely. Now, the compulsive drug-seeking behavior of addiction is differentiated from the normal responses of tolerance and withdrawal experienced by some when using prescribed medications. While drug (substance) dependence had been considered a mental disorder in previous editions of *Diagnostic and Statistical Manual of Mental Disorders* (DSM), it is no longer considered a disorder in DSM-5.

However, DSM-5 does describe several substance-related and addictive disorders. These include alcohol use disorder, cannabis use disorder, and stimulant use disorder. To make such diagnoses, it must be evident that there is impaired control over the use of the substance or addictive behavior and that it significantly disrupts the lives of the user. Currently, the causes of these disorders are not well understood. However, there are probably multiple causative factors. These may include biological or genetic history, psychological traits and coping skills, and environmental factors such as parent's use of substances and peer influence.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Addiction; Alcohol Use Disorder; Cannabis Use Disorder; Stimulant Use Disorder; Substance-Related and Addictive Disorders

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Drug Enforcement Administration (DEA)

The Drug Enforcement Administration is a federal law enforcement agency that enforces controlled substances laws and regulations. It is also called the DEA.

Definitions

- **Benzodiazepines** are a class of drugs that slow the nervous system and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms. They are highly addictive.
- **Controlled substances** are a drug or chemical whose use, manufacture, and possession laws are regulated by the federal government.

These can be illegal substances or prescription medication.

- **Controlled Substances Act** was passed into law in 1973 to regulate the importation, manufacture, possession, and use of certain substances.
- **Illicit drugs** are illegal drugs that have no medical use and are often used for their ability to distort an individual's mental process.
- **Opioids** are a group of drugs that reduce pain. They are highly addictive and include both prescription drugs like Percocet and illegal drugs like heroin.
- **Psychoactive** is a drug or substance that has a significant effect on mental processes. There are five groups of psychoactive drugs: opioids, stimulants, depressants, hallucinogens, and cannabis.
- **Psychotropic medications** are prescribed drugs that affect thinking, feeling, and behavior. They include antipsychotic, antianxiety, antidepressant, and antimanic medications.
- **War on Drugs** refers to the national campaign against drug abuse, which was popularized during the early 1970s following a speech by President Richard Nixon in which he publicly declared drug abuse as "public enemy number one."

Description

The Drug Enforcement Administration (DEA) is a law enforcement agency under the U.S. Department of Justice that enforces controlled substances laws and regulations. Its goal is to reduce illegal drug use and drug trafficking in the United States. The DEA enforces the Controlled Substances Act. It regulates and monitors the growing, manufacture, and distribution of controlled substances and illicit substances. Controlled substances are often abused and used for nonmedical purposes. Psychotropic medications such as opioids and benzodiazepines have medical purposes, but they are also used for nonmedical purposes. Many psychoactive substances have medical purposes, but many psychoactive substances are used by individuals to experience the "high."

In response to increasing drug trade and related crimes, President Richard Nixon declared an all-out global war on the drug menace. It became known as the War on Drugs. The Drug Enforcement Administration was initiated on July 1, 1973, and signed into effect by President Richard Nixon. The DEA is led by an Administrator of Drug Enforcement, who is appointed by the president of the United States. The creation of this federal agency was to prevent illicit drug trafficking based on the growing concerns about the availability of drugs in the United States.

Impact (Psychological Influence)

Though the DEA began with just 1,470 special agents and a budget of less than $75 million, the agency has grown considerably now, staffing some 5,000 agents and operating on a budget of over $2 billion. Over the past several decades the agency has improved its operations and influence by adding new divisions and incorporating advancements in technology. DEA efforts have increased in recent years in response to the drastic rise in oxycodone, Xanax, and other prescription drugs resulting from the pill mill and pain clinic epidemics. Efforts have also focused on black market drugs, including crack cocaine, heroine, Ecstasy, and steroids. Most recently, the DEA has been in the middle of the national controversy over the possible legalization of medical marijuana.

Jon Sperry, PhD, Len Sperry, MD, PhD, and Melissa Mariani, PhD

See also: Barbiturates; Benzodiazepines; Detoxification; Drug Dependence

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DSM

See Diagnostic and Statistical Manual of Mental Disorders (DSM)

Dual Diagnosis

Dual diagnosis is the co-occurrence of a mental disorder and a substance-related disorder.

Definitions

- **Biopsychosocial** refers to the interrelationship of biological, psychological, and social factors.
- **Co-occurrence** means that two things are happening at the same time.
- **Comorbid** refers to the occurrence of two or more disorders in the same person that can start at the same time or one after the other.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **Motivational interviewing** is a five-stage model used by clinicians to help clients with substance abuse problems become motivated to change. The five stages are pre-contemplation, contemplation, preparation, action, and maintenance.
- **Substance-related disorders** are a class of DSM-5 disorders characterized by the use of one or more substances that lead to significant distress or disruption of daily life. Alcohol and cannabis (marijuana) are examples of these disorders.

Description

Dual diagnosis is the co-occurrence of a mental disorder and a substance disorder. Either disorder can occur first, but one does not necessarily cause the other. Both mental and substance disorders are influenced by biopsychosocial factors. Genetic factors play a role in an individual's susceptibility to both. Substance use may result in the expression of symptoms in individuals predisposed to a mental disorder. From a psychological standpoint, it may be that those with a mental disorder use substances to make themselves feel better. Environmental factors such as physical, emotional, and sexual abuse can also play a role. When an individual begins using drugs, this drug use may change brain functioning in a manner that increases the possibility of a disorder.

The term "dual diagnosis" was originally used by researchers and practitioners during the mid-1980s. During this time, several initiatives began the integration of mental health and substance abuse services to overcome the problems associated with single treatment efforts. Traditionally, patients with co-occurring disorders received mental health care and substance abuse services from two different practitioners in two different locations. This sequential treatment approach made it difficult for patients to receive comprehensive care, to access care, and to integrate information from different practitioners.

A dual diagnosis is correlated with multiple problems such as relapse, frequent hospitalization, depression, suicidality, imprisonment, homelessness, and interpersonal difficulties. Individuals with dual diagnoses have higher rates of symptoms, hospitalization, housing problems, and dysfunction than individuals diagnosed with a single disorder. Furthermore, treatment costs are higher among people with dual diagnoses compared to those with a single diagnosis. Those with comorbid disorders are more susceptible to dropping out of outpatient treatment and are frequent users of hospital and emergency services. To increase treatment outcomes, dual diagnosis treatment facilities integrate mental health interventions and substance

abuse interventions within one program. Interventions for both mental illness and substance abuse require long-term efforts that work to stabilize, educate, and promote self-management. A team approach of mental health and substance treatment practitioners working together can greatly improve care and reduce treatment costs. Comprehensive treatment programs offer individual, group, and family counseling; psychiatric services; medication monitoring; psychoeducation; case management; and outreach services. Individuals with mental disorder are frequently unaware that they have a substance abuse problem and may not be motivated to seek treatment. Motivational interviewing is useful to help individuals gain awareness, develop motivation, and elicit behavior change. Unless treatment is successful, the presence of dual diagnosis greatly reduces individuals' ability to live within and contribute to their community.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Comorbidity; Substance Abuse Treatment

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Dyslexia

Dyslexia is the impairment that affects a person's ability to read written language with the speed and ability of others.

Description

Dyslexia is another term for specific learning disorder for people who have trouble with reading. Some researchers suggest that 15% of the general population have dyslexia. The diagnosis is not related to intelligence, vision, or other learning disorders. It is estimated that 80% of all individuals diagnosed with learning disorders have a form of dyslexia.

Dyslexia impairs an individual's ability to easily recognize and understand written information. Even though reading is a challenge for these people, some with dyslexia experience an increase in their thinking and visualization abilities. Although most children with dyslexia are identified when they go to school, there are some whose condition is not fully diagnosed until adulthood. Identifying it can be complicated because children with the diagnosis have normal vision and intelligence.

Causes and Symptoms

Although difficulties with reading can arise from different sources, dyslexia is distinct since it is caused by neurological deficits. This means that there are similar brain differences among those with dyslexia. Researchers have identified that these differences are usually located in the temporal processing center of the brain.

There are many common symptoms of dyslexia. Symptoms include delayed letter recognition and difficulty in rhyming and listing words that begin with the same sound. These children can also be slow to learn letter sounds and read slowly. Often the recognition of words is affected and therefore the child can be reluctant to read. If a child exhibits one or more of these symptoms, it does not necessarily mean that the child has dyslexia. A thorough evaluation is needed to determine if a child has dyslexia and not some other problem which leads to difficulties in reading.

Although dyslexia mainly affects a person's ability to read and understand information, it can also impair language expression. It can also be linked to and complicated by other disorders, such as attention-deficit disorder and mathematics disorder. Dyslexia and IQ are not related since intelligence develops separately from reading.

Diagnosis and Prognosis

The diagnosis of dyslexia is now officially called specified learning disorder, with deficiency in reading. In

order to qualify for this diagnosis, a person is required to have trouble with identifying and understanding written words. This can include problems such as poor fluid reading and frequent spelling mistakes. Dyslexia is usually recognized during the early years of school as children struggle to learn to read. People with dyslexia can learn to read with good comprehension, but it generally takes them longer to read than others. They may also perform more slowly at related tasks such as spelling and sorting words.

Treatment

In order to help people with dyslexia with their reading difficulties, different supports can be put into place. Therapy and educational supports aim at helping children work through visual and auditory processing of words. Usually these supports are most effective when used in childhood while the brain is still developing. It is important to note that there is no cure for dyslexia. It's a lifelong condition caused by inherited traits that affect how your brain works. However, most children with dyslexia can succeed in school with tutoring or a specialized education program. Emotional support also plays an important role in helping people adjust to the difficulties they experience. The use of relaxation and anxiety-reducing strategies benefits people with dyslexia, who experience stress as a result of the disorder.

Alexandra Cunningham, PhD

See also: Reading Disorder; Specific Learning Disorder

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Dyspareunia

Dyspareunia is a mental disorder characterized by genital pain during sexual intercourse.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria. The current edition is DSM-5.
- **Exposure** is a cognitive behavior therapy intervention (method) in which an individual is exposed to a feared object or situation. It is also referred to as flooding.
- **Genito-pelvic pain/penetration disorder** is a mental disorder in women characterized by persistent fear, pain, or difficulty with vaginal intercourse. Previously this disorder was referred to as dyspareunia and vaginismus.
- **Pelvic floor muscle training** involves a series of exercises designed to strengthen the muscles of the pelvic floor. These exercises are used to treat problems with urine leakage, bowel control, and pelvic pain.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy or therapeutic counseling.
- **Sexual dysfunctions disorders** are a group of mental disorders characterized by significant difficulty in responding sexually or experiencing sexual pleasure. They include delayed ejaculation, female organismic disorder, and genito-pelvic pain penetration disorder.
- **Systematic desensitization** is form of cognitive behavior therapy that gradually exposes individuals to their phobia (fear) while remaining calm and relaxed.
- **Vaginismus** is the inability to allow vaginal penetration because of anxiety and fear of pain that results in vaginal spasm.

Description and Diagnosis

Dyspareunia was a sexual disorder in DSM-IV-TR but is not listed as such in DSM-5. It is characterized by genital pain during sexual intercourse. This pain is experienced during intercourse, but for some, it may be experienced either before or after. While it is experienced in males and females, it is more common in females. This disorder has been combined with vaginismus in the current DSM-5 in the diagnosis of genito-pelvic pain/penetration disorder. These two disorders were combined in DSM-5 because it was difficult for clinicians to distinguish between these two disorders and because they commonly occurred together.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, an individual may be diagnosed with this disorder if he or she experiences repeated pain accompanying intercourse. As with most mental disorders, these symptoms must cause the individual distress. The pain cannot be better explained by an alternative cause such as a lack of lubrication, medical condition, or substance use. This disorder may be present for an individual's entire life, or it may begin after a period of normal sexual functioning. Symptoms may occur in a particular circumstance or in all situations involving intercourse (American Psychiatric Association, 2000).

The cause of this disorder is unclear. It is believed that sexual abuse, body-image issues, relationship issues, religious beliefs, and a history of vaginal infection may contribute to the manifestation of this disorder. However, for the majority of individuals, a combination of psychological, physiological, and social factors are likely to be present. For this reason, it is important for a clinician to be diligent in his or her assessment of this disorder.

Treatment

Treatment includes a comprehensive medical evaluation to identify any medical condition that might cause dyspareunia. If one is found, then medical treatment is appropriate. If no such cause is identified, it is usually treated with a combination of physical therapy and psychotherapy. Physical therapy is necessary to help the individual learn how to train and control pelvic floor muscles. The most common form of psychotherapy for this disorder is cognitive behavior therapy (CBT). CBT is used to reduce fear, anxiety, and pain. It emphasizes systematic desensitization and exposure techniques. If trauma issues are involved, it would also address them or refer for specialized treatment.

Len Sperry, MD, PhD, and
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See also: Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Exposure Therapy; Genito-pelvic Pain/Penetration Disorder; Psychotherapy; Sexual Dysfunctions; Specific Phobia; Vaginismus

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E

Early Recollections

Early recollections is a personality test that analyzes single-incident memories from childhood.

Definitions

- **Adlerian therapy** is a psychotherapy approach developed by Alfred Adler that emphasizes the individual's life style. Connectedness with others (belonging), meeting the life tasks, and contributions to society (social interest) are considered the hallmarks of mental health.
- **Inferiority complex** is a behavioral manifestation of a subjective feeling of inferiority.
- **Inferiority feeling** is the emotional reaction to a self-appraisal of deficiency that is subjective, global, and judgmental.
- **Life style** refers to one's attitudes and convictions about belonging and finding a place in the world.
- **Life style convictions** are the attitudes and beliefs that direct an individual's sense of belonging.
- **Life tasks** are the main challenges (work, love, and friendship) that life presents to all individuals.
- **Private logic** are convictions that run counter to social interest and fail to foster a constructive sense of belonging with others.
- **Projective technique** is a psychological test in which an individual's responses to ambiguous stimuli like are analyzed to determine underlying personality traits, feelings, or attitudes.
- **Safeguarding mechanisms** are the behaviors of attitudes that individuals select to evade responsibility and not meet the life tasks. Safeguarding mechanisms are called defense mechanism by other approaches.
- **Social interest** refers to the behaviors and attitudes that display an individual's sense of belonging, concern for, and contributions to the community.

Description

Early recollections (ERs) are a projective technique in which early memories are used to identify an individual's life style convictions and other personality dynamics. Research indicates that memories are not identical simulations of the past but are stories shaped by one's current view of others, the world, and ourselves. As a result, the gathering of ERs can be used as a projective technique that indicates one's strengths, goals, lines of movement, fears, worries, and other relevant psychological data. ERs provide a rapid, accurate, and cost-effective personality assessment that has similar reliability and validity to other personality tests. ERs are typically elicited by a counselor or psychotherapist both to assess the client's life style convictions and personality and to monitor change in the course of therapy.

Developments and Current Status

Alfred Adler (1870–1937) was a Viennese physician who developed Adlerian therapy. In his earliest

writings, he emphasized the clinical value of understanding the individual's life story. Adler viewed it as the story that an individual repeats to himself or herself to warn or to comfort himself or herself. It helps the individual focus on his or her goals. Based on past experiences, this story prepares the individual to meet the future with a ready-made, already-tested style of action. Adler called this story or narrative the "life style." It is important to distinguish life style from the contemporary uses of the word "lifestyle" as in "lifestyles of the rich and famous." Life style and its related life style convictions specify the individual's subjective view of oneself, others, and the world.

An individual's life style develops based on childhood experiences and perceptions of those experiences. ERs are those single incidents from childhood in which the individual reconstitutes in present experience as mental pictures or as focused sensory memories. They are understood dynamically; that is, the act of recollecting and re-remembering is a present activity. Historical accuracy is of no concern with these recollections. Rather, ERs, as understood in Adlerian therapy, mirror presently held convictions, evaluations, attitudes, and biases. In such memories, the level of activity or passivity of an individual is very likely to predict how the individual will respond to present and future circumstances. For example, in a series of memories, an individual who passively accepts unfavorable circumstances in his or her memories is likely to respond in a similar passive way in present life situations. In contrast, an individual who acts to improve circumstances in a series of memories is likely to respond in an active way in present life situations.

Individuals develop four life style convictions: a self-view—the convictions one has about who one is; a self-ideal—the convictions of what one should be or are obliged to be to have a place; a world view—one's picture of the world or convictions about the not self and what the world demands of the individual; and one's ethical convictions—a personal moral code. When there is conflict between the self-concept and the ideal, inferiority feelings develop. It is important to note feelings of inferiority are not considered abnormal. However, when the individual begins to act inferior rather than feel inferior, the individual expresses an "inferiority complex." Thus, while the inferiority feeling is universal and normal, the inferiority complex reflects the discouragement of a limited segment of our society and is usually abnormal.

One of the main tools Adlerian therapists use to assess how an individual is functioning is a life style assessment. The goal of the life style assessment is to explore the individual's perceptions of his or her childhood experiences to discover the influence those perceptions have on the individual's current functioning. Basic to life style assessment is the elicitation of ERs.

The basic technique of eliciting ERs begins by asking the individual to think back before the age of 10 and to verbally share the earliest memory that comes to mind. It is essential that the focuses are on experiences occurring before the age of 10. Ten years is considered the age at which a child develops the ability to record events in chronological sequence. Then, the individual is asked to describe the memory as if it were a video recording with a beginning, middle, and end, and that has a feeling associated with it. The therapist writes down the memory using as many of the individual's words as possible. Then, the therapist asks the individual to freeze a certain scene or frame of the most vivid part of that memory and describe that frame. The individual is then asked to indicate his or her feeling or feelings about that vivid scene. Next, the individual is asked to indicate his or her thought or thoughts about that vivid scene.

Usually a minimum of three ERs are collected. From these, the therapist looks for themes. These themes usually offer valuable insight into the individual's presenting problem or concern. There are many ways to interpret themes from ERs. One way of interpretation is to notice who is and who is not included in the ERs, who else may be present in the ERs, and the extent of details that are included and what is emphasized. Overall, ERs provide a quick, accurate, and clinically useful assessment of an individual's personality dynamics, particularly life style convictions.

Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Adlerian Therapy

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Eating Disorders

Eating and feeding disorders are a group of extreme and potentially life-threatening beliefs, feelings, and behaviors about personal weight and food consumption.

Definitions

- **Binge eating** or bingeing is an out-of-control eating episode in which an abnormally large amount of food is ingested in a short period of time.
- **Compensatory** behaviors include self-induced vomiting, use of laxative or diuretics, fasting, and excessive exercise.
- **Diuretics** are substances that elevate the rate of urination and water loss.
- **Laxatives** are drugs, medications, or substances that stimulate the evacuation of the bowels.
- **Low weight** is weight that is less than minimally expected for age and height.
- **Purging** is to clear the stomach and/or the intestines of material by the use of laxatives, diuretics, or self-induced vomiting.

Description

Feeding and eating disorders (FEDs) are a group of psychological disorders characterized by impaired eating habits and abnormal perception of one's weight. FEDs have serious health consequences and are potentially life threatening. Anorexia, bulimia, and binge eating are the most commonly known FEDs but are not the only FEDs listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).

Causes and Symptoms

Anorexia nervosa is characterized by self-starvation and excessive weight loss. Approximately 90%–95% of people diagnosed with anorexia are females. Symptoms include low body weight, inadequate food intake to maintain weight, an extreme fear of gaining weight or becoming overweight, disturbed perceptions of body image, and an inability to recognize the seriousness of the behaviors. People suffering from anorexia are overly preoccupied with weight, food, fat and calorie intake, and dieting. Sufferers often develop food rituals such as arranging food on their plate or eating foods only in a specific order. They may make excuses to avoid mealtimes or situations where food may be consumed and make frequent reference to feeling fat or overweight. In spite of extreme thinness, sufferers perceive themselves as overweight. Self-starvation is the essential component of anorexia and as such has significant and serious health consequences, including muscle loss, reduced bone density, severe dehydration, kidney failure, weakness, fatigue, low blood pressure, slow heart rate, loss of hair, loss of menstrual cycle, and death. Anorexia is one of the most lethal mental health disorders, with 5%–20% of people suffering with anorexia dying from complications associated with starvation.

Avoidant/restrictive food intake disorder is similar to anorexia, but food aversion is not related to a disturbance of body image. Food is avoided for a variety of reasons such as lack of interest in eating; dislike or aversion to certain food characteristics such as the smell, color, or texture; and fear of negative consequences of eating, such as choking or vomiting. Avoidant/restrictive food disorder is more prevalent in children than in adults and is equally common in males and females.

Bulimia nervosa is characterized by a sense of out-of-control binge eating and engaging in excessive behaviors in order to compensate for the amount

of food ingested. Compensatory behaviors include self-induced vomiting, abuse of laxatives or diuretics, excessive and extreme exercise. Health consequences include damage to the digestive system; dehydration and electrolyte imbalances; inflammation and damage to the esophagus from frequent vomiting; tooth decay from stomach acids; and in rare cases stomach rupture. Approximately 1%–2% of the U.S. population suffers from bulimia, with 80% being female.

Binge eating disorder is similar to bulimia, but individuals do not engage in the compensatory behaviors associated with bulimia. Symptoms include a sense of out-of-control eating, eating alone due to shame, feelings of guilt, and shame over binging. Health consequences are less severe than bulimia and include high blood pressure, heart disease, diabetes, and weight gain. Approximately 1%–5% of the population suffers from binge eating disorder, with 60% being female.

Other eating disorders recognized in the DSM-5 include pica disorder, which is characterized by eating of nonfood items, and rumination disorder, which is characterized by regurgitating previously swallowed food to be re-chewed, re-swallowed, or spit out. Prevalence data for pica and rumination disorder is inconclusive.

Factors contributing to the development of food eating disorders include a complex combination of interpersonal, social, behavioral, biological, and psychological dynamics. Interpersonal and psychological issues include low self-esteem, feelings of inadequacy, lack of control, and an inability to express emotions. Social factors may include peer pressure to look thin, being ridiculed over one's appearance, and being bullied or being physically, emotionally, or sexually abused. Family dynamics also play a role in the development of FEDs. Current research is investigating the role of biological and genetic factors in the development of FEDs.

Prognosis

Psychologists, counselors, clinical social workers, psychiatrists, medical physicians, and nutritionists treat food eating disorders. A combination of psychotherapy and group counseling provided simultaneously with medical and nutritional interventions is the most effective form of treatment. Counseling addresses the underlying psychological, interpersonal, social, cultural, and family dynamics that contribute to the eating disorder. Medical and nutritional professionals monitor, guide, and equip clients in recovery, leading to healthier food-related behaviors. When FEDs become severe, intensive inpatient treatment may be necessary.

The National Eating Disorders Association (NEDA), founded in 2001, is a leading nonprofit prevention and advocacy organization that assists individuals and families better understand FEDs. The NEDA maintains an extensive online web presence. FEDs are complex and serious health conditions that develop in a variety of ways. FEDs are treatable, with full recovery possible with professional intervention.

Steven R. Vensel, PhD

See also: Anorexia Nervosa; Binge Eating Disorder; Bulimia Nervosa

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Economic and Financial Stress

Economic and financial stress is often a response to trying unsuccessfully to balance outgoing money for bills and earning enough income. It is a common challenge that many face in an attempt to meet personal and family financial obligations. In times of economic

decline, such as a recession, many Americans blame the economy for the majority of stress they experience. Numerous studies have found a strong link between economic and financial stress and an increased rate of mental health issues. Economic downturns, such as the Great Depression or the U.S. recession that began in 2007 and lasted well into 2013, were linked to increased rates of psychological disorders, including depression, suicide, substance abuse, domestic violence, and antisocial behavior. Among the most significant factors in the onset of mental health are job loss and underemployment, both of which have been connected to depression and substance abuse.

Definition

- **Economic and financial stress** is the physical and emotional response to external events that affect an individual and/or his or her family's economic stability. It can be triggered by the loss of a job or home or any change in economic status or stability.

Economic and financial stress is a common occurrence for many during a bad economy, but the problem is a chronic one for those living near or below the poverty line. Many individuals become frustrated by the high prices associated with groceries, gas, and other necessities. Unemployment has plagued many Americans, causing devastation and financial ruin for families all over the country. Financial and economic stress is often experienced when working on budgets, paying bills, worrying about saving money for emergencies, or being able to afford necessary items. Financial and economic stress can also be influenced by an attempt to maintain social status.

There are different emotional and physical responses to economic and financial stress. Some individuals may have difficulty sleeping, experience weight gain or loss, or develop symptoms of anxiety, such as panic attacks.

Throughout U.S. history, there have been several major turns in the economy that have brought on great stress, frustration, and concern for many. The loss of jobs, income, and even homes can often lead to significant mental distress. There is also concern that this form of stress can have a large effect on four key mental health concerns: major depression and anxiety disorders, suicide, substance abuse, and violent behavior. There is a higher rate of suicide among those who are unemployed.

Current Status

One of the most common causes of economic and financial stress among young adults has to do with being overwhelmed by college loan debt. Not only do these young adults leave college with hefty student loans, many have a difficult time finding work in their respective fields or at adequate salaries, which only adds to their inability to pay back the loans. This, in turn, has hurt other industries, as this generation is not spending money on cars, homes, or building families and instead are working simply to make loan payments. Economic and financial stress has also led many young adults to remain living with their parents after college graduation and for some even after starting families.

Mindy Parsons, PhD

See also: Domestic Violence; Homelessness; Poverty and Mental Illness

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Ecstasy (MDMA or 3,4-Methylenedioxy-Methamphetamine)

Ecstasy is a synthetic, psychoactive drug—known as MDMA—which produces stimulant and hallucinogenic effects.

Definitions

- **Catecholamines** are a group of neurotransmitters released by the brain in response to acute stress. These include dopamine, norepinephrine, and epinephrine.
- **Dopamine** is a chemical messenger in the brain that transmits nerve impulses that regulate attention, concentration, emotion, movement, impulse control, and judgment.
- **Neurotransmitters** are a group of chemical messengers in the brain that messages to other nerve cells. Common neurotransmitters include acetylcholine, dopamine, norepinephrine, and serotonin.
- **Norepinephrine** is a chemical messenger in the brain that serves to transmit nerve impulses that regulate attention and power the "fight-flight" stress response. As such, it causes constriction of blood vessels. It is also called noradrenaline. Serotonin is a chemical messenger in the brain that serves to transmit nerve impulses that regulate mood in terms of calmness, happiness, pain, sexuality, and sleep. Low levels are associated with depression and compulsivity.

Description

Ecstasy is the popular name for the synthetic, psychoactive drug MDMA. It is known as a club drug and has several street names, including Adam, B-bombs, bean, Blue Nile, clarity, crystal, decadence, disco biscuit, E, essence, Eve, go, hug drug, Iboga, love drug, molly, morning shot, pollutants, Rolls Royce, Snackies, speed for lovers, sweeties, wheels, X, and XTC. It is chemically similar to methamphetamine and to mescaline. Ecstasy acts both as a stimulant and as a psychedelic, producing an energizing effect as well as distortions in time and perception and enhanced enjoyment from tactile experiences. Ecstasy exerts its primary effects in the brain on neurons that use the neurotransmitter serotonin to communicate with other neurons. Serotonin is central in regulating mood, aggression, sexual activity, sleep, and sensitivity to pain. Most users take ecstasy orally. Users also sometimes inhale or inject it. Although ecstasy is available as a capsule or a powder, it is usually sold in tablet form.

Ecstasy is absorbed quickly after being ingested and can be detected in the blood within 30 minutes. While its peak effects occur in 60 to 90 minutes, the main effects last three to five hours. Women are more sensitive to ecstasy than men and are more likely to experience an optimal effect of the drug at a lower dose, proportional to weight, than men. Most users of ecstasy are white teenagers and young adults from middle- and upper-class households. According to the National Survey on Drug Use and Health in 2010, an estimated 695,000 Americans had used Ecstasy within the past month, and almost 1 million Americans report using it for the first time. Marijuana, alcohol, and cocaine are commonly used with ecstasy.

Ecstasy was first synthesized in 1912 by Merck, the pharmaceutical giant, which patented it in 1914. The name "ecstasy" was coined in the early 1980s to increase the market for the drug. Ecstasy became popular as a club drug and was often sold in nightclubs and bars. By the mid-1980s.the U.S. Drug Enforcement Administration banned ecstasy. Currently, it is classified as a Schedule I drug, meaning it has high potential for abuse and no currently accepted medical value.

Precautions and Side Effects

Recently, an herbal version of ecstasy has been widely available. Although those who take herbal ecstasy believe it to be a legal, safe alternative to ecstasy, there are reports of numerous adverse effects, including severe reactions such as high blood pressure, seizures, heart attacks, strokes, and death. Ecstasy in the form of MDMA causes the release of dopamine, serotonin, and norepinephrine. Research shows that chronic use of MDMA causes brain damage by destroying neurons that release serotonin resulting in memory problems that persist for at least two weeks after stopping use of the drug. Long-term effects of ecstasy use may result in shrinkage of the hippocampus, resulting in cognitive impairment. Other research has found that the use of

this drug damages neurons that regulate dopamine resulting in tremors, unsteady gait, and paralysis, which are symptoms of Parkinson's disease. Exposure to MDMA during pregnancy is associated with learning deficits that last into adulthood.

While most users report intensely pleasurable experiences after taking ecstasy, about 25% of users also report undesirable experiences. Short-term adverse reactions that have been reported include dilated pupils, unusual sensitivity to bright light, headache, sweating, increased heart rate, tooth grinding, spasms of the jaw muscle, loss of appetite, nausea, muscle aches, fatigue, dizziness, vertigo, thirst, numbness, tingling skin, retention of urine, staggering gait, unsteadiness, tics, tremors, restlessness, agitation, paranoia, and nystagmus. Diving a car under the influence of ecstasy is unsafe. The depletion of serotonin seems to cause "midweek blues," which is the lethargy, concentration and memory problems, and depressed mood that many ecstasy users experience for a few days after taking the drug. Finally, ecstasy users tend to develop tolerance to the drug with repeated use. Novice users may take one or two tablets per session, whereas experienced users may need to take three or more tablets to achieve the same effect. Heavy users sometimes binge use, either by taking several tablets simultaneously or by repeatedly taking tablets during a single session that may last up to 48 hours.

Len Sperry, MD, PhD

See also: Drug Enforcement Administration (DEA)

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Effexor (Venlafaxine)

Effexor is a prescribed antidepressant medication used to treat depression and generalized anxiety disorder. Its generic name is venlafaxine.

Definitions

- **Neuroleptic malignant syndrome** is a potentially fatal condition resulting from combining medications and characterized by severe muscle rigidity (stiffening), fever, sweating, high blood pressure, delirium, and sometimes coma.
- **Norepinephrine** is a neurotransmitter (chemical messenger) in the brain believed to regulate mood.
- **Selective serotonin norepinephrine reuptake inhibitors (SNRI)** are medications that act on and increase the levels of serotonin and norepinephrine in the brain that influences mood. They differ from selective serotonin reuptake inhibitors which act only on serotonin.
- **Serotonin** is a neurotransmitter (chemical messenger) in the brain believed to regulate attention, mood, and powers the "fight-flight" stress response.
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. It occurs when a number of medications that increase serotonin are taken together. Symptoms include high blood pressure, high fever, headache, delirium, shock, and coma.

Description

Effexor is in the class of antidepressant medication known as serotonin and norepinephrine reuptake inhibitors (SNRIs). It is primarily used to treat depression and generalized anxiety disorder. Effexor has also been used to treat obsessive-compulsive disorder and irritable bowel syndrome. Effexor has actions common to both the tricyclic antidepressants, such as Tofranil and Elavil, and the selective serotonin reuptake inhibitors (SSRIs), such as Prozac, Zoloft, and Paxil. Effexor is thought to work by increasing the levels of the neurotransmitters (chemical messengers) in the brain.

Precautions and Side Effects

Those taking Effexor should be monitored closely for insomnia, anxiety, mania, significant weight loss, and

seizures. Its use should also be monitored in children and adults up to age 24 because they are at an increased risk of developing suicidal thoughts. Caution should also be exercised when prescribing Effexor to those with impaired liver or kidney function, those over age 60, children, individuals with known bipolar disorder or a history of seizures, and those with diabetes. Care should be taken to weigh the risks and benefits of Effexor in women who are or wish to become pregnant, as well as in breast-feeding mothers. Those with diabetes should monitor their blood or urine sugar carefully, since Effexor can affect blood sugar. Alcohol should not be used while taking Effexor. Care must be taken in driving, operating machinery, or participating in hazardous activities when taking this medication. Effexor use should not be stopped abruptly since it can cause withdrawal symptoms (serotonin discontinuation syndrome).

Some common side effects with Effexor use include nausea, drowsiness, dizziness, dry mouth, constipation, loss of appetite, blurred vision, nervousness, trouble sleeping, unusual sweating, and yawning. Like other SNRIs sexual side effects are relatively common in Effexor. These include impotence and decreased sex drive.

Effexor interacts with a number of other medications. Dangerously high blood pressure has resulted from the combination of Effexor and monoamine oxidase inhibitors like Nardil or Parnate. Effexor also interacts with Desyrel, Meridia, and Imitrex and may cause a condition known as neuroleptic malignant syndrome. Those taking blood thinners, including aspirin, are at risk for increased bleeding when taking Effexor. The sedative effects (drowsiness) of Effexor are increased by other central nervous system depressants such as alcohol, sedatives, sleeping medications, or other medications used for mental disorders such as schizophrenia.

Len Sperry, MD, PhD

See also: Antidepressants; Depression; Generalized Anxiety Disorder

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Ego and the Mechanisms of Defense, The (Book)

Child psychoanalyst Anna Freud's most popular work, *The Ego and the Mechanisms of Defense*, discusses how human defense mechanisms protect the psyche from states of stress and anxiety.

Definitions

- **Anna Freud**, daughter of Sigmund Freud, is best known as the founder of child psychoanalysis, developer of ego psychology, and author of *The Ego and the Mechanisms of Defense*.
- **Defense mechanisms** are unconscious, maladaptive coping strategies that people use to prevent unpleasant feelings and experiences.
- **Ego psychology** is a formal theory of psychoanalytic thought based on Freud's structural model of the id, ego, and superego and their related functions.

Description

Considered the founding text in ego psychology and child psychoanalysis, *The Ego and the Mechanisms of Defense*, written by Anna Freud (1895–1982), was first published in German in Vienna in 1936. Due to its popularity it was translated into English soon after, two years before Sigmund Freud's death. It has since been updated/revised. *The Ego and the Mechanisms of Defense* is the publication that Anna, the youngest of Freud's six children, is best known for. She is also the only one of Freud's children to make her own mark in the area of psychoanalysis, credited as the founder of child psychoanalysis. Beginning her professional

career as a schoolteacher, Anna gained firsthand knowledge of children and adolescents. However, after undergoing psychoanalysis with her father, her interests in the field peaked, leading to her eventual professional transition.

The Ego and the Mechanisms of Defense discusses the individual ego's defense reactions that arise from conflicts among the id, ego, and superego. Human beings tend to react in a variety of ways in an attempt to alleviate feelings of anxiety and stress. These *defense mechanisms* are unconscious coping strategies that people use to prevent themselves from experiencing unpleasant feelings or situations. Defense mechanisms, though they can result in both positive and negative consequences, are viewed as maladaptive as they attempt to distort, deny, or manipulate reality. Anna Freud listed 10 defense mechanisms based on her father's works: (1) repression, (2) regression, (3) reaction formation, (4) isolation, (5) undoing, (6) projection, (7) introjection, (8) turning against one's own person, (9) reversal into the opposite, and (10) sublimation/displacement; but she went on to hone this list to five main ones in her later research (repression, regression, projection, reaction formation, and sublimation).

Impact (Psychological Influence)

The Ego and the Mechanisms of Defense is considered a classic contribution to psychoanalytic psychology. This seminal text provided the foundations of child psychoanalysis as Freud included several clinical illustrations from analysis with children and adolescents. The book remains a staple used in modern-day child psychology courses.

Melissa A. Mariani, PhD

See also: Defense Mechanisms; Freud, Anna (1895–1982); Freud, Sigmund (1856–1939)

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Ego Depletion

"Ego depletion" is the term used to describe the temporary exhaustion of self-control.

Definitions

- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. This is the original theory of Sigmund Freud.
- **Self-control** is the capacity for self-discipline. Some use this term interchangeably with willpower.
- **Willpower** is the ability to resist a short-term temptation in order to achieve a long-term goal. It also involves the ability to delay gratification. Some use this term interchangeably with self-control.

Description

"Ego depletion" is a term used to describe significant expenditure of the mental energy required for self-control or willpower. The depletion of this resource affects the individual's capacities for further self-control. An example of this is when an individual deliberately forgoes a tasty but unhealthy breakfast but later succumbs to the temptation for a sweet roll and coffee later in the morning. The term "ego depletion" was coined by the American psychologist Roy Baumeister (1953–). He credits Freud and psychoanalytic theory, particularly the concepts of ego and psychic or mental energy. Baumeister considers willpower to be like a muscle. A specific muscle has a given amount of energy to do work and it can be used up slowly or rapidly in a given amount of time. The more work a muscle does in a single action, the more energy is used and the less is available for further action.

As a muscle's energy may be used slowly over many small actions or quickly in fewer large actions, so too can an individual's ability to exert the willpower decrease with his or her choices. That is because individuals have only a limited amount of mental energy that they may utilize in a given amount of time. As

individuals use this energy for self-control, they deplete this energy and have less available for the next action. Furthermore, the more difficult a given decision is, the more mental energy is required to act on the decision. Also like muscles, ego depletion is a temporary state. As time lapses between willpower act, the energy used from previous acts is slowly replaced. When it is overused its energy is depleted. So too with self-control. When willpower is overused, an individual's capacity for self-control is reduced because of ego depletion. Baumeister's research shows that ego depletion is linked to depletion of blood glucose (sugar) levels. More specifically, ego depletion causes a slowdown in regions of the brain associated with self-control. In short, ego depletion results in slower brain functioning, which subsequently diminishes willpower. At the same time, it also increases cravings for food, alcohol, drugs, and other forbidden desires. In addition, ego depletion increases the intensity of feelings, particularly negative or unpleasant ones. Fortunately, there are strategies for increasing willpower and decreasing ego depletion.

Len Sperry, MD, PhD, and
Jeremy Connelly, MEd

See also: Psychoanalytic Theory; Willpower

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Ego Development

"Ego development" refers to the psychological concept of the ego and the nature of its development across the human lifespan.

Description

The ego is the internal process that allows a person to make sense of the world around him or her and have a distinct personality from all others. It is the lens though which all experiences are captured. The ego is the person within the human body.

The most prominent conceptualization of ego is that of Jane Loevinger (Loevinger, 1976). Loevinger theorizes that the ego is a holistic construct that unifies the personality into a single whole. The ego develops a frame of reference within a person that integrates all of a person's experiences into an understanding of the world and how to live in it. Loevinger referred to the ego as the "master trait" that organizes our experiences and shapes how we make meaning, develop a worldview, and gain a sense of self. The ego changes on one's experiences, so it is always developing. It was important to Loevinger to develop an understanding of the concept of ego based on research. She developed the Washington University Sentence Completion Test, which is the primary measurement of ego development.

Loevinger describes four domains that are woven together to form the ego. The first is *character development* that incorporates impulse control and moral development. The second domain is *cognitive style* that includes conceptual complexity and cognitive development. The third is *interpersonal style* that defines our attitudes toward relationships and other people. The forth domain is *conscious preoccupations*, which are the focus of the most dominant conscious thoughts and behaviors. The focus of our thoughts and behaviors changes over time and can include focusing on getting our needs met, or conformity to rules, and many other foci depending on one's age and experiences.

Loevinger theorized that the ego develops in stages and each stage is built on the previous stage. Each stage represents a restructuring of the self and greater awareness of self, others, personal autonomy, and responsibility. Loevinger proposed nine stages of ego development.

(1) Presocial and symbiotic stage. This is early infancy with exclusive focus on gratification of immediate needs and attachment to mother. There is no language at this stage. No conceptualization of others or self.
(2) Impulsive stage. Asserting a growing sense of self, demanding, impulsive, dependent, a focus on bodily feelings, and age-appropriate sexuality and aggression. Dichotomous thinking, that is, categorizes experiences as either good or bad/nice to me or mean to me.

(3) Self-protective stage. Beginning to develop self-control, complaining, blaming; focus on not getting caught and learning rules and externalizing blame.
(4) Conformist stage. Beginning to conform to social norms and rules, invested in belonging, black and white thinking, cognitive simplicity, and moralistic. Belonging to and gaining approval of group is most valued.
(5) Self-aware. Increasing but limited self-awareness; self-critical and beginning to become aware of inner feelings about self and others; beginning to reflect on God, death, relationships, and health.
(6) Conscientious. Rules are internalized, responsible, self-critical, reflective, and empathic; true conceptual complexity, able to discern patterns, and can see the broader social perspective; guilt triggered by hurting others and morality is based on principles.
(7) Individualistic. Increasing sense of individuality, recognition of individual differences, and emotional dependence; awareness of inner conflicts without need to resolve; value relationships over achievements; unique expression of self.
(8) Autonomous. Respectful of autonomy of self and others. Relationships are understood as emotionally interdependent rather than dependent or independent; high toleration for ambiguity and conceptual complexity; able to cope with inner conflicts between needs and duties. Deepening self-acceptance results in self-fulfillment valued over achievement.
(9) Integrated. A rare stage to attain. Empathic and wise with a full sense of identity and self-actualization; at peace with self and seeks to further understand and fulfill potential intrinsic nature; reconciled to one's destiny.

Current Status

Ego development will continue to be a focus of inquiry as social researchers seek to further understand human relationships, needs, and challenges.

Steven R. Vensel, PhD

See also: Ego Psychology

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Ego Psychology

Ego psychology is a form of psychoanalysis. It is based on Freud's model of the mind and the role of the ego in managing competing demands.

Definitions

- **Defense mechanisms** are strategies for self-protection against anxiety and other negative emotions that accompany stress.
- **Ego depletion** is the term used to describe the temporary exhaustion of self-control. It is also known as willpower depletion.
- **Object relations** is a form of psychoanalytic psychology which explains the essential need for close relationship. The attempted fulfillment of this need through mental representations of self and others is believed to determine one's motivations and behaviors.
- **Oedipus complex** is the desire for sexual involvement with the parent of the opposite sex and a concurrent sense of rivalry with the parent of the same sex. Freud considered the complex a critical stage in normal developmental.
- **Psychoanalysis** is a theory of human behavior and a form of therapy based on psychoanalytic theory. In psychoanalysis clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams. It was initially developed by Sigmund Freud.

- **Psychoanalytic psychology** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations, delusions, and disordered thinking.
- **Subconscious** is the part of the conscious mind which consists of information that is not in awareness unless attention is directed to it. It is also called the preconscious.
- **Unconscious** is the part of the conscious mind which consists of the primitive, instinctual wishes and information that operates without awareness and over which one does not have active control.

Description

Ego psychology is a form of psychoanalysis. It is based on Sigmund Freud's (1856–1939) theory about how the human mind is structured. According to Freud, the mind is divided into three parts: the id, the ego, and the superego. Each of these parts has specific functions and develops at different times during childhood. The id (German for "it") is the primitive instinctual drive. It is present at birth and is concerned with gratification and pleasure. The id operates under what Freud called the "pleasure principle." It is considered to be irrational because it is not based on reality. The ego (Greek for "I") develops between six and eight months after birth. One function of the ego is to manage the impulses of the id in rational, socially acceptable ways. The final part of the mind to develop is the superego. This occurs in the first few years of life and is the result of the resolution of the Oedipus complex. The superego is responsible for an individual's notion of right and wrong. It is concerned with morality and rules. The superego reflects the beliefs and values of a child's caregivers, usually parents. Like the id, the superego is also irrational. Freud further separated the mind into conscious and unconscious realms. He described three levels of human consciousness. At the surface (or top level) is the conscious; just below this is the preconscious or subconscious, and at the very bottom is the unconscious. The id and superego operate outside of individuals' awareness in the subconscious. The ego is both conscious and subconscious, with some material held in the preconscious memory. According to Freud, there are different layers. One of the main goals of psychoanalysis is to make individuals aware of their subconscious thoughts and drives in order to change their behavior.

The ego must balance the competing demands of the id, the superego, and society in general. According to ego psychology, personality is determined by the way in which an individual's ego manages the conflicting pressures of the id and the superego. The ego has many functions with which to accomplish this task. Some of these are reality testing, impulse control, object relations, and defense mechanisms. Reality testing is the ability to distinguish what is happening in one's own mind from the outside world. This function allows individuals to see themselves as separate from their environments and respond to various stimuli in appropriate ways. Those who experience symptoms of psychotic disorders such as hallucinations or delusions are unable to do this. Impulse control is the ability to hold back urges without acting on them. For example, the primitive instinctual drive may prompt an individual to assault someone who cuts him or her off in traffic. The healthy ego will inhibit this behavior and satisfy the urge in more acceptable ways. Those with impulse control disorders and addictions are said to have poor ego functioning in this area. Object relations refers to the way individuals perceive themselves and others. This is based on childhood development and early experiences with others. Finally, defense mechanisms are a primary way in which the ego manages the competing demands of the id and superego. A defense is an unconscious effort to protect individuals from unacceptable or uncomfortable feelings. Some of these are considered primitive, while others are more sophisticated and mature. Splitting is an example of an immature defense mechanism. It occurs when others are considered all good or all bad, with no middle ground. Humor is an example of a mature defense mechanism.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Defense Mechanisms; Ego Depletion; Ego Development; Object Relations Theory; Psychoanalysis; Psychoanalytic Theory; Psychotic Disorder; Subconscious

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Elavil (Amitriptyline)

Elavil is a prescription antidepressant medication used to treat various forms of depression and some forms of pain. Its generic name is amitriptyline.

Definitions

- **Neuroleptic malignant syndrome** is a rare and life-threatening complication of antipsychotic medication use. The syndrome is characterized by high fever, muscle rigidity, changed mental status, or changes in book pressure.
- **Selective serotonin reuptake inhibitors** are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.
- **Tricyclic antidepressants** are an older class of antidepressants called tricyclic because of their three-ring chemical structure.

Description

Elavil is in the class of medications known as tricyclic antidepressants. Elavil and the other tricyclics are thought to work by blocking reabsorption of neurotransmitters (chemicals messengers), particularly serotonin. They have long been used to treat depressive disorders but have largely been replaced by the selective serotonin reuptake inhibitors. Elavil is sometimes prescribed for various types of chronic pain, including cancer pain and neuropathic pain (nerves), and to prevent migraine headaches. Since it is usually given at bedtime, it also promotes sleep.

Precautions and Side Effects

Elavil should not be stopped abruptly. Instead, the dose should be decreased gradually and then discontinued. Headache, nausea, and a worsening of original symptoms are likely if it is stopped abruptly. Individuals may need to stop this medication before surgery. Children and adults up to age 24 are at an increased risk of developing suicidal thoughts or behaviors when they first begin taking Elavil and other antidepressants. Those taking the monoamine oxidase inhibitors (MAOIs) like Parnate or Nardil should not combine it with Elavil. Elavil should be used with caution in those with glaucoma, seizures, urinary retention, overactive thyroid, poor liver or kidney function, alcoholism, asthma, digestive disorders, enlarged prostate, seizures, or heart disease. Since fetal deformities have been reported with taking this drug during pregnancy, women should discuss the risks and benefits of Elavil with their doctors. Breast-feeding should be avoided while using Elavil.

Common mild side effects of Elavil can include drowsiness, dizziness, dry mouth, blurred vision, constipation, weight gain, or trouble urinating. More serious but uncommon side effects include easy bruising, persistent heartburn, shaking, mask-like facial expressions, muscle spasms, severe stomach pain, decreased sexual desire, impotence, or painful breasts. Medical attention should be sought for these rare but serious side effects: black stools, vomit that looks like coffee grounds, severe dizziness, fast and irregular heartbeat, fainting, or seizures. Elavil occasionally causes a very serious condition called neuroleptic malignant syndrome.

Elavil may decrease the therapeutic effective of some medications used to treat high blood pressure. It should not be taken with other antidepressants, particularly MAOIs, or with Ritalin. It should not be taken with Tagamet or Neo-Synephrine or other over-the-counter medications without checking with one's doctor. Those taking Elavil should avoid the natural remedies like St. John's wort and belladonna. Because

black tea can decrease the absorption of this medication, Elavil should be taken at least two hours before or after drinking such tea.

Len Sperry, MD, PhD

See also: Antidepressants; Depression

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Elder Abuse

Elder abuse is the physical, sexual, or emotional abuse of an elderly individual, usually one who is disabled or frail. It is also called senior abuse.

Definitions

- **Abandonment** involves the desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that individual.
- **Emotional abuse** involves inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts.
- **Exploitation** involves illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder.
- **Neglect** involves refusal or failure by those responsible to provide food, shelter, health care or protection for a vulnerable elder.
- **Physical abuse** involves inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder or depriving the elder of a basic need.
- **Sexual abuse** involves nonconsensual sexual contact of any kind, coercing an elder to witness sexual behaviors.

Description

Elder abuse is harm or abuse of individuals over the age of 65. It is a crime that all health-care and social service professionals are mandated to report. It can involve abandonment, emotional abuse, exploitation, neglect, physical abuse, or sexual abuse. It is not uncommon for an elder to experience more than one type of mistreatment at the same or different times. For example, someone who financially exploits an elder may also neglect to provide appropriate care in the form of food, medication, or shelter. There are two categories of elder abuse. One is domestic elder abuse, which is committed by someone with whom the elder has a special relationship such as a spouse or child. The other is institutional abuse, which is committed by a caregiver obliged to provide care and protection in a residential facility such as an assisted living facility (nursing home) or group home. The National Center on Elder Abuse (NCEA) reported that in 2013 nearly 6 million cases of elder abuse were reported.

The typical victim of elder abuse is a 75-year-old Caucasian female who lives with an adult child on whom she depends. Those with Alzheimer's disease or other types of dementias are twice as likely to be abused. This often occurs because of unsettling personality changes in these individuals. Demented elderly can be exasperating due to their memory loss, incontinence (loss of bladder control), and frequent aggressive behavior. Such factors are extremely taxing on caretakers. The result can be full-blown elder abuse and the resulting shame. The NCEA predicts that elder abuse will continue to rise. Among the many factors supporting this prediction is that the elderly and their adult children are expected to spend increasingly more time together. Because of increasing life expectancy, adult children can expect to spend more time taking care of their aging parents than their parents took care of them! The child might have been at home for the first 18 to 20 years of life. However, with elders living into their late 80s and early 90s, an adult child might have to take responsibility for a parent over 65 for 25

or more years. Elder abuse may be one of the most distressing and difficult situations that adult children will face in their lives.

Len Sperry, MD, PhD

See also: Abuse; Neglect; Sexual Abuse

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Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT) is a medical intervention for severe mental disorders in which seizures are induced with an electrical impulse. It is also referred to as shock treatment or electroshock therapy.

Definitions

- **Amnesia** is a disturbance of memory characterized by partial or total inability to recall past experiences. It can result from trauma or from medication or electroconvulsive therapy.
- **Epilepsy** is a neurological disorder characterized by periodic loss of consciousness with or without convulsions. It is caused by brain damage, or the cause may be unknown.
- **Metrazol** is a synthetic stimulant pharmaceutical used to produce electrical stimulation in the brain and induce seizures.
- **Seizure** is uncontrolled electrical activity in the brain which can produce convulsions (spasms), loss of consciousness, amnesia, or physical symptoms depending on its cause and the area of the brain affected.
- **Therapeutic clonic seizure** is a type of seizure in which an individual loses consciousness and has convulsions characterized by repetitive, jerking (clonic) movements.

Description

Electroconvulsive therapy is a medical intervention for the treatment of major depression and severe mental disorders in individuals who have not responded to other treatments. ECT is administered by placing electrodes on one or both sides of the head and passing a brief electrical impulse through the brain. This procedure is performed while the individual is under anesthesia. Its purpose is to induce a therapeutic clonic seizure that lasts for about 15 seconds. The expected benefit is that the individual's symptoms may remit. How ECT works is unknown, but there are a number of theories for explaining its effectiveness. One theory suggests that ECT causes an alteration of neurotransmitters (chemical messengers) in the brain that results in increased mood and energy. Another theory suggests that ECT modifies stress hormone regulation in the brain, resulting in positive outcomes. Treatment outcomes can be influenced by the placement of electrodes, frequency and duration of the treatments, and the electrical voltage or waveform of the shock.

Development and Current Status

Constance Pascal (1877–1937), a French psychiatrist, introduced the term "shock." Previously the term "shock" had been used in medicine to imply a combination of low body temperature (hypothermia) and low blood pressure (hypotension). In 1926, she wrote a book titled *Le Traitement Desmaladies Mentales Par Les Chocs*. In that book Pascal theorized that psychopathology was due to mental shock. Therefore, to treat mental illness and restore healthy functioning of the brain, she argued that the brain and body must be shocked back into balance. She believed that this could be achieved through the injection of gold, insulin, or vaccines. A year later, psychiatrists began experimenting with injecting large doses of insulin to induce a form of shock. This research was further developed by Manfred Sakel (1900–1957) and the result was termed

"insulin coma therapy" (ICT). ICT was the first type of shock therapy.

Ladislas Meduna (1896–1964) was a psychiatrist who believed that seizures were an essential component of effective shock therapy. His theory was based on his studies of biopsies of human brain tissues from individuals with epilepsy and major mental disorders. Seizures often occur in comas and both are forms of shock. Meduna began injecting camphor and Metrazol to induce seizures. Meduna went on to work with Ugo Cerletti (1877–1963) of the Rome University psychiatry clinic. Cerletti suggested using electricity instead of Metrazol to induce seizures. Cerletti and a colleague Lucio Bini (1908–1964) are credited with inventing ECT in 1938.

ECT is a controversial treatment modality. The main concern is whether its benefits outweigh risks, which include brain damage and memory loss. Peter Breggin (1936–), an American psychiatrist, is one of the most vocal critic of ECT. He believes ECT causes closed head injury and advocates for replacing it, as well as psychiatric medications, with more humanistic approaches like psychotherapy and education. Although advancements in research and technology have rendered ECT a safe procedure, the controversy still exists. Because of such concerns, ECT is rarely used as the first attempted intervention.

Today, ECT is used primarily to treat chronic mental conditions where other interventions have failed. Vagus nerve stimulation (VNS) and transcranial magnetic stimulation (TMS) are modern variations of ECT. Both VNS and TMS are more precise methods of inducing seizures.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Depression; Seizures

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Electroencephalography (EEG)

Electroencephalography is a medical diagnostic test that records electrical activity on the scalp to evaluate various brain functions and psychological disorders. It is also known as the brain wave test.

Definitions

- **Computed tomography** is a medical diagnostic test in which computer-processed X-rays produce tomographs (cross-sectional images) of body areas.
- **Encephalitis** is an inflammation of the brain.
- **Epilepsy** is a neurological disorder characterized by recurrent seizures with or without a loss of consciousness.
- **Fast Fourier transform** is a mathematical process used in EEG analysis to investigate the composition of an EEG signal.
- **Magnetic resonance imaging** is a medical diagnostic test which uses electromagnetic radiation and a strong magnetic field to produce detailed images of the brain and internal organs.

Description

An electroencephalogram (EEG) is a neurological test for recording electrical activity of the brain. Electrodes are placed in a standard pattern on the individual's scalp. The electrodes are then connected to a recording device. This device makes a continuous graphic record of the individual's brain activity (brain waves) on a strip of recording paper or computer screen. This graphic record is called an EEG. If the display is computerized, it is called a digital EEG. Usually, the EEG takes about one hour to administer. However, long-term EEG monitoring is often used for diagnosis of seizure disorders or sleep disorders.

The EEG is a useful tool in the diagnosis and management of epilepsy and other seizure disorders. Also, the EEG is a useful test in making or confirming the diagnosis of stroke, brain tumors, encephalitis, and sleep disorders. It can also determine brain status and brain death. A quantitative version of the EEG (qEEG) produces a brain map that can increase the test's diagnostic value. The qEEG involves modifying the EEG signals with a computer using the fast Fourier transform algorithm. The result is displayed on a schematic map of the head to form a topographic image. This brain map is particularly useful in the diagnosis of Alzheimer's disease and mild closed-head injuries. It can also identify areas of the brain with abnormally slow activity and differentiate between early dementia (increased slowing) and uncomplicated depression (no slowing). The qEEG is also known as BEAM (brain electrical activity mapping).

Developments and Current Status

In 1924, the German psychiatrist Hans Berger (1873–1941) recorded the first human EEG. Since that time the use of this neurological test has greatly expanded because of refinements such as BEAM and magnetoencephalograph (MEG). MEG measures both the individual's electrical field and activity and the associated magnetic field. This magnetic field is detected with a biomagnetometer and recorded as an MEG. Data provided by it is quite different from that provided by computed tomography and or magnetic resonance imaging. Both of these brain imaging instruments provide still images of the brain. These images are useful in providing structural and anatomical information. In contrast, MEG provides information on the brain in real time. It is used to map cognitive functions such as speech, memory, attention, and consciousness. MEG also provides surgeons with real-time computer-generated images of lesions (tumors) essential in planning surgery.

Len Sperry, MD, PhD

See also: Magnetic Resonance Imaging (MRI); Single-Photon Emission Computed Tomography (SPECT)

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Electronic Communication

"Electronic communication" refers to communicating through the use of electronic media such as computers, cellular phones, fax machines, or other devices using e-mail, voice mail, texting, instant messaging, and/or video conferencing. Electronic communication is any type of communicating that is based on electricity; it is also referred to as computer-mediated communication (CMC).

Definitions

- **Computer-mediated communication (CMC)** describes the electronic means of communicating via the Internet including e-mailing, text messaging, social networking, and video conferencing.
- **Electronic messaging** is the sending and receiving of an e-mail, instant message, or text message from a computer, cellular phone, or electronic tablet.
- **Transmission** is the act of sending a message in the form of text, picture, or video or other information from a given source.

Description

Electronic communication describes the sending and receiving of information through the use of various types of electronic media. These vehicles for communication include television, radio, desktop computers, cellular phones or other handheld devices, fax machines, gaming consoles, and/or electronic tablets. Use of electronic media differs from static, or print, media in that it is interactive. People use several types of electronic

Electronic communication describes the sending and receiving of information through the use of various types of electronic media. While such communication has brought the world closer together than ever before, it can also lead to misunderstandings and can be used to commit harmful acts such as cyberbullying. (Akulamatiau/Dreamstime.com)

communication, such as e-mail, text messaging, social networking, and video conferencing. Electronic means of communication has drastically increased over the past few decades with advances in technology. Prior to these advancements, communication was limited to what a person could see and hear in front of him or her or how far the person was able to physically travel to transport that information via land, sea, or air. However, the development of the World Wide Web and the Internet has changed that, making it possible for people to communicate with one another regardless of their proximity. It also permits communication to happen almost instantaneously. Using these means, people are able to communicate greater amounts of information more quickly and cost effectively, over greater distances, and to larger numbers of people. This form of communication affords users with both personal and professional benefits.

Electronic communication allows people to transmit various types of media (text, pictures, sound, video) into a single message. This can greatly enhance the communication experience and provide a richer context to the information being sent. However, studies indicate that approximately 60%–90% of information is communicated nonverbally. Effective communication thus relies on both the content of the message and the intent of the sender of that message. Therefore, the sender must be clear in determining both in order for the message to be received accurately. Experts have argued that no form of electronic communication can replace the traditional, face-to-face experience.

The foundation for electronic modes of communication began in the late 19th century with Thomas Edison and direct current electricity. The next invention that significantly impacted this movement was the telegraph and the use of Morse Code. Alexander Graham Bell's invention of the telephone soon followed. Next came transmitting messages via radio waves, which was a popular means because of its ease and cost effectiveness. The first computer was developed in the early 1940s and drastically changed the way people communicate. Developments in this media then exploded in the 1970s and 1980s with companies like IBM, Microsoft, and Macintosh. The National Science Foundation also created the basis of the Internet in the late 1980s. The 1990s on into the 21st century has seen much expansion in modes of electronic communication, with cellular phones, tablets, and the use of social networking.

Impact (Psychological Influence)

Reports indicate that over 70% of all communication nowadays is communicated electronically. While this type of communication is on the rise, many people are not adequately trained in its use and this can lead to miscommunication and error, which can be problematic in social settings and business dealings. Adolescents, teens, and young adults in particular are subgroups that are using electronic means of communicating at high rates. Technology statistics from the PEW Internet and American Life Project indicated that

71% of teens own a cell phone, 94% utilize the Internet (with more than half using it daily), 58% have a profile on a social networking site, and 26% maintain a personal web page. Determining which types of interactions can be communicated effectively using electronic means and what should be done via phone call or face-to-face is imperative.

Melissa A. Mariani, PhD

See also: Cyberbullying; Facebooking; Sexting; Social Media

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Ellis, Albert (1913–2007)

Albert Ellis was an American psychologist who developed rational emotive behavioral therapy.

Description

Albert Ellis was an influential American psychologist and author. He began his career as a sexologist before pioneering the development of rational emotive behavior therapy (REBT), a form of psychotherapy that focuses on disputing irrational thoughts, beliefs, and expectations. It evolved from rational therapy and rational emotive therapy. Disputation is a therapeutic technique consisting of a series of questions asked by the therapist to guide a client away from irrational beliefs and toward more helpful and healthy thought patterns. Designed to help people actively overcome challenges and live more fulfilled lives, REBT grew from a fringe school of thought to become a major philosophy and practice. A prolific writer and active social commentator, Ellis continually advocated the use of intention-based REBT therapy for changing patient behavior and beliefs in a variety of personal and social situations.

A charismatic and influential psychotherapist, Albert Ellis significantly shifted the course of his chosen profession over the course of his lifetime. Originally a proponent of traditional psychoanalysis, his expertise in sex and sexual practices, and his personal behavior modifications led him to create rational emotive behavior therapy in the late 1950s. Part of the cognitive-based therapy family, REBT is a hands-on, engaged system for helping patients identify and modify their beliefs to allow for more healthy/rational thoughts and greater personal well-being.

Immensely popular with the general public through his best-selling self-help books, Ellis's approach was initially viewed as little more than a provocative, fringe-element challenge by his peers. They criticized his directive and confrontational methods, which were in sharp contrast to the general practices of the day. Yet Ellis's models of treatment became increasingly accepted because it worked—often quite quickly—in the lives of his clients. Over his 60-year career, his work moved to the mainstream and permanently altered the modern therapeutic landscape. By the 1980s, he was universally viewed as one of the profession's most influential figures along with Sigmund Freud and Carl Rogers, winning many national and international achievement awards.

Credited with more than 800 scientific papers and some 80 full-length books, Albert Ellis was an outspoken voice for change with the psychoanalytic community. However, his voice was not universally welcomed, as his theories were a sharp departure from the methods that dominated the 1950s when he began publishing his REBT works. Profane, provocative, directive, and confrontational, Ellis was also considered warm, funny, and deeply committed to helping his clients improve their lives.

Born into a poor family, Ellis was a shy and sickly child with distant parents. He was frequently hospitalized but used his early challenges to test coping methods that became the foundations of his REBT practice. For example, he challenged himself to talk to 100 unknown females to get over his fear of rejection, and through this and other behavior-changing

Albert Ellis was an influential American psychologist and author. (AP Photo/Jim Wells, File)

experiments he developed an early interest in counseling philosophies.

Still, he traveled a circuitous path to psychotherapy, trying his hand at business and writing fiction before turning to the field. Early on, he focused on human sexuality, partnering with Kinsey and publishing several notable books, including the influential *Sex without Guilt* in 1958. This gave him early recognition as a pioneering thinker in the American sexual revolution of the 1960s and provided him with valuable experience using cognitive interventions to shift both belief and behavior.

These experiences, coupled with his childhood behavior modification experiments, led him to challenge the dominant psychoanalytical practices of the 1950s and 1960s, which were nondirective and passive when dealing with clients. In sharp contrast, Ellis favored a directive, intentional approach designed to challenge and lead clients to a more rational and healthy way of thinking and living.

This approach contained several practices that were considered groundbreaking at the time but are now widely accepted. For example, Ellis promoted scientific and outcome-based testing of psychoanalytic

approaches to evaluate their true effectiveness with different client populations. He assigned homework to reinforce sessions, insisting that learning did not happen solely in the therapeutic environment. Multiple approaches beyond talk therapy were encouraged, including anything that pushed the client to change, such as group sessions, hypnotherapy, imagery, and singing.

While his peers were shocked, his clients praised him for getting results in their lives. His ABC-DE framework allowed the therapist and client together to challenge thought patterns and recognize "irrational" beliefs that were holding the client back from desired achievements. During his weekly Friday night workshops held at his New York institute, he demonstrated his approach with volunteers in front of a live audience, beginning in 1965 and continuing until his death. Despite publishing a mountainous amount of literature, traveling and speaking globally, marrying three times, and running multiple institutes dedicated to his theories, it is estimated he personally conducted over 300,000 therapeutic sessions before his death in 2007.

Ellis's status as an influencer has not diminished since his death. His REBT theories continue to shape modern psychotherapeutic practice, with his research actively carried on by his widow, Debbie Joffe Ellis, and the Albert Ellis Institute in New York. While other types of cognitive behavior therapy, a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts, are perhaps now more widespread, there is no denying that elements of his REBT teachings paved the way.

Even outside of the psychoanalytic community, his plain-English self-help books remain on shelves around the world, enduringly popular and continuously encouraging the general public to adopt his tenets of rational living.

Mindy Parsons, PhD, Len Sperry, MD, PhD, and George Stoupas, MS

See also: Cognitive Behavior Therapy; Psychoanalysis; Rational Emotive Behavior Therapy (REBT)

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Emotional Intelligence

Emotional intelligence is the ability to identify and make sense of one's own emotions and the emotions of others. It is also known as EQ.

Definitions

- **Countertransference** refers to the feelings evoked within a clinician during psychotherapy. Unless recognized and dealt with, these feelings can interfere with treatment.
- **Hard-wired** means genetically determined.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

- **Transference** refers to the feelings evoked within a client during therapy with a mental health practitioner. Feelings the client has, or had, for someone else are directed toward the therapist.

Description

Emotional intelligence (EQ) is the capacity to recognize, understand, and manage personal emotions and to identify and respond to the emotions of others. It influences how individuals think, behave, interact with others, and make decisions. Emotional intelligence is different from intelligence (IQ), which is the capacity to learn, reason, and problem solve. Intelligence remains relatively stable throughout life, whereas emotional intelligence can be learned and developed.

The term "emotional intelligence" was originally used in 1964 by Michael Beldoch (1931–) in the book *The Communication of Emotional Meaning*. The term became better known because of psychologist Daniel Goleman's (1946–) best-selling book *Emotional Intelligence—Why It Can Matter More Than IQ*, published in 1995. Goleman contends that emotional intelligence is equally important, if not more important than IQ. Positive emotions influence an individual to perceive positive events as more likely to arise in the future. The opposite is true of negative emotions. They influence an individual to perceive negative events as more likely to happen. In other words, different emotions lead to different thoughts, perceptions, expectations, and behaviors. Individuals with the ability to express, understand, and manage their emotions are better able to estimate the likelihood of a future event and the possibilities associated with it. They are also better able to attend to internal and external events and regulate their mood to effectively cope with situations.

The human brain is hard-wired so that emotions have an advantage over thoughts. Whenever an individual touches, tastes, smells, sees, or hears something, electrical signals are sent to the brain. Before getting to the part of the brain where logic and reason takes place, these signals travel through the limbic system. The limbic system is where emotions are created and experienced. Therefore, events are first experienced emotionally, and then thoughts follow. Humans do not have control over emotional experiences but do have control over the thoughts that occur afterward. Awareness of emotions allows for control over the type of response chosen once feelings are experienced. The way an individual responds to emotions is influenced by his or her personal history.

Emotional intelligence is equally important for therapists as it is for their clients. How a therapist responds to personal feelings that arise (countertransference) during a therapy session can influence the outcome of treatment. Similarly, how a client responds to personal feelings toward the practitioner (transference) will impact the therapeutic process and achievement of treatment goals.

Emotional intelligence requires four sets of personal and interpersonal skills. They are self-awareness, social awareness, self-management, and relationship management skills. Self-awareness is the ability to assess one's own emotions and understand personal patterns of responding to situations. Social awareness is the ability to identify and understand other individuals' emotions. Self-management is the ability to regulate personal emotions and choose appropriate behaviors. Finally, relationship management is the ability to have awareness of one's own emotions and the emotions of others and to use this awareness to develop and maintain interpersonal relations. Practice of these skills is necessary to develop the emotional capacity to effectively cope with internal and external stimuli. Emotional intelligence is particularly helpful in dealing with stressful events that have the potential to negatively impact physical and mental well-being.

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See also: Emotionally Focused Psychotherapy; Positive Psychology

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Emotionally Focused Psychotherapy

Emotionally focused psychotherapy is a psychotherapy approach for increasing awareness, understanding, and ability to manage emotional experiences. It is also known as EFT.

Definitions

- **Adaptive** means having the ability to adjust to a circumstance.
- **Arriving** means to get to the place where emotions can be identified and understood.
- **Emotion coach** refers to the role of the therapist in emotionally focused psychotherapy. The emotion coach collaborates with an individual, couple, or family to assist in the development of emotional awareness, acceptance, and understanding. The emotion coach is the facilitator of emotional change.
- **Emotional intelligence** is the ability to recognize, understand, and manage personal emotions and to identify and respond to the emotions of others. It influences how individuals think, behave, interact with others, and make decisions.
- **Leaving** refers to moving away from the emotions originally arrived at toward transformation of those emotions.
- **Maladaptive** refers to the inability to adjust to a circumstance.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

Description

Emotionally focused is a form of couple's therapy that assists in the expression and restructuring of emotional responses. It helps couples change maladaptive emotional reactions toward each other to more adaptive responses that strengthen the relationship. EFT is also used with individuals and families. EFT views emotions as the fundamental element in development of the self. Emotions have adaptive and maladaptive functions. They are instrumental in helping individuals adapt and respond to their environment. They are biological functions that assist in the appraisal of situations, others, and one's self. Emotions communicate goals, regulate personal interactions, and influence decisions. Since emotions are significantly influenced by past experiences, they can be negative reactions to events. However, expression of emotions can assist individuals in changing negative responses.

Emotion-focused psychotherapy subscribes to "bottom-up processing" to assist in changing negative emotional responses. This requires an individual to develop awareness and keep track of physical sensations that arise in the body. Any thoughts that arise are ignored, while physical signals are felt in the fullest until they subside or are appropriately identified. An emotion coach collaborates with an individual to assist in developing awareness and understanding of emotional experiences. Together they identify alternative emotional responses. A supportive, safe, and accepting environment promotes openness and positive interactive experiences that provide emotional comfort. The goal is to identify bodily sensations and feelings, develop adaptive emotional responses, and enhance emotional intelligence. Individuals who have emotional intelligence have awareness and understanding of their own emotions and the emotions of others. They also have the ability to manage their emotions in a way that enhances well-being.

There are two phases in emotionally focused psychotherapy, arriving and leaving. In phase one, the emotions coach guides the individual to "arrive" at his or her emotions by (1) developing awareness of his or her emotions; (2) feeling, accepting, and managing his or her emotions, (3) describing his or her feelings with words to promote problem solving, and (4) helping the individual develop the ability to determine if his or her emotional responses are congruent with his or her feelings. If they are not, helping them assess the main feelings they are experiencing can be very therapeutic.

Phase two involves learning how to change maladaptive emotional responses in order to "leave" the emotions the individual initially arrived at. The

emotions coach assists the individual to move forward by helping him or her (1) decide if an emotion is adaptive and should be reinforced or maladaptive and needs to be transformed, (2) identity the thoughts associated with maladaptive emotions, (3) identify and use adaptive emotional responses, and (4) dispute negative thoughts associated with negative emotions and replace them with positive thoughts. The emotions coach plays an instrumental role in helping the individual to develop an awareness and acceptance of his or her emotions. The emotions coach also guides the individual through the process of transforming negative emotional responses into healthy and adaptive emotional responses.

Developments and Current Status

Emotionally focused psychotherapy was developed by Susan Johnson (n.d.) and Leslie Greenberg (1945–) in the 1980s. Initially, it was Johnson who discovered that couples with problems remained caught in dysfunction due to negative emotional interactions. She used attachment theory as the foundational element for emotionally focused psychotherapy. Attachment theory describes how individuals in relationships react to a perceived hurt, separation, or threat.

Emotionally focused psychotherapy is considered one of the most scientifically confirmed therapy treatments in the domain of couples therapy. It integrates components of person-centered, experiential, gestalt, and existential therapy with several theories such as modern emotion, cognitive, attachment, narrative, interpersonal, and psychodynamic theory. It works to improve emotional, psychological, physical, and relationship closeness. Emotionally focused psychotherapy has also been scientifically proven in the treatment of depression. It is gaining recognition in the treatment of other disorders such as trauma, anxiety, and eating disorders.

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See also: Couples Therapy; Emotional Intelligence; Family Therapy; Psychotherapy

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Empirically Supported Treatment

Empirically supported treatments are therapeutic interventions (techniques) that research demonstrates to be effective in facilitating therapeutic change. It is also known as evidence-based treatments.

Definitions

- **Accountability** is the expectation or requirement to conduct evaluations and report performance information.
- **Benchmark** is a standard by which a product or clinical activity can be measured or evaluated.
- **Evidence-based practice** is a form of practice that is based on the integration of the best research evidence with clinical experience and client values.
- **Health Maintenance Organization** is an organization that provides or arranges managed care.
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking,

feeling, and behavior. It is also called therapeutic counseling.

- **Randomized controlled trial** is a research design in which participants are assigned randomly (by chance) to an experimental treatment or one that receives a comparison treatment or placebo.

Description

Empirically supported treatments (ESTs) are health-care practices that utilize scientific evidence to defend their use. EST refers to therapeutic interventions demonstrated to be useful in randomized controlled trials or their equivalents. This means that evidence-based treatments have been proven to produce therapeutic change in the controlled contexts of scientific research. These research findings are the evidence that supports the use of certain treatments instead of alternative treatment options.

EST is similar to the concept of best practices. Both aim to increase accountability of health-care practices. EST is also similar to but different from evidence-based practice (EBP). EBP may include ESTs, but it is larger in scope than treatments. EBP involves specific interventions (practices) used to bring about therapeutic change. However, EBPs do not have the scientific support of ESTs. More specifically, to merit that designation, ESTs demonstrated that they are (1) superior to a placebo treatment in two or more randomized controlled studies, (2) equivalent to a well-established treatment in several rigorous and independent controlled studies, or (3) effective in a large series of single-case controlled studies. At the present time ESTs are performed with treatment manuals that specify how the intervention is to be conducted.

Development and Current Status

Prior to the 1990s, there were no specific guidelines for either clinicians or consumers regarding which treatments to select for which conditions. This changed in 1993, when a task force appointed within the American Psychological Association developed a set of criteria for "empirically validated treatments." Later these came to be known as ESTs. These treatments have been proven to produce therapeutic change in controlled contexts of scientific research. There has been considerable controversy about ESTs. Some believe that the controlled context of scientific research cannot be replicated in clinical practice. Others contend that the results of scientific study are generalizable to clinical contexts. For the past two decades this debate has been fueled by the increasing expectation for accountability. Increasingly, medical and psychological practice has become more accountable and evidence based. Division 12 of the American Psychological Association (APA) provides a list of treatments that are empirically supported for use with specific health needs. APA also provides the scientific standards for defining treatment effectiveness.

Resources for health-care interventions are limited. This fact has created an effort to conduct medical and psychological practice in the most efficient manner possible. EST attempts to achieve get the best results for less money and in the shortest amount of time. Modern use of ESTs has its roots in Health Maintenance Organizations. Managed care was established to increase the efficiency and cost effectiveness of health care. ESTs can and do have a critical role in managed care. Managed care encourages and often requires health-care professionals to incorporate ESTs as well as EBPs into the health-care process.

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See also: Evidence-Based Practice; Managed Care

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Encopresis Disorder

Encopresis disorder is a mental disorder characterized by the voluntary or involuntary passage of stools in a child who has already been toilet trained.

Definitions

- **Behavioral modification** is a treatment approach that replaces undesirable behaviors with more desirable ones through positive or negative reinforcement.
- **Conduct disorder** is a mental disorder characterized by repetitive and persistent pattern of behavior in which the basic rights of others, societal norms, or rules are violated.
- **Constipation** refers to bowel movements that are infrequent and difficult to pass.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Elimination disorders** are a group of DSM-5 disorders characterized by the inappropriate elimination of feces or urine. They include enuresis and encopresis.
- **Incontinence** is the inability to control the release of feces or urine.
- **Laxative** is a medication that helps an individual to have a bowel movement.
- **Oppositional defiant disorder** is a mental disorder in the DSM-5 that is characterized by a pattern of angry and irritable mood, argumentative and defiant behavior, and vindictiveness.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Sexual abuse** involves nonconsensual sexual contact of any kind, coercing an elder to witness sexual behaviors.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Encopresis is one of the DSM-5 elimination disorders. The core feature of encopresis involves an individual repeatedly having bowel movements in inappropriate places after an age when bowel control is normally expected (e.g., on the floor or in the clothing). Encopresis is also referred to as fecal incontinence and soiling. After the age of four years, a child is expected to be toilet trained. After the age of four, if a child is repeatedly having bowel movements regularly and over a period of months in inappropriate places, the child may be diagnosed with encopresis. Encopresis is more prevalent among males and approximately 1% of five-year-olds have this disorder (American Psychiatric Association, 2013).

This disorder may be intentional but is more often involuntary. When fecal incontinence is clearly intentional, features of conduct disorder and oppositional defiant disorder may be present. These disorders include problems with self-control of emotions and behaviors (e.g., being angry, resentful, intimidating others, and violating social norms). Sexual abuse may also be a contributing factor in voluntary encopresis. An individual with voluntary incontinence has control over where and when he or she will have a bowel movement. The individual chooses to have a bowel movement in inappropriate places. Older children may choose to smear feces or hide feces in their home. Younger children with encopresis may act out as a result of a power struggle with their caretaker. When fecal incontinence is involuntary, an individual has no control over bowel movements. Involuntary incontinence usually results from withholding feces, resulting in constipation. As the feces continues to build up in the large intestine, leakage will most likely occur in the individual's clothing. This may cause a child or individual to feel shameful and avoid social situations. The amount of impairment may depend on the child's self-esteem; bullying and teasing by peers; and the rejection, anger, and consequences of the caretaker. Nearly 95% of encopresis is due to

involuntary incontinence (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they have repeated passage of stools in inappropriate places, whether the act is involuntary or intentional. The individual must be at least four years of age (or at an equivalent developmental level) and at least one such event must occur each month for a period of at least three months. Repeated passage of feces in inappropriate places must not be attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition except through the process involving constipation. In addition to the DSM-5 criteria needed to make the diagnosis of encopresis, there are two specifiers that must be included to make this diagnosis. The diagnosis of encopresis can specify whether the disorder is with constipation and an overflow of incontinence. This specifier is made by a physical examination or by history and there is evidence of constipation. Alternatively, the diagnosis of encopresis can specify whether the disorder is without constipation and an overflow of incontinence by history or physical examination (American Psychiatric Association, 2013).

The most common cause of encopresis is long-term constipation. Constipation may occur for several reasons, including stress, low fiber diet, not drinking enough water, lack of exercise, and changes in bathroom routines (e.g., using a bathroom that is not your own). Physical problems associated with the intestine's inability to move stool may be another cause of encopresis. Another causal factor of encopresis may involve emotional issues. A child may develop a fear or frustration related to toilet training. This may be attributed to premature toilet training and stressful events in the child's life (e.g., parents divorcing, relocation of residences, the birth of a new child). In some instances, a child may simply refuse to use the toilet.

Treatment

There are several treatments available for those with encopresis. Addressing the cause of the constipation usually treats involuntary encopresis. Treatment can include adding more fiber to the individual's diet, short-term use of a laxative, and increasing the amount of water intake. Involuntary incontinence usually ceases once constipation is resolved. The treatment used for voluntary encopresis will depend on the cause of the disorder. Often scheduling toilet times and praising and rewarding a child for using the toilet may be helpful and eliminate encopresis. Psychotherapy, using behavioral modification, is another form of treatment that has been found to be effective. With proper treatment, prognosis for encopresis is relatively high due to the majority of cases being involuntary.

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See also: Conduct Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Oppositional Defiant Disorder (ODD); Psychotherapy; Sexual Abuse

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Enuresis

"Enuresis" is a term for involuntary urination, most frequently experienced as bed-wetting, which affects children and adolescents between the ages of 5 and 17.

Description

Enuresis, the involuntary voiding of urine, is a medical condition most commonly diagnosed in children. There are three subtypes of enuresis. Nocturnal enuresis, or nighttime bed-wetting, is the most common form of enuresis and is more common in boys than in girls. Diurnal enuresis is daytime wetting, which is more common in girls than boys. The third type of enuresis is a combination of nocturnal and diurnal enuresis.

Causes and Symptoms

The term "enuresis" describes a specific medical condition and diagnosis. It is important to note that although enuresis has a psychological medical code, children who suffer from enuresis are not considered to be suffering from psychological problems. In order to be diagnosed with enuresis, a person has to have occurrences of involuntary wetting at least twice a week for three months. The individual must be older than the age of anticipated bladder control, usually five years old. The wetting is not due to a general medical condition. "Primary enuresis" refers to children who have never gained control of their bladder. "Secondary enuresis" refers to children who have been successful at bladder control for at least six months but revert to wetting due to stress.

There is no clear etiology or identified cause of enuresis, but many theories exist. Urinary control is part of the maturing process and nighttime bladder control is the last to develop. Nocturnal enuresis (NE) is by far the most common form of enuresis and has received the most attention from researchers and medical professionals. Genetics may be a factor in NE, as children who have one parent who were bed wetters are 43% more likely to develop NE. Children with both parents who were bed wetters are 77% more likely to develop NE compared to children whose parents did not suffer from NE. Other theories have been proposed to explain NE, such as children who have small bladders, who are deep sleepers, or who have received improper toilet training. However, none of these theories have resulted in any conclusive evidence as to the cause of NE. Researchers agree that there are many factors leading to enuresis.

Prognosis

The percentage of the population with enuresis changes with age. Approximately 20% of five-year-olds have monthly bed-wetting episodes. Bed-wetting decreases to 10% of children aged six years, and of these cases approximately 15% gain bladder control each year. By age 15, 1%–3% of teenagers experience nighttime bed-wetting. From ages four to six the number of boys and girls diagnosed is about equal, with boys increasing in ratio with age. By age 11 there are approximately twice as many boys as girls suffering from NE.

Enuresis is often a cause of great stress for families and children. Bed-wetting is associated with low self-esteem in children, which improves as the condition is overcome. An unfortunate but common parental response is to punish or shame a child for bed-wetting. Studies indicate that children rarely wet the bed intentionally, and punitive parental responses are ineffective and often make the condition worse. The most effective treatment is to allow the child to mature as virtually all children outgrow bed-wetting. Other strategies to control NE include the use of bed-wetting alarms which make a loud sound when moisture is detected in order to associate the feeling of a full bladder with waking up. Use of diaper-type underwear made specifically for sleeping has been very helpful in reducing family and child stress.

Enuresis is a common and stressful problem for many children, adolescents, and their families. Developing a positive approach that avoids shaming is an important consideration in helping a child outgrow enuresis.

Steven R. Vensel, PhD

See also: Encopresis Disorder

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Envy and Gratitude (Book)

Envy and Gratitude is a now famous monograph written by the well-known psychoanalyst Melanie Klein (1882–1960) and published just three years before her death.

Description

In this controversial work, Klein theorized that even infants are torn between the struggle for goodness or

destructiveness, which she defined as gratitude and envy. A controversial and important work, Melanie Klein's *Envy and Gratitude* was first published in 1957 at the end of her career. Since its first publishing, this both highly acclaimed and criticized monograph has become a topic of debate and study for psychoanalysts and feminists alike.

Envy and Gratitude explores Klein's theory about how infants are torn between the two grounding emotions of the human experience—envy and gratitude. As Klein described it, infants struggle with a primary envy. Therefore, infants must fight a constant battle between the two forces of envy and gratitude, between the "life and death instincts" that all humans face. Largely theoretical in nature, Klein's views on infant psychosis in *Envy and Gratitude* led to what is now known as the Kleinian Theory in clinical practice.

Unlike other psychoanalysts before her, Klein believed the primal feelings of envy or gratitude are present at the beginning of life. Drawing on her extensive experience with children and developmental psychosis, Klein theorized that a mother's breast is the first source of this primal feeling of envy or gratitude. In *Envy and Gratitude*, she describes how a mother's breast plays a central role in the developmental psyche of infants. As Klein explains it, an infant experiences satisfaction and gratitude by nursing on a mother's breast—the central object of the infant's world. In the same way, an infant feels denied and experiences envy when a mother's breast is taken away.

When *Envy and Gratitude* was first released in 1957, many psychoanalysts criticized Klein's "wild analytic approach." However, Klein also drew high praise from psychoanalysts all over the world for her bold views. At her death three years after publishing *Envy and Gratitude*, Klein was described as "second only to Freud in overall importance to both the science and art of psychoanalysis."

Impact (Psychological Influence)

In the 50th anniversary year of *Envy and Gratitude*, a group of psychoanalysts published *Envy and Gratitude Revisited*. This collection of 14 critical essays examines how Klein's views on envy in the original *Envy and Gratitude* have influenced the work of contemporary mental health professionals. Each of these 14 psychoanalysts presented his or her own reflections on Klein's original work. These authors also gave their own theories of how envy relates to a host of diverse topics, including narcissism, compulsion, jealously, greed, and gender issues. Even 50 years later, Melanie Klein's timeless work continues to make a significant contribution to the psychoanalytic world. Other notable works by Klein include *Love, Guilt and Reparation: And Other Works 1921–1945, The Psychoanalysis of Children, Envy and Gratitude*, and *Narrative of a Child Analysis*.

Mindy Parsons, PhD

See also: Klein, Melanie (1882–1960); Object Relations Theory; Psychoanalysis

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Envy and Jealousy

Envy and jealousy are generally considered negative emotions associated with a person's desire to have something or someone that someone else already has and not having it feels like a threat to the person's sense of self.

Description

Envy and jealousy stem from a negative comparison to what someone else has. Envy and jealousy can be over a way of thinking, feeling, or acting or with a tangible item, such as clothes, car, home, and spouse. It includes a resentful awareness of an advantage enjoyed by another joined with a desire to possess the same advantage.

These two highly negative emotions are often a response to an individual's belief that someone else has some type of advantage of him or her. These negative emotions can lead to negative self-thoughts by focusing on what others may have or who they may be with. Envy can sometimes be connected to depression and low self-esteem and, when left unchecked, may escalate to destructive or even violent behavior.

Although from childhood people learn that direct expressions of envy and jealousy can be dangerous, some people find themselves consumed by comparisons. Comparison leads to stress and can depress and divide people. Envy can end up ruining relationships and lives, as well as being highly destructive in the workplace.

While most Americans tend to think they are beyond class distinctions, Gallup Polls have disproved this assertion. Social class is only one example of social comparison. People compare to evaluate themselves and hope to improve their own self-esteem and status. However, just the opposite is often a result from engaging in such exercises. These thoughts and emotions can end up angering or humiliating the person who focuses on comparisons, and especially those who have more than he or she does.

Envy and jealousy are synonymous and often are used interchangeably. While they are related, it is important to note the differences between envy and jealousy. Envy is seeing that someone has something or someone that the individual feels the person does not deserve, while jealousy also expresses disappointment.

Jealousy and envy date back in written history to the Bible and the story of Adam and Eve's sons, Cain and Abel. Cain and Abel both gave offerings to God, but Cain's was rejected while Abel's was received. It is believed that in a jealous rage Cain killed his brother Abel.

Envy and jealously are sometimes seen with narcissistic personality disorder. Many individuals who have this form of personality disorder believe that others are envious of them. It is important for a narcissist to feel superior to others. Envy and jealousy have also been associated with borderline personality disorder.

Current Status

Envy and jealousy have often been associated with the color green in English-speaking cultures. Terms such as the "green eyed monster" and "green with envy" have been frequently used popular expressions. The media has played on this with the candy green M&M's by portraying others as being envious of her. This is also seen in the Disney classic Snow White where the Evil Queen is envious of Snow White's youth and beauty. She is so overcome with jealousy that she tries to end Snow White's life.

Mindy Parsons, PhD

See also: Borderline Personality Disorder; Narcissistic Personality Disorder

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Epigenetics

Epigenetics is the study of changes in genes that do not involve alteration of the genetic code.

Definitions

- **DNA** is short for deoxyribonucleic acid. It is a molecule found in all living organisms which contains the blueprints that dictate growth and functioning.
- **DNA methylation** is an epigenetic mechanism used by cells to regulate gene expression.

- **Epi** is a prefix used to mean above, over or in addition to.
- **Epigenesis** refers to the series of developmental processes an organism goes through. Environmental factors (i.e., diet, weather) can greatly influence this process.
- **Gene expression** is the process by which information from a gene is used to make proteins.
- **Genes** are the carriers of the genetic code present in each cell.
- **Genetic code** is the sequence of nucleotides in DNA or RNA that is the biochemical basis of heredity (inherited traits).
- **Genetics** is the scientific study of genes and heredity. It focuses on how living things inherit traits from parents.
- **Genotype** is one's genetic makeup and the potential for unique traits or characteristics to develop.
- **Nucleotides** are the molecular subunits of the nucleic acids, DNA and RNA. Nucleotides transport energy inside a cell.
- **Phenotype** refers to the observable traits of an organism, such as size, shape, color, and behavior. Phenotype is determined by a combination of gene expression and environmental factors and their interaction.
- **Proteins** are nutrients used as energy sources (calories) by the body. They are essential components of muscle, skin, and bones.
- **RNA** is short for ribonucleic acid. It is a group of molecules found in all living organisms that work together to transfer genetic information from DNA to proteins in the cell. RNA play a significant role in the expression of genes.

Description

Epigenetics is the study of factors that influence genetic expression but are not part of the DNA (or gene) sequence. These factors impact the growth and development of all organisms. Development is shaped by the interaction between genes and the environment. Epigenetic traits occur in addition to, or on top of, genetic traits. Epigenetic processes have the potential to change when, and if, particular genes are activated but do not have any impact on the order of the nucleotides contained in a DNA molecule. Nucleotides are the foundational components of DNA and RNA (nucleic acids). Epigenetic changes can also activate or suppress protein molecules related with DNA. These molecular activities influence the expression of genes that an organism needs to function.

The term "epigenetics" was originally coined by C. H. Waddington (1905–1975) in 1942 when he combined the words "epigenesis" and "genetics." Waddington worked in the scientific fields of biology and genetics and believed that both fields should be united. He hypothesized that genes interact with environmental influences to create a particular phenotype. The term "epigenetics" has also been used in the field of psychology. Erik Erikson (1902–1994) used the word in his 1968 book *Identity: Youth and Crisis*. Erikson believed that an individual's personality is developed during his or her progression through eight psychosocial stages. Movement through these stages is significantly impacted by environmental factors.

Epigenetic modifications are affected by stress, nutrition, and self-care during pregnancy. After birth, early developmental (life) experiences have the potential to trigger epigenetic changes that impact the brain, physiology, and behavior. For example, abuse, neglect, and separation from the primary caregiver can result in changes in DNA methylation and gene expression. Epigenetic changes have the potential to affect an individual's ability to respond and adapt to life experiences that occur early in the developmental process.

Len Sperry, MD, PhD, and
Christina Ladd, PhD

See also: Brain; Erikson, Erik (1902–1994); Psychosocial Development, Stages of

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Erectile Disorder

Erectile disorder is a mental disorder characterized by the inability to achieve or maintain erections during sexual activities with a partner. It is also known as impotence.

Definitions

- **Acquired erectile disorder** means sexual difficulties began occurring after a period of normal sexual functioning.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Lifelong erectile disorder** means sexual difficulties have been reoccurring since the first sexual encounter.
- **Sexual dysfunction disorders** are a group of mental disorders characterized by significant difficulty in the ability to respond sexually or to experience sexual pleasure. Disorders include delayed ejaculation, female organismic disorder, and genito-pelvic pain/penetration disorder.

Description and Diagnosis

Erectile disorder is one of the DSM-5 sexual dysfunction disorders characterized by failure to attain or keep penile erection or rigidity when engaging in sexual activities with another person. A thorough medical and sexual history is required to determine how long the problem has been occurring. Additional information regarding relationship, partner, personal, cultural, and medical factors must be obtained.

The occurrence of this disorder is higher among men over the age of 50. Around 40%–50% of men aged 60 to 70 and older experience erectile disorder. Approximately 13%–21% of men between the ages of 40 and 50 report occasional erectile difficulties. Approximately 2% of men younger than 40 to 50 years experience significant problems with erections. Although 20% of men are afraid they will have difficulty obtaining and maintaining an erection during their first sexual encounter, only 8% actually experience a problem (American Psychiatric Association, 2013). As a man ages, the probability of experiencing erectile disorder increases.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience several symptoms during most sexual encounters, approximately 75%–100% of the time. The problem must occur for a period of at least six months and cause the individual a great deal of distress. The disorder is not the result of mental illness, relationship difficulties, substance abuse, medication side effects, a medical condition, or other stressors. The problem might be situational where the individual might experience erectile disorder only with particular partners, in particular situations, or with specific forms of stimulation. Conversely, the problem might be general in nature, which would indicate it is not attributable to a particular person, situation, or type of stimulation. The problem may have first occurred when the individual initially became sexually active (lifelong) or after a history of normal sexual performance (acquired) (American Psychiatric Association, 2013).

The cause of this disorder may be attributed to physical and/or psychological influences. Acquired erectile disorder tends to be ongoing and is associated with biological factors such as heart disease, diabetes, and neurological disorders. Lifelong erectile disorder tends to be intermittent and is associated with psychological factors such as anxiety or use of drugs or alcohol.

Treatment

Erectile disorder is treated with medication, lifestyle changes, or psychological treatment depending on the type. For acquired erectile disorder, the first step in treatment is to obtain a medical exam to diagnose and

treat underlying health or lifestyle problems that may be contributing to the sexual dysfunction. Then any psychological issues contributing to the sexual problem may be addressed. The lifelong type is typically treatable with psychological treatment interventions. It is used to reduce anxiety and address relationship concerns or other stressors that may influence erectile issues. Both types may also be treated with prescribed medications.

Christina Ladd, PhD, Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Sexual Dysfunctions

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Erickson, Milton (1901–1980)

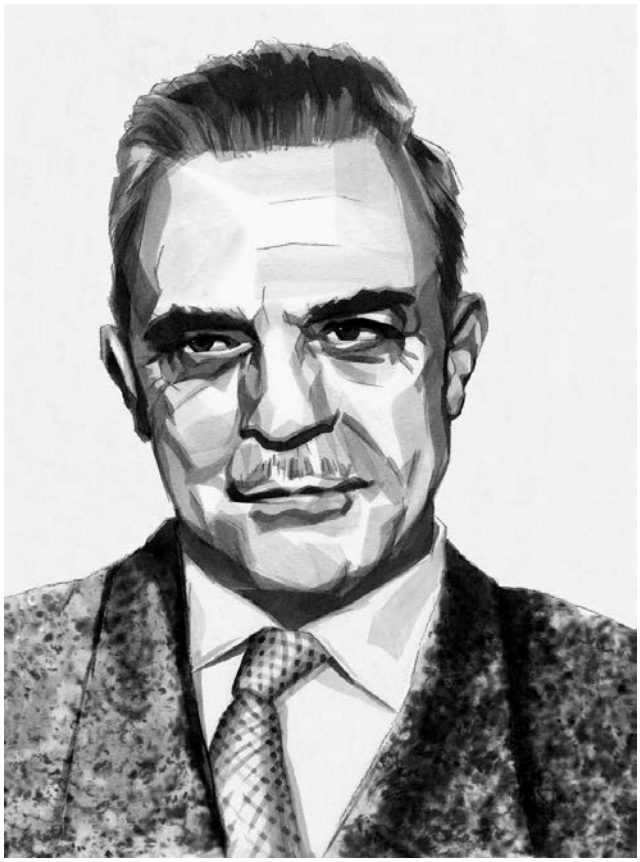
Milton Erickson was an American psychiatrist best known for his pioneering work in clinical hypnosis and family therapy.

Description

Milton Hyland Erickson was born in Aurum, Nevada, on December 5, 1901, and grew up on a farm in Lowell, Wisconsin, with eight siblings. As a child Erickson suffered from dyslexia, was color blind, and tone deaf. At age 17 Erickson contracted the viral infection of polio and was so severely paralyzed that doctors informed his parents that his death was imminent. Although he survived the polio attack, he was left paralyzed and unable to speak. For months all he could move was his eyes. Observing his family members for hours on end he became vividly aware of the significance of nonverbal communication. He noticed that body language, tone of voice, and other nonverbal expressions often contradicted what people were saying to him. He observed that people could say "yes" but really mean "no" at the same time. During his long recovery Erickson also began to concentrate on "body memories" of muscle movement and was eventually able to regain the ability to talk and use his arms. Erickson developed keen insights into human behavior through these experiences and became very interested in the unconscious mind and hypnosis, a psychological technique used to induce a trance state. When the mind is in a trance, it is an altered mental state of consciousness in which a person experiences heightened concentration with a greater ability to block out distractions.

No longer having the strength required to be a farmer like his father Erickson decided to enroll in college. Intending to build up his strength in order to have the health and endurance needed for his studies, Erickson embarked alone on a thousand-mile canoe trip. At first Erickson was able to swim only a few feet and was unable to pull his canoe out of the water. By the end of the trip he was able to swim over a mile and could walk with the use of a cane. Erickson graduated from the University of Wisconsin School of Medicine in 1928 as a medical doctor with a degree in psychology.

After graduating from medical school as a psychiatrist, Erickson worked in psychiatric hospitals and earned a reputation in the psychiatric community for his work in hypnosis. While at Wayne County Hospital in Michigan as director of Psychiatric Research and Training, Erickson conducted extensive research in the therapeutic value of hypnosis. His final medical appointment was as clinical director of the Arizona State Hospital. Erickson retired from hospital work in 1948 due to the progressive effects of polio. In spite of being in constant pain and struggling with the progressive loss of mobility Erickson remained extremely active in teaching, writing, and private practice. He was an associate editor for a medical journal, *Diseases of the Nervous System*, was a consultant to the U.S. government during World War II studying the effects of propaganda and the psychology of the enemy, and provided hypnosis to the U.S. Olympic Rifle Team who went on



Milton Erickson was an American psychiatrist best known for his pioneering work in clinical hypnosis and family therapy. (Jan Rieckhoff/ullstein bild via Getty Images)

to beat the Russians for the first time. Erickson was the founding president of the American Society for Clinical Hypnosis and established the *American Journal of Clinical Hypnosis*, serving as editor for 10 years.

Erickson is best known for his unique and pioneering approach to hypnosis, which differed from traditional forms of hypnosis in use at the time. Traditional hypnosis was direct and authoritative, but Erickson's approach was flexible, accommodating, and less direct. Eventually becoming known as Ericksonian hypnosis, Erickson believed that the unconscious mind was always at work, always listening, could be influenced, and contained all of the necessary resources to bring about positive change. He frequently used the imagination, stories, jokes, riddles, and metaphor to communicate to a client's unconscious mind. He believed that trance states are an everyday common experience that most people are not aware of when they are in a trance state. Being deep in thought while driving or waiting in line or being lost in a book are examples of trance. Erickson used the naturally occurring trance states clients would be in. He also developed verbal and nonverbal techniques to induce trance in clients. Clients did not have to be consciously aware of the message for the intervention to have an effect. For instance, instead of talking directly and consciously about bed-wetting to a 12-year-old boy struggling with that problem, Erickson used the metaphor of how to throw a baseball. Explaining about the muscle control and timing needed to throw a ball communicated to the child's subconscious mind what would be needed to stay dry during the night. Erickson also brought greater flexibility to the use of hypnosis and believed that clients were able to find their own unique solutions rather than imposing them on the client.

Milton Erickson revolutionized the practice of hypnosis and became known as the world's leading hypnotherapist. Many of his psychotherapeutic strategies have been adopted into mainstream psychotherapies and family therapy. Erickson traveled and lectured extensively; he was a prolific writer authoring several books and over 140 scholarly articles before his death on March 25, 1980.

Steven R. Vensel, PhD

See also: Hypnotherapy

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Erikson, Erik (1902–1994)

Erik Erikson was a German American psychologist best known for his theories of psychosocial developmental,

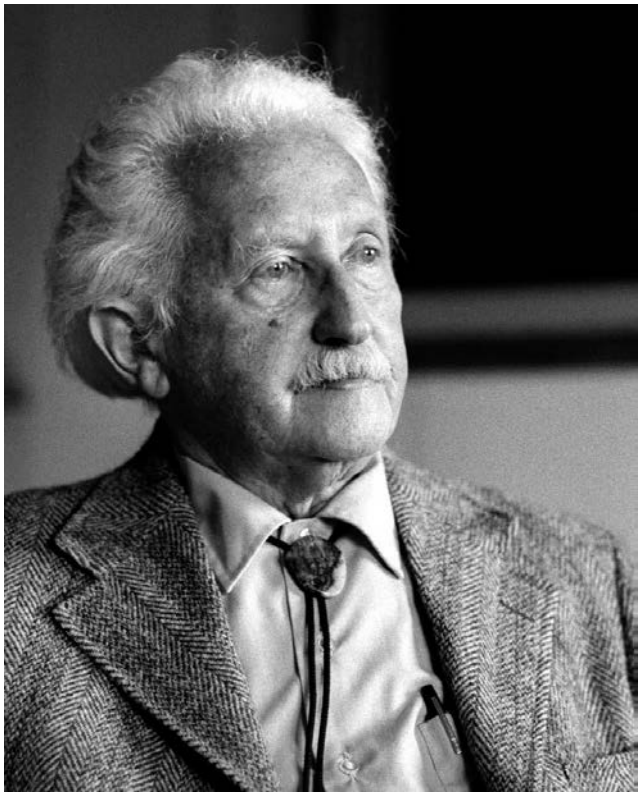
identity formation, and creating the phrase "identity crisis." He is listed in the top 20 most eminent psychologist of the 20th century.

Description

Erik Erikson was born Erik Salomonsen in Frankfurt, Germany, on June 15, 1902. His mother, Karla Abrahamsen, was Danish and came from a prominent Jewish family in Copenhagen, Denmark. Karla was married to Waldemar Salomonsen but was not living with him when she became pregnant with Erik. Erikson never knew his birth father, or his mother's first husband, and details of his birth were concealed from him during childhood due to his birth coming from an extramarital relationship. Erikson was adopted by Karla's second husband, physician Theodor Homberger, and was raised believing that Homberger was his birth father. When Erikson learned the truth of his birth history, he was left with a sense of confusion over who he really was. Erikson was frequently teased by his temple school classmates for being "Nordic" because he was tall with blond hair and blue eyes, which added to his identity confusion. In grammar school he was teased for being Jewish. These childhood experiences led to a lifelong interest in how personal identity is formed and how individuals figure out who they are.

After high school Erikson traveled throughout Europe before entering and graduating from art school. In Vienna, Austria, Erikson taught children of American parents who had come for Freudian psychoanalytic training. During this time he met Anna Freud, Sigmund Freud's daughter, and received psychoanalysis from her. His experience with Freud and analysis resulted in a deep sense of personal growth and eventually led him to become an analyst himself. Erikson trained at the Vienna Psychoanalytic Institute. He also studied the Montessori method, an educational approach that focused on a child's natural self-constructed psychological, physical, and social development. While teaching in Vienna he met Joan Serson, a Canadian dance instructor teaching at the same school as Erikson. They were married in 1930. When the Nazis came to power in Germany, Erikson emigrated to Denmark. In 1933 he moved to the United States where he changed his name from Erik Homberger to Erik H. Erikson.

Erikson held teaching positions in several universities, including Harvard Medical School and the University of California at Berkeley. While at Berkeley he began his research into childhood and development by studying the cultural and childrearing practices of the Lakota and Yurok Indian tribes. He also held positions in hospitals, institutes, and child guidance centers as well as maintaining a private practice. During his career he published a number of books addressing theories of identity and development. His books included *Childhood and Society* (1950), *Identity: Youth and Crisis* (1968), and *Life History and the Historical Moment* (1975). His book *Gandhi's Truth* (1969) won a Pulitzer Prize and the U.S. National Book Award in Philosophy and Religion.



Erik Erikson, one of the most influential psychologists of the 20th century, was best known for his theories of psychosocial development and identity formation. He coined the phrase "identity crisis." (Ted Streshinsky/Corbis)

Impact (Psychological Influence)

Stages of psychosocial development. Erikson is best known for his theory of the eight stages of psychosocial development. Although trained in Freudian psychoanalytic theory, Erikson rejected Freud's deterministic beliefs that personality is developed in the context of unconscious aggressive and sexual instincts in childhood. Erikson believed that the environment in which a child developed was essential in the development of self-awareness and identity. Erikson taught that people develop throughout their lifespan and are impacted by social, biological, and psychological factors. As people move through life, they are faced with age-specific challenges and tasks that must be mastered in order for a healthy identify to form. Once a positive identity is formed in one stage, they are able to move to the next stage. When a person is unable to cope with a particular stage, he or she develops a poor self-image which has a negative impact on subsequent stages of development. Erikson identified eight stages of development: Trust versus Mistrust (birth to 1 year old), Autonomy versus Shame and Doubt (1 to 2 years old), Initiative versus Guilt (3 to 5 years old), Industry versus Inferiority (6 to 11 years old), Identity versus Role Confusion (adolescence), Intimacy versus Isolation (early adulthood), Generativity versus Stagnation (middle adulthood), and Integrity versus Despair (later life).

Identity crisis. Erikson coined the phrase "identity crisis" as a description of what can occur during adolescence when physical, sexual, and cognitive growth is at a maximum. An identity crisis is a time of deep reflection and analysis of oneself as an individual develops a separate and unique self-image and identity from that of his or her parents. It is a time during which an adolescent unifies all that he or she is in terms of temperament, giftedness, body type, abilities, strengths, and weaknesses. Included in this emergent identity is an appreciation of the many possibilities open to the individual, including the development of personal values, roles, occupational choices, friendships, and sexuality. Successful resolution of the crisis is influenced by the successful resolution of previous stages.

Erik Erikson made significant contributions to the fields of child development, psychology, psychotherapy, and theories of human development. Erikson was an influential and pioneering psychoanalyst whose groundbreaking and original developmental theories continue to be taught throughout the psychological, child development, and mental health professions.

Steven R. Vensel, PhD

See also: Psychosocial Development, Stages of

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Ethics in Mental Health Practice

Ethics in mental health practice is the moral, legal, and value-based system that guides professional thinking, decisions, and behavior.

Definitions

- **American Counseling Association** is the professional organization for the counseling specialties, including school counseling, clinical mental health counseling, career counseling, and rehabilitation professional counselors.
- **Involuntary hospitalization** is the legal process whereby individuals are placed in inpatient mental health treatment against their will.
- **Law** is the collection of rules that govern the behavior of individuals in a community, state, or country.
- **Morality** is the perception of correct and proper behavior, often based on culture or religion.

- **Values** are principles that govern virtuous behavior. When values are lived or put in action, they are known as virtues.

Description

Ethics guide professional thinking and behavior. It determines how mental health professionals make decisions and conceptualize situations. While ethics is commonly thought of as "doing the right thing," it is much more complex. Ethics in mental health practice may refer to morality, values, or rules and laws. There are two main types of ethical practice. Mandatory ethics refers to complying with the minimum standards of professional behavior dictated by the law. This is simply following the rules. By contrast, aspirational ethics is the highest form of ethical thinking and behavior. This involves not just following the rules but understanding the principles behind them and striving to embody them in practice.

There are six principles that form the basis for ethical professional practice. These principles guide ethical thinking and behavior. They are autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity. Autonomy is the freedom of clients to choose their own direction. Mental health professionals guided by this ethical principle do not force particular treatments or decisions on clients. "Nonmaleficence" means doing no harm to others. This principle prohibits professionals from doing anything that would hurt clients. Such actions may include improper diagnosis or exploitation. "Beneficence" refers to increasing the well-being and good of others. It requires that professionals act to improve their clients' lives. The ethical principle of justice is being fair and giving equally to others. This includes all individuals regardless of age, sex, race, ethnicity, disability, socioeconomic status, culture, or other characteristic. "Fidelity" refers to being trustworthy and keeping promises to clients. This is necessary for an effective therapeutic relationship. Finally, "veracity" means truthfulness. Mental health professionals must be open about client rights, risks of treatment, and other factors so clients are well informed.

All professional mental health organizations have their own specific codes of ethics. These provide guidance on how professionals should behave and they set forth specific expectations. For example, the Code of Ethics of the American Counseling Association provides guidelines for counselors on topics ranging from confidentiality to social media. These codes also instruct professionals on how to resolve ethical dilemmas. Unethical activity by mental health professionals may include inappropriate relationships with clients, use of improper treatments, or fraud. Many unethical activities are also illegal, such as billing an insurance company for services that were not provided. However, not all unethical activities are illegal. Engaging in a sexual relationship with an adult client is considered unethical but legal. The consequences for unethical professional practice range from mandated supplemental training and supervision to loss of license. These consequences are typically decided by the organization responsible for issuing and overseeing professional licenses.

In mental health practice, there are often conflicts between different ethical principles For example, a counselor who operates from the principle of beneficence may encourage a client to assert himself or herself to an abusive family member. The intention may be to increase self-esteem and practice healthy communication skills. However, this may result in harm to this client if his or her assertiveness leads to intensified abuse. In this case, the principle of nonmaleficence may have been violated. Another ethical dilemma is presented by the practice of involuntary hospitalization. In this situation, individuals' right to make their own decisions (autonomy) is taken away because they are deemed unable to care for themselves. This practice may be justified on the grounds that it protects the client from harm (beneficence).

Len Sperry, MD, PhD, and George Stoupas, MS

See also: American Counseling Association (ACA); Involuntary Hospitalization

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Ethnicity

"Ethnicity" refers to a shared distinctive culture based on region of the world, language, religion, and lifestyle.

Description

Our individual identity, our understanding of the world, and the way we act are all heavily influenced by our personal history, including our ethnicity. Ethnicity is usually defined by shared cultural practices, including language, customs, religion, food, and celebrations of life. People of the same ethnicity often celebrate events such as birth, marriage, and death in a similar way. Ethnicity is not race nor is it a nationality. Race usually refers to a person's physical appearance, such as skin color, eye color, hair color, and bone structure. Nationality is defined by citizenship in a country and many nations are comprised of different ethnic groups. For example, in the United States there are citizens who come from many different ethnic backgrounds.

Ethnic identity plays a large part in the development of human identity. It is the principal way that people identify themselves with others. It gives individuals a sense of belonging to a particular cultural group. For example, many U.S. citizens with origins in Latin America often identify themselves as Hispanic. People who identify themselves as Hispanic are likely fragmented into smaller groups depending on country of origin and even region or dialect of origin within certain countries.

Current Status and Impact (Psychological Influence)

The values of the ethnic culture in which someone is raised have a big influence on personal ways of thinking and behaving. This especially applies to physical health and self-care. Ethnicity influences the extent to which we can tolerate both physical and psychological pain. This reality provides a challenge for health-care professionals who need to take into account ethnic and multicultural aspects in the treatment of each client.

The influence of ethnicity also plays a role in keeping people in predetermined social and economic classes. Lack of access to education and resources may mean that people consume foods that are not nourishing, and this may result in diets high in saturated fat, cholesterol, and carbohydrates. This can in turn lead to chronic health conditions such as diabetes, high blood pressure, and stress.

Many ethnic groups have inherited beliefs and patterns of behavior which may increase their health risks. They may believe that preventive interventions, such as mammograms or colonoscopies, are invasive or indecent. They may believe that seeing a therapist or a counselor means a person is either mentally ill or morally weak. Health-care professionals need to be sensitive to the role that ethnicity can play in the knowledge, acceptance, and use of medical diagnosis, procedures, or interventions.

Ethnicity and culture are also extremely important factors in the field of caregiving. Cultural biases may lead to the conclusion that someone from the community should be a caregiver who does not have the skills to do it well. Ethnicity can help determine not only the quality and complexity of the caregiving but also the way that caregivers do or do not recognize the stress they are under and the kind of coping mechanisms they use to help them do their work effectively.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Immigration, Psychological Factors of; Multicultural Counseling; Prejudice; Racial Identity Development; Social Justice Counseling

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Evening Primrose Oil

Evening primrose oil is a natural remedy used for skin conditions such as eczema as well as various other medical conditions.

Definitions

- **Antioxidants** are substances that protect the body from damaging reactive oxygen molecules in the body. These reactive oxygen molecules are thought to play a role in the aging process and the development of degenerative disease.
- **Prostaglandins** are a group of unsaturated fatty acids involved in the contraction of smooth muscle, control of inflammation, and other body processes.

Description

Evening primrose oil comes from the seed of the evening primrose plant. It is used as a dietary supplement by alternative medical practitioners to relieve the discomfort of symptoms associated with premenstrual syndrome (PMS), eczema, sunburn, fibrocystic breast disease, arthritis, diabetes, and osteoporosis. Other uses are irritable bowel syndrome, peptic ulcer disease, multiple sclerosis, nerve damage related to diabetes, cancer, high cholesterol, heart disease, Alzheimer's disease, and chronic fatigue syndrome. It has been used in children for attention-deficit hyperactivity disorder. Women use it for PMS, breast pain, and hot flashes. However, clinical studies have shown it to be effective in treating breast pain and osteoporosis. While there is some evidence that it can reduce the symptoms of PMS, Alzheimer's disease, and attention-deficit hyperactivity disorder, clinical trials have yet to establish its efficacy in these conditions. Evening primrose oil is believed to work because it is a source of essential fatty acids (EFAs). EFAs regulate pain and inflammation and help produce hormone-like substances such as prostaglandins. Evening primrose oil is thought to work by stimulating anti-inflammatory prostaglandins, which helps reduce inflammation and relieve various symptoms.

Precautions and Side Effects

Evening primrose oil should not be given to patients with epilepsy, and medical supervision is needed if used in children. Evening primrose oil has few reported side effects. Those reported are nausea, headache, and loose stools. Rarely, bruising of the skin is reported. Evening primrose oil should not be used with Neurontin, Dilantin, or other anticonvulsant medications, since it can lower the threshold for seizures. While other significant drug interactions have yet to be reported, those taking evening primrose oil would do well to mention this to their physicians.

Evening primrose oil comes from the seed of the evening primrose plant. It is used as a dietary supplement. Proponents claim that it can ease symptoms associated with Alzheimer's disease and attention-deficit hyperactivity disorder (ADHD), among many other conditions. (Pipa100/Dreamstime.com)

Len Sperry, MD, PhD

See also: Neurontin (Gabapentin)

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Everything You Always Wanted to Know about Sex (but Were Afraid to Ask) (Book and Movie)

Everything You Always Wanted to Know about Sex (*but Were Afraid to Ask*) is a sex manual that was published in 1969 by David Reuben.

Description

The 1960s was an era of social change. This was a period of time that included a sexual revolution. Sex became news and people started talking about sexual experiences and sexual practices more openly than before. Two factors helped create this change. First, the birth-control pill was introduced, which helped women prevent pregnancy after sex. The second was the publication of a groundbreaking study of human sexual responses in 1965 by scientists William H. Masters and Virginia Johnson.

In a time where sex was being revolutionized, people were interested in learning more. Psychiatrist Dr. David Reuben wrote and published the book *Everything You Always Wanted to Know about Sex* (*but Were Afraid to Ask*). The book was aimed at giving a good amount of information about sexuality in an interesting and informative way. Even in the revolutionary atmosphere of the 1960s, the content of the book was still shocking to many. This was because of its honest discussion of sex acts, sexual positions, and group sex. The book is also detailed and provides good information on male and female sexual anatomy. It quickly became a national and international best seller.

In that same year director and filmmaker Woody Allen produced a movie with the same name. The film contained scenarios based roughly around the content of the book. But it also aimed at highlighting the funny side of some of the basic sexual practices it described. The movie was also a success, both commercially and critically.

Impact (Psychological Influence)

There are some significant cultural impacts associated with the book *Everything You Always Wanted to Know about Sex* (*but Were Afraid to Ask*). It was one of the most popular nonfiction books of its era in the United States and internationally. Its openness and material had a profound effect on sex education and changed cultural attitudes toward sex. Despite the initial shock of some people, the book was successful and had many imitators. One such work was *The Joy of Sex*, an illustrated manual published in 1972. Reuben's book helped support and encourage new ways that people wrote, thought, and talked about sex.

Due to the spread of sexually transmitted diseases and HIV/AIDS in the1980s and 1990s, critiques of the book emerged. Some believed it did not address the psychological effects of the social and moral changes it supported. In addition, the book presented information only on heterosexual relations. The book was not overtly negative to other viewpoints; it just did not include them. The book also received criticism for being overly optimistic about sexual relations and about sexual identity itself. It was revised and republished in 1999 to address some of these issues.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Conjoint Sexual Therapy

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Evidence-Based Practice

Evidence-based practice (EBP) is a form of practice that is based on the integration of the best research evidence with clinical expertise and client values.

Definitions

- **Accountability** is the expectation or requirement to conduct evaluations and report performance information.
- **Best practice** is a method that has consistently shown results superior to those achieved with other means, and that is used as a benchmark.
- **Empirically supported treatments** are therapeutic interventions that research demonstrates to be effective in facilitating therapeutic change.
- **Health Maintenance Organization** (HMO) is an organization that provides or arranges managed care.
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Randomized controlled trial** is a research design in which participants are assigned randomly (by chance) to an experimental treatment or one that receives a comparison treatment or placebo. It is also known as randomized clinical trials.
- **Treatment** is a technique used to promote health and well-being, often implemented after a diagnosis is formulated.

Description

Evidence-based practice is similar to the concept of best practices. Both aim to increase accountability of health-care practices. EBP in psychotherapy integrates the findings of scientific research with clinician expertise and client needs and preferences (values). "Evidence-based practice" refers to the therapeutic process a psychotherapist chooses, when those choices are informed by research evidence.

Evidence-based practice is similar to but different from empirically supported treatments (ESTs). EBP may include ESTs, but it is larger in scope than treatments. EBP involves specific interventions (practices) used to bring about therapeutic change. More specifically, to merit that designation, ESTs demonstrated that they are (1) superior to a placebo treatment in two or more randomized controlled studies, (2) equivalent to a well-established treatment in several rigorous and independent controlled studies, or (3) effective in a large series of single-case controlled studies. Clearly, the extent of research support for EBP is significantly less than that for ESTs.

Development and Current Status

Prior to the 1990s, there were no specific guidelines for either clinicians or consumers regarding which treatments to select for which conditions. In 1993, a task force of the American Psychological Association developed a set of criteria for "empirically validated treatments." Later these treatment came to be known as ESTs. However, there has been considerable controversy about ESTs. Some believe that the controlled context of scientific research cannot be replicated in clinical practice. Others contend that the results of scientific study are generalizable to clinical contexts. For the past two decades this debate has been fueled by the increasing expectation for accountability. Increasingly, medical and psychological practice has become more accountable and evidence based. In response, many have championed EBP as an alternative to ESTs.

EBP is a form of practice informed by scientific research. It also includes clinical judgment and client values. EBP in medicine was defined by the Institute of Medicine (2001) as "the integration of best research evidence with clinical expertise and patient values." The American Psychological Association (2005) modified that definition as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." The challenge for the clinician is to

plan and implement treatment that balances all three: research, clinical expertise, and client characteristics. This challenge is very real as reimbursement for non-EBP clinical services is less likely. Insurance companies are increasingly demanding that clinicians provide evidence for the empirical basis underlying treatment as a condition for reimbursement for services. This fact has created an effort to conduct medical and psychological practice in the most efficient manner possible. EBP is largely about the effort to get the best results for less money and in the shortest amount of time. While EBP was not officially introduced until the 1990s, the effort was largely inspired in the 1970s with the implementation of Health Maintenance Organizations (HMOs). HMOs were the first federally legislated form of managed care. Managed care was established to increase the efficiency and cost effectiveness of health care. EBP can and does have a critical role in managed care.

EBP is about making informed choices in clinical practice to increase the probability of therapeutic outcomes. It increases consistency in therapy and assists in making the best possible therapeutic choice. EBP is largely based on clinician intuition as a result of several factors: there is an absence of research available for many practice concerns; every client has unique characteristics, values, and preferences; and the clinical expertise of the clinician effects therapeutic outcomes in a unique way. Clinical decision making is a very real challenge that is rendered more consistent and effective through the use of EBP.

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Layven Reguero, MEd

See also: Best Practices; Empirically Supported Treatment; Managed Care

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Evil

In the psychological sense, "evil" refers to the capacity of a human being or group of human beings, who appear to be ordinarily good people, to transform and begin acting in ways that are intentionally harmful, cruel, or abusive.

Definitions

- **"Banality of evil"** is a phrase used by political theorist Hannah Arendt to describe the mindless actions of high-ranking Nazi figure Adolf Eichmann, an unremarkable figure who engaged in atrocious crimes against countless numbers of Jews for senseless reasons.
- **"Lucifer Effect"** is a term coined by psychologist Philip Zimbardo as a result of his Stanford Prison Experiment to explain how ordinary, decent people were capable of inflicting harm and abuse on others when the situation perpetuated it.
- **Obedience studies** ("Milgram's Experiments"), led by psychologist Stanley Milgram during the early 1960s, articulated the salience of real or perceived authority at influencing a human being's thoughts, values, and actions.
- **Stanford Prison Experiment,** conducted by a team of psychologists at Stanford University in 1971, evidenced how powerful situational factors could be in changing individual thoughts, feelings, attitudes, and behaviors.

Description

People have been interested in the concept of evil for centuries. Theologians, philosophers, and psychologists alike have questioned how evil develops as well as its effect on human behavior, relationships, and on society as a whole. Debate has ensued regarding both biological and environmental factors that contribute to evil. "Evil" is a negative term that describes disdainful, violent, cruel, or abusive characteristics or actions. It has a religious connotation and is historically associated with Lucifer, God's fallen angel. Originally God's favorite, most beloved angel, Lucifer fell from grace and was cast into Hell after challenging God's authority. He was then referred to as either "Satan" or the "Devil." Given this explanation, people now use the word "evil" to describe a characteristic transformation from positive to negative: good to bad, right to wrong, helpful to harmful, decent to monstrous.

Development

Psychologist Stanley Milgram's obedience studies were some of the first to reveal how normal, mentally well people could inflict severe harm (via electric shock) on innocent victims simply because they were instructed to do so. Philip Zimbardo extended on this research conducting the famous Stanford Prison Experiment in 1971. After being assessed for mental and physical health, 24 males were selected for the study. These participants, half designated guards and the other half prisoners, were placed in a mock prison environment for a period of one to two weeks. Researchers remained on site to record daily events by videotape. The "guards" were instructed to maintain order and keep the "prisoners" in line. The prisoners were subjected to a typical incarceration situation, confined three to a cell, given limited mobility and privileges, and required to follow the established rules. After just six days the experiment had to be shut down after it became apparent that the interactions among participants were getting out of control. Guards abused their power, treating prisoners in harmful, degrading, and abusive manners and the prisoners exhibited signs of acute distress and anxiety. Study findings suggested that even good, decent people could turn to evil ways if the situation encouraged it. Zimbardo termed this the "Lucifer Effect" and went onto publish a *New York Times* best seller with the same title in 2007. This launched national interest on the topic of evil, questioning what factors either promote or diminish abusive, harmful actions and allow them to perpetuate. Lessons learned from the Stanford Prison experiment have been cited in cases involving violent, abusive tactics, brainwashing, manipulation, and mind control.

Current Status and Results

Instances of human evil such as racial, gender, and sexual prejudice have been evident throughout history. Matters of war and acts of terrorism promote hated, loathing, retaliation, and retribution. In particular, heinous crimes of genocide (ethnic cleansing) articulate evil. The Holocaust in one of the most fundamental examples of pure evil. The Nazi regime was successful in annihilating millions of Jews during World War II, an unimaginable human atrocity. More recently, in 2003–2004, U.S. military personnel of the army and Central Intelligence Agency were found to have engaged in acts of abuse and torture toward Iraqi prisoners at Abu Ghraib Prison, spawning outrage, criticism, and concern.

Research investigating acts of abuse and oppression have noted that evil does not happen in a vacuum. Psychologists Thomas Carnahan and Sam McFarland suggest that creating a dynamic that perpetuates an "us" against "them" mentality may allow for evil, tyrannical acts to occur more readily. Though it was once believed that the evil characteristic appears out of thin air in normal, well-adjusted people, further investigation into the Milgram and Stanford Prison studies have revealed that participants who inflicted harm on others scored higher in aggression, authoritarianism, narcissism, and dominance and lower in empathy and altruism. Psychologists have long described a "dark triad of personality" that includes narcissism, Machiavellianism (willingness to manipulate situations or others for personal gain), and psychopathy (antisocial behavior and lack of empathy). A fourth dark trait has been added, sadism, or gaining pleasure from inflicting harm or pain on others, as a result of these studies' findings.

Melissa A. Mariani, PhD

See also: Obedience Studies; Stanford Prison Experiment

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Evolutionary Psychology

Evolutionary psychology (EP) is an approach to psychology that incorporates principles from evolutionary biology into an understanding of human behavior.

Definitions

- **Evolution** is a theory first proposed by Charles Darwin that states all species and organisms develop and change through the natural selection of small, inherited variations that increase the ability of the species or organism to compete, survive, and reproduce.
- **Evolutionary time** refers to an unspecified amount of time usually in the hundreds of thousands to millions of years.
- **Natural selection** is a process by which an organism or species best adapted to an environment is able to survive longer and reproduce in greater numbers, with the adaptive traits being passed down to the next generation. As the number of adapted offspring increases, there is an ever-decreasing chance for the less adapted organism to reproduce eventually resulting in the extinction of the less adaptive traits.

Description

Evolutionary psychology is not a specific method of psychotherapy but rather an approach to understanding human behavior based on the principles of evolution, adaptations, and natural selection. Evolutionary psychologists hold that EP is not a subdiscipline of psychology but rather a biologically informed framework that encompasses all fields of understanding human behavior. Psychologists agree that human behavior is the result of internal psychological mechanisms that take place within the human brain. Most fields of psychology have a perspective or theory on what the specific internal mechanisms are and how they operate. For instance, cognitive psychology explains human behavior in terms of cognitive structures (how we think) and the impact of these thoughts on feelings and behaviors. What distinguishes evolutionary psychologist from other schools of thought is the belief that the internal psychological mechanisms are actually evolutionary adaptations produced through natural selection as our ancestors lived, reproduced, and died throughout evolutionary time.

One of the major goals of EP is to identify emotional and cognitive adaptations that have evolved and which characterize the psychological nature of human beings. EP focuses almost exclusively on how the brain has evolved and how it generates emotions and behavior. According to EP, natural selection has resulted in psychological adaptations within the brain producing universal frames of meaning (true across all cultures) in how humans interpret events; experience emotion; mate and reproduce; and make meaning of other's behaviors and form social relationships, to name a few.

EP consists of several core principles that link psychology, evolutionary biology, and brain functioning. The first principle is that the brain is a physical system designed to process information and produce behavior. The brain is governed by electrochemical reactions, which function like organic neural computer circuits and which determine how it processes information. Second, the neural circuits were established through natural selection in order to solve problems. These problems were recurring and had to do with mating, parenting, social dynamics, motivation, and cognitive development. Third, most brain functions and problem solving are unconscious and involve extremely complex neural circuitry. Fourth, natural selection has produced specialized parts of the brain for solving specific types of problems. The final principle is that our modern human skulls house a Stone Age brain. The human brain has evolved over millions of years and only the

smallest fraction of time has been lived in a modern society. For 10 million years natural selection has formed the human brain to solve hunter-gatherer problems of living. The modern computer age is less than 30 years old, the industrial revolution began only 200 years ago, and agriculture first appeared only about 10,000 years ago. There have not been enough generations for the brain to develop circuits adapted to our postindustrial society. Evolutionary psychologists believe that the key to understanding how the modern human mind works is to understand that it has not evolved to solve modern problems.

EP is a new approach to understanding human behavior that blends evolutionary biology and psychology to gain a deeper insight into the human mind. EP can be applied to fields such as social psychology, cognitive psychology, and personality theory.

Steven R. Vensel, PhD

See also: Epigenetics

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Excoriation Disorder

Excoriation disorder is a mental disorder characterized by recurrent picking at one's own skin.

Definitions

- **Acceptant and commitment therapy** is a type of psychotherapy that helps individuals accept the difficulties that come with life. It is a form of mindfulness-based therapy. It is also known as ACT.
- **Antiseizure medications** are prescription drugs used to treat epilepsy (seizures) as well as burning, stabbing, and shooting pain. It is also called anticonvulsant medications.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing faulty behaviors, emotions, and thoughts. It is also known as CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Obsessive-compulsive and related disorders** are a group of DSM-5 disorders characterized by preoccupations and repetitive behaviors. They include obsessive-compulsive disorder, hoarding disorder, and excoriation disorder.
- **Obsessive-compulsive disorder** is a mental disorder characterized by unwanted and repeated thoughts and feelings (obsessions) or behaviors that one feels driven to perform (compulsions). It is commonly referred to as OCD.

Description and Diagnosis

Excoriation (skin picking) disorder is one of the DSM-5 obsessive-compulsive and related disorders. It is characterized by the recurrent urge to pick at one's own skin, often to the extent that damage occurs. Individuals may pick for several reasons. They may pick when they are anxious or bored or during times when they aren't even aware they are picking. They may pick to cope with negative emotions (e.g., sadness, anger, and anxiety) or in response to tension and stress. When picking their skin, individuals often experience a sense of relief, which may be followed with feelings of guilt and shame.

The most common sites that individuals pick are the arms, hands, and face; however, many individuals

pick from many different sites on the body. Individuals with this disorder pick at pimples, scabs, and even healthy skin. Most pick their skin with their fingernails, while others may use pins or tweezers and others even bite their skin. Some individuals may search for a particular kind of scab to pick and may examine, play with, and even eat the skin after it has been pulled. Some individuals spend several hours a day picking their skin, and this can lead to significant distress in their life, particularly with occupational, social, or other areas of functioning. For example, students may miss school and have difficulty studying and completing assignments because of skin picking.

Individuals with this disorder often feel a sense of loss of control and embarrassment. Individuals usually pick their skin in private or sometimes in front of family members. Individuals may avoid social situations as well as going out in public due to the shame of skin picking. Most individuals with this disorder hide their scars and lesions by concealing it with makeup or wearing clothing that hides the area of skin that has been damaged. Skin picking can be very severe and lead to tissue damage, scarring, infection, and life-threatening conditions. Infections may require antibiotic treatment and in some cases may require surgery. Excoriation is more common among females and may present at any age, although it is most common during the onset of puberty (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they have engaged in recurrent picking of their own skin resulting in skin lesions. Individuals must have had repeated attempts to decrease or stop picking. This behavior must cause significant distress or impairment in social, occupational, or other areas of functioning. Distress with this disorder refers to a loss of control, shame, and embarrassment. Significant impairment with this behavior includes several areas of functioning, such as social, educational, occupational, and leisure. The skin picking behavior cannot be a result of any physiological effects of a substance or another medical condition. Skin picking behavior cannot be better explained by symptoms of any other mental disorder (American Psychiatric Association, 2013).

The exact causes of this disorder are unknown. Environmental factors may play a role in excoriation disorder. For example, individuals who grew up in families who engaged in and witnessed skin picking may be more prone to developing this disorder. Biological factors may also play a role. For example, the disorder is passed down from parents to children. Another possible cause of excoriation disorder may be a coping mechanism for individuals to deal with turmoil and stress within them, and these individuals have an impaired stress response. Skin picking behavior may also result from repressed rage felt by overbearing parents. These individuals often have other psychological symptoms, like anxiety and depression. Excoriation disorder is more common in individuals with obsessive-compulsive disorder (OCD). Excoriation disorder and OCD share several of the same features. For example, individuals with skin picking disorder will pick their skin over and again, often in response to recurrent thoughts or urges to pick their skin. OCD is also characterized by urges to engage in repetitive behaviors (rituals) in response to recurrent thoughts and impulses.

Treatment

Treatment for this disorder typically involves psychotherapy and medication. Cognitive behavior therapy (CBT) has been found to help individuals with skin picking disorder. The goal of CBT is to have an individual focus on and change his or her thoughts and behaviors. Acceptance and commitment therapy (ACT) has also been shown to be effective. ACT theorizes that greater well-being can be attained by overcoming negative thoughts and feelings. The goal of ACT is to have an individual look at his or her character traits and behaviors that will assist in reducing avoidant coping styles. ACT also focuses on individuals making a commitment to behavior changes. Some antidepressant medications (e.g., SSRIs, such as Prozac) are often prescribed and are effective in treating this disorder. Antiseizure medicines, such as Lamictal, are also being used for this disorder.

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Elizabeth Smith Kelsey, PhD

See also: Acceptance and Commitment Therapy; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Obsessive-Compulsive Disorder

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Executive Functions

Executive functions are high-level cognitive abilities such as planning, organizing, reasoning, decision making, and problem solving that influence more basic abilities such as attention, memory, and motor skills.

Definitions

- **Attention-deficit hyperactivity disorder** is a disorder of the nervous system characterized by inattention, hyperactivity, and impulsiveness.
- **Autism spectrum disorders** are disorders with impaired ability to communicate and interact socially and with repetitive behaviors or restricted interests (e.g., autism and Asperger's syndrome).
- **Learning disabilities** are disorder characterized by difficulty with skills such as reading or writing in individuals with normal intelligence.
- **Tourette's syndrome** is a disorder of the nervous system, characterized by a variable expression of tics (unwanted movements and noises).

Description

Executive functions are the cognitive process that regulates an individual's ability to organize thoughts and activities, prioritize tasks, manage time efficiently, and make decisions. Those with executive function problems are likely to have difficulty planning a project, difficulty anticipating how much time a project will take to complete, trouble communicating details in an organized, sequential manner, difficulty with the mental strategies involved in memorization and retrieving information from memory, trouble initiating activities or tasks, or difficulty retaining information while doing something with it, such as remembering a phone number while dialing. Impairment of executive function is noted in a range of disorders, including attention-deficit/hyperactivity disorder, autism spectrum disorders, Tourette's syndrome, and learning disabilities.

Developments and Current Status

In the 1980s, the American psychologist Michael Posner (1936–) and his colleagues influenced recent research into executive functions. He identified a separate "executive" branch of cognitive function responsible for focusing attention. Because individuals with deficits in executive functioning have difficulty with learning in school and job performance, the assessment of executive function is common. There is no single test or battery (series) of tests that identifies all aspects of executive function. For that reason, psychologists and learning disorder specialists use various tests. Some of the most common are the Wisconsin Card Sorting Test, the Stroop Color and Word Test, and the Color-Word Interference Test.

Wisconsin card sorting test. This test measures the ability to shift cognitive strategies in response to changing environmental contingencies as well as the ability to develop and maintain an appropriate problem-solving strategy across changing stimulus conditions. It consists of 128 response cards and 4 stimulus cards that depict figures of varying forms, colors, or numbers of figures.

Stroop color and word test. This test is used to assess cognitive flexibility in the sense of ability to inhibit a more automatic verbal response (reading color words) in order to generate a conflicting response of naming the dissonant ink colors.

Color-word interference test. This test assesses cognitive flexibility by requiring the test-taker to inhibit reading words standing for colors while naming the colors themselves. It then asks the test-taker to switch back and forth between naming the dissonant (wrong) ink color and reading the conflicting word.

Len Sperry, MD, PhD

See also: Autism; Learning Disorders; Neuropsychological Tests

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Exhibitionistic Disorder

Exhibitionistic disorder is a mental health disorder that is characterized by the exposure of one's genitals to others in order to gain sexual satisfaction.

Definitions

- **Antiandrogens** are medications that block male sex hormones.
- **Aversion therapy** is a form of psychotherapy that focuses on reducing or avoiding an undesirable pattern in an individual by conditioning that individual to associate the behavior with an undesirable stimulus.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hormones** are chemical substances produced in the body that control and regulate the activity of certain cells or organs.
- **Impulse control** is the degree to which an individual can control the impulse to act or the desire for immediate gratification.
- **Paraphilia** is a sexual disorder in which individuals can only become aroused by inappropriate object, actions, or fantasies.
- **Paraphilic disorders** are a group of DSM-5 mental disorders characterized by unusual sexual preferences and behaviors that are distressing or detrimental to one's self or others. They include exhibitionistic disorder, pedophilic disorder, and fetishistic disorder.
- **Selective serotonin reuptake inhibitors** are the most commonly prescribed antidepressant medication because they generally have few side effects.
- **Serotonin** is a chemical messenger in the brain that regulates learning, sleep, mood, and appetite. It is involved in disorders such as depression and anxiety.
- **Social skills training** is a treatment method that assists individuals to learn specific skills that are missing or those that will compensate for the missing ones.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.
- **Testosterone** is a hormone that influences the sexual drive in both men and women.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions and compulsions on a plan called the Twelve Steps.

Description and Diagnosis

Exhibitionistic disorder is one of the DSM-5 paraphilic disorders. It is characterized by the compulsion to expose one's genitals to other individuals (usually strangers) in order to gain sexual satisfaction. The exhibitionist usually does not have the intention of further sexual activity with the other individual. Some exhibitionists have a desire to shock or upset the individual, while other exhibitionists fantasize that the individual (target) will become sexually aroused by their

display. In some instances, the exhibitionist masturbates while exposing himself or herself to the individual. Some symptoms associated with exhibitionistic disorder include an individual having recurrent fantasies of exposing himself or herself but rarely or never acting on the fantasies. Other individuals have difficulty controlling urges and have exposed themselves to at least three individuals. Another aspect of this disorder is impulse control.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they have intense and recurrent arousal from exposing one's genitals to an unsuspecting individual. This must occur for a period of at least six months as demonstrated by urges, behaviors, and fantasies. An individual can be diagnosed with this disorder if he or she has acted on sexual urges with a non-consenting individual. The sexual urges must cause significant distress or impairment in occupational, social, or other meaningful areas of functioning. If the individual is living in a controlled environment (e.g., institution) to restrict his or her exhibitionistic behavior, the specifier "In a controlled environment" must be included in the diagnosis. An individual who has not acted on urges with a non-consenting individual and has not had any distress or impairment for at least five years in social, occupational, or other areas of important functioning, the specifier "In full remission" must be included in the diagnosis. There are three subtypes for exhibitionistic disorder listed in the DSM-5 that are based on physical maturity, age, of the non-consenting individuals (American Psychiatric Association, 2013).

The exact cause of exhibitionistic disorder is unknown. However, there are a number of theories about its origin or cause. One theory is biological and assumes that as testosterone increases in males so does deviant sexual behaviors. Some medications are prescribed to exhibitionists in order to lower their testosterone levels. Another theory is that emotional abuse caused by growing up in a dysfunctional family poses significant risk factors in developing exhibitionist disorder. It is also thought that exhibitionists regard their mothers as rejecting them based on their different genitals. Therefore, they grow up with a desire to force women to accept them by making women look at their genitals. Antisocial personality disorders, alcohol abuse, and pedophilic interest may be considered risk factors for exhibitionist disorder in males with exhibitionist preferences. The prevalence of exhibitionist disorder is higher in men than among women (American Psychiatric Association, 2013).

Treatment

Treatment for this disorder usually includes a combination of psychotherapy, medications, and other treatments. Several different forms of psychotherapy have been found to be effective in treating exhibitionistic disorder. In particular, cognitive behavior therapy has been found to help individuals diagnosed with exhibitionistic disorder. Individuals are encouraged to recognize irrational behaviors and to change other distorted patterns of thinking. Aversion therapy is another form of method used for treating individuals with exhibitionistic disorder. This type of therapy involves asking the individual to fantasize about specific events that led to exhibitionism. A very unpleasant scene is inserted into the events. For example, an individual might be asked to imagine an undercover agent approaching as the individual is exposing himself or herself or imagining his or her target laughing at him or her. Another treatment method that is often used for individuals with exhibitionistic disorder is social skills training. It is believed that some men develop paraphilias partly because they never developed health relationships with other individuals. The relationships may be either sexual or nonsexual. Twelve-Step Programs for sexual addicts may be another method of treatment. Exhibitionists often feel guilty and anxious about their behavior and are often helped by the social support available in Twelve-Step Programs.

Several different medications are prescribed and used to treat an individual with exhibitionistic disorder. Selective serotonin reuptake inhibitors (SSRIs) are medications often used in treating paraphilia's. SSRIs have been found to be effective because, as the levels of serotonin increase in the brain, the sex drive decreases. Female hormones (estrogen) are also used to treat individuals with exhibitionistic disorder. The hormone used in treating this disorder works by stimulating the liver, which produces a chemical that clears

testosterone from the bloodstream. Antiandrogens are also used. These medications block the uptake of testosterone and reduce the blood levels of testosterone and significantly reduce repetition of the deviant behavior. Removal of the testes, surgical castration, is another treatment option for exhibitionists. This procedure reduces the levels of testosterone in the blood, thus decreasing the sex drive. This form of treatment, however, is generally used for serious sexual offenders, such as violent rapists and pedophiles.

Elizabeth Smith Kelsey, PhD, and Len Sperry, MD, PhD

See also: Aversion Therapy; Brain; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Paraphilic Disorders; Serotonin; Social Skills Training; Twelve-Step Programs

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Existential Psychotherapy

Existential psychotherapy (EP) is an experiential and relationship-oriented approach to psychotherapy that focuses on meaning and the nature of the human experience.

Description

Existential psychotherapy focuses on the nature of the human condition, the capacity for self-awareness, and the freedom to choose one's own fate. Individuality, freedom, autonomy, personal responsibility, and the search for meaning are key concepts. The goals in existential counseling are to help individuals become aware of their own possibilities and to recognize that they are responsible for both positive and negative events that take place in their lives. This method of psychotherapy is less focused on technique and more focused on understanding freedom and responsibility, meaning and meaninglessness, isolation and relationships, and living and dying. Existential psychotherapy is a philosophical approach to helping and is well suited to individuals with existential concerns such as life transitions, making sense of life, disappointments in life, discovering values, and seeking self-expression and self-fulfillment. Existential therapy can be provided in individual or group counseling sessions.

Development

Existential psychotherapy is deeply rooted in existential philosophy, which was developed over many years and was not founded by any one individual. Both 19th- and 20th-century philosophers influenced existentialism. Søren Kierkegaard (1813–1855), Friedrich Nietzsche (1844–1900), Martin Heidegger (1889–1976), and Jean-Paul Sartre (1905–1980) are some of the early philosophers who made significant contributions to the movement. More recently, contemporary existential psychotherapy has been highly influenced by the work of Viktor Frankl, Rollo May, James Bugental, Otto Frank, and Irvin Yalom. All of these therapists individually contributed to the development of existential psychotherapy.

Existential psychotherapy does not rely on any specific techniques. EP is based on the understanding and exploration of what it means to be human. The existential perspective is that human beings are in a constant state of transition and continually need to re-create and find meaning in existence. Assisting people in finding a balance between the difficulties, tragedies, and dilemmas of being human and discovering the opportunities, possibilities, and meaning in the human experience is a fundamental aspect of the approach.

The core dimensions of EP include the following: (1) People have the ability to be self-aware, which leads to greater awareness of potential, motivation, and alternatives in living. (2) People are free to choose and are responsible to shape their own destinies. (3) People must develop the courage to create their own self-identity in order to authentically relate to others. (4) People search for significance, meaning, and purpose in life, which are discovered through engagement

with what is valued. (5) Anxiety is unavoidable and can lead to change. (6) Awareness of the inevitability of death provides the motivation to live life fully with meaning and significance.

Current Status

Existential psychotherapy is a here-and-now approach that focuses on what people are becoming, not on past experiences or childhood dynamics. A meaningful and authentic relationship between the client and therapist is essential with the understanding that both may be changed by the encounter. The central goal of EP is to help people become aware of their possibilities, understand their own freedom and responsibility in making choices, and identify what is keeping them from living a meaningful life.

EP is more a style and philosophy of psychotherapy than a specific model of therapy. The lack of techniques unique to EP has resulted in an approach that is difficult to research and suffers from a lack of evidence-based treatment outcomes. Other criticisms of the existential approach include its lack of training models and language and concepts that can be perceived as mystical and vague. A significant limitation to EP is the level of philosophical knowledge required of the practitioner and a deep understanding of what it means to be human.

Existential psychotherapy is a philosophical and experiential approach to helping. EP is provided through an authentic relationship that assists individuals in developing the courage to finding meaning and significance in life while facing the realities of life.

Steven R. Vensel, PhD

See also: Frankl, Viktor (1905–1997); May, Rollo (1909–1994)

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Expertise

Expertise is the special knowledge or skills in a particular subject area learned from experience resulting in a high level of proficiency or competency.

Definitions

- **Attitude** is the predisposition or tendency to respond positively or negatively to specific ideas, individuals, or situations.
- **Competency** is the capacity to integrate knowledge, skills, and attitudes reflected in the quality of clinical counseling practice.
- **Deliberate practice** is the effort and time devoted to reaching for objectives just beyond one's level of proficiency (skills) and using interventions to increase one's proficiency.
- **Expert** refers to one who practices with a high level of expertise or proficiency.
- **Knowledge** is information about various topics that includes definitions and explanations of processes that explain larger constructs.
- **Master therapists** are psychotherapists who are considered by fellow therapists to be "the best of the best" in terms of expertise in psychotherapy. They are also called expert therapists.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Reflective practice** is a process that expert therapists utilize in which they continue to learn from experiences and increase their capacity to work effectively with clients.
- **Second-order change** is long-lasting change that can be achieved in counseling when clients experience symptom or conflict reduction and long-lasting personality change.
- **Skills** are capacities that can be acquired (learned) through education and "hands-on" training.

- **10,000 hours rule** is the rule based on the research finding that at least 10,000 hours of deliberate practice are required to achieve expertise in a given occupation.

Description

"Expertise" refers to the characteristic way in which experts think and act. It distinguishes the performance of experts from the less experienced. When it comes to psychotherapy, expert therapists are also called master therapists. These individuals have an advanced ability to quickly assess situations and easily design appropriate treatment interventions. They have the ability to quickly determine when treatment interventions are not effective and can modify treatment very efficiently compared to their peers. They engage in lifelong learning and continue to learn the nuances of working with clients through additional training and reflective practice. Expert therapists have the ability to engage their clients in highly effective therapy to ultimately achieve treatment goals and effect change with their clients in a relatively short amount of time.

Psychologist Anders Ericsson (1947–) has pioneered the study of expertise. Based on his research he has proposed the 10,000 hours rule. He reports that it takes 10,000 hours for the brain to assimilate a particular skill. This 10,000 rule also applies to counselor development. The beginner or novice counselor engages in reflective and deliberate counseling practice that will lead to more advanced counseling skills, knowledge, and attitudes. It should be noted that 10,000 hours of the same practice without learning from experience does not result in expertise.

Expertise has been studied in various professions and among specific behaviors such as violinists, chess players, educators, and athletes. Experts are characterized by being highly skilled in a particular skill area. Expert or master therapists are more effective and are able to navigate the nuances of working with individuals in psychotherapy. The process of expertise begins with the beginner stage, advanced beginner, minimally competent, proficient, and finally the expert stage.

Beginning therapists possess a very limited capacity to assess, analyze, and intervene. They are overly reliant on basic principles and techniques and are rule-bound, but they are very inexperienced and need supervision. Advanced beginners possess some capacity for assessment or diagnosis, and application of interventions, but they experience difficulty generalizing this capacity to different patients and new situations. They require clinical supervision and additional training in most counseling functions. Therapists in the minimally competent developmental stage hold the capacity to function independently but with a minimal competence and minimal effectiveness. They are able to cope with and handle crises or other problems as they arise and are able to integrate theory and research in most aspects of their practice. Proficient therapists have the capacity to function independently and effectively. Their performance is guided by flexibility and a clear understanding of their clients' personalities and patterns. They are able to integrate their personal with their professional life and values. The expert or master therapist has an intuitive grasp of clinical situations and is able to very efficiency work with clients on reducing symptoms and effecting lasting change or second-order change. Therapists who function at the expert or mastery stage spend a significant amount of time in training, supervision, and reflective practice.

Expert therapists practice and display high levels of the following competencies: clinical competence, ethical competence, cultural competence, social interest, and well-being or self-care. Clinical competency is evidenced by clinical intuition and judgment shown by clinicians based on their clinical knowledge, skills, and attitudes and reflection on those experiences as they relate to the specific circumstances of a particular patient. Cultural competency is the clinicians' awareness of cultural variables in themselves and in their clients that may affect the therapeutic relationship and treatment process. Ethical sensitivity is the capacity to recognize, anticipate, and respond to the suffering and vulnerability of those receiving professional services, especially among ethical and moral aspects. Social interest is the clinician's orientation of connecting to other human beings and searching for a sense of purpose through helping others and empowering clients to enhance their own sense of social interest. Lastly, expert counselors are usually able to balance work and personal life while actively engaging in self-care practices to maintain their own emotional, social, and physical well-being.

Based on his research Thomas Skovholt (1944–) described the attributes of master therapists. He discussed qualitative research and interviews about master therapists. He identified that mastery is achieved through an ongoing effort to improve skills, being open to feedback from supervisors, seeking new knowledge through continuing education and training, and significant clinical experience, which is a given. Skovholt and Jennings identified 11 characteristics of the ideal therapist, and they suggest that master therapists possess many of these traits: master therapists are voracious learners, they use their accumulated experiences, they value cognitive complexity and ambiguity, they have emotional receptivity, they are healthy and nurture their own emotional well-being, they are aware of how their emotional health affects their work, they possess highly developed relational skills, they cultivate strong working alliances with clients, they excel in using their exceptional therapy skills, they trust their clients, and they are culturally competent (Jennings and Skovholt, 1999). These attributes were found among their qualitative research done among master therapists.

In summary, master or expert therapists demonstrate high levels of clinical, ethical, and cultural expertise, social interest, and self-care. They have significant relational skills and are able to form very effective therapeutic alliances with clients. Research identifies that mastery takes approximately 10,000 hours with deliberate and reflective practice. Master therapists are able to quickly effect long-lasting change with clients in a relatively short amount of time. Understanding traits of master therapists informs graduate counseling and psychology programs about important competencies and processes that can influence competent trainees.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Master Therapist; Psychotherapy

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Exposure Therapy

Exposure therapy is a behavior therapy intervention (method) in which a client is exposed to a feared object or situation. It is also referred to as flooding.

Definitions

- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **Classical conditioning** is an involuntary process of neurological change in response to a stimulus that causes a reaction. Classical conditioning occurs when the involuntary reaction is associated (paired) to a new unrelated stimulus causing the reaction to occur automatically when the new stimulus is present. It is also known as Pavlovian conditioning.
- **In vivo** is a Latin term that means "in the living" and signifies therapeutically that an intervention is occurring in real life, as opposed to in an imagination or in a theory.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Reciprocal inhibition** is a therapeutic technique that obstructs the presence of one response through the introduction of an opposite response.

- **Relaxation training** a progressive tensing and relaxing of specific muscle groups to teach acceptance and letting go of anxious symptoms.
- **Systematic desensitization** is a form of exposure therapy that gradually exposes an individual to his or her phobia while teaching him or her to stay relaxed in the increasing presence of his or her phobia. It is also known as graduated exposure therapy.
- **Virtual reality exposure therapy** is form of exposure therapy that uses computer-generated imagery to expose a client to simulations of a dreaded object or event.

Description

Exposure therapy is a behavior therapy intervention in which the therapist intentionally exposes a client to a feared object or situation. Exposure therapy is based on the premise that confronting dreaded objects or situations results in a reduction of distress. A variety of psychotherapeutic techniques are available in exposure therapy. The basic technique utilized in exposure therapy is called in vivo exposure. In vivo exposure therapy requires that the client be exposed to his or her dreaded object or situation in real life. For example, a therapist could bring real live spiders into a counseling session with a client who suffers from arachnophobia (fear of spiders). Another form of exposure therapy is imaginal exposure, which instructs a client to imagine being in the presence of a dreaded object or situation. As in the previously given example, a client with arachnophobia would be instructed to imagine spiders or situations involving spiders. Research evidence and clinical experience suggest that imaginal exposure is not as therapeutically effective as in vivo exposure therapy. A type of imaginal exposure therapy occurs with the assistance of virtual reality technologies. As a result of advancements in computer-generated imagery, virtual reality exposure therapy can be as effective as in vivo therapy. Interoceptive exposure is a type of exposure therapy that exposes a client to sensations that typically occur with exposure to his or her feared object or situation. If a client suffering from arachnophobia has a symptom of shortness of breath (hyperventilation) when exposed to spiders, the therapist using interoceptive exposure therapy might suggest that the client breathe through a straw or into a paper bag to expose the client to the sensation without spiders present. If the client hyperventilates on being exposed to spiders, then exposure to hyperventilation without spiders present eventually reduces or removes the fear of the symptom and often alters the involuntary response (hyperventilation) to the classically conditioned stimulus (spiders). The fear response to a particular stimulus is replaced with a relaxation response to the same stimulus.

Exposure therapy is similar to but different from systematic desensitization. Both exposure therapy and systematic desensitization are therapeutic techniques that focus on the extinction (removal) of a conditioned response. Exposure therapy (flooding) encourages a patient to confront a fear and refrain from reacting in a typical manner. There is no subtlety to exposure therapy. It is an all or nothing exposure to a phobia that teaches a patient to tolerate the distress associated with the exposure. Therapists must be trained to assist the patient through the distress that results from exposure to a phobic stimulus. In contrast, systematic desensitization trains a patient to tolerate progressive exposure to a phobia. In systematic desensitization, the therapist will work with a client to develop an exposure hierarchy, or feared situations ranked from most tolerable to least tolerable. Systematic desensitization teaches a client to stay relaxed when exposed to his or her phobia in increasing amounts over time. The gradual nature of systematic desensitization makes it a different behavioral intervention than exposure therapy. Exposure therapy floods a client with fear until the client learns that the feared outcome is not likely to occur.

While it is important in exposure therapy to expose a client to his or her fear response, care must be taken not to overwhelm the client. The clinician works closely with the client to ensure that the client does not experience overwhelming fear during the process of exposure therapy. This is a critical aspect of the intervention as the conditioned response of fear must be replaced with relaxation. Further, exposure therapy is

most effective when flooding occurs daily until extinction of the response occurs. This might require therapists to assign exposure-based "homework" between weekly sessions.

Development and Current Status

Exposure therapy was introduced by Joseph Wolpe (1915–1997), a psychiatrist from South Africa, in the 1950s. Wolpe coined the term "reciprocal inhibition" to describe the process of classically conditioning an opposite response to replace an automatic reaction to a stimulus. It was believed that a reaction and its opposite reaction could not exist simultaneously in a patient. Exposure therapy is fundamentally associated with reciprocal inhibition. Reciprocal inhibition creates response prevention, which is the blocking of unwanted avoidance behaviors. Wolpe's discoveries led to treatments that briefly increase a client's experience of anxiety but eventually lead to the extinction (removal) of anxiety. During exposure it is necessary for the client to remain as relaxed as possible. Psychotherapeutic techniques of relaxation training paired with exposure are highly effective. A client quickly learns to maintain relaxation in the presence of a feared stimulus. Although exposure therapy was originated by behavior therapists, today this technique is commonly used by cognitive behavioral therapists and even by psychodynamically oriented therapists.

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See also: Empirically Supported Treatment; Evidence-Based Practice; Systematic Desensitization

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Expressive Arts Therapy

Expressive arts therapy is the practice of using storytelling, imagery, dance, drama, poetry, movement, music, dream work, and visual arts to help promote and encourage personal growth and healing.

Description

Expressive arts therapy is a technique using a multitude of creative mediums to complement and work with the therapeutic process. The notion of expressive arts is not grounded in a specific technique but rather as a response to human suffering. A therapist using expressive arts must be prepared to use a variety of modalities to meet the individual needs of clients. It allows for the human psyche to express itself in an authentic, nonverbal manner through images as opposed to words. These images can be done with motion, sound, action, pictures, and so forth. Many argue that people can express themselves in their truest form by utilizing these creative formats or through creative projections.

Expressive arts therapy is considered to be a relatively new approach to therapy; however, many believe it connects back to ancient traditions in healing. Each form of expressive arts therapy has its own branch as well as specific training, for example, art therapy, play therapy, and music therapy. Each of these has its own form of training and credentialing. Forms such as art therapy and music therapy have been in formal practice longer and have journals as well as organizations. Many of these have their own ethical guidelines and standards of practice that clinicians must adhere to.

Expressive arts therapy is sometimes referred to as creative arts in counseling. The art forms include auditory, written, visual, or combinations. Creative arts allows for healing both physically and mentally. In terms of counseling, creativity allows for clients to be more in tune with themselves and encourages them to invest in the process so that they can continue to grow. Using the expressive arts in counseling is considered to be a six-step process. The first step is preparation where background information and data are collected. The second step is incubation where the mind is allowed to wander from the problem at hand. The next step is

ideation whereby ideas are generated using divergent thinking. This is followed by illumination where there is enlightenment. The fifth step is evaluation, which allows for critical and convergent thinking. The final step of verification is where there is a product or action.

Development and Current Status

Incorporating art into life dates back to ancient times. People would sing, dance, and tell stories all to explore life, find their place, and honor others. Healing practices of indigenous cultures centered around expressive art techniques and rituals. For example, ancient Egyptians encouraged those who were identified as mentally ill to pursue creativity and artistic interests so that in these actions their feelings could be released and they could become whole again. Expressive arts therapy is grounded in humanistic psychotherapy and systems theories.

The Expressive Therapies Program at Leslie University in Cambridge, Massachusetts, was founded in the 1970s by Shaun McNiff, Paolo Knill, Norma Canner, and their colleagues. The emphasis was on having a creative therapeutic community composed of students and faculty. In the 1980s Paolo Knill went on to develop a network of training programs in North America as well as in Europe. These training institutes now exist around the world. Courses exploring the expressive arts are also now a part of many graduate-level counseling programs.

Over the past 20 years there has been a growth in the field, resulting in separate fields of practice. Clinicians using this modality have to first understand the creative exploration process. Clinicians must understand how to be creative in using these modalities to assist clients. The other side of this is that the term "creativity" is somewhat overused. The key component is divergent thinking, which is thinking in a flexible and exploratory manner. These are associated with coping skills and positive mental health, as well as resiliency and even happiness.

Creativity or expressive arts in counseling allows for a product to be created that helps provide the client with insight that allows for change within the client. For instance, a client may be given the task of a music autobiography where he or she identifies songs that connect to various important points of his or her life. At first the client may not realize the connection, but in processing and exploring the songs and their connections, this allows for the client to develop deeper more meaningful insights that allow for growth and healing. Creativity and the expressive arts transcend ethnicities, cultures, races, genders, and age.

Mindy Parsons, PhD

See also: Art Therapy; Dance Therapy; Music Therapy; Play Therapy; Sand Tray Therapy

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Organizations

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Association for the Study of Dreams
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International Expressive Arts Therapy Association
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Expressive Language Disorder

Expressive language disorder is a deficit in the normal development of language used to communicate with others.

Description

The development of language follows a general pattern when there are no intellectual, developmental, sensory, or neurological disorders. Even without the presence of these diagnoses, there are some individuals who struggle with expressing themselves using language. These individuals may be diagnosed with expressive language disorder (ELD). Usually people with ELD can understand language while they are not themselves able to communicate clearly in response. In other words, their receptive skills, or ability to understand language, are better than their expressive language. Expressive language is the ability to use language effectively. These individuals demonstrate a normal range of intelligence or IQ as measured by testing.

Expressive language disorders fall into two categories. ELD can be acquired, which is usually the result of an accident or illness that causes brain damage. This could include temporary or permanent damage caused by something like a stroke. The other type of ELD is developmental, meaning that language acquisition is slower and later than usual. For an accurate diagnosis of ELD the language deficit cannot be the result of a neurological problem. The developmental type is more common in children, and the acquired type occurs more often among adults or the elderly. It is estimated that 10%–15% of children under the age of three are diagnosed with language development delays, including ELD. In more mild cases, the disorder may not be recognized until they go to school where the prevalence of ELD falls off to the 5%–7% range.

Causes and Symptoms

In the acquired type of ELD, accidents involving head injury are a common cause of the disorder. But children born into families with a history of language delays are more likely to be diagnosed with the developmental type of ELD. If factors that affect general development, such as malnutrition, exist, a child is more likely to be diagnosed with ELD.

Clinical symptoms of this disorder include limited vocabulary and fewer verbal expressions. Many also make mistakes with verb tense and have difficulty remembering new words. Children with expressive language delays do not talk as much or as often as their peers. Yet they generally understand what is said to them. For example, children with this disorder may be

able to follow two-step commands but may not be able to name their body parts. ELD may manifest itself in difficulties with written language as well.

Diagnosis and Prognosis

Expressive language disorder is medically classified as speech sound disorder. ELD may be suspected when there are difficulties with academics or socialization. Medical testing should be conducted to determine whether a diagnosis of ELD is correct. Social withdrawal and co-occurring diagnoses, such as attention-deficit disorder, are commonly associated with ELD.

Unfortunately, developmental and acquired language disorders do not improve when untreated. Without intervention, the frustration that children and adults with ELD experience may lead to behavior problems. In the case of some children, they may stop attempting to learn as they reach adolescence. When concerned about language development issues, it is best to consult a speech-language pathologist to see if a diagnosis of ELD is appropriate.

Treatment

Language therapy is the best and most direct means to treat this disorder. The goal of this therapy is to use speech therapy techniques to increase the number of words and phrases a child or adult can use. Ideally a supportive community of parents, teachers, and health-care professionals should be involved in the treatment. In cases where the self-esteem of the individual has been severely affected, some counseling or psychotherapy may also be recommended.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Speech Sound Disorder; Speech-Language Pathology

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Extraversion and Introversion and Personality Type

"Introversion" and "extraversion" refer to two components of personality type originally developed by Swiss psychiatrist Carl G. Jung (1875–1961) and are a part of most theories of personality type.

Definition

- **Dichotomy**, or dichotomous, refers to the division of two opposing or contradictory constructs, ideas, or forces in which being high in one is to be low in the other.

Description

"Personality type" refers to a collection of personality traits and preferences that produce a consistent and predictable pattern of thinking, feeling, and behaving. Extraversion and introversion (E/I) are two components of personality type first proposed and developed by Swiss psychiatrist Carl Jung in the 1920s to explain differences in people's behaviors. Jung believed that differences in behavior were accounted for by how individuals use their minds in different ways. These differences result in reliable patterns of behavior that can be identified in order to better understand individuals. Personality type consists of several identified and labeled patterns of thinking and behaving. There are many theories of personality type, with a variety of different labels depending on the theorist and model of personality theory. Extraversion and introversion are identified patterns that virtually all personality type theories utilize in their research, including the Neo Inventories based on the Big Five factor model and the Myers–Briggs Type Indicator (MBTI).

One of the most popular and widely used instruments in understanding normal personality differences

is the (MBTI). Building on Jung's theories Katharine Cook Briggs (1875–1968) and her daughter Isabel Briggs Myers (1897–1961) applied Jung's ideas to understanding psychological type and appreciating differences between people. The MBTI measures preferences based on four dichotomies, each consisting of two opposite poles. E/I represents one of the polar dichotomies where extraversion is on one end with introversion on the other and scoring high on one end corresponds with scoring low on the other. The MBTI does not measure the strength of a preference but rather the clarity of the preference. High or low scores do not mean you are highly extraverted or introverted but rather you have a clear preference for one or the other. The MBTI identifies preferences by asking respondents to choose between two dichotomous statements such as the following: do you prefer to focus on the outer world or on your own inner world?

Myers–Briggs identifies extraverts as people who focus on the outer world of people and activities; they direct their energy toward, and receive their energy from, interacting with people and activities. Extraverts prefer to communicate by talking, learn best by doing, are sociable and expressive, and take initiative in work and relationships. Extraverts are outgoing, comfortable with people and groups, have a wide range of friends, and can be impulsive. Introverts prefer the inner world of ideas, memories, and thoughts. Introverts are reflective, often seen as "reserved," comfortable with being alone, have a small group of trusted friends, and can be slow to act.

Over the past 50 years, personality researchers have identified five dimensions or domains to personality commonly referred to as "The Big Five" or the "Five Factor Model" (FFM) of personality. The Big Five has been extensively researched, with a considerable body of literature supporting the FFM. The investigations of many personality theorists, including Robert McCrae, and Paul Costa, Jr., have led to the development of the NEO Inventories, which use a lexical approach to identifying the dimensions of personality. The lexical approach recognizes that people use natural language to describe experiences. Thousands of trait adjectives (e.g., nervous, accommodating, outgoing, friendly) were scientifically analyzed in numerous research studies and led to the identification of the five personality traits that exist, in varying dimensions, in all people. The FFM differs from the MBTI in that the MBTI identifies discrete and specific "types," whereas the FFM describes people in terms of a continuous dimension. For instance, in the MBTI a person is designated as either an extravert or an introvert; in the FFM a person is located somewhere along a path between extraversion and introversion. The FFM recognizes that most people are actually "ambiverts" and display a combination of introverted and extraverted tendencies. The FFM domains of personality are neuroticism, extraversion, openness, agreeableness, and conscientiousness.

The FFM identifies extraverts as sociable, preferring large groups and gatherings. They are assertive, active, and talkative and like excitement and stimulation. They are also upbeat, optimistic, energetic, and cheerful. Introversion is not to be seen as the opposite of extraversion but rather the absence of extraverted preferences. Introverts are reserved but not unfriendly, independent rather than followers, even-paced not sluggish, and prefer to be alone but not because they are shy. Although introverts are not highly spirited, they are not unhappy or pessimistic. The FFM does not relate introspection or reflection to E/I.

Current Status and Impact (Psychological Influence)

Both the MBTI and FMM have made a considerable impact on society but in different ways. The MBTI is an extremely popular personality indicator that has been used in thousands of consumer, education, self-help, and business applications throughout the world. The MBTI has been criticized by researchers as lacking a scientific psychometric instrument and has not been utilized in scientifically rigorous personality research. The FFM and the NEO Inventories are highly regarded by researchers for their scientific and psychometric qualities and are extensively used in a vast array of personality research inquiry.

The concept of E/I has been widely accepted as a fundamental dimension of personality and embraced by both the scientific community and general population. E/I continues to be extensively researched, and

many scientific articles and popular trade books have been published.

Steven R. Vensel, PhD

See also: Five-Factor Theory; Personality Tests

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Eye Movement Desensitization and Reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) is an effective form of psychotherapy that assists people in the alleviation of psychological, emotional, and physiological distress related to traumatic experiences and memories.

Definitions

- **Bilateral eye movement** is to look with the eyes to the right and then to the left without moving the head.
- **Desensitization** means to decrease unwarranted negative emotional response to situations or circumstances by repeated exposure to memories or triggers.
- **Reprocessing** means to rethink, reorganize, and reconsider the meaning and significance of painful events.
- **Triggers** are situations that activate memories and emotional states associated with a past traumatic event.

Description

Eye movement desensitization and reprocessing is a type of psychotherapy developed by Francine Shapiro that assists individuals heal from the emotional distress of traumatic experiences. EMDR facilitates the accessing and reprocessing of traumatic and painful memories that are causing psychological distress. EMDR is known for its unique use of eye movement during the treatment phase of psychotherapy. During treatment clients are instructed to move their eyes back and forth while thinking about the traumatic event, present triggers, and anticipated future situations. In addition to eye movement, alternate tapping of left-then-right fingers or hearing auditory tones directed at left-then-right ears can be utilized. This "dual stimulation" of memories/thoughts and physical stimulation aids in desensitizing the client to the traumatic event, thus reducing the unwanted and unwarranted emotional response. Reprocessing focuses on vivid visual images related to the memory, negative beliefs about self, related emotions and body sensations, and developing new positive beliefs. During treatment clients develop new insight and associations regarding the memories, triggers, and beliefs about the traumatic experience.

EMDR consists of eight phases of treatment. Phase one includes history taking, assessing readiness for EMDR, identifying targets for reprocessing, and the development of a treatment plan. Phase two consists of assessing client coping skills and equipping the client with methods for handling and reducing psychological stress. In phases three through six, targets are identified and processed using EMDR. Phase seven is closure and clients are instructed to journal any related material that may arise. Phase eight examines the progress made.

Development and Current Status

EMDR was developed by American psychologist Francine Shapiro (1948–) who, in 1987, was taking a walk and thinking through some personally

Eye movement desensitization and reprocessing is an effective form of psychotherapy that assists people in the alleviation of psychological, emotional, and physiological distress related to traumatic experiences and memories. (BSIP/UIG via Getty Images)

distressing memories. She observed that her eyes movements might be related to the decrease in the negative emotions she experienced during the walk. Over the next several years Shapiro further explored the interaction between eye movement, memories, and cognitions resulting in the development of Adaptive Information Processing (AIP) theory. The AIP model theorizes that memory networks contain related images, emotions, sensations, and thoughts related to events that take place in life. Humans have an inherent information processing system that naturally results in adaptation to these events. AIP hypothesizes that information related to traumatic events is not fully processed and the memories are stored as they were experienced at the time of the stressful event. Shapiro proposed that unprocessed stressful experiences cause distress and mental health problems such as anxiety and post-traumatic stress disorder (PTSD). According to Shapiro EMDR alleviates the distress by processing the experiences and linking them to more adaptive information.

EMDR has been highly researched as a treatment for PTSD and has been found to be effective in the reduction of PTSD symptoms when compared to no treatment. EMDR has been found to be equivalent in outcomes to more traditional exposure therapy and cognitive behavior therapy. EMDR has been criticized as being a modification of existing exposure therapy, with the eye movements being noncritical to outcomes. Some research suggests that eye movement may not contribute to positive outcomes and other research indicates it does. The exact function of the eye movement component of EMDR is inconclusive and continues to be investigated. EMDR is also being

studied in assessing the effectiveness of the method in treating a variety of mental health disorders such as phobias, anxiety, panic, and depression. EMDR is a complex psychotherapy, which utilizes numerous psychotherapeutic techniques that contribute to its effectiveness in treating trauma-related distress.

Steven R. Vensel, PhD

See also: Exposure Therapy; Post-Traumatic Stress Disorder (PTSD)

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Mental Health and Mental Disorders

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Mental Health and Mental Disorders

AN ENCYCLOPEDIA OF CONDITIONS, TREATMENTS, AND WELL-BEING

Volume 2: F–P

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This book discusses treatments (including types of medication and mental health therapies), diagnostic tests for various symptoms and mental health disorders, and organizations. The authors have made every effort to present accurate and up-to-date information. However, the information in this book is not intended to recommend or endorse particular treatments or organizations, or substitute for the care or medical advice of a qualified health professional, or used to alter any medical therapy without a medical doctor's advice. Specific situations may require specific therapeutic approaches not included in this book. For those reasons, we recommend that readers follow the advice of qualified health care professionals directly involved in their care. Readers who suspect they may have specific medical problems should consult a physician about any suggestions made in this book.

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Vygotsky, Lev (1896–1934)
Watson, John B. (1878–1958)
Whitaker, Carl (1912–1995)
White, Michael (1948–2008)
Wilson, Bill. *See* Alcoholics Anonymous (AA)
Wolpe, Joseph (1915–1997)
Wundt, Wilhelm (1832–1920)
Zimbardo, Philip (1933–)

Social Issues

Adverse Childhood Experiences
Aggressive and Antisocial Behavior in Youth
Baby Boomers
Binge Drinking
Blended Families
Bullying and Peer Aggression
Child Abuse
Cliques
Columbine Shooting
Cults
Cyberbullying
Date Rape

Divorce
Domestic Violence
Drug Culture
Economic and Financial Stress
Elder Abuse
Ethnicity
Foster Care
Gangs
Hazing
Homelessness
Human Trafficking
Immigration, Psychological Factors of
Mass Shootings
Mental Health and Violence
Military Mental Health
Millennials
Parents, Overinvolved
Peer Groups
Performance-Enhancing Drugs
Poverty and Mental Illness
Prejudice
Prescription Drug Abuse
Profanity
Prostitution
Racial Identity Development
Road Rage
Single-Parent Families
Smoking Cessation
Social Justice Counseling
Socioeconomic Status
Temper Tantrum

Tests, Experiments, and Classifications

Beck Depression Inventory
Behavioral Assessment
Bender Gestalt Test
Brain Imaging
Children's Apperception Test (CAT)
Children's Depression Inventory
Computed Tomography (CT)
Conners Rating Scales
Diagnosis
Diagnostic and Statistical Manual of Mental Disorders (DSM)
Disability and Disability Evaluation
Early Recollections
Electroencephalography (EEG)
Executive Functions
Family Assessment
Hamilton Anxiety Scale (HAM-A)
Hamilton Depression Scale (HAM-D)
Hare Psychopathy Checklist-Revised (PCL-R)
Individualized Education Plan (IEP)
Insanity Defense
Intelligence Testing
International Classification of Diseases
Kaufman Adolescent and Adult Intelligence Test (KAIT)
Kaufman Assessment Battery for Children (K-ABC)
Magnetic Resonance Imaging (MRI)
Mental Competency Evaluation
Mental Measurements Yearbook, The
Mental Status Examination
Millon Clinical Multiaxial Inventory (MCMI)
Mini-Mental State Examination
Minnesota Multiphasic Personality Inventory (MMPI)
Neuropsychological Tests
Obedience to Authority: An Experimental View (Book)

Personality Tests

Polysomnography

Positron Emission Tomography (PET)

Psychodynamic Diagnostic Manual (PDM)

Qualitative Research

Quantitative Research

Rorschach Inkblot Test

Single-Photon Emission Computed Tomography (SPECT)

Special Education

Stanford Prison Experiment

Subjective Units of Distress Scale (SUDS)

Suicide Assessment

Thematic Apperception Test (TAT)

Wechsler Adult Intelligence Scale (WAIS)

Wechsler Intelligence Scale for Children (WISC)

Wide Range Achievement Test (WRAT)

Treatment

Acceptance and Commitment Therapy (ACT)

Acupressure

Acupuncture

Addiction Counseling

Adlerian Therapy

Advocacy Counseling

Anger Management

Animal-Assisted Therapy

Anxiety Reduction Techniques

Applied Behavior Analysis

Art Therapy

Assertiveness Training

Aversion Therapy

Behavior Therapy

Behavior Therapy with Children

Behavioral Activation

Behavioral Health

Behavioral Medicine

Bereavement Counseling

Best Practices

Bibliotherapy

Biofeedback

Biopsychosocial Therapy

Body Work Therapies

Bowen Family Systems Theory

Brief Dynamic Psychotherapy

Brief Therapy

Career Assessment

Career Counseling

Case Conceptualization

Case Management

Case Manager

Clinical Health Psychology

Clinical Mental Health Counseling

Clinical Psychology

Clinical Trial

Coaching

Cognitive Behavior Analysis System of Psychotherapy (CBASP)

Cognitive Behavior Therapy

Cognitive Behavioral Modification

Cognitive Problem-Solving Skills Training (CPSST)

Cognitive Remediation

Cognitive Retraining

Cognitive Therapies

College Counseling

Combined Treatment

Common Factors in Psychotherapy

Community Mental Health

Preface

The quest to understand mental health and its disorders is first noted in the writings of the ancient Greeks. With today's new technologies and constant research, scientists have uncovered many causes of mental disorders and conditions as well as new treatments to reduce symptoms as well as prevent these conditions. "Mental health" is a broad term that encompasses both dysfunction and well-being from conception through the life span.

The purpose of this encyclopedia is to provide a wide-ranging reference source on mental health and its disorders, written at a level accessible for upper high school and college students as well as for the layperson. The encyclopedia provides insights into the discipline of mental health and covers both healthy functioning and mental disorders or conditions, treatment methods, and factors that promote mental health and well-being.

Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being aims to open the door to mental health research for readers, as well as direct them to accurate and current resources for further investigation.

Scope

This encyclopedia helps the reader understand mental disorders and their treatment as well as normal development and prevention of mental illness. This reference work covers virtually every topic and consideration involving mental health. The reader will find that the 875 entries in this three-volume work comprise six areas of emphases:

- Mental disorders and conditions. These include both common and relatively rare disorders. Also included are diagnostic characterizations that follow the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, commonly known as DSM-5.
- Treatment of these disorders. These include prescribed medications, psychological therapies, and herbs and other natural remedies.
- Tests and assessment methods used in evaluating or diagnosing mental conditions. These include standardized paper and pencil tests as well as biological and brain-imaging methods.
- Common psychological terms and concepts associated with mental and emotional well-being.

- Highly regarded individuals and organizations influential in researching disorders, developing treatments, or fostering professional development.
- Popular and classic books and films as well as high-profile individuals and culture-changing events. These have significantly influenced our understanding of mental health and illness and are also profiled.

To increase readability, technical terms are defined near the beginning of most entries. Terms are also included in the glossary at the end of volume three.

Contributors

The 13 contributors to this encyclopedia are all uniquely qualified to speak with authority regarding at least one aspect of mental health and its disorders. They have formal training and experience in psychiatry, clinical psychology, clinical mental health counseling, or child and adolescent development. Most have specialized in working with children, adolescents, and young adults and recognize the critical role of culture in mental health and illness. The collective expertise of these contributors allows a much broader understanding of mental health issues than a single author could ever provide.

User-Friendly Features

Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being is organized in the customary A–Z encyclopedia format. At the front of each volume is an alphabetical listing of all entry headings ("Alphabetical List of Entries"), allowing the reader to scan the list of all entries. A "Guide to Related Topics" is an additional aid, listing all the entries in the book under broad topics. Readers can look under topics such as "Disorders," "People," and "Social Issues" to quickly see all the entries included for that topic.

All entries have a "See also" section that connects the reader to other relevant topics. For example, in the entry "Anxiety Disorders in Adults" the connecting and cross-references will direct the reader to other entries that discuss similar disorder symptoms (Agoraphobia, Generalized Anxiety Disorder, Panic Attack, Panic Disorder, Social Phobia, Specific Phobia), and various treatment methods and approaches (Antianxiety Medication, Antidepressant Medication, Cognitive Therapy, Exposure Therapy).

Further Reading and Selected Resources

Each entry also includes current, reliable sources for additional statistics, research, or consumer-friendly education. Books, articles, and websites are included, allowing the reader to choose the level of detail and depth for further data and material. "Recommended Resources," a specially chosen short list of good books and online resources that are helpful to the layperson or student, is featured at the end of volume three. That volume also includes the "Glossary" of terms, with succinct definitions or descriptions of concepts, disorders, treatments, tests, and important people. The "List of

Organizations" features more than 120 groups and resource centers, ranging from the Albert Ellis Institute to the Association for Applied Sport Psychology to the Workplace Bullying Institute. The encyclopedia concludes with a comprehensive index.

Where to Start?

Obviously a reader's starting point is individually driven; however, if you are interested in a specific mental disorder, please read that entry first and follow it up with reading the "See also" selections. If you are using this reference for a research paper on a specific topic, simply start at the index or list of entries to guide you through the encyclopedia. Moreover, the further reading sections at the end of every work will provide you with additional references for your investigation. Finally, if you have an inquisitive mind and are a lifelong learner, allow yourself to be immersed in this ever-growing field of mental health as detailed in entries in these three volumes. You will find interesting and valuable information about this ever-developing field that may just pique your interest as it has mine.

Concluding Note

While this encyclopedia broadly overviews the expanding field of mental health in its extensive number of entries, it does not provide complete information on any one topic. The "Recommended Resources" section at the end of volume three provides readers with additional information to explore selected topics more fully. Furthermore, the material in this encyclopedia is not intended to be used for diagnostic purposes or for psychological treatment. While self-knowledge can be very helpful, it is not a substitute for professional help. Finally, because indications for psychological treatments continually change, readers are advised to seek updates from health professionals, professional literature, or authoritative websites.

Acknowledgments

This project was a joy to work on as it allowed me to share my passion about mental health and well-being with everyone. However, this project was enormous and could not have been completed without the help and devotion of my coeditors, Alexandra Cunningham, PhD, Melissa Mariani, PhD, Mindy Parsons, PhD, and Steven Vensel, PhD, and the other contributing authors.

Len Sperry, MD, PhD

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Introduction: Mental Health

Mental health is a continuum, ranging from states of well-being to stressful life experiences to severe mental disorders. We hope that readers of *Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being* will find it a useful reference source for specific purposes like academic assignments, term papers, job reports, or, more generally, for better understanding themselves and others.

This three-volume encyclopedia is subtitled *An Encyclopedia of Conditions, Treatments, and Well-Being*. The following paragraphs will focus on these three concepts: conditions or mental disorders, treatments, and well-being. Before that let's first look at mental health.

Mental Health

So what is mental health? Mental health can be thought of as successful mental functioning that results in productive activities, fulfilling relationships, and the ability to cope with change and adversity. Another way of saying this is that mental health is indispensable to effective personal functioning, interpersonal and family relationships, and community life.

Change exerts a constant influence on mental health and can be a major source of anxiety for many in their personal and professional lives. Change, by itself, whether for good or not, can be a source of stress and can negatively influence mental health. For example, technological changes continue at an accelerating pace, and while they can be useful to many individuals, they pose a stressful challenge to others.

Advances in health care can positively or negatively affect mental health. For example, older adults today have increased their life and health expectancies compared with Americans 10 years ago. That means that those over the age of 65 have fewer physical health concerns. But a decline in mental faculties among an increasing number of aging adults can create significant mental health concerns. For instance, dementia and Alzheimer's disease were not major health and mental health concerns in the past because relatively few lived past the age of 60. In 1900 there were 120,000 Americans over age 85, while today there are more than 4 million older adults of that age, making them the fastest-growing age group. The U.S. Census Bureau estimates that by 2030 there will be 72 million adults over the age of 65, which represents 20% of the American population. Among those 85 and older it is estimated that 50% will be diagnosed with Alzheimer's disease (Vincent and Velkof, 2010). The point of these examples is that mental health and mental disorders are influenced by various factors.

Mental Disorders

Mental disorders are primarily disorders of the brain. These conditions usually have multiple causes and result from complex interactions between individuals' genes and their environment. Lifestyle factors and health behaviors, like smoking and exercise, and life experiences, such as severe and prolonged stress or a history of abuse, are such factors. Typically, such factors interact with an individual's genetic or biological predisposition to a mental disorder. For example, a traumatic brain injury or a mother's exposure to viruses or toxic chemicals while pregnant may play a part. Other factors that can increase the risk for mental illness are the use of illegal drugs or having a serious medical condition like cancer. Research on the causality of mental illness has convincingly replaced the now-disproved belief that mental illness is a moral failure.

Mental illnesses occur at similar rates around the world, in every culture and in all socioeconomic groups. Statistics reveal that one in five individuals suffer from a mental disorder. This represents at least 20% of Americans. However, only one-fourth of those individuals with disorders are receiving treatment (SAMHSA, 2014). And, currently, only about 4% of America's health-care budget is spent on mental health treatment and prevention.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (called DSM-5), published by the American Psychiatric Association, provides a common language and standard criteria for the classification of mental disorders. It is the most commonly used clarification system in North America. It classifies mental disorders into categories. There are more than 20 categories of which the following are the most common.

- Anxiety disorders are disturbances in brain mechanisms designed to protect you from harm.
- Mood disorders are disturbances in usual mood states.
- Psychotic disorders are disturbances of thinking perception and behavior.
- Personality disorders are maladaptive personal characteristics.
- Eating disorders are disturbances of weight and feeding behavior.
- Substance-related and addiction disorders are disturbances of cravings.
- Neurodevelopmental disorders are early disturbances in usual brain development.
- Trauma- and stressor-related disorders are disturbances related to significant stressful events.

For example, post-traumatic stress disorder (PTSD) is one of the trauma- and stressor-related disorders. It is a common occurrence in those who witnessed or survived traumatic situations. Many veterans of the war in Iraq and Afghanistan suffer from PTSD and experience symptoms of flashbacks, nightmares, feelings of constant vigilance, and depression. But not all who were deployed to Iraq experience PTSD. Rather, it is most likely to occur in those with a biological predisposition.

Depression is a mental disorder experienced by more than 120 million American adults each year. Depression is a leading cause of drug and alcohol use. Sleep difficulties result in nearly 50 million prescriptions being written for sleep medications per year. Many individuals manage their anxieties by overeating or smoking. Over

time, unhealthy ways of coping take their toll on physical as well as mental health, particularly in those who are predisposed to such conditions.

Treatment

Significant advances have been made in the treatment of mental disorders. This increased understanding of the causes of mental health disorders (at least some of them) and increasingly effective treatments allow clinicians to better tailor treatment to those disorders. As a result, many mental health disorders can now be treated almost as effectively as medical conditions.

Generally, treatment for mental health disorders is characterized as either somatic (biological) or psychological. Somatic treatments include drugs, electroconvulsive therapy, and other therapies that stimulate the brain. Psychological treatments include psychotherapy (individual, group, or family and marital), behavior therapy techniques (e.g., relaxation training or exposure therapy), and hypnotherapy. Research suggests that for major mental health disorders like major depressive disorder, a treatment approach involving both drugs and psychotherapy is more effective than either treatment method used alone.

Clinicians who treat mental disorders include psychiatrists, clinical psychologists, mental health counselors, social workers, and psychiatric nurse practitioners. However, in most states, psychiatrists and psychiatric nurse practitioners are the only mental health clinicians licensed to prescribe drugs. Other clinicians practice psychotherapy primarily. Many primary care doctors and other medical specialists also prescribe drugs to treat mental health disorders.

Well-Being

In the past, mental health treatments focused largely on reducing symptoms or returning the individuals to their previous level of functioning. Today, however, treatment may also focus on increasing individuals' functioning, resilience, and prevention. This focus is known as well-being. Well-being is defined as how individuals think about and experience their lives. It is an indicator of how well individuals perceive their lives to be going. It reflects several health, job, family, and social outcomes. Accordingly, higher levels of well-being are associated with decreased risk of disease, illness, and injury. It is associated with faster recovery for illness, better immunity, increased longevity, and better mental health. Those with high levels of well-being are more productive at work, tend to get along better with others, and are more likely to contribute to their communities.

While there is not yet consensus among researchers or clinicians on the definition of well-being, most agree that well-being involves the presence of positive emotions and the absence of negative emotions. Most would agree that it includes satisfaction with life, a sense of personal fulfillment, and positive functioning. In short, it is about judging life positively and feeling good. Furthermore, most agree that well-being is broader and more inclusive than mental health. In fact, several kinds of well-being can be described and are currently being researched. These are physical well-being, economic well-being, social well-being, emotional well-being, and psychological

well-being. Depression, anxieties, addictive behaviors, and severe physical pain make it difficult to attain and maintain well-being. The reason is that these conditions interfere with the ability to see beyond one's immediate negative experience.

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Facebooking

"Facebooking" is a term used to describe the act of being on the popular social media site, Facebook, by posting messages, pictures, or updating one's profile. Facebook presently hosts some 1.39 billion monthly active users, as of December 31, 2014.

Description

"Facebooking" refers to using the social networking site, Facebook, to communicate with other people or post information about oneself. The word is used as a verb to describe when a person logs into the Facebook site to update information or to review the information posted by others. Simply the act of being on Facebook can be considered "facebooking."

"Facebook was founded by 19-year-old Mark Elliot Zuckerberg and his Harvard classmates Eduardo Saverin, Andrew McCollum, Dustin Moskovitz, and Chris Hughes in February 2004. This was the beginnings of the social networking service which would eventually be known as Facebook." The site began when Zuckerberg, immediately following a breakup with his then girlfriend, hacked into the Harvard networking system and started an online voting site where fellow students could rate the attractiveness of college co-eds. The site was originally known as "thefacebook.com" (the F in facebook was lower case). The site's popularity caught on quickly to other college campuses, even reaching to other nations. Legal controversy surrounded the company when two of Zuckerberg's classmates, the Winklevoss twin brothers, claimed that he stole the idea for the site from them. The lawsuit resulted in Zuckerberg settling for an undisclosed sum. Simultaneously, a legal suit from friend and partner, Saverin, also resulted in a large settlement. Facebook, however, continued to rise in popularity and profitability.

Impact (Psychological Influence)

Though Facebook was developed and intended for use by college students, it has become increasingly popular with youth and older adults alike. Users have to be 13 years or older. This drop in the age requirement from college age drastically increased membership numbers for the site. Users of Facebook post pictures, messages, and updates. Young and older adults use the site to stay in touch with friends and family and for networking purposes. Whatever the case, people can be found facebooking around the clock on home computers, laptops, tablets, and smartphones. At present, Facebook still remains a popular means for people to stay connected, but other social media sites, including Instagram (owned by Facebook), Twitter, Tumblr, and any number of dating and other sites help people connect electronically.

Melissa A. Mariani, PhD

See also: Electronic Communication; Social Media

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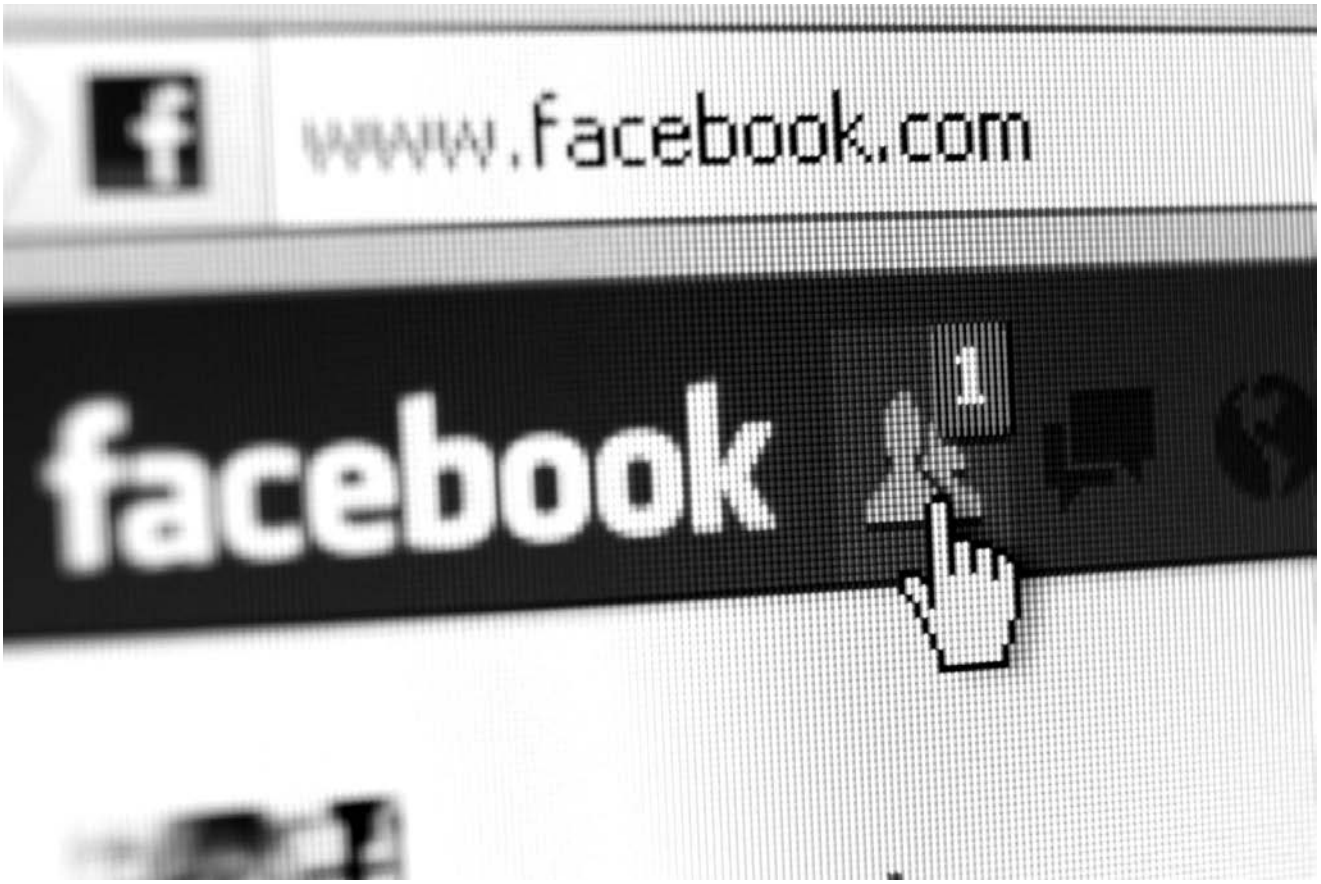

"Facebooking" refers to using the social networking site Facebook to communicate with other people or post information about oneself. Although the use of Facebook and similar sites is now widespread, some researchers fear that overuse may cause psychological harm. (Agencyby/Dreamstime.com)

Factitious Disorders

Factitious disorders are a group of mental disorders in which individuals intentionally act as if they are physically or mentally ill for no obvious benefit. It is also known as Munchausen syndrome.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) beliefs, behaviors, and emotions.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Ganser syndrome** is a mental disorder in which individuals give silly or absurd answers to simple questions.
- **Malingering** is the practice of intentionally exaggerating or faking physical or psychological symptoms for personal gain.
- **Munchausen by proxy** is a mental disorder in which caregivers fabricate or cause symptoms, falsify medical history, or tamper with laboratory tests in order to make a child appear sick.
- **Munchausen syndrome** is a mental disorder characterized by fabricated and convincing physical symptoms and a false medical history. It was named after Baron von Munchausen who is known for telling exaggerated stories. It is also known as factitious disorder.

- **Sick role** is the protective role given an individual with a medical or mental condition, which accords him or her special treatment and excuses him or her from specific expectations or responsibilities.
- **Somatic symptom and related disorders** are a group of DSM-5 mental disorders characterized by prominent somatic symptoms and significant distress and impairment. They include somatic symptom disorder and factitious disorder.

Description and Diagnosis

Factitious disorder is one of the group of disorders known as somatic symptom and related disorders. Individuals with this disorder seek or continue medical consultation for symptoms that they consciously have created. They make up and report symptoms such as dizziness, stomach pains, blackouts, and seizures. They may also contaminate lab samples or inject themselves with substances in order to create symptoms or get physicians to order various diagnostic tests. For instance, they may inject themselves with insulin to dangerously lower blood sugar in hopes of being hospitalized. Or, they may undergo unnecessary surgeries or other procedures.

The hallmark of this disorder is conscious deception. These individuals are not delusional nor psychotic. The purpose of their deception is get others see them as "sick" rather than some financial reward or an excuse from a responsibility. This disorder shares similarities with Munchausen syndrome, Munchausen by proxy, and Ganser syndrome, but it differs from malingering. Factitious disorder is sometimes diagnosed in health-care professionals and hospital employees.

The cause of this disorder is not well understood. It may be that biological, psychological, and environmental factors play a role in its development. Some diagnosed with this disorder report a history of abuse or neglect as a child. Others have a history of frequent illnesses, surgeries, or psychological symptoms. Others witnessed family members who were repeatedly hospitalized or had ongoing medical treatment. They may also have had a pattern of lying as children. Some have concluded that they are sick, are weak, or need the care of others. This conclusion is likely based on early experiences of being sick or of getting attention only when they were sick. Fabricating of symptoms may serve to confirm what they believe to be true about themselves. This core belief powerfully fuels their sick role behavior. Being faced with the challenges of adulthood, they may not know how else to be if not "sick." They may also not know how to connect with others outside of the sick role.

Treatment

The primary treatment for factitious disorder is psychotherapy. Cognitive behavior therapy can be used to change the thinking and behavior of individuals with the disorder. The basic goal of treatment is to modify their sick role behavior and reduce their misuse or overuse of medical resources. After this goal is met, treatment can focus on underlying psychological issues. This includes identifying and modifying maladaptive (faulty) beliefs about themselves and others. It can also focus on healthier ways of relating to others. Working with the family may be useful, particularly if family members have rewarded or reinforced the individual's sick role behavior.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Malingering; Somatic Symptom Disorder

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False Memory Syndrome

False memory syndrome is a condition in which a person believes he or she is the victim of abuse that in reality never actually occurred.

Definitions

- **Memory recovery techniques** include an array of methods including recovered memory therapy, hypnosis and age regression, guided imagery, dream interpretation, body memory, free association, past life regression, and the use of sodium amytal (so-called "truth serum").
- **Recovered memories** are the apparent recollection of childhood abuse of which the person had no previous knowledge prior to therapy.
- **Repression** is a Freudian defense mechanism in which memories of traumatic experiences are hidden from or "repressed" out of conscious awareness.
- **Syndrome** refers to a set of symptoms that occur together.

Description

"False memory syndrome" (FMS) is a term used to describe a condition in which a person's life is centered on a memory of a traumatic experience that did not actually happen. FMS is not characterized by specific memories but rather the absolute belief that the traumatic experience happened. These beliefs are so strong that it orients the person's personality and disrupts the development of other adaptive behaviors. People suffering from FMS may go to great lengths to avoid any evidence that might refute the memory, thus making recovery difficult.

Current Status and Impact (Psychological Influence)

The issue of false memories came about in the 1980s when, during that decade, thousands of adult children accused their parents of past sexual abuse and ritualistic satanic torture. These abuses had allegedly occurred years in the past, sometime decades, and had supposedly been repressed until the memory was recalled during therapy. There were a rash of lawsuits, arrest, and convictions all based on recovered memories of adult survivors with little or no supporting evidence. Large numbers of families were torn apart by these horrific accusations that included murder, incest, ritualistic satanic sacrifice, and torture. By the 1990s accused parents began to seek help and support in discovering what was causing their adult children to make these kinds of accusations. Concerned parents, mental health professionals, and researchers began to organize throughout the United States, Canada, and other countries. In 1992, a group of families, scientists, and mental health professionals affiliated with the University of Pennsylvania and the Johns Hopkins Medical Institution founded the False Memory Syndrome Foundation (FMSF).

Memory researchers began to study memory dynamics and how false memories are formed. Key findings have concluded that exposure to misinformation induces memory distortions and the development of false memories. Elizabeth Loftus, a leading researcher into the creation and nature of false memories, conducted over 200 experiments involving over 20,000 individuals. In one experiment the researchers interviewed parents, siblings, or close friends, who recounted three childhood events that adult research subjects experienced in childhood. They gave these subjects a written booklet describing in one paragraph each of the three events that actually happened and one event that did not. The fictitious story was that the subject as a five-year-old child had been lost in a shopping mall for an extended period of time, was crying, and was aided and comforted by an elderly woman before being reunited with the family. After reading each story the subjects were instructed to write about what they remembered or to indicate that they had no memory of the events. Each subject was then interviewed to examine how much detail they remembered of the events. Results indicated that almost 30% of the subjects claimed to remember the fictitious event constructed for them. This, and many other studies, provided evidence that people can be led to remember their past in different ways and that they can be coaxed into "remembering" events that never happened.

Memory recovery techniques (RMTs) were embraced by mental health clinicians and led to the sharp increase in unfounded abuse accusations. As the controversy increased, researchers began to focus on RMTs and how they were creating the false memories.

Although there are many memory recovery methods, some of which are used appropriately in other forms of psychotherapy, when used for the purpose of recovering repressed memories of abuse they share several commonalities. RMTs were based on the Freudian concept of repression, which has been studied and found to have no credible scientific basis. In fact, the evidence strongly supports that people do not forget horrific events and are seldom incapable of remembering their trauma. One of the strongest associated practices that led to FMS was that therapists believed that almost any behavioral health problem was a sign of underlying and repressed abuse. These therapists would suggest to their clients that the issue (depression, substance use, eating disorders, anxiety, etc.) is actually a sign of some kind of abuse that needed to be uncovered in order for the problem to be resolved. Clients were encouraged to explore their past and think about the horrible events that could have taken place. As they did so, they were often overwhelmed with strong feelings of revulsion when thinking about possible horrible events. They were informed that these feelings were evidence of abuse and not just normal feelings any healthy person would have when thinking about such horrors. Clients would have a sense of hope that their real problem was being addressed and would participate in the further "uncovering" of the root of the problem, which most often was identified as their abusive parents and what they had done to them. Thousands of families were torn apart as clients were instructed to cut off all contact with their parents.

By 2001 the FMSF had been contacted by more than 15,000 families who had been impacted by accusations from their adult children. Because of the destructive and injurious nature of the false accusations, victimized parents, and their adult children many of whom retracted their accusations, brought legal malpractice suits against the therapists and were awarded large financial judgments. Memory recovery techniques have been investigated and found to be highly associated with FMS. As a result of the intensive research aimed at understanding the nature of memory, most professional mental health associations caution the use of these techniques to their members. According to the FMSF, the number of new cases of FMS has sharply declined as articles, books, and academic materials are readily available and are often included in mental health education settings.

Steven R. Vensel, PhD

See also: Sexual Abuse

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Family Assessment

Family assessment is the evaluation of family characteristics, relationship patterns, and family dysfunction (disturbing behavior) and their influence on individual family members.

Definitions

- **Family resilience** is the ability of a family unit to cope with adverse events. The family is able to return to its prior state of healthy functioning.
- **Posttests** are tests given to individuals after specific training or instruction to measure the impact of the training or instruction.
- **Pretests** are tests given to individuals before specific training or instruction takes place to establish a baseline of achievement level.
- **Reliable** means that similar results will be achieved with repeated administration of a test.
- **Valid** means that a test is measuring what it was intended to measure.

Description

Family assessment is the gathering of information regarding family factors that impact individual family members. The information is collected from family members' reports and from outside observation by trained individuals. The basic premise of family assessment is that individual family members must be considered in the context in which they live. They are a part of a larger system and cannot be viewed separate from that system. Effective family assessment is based on a biopsychosocial approach. This approach considers the biological, psychological, and social factors that influence the family system and its individual members.

Family assessment measures are used with individuals, couples, and families. They identify presenting issues, distressing symptoms, and functioning status. They facilitate the process of identifying treatment goals, gauging treatment progress, and modifying treatment goals. Such measures are utilized to gather information regarding physical and emotional abuse, divorce and custody issues, family resilience, and communication difficulties. Family assessment may also be used as an intervention tool to provide support and encouragement to family members throughout the therapeutic process. Comprehensive family assessment requires a collaborative effort between therapist and family members. It engages individual members and results in important information regarding family strengths and weaknesses.

There are several types of assessments, including qualitative, standardized, observational, ongoing, and self-report assessments. Qualitative assessments involve gathering information in an unstructured manner, which results in subjective data. Standardized assessments are objective and considered statistically valid and reliable measures. Observational assessments require a trained individual to observe and log family and individual behaviors. Ongoing assessments are performed continuously throughout the therapeutic process instead of particular points in time (as with pretests/posttests). Finally, self-report assessments rely on each family member to rate his or her own feelings while taking part in particular activities. Each family member also rates other family members' behaviors.

Christina Ladd, PhD, and Len Sperry, MD, PhD

See also: Family Therapy and Family Counseling

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Family Constellation

Family constellation is the influence that a family can have on an individual member's personality development and life goals.

Definitions

- **Adlerian psychology** is an approach to psychology that understands individuals as social beings with a need to belong and strive for significance. It is also known as Individual Psychology.
- **Early recollections** is an assessment technique for analyzing the first memories that an individual can recall. Themes about individuals' personality including view of themselves and others are hypothesized with this technique.
- **Family dynamics** are the roles, relationships, structure, and functions of a family system.
- **Ordinal birth order** is the true order that an individual is born in a family, for example, being the first born, second born, or only child.
- **Psychological birth order** is the perceived position or role that an individual takes or is given in a family system.
- **Rudolf Dreikurs, MD,** was an American psychiatrist and educator known for advancing

Adlerian psychology through his writings and professional publications.

- **Theoretical orientation** is a theoretical explanation for the development of personality and also what causes human suffering.

Description

Family constellation is the dynamic that past family influences have on an individual's development. An individual's birth order can inform what role he or she plays in the family and how he or she subsequently acts as an adult. An individual's ordinal birth position has less influence than his or her psychological birth order. Early roles that individuals assume can have a significant influence on the development of their personality and life goals. The family climate is also a family constellation dynamic that consists of the values and degree of emotional warmth or lack of emotional support in a family. Family constellation also includes the relationships an individual has to siblings and his or her parents, but also his or her observation of the relationships between other relationships in the family. A child creates his or her own their definition of life and what life is like. Early recollections are asked to assess an individual's early goals and sense of belonging in his or her family or community.

The term "family constellation" comes from the Adlerian psychology literature. Rudolf Dreikurs (1897–1972) expanded Adlerian psychology by refining the use of Adlerian techniques with families. He developed a systematic way of assessing family dynamics based on birth order. Many therapists assess their client's family constellation regardless of their theoretical orientation. Therapists use information about their client's family constellation to better understand their clients and their presenting struggles. Family therapy can be utilized when family dynamics are dysfunctional and negatively impact the functioning of specific members in a family.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Adverse Childhood Experiences; Attachment Styles; Child Abuse; Early Recollections; Individual Psychology; Lifestyle and Lifestyle Convictions; STEP Parenting Program

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Family Education

"Family education" is the term for helping family members of people with mental disorders understand and cope with their relative's disorder and its impact on the family.

Description

The emphasis on family education in mental health is relatively new. This includes families who have members suffering from severe mental illnesses such as schizophrenia, major depression, or bipolar disorder. During much of the 20th century, patients with severe mental illness were confined to institutions. Many times this meant their families were not actively involved in treatment. Some clinicians, such as Gregory Bateson, thought that it was the families, especially the parents, who were in some way responsible for the mental illnesses of their children. Therefore, he and other like-minded mental health professionals viewed isolation from the family as a therapeutic necessity.

Straightforward family education is based on providing knowledge and support but does not involve the family in therapeutic interventions. There are differences and similarities between family education and psychoeducation. Psychoeducation is more therapeutic in its intention and purpose, whereas education concentrates on helping with basic understanding. Both approaches involve families learning about the disease of their family members in order to help them. It also aims to teach family members how to cope with their own feelings and behavior in the environment.

Development

Over the past 20 years, family education has come into its own as a science, with evidence that severe mental illnesses are overwhelmingly neurobiological in origin. This contradicts claims by Bateson and others that many conditions were based on family dynamics or dysfunctions. The emphasis in family education addresses the reality that when undetected and untreated, mental disorders often worsen. This means that neither the patients themselves nor their families are to blame for their mental illnesses. In fact, it is now recognized that families may actually be in a position to increase the effectiveness of therapeutic measures through their understanding and support.

There has been a rapid increase in family education about mental diseases, their symptoms, and their effects on the individual. The identification of a whole range of coping mechanisms that can help family members is a major goal of family education. This becomes especially important since the majority of those suffering from severe mental health challenges now live with their families. This represents a change from decades ago when people were isolated in hospitals. Families now provide housing assistance and help with daily living to their diagnosed family members. The range of the kinds of supports family members provide is vast. This includes helping the patient manage medications, get to medical appointments, support therapy, and avoid relapse. Family members also often provide financial support through identifying and accessing community services, social benefits, and entitlements that their family members are eligible for.

Current Status

The National Alliance for the Mentally Ill (NAMI) coordinates the efforts of thousands of support and family education groups in the United States. This organization is comprised of families and individuals seriously affected by mental disorders. The members of NAMI provide not only family education but support groups and political advocacy for the rights of those with psychiatric conditions.

Family education is now such an important and integral part of treatment that recommendations for how to work with and involve families have become part of best practice guidelines for clinical professionals in the field. Society has begun to change as well. Information and news about people with mental illness, especially schizophrenics, have become part of mainstream culture in movies, television shows, and more. Aside from gaining mainstream recognition, the scientific research has provided evidence that family education and support leads to improved patient outcomes.

Alexandra Cunningham, PhD

See also: Psychoeducation; Psychoeducational Groups

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Family Life Cycle

The family life cycle describes developmental stages that occur throughout the life of a variety of family structures.

Definitions

- **Blended families** are families in which one or both parents have children from a previous relationship and have merged to form a new family.
- **Empty nest** is a phrase that describes the family after all of the children have permanently left the home.
- **Extended families** consist of the parents and their children and other biologically related family members such as grandparents, aunts, uncles, and cousins. They may or may not live in the same household.
- **Nuclear families** are traditional families that are comprised of a cohabiting and committed couple and their biological children.

- **Single-parent families** are families in which children are being raised by one parent.

Description

Like individuals, families develop in progressive stages, with specific challenges and tasks to be accomplished before moving to the next stage. Family life cycle theory takes into account the individual developmental task of each family member and its impact on the family as a whole or interdependent system. Each family member is challenged to adapt to the needs of the family as family members move through their developmental stages. Numerous scholars have proposed theories about the family life cycle. Carter and McGoldrick (1999) identified the following six stages:

(1) Stage one, the unattached adult, occurs when a single young adult leaves home. The task in this stage is for the young adults to accept emotional and financial responsibility for their life. They must establish a sense of identity separate from that of their parents, establish intimate relationships, and develop work and financial independence.
(2) Stage two, newly married adults, is when the young adult gets married, bringing two families together. The task is to be committed to another individual and form a marriage. They must also realign their relationships with their extended families and friends to include their spouse. The final task in this stage is to prepare for childbirth and becoming parents.
(3) Stage three, the childbearing family, occurs when the couple begins to have children. This stage has distinct task associated with the ages of the children. The task with newborns and preschool children (birth to age six) is to accept new members into the family, adjust the marital relationship to include children, adapt to having less privacy and the energy demands of preschool children, join in parenting duties, and realign relationships with extended family members to include parenting and grand-parenting roles. The tasks related to school-age children (6 to 13 years old) include promoting educational achievement and the development of social skills.
(4) Stage four, the teenage years, occurs as the children become adolescents. The task is to increase flexibility and expand boundaries in order to give adolescents more freedom to participate in nonfamily experiences and increase their independence. The couple begins to refocus on midlife career and marital roles as well as begin to adjust to caring for aging parents.
(5) Stage five, launching, occurs as young adult children move out of the house. The tasks in this stage include accepting exits and entries into the family, adapting and redefining the marriage relationship to the "empty nest," developing new ways of relating with the adult children, adapting to in-laws and grandchildren, dealing with dependency needs and death of aging parents (grandparents), and preparing for retirement.
6) Stage six, retired adults, occurs as families move into later life. The tasks are to accept the shifting of generational roles, maintain personal and couple physical functioning and interest despite physiological decline, explore new family and social roles, and support the developing central role of the middle generation (adult children). The adult children now begin to take a more central role in the family and must make room for the wisdom and experience of their aging parents; they must provide support to the aging generation without being overly controlling. The aging parents must now face the loss of the spouse and others of their generation and ultimately prepare for their eventual death.

The family life cycle varies depending on the structure of the family. Divorce and remarriage offers additional complexity to the stages of family development. Carter and McGoldrick (1999) list three stages in the formation of post-divorce families. Stage one occurs as the individual recovers from the loss of the first marriage and enters into a new relationship. The task is to prepare for the complexity and difficulties in

forming a new family structure. Stage two occurs with the planning of a new marriage and family. This is a complex stage with many tasks, which include facing fears about a new long-term relationship that includes children from the previous marriage and possible children from the new relationship; navigating through the difficulties of becoming a stepparent; setting boundaries and developing a cooperative relationship with the ex-spouse/children's other parent; helping children work through fear, anxieties, and loyalty issues; and realigning relationships and maintaining connection with extended family members. Stage three occurs with a new marriage. Tasks include restructuring boundaries to include a new spouse, restructuring finances, assisting and supporting children's ongoing relationship with nonresidential parent, and becoming a stepparent.

Family life cycle theory identifies the stages and challenges an individual goes through from young adulthood to retirement as a member of a family. Successfully meeting the challenges and transitioning from stage to stage can have a profound effect on the quality of life children will have as adults. Disruptions can occur that have a negative impact on the family life cycle and include severe illness, death of a family member, poverty, and domestic violence. Skills that could not be learned in one stage can be learned in later stages. Families, like individuals, change, grow, and develop as time goes on.

Steven R. Vensel, PhD

See also: Divorce; Family Therapy and Family Counseling

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Family of Origin

"Family of origin" (FOO) refers to the family an individual grew up in and is recognized by mental health experts as having a significant influence on patterns of thinking, feeling, and behaving.

Definition

- **Family constellation** refers to the relationship characteristics within a family unit.

Description

The influence of an individual's FOO has long been recognized as having a significant impact on how people interpret events and respond to the world around them. Most mental health professionals use the term "FOO" as a general identifier when referring to experiences in childhood that influence current functioning. As a clinical concept, the term "FOO" is generally associated with family systems theory and most often attributed to Murray Bowen (1913–1990) family systems theory. As a general psychological concept, FOO influences have been recognized by most of the pioneering psychology theorist.

Early theorist Alfred Adler (1870–1937) recognized that interactions between parents, children, and siblings strongly impacted the development of children and had a lasting impact on adult behaviors. Adler conceptualized that individuals develop a "style of life" associated with growing up in a social and family context. Parent attitudes, parent–child relationships, sibling relationships, and family constellation, including birth order, all attribute to core repetitive patterns of thinking, feeling, and behaving. Every individual has a unique "lifestyle conviction" which characterizes his or her attitudes about life, self, difficulties, others, the other sex, and work. The attitudes and lifestyle convictions contribute to an individual's "private logic," which is an individual's characteristic way of thinking, perceiving, feeling, responding, and behaving. Adler referred to a person's subjective view of the objective world as "schemas of apperception." Since Adler's conceptualizations of schema of apperception, the term "schema" or "schemata" has emerged as a somewhat general term used by various psychotherapy disciplines when referring to FOO experiences and their effect on individual patterns of thinking, feeling, and behaving.

Impact (Psychological Influence)

FOO experiences and their link to adult (including college-age adults) problems in living have received

considerable investigation, with a clear link between the two in a variety of categories. A wide and deep literature exists, examining the effects of family dysfunction; parental alcohol abuse; child emotional, physical, and sexual abuse; neglect; and exposure to domestic violence on adult children. All of these childhood experiences have been linked to a wide variety of adult difficulties, including depression, anxiety, panic, problems with eating, substance use disorders, and suicide. Growing up in a dysfunctional family has also been linked to difference in marital satisfaction, with those growing up in healthier families experiencing greater marital satisfaction and fewer relationship problems as adults. Exposure to adverse childhood experiences, including having a parent with a severe mental illness or a parent who is engaged in criminal behaviors, has been linked to greater health risk and death from risk factors such as smoking, obesity, physical inactivity, and sexually transmitted disease due to a high lifetime number of sexual partners.

Although negative FOO experiences are associated with adult difficulties, they can be overcome. Psychotherapists provide two broad approaches to assisting people who grew up in dysfunctional homes. A schema-oriented approach such as Adlerian psychotherapy can be used to assist clients in recognizing and gaining insight into their FOO experience and its impact on their emotional, psychological, relational, and behavioral functioning. Psychotherapists may also choose a here-and-now cognitive approach, such as motivational interviewing, which requires no need to examine FOO experiences in order for change to take place.

FOO experiences have a deep and long-lasting impact on individuals throughout their life span, and these effects can have both positive and negative consequences. Because of the importance of FOO experiences, researchers will continue to explore ways to improve family functioning and enhance recovery methods for those exposed to adverse childhood experiences.

Steven R. Vensel, PhD

See also: Adler, Alfred (1870–1937); Adlerian Therapy; Bowen Family Systems Theory; Family Therapy and Family Counseling; Motivational Interviewing;

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Family Psychoeducation

Family psychoeducation is the process of teaching family members about psychological issues and strategies to helping a family member experiencing mental health issues.

Definitions

- **Psychoeducation** is the process of making a person, or his or her family, familiar with psychological disorders and concepts that support the goals of therapy.
- **Well-being** is the state of being happy, healthy, or successful.

Description

Family psychoeducation is the supportive learning approach for those affected by mental health issues and disorders. The goal of this element of treatment is to help therapists, clients, and family members work together to support health. Usually family psychoeducation is one part of a client's treatment plan and is considered secondary.

Psychoeducation to family members is usually facilitated by a mental health professional and can occur individually or in a group format. Groups for family psychoeducation are usually based on one or a group of diagnosis and a forum for members to meet other people who share similar experiences. The approach

can last anywhere from one session to years of individual and group education sessions.

It is important to provide education to the public about the honest and practical information about mental disorders. More serious conditions such as schizophrenia, bipolar disorder, and major depression are disorders that have been well researched and understood. Providing easily understandable explanations of these disorders and ways to support people diagnosed is a major function of psychoeducation. This often occurs with the client with the disorder themselves along with their family members.

Many people find that family psychoeducation in groups is important because it allows them to feel less lonely and enables them to participate in their family member's treatment. Individual treatment outcomes have been shown to improve when families are educated and supported through psychoeducation. There are specific elements that need to be in place for family psychoeducation to be effective. These include accurate education about the disorder, resources to handle crises, skills training and problem-solving opportunities, and time for emotional support.

Family psychoeducation is usually structured in three phases and functions based on six principles. Families will engage in the phases of psychoeducation, which include joining with the therapist and group members, engaging in a workshop or learning experience, and being involved in follow-up or ongoing sessions. Often these phases occur across a series of approximately 10 sessions but can be shorter or longer-term that that.

The principles of practice for family psychoeducation hope to guide the mental health professionals responsible for implementing this service. The first principle is that the client defines the meaning of family and who that includes. This allows for flexibility and the client to invite a variety of social supports to be included and support him or her in treatment. The second principle stresses the importance of the therapeutic relationship among the counselor, client, and family members. Trust has to be established among all of the people involved in treatment.

The third principle in providing family psychoeducation is that education and resources are an essential part of treatment. In order to support this, the fourth principle insists that ongoing guidance and skills training are important as well. This ensures that clients and families get new skills for managing the issues that accompany mental disorders. The last two principles are to assist families with problem solving and to provide this in an emotionally supportive environment.

Current Status

Research to support the impacts of family psychoeducation is vast. In some studies, family psychoeducation has been shown to significantly reduce relapse and hospitalization for those with substance use disorders. It has also been proven to positively impact the well-being of the family. Families with better well-being reported being more knowledgeable, less confused and stressed, and more connected and were not as physically ill. Research has also demonstrated that those who were involved in family psychoeducation have improved employment rates.

There are several disorders that family psychoeducation has been researched and has positive results. Those include bipolar disorder, major depression, obsessive-compulsive disorder, and borderline personality disorder. Instances in which groups have been measured effective have occurred in both populated and more rural areas and across gender, culture, and socioeconomic factors. The implementation of family psychoeducation is fairly low cost and helps to lower incidents of medical care needed and crisis interventions.

Alexandra Cunningham, PhD

See also: Family Education

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Family Therapy and Family Counseling

"Family counseling" and "family therapy" are synonymous terms used to describe a form of therapy that

focuses on at least two or more members of a couple or family unit that works to improve relationships and communication. Instead of focusing on a single individual, family counseling involves the family being treated as a whole unit using one of the various psychotherapy approaches to improve communication and family relationships.

Description

Family therapy has also been referred to as marriage and family counseling, and family counseling and family systems therapy. This form of therapy works specifically with families and couples who are engaged in intimate relationships to help foster change and growth. There are numerous schools of family therapy that use various approaches to working with the family or couple, including multigenerational family therapy, conjoint family therapy, symbolic-experiential family therapy, structural family therapy, strategic family therapy, solution-focused therapy, feminist family therapy, and cognitive behavior therapy.

Family therapy is focused on either a couple engaged in a relationship or a couple with their children. It can also include extended family members or more than two generations either for one session or for multiple sessions depending on the needs of the family.

Development

Family counseling and therapy was introduced in the early half of the 20th century. The formal development of family therapy dates to the 1940s and 1950s with the American Association of Marriage Counselors which was founded in 1942. This organization was the precursor to the American Association for Marriage and Family Therapy (AAMFT). Initially family counseling was strongly influenced by psychoanalysis, with significant contributions from learning theories and behavior therapy.

Originally, key therapists such as Carl Rogers and Sigmund Freud believed that while family life was an important factor in shaping an individual's life, it was actually the beliefs that the individual held about his or her family that was most critical. However, in the 1950s, work from clinicians such as Jay Haley and Virginia Satir introduced ideas focusing on the roles of communication in the family. The 1960s brought more schools of thought into family therapy looking at the system of the family and functioning within that system. Moving forward from the 1980s, many practitioners have utilized techniques from various schools of thought and adapted them to the particular family's needs.

Over the past 40 years, family counseling has come into prominence. The rise in popularity has followed the changes in the American family. From a fundamental standpoint, family counseling is different from individual counseling. There is an intimacy and intensity that is present in the work that makes it unlike any other treatment.

Murray Bowen was one of the original creators of mainstream family therapy. His approach has often been called multigenerational family therapy. He put an emphasis on the family of origin and encouraged the exploration of this through creating a genogram with his clients. The genogram is a graphic display of family connections going back ideally at least three generations. It allows for the participants to identify patterns within their family as well as ways of communicating and maintaining relationships.

Current Status

There were three important trends that occurred in the United States that impacted the growth and development of family counseling. The first was that at the end of World War II there was a sharp increase in the divorce rate. Ironically enough this was also the time of the baby boom, which began in 1946. The second trend was the change in the role of women. After the war, more women were seeking employment that was outside of the home. This impacted family dynamics, and some social changes were unsettling for family members. The third trend was the expanding life span. People, family members, being impacted by these changes set the path for new conceptualizations and ways of working together.

Family counseling recognizes the importance of the family on the individual. The emphasis in family and counseling is on the dynamics between family members, thereby allowing various perspectives for the clinician. When looking at family counseling, there

is generally an identified patient, who is viewed as the cause of the trouble within the family unit. However, most clinicians do not view one member of the family as the problem but rather look at the whole picture. There is an emphasis on allowing the family to be greater than the individual parts, meaning that the patterns need to be examined as opposed to simply the actions of one member. There is also a strong focus on all behaviors as a form of communication, meaning we must look at both what is being said and how it is being interpreted.

The education of family and marital counselors has had guidelines put in place by the AAMFT. These standards are based on those created by the Commission on Accreditation for Marriage and Family Therapy Education. It has been estimated that 50% of all problems that a client comes to counseling to work on are related to marriage or family issues or concerns. All individuals have to at some point acknowledge the ability to interact and develop cohesion with others. Looking at it from the family perspective can allow for growth in other arenas.

Mindy Parsons, PhD

See also: Adler, Alfred (1870–1937); Bowen Family Systems Theory; Conjoint Family Therapy; Haley, Jay (1923–2007); Kim Berg, Insoo (1934–2007); Minuchin, Salvador (1921–); Satir, Virginia (1916–1988); Strategic Family Therapy; Structural Family Therapy

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Organizations

American Association for Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314-3061
Telephone: (703) 838-9808
Fax: (703) 838-9805
Website: www.aamft.org

American Counseling Association (ACA)
5999 Stevenson Ave.
Alexandria, VA 22304
Telephone: (800) 347-6647
Fax: (703) 823-0252
E-mail: info@aca.org
Website: http://www.counseling.org

American Family Therapy Academy (AFTA)
150 Summer Street
Haverhill, MA 01830
Telephone: (978) 914-6374
Fax: (978) 914-6374
E-mail: http://www.afta.org/contact
Website: www.afta.org

American Psychological Association
Division 43: The Society for Family Psychology
750 First St, NE
Washington, DC 20002-4242
Telephone: (202) 336-6013
Toll free: (800) 374-2721
E-mail: apa@psych.org
Website: http://www.apa.org/about/division/div43.aspx

International Association of Marriage and Family Counselors (IAMFC)
A Division of the American Counseling Association
6101 Stevenson Ave.
Alexandria, VA 22304
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E-mail: webmaster@counseling.org
Website: http://www.iamfconline.org/

Fatigue

Fatigue is a temporary state of listlessness, lack of energy and motivation, or feeling of general malaise, which is commonly experienced from normal, everyday activity but may also signify an underlying medical problem.

Definitions

- **Chronic fatigue syndrome** is a prevailing state of exhaustion that lasts longer and is more profound than normal, day-to-day weariness and can result in diminished physical, mental, and emotional capacity often requiring one to seek medical or psychological intervention.
- **Major depression** is a clinical psychological diagnosis that persists over time and is characterized by overwhelming feelings of sadness, hopelessness, and difficulty engaging in normal everyday activity.

Description

Fatigue is a temporary state of physical, psychological, or emotional tiredness that can affect one's level of productivity. People suffering from fatigue report being overtired, overworked, feeling run-down, lifeless, and depleted of energy. One can experience mild fatigue after engaging in excessive activity, either physical or mental, and also from lack of or too much sleep or food/drink. Cold or flu symptoms may also produce this state. Most often fatigue is the result of an individual's habits or routines, including physical exertion or cognitive demands; however, fatigue can also signify an underlying medical condition. Normal, or acute, fatigue is common, and nearly every person struggles with bouts of fatigue from time to time. Healthy individuals are usually able to resolve fatigue symptoms within a few hours to a day with proper care. One must be concerned when fatigue begins to interfere with regular everyday life and does not resolve itself within a few days. Certain health problems may be associated with abnormal levels of fatigue, including some forms of cancer, diabetes, allergic reactions, respiratory complications, immune disorders, adrenal diseases, thyroid conditions, and viral infections.

Chronic fatigue is a syndrome characterized by persistent listlessness and lack of motivation. Those suffering from this condition find it difficult to even get out of bed each day. This condition can be the result of or lead to major depression. Unlike normal fatigue, those suffering from chronic fatigue require medical assistance from a health-care practitioner or mental health provider.

Current Status and Impact (Psychological Influence)

Fatigue is common and is listed as one of the top 10 complaints reported by patients when they visit the doctor. Some 5%–20% of the general population specifies this as a health concern. Fatigue is twice as common in women than men. Those who are overweight, smoke, and consume alcohol are also more likely to report feeling fatigued. Inactive people are twice as likely to complain of exhaustion than those who engage in daily activity. There is great overlap, near 90%, between individuals diagnosed with chronic fatigue syndrome and major depression. Health-care professionals encourage people to develop proper nutrition, sleep, and exercise patterns and manage stress appropriately in order to prevent fatigue.

Melissa A. Mariani, PhD

See also: Major Depressive Disorder

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Feeding Disorder of Infancy or Early Childhood

"Feeding disorder of infancy or early childhood" is the label that describes the persistent failure of the child to get adequate nutritional intake, as reflected in significant failure to gain weight or significant weight loss over at least one month in the absence of gastrointestinal or other medical conditions.

Definition

- **Feeding** is the act of eating, taking, or being given nourishment.

Description

Every child needs adequate nutrition for both physical growth and brain development, which is why severe feeding disorders in infancy can be life threatening. Approximately one-fourth of normally developing infants and up to 80% of those with developmental delays suffer from feeding problems. About 3% of pediatric hospital admissions are for problems with failure to thrive/feeding.

This disorder is equally common in both girls and boys. Some infants and children develop a nonphysically based reluctance or distaste for eating, which affects their ability to grow and thrive. For feeding to successfully support development, the parent who feeds the child and the infant need to be supported adequately. What might seem like the simplest of functions can be a source of multiple problems. This includes the physical way the child is fed but also the social and emotional dimensions of feeding.

Even when the child is getting nutrition, there can be a range of problems associated with feeding, which can involve a complicated process of mistakes, missteps, and misunderstandings. As the child matures enough to interpret the parents' behavior around feeding, the negotiations that occur between parent and child around the feeding process can provide a forecast of future interactions around many other daily tasks.

Causes and Symptoms

Although specific causes of this feeding disorder are often unknown, it is clear that a variety of factors are involved. These can include poverty, dysfunctional child–caregiver interactions around food and feeding, or parental misinformation about the appropriate diet needed to meet the child's needs. This can lead to attempts to either overfeed or underfeed. The child may also have developed fears or stress around eating due to previous physical experiences, such as choking, or dislike for the taste or smell of certain foods or, finally, to caregiver alienation or aggression. Among the symptoms are weight gain or loss, constipation, vomiting, excessive crying, excessive sleepiness or lethargy, and irritability, which seem to have no physical cause.

Diagnosis and Prognosis

Adequate diagnosis ideally requires a multidisciplinary team whose members can bring their expertise to bear on the specific functions that have gone awry. Ideally, this team should include the following: pediatricians, outreach nurses, dietitians, social workers, behavior specialists, and parents. When possible the team should include a psychiatrist or clinical psychologist competent with psychodynamics in order to assess (a) the parents in regard to their mental status, attachment system, and temperament, (b) the child's development, and (c) the parent–infant interactions especially in regard to temperamental fit and communication.

The prognosis for infants and children with this disorder depends very much on the speed with which the problem is addressed. If addressed early and quickly, the condition is usually mild and resolved easily with minimal long-term impact. If left untreated, however, feeding disorders can lead to delayed physical and mental development that may have an effect on the rest of the child's life.

Treatment

If the condition of the infant or child is severe, hospitalization may be required in order to efficiently increase the number of calories and amount of fluid taken in. The child should also be checked for any vitamin or mineral deficiencies. Ongoing treatment is best done in the context of the whole family, with the support and direction of the multidisciplinary team. Various interventions and activities will be used, such as sessions with the parents to help them understand the reasons for the problem. Nutritional supplementation for the child is a critical intervention. Treatment for any psychologically based physical feeding problems, such as reflux, is also important. Therapy, including practice, with both parents and infant to relearn the feeding process is helpful. Occupational therapy

assessment and strategies are useful to work on specific feeding sensitivities.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Eating Disorders

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Feeling Good: The New Mood Therapy (Book)

Feeling Good, The New Mood Therapy was written by psychiatrist David D. Burns, MD, who studied under the founder of cognitive behavior therapy, Dr. Aaron T. Beck. It was first published in 1980 and has been revised.

Description

This self-help book was written to offer practical advice, insight, and hope to those struggling with depression and specifically for those who are looking for treatment without medication by using the principles of cognitive behavior therapy (CBT). Its author teaches at Stanford University School of Medicine and played an important role in popularizing CBT. The foreword in the book was written by noted psychiatrist Dr. Aaron T. Beck, the developer of CBT and under whom Burns studied.

Challenging traditional psychiatric views that depression was an emotional disorder, Burns emphatically states that each and every bad feeling is a direct result of distorted negative thinking and that these negative thoughts are the root cause of self-defeating emotions. He emphasized that feelings are created by thoughts and have nothing to do with actual events. Burns can take some credit for the explosion of popularity for cognitive therapies. Since the release of his book, CBT has become one of the most widely used and researched therapies throughout the world. Beck credits much of his work in CBT to Dr. Albert Ellis, who created rational emotive behavior therapy.

As a self-help book, it offers an adjunct to traditional therapy, as it quickly became one of the most recommended books by clinicians. In fact, to date, *Feeling Good: The New Mood Therapy* has sold more than 4 million copies and has been published in more than a dozen countries around the world.

Impact (Psychological Influence)

Nearly two decades after it was published, a survey of the top recommended self-help books among mental health professionals ranked Burns's *Feeling Good* as the number one most helpful book on depression. The *Feeling Good Handbook*, also by David Burns, was ranked second.

One study was published in 2010 on the use of bibliotherapy. In this study, one group of depressed patients were assigned to read the book *Feeling Good*; another group of depressed patients were prescribed antidepressants. When results were compared, both groups showed statistically significant increases in quality of life and a reduction in depressive symptoms. Notably, one group achieved those results through reading and the other group through medication. The study's results offered evidence that the group that read *Feeling Good* was as effective as the group taking antidepressants.

Mindy Parsons, PhD

See also: Beck, Aaron T. (1921–); Bibliotherapy; Cognitive Behavior Therapy; Ellis, Albert (1913–2007); Rational Emotive Behavior Therapy (REBT)

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Female Brain, The (Book)

The Female Brain is a controversial book that came out in 2006 written by American neuropsychiatrist Louann Brizendine, which attempts to tackle the myth of the unisex brain.

Description

The 2006 book *The Female Brain* by Louann Brizendine spurred controversy based on its main theme that women behave differently than men due to hormonal differences in their brain chemistry. Brizendine, a neuropsychiatrist from the University of California at San Francisco and founder of the Women's and Teen Girls' Mood and Hormone Clinic, states that females have uniquely adept verbal abilities, are better at relationships, as well as reading others' emotional states, and are skilled at reducing conflict. The book provides many examples to support what Brizendine states are scientific facts. There are seven chapters in the book. They describe different stages of the female lifecycle, including puberty, motherhood, and menopause. Each chapter goes into detail about anatomical, structural, and hormonal/chemical makeups specific to women, which Brizendine connects to variations in thoughts, feelings, ideas, and ultimately behavior. Changes in estrogen, progesterone, oxytocin, and neurotransmitters, she states, significantly affect brain functioning, "hard-wiring" it to particular aptitudes and vulnerabilities. Differences in brain size and structure are also noted, including a more active prefrontal cortex responsible for regulating serotonin levels that calm the body down and higher activity in the hippocampus that is responsible for emotional memory. Variations in estrogen and testosterone levels can be distinguished in either the male or female brains as early as eight weeks in utero.

Impact (Psychological Influence)

Dr. Brizendine contends that her writings are based on research and medical science; however, critics have contested many concepts, arguing that they are rather gross generalizations. Supporters include Deborah Tannen of *The Washington Post* and Daniel Goleman, author of *Emotional Intelligence*. Critics include Cordelia Fine, author of *Delusions of Gender*, and phonetician Mark Liberman, who wrote a series of blogs attacking Brizendine's book. Some feminists, in particular, have attacked Brizendine citing that the ideas she presented supported misogynistic views that women are overemotional, hormone-crazed, and less intelligent than men. Despite mixed reviews, *The Female Brain* sold well and continues to spawn debate.

Melissa A. Mariani, PhD

See also: Feminist Counseling; Women's Mental Health Issues

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Female Development, Stages of

The five Female Stages of Development, also known as the Tanner Stages or Tanner Scale of Development, describe the physical changes that females go through during puberty.

Definitions

- **Growth spurt** refers to a sudden increase in height, weight, and other bodily developments that are typically experienced in the first year of life and again in adolescence during puberty.
- **Psychoanalytic sexual drive theory** refers to Sigmund Freud's theory that suggests that

anxiety and attachment problems reported in adulthood stem from unresolved issues from not adequately progressing through the five stages of sexual development: oral, anal, phallic, latent, and genital.

- **Puberty** is the process of physical changes that happen in a child's body, typically between the ages of 10 and 12 years, indicative of sexual maturation.
- **Tanner Stages/Tanner Scale,** identified by pediatrician James Tanner, describes the physical development of children, adolescents, and adults, specifically changes in their primary and secondary sex characteristics.

Description

There are stages that outline the physical changes that males and females experience as they progress through childhood, adolescence, and adult sexual development. These are commonly referred to as the Tanner Stages or Tanner Scale after their developer, British pediatrician James Tanner. The stages/scale describe development that typically happens for normal, healthy individuals around certain ages; however, every individual is unique and may progress through the stages differently. Physical measurements of development based on external primary and secondary sex characteristics including growth changes of the breasts, genitalia, testicles, and pubic hair are noted at each stage. According to this model, both males and females encounter five gender-specific stages of sexual development. These stages include prepubescence (Tanner Stage I), early puberty (Tanner Stage II), mid-puberty (Tanner Stage III), late puberty (Tanner Stage IV), and adulthood (Tanner Stage V). In females, Stage I typically occurs in children aged 10 and younger and is characterized by the absence of glandular tissue in the breast area and lack of pubic hair in the genital region. In Stage II, between the ages of 10 and 11½ years, breast buds begin to form, areola begin to widen, and a small amount of light, downy hair begins to cover the labia. A growth spurt also occurs around this time as females increase in height and weight. In Stage III, ages 11½ to 13 years, breasts continue to rise and fill out as do the areola and the genital hair becomes more coarse and curly and extends to cover a little wider area. This is also the most common age for a female to experience her first menses, or period. In Stage IV, females between the ages of 13 and 15 encounter further breast enhancement and continued growth and extension of pubic hair. Finally, in Stage V, ages 15 and older, the breasts have reached their final adult size with central projecting papilla and the pubic hair has extended out to the medial surface of the thighs.

Psychoanalyst Sigmund Freud was one of the first theorists to write about and openly discuss childhood sexual development. His *psychoanalytic sexual drive theory* posited that all human beings are driven by an instinctual libido that develops in five stages: oral, anal, phallic, latent, and genital. Each stage is focused on a different erogenous zone that is the source of the drive. The oral stage's focus is the mouth; the anal stage is characterized by the anus, bowel, or bladder; the focus of the phallic stage is on the genitalia; sexual feelings then dominate the latency stage, followed by matured sexual interests in the genital stage. Freud suggested that if a person does not progress healthily through each stage, then this could be a source of potential anxiety, fear, or distress later in life.

Current Status and Impact (Psychological Influence)

Though traditional stages of female development are still referred to, decreasing trends have been noted in mean ages, particularly in the United States. Young females are noting the onset of breast development as early as ages eight and nine. Developmental age shifts may be attributed to nutritional factors, exercise, exposure to hormones, and environmental factors. Children who mature earlier may be more likely to engage in sexual activity at younger ages, exposing themselves to consequences including teen pregnancy, transmitting or contracting STDs, and being involved in unhealthy relationships.

Melissa A. Mariani, PhD

See also: Freud, Sigmund (1856–1939); Psychosexual Development, Stages of

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Female Orgasmic Disorder

Female orgasmic disorder is a mental disorder characterized by difficulty in achieving or experiencing orgasms during normal sexual activity.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **DSM** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition is DSM-5.
- **Orgasm** is the peak of sexual excitation characterized by extremely pleasurable sensations.
- **Sensate focus exercises** is a form of treatment where individuals and couples are instructed to focus on physical sensation that gradually and systematically become more intense in nature. These are completed as exercises given by a therapist but completed in private.
- **Sexual dysfunctions disorders** are a group of mental disorders characterized by significant difficulty in the ability to respond sexually or to experience sexual pleasure. It includes delayed female organismic disorder and genito-pelvic pain/penetration disorder.
- **Systematic desensitization** is a form of cognitive behavior therapy that gradually exposes individuals to their phobia (fear) while remaining calm and relaxed.

Description and Diagnosis

Female orgasmic disorder is a sexual dysfunction disorder characterized by few or no female orgasms during otherwise normal sexual activity. This disorder ranges from a complete lack of orgasm to infrequent orgasm to marked reduction in the intensity of orgasm. There are two primary types of female orgasmic disorders. One involves acquired difficulty and the other describes the lifelong absence of orgasm. An important aspect of this disorder is that it describes a woman's subjective experience of both orgasm and the resulting distress. It should be noted that the experience of orgasm and sexual satisfaction varies significantly between individuals. Therefore, there is no "normal" experience that a clinician can use to make comparison. In addition, many with this disorder may experience other sexual dysfunctions disorders. Estimates of the prevalence of this disorder are not certain (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, for individuals to be diagnosed with this disorder, they must exhibit difficulty achieving orgasms between 75% and 100% of sexual episodes. This difficulty must persist for a minimum of six months and cannot be due to temporary distress resulting from the romantic relationship. One of the most important diagnostic criteria of this disorder is that it must cause significant distress. As it pertains to the DSM-5, a female may report sufficient satisfaction with sexual activity without experiencing orgasm regularly or at all; therefore, the diagnosis does not apply. In the United States, estimation of prevalence is not certain. Also, many women who suffer from this disorder may also suffer from some of the other sexual dysfunctions disorders (American Psychiatric Association, 2013).

The cause of this disorder includes physiological, social, and psychological factors. Some of the physiological ones include spinal cord injury, nerve damage, a history of pelvic surgery, and the use of antidepressants.

Some of the social and psychological factors include differing expectations and sexual experience between partners, cultural beliefs regarding sex, psychological trauma, and poor or distorted body image.

Treatment

Because of this wide range of causation of this disorder, there are various treatment strategies employed in its treatment. Treatment begins with a thorough evaluation. This includes physical exam, which rules out medical concerns and reveals possible physiological cause. It also includes a detailed developmental and sexual history. This history should include a careful assessment of the individual's sexual and relational beliefs and explanatory model (explanation) of the cause of the disorder. Based on this evaluation, a treatment plan is developed, which is tailored to individual's specific beliefs and explanatory model. Common treatment interventions include cognitive behavior therapy, systematic desensitization, and sensate focus exercises. Currently, there are no medications known to resolve the symptoms of this disorder.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Sexual Dysfunctions; Systematic Desensitization

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Female Sexual Interest/Arousal Disorder

Female sexual interest/arousal disorder is a mental disorder characterized by little or no sexual interest and arousal.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt an individual's daily functioning.
- **Diabetes** is a disease in which there are high levels of sugar in the blood and is usually a chronic (lifelong) condition.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Major depressive disorder** is a mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Sexual dysfunctions** are a group of DSM-5 disorders characterized by a significant disturbance in responding sexually or in experiencing sexual pleasure. This group includes erectile disorder, female orgasmic disorder, and female sexual interest/arousal disorder.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.
- **Thyroid disorder** is a medical condition affecting the thyroid gland's making and storing thyroid hormones. It is characterized by weight changes, irregular menstrual flow, and tiredness.

Description and Diagnosis

Female sexual interest/arousal disorder is one of the DSM-5 sexual dysfunctions. It is characterized by a lack of or significantly reduced sexual interest and arousal. The disorder is often associated with difficulties in having an orgasm, pain during sexual activity, very little sexual activity, and differences in sexual desire between partners. Individuals with this disorder often have difficulties in their relationships. For example, the male partner may feel that his sexual needs are not being met. This disorder is often associated with depressive disorders (e.g., major depressive disorder). If a woman has been diagnosed with a depressive disorder, this can contribute to a lack of desire for sexual activity. A woman with this disorder may not have realistic expectations regarding the appropriate level of sexual interest or arousal. For example, she may have a lack of information about sexuality (e.g., poor sexual techniques).

Other symptoms of this disorder include feelings of disconnection, isolation, or boredom during sex. These symptoms can interfere with sexual interest and arousal if a woman does not feel close to her partner and does not find sexual activity pleasurable. Another symptom of this disorder is self-image problems a woman has (with her body). She may be shy, embarrassed, and not want her partner to see her body undressed. Women with histories of emotional or sexual abuse, rape, incest, or other traumatic experiences may also contribute to a lack of interest or arousal in sexual activity.

The occurrence of this disorder as defined in the DSM-5 is unknown (American Psychiatric Association, 2013). The occurrence of problems with sexual arousal and low sexual desire may differ considerably in relation to culture, age, length of symptoms, and the existence of distress. With regard to the length (duration) of the symptoms, there are noticeable differences in the approximation of occurrence between short-term and long-term problems associated with lack of sexual interest. When distress about sexual functioning is required, the approximation of occurrence is considerably lower. Sexual desire may decrease with age for women. Furthermore, some older women report having less distress about low sexual desire than do younger women (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if an individual has a lack of or significantly reduced sexual interest and arousal as exhibited by at least three of the following symptoms. An individual must have a reduced or absent interest in sexual activity. The individual's sexual and erotic fantasies or thoughts must be reduced or absent. An individual is usually not receptive to a partner's attempts to initiate sexual activity (e.g., there is either no initiation or reduced initiation for sexual activity). During sexual activity there is absent or reduced sexual pleasure and excitement in nearly all or all sexual experiences. An individual's response to erotic cues (e.g., verbal, written, or visual sexual cues) is reduced or absent. During sexual activity there is reduced or absent nongenital or genital sensations in nearly all or all sexual experiences. All of the symptoms described must last for at least six months. All of the symptoms described must cause clinically significant distress to an individual. The sexual dysfunction cannot be better accounted for by a nonsexual mental disorder or cannot be the result of intense relationship distress (e.g., violent relationship with partner). The sexual dysfunction cannot be better accounted for by other significant stressors and cannot be caused by the effects of a substance or medication or another medical condition. If an individual is diagnosed with female sexual interest/arousal disorder, it must be specified whether it is a lifelong or acquired disorder. If the disturbance has been present since the individual became sexually active, it will be classified as lifelong. If the disturbance began after a period of normal sexual activity, it will be classified as acquired. Generalized (e.g., not limited to certain partners, stimulation, or situations) and situational (e.g., occurs only with certain partners, stimulation, or situations) must be included in the diagnosis. A specifier of the level of distress must also be included in the diagnosis. The levels include mild, moderate, and severe (American Psychiatric Association, 2013).

Some potential causes of this disorder may include temperament, environment, genetic, and physiological factors. Temperament factors include a woman having negative thoughts and attitudes about sexuality and possibly a previous history of mental disorders. Some environmental factors that may contribute to

this disorder include difficulties with one's partner, the sexual functioning of the partner, and the developmental history of the individual (e.g., early relationships with caregivers and stressful events during childhood). Some genetic and physiological factors that may cause this disorder include some medical conditions (e.g., diabetes and thyroid disorders). There seems to be a strong connection with genetic factors on vulnerability and sexual problems found in women (American Psychiatric Association, 2013).

Treatment

Treatment for this disorder may include psychotherapy and medication. Psychotherapy can be helpful for couples addressing their emotions, communication, and relationship problems. Individual or couples therapy can be beneficial. Problem-solving strategies related to sexual dysfunction may also be the focus of the therapy sessions. If an individual is taking an antidepressant medication, she may need to have this adjusted. Some effects of antidepressant medication can reduce sexual interest and arousal.

Elizabeth Smith Kelsey, PhD, and
Len Sperry, MD, PhD

See also: Antidepressant Medications; Depressive Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Psychotherapy

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Feminist Counseling

The feminist counseling approach, also referred to as feminist therapy, examines the influence of societal, political, and cultural factors specific to women in order to empower them to change, grow, and manage life's challenges effectively.

Definitions

- **Feminism** refers to the belief system or organized movement that advocates for equal rights between men and women.
- **Feminist therapy,** also called feminist counseling, is based on feminist theory which teaches that inequities between males and females exist in society and contribute significantly to the stress and anxiety women experience and that acknowledging these factors and dealing with them honestly can result in empowerment.
- **Sexism** defines prejudice or discrimination based on a person's sex or gender.

Description

Feminist counseling is a therapeutic approach that is based on feminist theory. It is also known as feminist therapy. Feminist theory posits that social, political, and other discrepancies between males and females exist in society based on underlying sexist views that men and women are not equal and should not be afforded the same rights. These beliefs, views, opinions, and their resulting consequences contribute to emotional and psychological stressors on women. The theory suggests that many of the problems women seek counseling for are the result of disempowering situations that they experience in their daily lives. Counselors or therapists who practice feminist counseling techniques work to empower women and encourage them to educate themselves and become active both socially and politically.

There are several guiding principles that dictate feminist counseling practice. One primary principle is the existence of an egalitarian relationship between counselor and client. Rather than regarding the counselor as an expert, the counselor and client are seen as equals who work together to achieve specific therapeutic outcomes. Another principle is the belief that the client has within her the power to grow and succeed.

This is referred to as a strengths-based approach to therapy where the client is seen as responsible for rescuing herself or solving her own problems. Accountability is another guiding principle. The counselor must remain accountable to the client and accept and validate her feelings and experiences. Acknowledging, educating, and empowering techniques are used to facilitate change. Lastly, the most important guiding principle of feminist counseling is a focus on the overall well-being of the client.

Development (History and Application)

Feminist theory emerged out of the Feminist Movement of the 1960s and 1970s. Feminists exposed examples of gender bias, inequity, and negative attitudes toward women in mainstream society. They also proposed that traditional psychological theories, such as Freud's psychoanalytic theory, portrayed women in a negative manner and failed to represent the female perspective. This is important due to the fact that women represent the majority of individuals who seek therapy. The female perspective is a unique one and should therefore be addressed by a counselor/therapist who understands, accepts, and can relate to that experience. Feminist theory is not concrete but ever changing, and it continually gets revised based on changing social contexts.

Current Status

Feminist theory and feminist counseling have contributed to further educating men and women on gender prejudice, bias, and sexism. Furthermore, the theory and practice have raised public awareness about the specific stressors and mental health issues that women face. One criticism of the approach is that it is a one-size-fits-all model that does not take into account individual circumstances. Another critique against the theory is that it attributes all female problems to some form of inequity or oppression. Some have suggested that this stance causes further divide between the sexes, blaming men for all that goes wrong with women.

Melissa A. Mariani, PhD

See also: Gender Issues in Mental Health; Social Justice Counseling; Women's Mental Health Issues

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Ferris Bueller's Day Off (Movie)

Ferris Bueller's Day Off is a 1986 American comedy film written, produced, and directed by John Hughes.

Description

Ferris Bueller's Day Off stars Matthew Broderick, Mia Sara, and Alan Ruck. Other notable actors include Jeffrey Jones, Jennifer Grey, Ben Stein, and Charlie Sheen. Broderick portrays a high school senior who decides to skip school with his girlfriend (Sara) and best friend (Ruck). The film is known for the character of Ferris Bueller, its humor and poignancy, and the redemption of Cameron Frye (Ruck). It is also known for breaking the fourth wall as when Bueller speaks directly to the camera, its use of Chicago as the film's backdrop, the 1961 Ferrari used in the film, and the iconic monotone line: "Bueller . . ., Bueller . . ., Bueller. . ." performed by economist Ben Stein. Themes include redemption, family relationships, teen angst, friendship, materialism versus relationship, and, in the words of Ferris Bueller, "Life goes by so fast, that if you don't stop and look around, you might miss it."

The film opens with Ferris Bueller (Broderick) deciding to skip school by faking an illness and convincing his best friend Cameron Fry (Ruck) to join him. Cameron is an unhappy, anxious, and gloomy individual living in an unhappy home. Ferris convinces Cameron to take his father's prized 1961 Ferrari California Spyder convertible. The two concoct a plan to

get Ferris's girlfriend Sloane Peterson (Sara) out of school and all three head off for a day in downtown Chicago. Meanwhile, the school's obsessive dean of students Edward Rooney (Jones), Bueller's arch nemesis, is sure Bueller is faking an illness to skip school and is determined to catch Ferris and make him repeat his final year in high school.

Arriving downtown, Ferris and company leave the car with two garage attendants who take the car on a joyride. The trio has a wonderful day doing whatever they want in the city, including having an expensive lunch, attending a baseball game at Wrigley Field, and a visit to the Sears Tower and the Art Institute of Chicago. During their time in Chicago, Ferris jumps up on a parade float and lip syncs and dances to the Beatles' "Twist and Shout." During this time Rooney, trying to prove that Bueller is faking, arrives at the Bueller home. Discovering that an intercom voice greeting is a recording, Rooney attempts to break into the home and is attacked by the family dog. Ferris's sister Jeanie returns home and mistakes a disheveled Rooney as an intruder and kicks him down the stairs and Rooney's wallet falls out of his pocket.

After retrieving the Ferrari the trio discovers that 100 miles have been added to the odometer. Fearing his father's reaction, Cameron becomes despondent. Back at Cameron's home they jack up the rear wheels of the car and put the car into reverse attempting to run the mileage backward. When it becomes obvious it is not working, Cameron has a cathartic moment. He realizes he can't continue to be afraid of a father who loves a car more than his own son; he tells Ferris and Sloane that he is tired of being afraid and putting up with everything. He will take a stand. In his anger Cameron kicks the front bumper of the Ferrari, damaging it. He is glad that he can't deny the damage he

Ferris Bueller's Day Off, starring Matthew Broderick as Bueller, is a 1986 American comedy film written, produced, and directed by John Hughes, who was responsible for a number of films exploring teenage identities. (Paramount Pictures/Photofest)

caused, making a confrontation with his father inevitable. He kicks the car one final time and the automobile falls off the jack, and with its wheels already spinning in reverse, it accelerates out the back window of the second-story garage.

Returning home Ferris is met by Mr. Rooney, who has finally caught Bueller in the act and will make him repeat the 12th grade. As he celebrates and gloats, Jeanie finds Rooney's wallet in the house and realizes he was the intruder. When Jeanie threatens to expose him to the police, Rooney accepts defeat and leaves. Ferris makes it to bed just in the nick of time before his parents arrive home from work.

Impact (Psychological Influence)

Ferris Bueller's Day Off was highly successful in the box office and with critics. It is considered an iconic classis of the teen genre. The film has been referred to as one of cinema's finest achievements, a brilliant masterpiece, and one of the greatest movies ever made. Roger Ebert referred to it as one of the most innocent and warm-hearted movies. According to the Internet Movie Database, the film has grossed over $70 million in the United States and was the 10th highest-grossing film of 1986. Rotten Tomatoes has given *Ferris Bueller's Day Off* a certified Fresh rating of 84%.

Steven R. Vensel, PhD

See also: Depression in youth

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Fetal Alcohol Syndrome

Fetal alcohol syndrome is a medical condition characterized by physical and mental abnormalities in the children of mothers with significant alcohol consumption during pregnancy.

Definitions

- **Alcohol-related birth defects** are the physical abnormalities that result from prenatal alcohol consumption.
- **Alcohol-related neurodevelopmental disorder** refers to the learning, cognitive, and behavioral problems caused by prenatal alcohol consumption.
- **Amniotic fluid** is the fluid surrounding a fetus within the uterus and protects the fetus from injury.
- **Behavioral therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **Central nervous system** is one of the two parts of the nervous system that contains the brain and the spinal cord. The peripheral nervous system is the other part of the nervous system.
- **Functional impairment** refers to problems associated with routine functioning including, but not limited to, social skill deficits, learning disabilities, communication problems, attention deficits, poor judgment, and academic difficulties. It may also be referred to as developmental disabilities.
- **Neurological impairment** refers to nervous system damage that may result in seizure disorders, epilepsy, impaired motor functioning, and poor eye–hand coordination.
- **Partial fetal alcohol syndrome** means that some fetal alcohol symptoms are present but not enough to warrant a diagnosis.

- **Philtrum** is the area between the nose and upper lip. In children with fetal alcohol syndrome, this area is smooth and flat.
- **Placenta** is the temporary organ that joins the mother and fetus for transferring oxygen and nutrients and eliminating wastes.
- **Structural impairment** refers to damage to the brain or brain structure. Brain damage may include deficits in learning, memory, emotion, and processing of visual and auditory information. Structural damage may include small head size.

Description

Fetal alcohol syndrome is the pattern of physical and psychological deficits (abnormalities) that can occur in a child whose mother drank high levels of alcohol during pregnancy. The degree to which these symptoms are experienced varies from one child to another. The effects of alcohol exposure on an unborn child may result in physical abnormalities such as growth deficiency, unusual facial features, central nervous system damage, developmental disabilities, learning disabilities, cognitive deficits, and executive functioning problems. More specifically, fetal alcohol syndrome may result in less than average weight and height, a short nose, low nose bridge, thin upper lip, small eye width, and smooth philtrum. Central nervous system damage may result in structural impairment such as small head size, neurological impairment such as epilepsy, and functional impairment such as learning disabilities and cognitive impairment. Psychological deficits may include social and behavioral difficulties such as academic problems, relationship difficulties, inadequate social skills, inability to adapt, lack of focus, and impulsivity. The four main conditions that must be present for a fetal alcohol syndrome diagnosis are central nervous system damage (primary criteria), growth deficiency, abnormal facial features, and exposure to alcohol in utero.

Fetal alcohol syndrome results from alcohol consumption during pregnancy. The alcohol passes through the placenta and reaches the fetus's developing nervous system. The alcohol remains in the amniotic fluid much longer than it remains in the mother's system. The alcohol negatively impacts the flow of oxygen and nutrition to the fetus. The amount of alcohol consumption that can cause damage to a developing fetus varies. The National Institute on Alcohol Abuse and Alcoholism considers heavy alcohol consumption to be five or more drinks during five or more days within a 30-day time frame. Fetal alcohol syndrome is one of the four fetal alcohol spectrum disorders. The other three are alcohol-related neurodevelopmental disorder, alcohol-related birth defects, and partial fetal alcohol syndrome.

Treatment

Fetal alcohol syndrome is not curable, but symptoms can be treated with medical and behavioral interventions. Medication may be prescribed for psychological problems either alone or in conjunction with behavioral therapy. Behavioral therapy can reduce symptoms associated with this condition.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Alcohol Use Disorder; Behavior Therapy; Developmental Disabilities; Psychopharmacology

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Fetishistic Disorder

Fetishistic disorder is a mental disorder characterized by repetitive and extreme sexual urges and sexually arousing fantasies involving nonhuman objects.

Definitions

- **Aversion therapy** is a form of psychotherapy designed to cause an individual to decrease or avoid undesirable behavior patterns by

conditioning the individual to connect the behavior with an undesirable stimulus.

- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Fetish** is a strong and unusual need or desire for an object, body part, or activity that causes a habitual erotic response or fixation.
- **Fetishist** is an individual who has a fetish for a specific object or situation.
- **Paraphilic disorders** are a group of DSM-5 mental disorders characterized by unusual sexual preferences and behaviors that are distressing or detrimental to one's self or others. They include exhibitionistic disorder, pedophilic disorder, and fetishistic disorder.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Selective serotonin reuptake inhibitors** are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain, resulting in symptom reduction. It is also referred to as an SSRI.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Fetishistic disorder is one of the DSM-5 paraphilic disorders. This disorder is characterized by repetitive and extreme sexual urges and sexually arousing fantasies usually involving nonhuman objects. The sexual urges and fantasies include suffering of oneself, one's partner, children, or other non-consenting individuals. Any object may become a fetish; however, the differentiating characteristic is its connection with sex or sexual gratification. An early indicator of this disorder is an increasing amount of time spent thinking about and touching an object of desire. The significance of the fetish object becomes more extensive over time. Sexual fetishes commonly involve underwear or other clothing. The texture of the clothing may be of importance and unusually includes silk, leather, or nylon. An attraction to a specific body part, such as breasts, hair, and feet, are examples of sexual fetishes. The form of an object may also play an important role in this disorder. Some individuals may become sexually aroused or have sexual urges from viewing or fantasizing about high heel shoes, boots, or lingerie. The presence of the fetish object may occur intermittently. For example, a fetish object may be necessary only during periods of stress in order to become sexually aroused. Other times, the individual can sexually perform and become aroused without the fetish or stimuli related to the fetish.

The occurrence of this disorder is difficult to access in the general population. While some individuals may seek treatment for this disorder, many others do not and continue to engage in fetishistic behavior in private. The fetish is usually not associated with criminal behavior. When fetishistic behavior is combined with other paraphilias or disorders, the result may involve criminal behavior. It is more common for males to have this disorder (American Psychiatric Association, 2013). The fetish usually begins during early adolescence and is likely to continue for most of the individual's sex like. For example, as an adolescent is masturbating and fantasying about the fetish object, the individual may suck, rub, or wear the item. An individual may even insert items into his or her body cavities.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if an individual has recurrent and intense sexual arousal for a period of at least six months from the use of highly specific focus on nongenital body part(s) and the use of nonliving objects as evidenced by fantasies, behaviors, or urges.

Significant impairment or distress in the individual's occupational, social, or other meaningful areas of functioning must occur as a result of the fantasies, behaviors, or urges. The fetish object the individual uses is not limited to clothing used in cross-dressing (e.g., transvestite) or in devices specifically used for the purpose of stimulating the genitals (e.g., dildo or vibrator). For an individual who is living in an institutional-type setting where opportunities to engage in fetishistic behaviors are restricted, the diagnosis must include the specifier "in a controlled environment." For an individual who has not exhibited any significant distress or impairment in social, occupational, or other important areas of functioning for at least five years, the diagnosis must include the specifier "in full remission." Additional specifiers must be included when and individual is diagnosed with fetishistic disorder. These specifiers include body part(s), nonliving object(s), and/or other fetishes (American Psychiatric Association, 2013).

There is no known cause of fetishistic disorder. Although the cause of fetishistic disorder is not clearly understood, there are some potential theories that have been suggested. A combination of psychological causes that focus around rejection and fears of inadequacy from normal sexual activity is one theory. Another belief is that fetishistic disorder develops from early childhood experiences. For example, an object may have been associated with a powerful form of sexual gratification or arousal. Sexual abuse is also suspected to play a role in some cases.

Treatment

Psychotherapy and medication are two common forms of treatment used for individuals diagnosed with fetishistic disorder. One form of therapy is called cognitive behavior therapy (CBT) and has been shown to be an effective with treating this disorder. CBT is built on techniques that reduce the distress associated with the fetishes. CBT primarily focuses on helping individuals take a look at their automatic thoughts that affect their mood and behavior. When an individual becomes more aware of his or her automatic thoughts, he or she may begin to learn to change his or her irrational (unreasonable) thoughts that lead to distress. Another type of treatment used for an individual with fetishistic disorder is known as aversion therapy. This involves presenting an individual with an unpleasant stimulus with the fetish as soon as the sexual arousal begins.

Medications are another effective form of treatment for this disorder. Several medications are available that hinder the production of sex steroids (estrogen and testosterone). When the level of sex steroids is decreased, sexual desire is reduced. An individual may have the ability to control his or her fetish without being preoccupied with sexual arousal. Selective serotonin reuptake inhibitors (SSRI) is another form of medication treatment used for individuals with this disorder. An SSRI is classified as an antidepressant and helps control paraphilia's symptoms that interfere with an individual's ability to function. Whether therapy or medication is used, the prognosis (likelihood) for removing a fetish is poor because most individuals do not have the desire to change such a behavior.

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See also: Aversion Therapy; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Paraphilic Disorders; Psychotherapy

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Fibromyalgia

Fibromyalgia is a medical condition characterized by widespread, unexplained pain and sensitivity to pressure or touch.

Definitions

- **Antidepressants** are prescription medications used to treat depression and depressive symptoms.

- **Antiseizure medications** are prescription drugs used to treat epilepsy (seizures) as well as burning, stabbing, and shooting pain.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **General anxiety disorder** is a mental illness characterized by a persistent state of worry or apprehension about an imagined danger.
- **Major depressive disorder** is a mental illness characterized by depressed mood or loss of interest in formerly pleasurable activities that lasts the majority of most days for at least a two-week period.
- **Medically unexplained symptoms** are subjective experiences of an individual that are abnormal for which medical doctors have been unable to identify a cause.
- **Rheumatology** is the field of medicine concerned with the painful disorders of the skin, joints, nerves, and bones of the body.
- **Somatic symptoms and related disorders** is a category of mental disorders in DSM-5 characterized by an individual's perception of bodily symptoms.

Description and Diagnosis

Fibromyalgia is a relatively common medical condition characterized by widespread, unexplained pain as well as sensitivity to pressure or touch in specific areas of the body. In addition to pain, individuals may experience trouble sleeping and feeling fatigued. This disorder occurs in about 2%–4% of adults, more often in women than in men. Those with fibromyalgia first seek the help of their primary-care health provider. In time, they are likely to be referred to a rheumatologist, a specialist in this disorder. This condition commonly co-occurs with certain mental disorders, including major depressive disorder and general anxiety disorder.

The symptoms of this condition are currently considered medically unexplained symptoms. As a result, there is significant debate about the causes and treatment of this condition among the professions. For example, medical professionals tend to view this condition as caused by an unknown physical factor. In contrast, mental health professionals tend to view it as partially caused by psychological issues. While fibromyalgia is not a diagnosis in DSM-5, some characteristics of this condition parallel elements of the somatic symptoms and related disorders category of disorders. Regardless of this debate, the condition affects the lives of many, is distressing, and requires compassionate treatment.

It is believed that certain genetic factors may make someone more susceptible to the manifestation of these symptoms than others. In addition to major depression and anxiety, individuals who are stressed or suffer from stress-related disorders are more likely to experience this disorder. Furthermore, individuals who have experienced physical or sexual trauma are also more likely to develop fibromyalgia.

Treatment

Because this condition is poorly understood, the method utilized in diagnosis is primarily ruling out other conditions. These individuals typically undergo a thorough physical exam, diagnostic body scans, and blood work before a tentative diagnosis can be made. Although most of the symptoms of fibromyalgia are nonspecific, individuals suffering from this disorder are likely to be unusually sensitive to touch in certain areas of their bodies. These areas include areas of the neck, elbows, lower back, hips, and knees.

The treatment of fibromyalgia is varied. Although a number of prescribed medications are used, there is no medication specific for the treatment of fibromyalgia. Instead, various medications are prescribed in hopes of relieving specific symptoms. These include antidepressants, antiseizure medications, and pain relievers. In addition, cognitive behavior therapy may be utilized. Somewhat surprising, one of the most effective treatments for this disorder is physical exercise.

Although a number of treatments are employed in the management of fibromyalgia, the condition is likely to be chronic. While not progressive nor life threatening, it is lifelong condition for many individuals.

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See also: Antidepressants; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Generalized Anxiety Disorder; Major Depressive Disorder; Medically Unexplained Symptoms; Somatic Symptom Disorder

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Figure Drawing

Figure drawing is a projective test used to gain insights into intelligence, trauma, emotional state, and relational interactions. Often used with young children, trauma survivors, and nonnative speakers, figure drawing offers a chance to access what may not be able to be expressed in words.

Description

Figure drawing is a popular, nonintrusive means of accessing the unconscious mind. It can offer a great deal of psychological information free of verbal camouflage and unhindered by linguistic barriers. As a result, therapists often use figure drawing tests and activities when working with young children, trauma survivors, or those who may be internalizing their true emotional states. The accuracy of figure drawing as an assessment tool varies constructs. For example, it offers modest validity for intelligence but greater accuracy in assessing the presence or absence of relational and emotional issues. Effective scales remain a challenge for those who use figure drawing, but improving standardized interpretation metrics is an area of ongoing and promising research.

It is an inexpensive and noninvasive assessment tool. However, depending on the population and area being measured, it offers only modest validity and may be best used as a starting point for therapeutic assessment rather than a firm measure of mental state, past events, or interactions with others.

Figure drawing activities attempt to provide a way for patients to easily express their inner psyche or prompt their memories for more details about past events. This might include basic Draw-A-Person (DAP) tests, asking children to mark touches on generic human body figures, or doing more advanced Kinetic Family Drawing activities, which seek to add motion to images to assess relational dynamics.

Development

The earliest figure drawing studies took place in Europe in the late 1800s and focused on children's drawings as a means of determining future personality and intelligence. Interest in children's drawings peaked between 1900 and 1915 before becoming somewhat eclipsed by other assessment methods for determining intelligence, mental state, and relational health. Yet figure drawing studies and assessments have been continuously conducted and are still well funded around the globe.

Many researchers seek to find the best use for figure drawings given the metric's inherent flaws. Once thought to be an appropriate metric for measuring childhood intelligence, figure drawing has instead been found to correlate more strongly with developmental state and socioeconomic status than true brain power, particularly for DAP tests. Figure drawing has also proved to be an error-ridden way to prompt young children to describe touches, trauma, and/or sexual abuse, with very low accuracy in multiple studies despite ongoing popular use in criminal justice settings (dolls in place of drawings did even worse as children were more likely to play with the dolls than accurately indicate past events, including those that had happened almost immediately prior to the test).

However, researchers around the world have found figure drawing quite useful for baseline analysis of

emotional states with regard to others, the environment, and past experiences in children and, more recently, adolescents. By looking at repeated symbols, placement of environmental objects, size, shape, shading, and proportions, researchers have found strong correlations between drawings and self-concept, body image, family dynamics, past trauma, and present mental well-being.

Current Status

In the last two decades, figure drawing has gained ground, and deeper, more accurate figural scales have been developed to boost empirical validity. While early figural scales focused on Caucasian body characteristics as norms and had limited ranges, more recent models incorporate broader body type possibilities and break down figure drawings into more specific variants. This gives a richer empirical analysis and lowers the chances of forcing participants into narrow, incorrect scale values.

Its modern popularity is also helped by figure drawing's noninvasive, low-cost, and easy-to-complete nature. This, coupled with the expansion of scales to include adolescent variables, has made figure drawing more accessible to educators and school psychologists who can quickly use it with students. Outside of pure diagnostic work, the shifted focus on DAP activities to indicate emotional states rather than intelligence has made figure drawing increasingly popular in trauma recovery and art therapy.

Mindy Parsons, PhD

See also: Expressive Arts Therapy

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Filial Therapy

Filial therapy is geared toward helping children aged 3 to 13 in their mental and emotional development by strengthening the bonds between the child and his or her parent or caregiver. The parent or caregiver is specially trained in child-centered skills to conduct weekly play sessions with the child that in turn creates a more secure bond and helps the child to become more resilient.

Description

Filial therapy is considered a strengths-based therapeutic intervention. Parents or caregivers are trained by the therapist to deliver child-centered therapeutic play sessions. Filial therapy empowers parents in building more satisfying relationships with their children. Family counselors have explained filial therapy as a way to bridge the gap between individual therapy for the child and therapy for the whole family.

The underlying principle of filial therapy seeks to make the parent the agent of change instead of the therapist. Parents are instructed on how to nurture their

children through child-centered skills that help them deepen their relationship and ability to connect with their kids. By actively working with parents through specific filial therapy training, parents are able to help create change and promote healing in their children simply by making their parent–child relationships stronger and healthier. Once the bond is stronger, it is believed that the children will in turn be more resilient, be able to withstand normal development difficulties, and be able to deal with other problems as they arise.

Filial therapy is a type of child-centered play therapy. The therapist or caregiver conducts weekly sessions with his or her child or children. The therapist provides consistent coaching, feedback, and support, but does not actually directly engage with the child. The goal is to empower the parents or caregivers in those interactions with the child and ultimately build secure relationships between them.

An important difference between traditional play therapy and filial therapy is that in play therapy it is the therapist who engages in play with the child, whereas in filial therapy it is the parent. Filial therapy play sessions typically last for 30 minutes, and the therapist discusses the child's progress with parents after each session.

Parents are taught that they must put their feelings and needs aside. The focus has to be on providing empathy and validation to the child. The parents conduct the 30-minute, nondirective play session. Four skills are taught to the parents to provide these sessions: structuring, empathic listening, child-centered imaginary play, and limit-setting. Filial therapy allows for parents to become responsive to their child's experiences and their internal needs focused on emotions. It also allows for parents to understand their child's developmental needs and challenges. Goals for children are focused on learning to express and accept their emotions, improve self-confidence, and develop coping strategies.

Filial therapy has also had implications beyond clinical practice. Parents and caregivers have found that by participating in this therapeutic model it has affected various other relationships in their lives. Parents have found positive changes in marriages, work relationships, peer relationships, and other familial relationships.

Development

Louise and Bernard Guerney developed filial therapy in the late 1950s and early 1960s as a new form of child-centered play therapy targeted toward children aged 3 to 13. It was important for the Guerneys to go beyond current models and create something that put parents or caregivers in the driver's seat of the session with their children. They felt that strengthening the bonds that parents have with children would be more effective than to have the therapist conduct the sessions.

Filial therapy was originally met with skepticism. However, research showed positive results both for children and for the relationship between the parent and child. In the original model, parents or caregivers met as a group to be coached and practice play skills before starting the weekly play sessions. The therapist would watch and then provide the parents with feedback. The first few sessions occur in the therapist's playroom before moving the weekly session to home. Filial therapy is an evidence-based treatment modality. Evidence has found it to be highly effective for various types of families and across cultures. Filial therapy can be adapted for younger and older children, but the ideal population is between the ages of 3 and 13.

Current Status

There are currently three models of filial therapy: the Guerneys', VanFleet's, and Landreth/Bratton's. Originally developed by the Guerneys, it has continued to be further developed by other clinicians and researchers such as Rise VanFleet and Garry Landreth with Sue Bratton. Landreth has emphasized that there be continued follow-up for parents through continued ongoing support. Landreth and Bratton created a standardized filial therapy format called Child-Parent Relationship Therapy.

Mindy Parsons, PhD

See also: Attachment Styles; Play Therapy

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Organizations

Association for Child and Adolescent Counseling (ACAC)
A Division of the American Counseling Association
6101 Stevenson Ave.
Alexandria, VA 22304
Telephone: 800-347-6647
Fax: (800) 473-2329
E-mail: webmaster@counseling.org
Website: http://www.counseling.org

Association for Play Therapy
3198 Willow Avenue, Suite 110
Clovis, CA 93612
Phone: (559) 294-2128
Fax: (559) 294-2129
E-mail: info@a4pt.org
Website: www.a4pt.org

National Institute of Relationship Enhancement and Center for Couples, Families and Children, founded in 1992 by Bernard Guerney
4400 East-West Hwy, Suite 24
Bethesda, MD 20814
Telephone: (301) 680-8977
Fax: (502) 226-7088
E-mail: niremd@nire.org
Website: www.Nire.org

Five-Factor Theory

The five-factor theory is a model used to classify five main personality factors. They are openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism.

Definitions

- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Factor** is a statistics term used to describe an underlying variable that explains other observed variables.
- **Personality** is the enduring pattern of perceiving, feeling, relating, and thinking about one's environment and oneself.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Trait** is an enduring pattern of behavior, thought, and emotion.

Description

The five-factor theory is a model used to classify five main personality dimensions or factors. It is sometimes called the "Big Five." This model was independently developed by several sets of researchers studying personality. They examined many different personality traits and found that there were five underlying factors for all of them. These were openness, conscientiousness, extraversion, agreeableness, and neuroticism. The five are represented by the acronym (an abbreviation formed from the initial letters of words) OCEAN:

- Openness to experience refers to an individual's adventurousness, imagination, and creativity. It is associated with intellectual curiosity, interest in the arts, and emotional sensitivity. Those with a high degree of openness tend to have unconventional beliefs and value new ideas. Individuals who are low on this dimension prefer familiarity, have conservative views, and may be resistant to change.
- Conscientiousness refers to an individual's sense of self-control. It is associated with

discipline, achievement, and planning. Those with a high degree of conscientiousness pay attention to details and prefer order. Individuals who are low on conscientiousness are impulsive and avoid responsibility.

- Extraversion describes an individual's sociability and assertiveness. Extraverts are outgoing, action-oriented, and energetic. Those who are low on this dimension are called introverts. They are quiet, are reserved, and require time to themselves.
- Agreeableness refers to an individual's desire for social harmony. This trait is similar to friendliness. Those with a high degree of agreeableness get along with others, value relationships, and seek to avoid conflict. Individuals low on this dimension place self-interest above the needs of others and are seen as hostile or uncooperative.
- Neuroticism is the degree to which individuals experience negative emotional states. Neurotic individuals are prone to anger, anxiety, and depression. They have difficulty regulating their feelings and tolerating stress. Those who are low on this dimension are calm, are emotionally stable, and can manage stress well. These personality factors are believed to be stable throughout life, especially once individuals reach adulthood. They are considered to be based on both biological and environmental factors.

A number of tests have been developed to measure these five dimensions in individuals. One of the most widely used is the NEO Personality Inventory. Research using this instrument has identified six additional aspects within each of the five traits. For example, neuroticism can be broken down into anxiety, hostility, depression, self-consciousness, impulsiveness, and vulnerability to stress. Openness to experience is represented by fantasy, aesthetics (art and beauty), feelings, actions, ideas, and values. The five-factor theory has been used in many types of research. This model has been shown to predict personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). It is also used to understand academic achievement and learning styles. For example, these five factors are related to grade point averages in college students. Success in work can be explained using the five-factor theory. Some businesses evaluate employees using this model. Good leadership skills have been associated with high levels of openness, while neuroticism often correlates to employee burnout. Despite having broad appeal, some have criticized this theory. Some argue that the theory is too simplistic because it focuses only on five personality factors. Other critics contend that it does not translate to some cultures and cannot explain early childhood experiences.

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See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Personality Disorders

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Flow, Psychological

"Flow psychology" refers to the state of total immersion and engagement while engaged in an activity.

Definitions

- **Intrinsic** means that some quality is part of the inherent and essential nature of a thing, occurring naturally.
- **Self-transcendence** is the sense of going or being beyond oneself, of overcoming the limits of the physical self.

Description

Psychological flow is the mental state of total immersion, involvement, and engagement in an activity. Sometimes referred to as "being in the zone," flow is

a state of complete and total immersion in an activity to the exclusion of everything else. There is no awareness of time, self, or others, only awareness for what is happening in the activity. Flow occurs in a wide variety of different activities. It occurs to professional and amateur athletes while skiing, playing golf, basketball, tennis, soccer, or driving a racecar, for instance. It occurs to artist, chefs, musicians, and actors. It occurs to hobbyists, electronic gamers, mechanics, and anyone who is involved in a passionate pursuit. It is a state in which nothing else matters and the experience is so fulfilling that people will do it no matter the cost, just for the sheer joy of it. A common example of flow is when individuals become so engrossed in video role playing games they forget to eat dinner or go to bed.

Flow psychology (Flow) was developed by Hungarian-born American psychologist Mihaly Csikszentmihalyi (1934–). Csikszentmihalyi referred to Flow as the psychology of optimal experience. Csikszentmihalyi believed that the best moments in life are optimal experiences in which the body or mind is stretched to the limit in a voluntary effort to accomplish something both difficult and worthwhile. An optimal experience is an end to itself, done for the sure joy of it with no expectation of some benefit; doing it is the reward. Csikszentmihalyi identified eight components to an optimal experience in order for Flow to occur.

The first component is that there must be a challenge that requires skill to accomplish. Optimal experiences are most often goal oriented, have rules, require concentration, and cannot be accomplished without skills. The second component is a merging of action and awareness. The actions required by the experience become spontaneous, automatic, performed with little or no conscious thought, with little awareness of self in preforming the actions required of the experience. The third component is that the experience must have clear goals and frequent feedback. A person must have a clear sense of how to measure progress toward that outcome. Goals may be self-determined such as when an artist sets a goal for the days painting, or measurable such as a level attained or distance run. Likewise, feedback may be subjective and reflective in nature, such as when a when a musician masters a new technique, or quantifiable, such as when a new next checkpoint is attained. The fourth and fifth components are that the experience requires concentration and a sense of control. During the experience the person is so focused that he or she is able to forget all of his or her problems; nothing exists except the experience. The sense of control doesn't mean being in control but rather that of exercising control over the situation and outcomes of the experience. The sixth component is loss of self-consciousness. When in an optimal experience, the awareness of self begins to diminish and all of the preoccupations with the self disappear. When there is no preoccupation with self, there is a sense of self-transcendence, a different way of being, an expansion of the concept of self and being a different kind of person. When the person is engaged in an optimal experience, time seems to pass differently. During the experience, time seems to stand still but after the experience, when out of the flow, there is a sense of "where did the time go?"

Psychological Flow theory and optimal experience are related to intrinsic motivation. Csikszentmihalyi believed that there is a relationship between the ability to experience Flow and the perceived levels of challenge and the skills needed to meet those challenges. For instance, when the challenge is low and the skills are low, a person experiences apathy or boredom. When the challenge is high and skills are low, a person experiences anxiety. When both the challenge and skills are either balanced, or where the challenge is just above the skill level so that an individual has to stretch to master the experience, Flow can occur.

The application of psychological flow has been the subject of research in fields such as education, sports, and video gaming. In education, Flow research has focused on the development of teaching activities to increase the likelihood of students being intrinsically motivated and engaged, in order to achieve a flow state. In sports, Flow research has focused on increasing athletic performance. Electronic game developers design games in which virtually all of the conditions for an optimal experience are met. The ability to easily enter a Flow state is one of the reasons video games are so popular.

Psychological Flow is a state of total positive immersion. Having the skills necessary to accomplish challenging task in which a person has a sense of being "in the zone" is part of an optimal experience.

The theory of psychological flow has provided insight into how people are motivated and engaged in a broad range of experiences.

Steven R. Vensel, PhD

See also: Motivation

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Focalin (Dexmethylphenidate)

Focalin is a stimulant medication prescribed for the treatment of attention-deficit hyperactivity disorder in children over the age of six and adults. Its generic name is dexmethylphenidate.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Attention-deficit hyperactivity disorder** is a mental condition characterized by a lack of concentration, impulsive or inappropriate behavior, and hyperactivity.
- **Dopamine** is a neurotransmitter (chemical messenger) in the brain that regulates concentration, impulse control, judgment, mood, attention, and disorders such as addiction, ADHD, and depression.
- **Monoamine oxidase inhibitors** are a class of antidepressant medications that inhibit several neurotransmitters, including serotonin.
- **Norepinephrine** is a neurotransmitter (chemical messenger) in the brain that regulates attention and drives the "fight or flight" stress response. It is also called noradrenaline.
- **Tourette's syndrome** is an inherited disorder characterized by tics (involuntary movements or vocalizations). Tics are preceded by a felt tension that is relieved after the tic is performed.

Description

Focalin is in the class of medications known as central nervous system (CNS) stimulants. It is used to treat poor concentration and impulse dyscontrol symptoms common in ADHD. ADHD and depression are believed to result from a decrease in norepinephrine. Focalin appears to work by increasing norepinephrine and dopamine levels in the brain. The result in an increase in attention span, mental focus, judgment, memory, and impulse control.

Focalin is commonly prescribed as a second choice of treatment for children and adults who do not do well on Ritalin, another CNS stimulant. Focalin comes in an extended release form (Focalin XR) and is favored over other extended release stimulants because the contents of capsules can be opened and mixed with applesauce for children who cannot, or will not, swallow large capsules.

Precautions and Side Effects

Focalin can be a habit-forming medication and should not be used for long periods or at higher doses than prescribed. It should not be used in those with a history of alcohol or substance abuse. It should be used with caution in those with bipolar disorder since it can trigger mania. Since it can lower seizure threshold in some individuals, it is not appropriate for use in those with a seizure disorder. Focalin should not be used by those with glaucoma (high pressure in the eye), Tourette's syndrome, or a family history of Tourette's. Similarly, it should not be used by those taking or have taken a monoamine oxidase inhibitor (MAOI) within the past 14 days. It must be used with caution in those with

hyperthyroidism, high blood pressure, liver function impairment or liver disease, kidney function impairment, or heart conditions. Dexedrine may be unsafe for use during pregnancy and breast-feeding, so its use is not recommended.

The most common side effects of Focalin include stomach pain, nausea, loss of appetite, and fever. Dry mouth and throat pain are common with the extended release formulation. Focalin can also cause a temporary slowing of growth in children. This is usually small and, in time, children usually catch up to within normal limits. Side effects that need medical attention include suicidal thoughts, confusion, chest pain, or heart palpitations, shortness of breath, restlessness, hallucinations (seeing or hearing things that are not really there), fainting, and seizures.

Focalin can increase, decrease, or alter the effects of other medications taken with it. These interacting medications include antidepressant medications such as MAOIs, selective serotonin reuptake inhibitors like Prozac and Paxil, and tricyclics such as Tofranil. Other medications are blood pressure drugs such as Catapres; cold or allergy medicines that contain decongestants; blood thinners; and seizure medicines such as phenobarbital, Dilantin, and Mysoline.

Len Sperry, MD, PhD

See also: Attention-Deficit Hyperactivity Disorder; Tourette's Syndrome

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Foster Care

Foster Care is the temporary placement of a child or infant with surrogate caregivers. Foster care was designed as a proactive attempt by society to address the needs of children in at-risk situations.

Description

Foster care is a protective intervention, but outcomes of foster care vary widely regardless of the child's situation on being placed in care (though most come from an environment of abuse or neglect). While some children benefit from foster care, others fail to thrive. Outcome differences in development, mental health, physical well-being, and societal adjustment have serious implications for long-term quality of life experience for children who have been placed in foster care.

Between 500,000 and 650,000 children in the United States are in foster care at any one time. Proponents of foster care note that 70%–80% of children in care were maltreated at home, and foster care is emphatically effective at stopping in-home abuse by biological parents. However, the demand for care exceeds the availability of caregivers by 30%–40%, adding an urgency to research and policy recommendations.

Historically, much of the research focused on the experiences of children in foster care. These turned up largely negative outcomes—poor adjustment, depression, substance abuse, sexual abuse, and poverty—particularly for girls and children in institutional settings instead of individual homes. However, more recent research has been able to dig more deeply into traditional findings, remove or lessen flaws and biases, and point policy makers in new directions.

Particularly in the past 10 years, research has been questioning existing approach of foster care by shifting the focus to the child's attachment ability and mental state. In the past, research focused on address gender, age at placement, mental health, physical well-being, commitment of caregivers, and frequency of reassignment. Yet these factors may have been red herrings in addressing true outcome-shifting factors.

Some children who enter foster care, particularly at older ages, experience negative outcomes. Drug abuse, sexual abuse, and increased rates of depression are higher among older foster children. However, some adolescents enter foster care and flourish, exhibiting resiliency and displaying no greater adjustment issues than youth who remain in their homes over the course of their lifetimes.

Current Status

New investments in randomized trials and longitudinal studies have yielded interesting results. In fact, when at last able to control for socioeconomic status and treatment histories, one team of longitudinal researchers seemed repeatedly confused by their subjects' nonconformity to "proven" facts about foster children's behavior and resilience. They were no more depressed than other children, no more likely to use drugs, and no more likely to be abused—with one notable exception. Children with specific, preexisting behavioral tendencies had particularly poor experiences in foster care and continued to have behavioral and adaptive problems even if they found a permanent, stable, and loving home.

It appears that the child's attachment and adaptive abilities are particularly critical in foster care success. This is true for all ages but particularly critical to be aware of when designing policies for infants and toddlers. New observational studies have illustrated that even infants can coach foster parents to conform to specific expectations around care (both in positive *and* in negative ways), perpetuating former care cycles. Researchers have thus been able to develop new coaching methods to create stronger commitment bonds that increase positive outcomes.

Another area of development is the realization that addressing children's behavioral problems requires a more nuanced and multifaceted approach. By identifying the root cause of behavior issues as the child's state and not the specific care environment, better support for the child can be given across multiple care experiences. This has the potential to reduce the negative effects of frequent caregiver changes and reduce poor academic performance, violence, substance abuse, and truancy—all stereotypical "foster care" markers that may have been mistakenly attributed for decades. Naturally, challenges do exist. Current foster care structures and regulations change slowly, and greater attention to mental health states makes it more difficult to blame "the system" for a child's ongoing problems.

Mindy Parsons, PhD

See also: Adoption; Child Protective Services; Group Homes

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Frames of Mind: The Theory of Multiple Intelligences (Book)

Frames of Mind: The Theory of Multiple Intelligences is a book authored by Howard Gardner, published in 1983, in which he sets forth his theory of multiple intelligences.

Definitions

- **General intelligence** is traditionally understood to be a measurable single capacity that every human being possesses.
- **IQ** stands for "Intelligence Quotient," which is a numerical score obtained on standardized tests of human intelligence.

Description

The book *Frames of Mind: The Theory of Multiple Intelligences* was authored by developmental psychologist Howard Gardner (1943–) and first published in 1983. The book posits Gardner's theory that human intelligence is not a single property of the human mind but rather a combination of eight distinct intelligences. Gardner defines intelligence as the ability to solve problems, or create products, that are valued in one or more cultural settings. According to Gardner all human beings possess various levels of multiple intelligences, no two people possess the exact same profile of intelligences, and intelligence is the way in which one carries out a task in virtue of one's goals. Gardner originally formulated seven intelligences: linguistic, logical-mathematical, musical, spatial, bodily kinesthetic, interpersonal, and intrapersonal. Since the first edition of the book, Gardner has added naturalistic and existential intelligences to the list.

Individuals who are oriented toward a linguistic intelligence are highly sensitive to spoken and written language and able to effectively express themselves. Authors, speakers, lawyers, poets, and song writers are examples of those who have high linguistic intelligence. Individuals who are oriented toward a musical or rhythmic intelligence are often very musically inclined and are able to hear musical patterns and recognize pitch, tone, and rhythms. Spatial intelligence involves an acute awareness of one's physical environment and the ability to see space in one's imagination. Architects, pilots, sculptors, and chess players are examples of people with high spatial intelligence. Individuals with bodily kinesthetic intelligence are agile and able to use their large and small motor skills to solve problems and handle objects skillfully. Actors, athletes, and dancers are examples. Interpersonal intelligence involves the ability to understand the intentions, desires, moods, needs, and motivations of other people. Teachers, religious leaders, and counselors are examples of professions where high interpersonal intelligence would be expected. Individuals with high intrapersonal intelligence are keenly self-aware of their own identity, abilities, motivations, fears, and emotional states. Naturalist intelligence involves sensitivity to the natural world, such as plants, herbs, minerals, seasons, animals, and other features of nature. Botanists, geologists, farmers, environmentalists, landscape architects, and chefs are examples of people who have high naturalist intelligence. Existential intelligence is the ability and inclination to ponder the questions of life, meaning, and existence.

Impact (Psychological Influence)

The theory of multiple intelligence (MI) has been embraced by some educators, and Gardner has been a proponent of incorporating MI into the classroom. Gardner argues that because children have a unique blend of multiple intelligences they learn in different ways and can be taught according to their MI profile. The idea behind the use of MI theory in education is not "how smart are you?" but rather "how are you smart?" This approach is considerably different than the prevailing educational approach, which regards intelligence as a single measurable capacity. Gardner's theory calls for a broader approach to education with teachers using different methods and activities to reach all students, not just those who perform well on IQ test. Gardner argues that IQ tests emphasize logical and linguistic intelligence and do not take into account any other types of intelligences. Some schools have worked to incorporate MI theory into their educational methodology in order to improve learning. There are numerous educational and self-help-style books written on MI topics addressing a wide range of educational and developmental aspects of the theory.

Contrasted to the positive response from the educational community, MI theory has been criticized by the psychological and other research communities for having no supportive empirical or experimental research that validates the theory. In spite of Gardner's claims of MI being supported by research, there are no publications from cognitive psychologists, cognitive neuroscientists, or evolutionary psychologists that indicate any research has been conducted to see if multiple intelligences exist or if they are just some kind of learning styles. There are no studies that offer any evidence that MI is a valid theory or to any of Gardner's (or MI supporters) claims about how MI is a superior measure of intelligence compared to general IQ measures.

Steven R. Vensel, PhD

See also: Emotional Intelligence; Intelligence Testing

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Frankl, Viktor (1905–1997)

Austrian neurologist and psychiatrist Viktor Frankl, a prominent figure in humanistic and existential psychology, is credited as the founder of logotherapy and author of the popular book *Man's Search for Meaning*, which details his experience as a Holocaust survivor.

Description

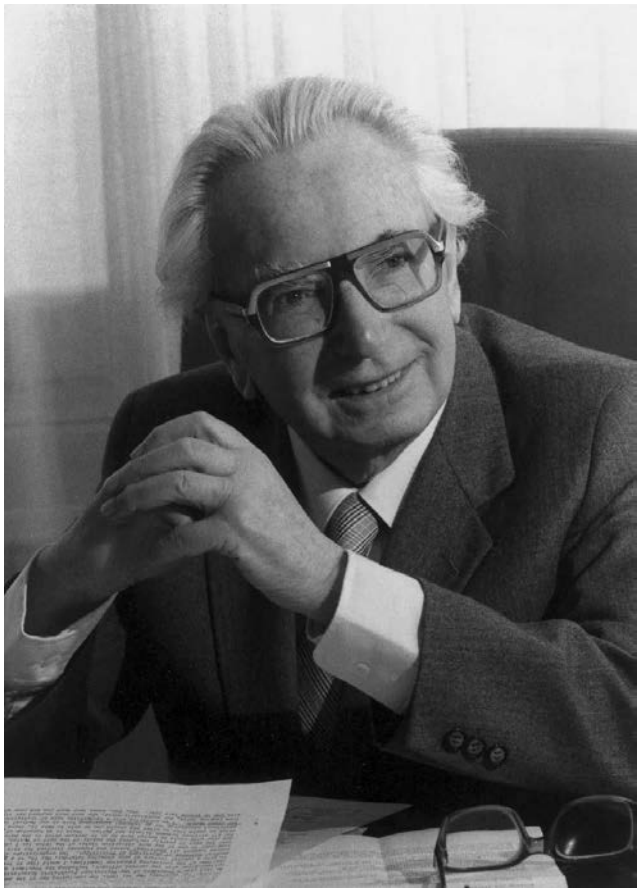
Viktor Emil Frankl was born March 26, 1905, in Leopoldstadt, Austria, the second of three children to Czechoslovakian-born parents, Gabriel and Elsa. Raised in the Jewish faith, Viktor had a happy childhood, showed early interest in his studies, and relayed hopes of one day becoming a doctor. His fascination with philosophy and psychology were also evident early on, and it is noted that Frankl wrote on these subjects on a final exam at *Gymnasium*, where he graduated from in 1923. He went on to pursue a medical degree at the University of Vienna, specializing in neurology and psychiatry. Frankl was particularly drawn to those suffering from depression and suicidal tendencies. As head of the neurological department at the Rothschild Hospital in Vienna during the early 1940s, he treated and prevented several Jewish patients from being sent to the Nazi euthanasia program. He married Tilly Grosser, in December 1941. In September 1942, Frankl, his wife, and his parents were sent to Theresienstadt, a Nazi concentration camp. Frankl, quickly recognized as a skilled doctor and psychiatrist, was permitted to work with struggling camp mates. In October 1944, he and Tilly were relocated to Auschwitz. He was later moved to Kaufering, a Dachau concentration camp, where he spent several months working as a slave laborer. Tilly was moved to the Bergen-Belsen camp, where she died in 1945. Frankl was later offered a move to Türkheim, a "rest-camp," where he served as a physician until his liberation by the Americans on April 27, 1945. Viktor and his sister Stella were the only immediate family members to survive the Holocaust. After his return to Vienna, Frankl wrote his famous work *Trotzdem Ja Zum Leben Sagen: Ein Psychologe Erlebt das Konzentrationslager*, translated in English to the title *Man's Search for Meaning* (1959), which recounted his three years in the concentration camps.

The prevailing theme from the book is that even the most horrific and painful circumstances can provide meaning in one's life. This theme is echoed in his writings on logotherapy and existential analysis. Existential analysis, considered the "Third Viennese School of Psychotherapy," in addition to Sigmund Freud's psychotherapy, and Alfred Adler's individual psychotherapy, is a therapeutic approach based on existential principles, which uses techniques including dialogue and questioning to foster meaning and develop insight about the human experience. Existentialism is a psychological theory which teaches that every individual consciously creates his or her own set of beliefs, values, and behaviors, by which he or she attributes meaning to his or her life. Logotherapy is a directive type of therapy developed by Frankl aimed at helping clients who are lacking purpose or exhibiting problem behaviors to find meaning; logotherapy literally means "therapy through meaning."

In 1946, he accepted a position as director of the Vienna Polyclinic of Neurology, where he remained until 1971. In 1947, he married his second wife, Eleonore Katharina Schwindt, with whom he had one daughter, Gabriele. In 1948, he earned a doctoral degree in philosophy. He died of complications from heart failure on September 2, 1997.

Impact (Psychological Influence)

Frankl taught at several higher institutions, including the University of Vienna, Harvard, Southern Methodist,



Austrian neurologist and psychiatrist Viktor Frankl, a prominent figure in humanistic and existential psychology, is credited as the founder of logotherapy. He authored the popular book *Man's Search for Meaning*, which details his experience as a Holocaust survivor. (Imagno/Getty Images)

and Duquesne University. He also received 29 honorary doctoral degrees from various universities all over the world. His works include 39 books, which have been translated in over 40 languages, the last of which were *Man's Search for Ultimate Meaning* (1997) and *Viktor Frankl: Recollections* (1997). The most popular and considered one of the most influential books of our time, *Man's Search for Meaning* is estimated to have sold over 9 million copies in the United States alone. In 1985, the American Psychiatric Association bestowed on him the Oskar Pfister Award for his significant contributions in the fields of religion and psychiatry, though he received many other awards and recognitions throughout his career. Viktor Frankl's logotherapy and existential analysis are regarded as the "Third Viennese School of Psychotherapy" and are likened to the contributions of Sigmund Freud's psychoanalytic theory and Alfred Adler's Individual Psychology.

Melissa A. Mariani, PhD

See also: Existential Psychotherapy; Paradoxical Intention

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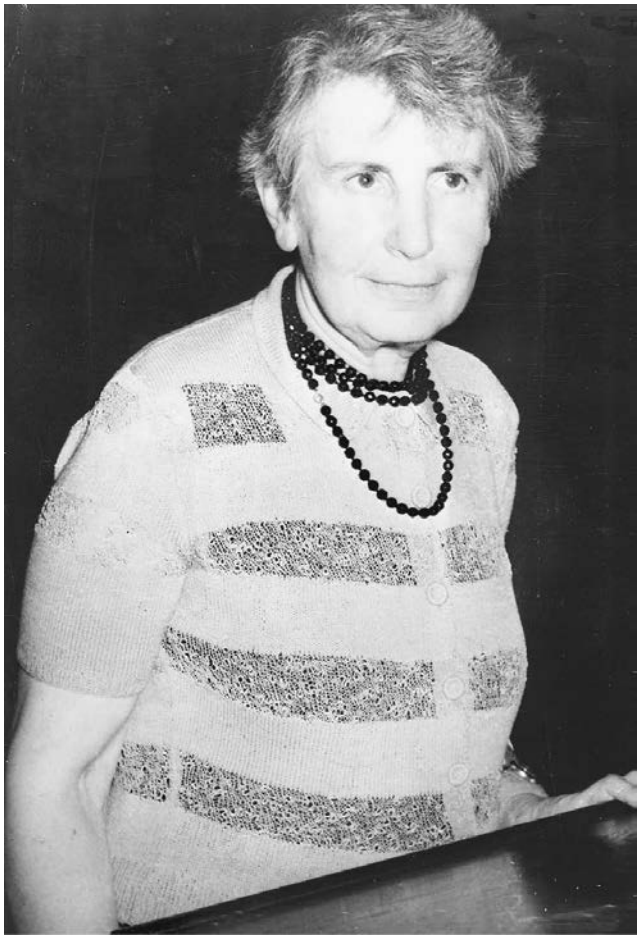
Freud, Anna (1895–1982)

Psychiatrist Anna Freud, daughter of Sigmund Freud, is best known for founding the field of child psychoanalysis.

Description

Born on December 3, 1895, in Vienna, Austria, Anna was the youngest of Sigmund Freud and his wife Martha Bernays's six children. She was a mischievous child who often fought with her siblings, in particular her 2½ year elder sister, Sophie, whom she was jealous of. Anna completed her education at the Cottage Lyceum in 1912 but was undecided about what career to pursue. She traveled alone to England in 1914 to improve her English but was sent back not long after once the war was declared. Her fondness for children led her to a teaching position back at her old school, the Cottage Lyceum, where she taught for years until moving into her father's career, psychoanalysis. Though Anna began reading Freud's writings several years earlier, it wasn't until he began to psychoanalyze her in 1918 that her interests in the profession peaked. She read, wrote, and participated regularly in conversations with Sigmund and his colleagues and later traveled together to the International Psychoanalytic Congress at The Hague in 1920. In 1922, Anna presented a paper titled "The Relation of Beating Fantasies to a Daydream,"



Psychiatrist Anna Freud shown in 1957, daughter of Sigmund Freud, is best known for founding the field of child psychoanalysis. (AP Photo/je)

a complete analysis of the sessions with her father, to the Vienna Psychoanalytic Society. Not long after, she was invited to be a member of the society. Freud then began working with children in private practice, laying the foundations of child psychoanalysis.

Now viewed as a leader in the field, Anna was first offered a teaching position at the Vienna Psychoanalytic Training Institute, which she accepted. In 1927 she became secretary of the International Psychoanalytical Association, serving in that role until 1934; then she became director of the Vienna Psychoanalytic Training Institute in 1935. Her most famous work *The Ego and the Mechanisms of Defense* was published the following year. In 1938 Freud fled with her family to England after the Nazis invaded. During that time Sigmund had been diagnosed with cancer and Anna cared for him until his death on September 23, 1939. Soon after she established The Hampstead War Nursery to offer foster care and other services to children who were victims of the war. Freud was deeply concerned about how stress and attachment disruptions experienced during childhood could later manifest into psychological disorders. She wrote about this in her book *Normality and Pathology in Childhood* (1966). In 1947 Freud began offering courses at the Hampstead with Kate Friedlaender to train therapists in how to effectively work with disturbed children. A clinic was added five years later to further meet the needs of young victims. Freud spent the remainder of her life traveling, teaching, and speaking internationally, traveling regularly to the United States, teaching at Yale Law School for a short time. She went on to receive a series of honorary doctorates beginning with Clark University in 1950 and ending with Harvard in 1980. Vienna University also awarded her an honorary medical doctorate. She died on October 9, 1982, in London. A year later, a collection of her works was published and the Hampstead clinic was renamed The Anna Freud Centre in her honor.

Impact (Psychological Influence)

Anna Freud is revered for the attention she provided and efforts she made to understand and improve the psychological wellness of children. At the time, psychological analysis had only been conducted with adults. As the founder of child psychoanalysis, she offered an alternative view for approaching therapy with children, emphasizing how disruptions in attachment and stressful experiences result in pathology. Child psychoanalysis uses both talk and play therapy to understand psychological processes and emotional disorders in children and adolescents. Anna Freud also expanded on her father's work in the area of ego psychology, where ego, according to psychoanalytic theory, is the part of the personality which operates according to the reality principle, mediating between basic impulses (id) and moral standards (superego). She also expanded on Sigmund Freud's work on defense mechanisms, which are the unconscious, maladaptive coping strategies that people use to prevent unpleasant feelings and experiences. The ego and

defense mechanisms are concepts that are central in present-day foundational psychology courses. Specifically, *The Ego and the Mechanisms of Defense* is a readily used text.

Melissa A. Mariani, PhD

See also: Defense Mechanisms; *Ego and the Mechanisms of Defense, The* (Book); Freud, Sigmund (1856–1939)

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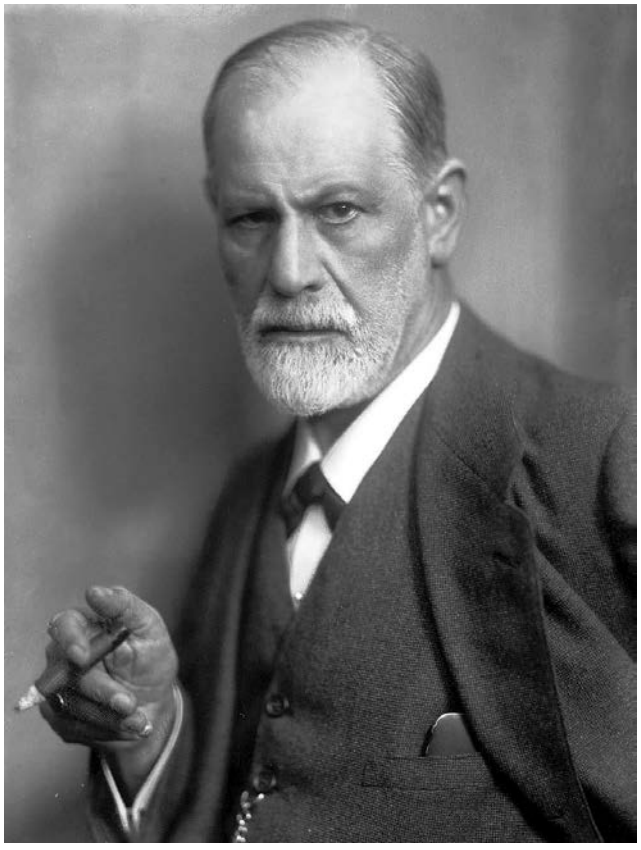
Freud, Sigmund (1856–1939)

Regarded as "the founding father of psychoanalysis" and considered one of the most influential thinkers of the early 20th century, Sigmund Freud's work as a medical doctor, physiologist, and psychoanalyst gave rise to many foundation concepts in the field of psychology. Psychoanalysis, developed by Freud, is both a theory and an approach to treatment that ascertains that people's thoughts, feelings, and behaviors are influenced by unconscious thoughts and the only way to resolve these conflicts and psychological well-being arises from bringing unconscious thoughts into awareness and making them conscious.

Description and History

Austrian psychoanalyst and neurologist Sigmund Schlomo Freud was born May 6, 1856, in Freiberg, Moravia, a small town in the Czech Republic, to Jakob and Amalia Freud, who raised their children in the Jewish tradition. When he was four years old the family relocated first to Leipzig and then to Vienna where Freud remained for the majority of his life. As a youngster Freud excelled in his studies beginning high school in 1865 at the prominent *Leopoldstädter Kommunal-Realgymnasium* and graduating with honors in 1873. He entered medical school at the University of Vienna, completing his MD in 1881. While working as a doctor and conducting research at Vienna General Hospital, Freud became engaged and later married Martha Bernays. The couple had a happy marriage, producing six children together; the youngest, Anna, also became a well-known psychoanalyst. Entering his private practice soon after, Freud began treating patients suffering from psychological illnesses. These clinical experiences provided much of the basis for his subsequent theory and treatment approach. In 1885–1886, he traveled to Paris to study hypnosis under French neurologist Jean Charcot and experimented with this technique on his return. He came to the conclusion that hypnosis did not appear to have lasting effects and later



Regarded as "the founding father of psychoanalysis" and considered one of the most influential thinkers of the early 20th century, Sigmund Freud and his work as a medical doctor, physiologist, and psychoanalyst gave rise to many foundation concepts in the field of psychology. (GL Archive/ Alamy)

abandoned it for a type of talk therapy, which he later termed "free association." Free association is a technique that is continued to be used in psychoanalysis, which invites patients to openly relay to the therapist, without any reservation, whatever thoughts, feelings, ideas, or experiences come to their minds.

Freud initially published his ideas on this approach in the 1895 book *Studies in Hysteria* with his Viennese colleague and friend Joseph Breuer. The two believed that traumatic life events deeply buried in one's unconscious were the cause of psychological disorders. The only way to resolve one's inner conflicts was to recall them, bringing them to the level of consciousness, where they could be dealt with. Breuer and Freud later parted ways disagreeing about the degree of emphasis Freud placed on sexuality, an opinion that was shared by many in the years to come. His psychosexual stages of development (oral, anal, phallic, latent, and genital) and Oedipus complex articulate the supposition that even small children are driven by sexual instincts, specifically that children may have suppressed sexual desires for their parent of the opposite sex. The next several years were spent in a period of introspection as Freud conducted his own dream analysis and in 1900 released his most popular work *The Interpretation of Dreams*. Freud's dream analysis was the process of assessing a dream's manifest and latent content to uncover its true meaning; Freud believed dreams to be "the royal road to the unconscious."

Much controversy surrounded his writings at this time, and several years passed prior to the psychological community recognizing him for his contributions. Soon after, he gained specific attention from a group of Viennese doctors, namely Wilhelm Steckel, Alfred Adler, Max Kahane, and Rudolf Reitler, with whom he formed a society of men who met regularly to discuss their ideas. This Psychological Society, which grew to attract others including Otto Rank and Carl Jung, spawned the psychoanalytic movement. In 1909, he traveled to the United States, which helped to boost his popularity, and received an honorary doctorate after delivering a series of lectures that were later compiled into the book *Five Lectures on Psycho-analysis*.

Freud's theory of the unconscious mind, as it was suggested and popularized by him, describes the human mind as being made up of both conscious (that of which we are aware) and unconscious (that of which we are unaware), and that the unconscious constitutes the majority of what drives one's thoughts, feelings, and behaviors. In his 1923 book *The Ego and the Id*, Freud introduced another foundational concept, a tripartite model of the mind comprised of the id, ego, and superego, each part responsible for specific conscious and unconscious processes. The id, present from birth, lies entirely in the unconscious, driving one's instinctual behavior and operating according to the pleasure principle. The ego functions in both the unconscious and conscious mind, and deals with reality. Lastly, the superego reflects one's moral judgment or "conscience." The remainder of Freud's life was devoted to his work as he regularly taught, lectured, and honed his theories. As the Nazi regime began its takeover in the early to mid-1930s, he and his family were eventually forced into exile to England in 1938. A lifelong tobacco smoker, Freud developed cancer, which he battled for years before eventually dying from the disease on September 23, 1939.

Impact (Psychological Influence)

Though Freud's work initially attracted many followers including Alfred Adler, Otto Rank, Carl Jung, and Abraham Maslow, many of these intellectuals would later diverge from Freud's theories to develop their own schools of thought. Despite the controversy surrounding his teachings, Freud remains revered for the significant contributions he made to the field. He has been professionally recognized on countless occasions receiving multiple awards and accolades both during his life and even after his death. His writings have influenced a wide variety of fields, including psychology, anthropology, philosophy, and semiology, and are considered some of the most influential academic concepts of the 20th century. Noted for developing the "First Viennese School of Psychotherapy," which is psychoanalysis, Freud's principles are still viewed as core psychological tenets, and his texts are included in foundational psychology coursework worldwide.

Melissa A. Mariani, PhD

See also: Defense Mechanisms; Freud, Anna (1895–1982); Psychoanalytic Theory

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Freud's Famous Cases

Sigmund Freud wrote about several clinical cases that influenced the development of psychoanalysis. Among the most famous cases were Anna O, Dora, Little Hans, the Rat Man, Schreber, and the Wolf Man.

Definitions

- **Oedipus complex** is the desire for sexual involvement with the parent of the opposite sex and a concurrent sense of rivalry with the parent of the same sex. Freud considers the complex a critical stage in normal developmental.
- **Psychoanalysis** is a theory of human behavior and a form of therapy based on psychoanalytic theory. In psychoanalysis, clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams. It was initially developed by Sigmund Freud.
- **Psychoanalytic theory** reflects a view of human behavior, which emphasizes the conflicts and compromises between the unconscious (internal) and conscious mind.

Description

Much of psychoanalysis grew directly out of Sigmund Freud's work with his patients in therapy. As he tried to understand and explain their symptoms, he grew increasingly interested in the role of the unconscious mind in the development of mental illness. His case studies largely influenced his understanding of human nature and the unconscious processes that influence thoughts, feelings, and behavior. They also provided him a rich source for developing the theory and practice of psychoanalysis.

The following are descriptions of six of Freud's most famous cases. They all include a brief note of how Freud's approach to psychoanalysis was influenced by the case. For most of the cases he treated, Freud assigned pseudonyms to protect patient's privacy.

Anna O. Anna presented with various hysterical symptoms (psychological conflict turned into physical symptoms), including paralysis. Anna began as the patient of Freud's colleague Josef Breuer. Breuer abruptly terminated treatment when his wife became jealous, suspecting that the young woman was experiencing sexual feelings for her husband. Breuer was called to Anna's bedside that same night to find her thrashing about in the throes of false labor, convinced she was pregnant with his child. Freud used the "cathartic method" (reexperiencing a trauma to relieve emotional suffering) Breuer had been using with Anna. Freud completed therapy with her and afterward, she become a social worker. Freud attributed hysterical symptoms to the unconscious mind's attempt to protect the patient from psychic stress. This case also provided Freud the basis for describing transference (the patient's unconscious feelings toward the therapist) and problem's with countertransference (therapist's unconscious reactions to the patient).

Dora. Dora was a teenager sent by her father to Freud for treatment of various hysterical symptoms. She was having sexual feelings toward an older male neighbor while her father was having an affair with that neighbor's wife. The father wanted Freud to bring Dora "to reason," by which he meant keeping her quiet about the affair. After 11 weeks of analysis and two famous dreams, Dora quit therapy claiming she was cured, although her conflicts reappeared. This deeply hurt Freud's feelings. Later, he would realize that hysterics often revealed unconscious conflicts in dreams and free association. He also identified the phenomenon of "flight into health," which is a temporary improvement in the early stages of psychoanalysis. Dora went on to become an unhappy spinster. This case is also known for the scientific empiricism of Freud's psychoanalytic method, as well as for its identification of transference. It is described by Freud in his account *A Case of Hysteria*.

Little Hans. Hans was a five-year-old who refused to leave his house for fear that a horse would bite him. Freud saw the boy only once and treated him by

proxy through his father. The problem began when his mother tried to stop him from masturbating by warning him that if he didn't stop a doctor would cut off his "widdler" (penis). Hans recognized that horses had large penises and that his mother had none. Soon castration fears (losing his penis) became mixed with his fears of competing with his father (Oedipus complex). Guided by Freud, Hans's father reassured the boy and was eventually able to help him overcome his fear. Hans was cured and grew up to be a musician, just like his father. Castration fears and the Oedipus complex would became important themes in psychoanalysis.

Rat Man. The Rat Man was an army officer who became extremely agitated after hearing a story of punishment of a prisoner of war. The prisoner was tortured when a pot of rats were overturned on his buttocks and gnawed their way into his bowels. The officer immediately imagined this happening to his father or his fiancé. Soon he developed obsessive thoughts to prevent it. Through therapy, Freud helped restore the man to health and he returned to military service. Unfortunately, he was killed a year later in World War I. This case was used by Freud to illustrate the phenomenon of displacement (taking out our frustrations on others that are less threatening) and the sadistic anal eroticism that he believed underlie most cases of obsessions.

Schreber. Daniel Paul Schreber was a highly respected judge until he began experiencing paranoid psychotic (extreme suspicion) symptoms. As his condition progressed, he believed that God was turning him into a woman and sending little men to torture him. In 1911, Schreber died in an asylum. Although Freud never treated Schreber, he read Schreber's *Memoirs* and drew his own conclusions from it. He concluded that Schreber's disturbances resulted from repressed homosexual desires. These repressed inner drives were projected onto the outside world and led to his paranoid delusions. Freud believed that he projected his feelings toward his psychiatrist to his brother, and then to God who represented Schreber's father. Consideration of the Schreber case led Freud to conclude that homosexuality was caused or exacerbated by paranoia. Not surprisingly, Freud's interpretation has been contested by subsequent theorists.

Wolf Man. The Wolf Man was a rich young Russian male who believed he could only make contact with reality after emptying his bowels with an enema. This case is famous because of the Wolf Man "infantile neurosis" (early life conflicts). The case is named from a childhood dream in which the patient sees white wolves with tails like foxes' sitting quite still on the branches of a large tree outside his window. Freud interpreted this dream and psychic conflicts as a result of witnessing his parents engaging in the primal scene (parental sexual intercourse). While therapy was progressing the patient became overly enamored of the analytic process. As a result, Freud set a termination date. The treatment successfully ended on that date and the Wolf Man went home to Russia. However, after the Russian Revolution, he returned to Freud destitute, homeless, and symptomatic. This case is significant for Freud's ideas about the interpretation of dreams and some of his theory of psychosexual development.

Len Sperry, MD, PhD

See also: Freud, Sigmund (1856–1939); Psychoanalysis

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Friday Night Lights (Movie)

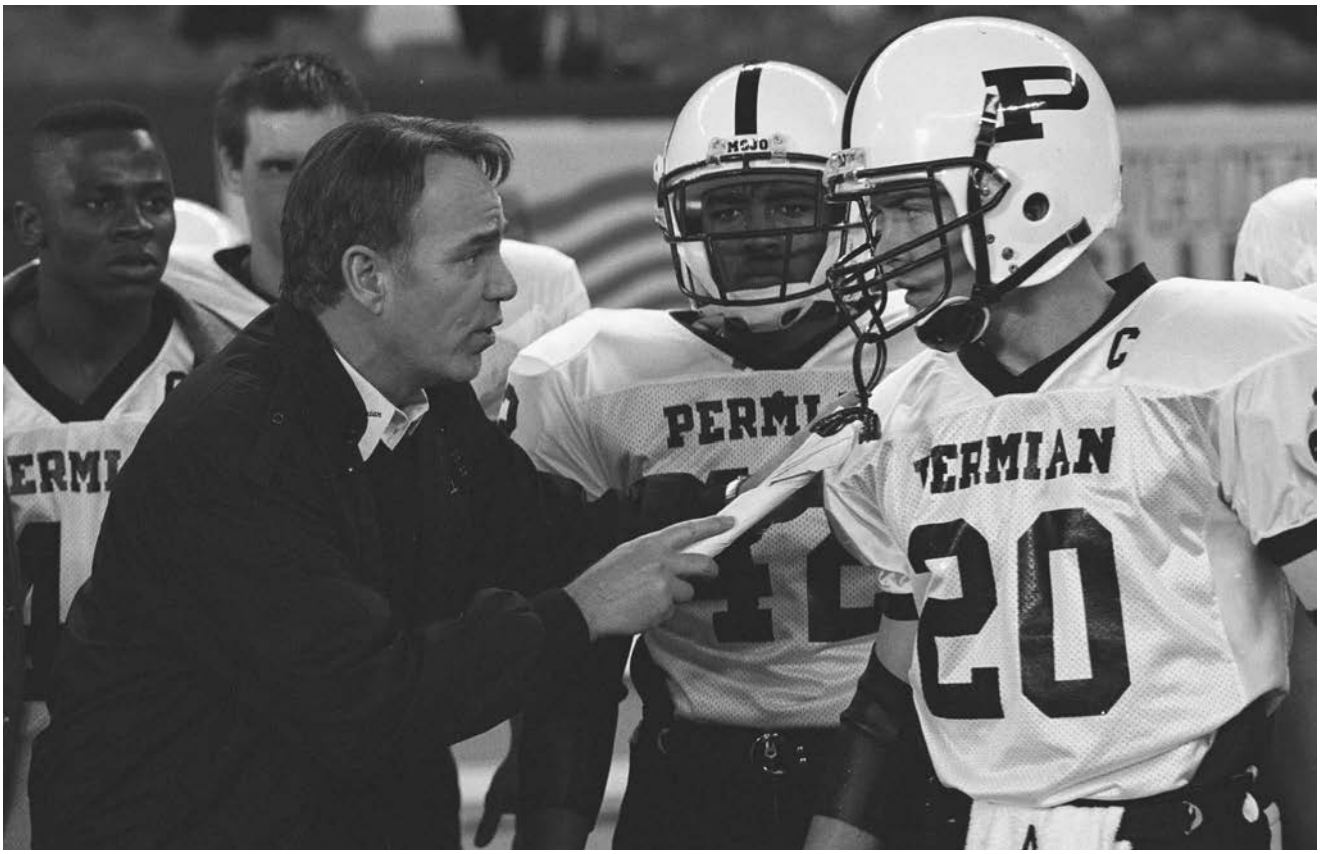
The 2004 movie *Friday Night Lights* documents a Texas high school football team, the Permian Panthers, in their quest toward a state championship. The successful film, based on the book by H. G. Bissinger, grossed over $61 million and spun off into a popular television show by the same name.

Description

Friday Night Lights was a box office hit in 2004, grossing over $61 million to date. Based on the nonfiction

book *Friday Night Lights: A Town, a Team, and a Dream*, by H.G. Bissinger, the film follows a high school football team in Odessa, Texas, as they make their way toward the state championship. The movie documents the Permian Panthers 1988 football season, but larger themes in the film emerge, including racism, segregation, and poverty. Actors include Billy Bob Thornton (Coach Gary Gaines), Derek Luke (James "Boobie" Miles), Lucas Black (Mike Winchell), Connie Britton (Coach Gaines's wife Sharon), Garrett Hedlund (Don Billingsley), and Tim McGraw (Billingsley's father).

The film is set in the small, troubled oil town of Odessa, Texas, where high school football is the one thing that brings everyone together. The Permian Panthers are eager to continue their long winning tradition, but several plots unfold throughout the movie, depicting human struggles far beyond the football field. Coach Gaines feels substantial pressure to keep his job and must ensure that his team makes it to the state finals. Many setbacks occur along the way, for one, a career-ending knee injury for star running back "Boobie" Miles in the first game of the season. This event also highlights the town's emphasis on sports over education, as Miles has no plans for college if it does not include playing football. Performing under pressure is another theme. Quarterback, Mike Winchell struggles with playing consistently and feels the emotional weight of his teammates' personal battles. Third string running back, Chris Comer, suffers from fear and anxiety about being hit after seeing Miles injured. Family struggles also ensue. The tumultuous relationship



Friday Night Lights follows a Texas high school football team, the Permian Panthers, in their quest toward a state championship. In a scene from the 2004 movie, Coach Gaines (played by Billy Bob Thomton) gives instructions to his quarterback (played by Lucas Black). Originally a book and then a film and television series, *Friday Night Lights* explores the psychological underpinnings of broader concepts such as racism. (Universal Studios/Photofest)

between fullback Don Billingsley and his alcoholic and abusive father dramatically impacts his ability to stay focused. This is compounded by the fact that Billingsley's father was himself a high school football state champion but was unable to get into college and is now stuck in a dead-end job.

Led by the father-figure Coach Gaines, the team bands together and makes it to the championship game only to lose in the final seconds to its rival, Dallas Carter High School. Despite this loss, the players resolve the issues facing them and in the end see the impact that football has had on who they are. The movie ends with the passing of the torch as Coach Gaines removes the names of his senior players from the roster board in his office and outside those players leave the field not before tossing a football symbolically to a group of young kids.

Impact (Psychological Influence)

Friday Night Lights received favorable reviews, including an 81% "Certified Fresh" rating on Rotten Tomatoes and a 70/100 score from Metacritic. Though Odessa residents were not receptive about the book's release, they did embrace the film. *Entertainment Weekly* ranked the movie number 37 in their list of "50 Best High School Movies." The popularity of the film also contributed to a spin-off television series with the same title, which ran from 2006 to 2011 and became a cult favorite, including after it went off the air. Actress Connie Britton reprised the coach's wife on the television version, but Kyle Chandler played the coach, and character names and locations were different from the film.

Melissa A. Mariani, PhD

See also: Breakfast Club, The (Movie)

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Frotteuristic Disorder

Frotteuristic disorder is a mental disorder characterized by deriving sexual pleasure or gratification from touching or rubbing against non-consenting individuals.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive (faulty) behaviors.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hormones** are chemical substances produced in the body that control and regulate the activity of certain cells or organs. Estrogen is one of the female hormones.
- **Paraphilia** is a sexual disorder in which individuals can only become aroused by inappropriate object, actions, or fantasies.
- **Paraphilic disorders** are a group of DSM-5 mental disorders characterized by unusual sexual preferences and behaviors that are distressing or detrimental to one's self or others. They include exhibitionistic disorder, fetishistic disorder, and frotteuristic disorder.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Frotteuristic disorder is one of the DSM-5 paraphilic disorders. Frotteuristic disorder is characterized by rubbing or touching one's genitals against the body or clothing of a non-consenting individual. The individual who is being touched or rubbed is a victim. Most often, the behavior occurs in situations where an individual with this disorder has the ability to escape easily. For example, many acts of rubbing against

a non-consenting individual occur in crowded places such as malls, buses, commuter trains, elevators, and busy sidewalks. The most common form of this disorder is rubbing one's genitals against the victim's thighs or buttocks. Another common form of frotteuristic disorder is rubbing one's hands over the victim's breasts or genitals.

Individuals with this disorder are more commonly male and their victims are usually female (American Psychiatric Association, 2013). This disorder usually begins in adolescence and tends to decrease with age. Individuals diagnosed with frotteuristic disorder usually fantasize that they have a personal and compassionate relationship with their victims when they make contact with them. However, once an individual with frotteuristic disorder makes contact, the individual's main concern is to escape to avoid being caught and potentially being arrested. The occurrence of frotteuristic acts occurs in up to 30% of adult males in the general population. Nearly 10%–14% of adult males treated in outpatient settings for paraphilic disorders meet the diagnostic criteria for frotteuristic disorder (American Psychiatric Association, 2013). However, it is difficult to establish how many individuals have this disorder because many rarely seek treatment.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if an individual has recurrent and intense sexual arousal for a period of at least six months from rubbing or touching a non-consenting individual as indicated by urges, fantasies, or behaviors. Significant impairment or distress in the individual's occupational, social, or other meaningful areas of functioning must occur as a result of the acts of the sexual urges with a non-consenting individual. For an individual who is living in an institutional-type setting where opportunities to engage in opportunities to rub or touch a non-consenting individual are restricted, the diagnosis must include the specifier "in a controlled environment." For an individual who has not exhibited any significant distress or impairment in social, occupational, or other important areas of functioning for at least five years, the diagnosis must include the specifier "in full remission." In addition, for an individual who has not acted on the urges with a non-consenting individual for at least five years, the diagnosis must include the specifier "in full remission" (American Psychiatric Association, 2013).

The exact cause of this sexual disorder is not known. In accidentally touching another's genitals, an individual might find the act sexually exciting. This may lead to repeated acts that reinforce and continue the behavior. Some individuals may believe their behavior is acceptable and do not need treatment, while others may be too embarrassed or ashamed to admit their behaviors. Since this disorder is a crime, many individuals do not seek treatment for fear of being prosecuted.

Treatment

Treatment for frotteuristic disorder can only be successful if an individual admits to having a problem and wants to change. Often, a ruling from a court order provides incentive for an individual with frotteuristic disorder to want or need to change. For individuals expressing a desire to change, behavior therapy is the most common form of treatment for this disorder. Behavior therapy helps an individual by teaching ways to control the impulse to touch non-consenting individuals. Medications can also be used to help individuals with this disorder. For example, female hormones like estrogen have been used to reduce sexual desire. The prognosis for removing this disorder from an individual's life is poor since most have no desire to change.

Len Sperry, MD, PhD, and Elizabeth Smith Kelsey, PhD

See also: Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Paraphilic Disorders

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Functional Medicine

Functional medicine is medical practice that identifies dysfunction in body systems and provides treatment that restores function and improves health. In contrast to conventional medicine that focuses on treating symptoms, functional medicine focuses on treating causes.

Definitions

- **Complementary and alternative medicine** involves diverse medical practices that are not considered part of conventional medicine. These include acupuncture, herbs, and homeopathy.
- **Functional medicine matrix** is a strategy for identifying and correcting causes and imbalances. It involves seven areas of functioning/malfunctioning: inflammation, digestion, nutrition, hormones, detoxification, energy metabolism, and mental/emotional/spiritual.
- **Integrative medicine** is medical practice that integrates the therapies and methods of complementary and alternative medicine with those of conventional medicine.
- **Personalized medicine** is medical practice that uses information about an individual's unique genetic makeup and environment to customize medical care to the individual's unique needs.

Description

Functional medicine is a dynamic approach to assessing, preventing, and treating complex chronic medical conditions. Such conditions are almost always preceded by a long-standing decline in functioning in one or more of the body's systems. Restoring health requires reversing that dysfunction. Such dysfunction is the result of a lifelong interaction among the individual's environment, lifestyle, and genetic predisposition. It represents a unique, complex, and interwoven set of influences that set the stage for the development of a chronic condition, Functional medicine begins with an assessment of the individual's core clinical imbalances, basic physiological processes, environment factors, lifestyle factors (diet, exercise, sleep, and stress levels), and genetic predispositions. The goal of functional medicine is to restore balance to the dysfunctional systems by strengthening the basic physiological processes that underlie them and by adjusting the environmental inputs that nurture or impair them. It intervenes at multiple levels to correct core clinical imbalances in order to restore the individual's functionality and health to the greatest extent possible. This contrasts with conventional medicine, which begins by making a diagnosis and then matching a medication to that diagnosis. Its goal is to reduce or eliminate symptoms. In short, functional medicine focuses on restoring function, whereas conventional medicine focuses on treating symptoms.

The basic premise of functional medicine is that the body's innate drive is to be balanced and healthy and that there is a continuum from optimal health to hidden imbalances to serious dysfunction to full-blown medical conditions. Functional medicine identifies the causes of malfunctioning and deals with them in a way appropriate to the individual's particular situation. Two scientifically grounded principles are the basis for functional medicine treatment. First, it adds what the body is missing to nudge its physiology back to a state of optimal functioning. Second, it removes whatever impedes the body (viruses, toxins, allergens) from moving toward this state of optimal functioning.

Functional medicine practitioners commonly use advanced laboratory testing to identify the root cause or causes of the individual's health problem. Conventional diagnostic methods are also used, particularly careful listening to the individual's history of symptoms and asking questions about diet, exercise, sleep patterns, work and interpersonal stressors, coping skills, support system, and purpose in life. For treatment, functional medicine practitioners use a combination of natural agents (supplements, herbs, and homeopathic remedies), nutritional and lifestyle changes, and emotional and spiritual counseling. If necessary, medications are also be used to nudge the individual's physiology back to an optimal state. In addition, educating individuals about their condition can empower them to take charge of their own health. Together, these interventions will result in more effective treatment outcomes.

Developments and Current Status

In addition to functional medicine, the past decade has seen the rise of personalized medicine, integrative medicine, and complementary and alternative medicine (CAM). All challenge the methods and practice of conventional medicine. While functional medicine shares some similarities with all three, it is quite different. It shares personalized medicine's emphasis on causes and genetic variability. But functional medicine has a much broader focus on causes, as illustrated in the Functional Medicine Matrix. It shares CAM's emphasis on optimal health and treating the whole person. But functional medicine is grounded in molecular biology and focusing on correcting imbalances in metabolic pathways. It shares much with integrative medicine but is more grounded in molecular biology and genomics. These four approaches are a formidable challenge to conventional medicine. It is becoming increasingly obvious that conventional medical practice is quickly being eclipsed. Medical care of the future will focus on causes and treating the whole person. It will identify how an individual's genes are affected by environment and lifestyle, and lead to disturbances in cellular communication, biochemistry, and physiology. Then, it will tailor a range of focused interventions to correct these causes and imbalances and return functioning.

Len Sperry, MD, PhD

See also: Personalized Medicine

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Fundamental Attribution Error

Fundamental attribution error is the tendency to explain behavior in terms of personal rather than environmental factors. It is similar to correspondence bias.

Definitions

- **Bias** is a tendency for explaining reality in a preferred or predictable way.
- **Correspondence bias** is the tendency to draw inferences about (explain) an individual's personality from behaviors that can be entirely explained by the situations in which they occur.
- **External locus of control** is the belief that one's decisions and life are controlled by forces outside the individual's control.
- **Internal locus of control** is the belief that one's decisions and life are within one's control rather than determined by external forces.

Description

The fundamental attribution error is a basic idea in the social sciences. It refers to the way individuals attribute (explain) the behavior of others. Specifically, individuals tend to the behavior of others as caused by personality (internal) factors rather than situational (external) factors. The fundamental attribution error favors an internal rather than external locus of control perspective. For an example, a man is observed shoplifting a loaf of bread. To explain his behavior, most would hypothesize that he is criminally minded, is dishonest, and has no regard for others. This perspective does not take into account other possible explanations for his actions, such as environmental factors. These may include poverty, lack of employment opportunities, or a sick family member who needs to be fed. According to the fundamental attribution error, individuals tend to see others as "bad apples" rather than exploring the possibility of a "bad barrel." This tendency is also applied to positive behavior. A successful CEO is often seen by others as inspired, strong, and gifted. This does not take into account other possible factors like a supportive family, educational opportunities, financial resources, or advantages gained by gender or race.

The fundamental attribution error was first researched by Edward E. Jones (1927–1993) and Victor Harris in a 1967 experiment. Participants read essays both for and against Fidel Castro (1926–), the

Cuban leader at that time. They then rated whether they thought the essay authors' personal attitudes toward Castro were positive or negative. Jones and Harris discovered that participants rated authors of pro-Castro essays as having positive personal attitudes even when they were told that the authors' positions were determined by flipping a coin. In other words, participants knowingly ignored the environmental explanation in favor of the personal.

There are several explanations for the fundamental attribution error. The first is the "just world" phenomenon. Many believe that there is justice in the world and that individuals get what they deserve in life. Whether bad or good things happen, it is because they were brought on by an individual. "Blaming the victim" for social problems such as homelessness or domestic abuse is another example. A second reason is convenience. Individuals have a tendency to look for the closest explanation which is others, rather than to take the time and effort to consider environmental causes. A third reason for error is cultural. Western cultures, such as those of North America and Europe, typically elevate the individual over the community or situation. Individuals from collectivistic cultures based on the family or community, like those in Asia, are less likely to commit this error.

Len Sperry, MD, PhD, and George Stoupas, MS

See also: Locus of Control

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GABA (Gamma-Aminobutyric Acid)

GABA is a neurotransmitter in the brain that has a natural calming effect. Its technical name is gamma-aminobutyric acid.

Definitions

- **Amino acids** are organic compounds that combine to form proteins. Amino acids and proteins are the building blocks of life.
- **Endorphins** are peptide (protein) compounds that reduce pain and improve mood.
- **Neurotransmitters** are chemical messengers between neurons (nerve cells).

Description

GABA is an inhibitory (calming) neurotransmitter in the brain. GABA is made from glutamine, an amino acid. GABA, glutamine, and glutamic acid are closely related, nonessential amino acids that as neurotransmitters support proper brain function and mental activity. GABA has a calming effect by decreasing neuron firing. Glutamic acid has a stimulant effect by increasing neuron firing. Glutamate is a primary source of brain fuel and mediator of both GABA and glutamic acid. Dr. Eric Braverman (2003) calls GABA, glutamic acid, and glutamate the brain's three musketeers because of their teamwork in the brain's messaging system. GABA has other functions, including its role in making endorphins and reducing levels of adrenalin, noradrenalin, and dopamine while increasing serotonin. Sufficient levels of GABA are linked to being relaxed and happy. Insufficient levels of GABA are linked to the sleeping problem insomnia, and feeling anxious, stressed, and depressed. Optimal GABA levels are linked to clear thinking, mental focus, and being in "the flow." Factors that reduce GABA levels include a lack of glutamine and low levels of vitamins B1 and B6, and the minerals zinc, manganese, and iron. Other factors include chronic stress, chronic pain, insomnia, low levels of the hormone progesterone, exposure to mercury and lead, alcohol withdrawal, high amounts of caffeine, and excessive electromagnetic radiation.

As a nutritional supplement GABA is used to decrease stress, anxiety, and nervousness, and to improve relaxation and mental focus and clarity. Medical conditions improved by GABA include depression, panic attacks, attention-deficit hyperactivity disorder, insomnia, mania, chronic pain, epilepsy, and hypertension (high blood pressure). It is also used in losing excess body fat and promoting body building.

Precautions and Side Effects

Those with bipolar or unipolar depressive disorders should not take GABA. Since it may cause drowsiness, caution must be taken in driving or using machinery while taking it. The effects of GABA on pregnant or breast-feeding women, children, or those with liver or kidney disease is unknown at this time.

GABA supplements are generally safe although they can increase the heart rate, sleepiness, or drowsiness when first taken. High doses of GABA are linked to side effects such as anxiety, numbness, tingling sensation, nausea, vomiting, increased blood pressure, fidgeting, flushing sensation, and an increase in growth hormone and prolactin levels. Caution is

indicated when taking GABA with any medication or substance that affects GABA pathways in the brain. These include barbiturates, antianxiety medications like Valium and Xanax, sleeping medications like Ambien, and alcohol.

Len Sperry, MD, PhD

See also: Stress

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Gambling Disorder

Gambling disorder is a mental disorder characterized by the uncontrollable and continuous need to gamble, which leads to significant problems.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Antisocial personality disorder** is characterized by a pattern of disregard for the rights of others, manipulation, impulsivity, deceit, and lack of remorse.
- **Bipolar disorder** is a mental illness that involves manic and depressive episodes. Symptoms may last anywhere from one day to several months.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Gambling** is the term for playing games of chance for money or betting.
- **Motivational interviewing** is a therapeutic method used to assess an individual's level of readiness for treatment and to facilitate motivation for treatment.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders characterized by maladaptive thoughts, excessive and repetitive behaviors, and physical symptoms. It includes alcohol intoxication, cannabis use disorder, and gambling disorder.
- **Twelve-Step Group** is a self-help group whose members attempt recovery from various addictions based on a plan called the Twelve Steps. Twelve-Step Groups can focus on specific addictions such as Alcoholics Anonymous and Gamblers Anonymous.

Description and Diagnosis

Gambling disorder is one of the DSM-5 substance-related and addictive disorders. It is characterized by persistent and repetitive dysfunctional gambling behavior that negatively impacts work, personal relationships, and social functioning. These excessive and reoccurring behaviors stimulate the reward system in the brain. The brain's reward system reinforces these behaviors and produces memories. Excessive gambling creates feelings of pleasure or of being high, similar to those created by substance use disorders. Individuals with this disorder are willing to wager money to win even greater stakes. The uncontrollable desire to bet isn't reinforced by winning but rather by the excitement that gambling provides. Typically, the disorder develops over a period of time. What might begin as an enjoyable social event, over time, has the potential

to become an addiction. Gambling may also be used as an unhealthy way to cope with negative emotions or life stressors. This, too, can lead to addiction.

Usually the betting or wagering has a severely negative effect on his or her life, specifically on relationships, finances, employment, or mental health. The individual may continue to gamble even after he or she has developed social, economic, interpersonal, or legal problems as a result of the gambling. The individual also suffers from the delusion that the next wager will restore him or her to normalcy in life or finances. Gambling disorder is an example of a process or behavior-based rather than a substance-based addiction.

Unlike the chemical changes that are the basis of addictions such as those to food, drugs, tobacco, or alcohol, the characteristic rush or emotional high of a process addiction is strongly connected to the series of steps or actions that are involved in the addictive behavior. Gambling disorder is very much connected to the excitement involved in the betting itself. The risk-taking provides an adrenaline rush that is pleasurable to the gambler. For a compulsive gambler, it is not what is being bet; it is the process of betting itself and the wager could be on anything.

The occurrence of this disorder is lower in females than males. The incidence of gambling disorder is approximately 0.2% for females and 0.6% for males. The occurrence of the disorder in the general adult population in America is around 1% (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if the repeated maladaptive gambling behavior continues in spite of unintended negative consequences. The maladaptive behavior must persist for at least one year. Common maladaptive behaviors include the need to wager increasingly more money so that a desired level of excitement can be achieved. They may also include the inability to control, cut back, or quit gambling. Individuals may continuously think about gambling or use it to cope with negative emotions or stress. They may continually try to win back money that was lost by gambling. They may make up stories or lie to hide the severity of gambling. They may have risked or lost an important relationship, job, or academic/career opportunity. Or, they may need financial help from others to cover gambling losses (American Psychiatric Association, 2013).

The cause of this disorder appears to involve several factors. An individual is at higher risk for gambling disorder when there is a family history (especially first-degree relatives) of alcohol use disorder. Gambling disorder is also associated with depression, bipolar disorder, antisocial personality disorder, or a substance-related disorder. An individual who is very competitive, restless, or easily bored may be at higher risk. Family factors, such as parents who gamble, increase the probability of offspring developing gambling disorder. Gambling also involves rewards and avoidance. Individuals who gamble often continue gambling after winning a large sum of money, or attempt to win back money that was lost due to gambling. The possibility of winning money increases different neurotransmitters in the brain, so gamblers often experience a high amount of excitement and energy while engaging in gambling behaviors. Gambling can also be a form of escape in which individuals gamble to temporarily escape or avoid depression, anxieties, stress, relationship problems, or other problems. Gambling can serve various purposes in an individual's lives, so treatment will often target those specific contexts.

Treatment

There are three basic approaches to treating this disorder. They are psychotherapy, medication, and groups. Psychotherapy can help the individual by exploring some of the underlying causes of the behavior. Cognitive behavior therapy can be helpful in reducing and eliminating gambling behavior. Medications may include antidepressants, mood stabilizers, or narcotic (opioid) antagonists. The third approach involves participation in groups like Gamblers Anonymous, which is a Twelve-Step Program. Ideally some combination of the three will provide the most help.

The goal of treatment for gambling disorder is to reduce gambling behaviors or to totally abstain from it. It is difficult to treat gambling disorder if the individual is unaware, or unwilling, to admit a problem exists. Even individuals who have experienced

significant consequences from gambling may be ambivalent about changing. For this reason, motivational interviewing may be helpful to assess level of readiness for treatment.

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See also: Addiction; Cognitive Behavior Therapy; Motivational Interviewing; Psychotherapy; Substance-Related and Addictive Disorders; Twelve-Step Program

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Gangs

The word "gang" refers to a close-knit group of individuals who share a particular identity and engage in delinquent, criminal, or violent behaviors.

Definitions

- **Gangster** is a term used to describe a member of a gang involved in organized crime.
- **Gang war** describes ongoing tensions, feuding, or violent activity between differing gangs.
- **Juvenile delinquency**, otherwise referred to as *juvenile offending* or *youth crime*, defines a violation of the law committed by a person under the age of 18, which would have been prosecuted as a crime if the minor were an adult.
- **Mafia** is used to define a particular type of organized crime unit, historically associated with Italian or Sicilian groups, that engages primarily in the criminal practices of racketeering, drug and gun trafficking, gambling, and fraud.
- **Street gang,** also called a youth gang, describes an organized group of peers with designated leadership, usually from similar backgrounds, who are involved in illegal activities and work to control particular territories.

Description

A gang describes a group of tightly connected individuals who have adopted a specific group identity and are involved in criminal activity and violent behavior. The terms "gang," "youth gang," and "street gang" are often used interchangeably. The word "gang" typically refers to the ongoing association of three or more members, generally minors or young adults aged 12 to 24, who engage in delinquent or criminal activities. Other gangs include prison gangs, motorcycle gangs, terrorist organizations, and hate groups. According to the federal definition, gangs adopt a group identity in order to incite an atmosphere of fear or intimidation. This identity may be expressed through the gang's name, slogan, symbol, hand sign, tattoo, color, style of clothing, or hairstyle. Other characteristics of these associations include some structure, perhaps in terms of leadership though this is not a requirement, and established rules or expectations for members; interest in maintaining a presence or control over a certain territory; and protection from rival gangs or law enforcement in exchange for one's membership and loyalty.

Males make up the majority of gang members. Racial/ethnic representation in gangs varies locally, with numbers reflecting the highest rates of membership among African American males, followed by similar numbers for both Hispanic/Latino and Caucasian males, and then other racial groups. In younger adolescent gangs, females can account for nearly half the members. Larger cities encounter

more gang-related problems than smaller cities and urban locations.

Gangs, in the modern sense, can be traced back to the early 1600s in London when rivaling groups terrorized the city. Though earlier reports have been noted, more formalized street gangs did not emerge in the United States until the early 19th century, attributing to increased immigration and poverty rates. In particular, battling among the Five Points Gangs in New York City has been well documented and was chronicled in the popular movie *Gangs of New York*. Resulting criminal activity arose out of these early gangs, including that of the Sicilian Mafia (La Cosa Nostra) and Al Capone. As these groups expanded their influence to other major cities, including Chicago, Atlantic City, and Washington, D.C., gang activity also grew. These criminal associations were heavily involved in illegal dealings involving drug trafficking, bootlegging, gambling, robbery, extortion, and murder. A later surge of gang activity in the Latino and black populations emerged during the 1950s and 1960s, particularly in cities like Los Angeles, New Orleans, and Miami. Ongoing gang wars among groups such as the Crips and the Bloods can be attributed to increased racial tensions and social inequities that were experienced by these marginalized groups. The most notorious transnational gangs still in existence include La Cosa Nostra, the 18th Street Gang (M-18), and Mara Salvatrucha (M-13) whose membership includes various nationalities and whose influence spans multiple countries.

Impact (Psychological Influence)

Gang activity has been reported all over the world, but the existence of gangs in the United States has become of increasing concern over the past several decades. The Federal Bureau of Investigation has estimated that there are some 33,000 active gangs currently operating in the United States responsible for the majority of violent crimes that occur in communities. In response to this growing problem, the FBI established the *National Gang Task Force* in the early 2000s to coordinate federal, state, and local efforts. In 2005, the *National Gang Intelligence Center* was developed to provide a data system for improving local task forces' ability to track and report trends in gang happenings and share that information across jurisdictions. Though complaints regarding gang activity rise each year, so do the arrests and convictions made, indicating that law enforcement and the judicial system are improving in their ability to locate, track, and prosecute these criminals.

Gang problems can result in both economic and social costs for societies. It has been estimated that crime costs U.S. taxpayers over $650 billion annually, with much of that crime being directly related to gang activity. Research suggests that gang involvement has been associated with several negative consequences, including higher dropout rates, increased rates of teen pregnancy, substance abuse problems, a greater propensity toward violent behaviors, higher rates of unemployment, and increased potential for future arrests and prison time. In addition, studies have linked gang membership with negative emotional effects like anxiety-related problems, post-traumatic stress, withdrawal from family and loved ones, and depression. In addition to law enforcement initiatives, the involvement of educational systems, religious institutions, nonprofit organizations, and family units is critical to addressing the gang problem.

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See also: Juvenile Offenders; Peer Groups

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Ganser's Syndrome

Ganser's syndrome is a rare mental disorder characterized by approximate but incorrect responses to questions. It is also known as prison psychosis.

Definitions

- **Adjustment disorder** is the development of disproportionate short-term emotional distress or behavioral problems following a stressful event.
- **Catatonia** is disorganized, limited, or complete absence of normal physical behavior.
- **Dissociative disorders** is a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness and which cause impaired functioning.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria. The current edition is DSM-5.
- **Factitious disorder** is a mental disorder in which an individual acts as if he or she has an illness by deliberately producing, faking, or exaggerating symptoms. In contrast to malingering, there is no personal gain involved.
- **Malingering** is the practice of intentionally exaggerating or faking physical or mental symptoms for personal gain.
- **Psychosis** is a severe mental condition in which an individual loses touch with reality.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Schizophrenia spectrum and other psychotic disorders** are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, schizophreniform disorder, schizoaffective disorder, and delusional disorder.

Description and Diagnosis

Ganser's syndrome is mental disorder in which individuals respond to questions with approximate rather than precise and accurate answers. These responses indicate that the question was fundamentally understood, but the answers provided are incorrect. For example, if an individual was asked to add 1 plus 1, they might answer "3," or they might be asked what color is snow and answer "black." This suggests that the individual comprehended what was being asking but is unable or unwilling to provide the precise answer. Some individuals with this disorder may exhibit a dull or cloudy consciousness and reduced sensitivity to stimulation. This syndrome is named for the German psychiatrist Sigbert Ganser (1853–1931), who published the first paper on the disorder in 1898.

There has been significant debate as to the validity of this disorder as a formal diagnosis. Some individuals with this disorder acts as if they have a physical or mental condition when there is none. For this reason, this disorder can be diagnosed as a form of malingering or a factitious disorder. Others consider it a dissociative disorder, while others have argued that it is better understood as a form of catatonia or psychosis. Ganser's syndrome was once categorized in the DSM as a dissociative disorder but is no longer represented in the current edition. Individuals with this disorder might be diagnosed with an unspecified schizophrenia spectrum and other psychotic disorder, or unspecified dissociative disorder. They may even be diagnosed with an adjustment disorder depending on what other symptoms are present. The occurrence of this disorder is unknown but is considered very rare.

The cause of this often confusing disorder is unknown. However, it is believed that it can be brought on by stress or the wish to avoid an unpleasant situation. For example, some facing a prison sentence may respond with approximate answers in hopes of being sent for mental health treatment rather than prison.

Treatment

As this disorder is uncommon, there is not a significant body of knowledge on which to base treatment decisions. It is most likely that the primary form of

treatment will depend on the other symptoms present. Depending on the severity of the other symptoms present besides Ganser's, individuals may require hospitalization.

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See also: Adjustment Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Dissociative Disorders; Factitious Disorders; Malingering; Psychosis; Schizophrenia Spectrum and Other Psychotic Disorders

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Gay, Lesbian, Bisexual, Transgender (GLBT/LGBT)

People who identify themselves as gay, lesbian, bisexual, or transgender are those who do not have a heterosexual, and perhaps stereotypical, sexual orientation.

Definitions

- **Bisexual** describes the sexual orientation of an individual who is romantically, physically, or sexually interested in both females and males.
- **Gay** can mean either a man who is sexually attracted to another man, or it can be used as a general term, encompassing both men and women who are homosexual. It refers to an individual's sexual orientation, one's romantic, sexual, or physical attraction to a person of the same sex or gender.
- **Gender identity** is the way in which one identifies one's gender, or personal sense of being male or female.
- **Homophobia/heterosexism** describes the condition of having an irrational fear of, aversion to, or discriminatory beliefs, attitudes, and behaviors toward homosexual and gender-variant persons.
- **Homosexuality** describes the sexual orientation of those who are attracted to, aroused by, or romantically interested in members of the same sex/gender.
- **Lesbian** describes a woman who identifies her sexual orientation as being romantically and sexually attracted to other women.
- **Transgender** describes individuals who are experiencing gender dysphoria and who do not personally identify with the gender they were assigned at birth.

Description

LGBT/GLBT are accepted terms used to refer to members of the gay community who identify themselves as nonheterosexual. The LGBT initials stand for lesbian, gay, bisexual, and transgender, though this is not meant to be an exclusive term. LGBT is more commonly used than GLBT, though it may be viewed as more of a feminist term given that women, lesbians, are listed first. A symbol often used to represent/refer to those in the LGBT community is a rainbow. "Homosexual" has historically been the word most often used to describe those who are nonheterosexual. The term "gay" became popular vernacular between the 1970s and 1980s, followed by the acronym LGB (lesbian, gay, bisexual) in the 1990s. From the late 1990s on, LGBT has been used to now include gender-variant (transgender) people. Sometimes the additional "Q" is added at the end, LGBTQ, to include those who identify as queer or still questioning their sexual orientation. The letter "I" may also be included at the end, LGBTI, to include intersex people. This evolution in terminology used to identify members is indicative of the LGBT communities' goal to include those who have been rejected, discriminated against, or felt marginalized by mainstream society. Some LGBT members feel that the term is too inclusive and

that issues experienced between classifications are different. Thus, those in the LGBT community are rightfully classified as a minority as they are often misunderstood, underrepresented, and denied equal human and civil rights.

Current Status and Impact (Psychological Influence)

Those who identify as lesbian, gay, bisexual, transgender, queer/questioning, or intersex have experienced significant prejudice throughout history and into the present day. Laws regarding same-sex unions, parenting, and adoption rights vary from state to state, with the majority of states still forbidding these rights. Federal laws making it illegal to discriminate or retaliate against (includes hate crimes) people based on their sexual orientation or gender identity are relatively recent. Until 1973, the *Diagnostic and Statistical Manual of Mental Disorders* labeled homosexuality as a mental disorder and after that, until 1987, as a sexual orientation disturbance. In addition, it took until 2011 to repeal the 1993 "Don't ask, don't tell" policy, which banned homosexual, bisexual, and gender-variant people from enlisting in the military. Though understanding, acceptance, and respect for LGBT members have increased in recent years, there is much further to go until they gain equality.

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See also: Gender Dysphoria; Gender Identity Development; Homophobia/Heterosexism; Homosexuality; Sexual Orientation; Transgender

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Gender Dysphoria

"Gender dysphoria" refers to the discontent that a person experiences from not identifying with the gender assigned at birth.

Definitions

- **Gender identity** is the way in which individuals self-identify their gender, or personal sense of being male or female.
- **Gender identity development** is the process by which an individual develops a private sense of his or her gender, of being a man or a woman.
- **Sexual identity** refers to whether one identities oneself as predominantly homosexual, heterosexual, or bisexual.

Description

Gender dysphoria is a feeling of discomfort and discontent resulting from the thought that the gender an individual was assigned at birth does not align with his or her personal identity. Such individuals are commonly referred to as transsexual or transgender. Research suggests that there are both biological and sociocultural factors that contribute to the prevalence of gender dysphoria. Biological contributors include differences in brain structure and chemistry, hormone exposure in utero, and variations in the genitalia. Sociocultural factors that may impact the presence of gender dysphoria include parenting styles, encouragement of either masculine or feminine traits, personal preferences, and media influences.

Gender dysphoria can result in substantial social, emotional, and psychological consequences. Anxiety, loneliness, social exclusion, and depression are symptoms often reported by those who are transgender. Additional distress can also result if the transgender person is involved in an intimate relationship and has come out seeking to change to the sex he or she feels most fits him or her. Depending on the age of the individual, these consequences may vary; younger children who are supported and encouraged to express

their personal gender identity openly may suffer less than adults who have lived years suppressing their feelings. Transgender persons have traditionally been subjected to misunderstanding, rejection, isolation, and harassment. Those experiencing symptoms indicative of gender dysphoria are encouraged to seek proper diagnosis, support, and treatment.

Treatment may include psychological counseling, noninvasive cosmetic procedures, and/or radical medical interventions. Individual counseling and small group support networks can assist transgender people in dealing with emotional, psychological, and social concerns. Cosmetic procedures such as electrolysis, hairstyle changes, makeup, and dress are less invasive. Medical interventions are more permanent and may be sought if the individual wishes to pursue sexual reassignment. These may include hormone therapy, removal of the Adam's apple, breast augmentation, and genital reconstruction.

Current Status and Impact (Psychological Influence)

Evidence approximates that 1 out of every 200 people in the United States suffer from gender dysphoria. DSM-5 classifies gender dysphoria in children and gender dysphoria in adolescents and adults as mental disorders. However, debate continues over whether it should be classified as a mental or medical disorder. Those opposed to a mental diagnosis argue that this classification places a negative stigma on those struggling with it. Proponents offer that a formal diagnosis encourages the severity of this disorder for transgender individuals and allows for medical support and possible insurance coverage for those pursuing treatment options. The concept of gender variance as opposed to simply a binary view of a person as either male or female is also a controversial one. This contributes to the stigma, secrecy, and isolation that transgender people often experience.

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See also: Gay, Lesbian, Bisexual, Transgender (GLBT/LGBT); Gender Dysphoria in Adolescents and Adults; Gender Identity Development; Homosexuality; Transgender

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Gender Dysphoria in Adolescents and Adults

Gender dysphoria in adolescents and adults is classified by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, as a mental disorder characterized by unhappiness with one's biological sex or its usual gender role and with the desire for the body and role of the opposite sex.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Gender** is the social, cultural, and psychological traits and role associated with one's sex.
- **Hormones** are chemical substances that are produced in the body that control and regulate activity of certain cells and organs.

- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Gender dysphoria in adolescents and adults is included in the gender dysphoria section of the DSM-5. It is characterized by distress that may be accompanied by conflict between an individual's sex and his or her gender. Adolescents and adults share the same features of gender dysphoria, with the exception that adolescent's secondary sex characteristics may not be present yet. Secondary sex characteristics include the development of breasts, facial hair, and other features that distinguish the two sexes. Adolescents may be very concerned with the imminent physical changes that are about to occur. Adolescents and adults with gender dysphoria may take on the behavior, mannerisms, and clothing of the desired gender. They often feel uncomfortable around others and worry that they will be judged because of their assigned gender. Individuals may act and present themselves as individuals of the opposite sex and often express a desire to change their bodies.

Some behaviors that adolescent males engage in include shaving their legs at the first sign of growth and binding their genitals to make erections less visible. Some behaviors adolescent girls engage in include binding their breasts, walking with their head and body downward, and wearing large sweaters to make their breast less visible. Sexually active adolescents and adults often do not show their partners their sexual organs or allow them to touch them. Adults with gender dysphoria often exhibit the following symptoms: the desire to have their genitals removed and to live as an individual of the opposite sex, and dressing and behaving in a manner characteristic of the opposite sex. Often, adolescents and adults with gender dysphoria withdraw themselves from social interaction and activity. Many experience isolation, depression, and anxiety.

The occurrence of this disorder in adult males typically ranges from 0.005% to 0.014% and in adult females from 0.002% to 0.003% (American Psychiatric Association, 2013). Many adults do not seek treatment for gender dysphoria; therefore, these are modest estimates. Many individuals do no seek treatment mainly because of the stigma that is associated with gender variation. The sex ratio of this disorder in adolescents is close to equal.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if an individual exhibits a noticeable conflict involving gender. In young adolescents, the individual must have a strong desire to be rid of the primary and/or sex characteristics. For a young adolescent, he or she must have a desire to prevent the development of anticipated secondary sex characteristics. An adolescent or adult must have a strong desire for primary and/or secondary characteristics of the other gender. The adolescent must also have a strong desire to be of the opposite gender and to be treated as the opposite gender (e.g., different from the individual's assigned gender). Adolescents and adults must have a strong conviction that they have the usual feelings and reactions of the other gender (e.g., different from the individual's assigned gender). The condition must cause significant impairment and distress in an individual's occupational, social, or other important areas of life. If an individual is diagnosed with this gender dysphoria, the specifier "with a disorder of sex development" is given coded if applicable. If an individual who has transitioned fully to the desired gender (with or without gender change) and has undergone or is planning to undergo at least one cross-sex medical procedure, then the specifier "post transition" must be included in the diagnosis.

The exact cause of gender dysphoria is unknown. It is possible that gender dysphoria may be caused by inherited (genetic) abnormalities, an imbalance in hormones during fetal and childhood development. The environment in which an individual is raised may influence gender identity. For example, children are generally socialized in gendered behavior after birth by their parents or caretakers. Individuals with gender dysphoria may have defects in child rearing and in normal bonding with others.

Treatment

Individual and family psychotherapy is recommended to treat adolescents and adults with gender dysphoria. The

focus of therapy is to improve symptoms of anxiety, depression, and low self-esteem. Psychotherapy is helpful in assisting individuals improve their individual function as much as possible within their biological gender. Some adolescents and adults choose hormone therapy to prevent bodily changes from occurring. For example, a female who identifies with being a male may be prescribed testosterone, while a male who identifies with being a female may be prescribed estrogen. Some adults choose gender reassignment surgery (also referred to as a "sex change" operation) as a form of treatment.

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See also: Anxiety; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Psychotherapy; Self-Esteem

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Gender Identity Development

"Gender identity development" refers to the process by which an individual develops a private sense of gender, of being a man or a woman.

Definitions

- **Gender dysphoria,** formerly termed gender identity disorder, is a formal diagnosis given to individuals who are experiencing gender dysphoria, or significant behavioral, social, and psychological discomfort related to not identifying with their birth gender.
- **Gender identity** is the way in which people identify their gender, or personal sense of being male or female.
- **Gender/sex roles** describe stereotypical characteristics, preferences, aptitudes, and behaviors of being either masculine or feminine.
- **Sexual identity** refers to whether one identities oneself as predominantly homosexual, heterosexual, or bisexual.

Description

Gender identity development is one's personal, private sense of being male or female, and it may or may not align with the person's assigned birth sex. A person's gender identity develops at an early age, around the age of two or three and is usually solidified by age five or six. Though fluid at first, gender identity progressively becomes more solidified as one grows and is further exposed to societal and cultural stereotypes. Gender identity development is affected by biological, cognitive, social, and cultural processes and is typically reinforced by societal norms associated with males and females. Biological aspects of gender identity development relate to chromosomal, hormonal, and genital structures. Social aspects vary greatly and relate to gender roles, social modeling, behavioral reinforcement, and personal preferences. Rigid sex roles can contribute to pressures to fit in to assigned gender categories. In most modern Western cultures there are two sex categories, male and female, and prescribed expectations that correspond to each. This may make nonconforming individuals, those who do not identify with traditional gender characteristics, feel threatened, unwelcomed, or misunderstood.

Sex differences have been an area of study dating back to the early 1600s though most research at that time was grounded in the preconception that females were by nature inferior to males. In the early 1900s, Sigmund Freud posited that psychological complexes manifest (Oedipus complex) as one progresses through the various sexual stages of development. Research in the 1960s focused on the root cause of homosexual orientation, which was believed to be a disorder at the time. Psychoanalyst Robert Stoller summarized some of the findings in his groundbreaking book *Sex and Gender: On the Development of Masculinity and Femininity* (1984) and was the first to use the term "gender identity." The feminist movement of the 1970s challenged

traditional gender roles, sex differences, and stereotypes, and resulted in great strides for women's rights. Judith Butler's *Gender Trouble: Feminism and the Subversion of Identity* (1990) is a highly regarded text in the area of women's studies and gender differences.

Current Status and Impact (Psychological Influence)

Gender identity, roles, and expectations have changed significantly over the past few decades as research continues to expand awareness, understanding, and acceptance. People are less likely nowadays to stereotype based on sex, resulting in more gender flexibility. However, the nature versus nurture debate still continues, as researchers investigate whether biological or social factors have more of an impact on gender identity. Research also continues to look at the influence of socialization and social modeling as possible answers to these questions. Most recent is the impact that media (books, television, movies, music, games, Internet) may have on gender identity development.

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See also: Gay, Lesbian, Bisexual, Transgender (GLBT/LGBT); Gender Dysphoria; Homosexuality; Transgender

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Gender Issues in Mental Health

Gender has been linked to both positive and negative consequences pertaining to mental health.

Definitions

- **Coping strategies** describe means or techniques, both positive and negative, that individuals use to help them deal with life's stressors.
- **Gender/sex roles** describe stereotypical characteristics, preferences, aptitudes, and behaviors of being either masculine or feminine.

Description

Gender contributes to how people behave as well as how they cope with everyday life experiences. From birth, certain expectations are placed on individuals based on their gender. These views regarding masculinity and femininity are referred to as *gender roles* and are commonly held by the majority of people in any given society or culture. Gender roles can be influenced by familial, cultural, ethnic, religious, and political factors. They are not based on biology but on learned norms and roles. Traditionally viewed masculine characteristics include independence, strength, toughness, assertiveness, and competitiveness. Characteristics associated with femininity include sensitivity, weakness, affectionateness, communicativeness, and emotional expressiveness. Though these descriptors are generally associated with each of the genders, they do not necessarily pertain to every individual, male or female.

Gender can be both a protective factor and an impeding factor to wellness. Behaviors, coping strategies, and communication skills specific to males or females reflect differences in mental health symptomatology, incidence rates of disorders, and resulting life consequences. Mental health professionals should consider gender when diagnosing possible causes and deciding on treatment procedures for their clients. Notable distinctions between the sexes have been documented throughout history. However, socialization and prescribed norms have contributed to this divide offering additional causes for psychological stress. Males have commonly been expected to provide financially outside the home, while females have been designated the caregiver role and additional household tasks. Each accompanies particular stressors. Furthermore, acting out behaviors are more accepted when displayed by males, whereas females are usually expected to be polite and maintain their composure. Historical views of male superiority/female inferiority can also add additional tension.

Current Status and Impact (Psychological Influence)

Research indicates that though true biological differences exist, socially constructed gender roles also contribute significantly to mental health issues in men and women. In childhood, boys are more likely to externalize problems, display a propensity for aggressive behaviors, and report higher rates of conduct disorders. Girls tend to internalize problems and evidence higher rates of anxiety-related problems and eating disorders. As males and females develop, variations in coping strategies are also noticeable. Men are more prone to abusing substances and attempt suicide than women. Depression and anxiety are more commonly seen in women with a correlation existing between those disorders and gender role pressures. Therefore, gender plays an important part in either protecting or impeding an individual's mental health.

Melissa A. Mariani, PhD

See also: Female Development, Stages of; Sexual Identity; Women's Mental Health Issues

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Generalized Anxiety Disorder

Generalized anxiety disorder is a mental disorder characterized by chronic anxiety and multiple, exaggerated worries.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Anxiety** is apprehension or worry about an imagined danger.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety, which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorder.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neuroticism** is a dimension of personality that describes an individual level of emotional instability and proneness to psychological distress.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

Generalized anxiety disorder is one of the DSM-5 anxiety disorder. It is characterized by anxiety and chronic worry, often about an imagined danger. Individuals with this disorder typically live in a constant, highly aroused state expecting some sort of danger. Their anxiety may focus on multiple specific concerns about their children, health, or job. Their worries may be also very broad and general. Also, individuals who suffer from this disorder may eventually come to literally worry about their worrying. Those with this disorder often experience sleeping difficulties, fatigue, irritability, or restlessness. They may also experience physical symptoms such as trembling, muscle tension, and sweating. Although these physical symptoms are generally mild, they often become overly focused and worry about an undiagnosed medical condition.

The likelihood that adults will experience this disorder at some point in their lifetime is 9%. It occurs

more frequently in those of European descent than non-European. Also, it occurs far more frequently in first-world nations than in the developing nations (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, the following symptoms must be present for this diagnosis to be appropriate. The individual must experience uncontrollable anxiety on the majority of days for a minimum of six months. An adult must experience a combination of at least three of the following while a child must experience only one: agitation, tiredness, trouble concentrating, moodiness, tense muscles, and difficulty sleeping. The symptoms must cause suffering or disruption in social or professional functioning. Lastly, these symptoms must not be caused by substance use, medical illness, or alternative metal disorder (American Psychiatric Association, 2013).

The cause of generalized anxiety disorder is not completely understood but is believed to be the consequence of genetics, biology, and environmental factors. The "flight or fight" response is one of the well-known biological components of this and other anxiety disorders. This flight or fight reaction is an automatic response to physical danger. As a result, certain functions such as digestion are shut down while others are primed for actions. Many of the physical symptoms experienced in this disorder are a direct result of this response. A high level of reactivity in certain areas of the brain results in some individuals being more susceptible to the disorder. It is also believed that those with a high-level neuroticism are more vulnerable to this disorder.

Treatment

Treatment for generalized anxiety disorder is likely to be long term. Methods employed may include medication, psychotherapy, or a combination of both. The common medications used for this disorder include the antianxiety medications such as Ativan, Cymbalta, and Xanax. The psychotherapies used for this disorder are numerous, but the most common is cognitive behavior therapy. The focus of this therapy in generalized anxiety disorder is changing the beliefs and behaviors of the individual. For example, if an individual maintains an exaggerated fear about his or her children's safety (belief), the therapist might help the individual challenge his or her thoughts with facts or alternative explanations. Also, if the same individual constantly checks on his or her children (behavior), he or she might be instructed to replace this act with an alternative that is not related to directly investigating children's whereabouts. An additional activity employed in the treatment of this disorder is vigorous exercise. Although the specific reasons why exercise is effective in diminishing symptoms are not completely clear, certain neurotransmitters (chemical messengers) that are part of the brain's reward system are released. This chemical activity is often experienced by the individual as a sense of well-being and relaxation. This experience is commonly referred to as the "runners high."

Len Sperry, MD, PhD, and
Jeremy Connelly, MEd

See also: Antianxiety Medications; Anxiety Disorders; Ativan (Lorazepam); Cognitive Behavior Therapy; Cymbalta (Duloxetine); *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Neurosis; Psychotherapy; Xanax (Alprazolam)

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Genito-Pelvic Pain/Penetration Disorder

Genito-pelvic pain/penetration disorder is a mental disorder characterized by fear, pain, or difficulty with sexual intercourse. Previously it was referred to as dyspareunia and vaginismus.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Dyspareunia** is the experience of genital pain during sexual intercourse.
- **Exposure** is a cognitive behavior therapy intervention (method) in which a client is exposed to a feared object or situation. It is also referred to as flooding.
- **Pelvic floor muscle training** involves a series of exercises designed to strengthen the muscles of the pelvic floor. These exercises are used to treat problems with urine leakage, bowel control, and pelvic pain.
- **Sexual dysfunctions disorders** are a group of mental disorders characterized by significant difficulty in responding sexually or experiencing sexual pleasure. They include delayed ejaculation, female organismic disorder, and genito-pelvic pain/penetration disorder.
- **Systematic desensitization** is a form of cognitive behavior therapy that gradually exposes individuals to their phobia (fear) while remaining calm and relaxed.
- **Vaginismus** is the inability to allow vaginal penetration because of anxiety and fear of pain that results in vaginal spasm.

Description and Diagnosis

Genito-pelvic pain/penetration disorder is one of the sexual dysfunctions disorders. It is characterized by recurrent or persistent fear, pain, or difficulty with vaginal penetration during intercourse. Pain with sexual activity is a common experience for many women. Approximately 15% of women in North America report ongoing pain during sexual intercourse (American Psychiatric Association, 2013). Women who experience pain rather than pleasure when attempting intercourse may avoid sexual activity as a way to avoid pain and manage anxiety. A link among pain, fear, and muscular tension during intercourse occurs. As with other phobias (fears), an aversion to and avoidance of physical pain results. In time, this becomes an anxiety/aversion pattern. Women may also develop other sexual dysfunctions such as reduced sexual interest or arousal as a way to avoid pain.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, women can be diagnosed with this disorder if they exhibit difficulties with vaginal penetration during intercourse for at least six months. They may experience difficulty with penetration during intercourse. They may experience pain during vaginal intercourse or penetration attempts. They may experience fear and anxiety in anticipation of penetration. Or, they may experience tightening of the pelvic floor muscles while attempting intercourse. This diagnosis cannot be made if the symptoms can better be explained by a nonsexual mental disorder. Nor can they be a consequence of severe relationship or other stressors. Women can experience these symptoms lifelong, or they can be acquired over time (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. It is often unclear whether biological, psychological, or social factors are the initial contributor to physical pain during penetration. However, once genital pain is experienced, all three factors may continue to reinforce pain avoidance. Other contributing factors to this disorder include partner factors, relationship factors, and individual factors such as poor body image, a history of sexual or emotional abuse, cultural and religious factors, and medical factors. These factors help the clinician understand the possible cause for the disorder as well as the maintenance of symptoms. If the cause of the disorder is primarily due to a physical condition of the sex organs, then the clinician would work with the individual to seek treatment from a medical professional who

treats this disorder. If the cause is more psychological in nature, the clinician would begin to explore the purpose of the symptom that perpetuates it. Finally, social or external factors should also be taken into account.

Treatment

Treatment for this disorder usually includes medical and psychological interventions. Prior to any psychological treatment for this disorder, the woman should be examined by a medical professional to rule out medical conditions that might contribute to sexual pain. Such medical conditions are then treated. If sexual symptoms remain, psychological treatment commences. However, because emotional and physiological components both reinforce the pain-fear-tension cycle, this disorder is best treated with a team approach, involving medical, physical therapy, and mental health professionals. Physical therapy focuses on pelvic floor muscle training. It teaches exercises that can be practiced at home. Cognitive behavior therapy (CBT) is used to reduce fear, anxiety, and pain. CBT emphasizes systematic desensitization and exposure techniques.

If trauma issues are involved, it would also be addressed or referred to for specialized treatment.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Exposure Therapy; Sexual Dysfunctions; Systematic Desensitization

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Genograms

Genograms are a detailed representation of a client's family tree, focusing especially on how individuals communicate and interact with one another, including psychological factors that affect relationships.

Description

Most individuals are influenced by the interactions with their families, and often patterns emerge and even repeat over several generations. Genograms offer a clinician a visual representation of a client's family tree, which shows even the most complex interpersonal relationships between family members using codes and symbols. The genogram often reveals patterns, events, and information that assist the therapist in clinically assessing an individual or family. The genogram is used for gathering information for diagnostic assessment of psychological issues and also as an intervention. Widely used by many family therapists, this counseling tool can be used to show a variety of information about a client's relationships, family, medical, social, and even developmental history.

Development

Although Murray Bowen (1913–1990) was the first to use genograms for family therapy, Monica McGoldrick and Randy Gerson popularized genograms in 1985 with the publication of their book *Genograms in Family Assessment*. Since then, the use of genograms has expanded to be used in the medical, education, social work, and genetic research fields.

Genograms offer far more than what is normally found in a family tree, such as date of birth, gender, and date of death. Other information in a genogram often includes major life events, behavior, occupation, education, illness, and interpersonal relationships, as well as information on mental health disorders such as drug addiction or depression. According to McGoldrick and Gerson, genograms offer a therapeutic tool for better understanding and individual and his or her family system, as well as a counseling intervention in and of itself.

An experienced clinician asks questions that are part of his or her overall assessment and a therapeutic intervention in terms of reframing the views of the client's family dynamics and interpersonal relationships. The development of genograms is commonly

associated with Bowen family systems therapy and is considered a useful means of collecting family information. On average, a genogram takes about 15 to 30 minutes to complete. Computer software programs are now available to help create genograms.

Mindy Parsons, PhD

See also: Bowen Family Systems Theory; McGoldrick, Monica

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Geodon (Ziprasidone)

Geodon is a prescribed antipsychotic mediation used to treat schizophrenia and mania. Its generic name is ziprasidone.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Delusions** are fixed false beliefs that persist despite contrary evidence. Delusions are distinct from culturally or religiously based beliefs that may be seen as untrue by outsiders.
- **Food and Drug Administration** is the federal agency responsible for monitoring safety standards for food and prescription medications.
- **Mania** is an elevated or irritable mood as well as mental and physical hyperactivity, and disorganized behavior. It is characteristic of the manic phase of bipolar disorder.
- **Schizophrenia** is a mental disorder in which it is difficult to distinguish real from unreal experiences. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description

Geodon is in a class of antipsychotic medications known as second-generation or atypical antipsychotics. It is primarily used to treat schizophrenia. Geodon is also used to treat acute manic and mixed episodes associated with bipolar disorder. It can be combined with lithium or Depakote in the maintenance and treatment of bipolar disorder. As one of the newer antipsychotics, Geodon is less likely to cause significant adverse side effects than the first-generation or typical antipsychotic medications. Geodon is not approved by the FDA for treating older adults with dementia-related psychosis.

Precautions and Side Effects

Geodon should not be taken by those with a history of irregular heart rhythms, congestive heart failure, or a recent heart attack. It can also lower blood pressure to dangerously low levels. Individuals with a history of seizures should use Geodon cautiously and with close medical supervision, as it may increase the risk of seizures. Geodon may also increase body temperatures to dangerously high levels so that those who exercise strenuously, are exposed to extreme heat, take anticholinergic medications (including common antidepressants), or are prone to dehydration should use the drug cautiously. Those with an increased risk of developing pneumonia should be carefully monitored while taking Geodon. Because there is a high incidence of suicide in those with psychotic illnesses, people using Geodon should be observed carefully for signs of suicidal behavior. Women who are pregnant or breast-feeding should not take Geodon, as it can harm the fetus. Some newborns of mothers who were on Geodon during pregnancy exhibited withdrawal symptoms, including respiratory problems and tremor.

The most common side effects of Geodon are rash, drowsiness, involuntary twitching, nausea, constipation, indigestion, and dizziness due to low blood

pressure. Less common side effects include rapid heartbeat, low blood pressure, agitation, tremor, confusion, amnesia, dry mouth, increased salivation, joint pains, and abnormal vision. Many of these side effects start to appear at higher dosages.

Geodon interacts with several medications. Drugs that cause drowsiness, such as antidepressants, antihistamines, some pain relievers, and alcohol, may increase the sedative effects of Geodon. Individuals taking Ambien concurrently with Geodon should be monitored for central nervous system effects such as respiratory depression and should avoid activities that require mental alertness and motor coordination. Medications, such as Tegretol used to treat seizures and bipolar disorder, that increase liver metabolism may cause Geodon to be less effective. Geodon may also decrease the effects of drugs used to treat Parkinson's disease, such as levodopa.

Len Sperry, MD, PhD

See also: Antipsychotics; Bipolar Disorder; Schizophrenia

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Gerontological Counseling

Gerontological counseling is a psychological method for working with older clients who face the emotional and mental health challenges associated with aging.

Description

The fastest-growing segment of the U.S. population is older adults. Although two-thirds of clinicians work with those 65 years and older, only one-third of these clinicians have received any graduate training in gerontological counseling, and even fewer worked with older adults in an internship or practicum setting. Gerontological counselors working with elderly clients face the emotional and mental health challenges associated with aging. It can be difficult to treat older adults, because they may have multiple psychological or physical issues, and often face social issues as well.

Development

Gerontological counseling gained attention after the passage of the Older Americans Act of 1965, and Medicare and Medicaid in 1966. At this time, social work also became a significant part of the health-care system. In the 1970s and 1980s, the struggle was to balance proper care for the elderly with proper diagnosis. Initially the focus on elder health care led to longer hospital stays; then there was a push for shorter hospital stays and collaborative care among practitioners.

There are many negative stereotypes about aging and the elderly held by society, and by older adults themselves. It's not unusual for the elderly to feel that therapy will be of no use to them. Unfortunately, many mental health professionals also feel the same way and are not interested in working with the elderly. Counselors in training indicate they have little interest in specializing in gerontological counseling. They are likely to see depression in the elderly as normal, while it's abnormal and more severe in younger adults, even when the two groups have identical symptoms. Professionals often think that there is little hope for improvement of symptoms and that older adults are unwilling or unable to change, though evidence shows the elderly are more open to change than middle-aged people.

Clinicians are generally of the opinion that psychotherapy is less appropriate for older adults. This can be a breach of patient rights, since stereotyping by mental health professionals limits access to mental health services by older adults and goes against the guidelines of professional organizations.

Though it has been found that up to 40% of older adults suffer from at least one mental disorder, only a fraction seek help. Treatment is important for the

elderly, since therapy can help relieve pain from physical problems, as well as mental issues.

A common mental issue among older adults is substance abuse of alcohol, prescriptions, and opioids. It can be a problem, since the elderly receive 35% of all U.S. prescriptions, yet account for only 13% of the population. Older patients don't often seek help for addiction, and families and physicians attribute symptoms to age.

Health-care providers also tend to contribute to the problem with overprescribing medications, prescribing for excessive periods of time, or failing to ask about a history of substance abuse.

After a diagnosis of addiction, older adults should be watched for related disorders, such as liver disease, malnutrition, withdrawal, depression, and dementia. Like other counseling, treatment outcomes for addiction in the elderly are good. Generally, therapy for addiction is more successful for older than for younger people.

Another important focus of mental health care for the elderly is sexuality. Therapists must address all of their client's needs, including sexuality, during their counseling sessions and not dismiss them due to the client's age and mental or physical state.

Counselors can help their older clients by encouraging them to discuss their sexuality. They can offer suggestions for physical limitations to intimacy and help the patient decide how and when to have sexual activity. They should be comfortable talking about sexuality with older adults and must take into account the client's cultural background so as to make appropriate suggestions.

Assisted living is the fastest-growing area of long-term care for older adults today and presents its own issues. Social workers are an important feature of assistant living and provide mental health counseling, help address dementia care, help elders and their families sort out the appropriate long-term care settings, and provide mental health services for residents in assisted living.

Current Status

There is a need for end-of-life mental health care for the elderly. Studies on aging must be focused on improving geriatric practice and policy. Currently there is a disparity between therapists' beliefs about the elderly and what is factual. The elderly need the same access to mental health care as younger clients. To combat age bias among therapists, more professional training is needed on how to address the unique needs of older adults.

Mindy Parsons, PhD

See also: Addiction; Psychotherapy; Senior Mental Health

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Gestalt Psychotherapy

Gestalt psychotherapy is an existential, experiential, and insight-oriented form of counseling.

Description

Gestalt therapy focuses on the present moment in therapy and what is taking place between the therapist and client. Great attention is given to the client's awareness and understanding of his or her perceptions, feelings, and behaviors, both verbal and nonverbal, in the here and now as they interact with the therapist. As clients

become increasingly aware of their reality, change automatically occurs.

Development

Gestalt psychotherapy was founded by husband and wife, Fritz and Laura Perls in the 1940s. Fritz Perls (1893–1970) was a controversial figure known as much for his showmanship as for his dramatic, confrontational, and hostile style. During the development of Gestalt therapy, many of Fritz's students emulated his confrontational style, which remains one of the most significant criticisms of the method. Laura Perls (1905–1990) also made significant contributions to Gestalt therapy and took a much more supportive and relational approach to the method. She is credited with correcting many of the excesses exhibited by Fritz.

Current Status

The word "gestalt" is defined as something made of many parts that are more than the combination of those parts. In other words, people are more than the sum of their parts. Gestalt therapy is "phenomenological," meaning that it focuses on the client's experiences and perceptions in discovering and understanding the meaning of events rather than the counselor interpreting or imposing the meaning on the client. Gestalt psychotherapy is also considered an existential therapy and is grounded in the belief that people are constantly remaking, rediscovering, and becoming themselves. Gestalt therapy is experiential, meaning that it is a type of therapy that utilizes talking, role-playing, and other activities in order to discover the hidden or subconscious issues related to client problems.

Gestalt psychotherapy places emphasis on the here and now. The focus of treatment is on what is happening at the present moment between the therapist and the client. The "now" is influenced by unexpressed and unresolved painful past experiences referred to as "unfinished business." Assisting clients in becoming fully aware in the here and now as they interact with the therapist is a primary goal of gestalt psychotherapy. As clients gain awareness, change automatically occurs. Through awareness clients are able to integrate their way of thinking, feeling, and behaving in ways that make sense to them and which results in greater sense of wholeness.

The therapist's own attitudes and behaviors have a deep impact on the therapeutic process. Developing an authentic relationship with the client is essential, and therapists must be highly knowledgeable and skilled in the concepts and methods of gestalt psychotherapy. "Experiments" are foundational to the gestalt process and are designed to provide new emotional experiences and insights into a client's thinking, feeling, and behaving in the here and now. Gestalt psychotherapy uses a wide range of experiments, which may include role-play, guided fantasy, and acting out past events rather than just talking about them. An example is the "empty chair" technique in which clients are instructed to speak to an actual empty chair while imagining the person who they were hurt by is sitting in the chair. Experiments are developed during client–therapist interaction, and therapists are often very creative as they invent experiments to enhance their client's awareness and promote change.

Gestalt psychotherapy is an insight-oriented approach to helping that focuses on the client's experiences in the here and now to promote personal responsibility and growth through awareness.

Steven R. Vensel, PhD

See also: Existential Psychotherapy; Perls, Fritz (1893–1970)

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Gifted Students

Gifted students are children who are acknowledged for a special talent, skill, or intelligence.

Definitions

- **Gifted** is an adjective that indicates the persons described have talent or natural ability greater than the expected norm or average.
- **Intelligence** is the capacity a person has to learn and understand information and solve problems.
- **Intelligence quotient** is a measure of intellect to determine a person's level of cognitive ability.

Description

Gifted students are recognized for their ability to think or create at levels more advanced than their peers. It is important to note that even the National Association for Gifted Children admits that there is no universally accepted definition of giftedness. For example, gifted does not simply mean intelligence although that can be one important factor in the recognition of giftedness. "Talented" is another operative term used to describe gifted students in different areas. This includes children who are creative, artistic, and excel interpersonally.

A child is designated as a gifted student after he or she completes a psychological evaluation with the result of a high intelligence quotient (IQ). It has been estimated that about 3 million elementary, middle, and high school students in the country would be considered eligible for gifted and talented programs. An even smaller percentage would be classified as highly gifted. Obviously there are not enough programs to accommodate the number of gifted students nor is the effectiveness of the existing programs clearly measurable. Although there are national directives for special education, the provision of educational programs is the responsibility of states and local communities. There is a challenge for educational systems to provide services that will help gifted and talented children. That challenge is to develop their skills and capabilities and not have their gifts lost in a system which often focuses on academic achievement.

Current Status and Impact (Psychological Influence)

Despite having services and programs in place, there is little convincing evidence that links student achievement to the results of programs for gifted students. In fact, students who are admitted to gifted programs at the lower end of testing may actually end up doing worse on testing and grade results. This could mean that being segregated with even better-performing students seems to sometimes have a negative effect on their efforts. It is also difficult to evaluate the effects of environment, culture, and family factors, which are outside the school environment.

Teachers and counselors are aware that children have a broad range of needs that are not only based on academics. This can be true for gifted students as well who may often be poor performers in the classroom for reasons such as a deficit of social skills.

Professionals working with gifted students need to be careful to analyze and judge each child's situation individually. There is also a need to balance the academic with the social aspects of education. Isolating the gifted can have negative social effects on students if educators are not aware of the dangers. Educators, parents, and counselors need to be ready to help not just with intellectual but with social and emotional supports as well.

Alexandra Cunningham, PhD

See also: Intelligence Testing

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Gifts Differing: Understanding Personality Types (Book)

Gifts Differing: *Understanding Personality Types* is a book about personality based on how individuals view the world and make decisions. It was written by Isabel Briggs Myers and first published in 1980.

Definitions

- **Couples therapy** is a type of psychotherapy that focuses on resolving conflicts and improving couple's relationships. It is also called marriage counseling and marital therapy.
- **Myers–Briggs Type Indicator** is a personality test for evaluating preferences in how individuals perceive (view) the world and make decisions.
- **Personality** is the enduring pattern of perceiving, feeling, relating, and thinking about one's environment and oneself.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

Description

Isabel Briggs Myers (1897–1980) and her mother, Katherine Cook Briggs (1875–1968), developed a system to classify personality types. This was largely based on the work of Carl Jung (1875–1961). Briggs Myers was not trained as a psychologist, but she learned about personality assessment by evaluating employees at a local bank. She developed her first test in 1944, called the Myers–Briggs Type Indicator (MBTI). It was formally published in 1957. The MBTI was initially tested on students and is now a very popular test used by millions. It is commonly used to assess an individual's fit in a specific job. It can also be used in individual psychotherapy and couples therapy. In her book *Gifts Differing: Understanding Personality Type*, Briggs Myers outlines the theory behind the test.

According to this theory, there are four different personality types or "preferences" across two different dimensions. The first dimension relates to how individuals perceive the outside world. Some rely on their five senses, such as touch and vision. These are called *sensing* (*S*) types. Others look to their internal reactions, or "gut feelings." These are *intuitive* (*N*) types, relying on intuition. The second dimension of personality relates to how individuals make judgments and decisions. *Thinking* (*T*) types prefer impersonal logical analysis, while *feeling* (*F*) types consider what something means to them. An individual's tendencies in these different areas result in his or her personality preference. The four preferences are *ST* (Sensing plus Thinking), *SF* (Sensing plus Feeling), *NF* (Intuition plus Feeling), and *NT* (Intuition plus Thinking). These preferences explain an individual's behavior in relationships, work, and other areas. For example, *ST* (Sensing plus Thinking) individuals focus on facts that can be verified by their senses. They are successful in jobs that require impersonal analysis, such as accounting, and are not focused on others. On the other hand, *NF* (Intuition plus Feeling) individuals are considered to be friendly and enjoy work that involves communication such as teaching. Another component of Briggs Myers's personality types is introversion and extraversion. Introverts prefer to develop their ideas gradually and need to have time alone. Extroverts move quickly and enjoy being around others. The final part of personality relates to individuals' preferred extraverted function. This may either be *judging* (*J*), for those who want matters settled, or *perceiving* (*P*), for those who like to explore new possibilities.

All of these components come together to form an individual's four-letter personality type. For example, an ESFJ represents an *extravert* who has a preference for *sensing* and *feeling*, with *judging* as the preferred extraverted function. The MBTI test consists of "yes" or "no" questions intended to identify an individual's personality type. Items include statements such as "you are almost never late for appointments" and "you enjoy having a wide circle of acquaintances." Some have criticized Briggs Myers's theory because she did not have formal education in psychology. Others have suggested that her categories were not based on research and misrepresented the work of Carl Jung. Nevertheless, the MBTI continued to be a popular assessment tool.

George Stoupas, MS, and
Len Sperry, MD, PhD

See also: Couples Therapy; Personality; Psychotherapy

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Ginkgo Biloba

Ginkgo biloba is an herbal remedy used for many medical conditions, including memory problems and dementia. It is commonly called ginkgo.

Definitions

- **The National Center for Complementary and Alternative Medicine** is part of the National Institutes of Health. Formerly called the Office of Alternative Medicine, it scientifically investigates complementary and alternative medicine healing practices, and disseminates authoritative information to professionals and the public.
- **Traditional Chinese medicine** is an ancient but still practiced form of healing based on harmony and balance. It emphasizes diet and prevention and uses acupuncture and herbal remedies to stimulate the body's own natural curative powers and reestablish balance.

Description

Ginkgo biloba is an herbal supplement made from the leaves of the tree Ginkgo biloba. It has been used in traditional Chinese medicine for nearly 5,000 years to treat memory loss and mood, nerve, circulatory, and many other health problems. When combined with ginseng, ginkgo can boost memory, improve the quality of life, and increase well-being. Ginkgo is often used for memory disorders, including Alzheimer's disease. It is also used for conditions that seem to be due to reduced blood flow in the brain, especially in older adults. These conditions include headache, ringing in the ears, vertigo, difficulty concentrating, and hearing disorders. Ginkgo is a top-selling herbal remedy in the United States as well as in Europe.

The effectiveness of ginkgo in relieving pain caused by clogged arteries in the leg, in treating Alzheimer's disease, and in improving blood flow to the brain has already been evaluated in well-designed studies and is generally accepted by practitioners of conventional medicine. The National Center for Complementary and Alternative Medicine is sponsoring clinical trials to determine safety and effectiveness of ginkgo as a treatment for more than a dozen other medical conditions. Information on these clinical trials can be found at http://www.clinicaltrials.gov.

Precautions and Side Effects

Ginkgo biloba is not recommended during pregnancy and breast-feeding, due to lack of reliable medical information. People who are preparing for dental or surgical procedures should stop taking ginkgo at least two days before their operation because of the risk of increased bleeding.

Ginkgo is generally safe and causes few side effects when taken at recommended doses for up to six months. The most common mild side effects are headache, dizziness, nausea, diarrhea, restlessness, racing heart, and allergic skin reactions. Serious side effects of ginkgo are rare. These include increased bleeding and the skin blisters and sloughs off (Stevens-Johnson syndrome).

Because ginkgo has blood-thinning properties, it can increase the blood-thinning and anticoagulant effects of medications such as Coumadin, Plavix, aspirin, Advil, or Motrin. Individuals taking these drugs should not begin taking ginkgo without talking to their doctor.

Len Sperry, MD, PhD

See also: Acupuncture

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Ginseng

Ginseng is an herbal remedy that is used to increase energy, reduce stress, and treat a number of medical conditions.

Definitions

- **Polysaccharides** are complex carbohydrates (nutrients) like starch or cellulose that are made up of sugar molecules that are linked together.
- **Traditional Chinese medicine** is an ancient but still practiced form of healing based on harmony and balance. It emphasizes diet and prevention and uses acupuncture and herbal to stimulate the body's own natural curative powers and reestablish balance.

Description

There are two main types of ginseng: Asian (Panax ginseng) and American ginseng (Panax quinquefolius). Other herbs are called ginseng, such as Siberian ginseng, but they do not contain the active ingredient of ginsenosides. Ginsenosides are chemical substances in the body that may increase insulin levels and lower blood sugar. Other active ingredients in ginseng are polysaccharides that can increase immunity.

For over 2,000 years Ginseng has been used in traditional Chinese medicine to increase energy, reduce stress, promote recovery from illness and injury, and improve mental and physical performance. It has also been used to treat various medical conditions, including infections, gastrointestinal disorders, circulatory problems, cancer, diabetes, and migraine headache. While many of these traditional uses of ginseng have yet to be scientifically verified, some have. For example, some research has found that Asian ginseng can boost the immune system, especially when taken with a vaccine, or by older adults recovering from an infection or other illness. Other research has shown that ginseng may lower blood sugar levels, which could benefit those with type 2 diabetes. Ginseng may also improve concentration and learning ability. In some research on mental performance, ginseng has been combined with ginkgo biloba. There has been less research on the use of ginseng to treat cancer, heart disease, fatigue, erectile dysfunction, high blood pressure, or menopausal symptoms. The National Center for Complementary and Alternative Medicine has reviewed such studies and concluded that ginseng merits further investigation. It has begun sponsoring clinical trials to determine safety and effectiveness of ginseng. Information on these clinical trials can be found at http://www.clinicaltrials.gov.

Precautions and Side Effects

Because ginseng may affect blood sugar levels, those taking diabetes medications should not use ginseng without first talking to their physician. Because caffeine can increase ginseng's stimulant effects, it may be necessary to cut back on coffee and other sources of caffeine. Because there is little evidence of its safety, ginseng is not recommended for women who are pregnant or are breast-feeding. Similarly, it is not recommended for children.

Generally, the side effects of ginseng are generally mild. These include nervousness and difficulty falling or staying asleep, nausea, diarrhea, and rash. Long-term use or high doses of ginseng has been reported to cause headaches, dizziness, stomach upset, breast tenderness, and menstrual changes. Such side effects can be avoided by taking ginseng for a few weeks but less than three months and then stopping it. After a short break, ginseng can be restarted.

Because ginseng has blood-thinning properties, it can increase the blood-thinning and anticoagulant effects of medications such as Coumadin, Plavix, aspirin, Advil, or Motrin. Individuals taking these drugs should not begin taking ginseng without first talking to their doctor.

Len Sperry, MD, PhD

See also: Ginkgo Biloba

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Glasser, William (1925–2013)

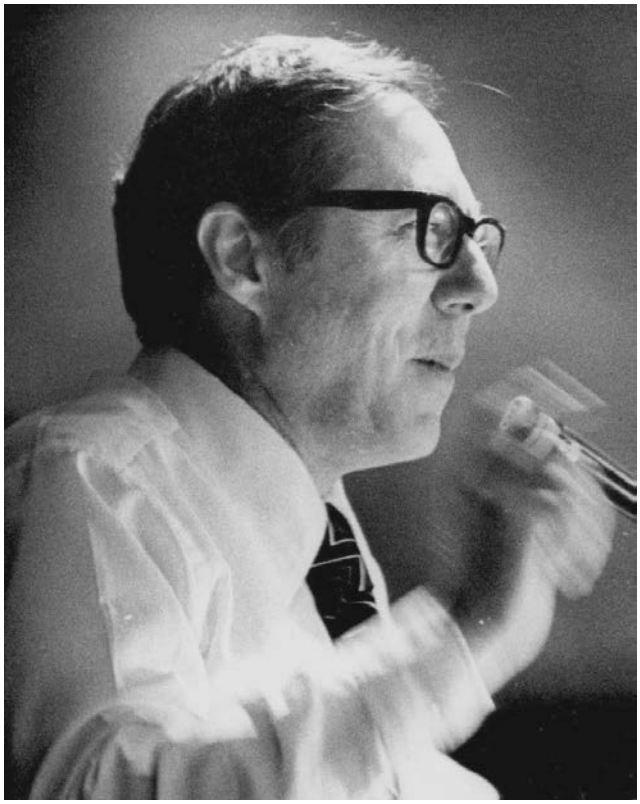
American psychiatrist and theorist William Glasser is known for his work in developing both a therapeutic approach, reality therapy, and a theoretical basis for that approach, termed choice theory, both of which emphasize personal choice and responsibility in explaining mental health and happiness. Glasser's ideas have been applied in the fields of education, management, and marriage and family therapy.

Description

William Glasser was born on May 11, 1925, in Cleveland, Ohio, to Ben and Betty Glasser. He graduated from Cleveland Heights High School in 1942 and went on to pursue a degree in applied sciences from Case Western Reserve University. After graduating, he worked for Lubrizol at Case as a chemical engineer but soon realized that this was not what he wanted to do long term. In 1946, he enrolled in Western Reserve University's psychology program, but was then drafted into the army. After completing basic training, Glasser was sent to Dugway Proving Ground in Utah where his duty was to test German poisonous gases. In 1953, he returned to school to finish his MD in psychiatry. He went on to complete his residence training in Los Angeles, California, at UCLA and the Veteran's Administration Center between 1956 and 1957. Glasser worked under psychiatrist, Dr. G.L. Harrington at the Veteran's Center, whom he credits as his mentor.

Glasser maintained a private practice for 30 years, from 1956 to 1985. It was during this time that he formed his own theory about how to approach mental illness, which he coined "reality therapy." This approach was in complete contrast to the popular "medical model" of the time that emphasized diagnoses and the use of prescription drugs. Glasser posited rather that people were responsible for their own choices and those that had difficulty in connecting and forming positive relationships with others eventually led to their unhappiness and mental instability. He believed that a person has the power to transform his or her life simply by making different choices. Choice theory, first termed "control theory," explains human behavior by stating that all humans choose to behave in ways that satisfy five basic needs, the most important being love and belonging. The tenets of this theory have been applied across several areas of study, including education, business, and relationships. Its goal is to increase connectedness to prevent human problems. Thus, Glasser is credited with making mental wellness a public health concern.

William Glasser's approach to counseling is referred to as "reality therapy," which he coined in 1965 in his book *Reality Therapy: A New Approach to Psychiatry*. Practitioners who work from this model must have a deep understanding and acceptance of control, or choice theory. Glasser believed that mental illness was caused by faulty choices and a person's unwillingness to accept responsibility for his or her actions. Brain malfunction was a true diagnosis only if it could be confirmed by a pathologist. Reality therapy's foundation is grounded in the belief that all people need to feel connected and cared for in order to protect them from life's woes. A reality therapy counselor will emphasize the present, avoid discussing symptoms or complaints, urge the client to focus on what he or she can do directly to change his or her feelings and physiology, refrain from criticism or blame, remain nonjudgmental, help the client to avoid making excuses, and assist in developing a realistic and workable plan toward positive change. In 1967, Glasser founded The Institute for Reality Therapy in Tempe, Arizona. In 1994, he changed it to The Institute for Control Theory, Reality Therapy, and Quality Management and then to The William Glasser Institute in 1996. Branches can now be found throughout the United States as well as internationally.



William Glasser's approach to counseling is referred to as "reality therapy"—a term he coined in his 1965 book *Reality Therapy: A New Approach to Psychiatry*. (Ernie Leyba/The Denver Post via Getty Images)

Some of the basic principles of Glasser's theory were influenced by scientist William T. Powers's writings on perceptual control theory (PCT). PCT states that humans behave in direct response to what they perceive in their environments. The range of actions one takes in a given situation depends on the possibilities one perceives in that situation. If one perceives that the possibilities are limited, then one acts in a confined manner or may not even act at all. Glasser's first called his theory "control theory" during the 1970s but later changed the name to "choice theory" in the late 1990s, so as not to confuse it with PCT. Choice theory has three main principles: (1) all humans do is behave, (2) almost all behavior is chosen, and (3) humans are driven by their genes to satisfy five basic needs: survival, love and belonging, power, freedom, and fun. The most important of these is love and belonging, as connectedness to others is a requisite in preventing problems such as mental illness, crime, abuse, and school failure. People are believed to be in control of their own lives; therefore, personal choice, responsibility, and ownership lead to transformation. Glasser's key book on the topic *Choice Theory: A New Psychology of Personal Freedom* was published in 1998.

Glasser's teachings have been applied in other areas, including education, business, substance abuse, and marriage and family therapy. He has worked with countless schools and businesses incorporating reality therapy and choice theory principles. A management style he termed "lead management" fosters an environment of non-coercion where members are trusted, respected, and valued, and strive to produce high-quality work. Several books were written applying this approach in schools, including Glasser's own popular work *The Quality School: Managing Students without Coercion* (1990). Glasser defined "quality schools" as those that apply the principles of reality therapy and choice theory, whereby the members respect one another, are responsible for the choices they make, and are held to high expectations.

In 2007, he coauthored *Eight Lessons for a Happier Marriage* with his wife Carleen, to help couples improve their relationship.

Impact (Psychological Influence)

William Glasser has had many profound accomplishments. He's been listed in *Who's Who in America* since the 1970s. In 1990, he was awarded an honorary degree of Doctor of Humane Letters, Honoris Causa, from the University of San Francisco. He was presented with the ACA Professional Development Award in 2003 and with the A Legend in Counseling Award in 2004. In 2005, he received the designation of Master Therapist from the American Psychotherapy Association and the Lifetime Achievement Award from the International Center for the Study of Psychiatry and Psychology. In July 2010, the William Glasser Association International was established to coordinate the institute's activities worldwide. Active organizations are located in the United States, Canada, the United Kingdom, Europe, Asia, Australia, New Zealand, and Central and South America. William Glasser died in his home in Los Angeles, California, on August 23, 2013, due to respiratory failure as a complication of

pneumonia. Glasser's work continues to impact several fields of study.

Melissa A. Mariani, PhD

See also: Reality Therapy

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Going Postal

"Going postal" is a slang term for becoming suddenly and uncontrollably angry to the point of violence. The term originated from a series of shootings involving U.S. postal employees.

Description

The term originated from a series of shootings involving current or former United States Postal Services (USPS) employees who shot and killed managers, coworkers, police, and the general public. The first reported shooting occurred on August 19, 1983, when Perry Smith charged into a Johnston, South Carolina, post office with a 12-gauge shotgun killing the postmaster and wounding two other employees. Three years later, Patrick Sherrill entered an Edmond, Oklahoma, postal facility and fatally shot 14 employees and wounded another 6, before killing himself. In 1989 John Merlin Taylor killed his wife, then two colleagues, and himself at Orange Glen post office in Escondido, California. Two years later, Joseph M. Harris killed his ex-supervisor and her boyfriend at their home in Wayne, New Jersey. He then shot two former colleagues at a Ridgewood, New Jersey, post office where they all previously worked together. Harris was subsequently convicted of murder and died on death row in 1996. In Royal Oak, Michigan, Thomas McIlvane killed four and wounded five, before killing himself in 1991. Then in 1993 Larry Jasion killed one, wounded three, and then killed himself at a post office garage in Dearborn, Michigan. At a Miami Beach, Florida post office, Jesus Antonio Tamayo shot his ex-wife and a friend as they were waiting in line, and then killed himself on September 2, 1997. A few months later, Anthony Deculit killed a coworker and wounded a supervisor and another coworker before killing himself at a postal facility in Milwaukee, Wisconsin. On January 30, 2006, the deadliest workplace shooting in the United States by a female occurred. Jennifer San Marco killed six employees and then herself at a Goleta, California, postal facility.

Impact (Psychological Influence)

These shootings occurred in the context of significant changes in the USPS to increase productivity. For many postal employees, the pressure of increasing demands from management became unbearable. Patrick Henry Sherrill well illustrates the enormity of the pressure on postal employees during that era. On August 19, 1986, two supervisors at an Edmond, Oklahoma, postal facility verbally abused Sherrill in an effort to further increase his productivity. Sherrill, who had excellent annual performance reviews, was then threatened with termination if his productivity did not increase appreciably. He subsequently attempted to transfer to a maintenance job. After learning that such a transfer was doubtful, he went home, got a gun, and returned and responded to his supervisors' demands with fatal gun fire. The explanation offered by the USPS and promulgated by the media was that problems in the USPS were undeniably problems with disgruntled postal workers, mostly by Vietnam vets who went to work for the postal service after military discharge. Unfortunately, it did not address the issue of mobbing, which involves abuse of employees in an organization which does not hold the abusers accountable for their actions.

Len Sperry, MD, PhD

See also: Mobbing

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Going Viral

"Going viral" is a term that refers to the overnight spread of information, through electronic means such as e-mail, Twitter, Facebook, and YouTube, making the information instantaneously popular.

Description

The cultural phrase "going viral" refers to information being spread through electronic media in a very short amount of time. The rate at which this information reaches others drastically increases the phenomenon's popularity. Various electronic means contribute to items "going viral" such as Twitter, YouTube, Instagram, Facebook, and e-mail. The "going viral" phenomenon follows the same concept as that of a computer virus. Once one person receives the virus (idea) from a source, he or she passes it along to another person, and so on and so on, until the information has fanned out to thousands or even millions of people in a relatively short span of time.

Most information goes viral because people choose to forward it, or pass it along, to friends, family members, and coworkers. Whether this information comes in the form of e-mail content, an image, a video, a blog article, a photo, a song, or a link, what makes it viral is that it has been passed on to many other people. Political content, celebrity news, jokes, and home videos are examples of topics that may go viral. It is not necessarily the information that is the critical factor but the passing along of the information by the person forwarding it or posting it on his or her online status. Viral information is an interesting occurrence because it is not determined by the creator but by the viewer or consumer.

The basis of the "going viral" dynamic has been present in various aspects of human behavior for centuries. Basically, human beings have used dialogue to forward information for some time. Topics and ideas that reach others "through word of mouth" can be likened to this process. The field of marketing has long capitalized on this type of phenomenon in order to popularize companies and their products. Viral information relies on some sort of hook in order for the information to catch on; however, one can never be certain what that hook may be or how to create it.

Impact (Psychological Influence)

Technological advances and the rise in popularity of certain forms of media like social networking sites, e-mail, Twitter, and Instagram have drastically increased the potential of information "going viral." In 2012, the video by Invisible Children named Kony became the most viral video in history, with over 34,000,000 views on the first day of its upload on March 5, 2012. As of April 1, 2013, it had been viewed more than 97,000,000 times.

Melissa A. Mariani, PhD

See also: Electronic Communication; Social Media

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Gottman, John (1942–)

John Gottman is a clinical psychologist and founder of the Gottman Institute who is best known for his research into marriage, couple, and family functioning.

Description

John Gottman is best known for his research into marriage and couples relationships and has published his

findings in over 200 peer-reviewed articles and authored over 40 books. Gottman and his wife, Julie Schwartz Gottman, PhD, lead the Relationship Research Institute, a nonprofit research institute. They also cofounded and run The Gottman Institute, a for-profit training center for family and marital therapists in the Gottman Method Couples Therapy.

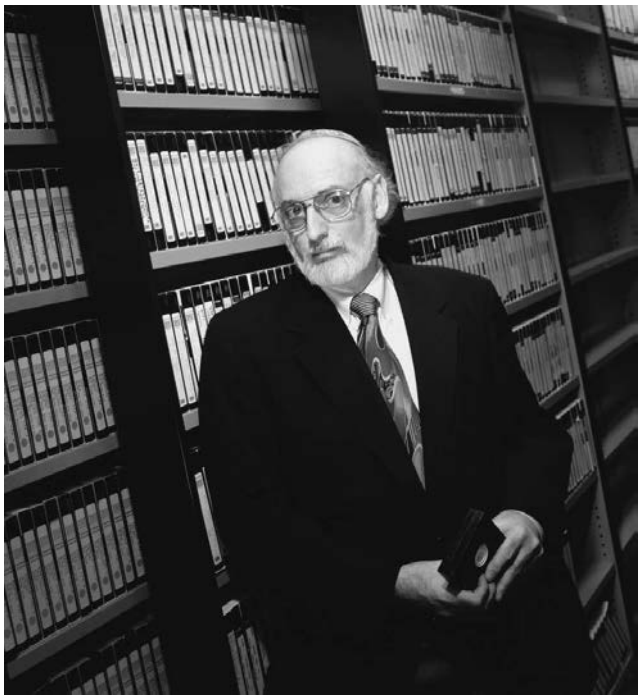
John Gottman was born on April 26, 1942, in the Dominican Republic to Jewish parents. He received a mathematics-physics undergraduate degree from Fairleigh Dickinson University in New Jersey in 1962. Gottman went on to earn two master's degrees: a master's in science in mathematics-psychology from Massachusetts Institute of Technology in 1964 and a master's in arts in clinical psychology-mathematics from the University of Wisconsin in 1967. Gottman received his PhD in clinical psychology in 1971 from UW in 1971.

Gottman taught at Indiana University for 5 years (1972–1976) and then at the University of Illinois for 10 years (1976–1986). From 1986 to 2002 Gottman was professor of psychology at the University of Washington where he remains as emeritus professor of psychology. He is currently the executive director of the Relationship Research Institute in Seattle, Washington.

Gottman launched his career in marital and family research with a 1969 peer-reviewed article on marital interaction and parenting. In 1986 Gottman set up the Family Research Lab, a furnished apartment overlooking a lake where he could videotape couples having discussions. Affectionately known as the "Love Lab," it was the first scientific observations of couple's interactions as they attempted to resolve conflicts. Since that time Gottman has become well known for his research on predicting divorce and has completed several studies that explored what predicts marital stability and divorce. In a 1992 study he was able to predict with 93.6% accuracy which couples would divorce. Building on that study Gottman conducted and published additional research findings on predicting divorce and marital stability. An example of how Gottman studied couples is his 1999 study. Using newlyweds who were married less than six months, Gottman videotaped couples discussing an ongoing marital conflict. Gottman coded the couple's interactions, facial expressions, vocal tone, speech content, positive and negative affect, physiological data, and self-ratings by each partner. Gottman was able to predict marital outcome over a six-year period.

Gottman's consistently high prediction rate suggests that the type of interaction and pattern of behavior can make couples vulnerable to divorce. One such pattern that Gottman observed he named "Four Horsemen of the Apocalypse." The four horsemen are criticism, contempt, defensiveness, and stonewalling, which predict the end of a relationship. Based on his research observations of couple's interactions and behavior patterns, Gottman published *The Seven Principles for Making Marriage Work* in 1999. The book is the culmination of what Gottman has learned about what makes marriages work and what makes them fail. The book also serves as the foundation for training lay people in conducting couples groups through the Gottman Institute.

Founded by John and Julie Gottman, the Gottman Institute serves two purposes. It provides direct services to couples and provides state-of-the-art training



John Gottman is a clinical psychologist and founder of the Gottman Institute. He is best known for his research into marriage, couple, and family functioning. (Andrew Brusso/Corbis)

to mental health professionals in the application of 30 plus years of marriage research. The Gottman Institute offers a wide variety of workshops and training for couples and professionals. In addition, licensed mental health practitioners are able to become Certified Gottman Therapist.

Impact (Psychological Influence)

John Gottman has received numerous awards in recognition of his research and work with couples. He has received four national Institute of Mental Health Research Scientist Awards; the American Association for Marriage and Family Therapy Distinguished Research Award; and the American Psychological Associating Presidential Citation for Outstanding Lifetime Research Contributions.

Steven R. Vensel, PhD

See also: Couples Therapy

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Grief

"Grief" is a term that refers to a person's emotional response or reaction to the loss of someone or something that was close to them.

Definitions

- **Anticipatory grief** is the type of grief associated with situations where the loss of a loved one is impending as with a terminal illness.
- **Bereavement** is a term that refers to the state of loss.
- **Complicated grief** describes when an individual does not cope well with a loss and it begins to impact his or her life in physically, emotionally, socially, and psychologically unhealthy ways, or at a level that is not considered normal in that culture and/or society.
- **Five Stages of Grief** is a popular theory used to describe the grieving process as outlined by Kübler-Ross; five stages are denial, anger, bargaining, depression, and acceptance.
- **Grieving process** describes steps or stages one goes through when experiencing or attempting to cope with a loss or tragedy.

Description

Grief is the emotion that describes how a person responds to loss. It is often used interchangeably with the term "bereavement" which defines the state of loss, while grief defines an individual's reaction to the state of loss. Loss can be related to things that are tangible, or can be measured, such as the death of a loved one or the loss of income, or intangible (abstract) such as the loss of one's youthfulness or sense of independence. People dealing with life-threatening diseases or family members witnessing a loved one's journey through a terminal illness may experience what is referred to as anticipatory grief. With this type of grief, the patient or loved one is preoccupied by thoughts and feelings surrounding the impending death. Grief is multifaceted, encompassing not only emotional reactions but also physical, cognitive, behavioral, social, and physiological components. Grief is distinct to each individual and each circumstance; no two people experience grief in the same way or in the same period of time. Multicultural differences can also impact how a person grieves. Some common ways people express grief include crying, angry outbursts, and talking about the

loss. Experiencing and expressing grief is natural and healthy; however, individuals may also struggle to deal with grief in effective ways. Children, in particular, may need assistance in working through loss situations. In these cases, a mental health professional or health-care provider should be consulted.

When one experiences a loss, one enters into what is known as "the grieving process." There are varying steps and terms used to describe this process depending on the theory. The most well known is the Kübler-Ross model, or Five Stages Theory. This model was developed by Elisabeth Kübler-Ross and outlined in her 1969 book *On Death and Dying*. The theory lists five distinct stages that people experience during a loss or tragedy: denial, anger, bargaining, depression, and acceptance. These stages are not linear and not every person experiences every stage. A later model, developed by psychologist George Bonanno, contradicts the Five Stages Theory based on evidence that the majority of people do not grieve. Rather, Bonanno's research suggested that most people are resilient when faced with loss or tragedy. His model refers to the Four Trajectories of Grief: resilience, recovery, chronic dysfunction, and delayed grief/trauma. Psychiatrist Mardi Horowitz also developed stages of loss, including outcry, denial and intrusion, working through, and completion. Like Kübler-Ross's model, these stages are not linear, and each individual does not necessarily experience every stage. Researcher and clinical psychologist Therese Rando came up with yet another model for the stages of grief. Her six Rs theory describes the way people respond to grief: recognize, react, recollect and reexperience, relinquish, readjust, and reflect. A similar approach was taken by psychologist J. W. Worden, outlining the four tasks of grief. They are (1) to accept the reality of the loss, (2) to work through the pain of grief, (3) to adjust to an environment in which the deceased is missing, and (4) to emotionally relocate the deceased and move on with life. Regardless of the model of theory that one subscribes to, the primary goal of a natural and healthy grieving process is acceptance.

Current Status and Impact (Psychological Influence)

Currently, the *Diagnostic and Statistical Manual* (DSM) does not specifically define grief or bereavement as a disorder, though other formal diagnoses may be associated with these experiences, including major depressive disorder, post-traumatic stress disorder, and generalized anxiety disorder. Prolonged grief disorder, previously referred to as complicated grief, has been proposed for inclusion in the DSM, though critics argue that this would pathologize a natural process. Though most people are able to cope effectively with grief a small percentage, approximately 10%–15% experience severe reactions, including those that affect their relationships, work, and health. Seeking the assistance of a psychologist, psychiatrist, or other mental health professional is recommended in these instances.

Melissa A. Mariani, PhD

See also: Bereavement; Grief Counseling

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Grief Counseling

Grief counseling is a type of specialized counseling service directed toward persons experiencing grief-related issues.

Definition

- **Grief therapy** is a therapy used to address those suffering with bereavement issues, which involves the use of psychotherapeutic techniques and/or psychotropic medications; it is distinguished from grief counseling in that it may be required for individuals displaying complicated grief, a level of grief considered outside of the cultural or societal norm.

Description

Grief counseling is a supplemental support service offered to people dealing with loss or bereavement issues. It focuses on assisting the client in coping through the grieving process. Psychologists, counselors, social workers, therapists, and other mental health professionals are schooled in providing this type of counseling. One may also receive further specialization, training, or certification in this area. Grief counseling can be offered on an individual basis or in a group setting.

Those dealing with the normal grieving process may find grief counseling beneficial. Most people who have experienced loss are encouraged to seek grief counseling as it is considered a healthy coping strategy for expressing one's thoughts and feelings. Counseling for grief differs from grief therapy in that the latter may be recommended for those who are grieving in unhealthy ways and/or are doing so for an extended period of time. Therapy is considered a more focused, intensive, and necessary form of treatment to prevent further possible consequences. It employs the use of psychotherapeutic techniques and/or possibly the assistance of psychotropic medications in order to assist the individual in dealing with his or her loss. Situations requiring grief therapy typically involve people who are suffering from what is referred to as complicated grief, that is, displaying levels of grief that are considered outside of societal or cultural norms. The goal of both grief counseling and therapy is acceptance and resolution of the client's feelings related to his or her loss.

Development

Grief counseling, though always a part of general counseling practice, began in the early 1940s with research conducted by psychiatrist Erich Lindemann on what he described as "normal grief." His article "The Symptomatology of Management of Acute Grief" was the first scholarly paper written that addressed grief counseling as a practice. A peak in interest then came during the late 1960s and early 1970s. Much of this was due to the work of Elisabeth Kübler-Ross and her seminal book *On Death and Dying* (1969), which examined how the medical community deals with the terminally ill. She also outlined five distinct stages experienced by the bereaved: denial, anger, bargaining, depression, and acceptance. Attachment theory, developed by psychoanalyst John Bowlby, also occurred around this time and contributed to a deeper understanding of bereavement. Bowlby suggested that grief was an adaptive process influenced by both past and present losses and environmental factors. Later in the 1970s, psychiatrist Colin Murray Parke expanded bereavement research focusing more on traumatic loss and complicated grief. In the 1996 book *Continuing Bonds*, Klass, Silverman, and Nickman discussed grief as an ongoing process rather than a completion of stages whereby healing can be fostered by holding onto bonds with the lost. Grief counseling practices in the 21st century require that practitioners have a multicultural understanding of grief responses.

Current Status

Modern grief counseling theory incorporates some aspects of the foundational theories; however, most counselors today oppose the idea that the grieving process is confined to phases and that one must successfully complete one or all of these in order to successfully resolve or effectively accept one's loss. The Oscillation Model is one such theory that indicates that individuals continually learn new ways to adapt to their different life. Furthermore, current research offers that it is not necessary for an individual to let go of his or her loved one in order to heal. Findings suggest both holding onto attachments and simultaneously letting go of the loss. Psychologist and researcher Robert Neimeyer recommends that grief counseling practice shift away from private and sequential models and more toward personalized/individualized care.

Melissa A. Mariani, PhD

See also: Grief; Kübler-Ross, Elisabeth (1926–2004)

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Group Counseling

Group counseling is a form of therapy that is used to help two or more participants resolve both typical and challenging problems in life. It is sometimes referred to as group therapy or group work.

Description

Group counseling is therapy that involves two or more people and a counselor who work together to achieve mutually agreed-upon goals. Ideally, groups consist of generally about 3 to 4 members for children or adolescent groups and as many as 8 to 12 members for adults. The size of the group is important as when the group becomes too large, it can hinder group interaction and the feeling of safety that is necessary for open and honest communication within the group. The groups typically meet weekly for as much as 6 to 16 weeks.

Group counseling provides an opportunity for deeper insight and understanding by providing an opportunity to help heal, provide support, and offer encouragement from other members. Groups are formed for common life problems that focus on interpersonal processes. The group leader sets the tone with being genuine and warm to encourage members to do the same as the higher degree of empathy and understanding present the better opportunity for growth for each member.

The purpose of group counseling is to guide members toward self-exploration and awareness. The goals of group counseling include helping the members to develop positive outlooks and improve interpersonal skills through interaction with other group members. The process is used to help facilitate the change process through feedback and support from other group members. The group allows for a safe environment to begin these skills so they can be used and applied in everyday life.

Development

Working in groups is a natural process and those in the helping professions, including counseling, have worked with people in group formats since the early 1900s. Group work in its larger context is typically broken down into different types of groups: task/work, psychoeducational, counseling, and psychotherapy groups. Each type has a distinct purpose for its members. It is often said in the field of counseling that "there's a group for that" as group counseling has grown dramatically offering various different types of groups for different needs.

Current Status

With the growth and increasing commonality of groups, the presence of the Association for Specialists in Group Work provides a wealth of information. This organization provides information not only about groups but also about the proper training to lead groups. The Association for Specialists in Group Work recommends that group leaders be adequately trained and have knowledge in the areas of human development as well as identification and treatment of common problems of living.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Group Therapy; Peer Groups; Psychoeducational Groups; Self-Help Groups

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Organization

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Group Homes

A group home is a residence for persons requiring care or supervision, such as troubled youth, the developmentally disabled, the elderly, or those suffering from addiction.

Description

Group homes are generally private residences that house children or adults with either mental or physical disabilities. For some residents, living independently is not an option as they require assistance to complete daily tasks. Group homes are also common for children or adolescents with behavioral problems, such as those who are dangerous to themselves or others. Thus, group homes are generally supervised to varying degrees based on the type of population being housed and their respective needs.

Group homes are common for children in foster care, runaway teens, at-risk youth, and the developmentally disabled. Group homes for adolescents are generally temporary or short-term placements, whereas with adults they tend to function as long-term placements although some adults build the skills necessary to move into independent living situations. In the early and mid-20th century, these functions were handled by asylums, orphanages, and other institutions.

Most group homes are single family homes adapted to the needs of the residents. Oftentimes, group homes are located in residential neighborhoods with no distinction from other homes in the community. Residents in group homes often have either chronic mental health disorders or physical disabilities. Each home has a team of workers who are present for around-the-clock care and supervision. The majority of group homes that house children are often temporary placements until a foster family becomes available. However, group homes for adolescents are also utilized for at-risk youth who require higher levels of care.

A primary goal of group homes is to build independence and self-care skills. Adult residents are among the most severely disabled. Group home staff provide transportation, meals, medication, and recreational activities. Group homes also often provide mental health services. Children who are psychotic, suicidal, or extremely aggressive are considered to be poor candidates for group homes; however, there has been a trend to use group homes as a short-term care option for adolescents with varying emotional and behavioral problems.

Development

Group homes were a response to the closing of institutions, asylums, and orphanages in the 1960s and 1970s. The first known use of the term "group home" was in 1967. Psychiatric hospitals were closing and those hospital patients needed places to go. A group home provided care for the individuals while allowing for adjustment into community. This functioned as a less-restrictive environment and was intended to reflect typical daily life.

Group homes are often funded by grant programs or through state and federal funds. Many are run by nonprofit organizations. They are considered positive alternative to institutionalization. Group homes within neighborhoods often receive opposition from those living in the residential area. The common reaction of residents to the news of a group home opening is "Not in my backyard," which spawned the acronym NIMBY. There are often protests, with residents concerned about safety, security, and declining property values. Social workers and case managers are constantly looking for ways to improve the relations between neighborhoods and the group homes.

Current Status

Research over the past 25 years has indicated that individuals in group homes have demonstrated increases in level of independence and function. Current research is also looking to determine best outcomes for children in residential group homes versus therapeutic foster

care. There is also a current debate about the short-term and long-term effects of living in group homes for adolescents.

Mindy Parsons, PhD

See also: Case Management; Foster Care

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Group Therapy

Group therapy involves one or more therapists meeting with several clients at one time, and it is widely used for a variety of psychiatric problems.

Description

Group therapy can be an important part of a client's treatment, depending on his or her diagnosis. Some patients may require a combination of group and individual therapy to improve. Patients with more serious mental health issues generally do best with several treatment formats.

It's common for patients to begin their treatment with individual therapy, and many patients prefer it. The idea of opening up to strangers can be uncomfortable. Newcomers to therapy may feel vulnerable and are often not at ease with the idea of sharing in a group. These patients can benefit from a two-step approach, whereby they start with individual sessions with a therapist and then move into group therapy.

Development

Treating patients in small groups has unique advantages. Groups may help participants to feel that they are not alone in their situation, because they spend time with others who are experiencing the same or similar issues. Groups also help participants gain the skills to relate to others. Group therapy can also have its challenges, however. It's possible to experience conflict among the members in a group. There also may be issues with the group dynamic. Some members may talk too much, while others talk too little. Subgroups may form, which can interfere with the dynamic of the larger group.

In a group therapy setting, it's important for the therapist to provide structure and boundaries while maintaining a safe space for the participants in the group. This allows members to feel comfortable about opening up. Therapists also should encourage members to form new attachments within the group.

Certain disorders respond well to group therapy. Group therapy has been responsible for breakthroughs with many patients, especially those with relational disorders. It is one of the best arenas for patients to learn how to relate to other people. One example is relational disorders, or dysfunctional patterns in dealing with others. Relational disorders are best treated in the same environments where they were created. Group therapy allows patients to reenact situations that cause them problems and work through them.

Group therapy allows for cohesion, where the group members stick together and are able to relate to each other. Cohesion can also refer to the relationship quality and structure of the group. In groups, members experience three types of relationships: member to member, member to group, and member to leader. Cohesion is unique to group therapy and is therapeutic to the participants.

The more cohesive the group, the more likely the members are to experience improvement. Member interaction leads to higher group cohesion. Because of this, it's important for group leaders to encourage interaction during sessions. Studies also show that groups lasting more than 12 sessions, with 5 to 9 members, have the highest cohesion rates and the best outcomes. Cohesion is especially important with younger group members. Young people have more positive outcomes from group therapy in a cohesive group, no matter what the setting or diagnostic classification.

Clients who have been abused, substance abusers, and those who have suffered traumatic events usually

achieve positive results in group therapy. Homeless patients tend to be diagnostically diverse, yet the group setting can still be effective. Those who suffer from PTSD, have been the victims of violence or abuse, and have a need for effective psychiatric treatment can benefit from including group therapy in their treatment. Shelters that provide on-site group therapy for homeless women give them a supportive environment, confidentiality, and a chance to connect, while helping women define boundaries and limit aggressive behavior.

The group therapy setting helps individuals to see themselves as others do, find their strengths, and empathize, which in turn help their ability to build relationships. Patients sharing in a safe environment can increase their sense of belonging and begin healing.

The gender makeup of a group matters to the dynamic. When a group is all female, the participants tend to set up a flexible order of speaking, express emotions, talk about personal experiences/problems, and learn from each other. Women are likely to create a nurturing environment and offer support and equality. However, in mixed groups, men can sometimes dominate the speaking and interrupt other participants.

It's important in any session that the group leader be seen as a member. If the leader does not share similar experiences, which is often the case, he or she must be able to draw upon his or her own experiences and relate them to what the group is going through. Otherwise, the group members may not open up in the session.

Current Status

Whether used as a standalone treatment or combined with other therapies, group therapy can help patients achieve maximum results. It is a valuable tool for treating patients for a variety of conditions. Group therapy offers a solid track record for patient improvement, especially when combined with a complementary treatment, such as individual therapy. It is used extensively within public mental health agencies. While it is an effective form of treatment, in most areas there are not enough therapists trained in group therapy.

Mindy Parsons, PhD

See also: Psychoeducation; Psychotherapy

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Guidance Counselor

Guidance counselors, now referred to as professional school counselors or school counselors, are counseling professionals who provide direct and indirect support services to students in educational settings.

Definition

- **Professional school counselors** are counseling practitioners employed in various educational settings who collaborate with parents and teachers to help students develop across academic, social, and career domains.

Description

Guidance counselors are practitioners who work in educational settings to provide a range of support services to students, parents, and teachers as a supplement to the regular school curriculum. They hold a minimum of a master's degree in school guidance and counseling and are either certified or licensed, depending on the state where they practice. These professional educators are employed in elementary, middle, and high school settings but may also work in district supervisory positions. There has been a recent shift in the school counseling field from use of the former term "guidance counselor" to "school counselor," "certified school counselor," or "professional school counselor." This change has been made in an attempt to increase awareness about the role of a school counselor and the appropriate tasks he or she should engage in on a daily basis.

Professional school counselors are qualified to design, implement, and evaluate comprehensive guidance programs focused on the needs of all students in areas related to their academic, personal/social, and career development. Daily tasks include both direct and indirect services. Direct services describe in-person interactions between the school counselor and students and include school counseling core curriculum, individual student planning, and responsive services such as individual or small group counseling, or responding to crisis. Indirect services are provided on behalf of the student to parents, teachers, other educators, and community organizations in an effort to promote positive relationships and provide additional assistance.

Guidance and counseling began with vocational/career guidance back in the 1950s after the launch of Sputnik, the Russian Space Station. This event spurred concern about students being prepared to compete with other nations in the fields of math and science. Soon after, the U.S. government passed the Elementary and Secondary Education Act, requiring funds to be set aside for guidance services in schools. At this time the term "career counselor" or "vocational counselor" best described the role of guidance counselors in schools, with limited time allotted to addressing student's personal and social needs.

The American School Counselor Association (ASCA), founded in 1952, is an international nonprofit organization that was developed specifically to meet the needs of professional school counselors. Its mission is to represent school counselors and to promote professionalism and ethical practices in the field. Regional, state, and local divisions of this organization have been established to support these professionals in providing services to all students in grades K-12. School counselors uphold the standards outlined in the ASCA National Model as well as in other related professional counseling associations.

Impact

Current concern in the field surrounds the lack of professional school counselors in schools and the duties with which they are required to perform which are oftentimes not reflective of their education and skill set. ASCA recommends a ratio of 1 school counselor for every 250 students; however, most schools have student numbers that greatly exceed this, while other schools may not have a certified school counselor on staff at all. As ASCA states, school counselors are called to provide comprehensive developmental guidance programs that address the personal/social, academic, and career needs of all students. Programs should also be current, culturally relevant, and preventative in nature, and promote and enhance student success. Accountability is another concern as professional school counselors are required to demonstrate the effectiveness of their services. Ongoing debate continues over how to document, evaluate, and reward professional educators that have a positive impact on student outcomes.

Melissa A. Mariani, PhD

See also: Counseling and Counseling Psychology; School-Based Therapy

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Guide to Rational Living, A (Book)

With more than 1.5 million copies sold, *A Guide to Rational Living*, written by legendary psychologist Dr. Albert Ellis and coauthored by Dr. Robert A. Harper, continues to be near the top of the self-help best-seller lists. Ellis's ideas have withstood the test of time, considering his book is still in print and in demand even though it was first published more than five decades ago in 1961.

Author Albert Ellis, PhD (1913–2007), was the creator of rational emotive behavior therapy (REBT) and is widely considered one of the most influential psychologists of all time. A 1982 survey placed him as the second-most influential psychologist of his time—ahead of Sigmund Freud and directly behind Carl Rogers. He is credited with thousands of speeches and workshops, more than 150 audio tapes, and writing more than 800 articles and 75 books, including several best sellers, such as *A Guide to Rational Living*, making him among the most prolific psychologists of his time.

Ellis shares his beliefs in the book as he writes that people can change their emotions and also their behaviors by simply confronting their irrational thoughts with facts and reason. This book was not written for therapists but for the average person to help understand how his or her emotions and irrational thoughts can lead to anxiety and depression. The authors state that emotions are often a result of reacting to other people. This, they say, creates emotion that is a three-way combination of physiological, psychological, and social reactions that are all occurring at the same time. Ellis and Harper explain how REBT helps an individual discriminate between rational and irrational thoughts, thereby helping him or her actually get better instead of just feeling better.

A Guide to Rational Living was Ellis's first book to outline his theory of REBT. This book offers an introduction to the theoretical foundations of REBT, which is based on the concept that our thoughts lead to emotions, which in turn influence our behaviors. Thus, since what we are feeling is based on what we are thinking, Ellis firmly believed that people can change emotions and behaviors by simply challenging irrational thoughts and confronting them with rational thought and reason.

The book breaks down what Ellis believes to be are the top 10 irrational thoughts and ideas that lead to most people experiencing negative emotions. This classic self-help manual lists these common irrational ideas, as well as walking the reader through the disputing irrational beliefs activity. For example, Ellis and Harper explain that we don't get upset, we "do" upset. Through unhealthy and self-defeating thoughts and emotions, we cause an emotional disturbance. The authors offer effective techniques to correct these faulty ways of thinking, which are divided into cognitive, emotive, and behavior categories.

Ellis credits Alfred Adler, Karen Horney, and Erich Fromm as being among his biggest influences. He is given full credit by Aaron T. Beck, considered to be the "father" of cognitive behavior therapy. Thus, many place Ellis as the "grandfather" of CBT. The ripple effect from Ellis is quite strong and includes those that Beck influenced, such as David D. Burns, MD, who wrote the best seller *Feeling Good: The New Mood Therapy*, a self-help guide that has sold more than 4 million copies and arguably can be traced back to Ellis's writings in *A Guide to Rational Living*.

Mindy Parsons, PhD

See also: Adler, Alfred (1870–1937); Beck, Aaron T. (1921–); Cognitive Behavior Therapy; Ellis, Albert (1913–2007); *Feeling Good: The New Mood Therapy* (Book); Horney, Karen (1885–1952); Rational Emotive Behavior Therapy (REBT)

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Guided Imagery

Guided imagery is a therapeutic technique that guides the imagination in a focused direction.

Description

Imagine that you are walking along a trail through a beautiful mountain valley on a perfect spring day. There is a creek on your right, rolling hills on your left, and a pond just a little further ahead. You feel the warmth of the sunlight filtered through tall pines, hear the gentle sounds of rippling water and singing birds, smell the fragrance of the forest pines, and up ahead see a pair of ducks paddling on the surface of the pond. Take a moment and explore this setting. What else do you see, hear, smell, and feel? Are you filled with a sense of peace and well-being in this perfect place? This is an example of an exercise in guided imagery, which involves the generation of mental and perceptual experiences in the absence of external stimuli.

Guided imagery (GI) is a powerful therapeutic technique used to focus and direct a person's imagination in order to bring about positive change. GI involves multiple senses using only the imagination. In the preceding example you most likely generated visual images (mountain valley, rolling hills, pine forest, creek, pond, ducks), auditory sensation (rippling water, singing birds), tactile sensation (warmth of the sun), olfactory sensation (smell of the pines), and emotional sensation (peace and well-being). GI frequently includes the use of metaphor and storytelling.

Guided imagery is used in a wide variety of settings and is utilized in many professions, including the medical and mental health fields. In health psychology GI has been found to decrease presurgical anxiety and decrease need of pain medications in postsurgical recovery. GI has been found to lower blood pressure, decrease muscle tension, and maximize treatment benefits across a wide range of medical conditions. In sports psychology GI is used to increase athletic performance by visualizing a perfect performance. For instance, a field and track sprint runner having difficulties in making a quick start states he gets distracted because all he can think about is getting his feet comfortable in the starting blocks. The therapist suggests that he focus on the image of a powerful drag racing car coming to the starting line, engine revving, with flames shooting out of the exhaust. The therapist helps the client hear the sounds, feel the power, and visualize how the tires grip the surface, how the front lifts up under the powerful acceleration, and how quickly the car accelerates and wins the race. Focusing on the image of a drag car race keeps the runner's mind clear of anything other than a fast and powerful start.

Guided imagery is used in most models of psychotherapy, and there is a wide body of evidence that GI is effective in promoting positive change. GI uses the imagination to explore events in the past, difficulties in the present, goals for the future, and the emotions related to these. GI has been utilized in reducing anxiety and stress; trauma recovery, resolving conflicts; overcoming depression; and treating eating disorders. In psychotherapy GI experiences can be fully guided, as in the earlier examples, or partially guided as when a therapist would ask "Imagine the most likely response, describe what you see, hear and feel."

Guided imagery is used to explore emotional themes, gain self-insight, and process relationship issues. One of the primary goals of GI is to assist clients in developing and engaging in their own images that promote growth, health, and emotional development. For instance, a therapist asks a student who is anxious and afraid to attend a new school to think of an animal and describe the scene that would symbolize the experience. The child describes a puppy that is surrounded by big barking dogs. The therapist could use this scene to explore issues of social anxiety, inadequacy, fear, and low self esteem. Using guided imagery the therapist could help the student develop a more positive self-image by exploring the benefits of being part of the pack and barking with the big dogs. The therapist could guide the story of a fearful puppy maturing into a happy part of the pack. GI often generates metaphors that can assist clients in developing helpful new beliefs, solutions, and attitudes.

Guided imagery is a flexible therapeutic technique utilized in most forms of psychotherapy. GI has been studied extensively as a therapeutic tool and is frequently utilized in reducing stress, seeing new possibilities, gaining insight, and moving toward a more positive future.

Steven R. Vensel, PhD

See also: Imagery Rescripting and Reprocessing Therapy (IRRT); Sports Psychology

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H

Haldol (Haloperidol)

Haldol is a prescribed medication used to treat psychotic disorders and other conditions. Its generic name is haloperidol.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Dementia** is a group of symptoms, including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of neurons (nerve cells) in the brain.
- **Extrapyramidal symptoms** are a group of side effects associated with antipsychotic medication use that are characterized by involuntary muscle movements, including rigidity, contraction, and tremor. It is also called EPS.
- **Psychotic disorder** is a severe mental disorder in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.
- **Tics** are involuntary, compulsive, repetitive, and stereotyped movements or vocalizations. While they are experienced as irresistible, they can be temporarily suppressed.
- **Tourette's syndrome** is a neurological disorder characterized by recurrent involuntary movements and vocal tics such as grunts, barks, or words, including obscenities.

Description

Haldol is one of the antipsychotic medications used for treating acute and chronic symptoms of psychotic disorders. It is also used to treating symptoms of dementia like agitation. In children, it has been used to manage severe behavior problems like combativeness and extreme outbursts that occur without immediate provocation. Haldol is also effective in controlling tics and inappropriate vocalizations associated with Tourette's syndrome in children and adults. It is believed that Haldol controls symptoms by blocking or lessening the effects of dopamine, a chemical messenger, in the brain.

Precautions and Side Effects

Because Haldol can cause low blood pressure, heart arrhythmias, and seizures, those with heart and blood pressure problems should be carefully monitored while taking this medication. Women who are pregnant or breast-feeding should consult with their doctor before taking Haldol. Haldol may cause extrapyramidal symptoms and signs of withdrawal in newborns, especially if the drug was taken during the last trimester of the mother's pregnancy. Signs of withdrawal include increased agitation, respiratory problems, and trouble feeding. Haldol may increase the action of central nervous system depressants such as anesthetics, alcohol, and some pain medications and sleeping pills.

Common side effects include dry mouth, lethargy, and restlessness. Other side effects include muscle stiffness or cramping, restlessness, tremors, and

weight gain. These are more likely to occur when Haldol is given in high doses and also with prolonged use. A more serious side effect is tardive dyskinesia, which involves involuntary movements of the tongue, jaw, mouth, face, or other groups of skeletal muscles. Haldol use can also result in the development of Parkinson-like symptoms. These include a taut or mask-like expression on the face, drooling, tremors, pill-rolling motions in the hands, a shuffling gait, and jerky movements when the hand muscle is passively stretched. The simultaneous use of Haldol and lithium, which was a common treatment for bipolar disorder, should be avoided.

Len Sperry, MD, PhD

See also: Psychotic Disorders

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Haley, Jay (1923–2007)

Jay Haley was a pioneer who changed the approach to individual and family therapy. Devoted to understanding human communication, Jay Haley used his background to hone his theories and put forth the idea that therapists were problem solvers who should guide their patients toward a solution. He felt therapists should take control of sessions and influence their patients. One of the architects of strategic therapy, he was influential in promoting the concept of therapists acknowledging their ability to influence the behavior of their patients.

Description

Haley graduated with a BA degree from UCLA in 1948 and in 1951 earned a BS in Library Science from the University of California at Berkeley. He studied communications at Stanford University and received an MA degree in 1953. In 1952, Haley joined anthropologist Gregory Bateson to consult on his "double bind" research. "Double bind" refers to a situation where a person receives two conflicting messages, and responding to either means failing the other.

The goal of the double bind project was to find a causal link between schizophrenia and family communication, instead of biology. Haley studied many different forms of communication while working on the project. However, the double bind theory was controversial and was never widely accepted. Haley worked with Bateson and his team, including John Weakland, Don Jackson, and William Fry, for a decade. During this time, he also worked with hypnotist Milton Erickson, who was a great influence on Haley.

Development

In 1959, Haley went to the newly formed Mental Research Institute in Palo Alto, California, as the director of research, and studied how families with schizophrenic members were different than families without. In 1967, Haley went to work with Salvador Minuchin at the Philadelphia Child Guidance Clinic and taught many of the best-known family therapists. Early in his career, Haley challenged the prevailing idea that psychotherapy meant long-term treatment. He was not afraid to challenge long-standing beliefs and traditions, and was a proponent of brief therapy. A major part of Haley's approach was that he was less concerned with the diagnosis of a patient and more concerned with solving the patient's her problems and getting him or her off medication so he or she could live a normal life. As one of the first to champion strategic therapy, Haley put forward the idea that therapists should be held accountable for their treatment and that they should look for solutions, not just listen. An effective therapist has a treatment goal in mind and works toward it. He pointed out that transition points in patients' lives led to their psychological problems and that their issues weren't just related to their personality. Haley believed that the patient's family was also part of the problem and should be part of the treatment.

Haley also was an early promoter of supervising therapy sessions behind a one-way mirror, as well as recording sessions to analyze later. This was a new approach at the time and came out of his experience with Bateson. This practice is now common in family therapy. Dedicated to teaching others, Haley was the first to document how to perform an initial patient interview in his book *Problem Solving Therapy*. Later in his career, he made training films for therapists with his wife Dr. Madeleine Richeport-Haley. He trained many in psychotherapy and preferred research and teaching over private practice.

Impact (Psychological Influence)

Haley wrote 20 books during his career, many aimed at taking the mystery out of the practice of therapy. Some of his most well-known titles include *Strategies of Psychotherapy* (1963), *Uncommon Therapy* (1973), *Problem Solving Therapy* (1976), *Leaving Home* (1980), and *Learning and Teaching Therapy* (1996). He also wrote many influential papers throughout his career.

In 1962, Haley cofounded the *Family Process Journal* with Nathan Ackerman and Don Jackson. This for-profit journal had no ties to universities or professional organizations but was devoted to the science and treatment of family behavior. Haley was the first editor of the journal and remained in that position for a decade.

Haley founded the Family Therapy Institute of Washington, D.C., with his second wife Chloe Madanes in 1974. There he taught and studied family therapy until 1994, when he moved back to California for the remainder of his career. In 1985, he was awarded the first Lifetime Achievement Award of the Milton Erickson Foundation. Today, Haley is remembered for his advances in strategic therapy and for training generations of therapists.

Mindy Parsons, PhD

See also: Family Therapy; Strategic Family Therapy

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Hallucinations

Hallucinations are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.

Definitions

- **Antipsychotic medications** are prescription medications used to treat psychotic disorders, including schizophrenia, schizoaffective disorder, and delusional disorder.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Delusions** are fixed, false beliefs that persist despite contrary evidence.
- **Hypnagogic hallucinations** are false perceptions that occur as individuals are falling asleep.
- **Hypnopompic hallucinations** are false perceptions that occur as individuals are awakening.
- **Illusions** are a misperception or false interpretation of an actual sensory image or impression.
- **Paranoia** is an unfounded or exaggerated distrust or suspiciousness of others.
- **Psychosis (psychotic disorder)** is a mental disorder characterized by a loss of touch with reality and psychotic features.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms

include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description

A hallucination is a sensory perception that occurs without the external stimulation of one of the senses (American Psychiatric Association, 2013). Hallucinations can affect any of the senses, although specific medical conditions and mental disorders are associated with specific types of hallucinations. Since they are commonly confused, care must be taken to distinguish hallucinations from illusions and delusions. Hallucinations are false perceptions without sensory stimulation. For example, widows will report "seeing" their dead spouse. In contrast, illusions are false interpretations of real sensory experiences. For example, drivers may report seeing what looks like a pool of water on a road when it is really a mirage caused by the reflection of light passing through layers of different air densities. On the other hand, delusions are false beliefs that persist without any basis in reality. For example, an individual may continue to insist that he or she is a war hero despite evidence that he or she is not old enough for military services. The term "hallucination" is not used for false perceptions that occur during dreaming or falling asleep (hypnogogic) or awakening (hypnopompic). These hallucinatory experiences are short lived and often occur without a mental disorder (American Psychiatric Association, 2013).

Among the most common hallucinations are the following.

Auditory hallucinations. Individuals with this type of hallucination hear sounds or voices that are not there. For example, individuals may hear voices talking about their behavior. The voices may also order them to act or behave in ways that they would not do on their own. These are the most common types of hallucination in schizophrenia.

Visual hallucinations. Individuals with this type of hallucination see other individuals or objects that do not exist. They may be unfocused images such as flashes of light. These images may appear to be distorted or strange, or frightening. These are the second most common type of hallucination in schizophrenia.

Tactile hallucinations. Individuals with this type of hallucination feel or sense something that is not there. It usually involves the sense of being touched or of something under their skin. For example, individuals may feel that invisible fingers are touching them even when no one else is close to them. It may be the sense the bugs are crawling under their skin. Or, it may be the sense that of electricity moving through their body.

Olfactory hallucinations. Individuals with this type of hallucination will smell odors that no one else does. For example, individuals may smell unpleasant odor such as decaying fish or burning rubber. Or, they may believe that the odor is coming from them. These are the least common types of hallucination in schizophrenia.

The causes of hallucinations are not well understood. However, they can be associated with certain mental disorders and medical conditions. Schizophrenia and other psychotic disorders may be the most common cause of hallucinations. Brain tumors, Parkinson's disease, inflections, stroke, and dementia are medical conditions associated with hallucinations. Substance abuse and medication side effects are common causes. Lifestyle factors such as sleep deprivation and severe fatigue are also associated with hallucinations.

Treatment

Hallucinations are treated with regard to the underlying cause. Such causes may be a medical condition, mental disorder, medication side effect, substance, or lifestyle factors. Accordingly, treatment may involve medical treatment, antipsychotic medications, cognitive behavior therapy, or substance abuse treatment for drug dependence.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Cognitive Behavior Therapy; Delusional Disorder; Delusions; Schizophrenia

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Hallucinogen-Related Disorders

Hallucinogen-related disorders are mental disorders characterized by the use of mind-altering drugs that cause auditory and visual hallucinations.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Auditory and visual hallucinations** are severely distorted perceptions of what is real.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Dissociative drugs** are substances that severely distort vision and hearing and produce a feeling of floating or feeling removed from reality. Examples are PCP, ketamine, and DXM.
- **DSM** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition is DSM-5.
- **Psychedelics drugs** are psychoactive substances that profoundly distort thoughts and perceptions. Examples include LSD ("acid"), mescaline, and MDMA ("ecstasy").
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders characterized by maladaptive thoughts, excessive and repetitive behaviors, and physical symptoms. It includes alcohol intoxication, cannabis use disorder, and hallucinogen disorders.
- **Twelve-Step Group** is a self-help group whose members attempt recovery from various addictions based on a plan called the Twelve Steps. Twelve-Step Groups can focus on specific addictions such as Alcoholics Anonymous and Narcotics Anonymous (NA).

Description and Diagnosis

Hallucinogen-related disorders are in the class of DSM-5 substance-related and addictive disorders. They are unique among the substance-related disorders because they cause auditory and visual hallucinations. Hallucinogens come from plants and mushrooms or can be made synthetically. They are categorized into classic hallucinogens (psychedelic drugs) or dissociative drugs (PCP). Both categories produce serious effects. These include disorientation, numbness, dizziness, vomiting, auditory and visual hallucinations, and increase in blood pressure and heart rate. Dissociative drugs increase the feelings of detachment from reality or of detachment from one's own body. In severe cases, hallucinogens may cause seizures, muscles spasms, violent behavior, and amnesia. They alter chemical actions in the brain to produce feelings of euphoria.

The occurrence of this disorder is much lower than that of other substance use disorders. Around 1 out of 200 individuals between the ages of 12 and 17 have this disorder. More females than males are diagnosed in this age group. Out of 1,000 individuals 18 years old and older, 1 is diagnosed with hallucinogen-related disorder. More males than females are diagnosed in this age group. The rate of occurrence is highest among individuals under the age of 30 and virtually zero for individuals over the age of 44. The occurrence of this disorder is higher among Native Americans, Alaska Natives, and Hispanics than whites, blacks, Asians, or Pacific Islanders (American Psychiatric Association, 2013). Some cultures use hallucinogens for medicinal and religious purposes.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can

be diagnosed with this disorder if they continue to use hallucinogens despite severe negative consequences. They must experience various symptoms. These include the following. Substance use is increased. There is an inability to decrease usage or stop using. Much time must be spent getting, using, or recovering from the drug, or they must have strong drug cravings. There must be repeated use despite negative consequences at work, home, school, or social life. Drug use must take precedence over other important activities, or it must continue during dangerous situations such as when driving a car or operating a machine. Its use must continue despite the activation or exacerbation of psychological and physical problems. Often, more of the drug is needed to obtain the desired effect. It is important to note that the DSM-5 does not provide any withdrawal symptoms for hallucinogens (American Psychiatric Association, 2013).

The cause of this disorder may be attributed to other substance use disorders. Addiction to alcohol, tobacco, and cannabis may increase the probability of hallucinogen-related disorder. Individuals with major depressive disorder and antisocial personality disorder are also at a higher risk of developing hallucinogen-related disorder. Furthermore, hallucinogens may seem attractive to recreational drug users because they don't have physical withdrawal symptoms, are inexpensive, are easy to access, and, with occasional use, result in few side effects.

Treatment

Hallucinogen-related disorders are treated with psychotherapy, Twelve-Step Group, and possibly medication. Psychotherapy may include cognitive behavior therapy. Involvement in a Twelve-Step Group like NA may be helpful. Medication treatment may be necessary to treat anxiety. An individual brought to treatment under the influence of hallucinogens needs to be kept calm and focused on reality.

Len Sperry, MD, PhD, and
Christina Ladd, PhD

See also: Addiction; Cognitive Behavior Therapy; Psychotherapy; Substance-Related and Addictive Disorders; Twelve-Step Programs

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Hallucinogens

Hallucinogens are a class of drugs that cause alterations in perception, thought, or mood. They are also known as psychedelic drugs.

Definitions

- **Controlled Substance Act of 1970** lists substances regulated by the Drug Enforcement Administration into one of five schedules. Each schedule reflects a drug's potential for abuse and dependence.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions. They are generated by the mind rather than by an external stimuli and can be caused by a medication, recreational drug, or mental disorder.
- **Serotonin** is a chemical messenger in the brain that serves to transmit nerve impulses that regulates mood in terms of calmness, happiness, pain, sexuality, and sleep. Low levels are associated with depression and compulsivity.

Description

Hallucinogens are a chemically diverse group of drugs that cause changes in a person's thought processes, perceptions of the physical world, and sense of time passing. The term "hallucinogen" is a misnomer since these drugs do not cause hallucinations at typical

doses. The kind of "hallucinations" induced by this class of drugs is actually modifications of regular perception. During this experience, users are most likely to be aware of the illusory and personal nature of their perceptions. Hallucinogens can be found naturally in some plants and can be synthesized in the laboratory. They are called psychedelic drugs and are abused as recreational drugs. With the exception of MDMA, hallucinogen use peaked in the United States in the late 1960s as part of the counterculture movement. It then gradually declined until the early 1990s, when it began to increase. The 2010 U.S. National Survey on Drug Use and Health reported that 1.2 million individuals had used hallucinogens in the past month, with 695,000 persons taking MDMA, or ecstasy.

The best-known hallucinogens are lysergic acid diethylamide (LSD), mescaline, psilocybin, and MDMA (ecstasy). Phencyclidine (PCP, angel dust) can produce perceptual distortions, as can amphetamines and marijuana. But these drugs are considered dissociative drugs, rather than hallucinogens, and act by a different pathway from classic hallucinogens. Dextromethorphan, the main ingredient in many cough medicines, has become popular among some populations because of the PCP-like effects that it produces. Although the various hallucinogens produce similar physical and psychological effects, they are a diverse group of compounds. However, all hallucinogens appear to affect the brain in similar ways. It is thought that these drugs act by binding to a specific serotonin receptor (5-HT2) in the brain. The effect is that serotonin is blocked, leading to increased free (unbound) serotonin in the brain. The result is a distortion of the senses of sight, sound, and touch; disorientation in time and space; and alterations of mood. With hallucinogen intoxication, users are not delirious, unconscious, or dissociated. Instead, they are aware that these perceptual changes are caused by the hallucinogen.

Unlike most medications, the mental state of the hallucinogen user and the environment in which it is taken can profoundly influence the user's experience. For example, LSD is known for its range of experiences from "good trips" symptoms like mellowness and psychedelic visions to "bad trips" symptoms like anxiety and panic attacks. Previous good experiences with a drug do not guarantee continued good experiences. Those with a history of psychiatric disorders are more likely to experience harmful reactions, as are those who are given the drug without their knowledge.

Specific Hallucinogens, Cautions, and Side Effects

LSD LSD is lysergic acid. It was first synthesized by a researcher attempting to develop a headache remedy. LSD also occurs naturally in morning glory seeds. It is listed as a Schedule I drug (Controlled Substance Act), meaning that it has no medical or legal uses and has a high potential for abuse. Street names for the drug include "acid," "yellow sunshine," "windowpane," "cid," "doses," "trips," and "boomers."

Mescaline. Mescaline or peyote is a naturally occurring plant hallucinogen. It has been used for centuries as part of religious celebrations and vision quests of Native Americans. In 1970, mescaline was listed as a Schedule I drug, but the state of Texas legalized peyote for use in Native American religious ceremonies. In 1995, a federal law was passed making peyote legal for religious ceremonial use in all 50 states.

Psilocybin. Psilocybin is the active ingredient in what are known on the street as "magic mushrooms," "shrooms," "mushies," or "Mexican mushrooms." Psilocybin-containing mushrooms are usually cooked and eaten or dried and boiled to make a tea. Although psilocybin can be made synthetically in the laboratory, there is no street market for synthetic psilocybin, and virtually all the drug comes from cultivated mushrooms. It is legal to possess psilocybin-containing mushrooms, in the United States, but it is illegal to sell them. It is a Schedule I drug.

Generally, mescaline and psilocybin produce uniformly milder symptoms than LSD. During a single drug experience, the user may experience a range of symptoms. Mood can shift from happy to sad or pleasant to frightening and back again several times.

MDMA. MDMA, better known as Ecstasy, is a popular "club drug" (rave and dance clubs). The psychoactive component of it is chemically similar to mescaline, while its stimulant component is similar to methamphetamine. During the time it was legal, many experimented with MDMA as a means of becoming more open and empathetic. Recreational use soon followed, and it was declared an illegal Schedule

I drug. MDMA is often associated with all-night raves or dance parties. It allow ravers to dance for hours with a feeling of empathy, reduced anxiety, reduced inhibitions, and euphoria.

PMMA. PMMA is a hallucinogen, with effects similar to MDMA. It can cause rapid heartbeat, high blood pressure, seizures, kidney failure, hyperthermia, hallucinations, and death. The compound in PMMA is often found in MDMA, making the substance even more potent and potentially fatal.

Salvia. Salvia (*Salvia divinorum*) is a potent psychoactive drug containing a chemical called salvinorin A. It is considered to be up to five times more potent than LSD. It is thought to act on opioid receptors of the brain and cause both physical and visual impairment and hallucinogenic effects. Salvia is not yet regulated by the federal government, but many states are creating legislation to ban the cultivation and sale of this plant.

Jimson weed. Jimson weed is an herb that produces fragrant flowers with a trumpet-like appearance. It can induce delirium, hallucinations, amnesia, and violent behavior. Symptoms of overdose include seizure, coma, and respiratory arrest. Ingesting it may require emergency treatment and hospitalization, since symptoms may be present for up to three days.

Len Sperry, MD, PhD

See also: Addiction; Drug Enforcement Administration (DEA)

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Hamilton Anxiety Scale (HAM-A)

The Hamilton Anxiety Scale (HAM-A) is a psychological test for assessing anxiety and its severity. It is also referred to as the Hamilton Anxiety Rating Scale.

Definition

- **Anxiety** is a state of uneasiness and apprehension about future uncertainties that is reflected in psychic (mental) and somatic (physical) symptoms.

Description

The Hamilton Anxiety Scale is a 14-item test that measures anxiety and its severity in children and adults. It measures overall anxiety, psychic anxiety (mental agitation and psychological distress), and somatic anxiety (physical complaints related to anxiety). Seven of the items address psychic anxiety, while the other seven items address somatic anxiety. It is administered by a trained interviewer who asks a semi-structured series of questions about symptoms of anxiety. The individual's responses are then rated on a five-point scale for each of the items. A score of zero represents an absence of the anxiety symptom being measured, while a score of four represents the presence of extreme symptoms. A total score of 17 or less suggests mild or no anxiety, 18 to 24 suggests moderate anxiety, and 25 or higher suggests severe anxiety. It takes about 15 to 20 minutes to administer the test.

Besides its use in assessing the presence and severity of anxiety, the HAM-A is also used as an outcome measure when assessing the impact of psychotherapy and other treatments, including medication. It can be administered before starting an antianxiety medication and during follow-up visits where medication dosage can be adjusted based in part on the individual's HAM-A score.

Developments and Current Status

The HAM-A was developed by Max Hamilton (1912–1988), a psychologist in 1959. He developed the scale by using the technique of factor analysis. With this statistical method, he generated a set of symptoms related to anxiety and determined which symptoms related to psychic anxiety and which related to somatic anxiety. Hamilton also developed the widely used Hamilton Depression Scale to measure symptoms of depression. While there is a tendency for depressed people to also score high on the HAM-A, some researchers have suggested that anxiety and depression

are so closely linked that people can easily score high on measures of both types of symptoms.

The paper and pencil version of this test is in the public domain, which means it can be accessed available without charge. There is also a computer-administered version. One reason that the HAM-A is widely used is that reliability studies have shown that it measures anxiety symptoms in a fairly consistent way. The measure's validity of HAM-A has also been supported by research. Although it was one of the first anxiety-rating scales to be published, it remains one of the most widely used instruments by clinicians.

Len Sperry, MD, PhD

See also: Anxiety; Depression; Hamilton Depression Scale

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Hamilton Depression Scale (HAM-D)

The Hamilton Depression Scale (HAM-D) is a psychological test for assessing depression and its severity. It is also referred to as the Hamilton Rating Scale for Depression and the Hamilton Depression Rating Scale.

Definition

- **Depression** is a state of low mood and reduced activity that affects an individual's thinking, behavior, feelings, and sense of well-being. It may be acute or chronic, mild or severe.

Description

The Hamilton Depression Scale is an interviewer-administered and rated measure for assessing the presence and severity of depressive symptoms in children and adults. It consists of symptoms common to depression such as anxiety, insomnia, mood, hypochondriasis, agitation or retardation, weight loss, and somatic symptoms. It is administered by a trained interviewer who asks a semi-structured series of questions about symptoms of depressions. The original version contains 17 items, which takes about 20 minutes to administer. This version, which is the most commonly used, consists of nine items which are scored on a five-point scale, ranging from zero to four; seven items are scored on a three-point scale, from zero to two, and the last item is scored on a two-point scale. The total score can range from 0 to 54. Scores between 0 and 6 suggest little or no depression, scores between 7 and 17 suggest mild depression, scores between 18 and 24 suggest moderate depression, while scores greater than 24 suggest severe depression.

Besides its use in assessing the presence and severity of depression, the HAM-D is also used as an outcome measure when assessing the impact of psychotherapy and other treatments, including medication. It can be administered before starting an antidepressant medication and during follow-up visits where medication dosage can be adjusted based in part on the individual's HAM-D score.

Developments and Current Status

The HAM-D was developed by Max Hamilton (1912–1988), a psychologist, in 1960. It has been revised a number of times, the last being in 1980. Hamilton maintained that the HAM-D should not be used only as a diagnostic instrument but rather used in combination with the patient's history, other tests, and clinician judgment. He also developed a self-report measure of depression in adults called the Hamilton Depression Inventory and the Hamilton Anxiety Scale, which is an interviewer-rated measure of anxiety and its severity.

Long considered the gold standard by those clinical researchers, the HAM-D has been criticized for

its overemphasis on insomnia and underemphasis on suicide thoughts and gestures. For example, it is not uncommon for depressed individuals who are on antidepressant medication to have lower HAM-D scores in part because of their improved sleep but who continue to experience suicidal thoughts.

There is considerable research to support the reliability and validity of the HAM-D. The scale correlates highly with other clinician-rated and self-report measures of depression, such as the Beck Depression Inventory. Despite some criticism, the HAM-D is considered one of the most common clinician-administered tests used to assessing depression.

Len Sperry, MD, PhD

See also: Depression; Hamilton Anxiety Scale (HAM-A); Beck Depression Inventory

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Hare Psychopathy Checklist-Revised (PCL-R)

The Hare Psychopathy Checklist-Revised (PCL-R) is a psychological test for assessing psychopathic (antisocial) tendencies.

Definitions

- **Psychopath** is an individual who manifests psychopathy.
- **Psychopathy** is a serious personality disorder characterized by antisocial, aggressive, and violent behavior and thoughts, and a lack of empathy.

Description

The Hare Psychopathy Checklist-Revised is a psychological tool used to rate psychopathic or antisocial tendencies in clinical, legal, and research settings. It is a 20-item symptom rating scale used by qualified examiners to compare an individual's degree of psychopathy with that of a prototypical psychopath. The PCL-R items reflect symptoms of psychopathy and include pathological lying, glibness and superficial charm, cunning and manipulativeness, lack of remorse or guilt, egocentricity, repeated violations of social norms, disregard for the law, and a lack of empathy. The interview portion of the evaluation covers the individual's background, including educational and work history, marital status, and criminal background.

The PCL-R is used in clinical, forensic, and research settings. It has long been used to assess individuals arrested or convicted of crimes, particularly adult males in prisons and criminal psychiatric hospitals, and those awaiting psychiatric evaluations or trial in correctional facilities. More recently, it has been also used effectively in diagnosing sex offenders, female offenders, and adolescent offenders. It is also being used as an indicator of the potential risk of psychopathy and in determining the length and type of prison sentences as well as treatment recommendations. The PCL-R is available in many languages, including French, German, Korean, Portuguese, Spanish, Hebrew, Japanese, and Swedish.

Each of the 20 items is given a score of 0 to 2 (does not apply to completely applies). The maximum score is 40. A score of 30 or above suggests a diagnosis of psychopathy, while those with criminal backgrounds typically score about 5. Non-psychopathic criminal offenders score around 22.

Developments and Current Status

The Psychopathy Checklist and the PCL-R were both developed by psychologist Robert D. Hare (1934–). The PCL-R contains two parts, a semi-structured interview and a review of the subject's file records and history. During the evaluation, the clinician, usually a psychologist or other such professional, scores 20 items that measure central elements of the psychopathic

character. The items cover the nature of the subject's interpersonal relationships, his or her affective or emotional involvement, responses to other people and to situations, evidence of social deviance, and lifestyle.

The PCL-R has a demonstrated record of reliability and validity among researchers and clinicians. Several American and European studies support the value of the PCL-R in assessing psychopathic traits and predicting the likelihood of future violent behavior. While there has been some controversy about the test and its use, the PCL-R is considered by the international scientific community an important forensic test for the assessment of psychopathy.

Len Sperry, MD, PhD

See also: Antisocial Personality Disorder; Sexual Sadism Disorder

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Harlow, Harry (1905–1981)

Harry Harlow (1905–1981) is considered a legend in the field of psychology. As a psychologist, Harlow's experimental studies with rhesus monkeys led to many important discoveries about how primates, including both monkeys and humans, love and socialize with each other.

Description

As one of the most respected psychologists of the 20th century, Harry Harlow is best known for his discoveries of the infant–mother relationship, which he uncovered through experimental studies with rhesus monkeys. Harlow is credited with revolutionizing animal learning and motivation in the 20th century. He is also cited with studying the human need for love and socialization.

Harlow began his career in 1930, after graduating from Stanford. At the time, psychologists were striving to make a difference and to be viewed as "real" scientists in the greater scientific community. This created the need for experimentation and research. At Stanford, Harlow had already experimented with rats in the laboratory. After he graduated, he moved to Madison, Wisconsin, to start his career. However, he had a problem. Harlow did not have a laboratory or rats for his experimental work. On a suggestion, he visited the local Madison Zoo. It was there he discovered his life's work and what he called his first important discovery—rhesus monkeys. Rhesus monkeys presented a more intriguing test subject than rats. Harlow invented a specialized instrument called the Wisconsin General Test Apparatus (WGTA) to test the intelligence of his rhesus monkeys. With this instrument, Harlow discovered his monkeys learned through problem solving—something that had never before been established.

By the late 1950s, Harlow was already breeding rhesus monkeys. In fact, Harlow had the only self-sustaining colony of monkeys in the United States. This gave Harlow the perfect condition for his studies into the mother–infant relationships of his rhesus monkeys. Harlow wanted to determine what inspires an infant to love its mother. At the time, leading authorities believed that infants instinctually loved their mothers because mothers fed them. To test this, Harlow separated infant rhesus monkeys from their mothers. He gave these infant monkeys surrogate, artificial mothers made of wire and cloth. The wire "mother" provided food, while the cloth "mother" provided comfort and warmth. Harlow observed as the infant monkeys continually huddled to the cloth "mother" instead of the wire, food-bearing "mother." Thus, he concluded that a mother's nurturing is what inspired her infant's love.

As these separated infants grew up, Harlow and his researchers observed they exhibited antisocial and other strange behavior, including the lack of desire

to mate or raise their young. Therefore, Harlow concluded that a mother's love was just one type of desired affection. After many additional studies with his rhesus monkeys, Harlow concluded there are five types of affectional patterns exhibited in primates: (1) the affection of infant and mother, (2) the affection of a child to child, (3) heterosexual affection, (4) maternal affection, and (5) paternal affection. Should any of these affections not be available, Harlow concluded another form of affection would fill its void.

Impact (Psychological Influence)

In 1975, Harlow became the first psychologist to ever win the Kittay International Scientific Foundation Award for this work with rhesus monkeys. Harlow's other notable achievements include serving as the U.S. Army's chief psychologist; helping establish the Human Resources Research Office; inventing the WGTA, which psychologists across the country started using; serving as the editor of the *Journal of Comparative and Physiological Psychology* in 1951; and being elected a member of the National Academy of Sciences and, in 1958, becoming the president of the American Psychological Association. Today, Harlow is remembered as one of the greatest psychologists of the 20th century.

Mindy Parsons, PhD

See also: Attachment Styles

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Hayes, Steven (1948–)

Steven Hayes is an influential psychologist who is most recognized for his work in applied behavior analysis and for developing acceptance and commitment therapy (ACT).

Description

Steven C. Hayes (1948–) is a clinical psychologist who received his training at West Virginia University. Currently he conducts research and teaches on the application of emotional acceptance in therapy. He has been recognized as one of the psychologists with the highest impact between 1986 and 1990. His background and experience in psychology include behavior analysis, addiction treatment, single-case design, and prevention. He is also recognized as the founder of both relational framework theory (RFT) and ACT.

Relational framework theory is an analysis of human language and learning. The theory is based on many of the principles of applied behavior analysis (ABA), a science that aims to understand and improve human behavior. The theory asserts that both language and learning help people to relate to others. Human development is our ability to create links or relationships between things and people. Context, or the relational frame, provides hints that allow people to learn from new information that may be different from what they already know. RFT has been used as the basis for early intensive behavior intervention (EIBI) with young children. For children with language delay or disorders, like autism, EIBI is an essential part of treatment and helps teach effective communication and social skills from a young age.

Relational framework theory also provides the theoretical underpinnings for the therapeutic approach known as acceptance and commitment therapy. The bulk of cognitive behavior therapy focuses on changing behavior through changing thoughts. ACT comes from a different perspective. Instead it does not try to change thoughts or judge them as right or wrong, but rather it evaluates them on whether the thoughts lead to a better quality of life. Acceptance of negative emotions and thoughts leaves people free from the struggle to change them. It also allows them to accept who they

are here and now. In this context ACT is practical in its approach to judgment-based thinking and decision making.

Impact (Psychological Influence)

Through the work of Steven Hayes and many others, the practice of ACT has become widely accepted. There are now numerous controlled studies and randomized clinical trials on the effectiveness of ACT for a variety of problems. Some of the most promising are in the area of chronic pain control. Most study results have been positive, but in a few studies the measurable effects have been questioned. Overall, these studies provide growing support for the effectiveness of ACT.

The impact of Steven Hayes's work in psychology is most significant through behavior therapy and ACT. Hayes has worked directly to advance behavior therapy, specifically ABA. He has also contributed to the organization and continuation of a coalition to develop guidelines for empirical therapeutic practices.

Alexandra Cunningham, PhD

See also: Acceptance and Commitment Therapy (ACT); Applied Behavior Analysis

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Hazing

Hazing is any ritual or activity where members of a particular group engage in the harassment and abuse (physical, verbal, or emotional) of nonmembers as a means for them to gain possible membership or acceptance into that group.

Definitions

- **Bullying** describes deliberate, repeated acts of aggression that are inflicted directly or indirectly over time by one or more dominant persons.
- **Harassment** means creating a hostile environment or unpleasant situation for a person by consistently exposing him or her to acts that make him or her feel uncomfortable; these attempts or advances from the perpetrator are uninvited and unwelcomed.

Description

"Hazing" refers to abusive acts carried out by members of a select group on nonmembers as a means of initiation. Hazing is known by different terms in several other languages, though all follow the same overall theme, referring to a rite of passage or the christening of a newcomer (e.g., in French the word "bapteme" meaning "baptism" and in Spanish the word "novato" meaning "newcomer" are used). Groups may consider these rituals a rite of passage, but hazing is prohibited by law as it can be extremely damaging to victims. Hazing acts may be comprised of physical violence, verbal humiliation, psychological abuse, and/or sexually oriented offenses. A wide range of behaviors can fall under these categories. Alcohol is commonly used in hazing practices, such as binge drinking. Over 80% of reported hazing rituals are associated with alcohol. Other behaviors include personal servitude, verbal demeaning, public insults, physical harm such as beating, spanking, paddling, or branding, and sleep or hygiene restrictions.

Various social groups have been known to engage in the practice of hazing, including fraternities, sororities, sports teams, military units, and gangs. Those subject to hazing may feel compelled to comply with orders they are given. Others are willing to participate even when they are subject to the most degrading and dangerous circumstances. In the United States, hazing is most often reported at the postsecondary, or college, level. Greek-letter organizations, social clubs, service groups, and sports teams have all been known to engage in hazing activities. From small acts of humiliation

and intimidation to full-blown ceremonies in front of large groups of people, hazing remains a current problem. Of most concern is when these practices extend over a prolonged period of time, hours, days, weeks, or even months. An example would be "Hell Week," which refers to the harassment of pledges over the course of several days. At the high school level, hazing is seen less frequently, though it has been known to occur there as well. Hazing practices in the military date back to World War I, though leaders maintain to not condone the behavior. The U.S. military defines hazing as the unwarranted affliction of cruel, abusive, oppressive, or harmful behavior on a fellow soldier. Similar practices have been reported in other rescue lines of work, including police forces, firefighters, and lifeguards. However, hazing is not limited to these workplaces. Regardless of setting, hazing is a complex social problem entailing the abuse of power, similar to other forms of harassment like bullying.

Hazing is poorly understood due to the secretive nature surrounding it. Victims are not likely to report practices as this would damage the chances of their admittance into the desired group. Experts have questioned why perpetrators engage in hazing rituals as well. Some report using hazing as a way to test potential members' toughness, loyalty, and compatibility levels, while others report that it provides pure entertainment. The question remains as to where the line gets crossed from a rite of passage used for bonding purposes to outright harassment and abuse. Though forms of hazing have occurred for centuries, recent consensus distinguishes it as socially inappropriate.

Impact (Psychological Influence)

Though forms of hazing have occurred for centuries, recent consensus distinguishes it as a socially inappropriate behavior. Since 1970, there has been at least one hazing-related death on a college campus each year. At present, 44 states in the United States have anti-hazing legislation. Several countries also have laws banning hazing practices. In 2008, a large-scale investigation surveying over 11,000 undergraduate students and 300 staff members at 53 colleges and universities throughout the United States reported that more than half of students involved in teams, clubs, and other organizations had experienced hazing. Additional results indicated that nearly half of these students had experienced hazing in high school. While one out of five students reported that they had witnessed hazing firsthand, 95% cited that they did not report the situation to anyone.

Melissa A. Mariani, PhD

See also: Bullying and Peer Aggression

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Health Counseling

Health counseling is a set of distinct methods and approaches used to impact a wide variety of patient health concerns and conditions through education, counseling, and psychotherapy.

Description

"Health counseling" is a general term referring to a variety of methods for effecting health behavior change. Five approaches to health behavior change have been identified, each with a distinct provider, focus, strategy, and duration.

Medical care counseling (MCC) is most often provided by physicians with the focus on providing information about prescribed treatment. MCC is very brief, sometimes lasting just a few seconds. Patients are expected to comply with instructions, and there is usually no educational component or follow-up monitoring

of the treatment. MCC includes descriptions of how often to take a prescribed medication, and advice to lose weight and get some exercise.

Patient care counseling (PCC) is most often provided by nurses, dieticians, or nurse practitioners in order to strengthen a patient's ability to self-manage his or her health condition. The focus of PCC is to increase patient understanding, improve health skills such as self-monitoring, and increase compliance to treatment. PCC usually provides short-term support and assistance to patients as they learn how to deal with significant health conditions such as diabetes, irritable bowel syndrome, asthma, and other chronic health problems.

Health promotion counseling (HPC) is most often provided by health counselors and nurse practitioners. The goal is to improve lifestyle and health behaviors by collaborating with the patient and developing interventions tailored to the needs and expectations of the patient. Individuals may or may not have signs or symptoms of disease. People seek HPC for a variety of reasons, including concerns about physical conditions such as weight loss, management of chronic medical conditions such as diabetes, concerns about aging, getting or staying fit, and relapse prevention for chronic conditions such as irritable bowel syndrome.

Health-focused counseling (HFC) is provided to patients who have been unsuccessful with MCC, PCC, or HPC in managing chronic health problems with low to moderate severity. The goal of HFC is to reduce symptoms by improving adherence to treatment requirements. HFC is usually provided at the doctor's office, most often by physicians and nurse practitioners who have some formal training in counseling. HFC focuses on assessing and reducing barriers to treatment compliance and increasing self-management. Treatment includes assessing and changing maladaptive thinking patterns leading to noncompliance. Psychotherapists such as social workers, psychologists, and mental health counselors also provide HFC and frequently use some form of cognitive restructuring therapy.

Health-focused psychotherapy is used in severe and complex cases in which the health condition is severely debilitating and progressive, causes severe pain, or is life threatening. Illness management and progression of these types of severe medical conditions are greatly affected by personality and family dynamics that run much deeper than just maladaptive thinking. Highly trained psychotherapists who understand how to assist individuals in modifying their core personality dynamics are needed in order to improve the health status of the patient.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy; Cognitive Restructuring; Nutrition and Mental Health

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Hip-Hop Music

Hip-hop music is a variety of rap music consisting of chanting, rhythm, and rhyme created mostly by young black musicians and often used to communicate feelings of oppression due to racial conflict or social injustices.

Description

Music is an important reflection of society, its challenges and changes. Hip-hop is often identified with the music genre of rap, which consists of chanting, rhythmic, and rhyming speech. Hip-hop music has a broader cultural influence than rapping alone. Because it heavily emphasizes rhythm and the role of the beat, it includes elements such as deejaying, scratching, break dancing and beatboxing. The language used in hip-hop often chops up words, uses short forms, and embraces broken English and slang expressions.

Hip-hop music developed in the African American community or "in the ghetto" where many of its musicians were raised. Hip-hop emerged from and traces

its origins to jazz and rock and roll during the 1950s and 1960s. It was recognized and named by the west coast musician Keith Cowboy in the 1970s as a way of imitating the rhythmic structure of soldiers marching. It spread quickly and diversified, and many of its leading musical figures became prominent cultural icons. Many of these icons, such as Tupac Shakur and Notorious B.I.G., were controversial and associated with violence and the defamation of women.

Some of the most successful contemporary icons of hip-hop are Dr. Dre, Snoop Dogg, Jay-Z, and Kanye West. Jay-Z has characterized hip-hop in this way, ". . . hip-hop was this youthful music that didn't have those boundaries outside of America. More specifically hip-hop had a voice. Jazz hit great notes and things like that but hip-hop spoke directly to the people, it spoke to their heart and how they were feeling" (Peterson, 2014).

Impact (Psychological Influence)

Hip-hop's influence has become worldwide, across all nations and musical genres. Its vibrancy and force have renewed interest in language and a kind of raw poetry that represents the attitudes, hopes, and fears of young people. Its rhythm and colorful phrases now influence the language of the entire culture.

Hip-hop is also a genre that includes negative and positive effects from a social and psychological perspective. The lyrics of the music often contain sexually graphic and violent themes. Some male hip-hop performers are routinely sexist, and some advocate violence against women. It has been linked to gang activity and drug use. Often young people who imitate hip-hop music can offend others with negative hip-hop attitudes and language, and by violating certain dress codes.

This music has also had positive cultural influences. Many hip-hop artists spread messages that stress the cultural richness that comes out of the African American heritage and its struggle for freedom and equality. Beyond this, many artists have begun to apply these same ideas to gender equality and the stupidity of violence, gang wars, and the use of drugs. The hopes, fears, and themes of hip-hop have broad cultural appeal. Although it may have started in the African American community, it now has a diverse audience in the United States and around the world.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Music

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Histrionic Personality Disorder

Histrionic personality disorders is a personality disorder in which individuals first appear to be charming, likable, energetic, and seductive. But as time passes, others find them to be emotionally unstable, immature, and egocentric.

Definitions

- **Borderline personality disorder** is a personality disorder characterized by unpredictable, impulsive, and self-destructive behavior, anger, mood swings, and troubled relationships.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Histrionic** refers to behavior that is very dramatic or excessive.
- **Hysterical personality** comes from the word "hysteria" which referred to a medical condition caused by the uterus (in Greek: "hysteria" means uterus). The belief was that various symptoms were caused by the movement of a uterus throughout various locations within a woman's body.

- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

Individuals with histrionic personality disorder may initially seem charming, likable, energetic, and seductive. In time, however, they are likely to be viewed as emotionally unstable, immature, and egocentric. Such individuals can function well both socially and professionally and have developed good social skills. However, they tend to use them to manipulate others into making them the center of attention. In the past, the histrionic personality was referred to as the hysterical personality. With the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1978, histrionic personality disorder replaced hysterical personality. Individuals with this disorder make up 2%–3% of the general population and about 15% in mental health treatment settings.

This personality disorder is more common in females than males. Females with histrionic personality disorder command center stage. They are exhibitionistic and use their charm, physical appeal, and seductiveness to get their way. Their emotions and relationships are intense, but they are also shallow. Males with this disorder also command attention but in a different way. They will brag about their business success or display their athletic ability prowess in golf or tennis. Their interests and attitudes are easily influenced by others. Their emotions and relationships are also intense, but neither lasts long; then they feel unappreciated. In its severe form this disorder can be mistaken for the borderline personality disorder.

The clinical presentation of this disorder can be characterized with the following: behavioral and interpersonal style, thinking style, and feeling style. The behavioral style is often dramatic and expressive while also being demanding, self-indulgent, and inconsiderate. Persistent attention seeking, shifting moods, and superficiality further characterize individuals' behavior. Interpersonally, these individuals tend to be exhibitionistic and flirtatious in their manner, along with attention seeking and manipulativeness. Their thinking style is generally impulsive and thematic (global), rather than being analytical and precise. They are easily suggestible and tend to rely on hunches and intuition. They are likely to deny their dependency on others but need and demand the approval of others. Their emotional style is characterized by exaggerated displays of feelings, including irrational outbursts and temper tantrums. Although they constantly seek others' reassurance that they are loved, at best they can respond only with superficial warmth and charm. In addition, they are very sensitive to rejection.

The cause of this disorder is not clear, and various factors appear to influence the development of the histrionic personality. These include childhood events such as deaths, divorce, or illnesses in the immediate family; genetics and parenting may be involved. As to parenting, such individuals are likely to have had parenting that involved minimal or inconsistent discipline. They may have grown up with at least one manipulative or histrionic parent who reinforced their attention-seeking behavior. In addition, individuals with a histrionic personality disorder tend to have characteristic view of themselves, the world, and others, and a basic life strategy. They typically view themselves sensitive and in need of others' admiration and approval. They tend to view the world and others as making them nervous, and so they believe they are entitled to special care and consideration. Accordingly, their basic life strategy is to do whatever it takes to attract attention and the approval of others.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of attention seeking and emotionality. More specifically, they tend to be uncomfortable in situations where they cannot be the center of attention. Their emotional reactions are usually shallow and rapidly shifting. Typically, they draw attention to themselves with the way they dress. Their manner of speech tends to be impressionistic with few details. They are

easily influenced by others or circumstances. They are likely to believe that their relationships are more intimate than they really are. In addition, they may engage in provocative and inappropriate seductive sexual behavior. Furthermore, they are dramatic and overly exaggerate their emotional expressions (American Psychiatric Association, 2013).

Treatment

The clinical treatment of the histrionic personality disorder usually involves psychotherapy. Such psychotherapy is likely to be effective if it has specific and focused treatment goals, limits, and interventions. The overall treatment goal is to assist individuals to moderate their emotional expression, to integrate gentleness with strength, and to encourage them to develop more genuineness, warmth, and empathy. Therapy is successful when these individuals are able to rely on their own self-acceptance rather than demanding approval and acceptance from others. Because this disorder can present as impulsive with potential for suicidal gestures, the clinician needs to discuss the matter of limits, boundaries, and personal responsibilities early in the course. Unless a concurrent acute psychotic or major depressive episode is present, psychotherapy is the principal mode of treatment.

Len Sperry, MD, PhD

See also: Borderline Personality Disorder; Personality Disorders; Psychotherapy

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HIV/AIDS

HIV stands for human immunodeficiency virus, a virus that results in significant deterioration of the immune system that can eventually lead to AIDS, or acquired immunodeficiency syndrome and various mental symptoms.

Definitions

- **Acute retroviral syndrome** results from the immune system's response, typically three to four months, to HIV viral replication.
- **Antiretroviral therapy** is regarded as the main type of treatment for HIV or AIDS consisting of drug combinations taken on a daily basis to counteract and prolong the spread of the disease.
- **Opportunistic infections** are infections caused by bacteria, fungus, or viruses that take advantage of a weakened immune system.
- **Pandemic** refers to the outbreak of a disease that spreads to a vast number of people in a relatively short period of time.
- **Sexually transmitted disease** is a type of infection or disease that is passed from person to person through some type of sexual contact (oral, anal, vaginal).

Description

HIV, or the human immunodeficiency virus, is a contractible infection that can lead to AIDS, or acquired immunodeficiency virus. Presently, there is no cure for HIV, meaning once a person contracts the virus, it remains in the body. HIV attacks the immune system, specifically the CD4 cells or T cells, which assist in fighting infection and boosting immunity. As the HIV virus progresses, it continues to destroy these cells, eventually resulting in AIDS and ultimately death.

Origins of HIV have been traced back to apes and chimpanzees in West Africa as far back as the late 1800s. This version of the virus, called simian immunodeficiency virus, or SIV, was believed to be contracted

by humans when they hunted these animals for meat. Existence of the virus in the United States was first reported during the 1970s. At the time, HIV/AIDS was viewed as a global pandemic. Over the past several decades with research, education, and prevention on the topic increasing, these diseases have seen a decline.

HIV is primarily transmitted from an infected person to another person through unprotected sexual contact (not using condoms). The HIV virus is contained in bodily fluids such as semen, pre-seminal fluid, rectal fluids, and vaginal fluids that are exchanged during intercourse. When infected fluids come in contact with a mucous membrane (rectum, vagina, opening of the penis, and mouth), transmission of the virus is likely to occur. The highest likelihood of transmission results from anal sex, followed by vaginal sex, and oral sex. A person's chances of contracting HIV increases dramatically if he or she has other sexually transmitted diseases/infections (STD/STI) such as syphilis, herpes, and HPV. Risk of HIV infection can also occur with blood-to-blood contact. The virus can be transmitted through an opening in the skin such as a cut, abrasion, sore, or incision site. In addition, transmission can happen if a contaminated needle or syringe is directly injected into the bloodstream, either from an accidental prick, from a faulty transfusion, or from sharing needles. Though HIV can also be passed from mother to child during pregnancy, birth, or breast-feeding, these cases are not as common. Cases of HIV being transmitted through saliva are extremely rare, and there is no evidence to suggest that one can contract the virus from kissing or sharing drinks with an infected person alone.

The only sure way to know if one has been infected with the HIV virus is to be tested for it. This can be done through a simple blood test; there are also home-based kits that gather saliva to detect the existence of the disease. Signs and symptoms of the virus vary; however, most people report experiencing flu-like symptoms, referred to as *acute retroviral syndrome*, within two to four weeks of contracting HIV. Other symptoms include fever, sore throat, swollen lymph nodes, and rash. During this initial period, the virus may not show up on a routine screening, so individuals are advised to repeat testing and refrain from unprotected sex or other risky behaviors, as the virus is highly contagious during this time. Furthermore, levels of the HIV virus are highest in concentration at this time, resulting in considerable diminishing of C4 cell counts. Normal CD4 counts range from 500 to 1,600 cells/mm^3.

The progression of HIV takes place over several stages from time of contraction to full-blown AIDS. Early detection and proper treatment can significantly delay progression of the disease from one stage to the next. However, the virus is still active during all of the stages and can be transmitted to others at any time. The initial stage of HIV is referred to as *acute infection* and occurs within two to four weeks after being infected with the virus. The majority of those infected report feeling sick as the virus multiplies very quickly and destroys healthy cells. In the next stage, *clinical latency* (inactivity or dormancy), people report being asymptomatic as the virus reproduces at very low levels during this time. This period can range from months to years to even decades. The final stage of HIV progression results in AIDS, or *acquired immunodeficiency syndrome*. Here, the immune system has become completely compromised exposing the person to increased infections, termed "opportunistic infections," and diminishing the person's chances of successfully fighting off disease.

Individuals with HIV/AIDS also can experience a range of mental health issues. The most common are feelings of acute emotional distress as well as depression and anxiety. Because the HIV/AIDS virus directly infects the brain, impairment in memory and thinking is also common. In addition, anti-HIV drugs can produce mental health side effects.

Impact (Psychological Influence)

Estimates suggest that 50,000 people are infected each year with HIV. Approximately a million people are currently living with HIV/AIDS in the United States alone and over 30 million people worldwide. In terms of risk factors, race and ethnicity play a role, with African Americans being the group with the highest incidence rates of HIV infection followed by Latinos/Hispanics. Age is also a factor, with young people aged 13 to 24 at the highest risk for contracting the virus. Type of transmission is another contributor, with men who have sex with men (MSM) being most affected followed by individuals who become infected through unprotected

heterosexual intercourse. Lastly, those who have STD/STI are much more likely to contract and pass along HIV than those in the general population.

There is no cure for HIV/AIDS; however, early diagnosis and adherence to effective treatment protocol can have a significant impact on one's life expectancy. Antiretroviral therapy, developed in the mid-1990s, remains the most common form of treatment and consists of daily oral doses of medications, including azidothymidine, to counteract symptoms and spread of the disease. Recent research is focused on the effectiveness of administering these medications in injection form. Other prevention strategies include behavioral interventions, including sex education, condom distribution, and counseling. Scientists have been studying HIV/AIDS for several decades and are hopeful that a cure will be developed one day.

Melissa A. Mariani, PhD

See also: Homosexuality

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Hoarding Disorder

Hoarding disorder is a mental disorder characterized by persistent difficulty discarding or letting go of possessions regardless of their actual value.

Definitions

- **Cognitive behavior therapy** is a form of counseling and psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Compulsions** are repetitive behaviors or mental acts that an individual feels compelled to perform in response to an obsession or to rules that must be followed rigidly.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Obsessive-compulsive disorder** is a mental disorder characterized by persistent thoughts and compulsive actions, such as cleaning, checking, counting, or hoarding. It is also called OCD.

Description and Diagnosis

Hoarding disorder is a compulsion to save items or to keep an excess of certain items. There is a significant degree of distress associated with getting rid of or parting with possessions. Hoarding disorder is one of a group of obsessive-compulsive and related disorders in DSM-5 because of its compulsiveness and because of the effect of hoarding on those who hoard and on their relationships. Hoarding results in clutter that limits the living space of the hoarder and other family members. Individuals with this disorder may appear quite normal in public. However, as family and friends become aware of the hoarding and attempt to reduce the clutter, distress increases in hoarders and in their close relationships.

Hoarders are often perfectionistic and have difficulty making decisions and organizing their lives. They procrastinate and are easily distracted. They are convinced that the items they have collected or bought have real value. Also, they may feel emotionally attached to these items. These beliefs and emotional attachments make it difficult for them to part with these items.

This disorder affects about 4% of the U.S. population. It affects both males and females, although in treatment settings, the majority of hoarders are female. Hoarding is three times more common in those over the age of 55 in comparison to those between the ages of 34 and 44 (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a

persistent and strong desire to keep and save items. They experience anguish when confronted with a need to discard items, regardless of their worth or necessity, or available space in their living area. The clutter that causes significant distress for the individual and family members takes time to reach a significant level. In addition, the hoarding is not the result of a brain injury or other medical condition, or because of another mental disorder (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, it does seem to be more common in those with a family history of hoarding. This means that genetics and upbringing are causative. Psychologically, those who hoard often worry that they will be without needed items or that desired items will be taken away from them. They believe that the minute something is discarded it will be essential to have it back, and, of course, then it will be too late. The influence of family and friends may also be a causative factor. They may believe they are helping the hoarder by clearing away clutter. But this may increase the hoarder's distress and lead to the reclaiming or repurchasing of these "needed" items.

Treatment

The clinical treatment of this disorder usually involves cognitive behavior therapy (CBT). It teaches individuals to view the objects around them in a new light and to change their hoarding behaviors. CBT sessions can help hoarders make better judgments and quicker decisions on whether to keep or discard objects. Most important, it helps them practice discarding items as they sort through the intense emotions that trigger hoarding. When family members are involved or living with the hoarder, they may be invited to become involved in the treatment process.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Obsessive-Compulsive Disorder (OCD)

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Holland, John Lewis (1919–2008)

John Lewis Holland is a psychologist best known for his creation of a career development model referred to as *The Holland Codes*, which align one's career alternatives with one's underlying character types.

Description

Psychologist and career development model creator John Lewis Holland was born on October 21, 1919, in Omaha, Nebraska to an advertising executive and elementary school teacher. He was one of four children. Holland's father emigrated from England to the United States where he initially worked as a laborer while attending night school at the YMCA. With his parents' encouragement, John also pursued an education, as did each of his siblings. In 1942, he graduated from the Municipal University of Omaha (now the University of Nebraska at Omaha) where he studied psychology, French, and Math.

After graduation, Holland served as a personnel clerk for a few years in the army during World War II. During this time, he received extensive experience in test administration and assessment under the advisement of social workers, psychologists, and physicians. He spent countless hours recording biographical information on soldiers. These experiences contributed to the eventual development of his own hypotheses about personality types. He decided to continue studying to be a psychologist and then sought a doctoral degree in counseling psychology at the University of Minnesota.

John Holland went on to create the career development model known as the *Holland Codes*, or *Holland's Occupational Themes*. His theory referred to person–environment explanations for vocational behavior. He also posited that people's career choices revealed aspects about their personality types and

underlying character. This is part of the psychological study called *typology*, founded on the premise that one can be classified based on certain characteristics or traits that are in common.

There are six Holland Codes, or schemes, each letter (RIASEC) representing a particular "type." "R" stands for Realistic (Doers), "I" for Investigative (Thinkers), "A" for Artistic (Creators), "S" for Social (Helpers), "E" for Enterprising (Persuaders), and "C" for Conventional (Organizers). These six types also generate 720 different personality patterns. The foundational principle behind Holland's Occupational Themes is that people seek out and flourish in careers that best fit their individual personality types. Holland also developed two interest inventories commonly used in career assessment—The *Vocational Preference Inventory* in 1953 and the *Self-Directed Search* (SDS) in 1970. The SDS is a career assessment tool and intervention to be used by persons interested in exploring themselves, specifically their interests, abilities, and vocational options. The SDS has undergone several revisions in 1977, 1985, and, most recently, 1994. The SDS is still readily used in career counseling practice today. A variety of inventories have incorporated aspects of the SDS, including the *Position Classification Inventory* in 1991 and the *Career Attitudes and Strategies Inventory* in 1994, both of which were developed by Holland and colleague Gary Gottfredson.

Holland continued working and developed his career theory at various places: Western Reserve University, the Veteran's Administration Psychiatric Hospital (1953–1956), the National Merit Scholarship Corporation (1957–1963), the American College Testing Program (1963–1969), and finally at Johns Hopkins University (1969–1980) where he earned the distinction of professor emeritus of sociology. He died on November 27, 2008, at the age of 89, at Union Memorial Hospital in Baltimore, Maryland.

Impact (Psychological Influence)

In addition to the inventories he created, Holland published several works that are regarded as foundational writings in career theory. These include *The Psychology of Vocational Choice* (1966), *Making Vocational Choices* (1973, 1985, 1997), and *The Dictionary of Holland Occupational Codes* (1982, 1989, and 1996, with Gottfredson). He was also awarded several merits for his contributions in the field. In 1994, he was given the American Psychologist Association's Distinguished Professional Contributions to Knowledge Award. In 1995, the American Counseling Association honored him with the Extended Research Award. Lastly, in 2008, APA again recognized his efforts by bestowing upon him the Award for Distinguished Scientific Applications of Psychology.

Melissa A. Mariani, PhD

See also: Career Assessment; Career Counseling

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Homelessness

Homelessness is characterized by a lack of permanent housing. It may involve living on the streets, staying in a shelter, mission, single-room occupancy facilities, or other unstable or nonpermanent situation.

Description

Homelessness is a severe and increasing problem. It's estimated that approximately 1% of Americans are homeless, including nearly 1.5 million children. In 2009, 1 out of every 38 children living in poverty in the United States ended up in a shelter or on the street. Though homelessness has many causes, the major

factors are lack of affordable housing and extreme poverty. Both of these factors have increased during the past decade. Other factors include substance abuse issues and mental health challenges.

Being homeless disrupts a person's sense of community belonging. It's difficult to maintain normal life activities like working and spending time with family when homeless. When people are homeless or living in low-quality housing, they tend to withdraw from their networks, which creates social and psychological isolation.

The effects of homelessness are often made worse by the stigma in media and health-care services. Many people have negative attitudes toward homeless people, more so than toward poor people who still have homes. This stigma can lead to less funding for social programs, or people being too embarrassed to seek the help they need. Another issue is that federal policy is aimed at homeless adults, instead of the families or children who are more likely to become homeless.

At special risk are homeless mothers. Homeless women with young children often have emotional issues or a major depressive disorder, such as post-traumatic stress disorder , and up to one-third of homeless mothers have been suicidal at some point. These women are also more likely to become victims of violence or to be substance abusers. Homeless families are much more likely to have mental health difficulties, substance abuse challenges, and unhealthy levels of stress.

Since children's emotional well-being is dependent on their parents, a mother's mental problems can lead to an increase in mental problems for her children. Homeless children are also at risk for lower grades in school and relationship problems, due to moving and a disruption of their routines.

According to numerous studies, being homeless increases the risk of mental issues in young people. Homelessness can trigger mental problems or can make them worse. Nearly half of homeless youth have been diagnosed with one or more psychiatric conditions, and most aren't getting any treatment. Having psychiatric problems tends to make young people more vulnerable to becoming homeless again in the future. The longer a child is homeless, the worse his or her condition can become.

Homeless kids are more likely to have witnessed violence in their families or communities, which contributes to their risk of mental problems. As many as one-fifth of all homeless preschoolers have emotional problems that need treatment, and by the time they reach the age of eight, one-third of children will have a major mental health disorder.

Children who are homeless also tend to have problems in school. They have lower test scores than other kids and have a higher rate of learning disabilities, and less than one in four homeless children graduates from high school. The longer kids remain homeless, the worse their problems at school. They often have low attendance rates and poor grades, and face social stigmatization.

Another disturbing trend among homeless children is they are more likely to use cigarettes, alcohol, or marijuana. Kids who use these substances before adulthood have more psychological and physical problems, and cigarette smoking among teens has been linked to major depressive disorder, disruptive behavior disorders, and other substance addiction problems in young people. Adolescent substance abuse also increases the risk of substance abuse as an adult. Children who are homeless are likely to experience hunger, stress, and abuse, or have a parent who abuses drugs or has mental or psychiatric disorders. All of these factors increase a child's risk of substance abuse. Homeless kids are also unlikely to take part in school programs designed to reduce or stop drug use, because they change schools often or miss classes.

Current Status

More needs to be done not only to cut down on homelessness but also to identify and treat mental health issues among homeless adults and children. Addressing and treating mental problems in homeless children especially can help improve their health and may help reduce the risk of future homelessness.

Mindy Parsons, PhD

See also: Deinstitutionalization; Economic and Financial Stress

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Homework in Psychotherapy

"Homework" refers to a psychotherapeutic technique that is frequently employed to extend treatment benefits into the real-life environment of clients. Homework assignments are most frequently used in cognitive behavioral therapies and are designed to be completed between psychotherapy sessions.

Description

The use of homework assignments is frequently utilized in psychotherapy. Homework assignments have several positive benefits to the psychotherapy process and have been shown to positively impact treatment outcomes. Homework allows clients to develop new insight and practice new skills in the real world outside of the treatment office. Homework also provides an opportunity for clients to experience success and develop confidence in the skills they have attained. Homework assignments allow clients to extend the therapeutic work and use between-session time to gain skills and insights. This extension of the therapy process results in gains that clients would otherwise pay for during a psychotherapy session resulting in cost savings to the client. In the early stages of psychotherapy, the therapist most often assigns homework. As treatment progresses, clients are encouraged to develop their own homework tailored to their specific needs.

There are many types of homework assignments. Reading assignments are a frequently employed task that provides psychoeducational benefits. Clients are often provided with reading material that will help them gain a deeper understanding of the issues they are addressing. For instance, frustrated parents of a child who has been newly diagnosed with attention-deficit hyperactivity disorder might be given a book to read on the challenges of parenting a hyperactive child. The therapist is confident that reading the book will be beneficial to the parents because the book is written from a parent's perspective and addresses many of the difficulties the client/parents are experiencing.

Between-session monitoring of behaviors, thoughts, feelings, physiological changes, interpersonal interactions, and a variety of other personal characteristics are frequently employed depending on the treatment goals and needs of the client. Evaluating and modifying inaccurate and dysfunctional thoughts while they are occurring are also frequently used in homework assignments. For instances, a client who presents with anxiety over taking exams reports that she has difficulty studying because she worries so much about the importance of the exam. The therapist helps her understand how thoughts and beliefs are what are causing the anxiety and inability to concentrate. She is given the tasks of writing down her thoughts about the exam and monitoring her emotions that correspond to those thoughts. During this process she discovers that her thought of "I'll never understand this" and "what if I fail?" are quite irrational given that she has consistently scored well in all of her previous exams. She is also given the tasks of finding more positive thoughts resulting in an increase in her ability to concentrate and a decrease in her anxiety.

Homework assignments are a very useful and frequently employed technique in psychotherapy.

Homework offers clients a way to extend the benefits of psychotherapy to between-session time periods and result in more positive and rapid treatment outcomes.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy

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Homophobia/Heterosexism

Homophobia/heterosexism describes the irrational fear of, aversion to, or discriminatory beliefs, attitudes, and behaviors toward homosexual and gender-variant persons.

Definitions

- **Gender identity** is the way in which one self-identifies one's gender, or personal sense of being male or female.
- **Gender identity disorder,** or gender dysphoria, is a formal clinical diagnosis given to those experiencing significant social, emotional, or psychological stress from not identifying with their assigned gender.
- **Heterosexuality** describes the sexual orientation of people who are attracted to, aroused by, or romantically interested in members of the opposite sex/gender.
- **Homosexuality** describes the sexual orientation of those who are attracted to, aroused by, or romantically interested in members of the same sex/gender.
- **Transgender** describes individuals who are experiencing gender dysphoria and who do not personally identify with the gender they were assigned at birth.

Description

Homophobia describes discriminatory feelings, opinions, and actions against individuals who are gay, lesbian, bisexual, or transgender. Homophobia combines the words "homosexual," meaning "same sex," and "phobia," meaning "fear." Psychologist George Weinberg is credited with coining the term in the 1960s. Other terms/phrases related to homophobia are "heterosexism," "sexual prejudice," and "homosexual panic." Heterosexist views assume that all people are, or should be, heterosexual and that those who aren't are not "normal." Variations of the word "homophobia" include *homophobic*, an adjective describing these types of views or behaviors, and homophobe, a noun used to refer to a person who possesses homophobic views or displays homophobic actions. Homophobia can be expressed both covertly (believed or felt but not shared or displayed openly with others) and overtly (verbally and behaviorally expressed in public). Both are damaging to victims, breeding fear, prejudice, contempt, and hatred. Two recognized types of homophobia are *institutionalized homophobia*, in which same-sex discriminations are bred by religious, local, state-, or national-level organizations, and *internalized homophobia*, which describes when a person represses or hides his or her personal same-sex attractions out of fear, disgust, or shame. Extreme cases of homophobia have resulted in violence or hate crimes.

Homophobia has a long history dating back to ancient Greece. Social reformer and the first gay rights activist Jeremy Bentham wrote that homosexuality was a victimless crime back in 1785, though his writings weren't published until 1978, out of fear for retaliation. Homosexuals were another group targeted by the Nazis during the Holocaust. Homophobia became a topic of

mainstream debate in the late 1960s and early 1970s. The first gay march was held in front of Independence Hall in Philadelphia, Pennsylvania, in 1962, marking the beginning of the gay rights movement. Brenda Howard, a bisexual activist known as the "Mother of Pride," is credited with coordinating the first LGBT pride march in New York in 1970. The 1972 book *Society and the Healthy Homosexual* brought attention to the oppression suffered by gay people who were classified as having a disorder simply due to their sexual orientation. In it, Weinberg argued that homophobia was more appropriately categorized as a disorder than homosexuality was. Soon after, the American Psychiatric Association removed homosexuality from the list of mental disorders and has since worked to reduce the social stigma associated with homosexuality. Though this increased understanding and acceptance, prejudice against people who are homosexual continued. Traditionally, Southern states, where the majority of people hold conservative views, and identify as primarily Republican, are less accepting of LGBT people.

Some religious denominations, particularly the Roman Catholic Church, have been public about their stance on homosexual behavior. The Catholic Church teaches that homosexual behavior is morally wrong as it is unnatural, not engaged in for the purpose of producing children. The Bible refers specifically to the destruction of Sodom and Gomorrah for their people's homosexual activity. However, recently the church's statements, influenced by Pope Francis, have encouraged members to refrain from passing judgment and breeding contempt. All major Islamic sects forbid homosexual behavior, and most of them deem these acts as criminally punishable under law.

Current Status and Impact (Psychological Influence)

The passing of several policies and laws have improved living, working, and social conditions for homosexuals. The Netherlands was the first country to legalize same-sex marriage in 2001. Since that time other countries have followed, including Sweden, Belgium, Canada, South Africa, Spain, France, and Mexico. In the United States, legalization of same-sex marriage is determined by each state. As a result of the landmark ruling by the U.S. Supreme Court ruled on June 26, 2015, same-sex marriage is legal in all states. In 2011, the 1993 "Don't ask, don't tell" policy that forbids homosexuals from serving in the U.S. military was repealed. LGBT people continue to gain acceptance and equality. Gay pride celebrations now happen worldwide every June.

Melissa A. Mariani, PhD

See also: Gender Identity; Gender Identity Disorder; Homosexuality; Transgender

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Homosexuality

Homosexuality describes the sexual orientation of those who are attracted to, aroused by, or romantically interested in members of the same sex/gender.

Definitions

- **Gender identity** is the way in which one self-identifies one's gender, or personal sense of being male or female.
- **Gender identity disorder,** or gender dysphoria, is a formal clinical diagnosis given to those experiencing significant social, emotional, or psychological stress from not identifying with their assigned gender.
- **Heterosexuality** describes the sexual orientation of people who are attracted to, aroused by,

or romantically interested in members of the opposite sex/gender.

- **Homophobia/heterosexism** describes the irrational fear of, aversion to, or discriminatory beliefs, attitudes, and behaviors toward homosexual and gender-variant persons.
- **LGBT** is an abbreviation for lesbian, gay, bisexual, and transgender, used to designate the greater group of nonheterosexual people.
- **Transgender** describes individuals who are experiencing gender dysphoria and who do not personally identify with the gender they were assigned at birth.

Description

"Homosexuality" refers to the sexual orientation of individuals who are romantically or sexually attracted to members of the same sex or gender. The term is derived from both the Greek word "homos," meaning "same," and the Latin "homo," meaning "man." It is recommended that "homosexual" be used as a noun rather than an adjective. Though "homosexuality" is most often used to refer to human beings, it has also been observed in various animal species. There are three categories of sexual orientation: heterosexuality, homosexuality, and bisexuality.

Homosexual or homosexuality may also be used to describe an individual's sexual and/or social identity as well as the individual's membership within the lesbian, gay, bisexual, transgender (LGBT) community. Common terminology used to describe a woman who is homosexual is "lesbian" and a man who is homosexual is "gay," though "gay" may also be generally used to refer to all members of the LGBT community. The process of disclosing to friends and family members one's sexual orientation is referred to as "coming out." Typically, this occurs during late adolescence and early adulthood, though some people may choose to hide their sexual identify for much longer.

Until the early 1970s, mental health practitioners and other medical professionals classified homosexuality a mental disorder. Debate is ongoing as to why a person develops a particular sexual orientation. Scientists support a biological/genetic explanation (nature) versus environmental contributors such as parent style and early childhood experiences (nurture). There is no evidence to support that a person chooses to be homosexual or not. Therefore, psychological counseling aimed at changing one's sexual orientation has been proven not effective by research. The conclusion is that homosexuality appears to be a normal variation in human sexual development.

Sexual relations among people of the same gender can be traced back to ancient time periods in Africa, Asia, and Europe. However, Karl-Maria Kertbeny, an Austrian writer, was the first person to anonymously publish the word "homosexual" in an 1869 pamphlet arguing against an antisodomy law. The book *Psychopathia Sexualis*, written by Richard von Krafft-Ebing in 1886, later popularized the terms "homosexual" and "heterosexual" used to describe sexual orientation. Since that time, these words have become part of common vernacular.

Current Status and Impact (Psychological Influence)

Homosexuals have experienced significant criticism, misunderstanding, and prejudice throughout history and on into the present day. Derogatory terms such as "homo," "faggot," "queer," and "fairy" have been used to refer to men who are homosexual. Likewise, slurs such as "lesbo," "butch," and "dyke" have been used to degrade women who are homosexual. "Homophobia," or "heterosexism," refers to discriminatory views of homosexuals and their lifestyles. Homophobia, however, is often the result of lack of knowledge, understanding, or personal experience with someone who is gay. Many religions continue to condemn acts of homosexuality and reject or seek to convert people who identify themselves as homosexuals. Others have welcomed LGBT people, and there are LGBT people serving as clergy and faith leaders. Significant progress has been made over the past few decades to increase visibility, understanding, and acceptance of those who are homosexual. Legal rights related to marriage, parenting, employment, military service, and equal access to health care have been debated. Anti-bullying legislation has also been passed to protect the rights of LGBT minors.

Melissa A. Mariani, PhD

See also: Gay, Lesbian, Bisexual, Transgender (GLBT/LGBT); Gender Identity; Gender Identity Disorder; Homophobia/Heterosexism; Sexual Orientation; Transgender

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Horney, Karen (1885–1952)

Karen Horney (1885–1952) was a psychoanalyst who was born in Germany and is most famous for her developments in the area of character and character development, feminine psychology, the conception of the self, and her theories on neurosis.

Description

Horney departed from the Freudian view early on in her career, going on to develop her own psychoanalytic philosophies. During the first half of the 20th century, Horney emerged as a pioneering and well-respected psychologist and psychoanalyst. Like other scholarly analysts of her time, Horney was an active researcher. She used psychoanalysis both as an intervention for her clients and as a research method.

A central theme in Horney's character was her independence of mind. Therefore, she resisted Freudian orthodoxy, instead cultivating her own practical experience as a clinician. Her theory was thus greatly influenced from her own practice. She was quick to react against the domination of men and the male viewpoint in society, and challenged current theories of the role of women, female sexuality, and the institution of marriage. She also disagreed with the emphasis Freud and his followers placed on biology. She argued for the importance of social influences on human development.

Development

As early as 1922, Horney began to question the classical analytic view of women. She pointed out that the psychology of women was described from a man's point of view and that often women would unconsciously yielded to those notions. Horney believed that each person has a central inner force that is common to all people, yet possesses unique character. This force, which she called the real self, is the source of growth.

Horney was born near Hamburg, Germany, in 1885, to a Protestant upper-middle-class family. Her Norwegian father was a sea captain and a diligent Bible reader. Her mother was a free-thinking Dutch woman who encouraged her daughter to pursue medical studies. While growing up, she kept a well-written diary with many insights. Many years after her death her journals were compiled and published in 1980 under the title *The Adolescent Diaries of Karen Horney*.

Horney decided to attend medical school when women doctors were unheard of in Germany. She studied medicine at the universities of Freiburg, Gottingen, and Berlin. After completing her medical education, she became one of the first women to undergo Freud's new treatment of psychoanalysis. After entering analysis with Karl Abraham, she became a founding member of the Berlin Institute of Psychoanalysis. She also practiced and taught there.

In 1932, Franz Alexander asked Horney to join him in Chicago to codirect the first American Psychoanalytic Institute. Two years later, because of theoretical differences with Alexander, she left Chicago for New York, where she joined the New York Psychoanalytic Institute. She was also invited to teach at the New School of Social Research, which had established a reputation for attracting the best minds of European immigrants who had escaped Hitler. The school provided the setting for the development of her novel psychoanalytic notions. Her lectures there were extremely successful and were the basis of her first two books *The Neurotic Personality of Our Time* and *New Ways*

Karen Horney was a psychoanalyst who was born in Germany and is most famous for her work in the area of character and character development, the conception of the self, and her theories on neurosis. (Bettmann/Corbis)

in Psychoanalysis. Another one of her major works is *Self Analysis*.

Anxiety, a central and organizing theme in her work, is present in today's world at a level that Horney and her contemporaries would have been unable to imagine. Her recognition of the role of the family in both engendering and mediating anxiety, as well as in shaping the individual's response to it, is today reflected in systems and developmental theories.

Impact (Psychological Influence)

One of Horney's greatest contributions to the field of psychology is in the area of character and character development. She was especially interested in how basic anxiety gave rise to neurosis. She delineated three major character types, each with its own subdivisions and each a solution to the problem of high anxiety and insecurity. In one type, the individual banks excessively on success and power. In another type, the individual relies heavily on relations and membership in a larger social entity. In the third type, the individual leans heavily toward avoidance, disengagement, and resignation.

Many of the ideas currently circulating in the psychological and psychoanalytic communities correspond directly with the theories Horney put forth during the first half of the 20th century. While radical for her time, her conviction that cultural factors exert a powerful influence on our ideas of gender and development has passed into mainstream thought. The 1940s began a very creative period in American psychoanalysis, and Horney was a major player, opening up the field for ongoing creative development.

Mindy Parsons, PhD

See also: Neo-Freudian Psychotherapies

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Hospitalization

Hospitalization is the act of placing a person as a patient in a formal medical facility.

Definition

- **Chronic** is used to describe a disorder that usually does not have a single cause, a specific onset, nor a stable set of symptoms. While cure may be possible, it is unlikely for advanced levels of the disease process.

Description

Hospitalization is one option available for critical or emergency medical care. "Hospitalization" is the term for medical treatment conducted within a professional clinical setting usually for a serious or life-threatening illness or condition. The picture is complex because there are a variety of institutions with the title hospital, from major medical centers with the highest level of medical expertise to simpler facilities that provide temporary or emergency care. This range also applies to care for those diagnosed with mental disorders. It also refers to inpatient treatment in a facility staffed by caregivers trained in psychiatry, psychology, and other fields.

The traditional full hospital setting is what in today's lingo is called tertiary care. Primary care is the simplest and most basic health care available within communities. An example of this is what a general practitioner can do during a regular office appointment. Secondary care steps up the level of services required. This is usually outpatient treatment, which requires more than one application and short-term, regularly scheduled visits. Tertiary care, or hospitalization, implies a medical facility, which provides a spectrum of choices for treating disease in a clinical setting from major surgery to physical therapy.

Modern hospitalization is an expensive and labor-intensive method of providing health care, and it has two aims. The first is to improve or rehabilitate a patient suffering from a curable illness. The second is the long-term care given to a patient who suffers from a chronic or incurable condition. These goals also apply to people diagnosed with mental disorders who can improve as well as for others who deal with issues chronically or more permanently.

Development

In the Middle Ages, hospitals began as charitable institutions founded by the church. In the 18th and 19th centuries, they came to be viewed as a service of society, not just of religion. Modern hospitals depend on a trained staff of nursing professionals even more than they do on physicians who are usually individual expert entrepreneurs within the health-care system. In fact it is noted that it was the professionalization of nursing that was the most important element in changing hospital life.

From the 18th century on, those judged mentally ill by society were increasingly confined, at times like prisoners, to institutions called asylums for the insane. This was especially true for those who had violent or self-destructive tendencies. Hospitalization was widespread and socially accepted. Many patients lived their whole lives within the confines of institutionalized hospital settings.

After World War II, mood-altering drugs began to supplement and then replace other forms of treatment. Their ability to control symptoms, such as hallucinations, seemed to create new options other than permanent hospitalization. During the 1980s many mental hospitals and institutions were shut down and the patients who had lived there were discharged. These people were sent to lead their lives in the outside world where it was presumed they would integrate into society. Deinstitutionalization was the movement of the day and drastically reduced the use of hospitalization to treat chronic mental disorders.

Current Status

While hospitalization remains an option for the severely mentally ill, it is the exception and not the rule. Controversies about costs, treatment protocols, and control within the health-care environment occur often. Because of this, hospitalization is now seen as the option of last resort. This is especially true for health-care insurance providers whose rules control payments for services, medications, and other therapies.

One of the greatest challenges in hospitalization is the growing population of elderly patients and the dilemmas that deinstitutionalization causes for caregivers and families of those who are sick and need assistance. This is especially true as the number of elderly patients with dementia or Alzheimer's gets larger. These people cannot live alone and their families often are unable to care for them adequately. It is no surprise therefore that the greatest costs associated with hospitalization are for the elderly in the final years of their lives.

Another hospitalization option that is being used is partial hospitalization. This would be considered a

secondary-care option rather than tertiary care. Successful use of partial hospitalization as a treatment option for patients requiring intensive services is usually determined after more intensive care. Continuing improvements in outpatient community services remain a great social challenge, including partial hospitalization and intensive outpatient treatment.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Deinstitutionalization; Partial Hospitalization Program

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House-Tree-Person Test

The House-Tree-Person (HTP) test is a projective drawing technique used originally as a measure of intelligence and later as a tool to investigate potential exposure to abuse.

Description

The House-Tree-Person test is often used to gain insight for the presence of abuse and child's perception of safety and security. Although the test was originally developed to assess a child's intelligence, it has since grown to include an assessment of personality dynamics and more.

The House-Tree-Person projective technique was first developed by John Buck in 1948. These three objects were selected as Buck believed that they would be symbolic representations of various aspects of the individual's life. For example, the house represents the subject's home life and family relationships. The tree is the symbolic representation of the relationships the client experiences in his or her environment. The person is associated with the client's interpersonal relationships. Buck felt that creativity represented personality characteristics. It was thought that through drawing, clients would project a self-portrait that can be used to assess personality dynamics.

Development and Current Status

Individuals are asked to draw these three objects and given no further description. After completing the drawing, the clients are sometimes asked to describe the house, tree, and person as well as how they feel about each other. Analyzing a person's drawings dates back to at least 1885, which was the earliest written article on the topic. The testing format originally recommended by Buck was that the client would sketch the picture with pencil and then answer 60 questions about the drawings. Then the client would complete the drawings again only this time he or she would have available eight or more crayons of various colors. Again, this was followed by the 60 questions about the drawings.

Projective tests often have validity and reliability challenges due to the wide variability among drawings, and this test is no different. Attempts to standardize the HTP test have repeatedly fallen short. This specific test has practical uses and is very easy to administer. However, the analyses are extremely subjective.

This projective assessment remains popular as it can be given to anyone over the age of three years. It is quick and easy to use and is considered to be minimally invasive. It is commonly used despite variances in reliability. There continues to be a growing interest in the psychological connections to drawings.

Mindy Parsons, PhD

See also: Art Therapy; Figure Drawings

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Organizations

American Art Therapy Association
4875 Eisenhower Ave., Suite 240
Alexandria, VA 22301
Telephone: (888) 290-0878
E-mail: info@arttherapy.org
Website: http://www.arttherapy.org/

American Professional Society on the Abuse of Children
1706 E. Broad Street
Columbus, OH 43203
Telephone: (614) 827-1321
Fax: (614) 251-6005
E-mail: apsac@apsac.org
Website: www.apsac.org

Association for Child and Adolescent Counseling
A Division of the American Counseling Association
6101 Stevenson Ave.
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Telephone: (800) 347-6647
Fax: (800) 473-2329
E-mail: webmaster@counseling.org
Website: http://www.counseling.org

Association for Creativity in Counseling
A Division of the American Counseling Association
6101 Stevenson Ave.
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Human Trafficking

The term "human trafficking" refers to the buying, selling, and smuggling of human slaves, mostly women and children, for profit.

Definitions

- **Bonded labor**, also referred to as *debt bondage*, defines when a person (adult or child) is enslaved and ordered to engage in some form of work (service industry, prostitution, sweatshop, or farming) to pay off a debt owed.
- **Forced labor,** or *involuntary servitude*, refers to the exploitation of workers who are vulnerable because of a debt owed, age, gender, or ethnic/cultural background.
- **People smuggling,** also known as *migrant smuggling*, defines the illegal movement of people out of a place, typically across an international border, with their consent.
- **Prostitution** refers to the business of engaging in some type of sexual behavior in exchange for money or some other benefit/compensation.
- **Servile marriage** defines when a person, typically female, is forced to enter into marriage against his or her will.
- **Sex trafficking** refers to the trading or movement of people, usually women, for the purpose of sexual exploitation.

Description

Human trafficking describes the process of purchasing, selling, and smuggling human slaves for the purpose of sexual pleasure, exploitation, forced labor, and/or financial profit. The majority of acts involve sexual exploitation. Most victims are female; half are children. Those who fall prey to trafficking may be runaways, victims of abuse, or refugees. Some are trafficked for the purpose of organ harvesting. Trafficking is considered a modern-day form of human enslavement as these crimes violate and exploit an individual's human rights. The acts often involve abduction, deception, fraud, and abuse of power. Most victims who suffer human enslavement have been coerced by their captors. They may be promised a better life, freedom, safe harbor, or money. Claims made by traffickers are untrue and misleading. Traffickers prey on

victims' vulnerability, make fraudulent claims to lure victims, and then exploit them. Subsequently, victims suffer from significant physical, emotional, and psychological distress related to their experiences, which may include starvation, rape, abuse, neglect, beatings, confinement, forced drug use, prostitution, and involuntary servitude. Most child victims end up evidencing suicidal tendencies.

Human trafficking is an illegal activity that can occur within a country or across borders. It affects almost every country in the world. Belgium, Greece, Israel, Italy, Japan, Thailand, and the Netherlands are among the nations that rank highest in human trafficking. Crimes have also been reported in all 50 U.S. states and some territories. Most of the human trafficking in the United States occurs in California, Florida, and New York.

The United Nations sought to establish consensus among countries by offering a broad, flexible definition that could empower domestic legal systems to respond proactively to trafficking through the *Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children*, commonly referred to as *Trafficking Protocol*, which was established on December 25, 2003. The document was signed by 117 countries and has since been used as a guiding document in protecting human rights worldwide. Most countries now have laws that criminalize the practice of human trafficking. Article 5 of the *Trafficking in Persons Protocol* requires that human trafficking crimes be prosecuted through domestic legislation. This includes attempts to commit trafficking offenses, participation as an accomplice in these crimes, and organizing or directing others to commit trafficking. Cross-border cooperation in both investigations and prosecutions is encouraged in order to prevent the spread of these heinous activities.

Acts of trafficking are often seen in conjunction with other crimes, including drug smuggling and gun trade. Criminal organizations including the mafia and terrorist units such as the Taliban have been known to engage in human trafficking. These groups are attracted to this type of crime because unlike drugs, humans can be sold over and over again. Natural disasters and epidemics have also been associated with increased incidences of trafficking. Following a hurricane, tsunami, tornado, or storm, people may be displaced from their homes and unable to locate loved ones, leading to increased vulnerability and susceptibility to predators. The AIDS epidemic in Africa also contributed to high incidences of trafficking victims given that many children were left orphaned.

Impact (Psychological Influence)

Human trafficking has become an increasing international concern over the past decade and even been deemed the greatest human rights challenge of this century. Estimates suggest that millions and millions of people are trafficked every year resulting in yearly profits upward of $30 billion. In 2007, U.S. Senate established January 11 as the National Day of Human Trafficking Awareness to shed light on this global problem. Soon after, President Barak Obama declared January National Slavery and Human Trafficking Prevention Month. The United Nations Office on Drugs and Crime's strategic plan is focused on (1) research, education, and consciousness raising, (2) promoting the protocol, and (3) strengthening partnerships and coordination among affected groups. Nonprofit groups have also been established to provide support to victims by offering humanitarian aid, safety relocation programs, and counseling services.

Melissa A. Mariani, PhD

See also: Prostitution

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Humanistic Psychotherapy

Humanistic psychotherapies include person-centered psychotherapy, gestalt psychotherapy, existential psychotherapy, and other approaches to helping based on humanistic principles.

Description

The humanistic approach to counseling focuses on the worth and dignity of the individual and the human potential for personal growth, awareness, creativity, choice, and self-direction.

Development

Humanistic psychology began to develop in the 1940s partly in response to behaviorism and psychoanalytic theory, which were the dominant theories of human behavior in the first half the 20th century. Behaviorism and psychoanalytic theories are referred to as "deterministic" theories. This means people have no real choice in how they behave. These theories are also considered "reductionist" theories, meaning they reduce complex human experiences and dynamics into just a few simplified components.

Behaviorism, or the science of behavior, is regarded as the "first force" in psychology as it was the focus of early psychological inquiry. Behaviorism taught that people's behavior was determined by conditioned responses. Just as dogs can be taught or "conditioned" to respond to stimuli, so human behavior is determined by their conditioning. Behaviorists essentially ignored the conscious mind, believing whatever was happening in the here and now had little impact on what had been conditioned. Psychoanalytic theory, the second force in psychology, considered people's behavior to be determined by their unconscious instincts and sexual drives. Psychoanalysts minimized the conscious here and now, believing it was only a weak expression of what was held in the unconscious. Behaviorism and psychoanalytic theory gave little thought to how personal values, consciousness, reasoning, creativity, meaning, or intentions impacted behaviors.

Humanistic psychology provided an alternative to these deterministic and reductionist perspectives of human development and behavior. Lead by individuals such as Abraham Maslow, Rollo May, and Carl Rogers, the humanistic movement emerged as a third force in psychology and has become the dominant philosophy of the helping professions. Humanistic psychology offered a new way of understanding human nature, how to study human behavior, and how to more effectively provide psychological help to individuals. Humanistic principles are found in the majority of current psychological helping theories.

Current Status

A holistic approach and the principle of irreducibility is a core value of humanistic psychotherapy. Irreducibility is the belief that humans are not irreducible to other phenomena. This means that people are understood as whole complex beings that interact and are interconnected with their social and physical environment as they develop and grow.

There are several principles that unify the differing approaches to humanistic psychotherapy. The humanistic approach to psychotherapy is built on the understanding that humans are able to make choices about their lives and are responsible for their own growth and development. A humanistic perspective takes a very positive view of people who are believed to operate from a sense of purpose and are capable of self-understanding, self-direction, and self-healing. They are able to make constructive changes in their lives and strive to become self-actualized and fully functioning. Natural human creativity and resourcefulness is valued as a powerful force in the process of change and growth.

Humanistic psychotherapy is here and now oriented. Fully experiencing the present moment is crucial to the therapy process. Learning to accept oneself and moving toward positive change are emphasized. Client's use of internal resources such as motivation, readiness to change, self-insight, and psychological mindedness are important determinants of change. Humanistic psychotherapy stresses the client's active role and responsibilities in the change process. Change occurs as people move toward congruence between what they wish they were like and what they are actually like.

A positive therapeutic relationship is the primary way change occurs in humanistic psychotherapy. The

role of the therapist is to believe in the client's inner resources and desire to be fully functional while providing a climate of trust and security. The therapist's positive regard, unconditional acceptance, respect, warmth, and empathic attitude toward the client provide a safe environment for self-exploration and change. The quality of the therapeutic relationship is considered to be more important than the techniques utilized in the change process.

Humanistic psychotherapy is based on a positive view of human nature. It relies on the belief that people are self-aware, are self-directing, and strive toward becoming fully functional. Humanistic psychotherapy brought into focus the importance of the client–therapist relationship and the role therapist attitudes and beliefs about clients play in the change process.

Steven R. Vensel, PhD

See also: Maslow, Abraham (1908–1970); May, Rollo (1909–1994); Rogers, Carl (1902–1987); Self-Actualization

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Hypersomnia and Hypersomnolence Disorders

"Hypersomnia" refers to difficulty staying awake during the day. Hypersomnolence disorder is a sleep disorder characterized by a recurrent pattern of excessive daytime sleepiness.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Continuous positive airway pressure (CPAP)** is a device for treating sleep apnea that delivers air into airways through a specially designed face or nasal mask.
- **Insomnia disorder** is a sleep disorder characterized by persistent difficulty in falling asleep and staying asleep.
- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.

Description and Diagnosis

Hypersomnolence disorder is a sleep disorder characterized by difficulty staying awake during the day. Individuals with this disorder can fall asleep at anytime and anywhere. For example, they may nod off at work or even when they are driving. Typically, they experience other sleep-related problems such as low energy and difficulty with concentration. This disorder is the mirror opposite of insomnia disorder in which limited sleep, rather than excessive sleep, is the problem.

Individuals with this disorder report disproportionate sleepiness, despite having slept an appropriate amount of time the preceding night. Individuals may experience periodic drifting into sleep during the day and may report that prolonged periods of sleep fail to be revitalizing (restorative). Difficulties may arise as individuals have difficulty awakening from sleep and may encounter abrupt and unintended sleep during quiet, low-stimulus activities. This increased need for sleep may adversely affect a person's concentration and memory during daily work, social, and school-related activities. Typically, the individual reports arriving late for work or other social engagements, fulfilling typical obligations, and having difficulty driving. These unintentional and intrusive moments of sleep may be dangerous if they occur when the individual operates heavy equipment or drive a car. About 40% of adults experience symptoms of hypersomnia on occasion although only 5%–10% of those evaluated in sleep disorders clinics are diagnosed with the disorder (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit extreme sleepiness, regardless of whether they had at least seven hours of sleep. Individuals reported experiencing repeatedly falling asleep during the day, sleeping excessively (more than nine hours per day) without feeling refreshed, and having difficulty fully awakening after being suddenly aroused from sleep. Individuals with this disorder may also have difficulty with concentration, connecting with others, and work-related activities. This sleep difficulty must have occurred three times per week or more and have lasted for three months or more. This difficulty must also cause significant distress for the individual or result in significant level of impaired functioning. In addition, the disorder cannot be the result of a substance, medication, other medical condition, or another sleep disorder (American Psychiatric Association, 2013).

As with other sleep disorders, the cause of hypersomnia and hypersomnolence disorder can be varied. It may be caused by another sleep disorder such as narcolepsy or sleep apnea. It can be due to drug or alcohol abuse. Sometimes, a medical condition such as multiple sclerosis, epilepsy, clinical depression, or obesity can contribute to it. Certain medications that are sedating can cause it. Lifestyle and environmental factors can also cause or exacerbate (worsen) it. These include poor sleep hygiene habits, such as watching television in bed or not having a regular bedtime schedule. It can also include changes in sleep habits and surroundings such as noise, temperature, light, or sleeping in a different bed. Common environmental factors that might be involved include jet lag or working a late shift.

Treatment

Treatment of hypersomnolence should begin with a medical evaluation, which might include a polysomnography and other sleep tests. Treatment depends on the cause of this sleep disorder. For instance, if it is caused by sleep apnea, the treatment is likely to be continuous positive airway pressure (CPAP). If it is due to a medication that causes drowsiness, another medication may be prescribed instead. If a cause is not determined, behavior therapy interventions and sleep hygiene may be used. Establishing better sleep hygiene may be sufficient. For example, going to bed earlier and getting more sleep at night may help considerably. This may also include reducing or eliminating alcohol and caffeine consumption. Specific medication to treat hypersomnia may be tried. These include antidepressants, such as Prozac, or stimulants like Ritalin or Provigil. Xyrem that is used to treat excessive daytime sleepiness related to narcolepsy might be considered.

Len Sperry, MD, PhD

See also: Behavior Therapy; Narcolepsy; Prozac (Fluoxetine); Ritalin (Methylphenidate); Sleep

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Hypnotherapy

Hypnotherapy is a form of psychotherapy that uses a hypnotic state to increase motivation or change behavioral patterns.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about imagined danger.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.

- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life.
- **Guided relaxation** is a technique used for relaxation and mental visualization (imagery) in order to improve an individual's mood and physical well-being.
- **Hypnotic state** is an induced state of relaxation and concentration that permits deeper parts of the mind to become more accessible.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.
- **Stress** is a state of emotional or mental tension or strain, which results from very unfavorable or demanding circumstances.
- **Subconscious** is that part of the conscious mind which consists of information that is not in awareness unless attention is directed to it. It is also called the preconscious.

Description

Hypnotherapy is a form of psychotherapy used to promote subconscious change in an individual by implementing new thoughts, attitudes, responses, feelings, or behaviors. Hypnotherapy may be used to help relieve symptoms an individual is experiencing. Some of these symptoms include emotional pain, chronic pain, and dysfunctional behaviors and habits (e.g., smoking, difficulty sleeping, overeating).

There are two theories of what occurs during hypnotherapy. The altered state theory suggests that hypnotherapy is an altered state of mind. The non-state theory suggests that hypnotherapy is a form of a role enactment that is imaginative. Hypnotherapy uses several techniques to bring a heightened state of awareness to an individual. Some of these techniques include intense concentration and guided relaxation. During the process of hypnosis (hypnotherapy) an individual's attention becomes very focused, while in the hypnotic state, anything occurring around the individual becomes ignored. While an individual is in a hypnotic state, a trained therapist will help guide the individual to focus on specific tasks or thoughts. During this process an individual will examine and explore painful feelings, thoughts, and memories that may be masked in his or her conscious minds. Furthermore, hypnotherapy assists individuals in understanding things differently, such as blocking the awareness of pain. Hypnotherapy has shown to be effective for individuals who experience depression and anxiety.

Developments and Current Status

Hypnotherapy was developed by James Braid (1795–1860). Braid was a Scottish surgeon who is best known for his theory and practice of hypnotism. Hypnotherapy continues to be effective in reducing anxiety and pain. Currently, hypnotherapy may not be a form of treatment used alone. Many individuals who are being treated with hypnotherapy are participating in psychotherapy. Although hypnotherapy can generate an extremely developed relaxed state of concentration and focused attention for an individual, it may not be the only form of treatment used for individuals who are experiencing difficulties. Cognitive behavior therapy is another form of therapy that can be used concurrently with hypnotherapy for treatment. A benefit to hypnotherapy is that individuals can learn to eventually hypnotize themselves outside of a hypnotherapy session. This can become more cost effective for an individual in addition to being able to improve sleep, reduce pain, and ease some symptoms of anxiety and depression on his or her own.

Len Sperry, MD, PhD, and Elizabeth Smith Kelsey, PhD

See also: Anxiety; Cognitive Behavior Therapy; Depression; Psychotherapy; Stress

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Hypochondriasis

Hypochondriasis is a condition characterized by a preoccupation with having a serious medical condition based on a misinterpretation of bodily symptoms.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) beliefs, behaviors, and emotions.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Illness anxiety disorder** is a mental disorder characterized by severe anxiety and a preoccupation of having a serious medical condition. Previously, this disorder was called hypochondriasis.
- **Malingering** is the practice of intentionally exaggerating or faking physical or psychological symptoms for personal gain. It is also referred to as fictitious illness.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Somatic symptom disorder** is a mental disorder characterized by bodily symptoms that are very distressing or result in disrupted functioning,

Description

Hypochondriasis is a condition characterized by an obsessive preoccupation about one's health, especially as it pertains to the misinterpretations of bodily sensations or symptoms. Individuals with this disorder spend significant times analyzing and interpreting insignificant physical sensation. An example of this is that while experiencing a brief headache, the individual becomes concerned that she has a brain tumor. Those with this disorder tend to research symptoms of illnesses and make their own diagnosis about medical conditions. While they may seek medical evaluation, they are likely to discount or reject the physician's professional opinions and formal diagnoses. They are also likely to seek numerous second opinions, if given a clean bill of health. It is believed that some use this behavior as a way to get attention. Typically, those who have such a preoccupation about their health are not engaging in purposeful malingering.

Before DSM-5, hypochondriasis was a formal diagnosis. When it was a formal diagnosis, it was estimated to affect approximately 4% of the population. It should be noted that hypochondriasis differs from two similar but different DSM-5 diagnoses: illness anxiety disorder and somatic symptom disorder. Recall that "hypochondriasis" is a general term for describing a preoccupation about physical symptoms and disease. Illness anxiety disorder involves a concern for symptoms but primarily describes individuals with a distressing level of anxiety about their health. This is in contrast to somatic symptom disorder, which describes those whose primary symptoms are a distressing preoccupation about physical symptoms or result in impaired functioning.

Treatment

Treatment for this condition is similar to what is employed in both illness anxiety disorder and somatic symptom disorder. Most often, individuals will be treated with some form of psychotherapy. It is important to recognize that those with this condition may feel others do not take them seriously. Therefore, it is imperative that the clinician form a strong alliance with the individual in order to foster trust and cooperation. Cognitive behavior therapy (CBT) is an effective approach used with individuals who experience a preoccupation about their health. The focus of CBT is to change the beliefs system surrounding illness and bodily symptoms, thereby reducing the anxiety. Another aim of therapy may be to desensitize the individual to his or her physical sensations, thereby reducing the focus on his or her body. Another form of therapy used with this condition is mindfulness. It can help individuals both cope with and

accept the anxious feelings regarding both their body and preoccupation about illness. If effective, the result of both treatments is a reduction in preoccupation and misinterpretation and an increased sense of well-being.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Illness Anxiety Disorder; Mindfulness Practices; Psychotherapy; Somatic Symptom Disorder

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Hypomania

Hypomania is a mental state characterized by an abnormally and persistently elevated or irritable mood and increased activity or energy.

Definitions

- **Antidepressants** are prescription medications that are primarily used to treat depression and depressive disorders.
- **Bipolar disorder** is a mental health disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more depressive episodes.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing faulty behaviors, emotions, and thoughts. It is also known as CBT.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- M**ania** is a mental state of expansive, elated, or irritable mood with increased energy or activity.
- **Narcissistic personality disorder** is a mental disorder characterized by a pattern of grandiosity, need to be admired by others, and lack of empathy.
- **Stimulant** is a drug, which increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity, or suppresses appetite. Examples are cocaine, amphetamines, and Ritalin.

Description

Hypomania is a mental state similar to mania but is classified as a milder form of mania. Hypomania is characterized by a period of a persistently and abnormally extensive, elevated, or irritable mood and persistently and abnormally increased activity or energy. These episodes last at least four consecutive days, are present most of the day, and occur nearly every day. Individuals who are experiencing a hypomanic episode are extremely talkative, energetic, and self-assured. Some symptoms associated with hypomania include grandiosity (exaggerated belief in one's importance), decreased need for sleep, distractibility, hypersexuality, and creativity. Individuals in a hypomanic state spend an excessive amount of time in activities that have a high potential for unpleasant consequences (e.g., engaging in buying sprees, sexual indiscretions, or unwise business deals). It can become problematic if the individual engages in such risky behaviors. Hypomania does not normally interfere with occupational functioning or interaction with others.

Hypomania is most often associated with bipolar disorder. Hypomania can also be caused from side affects of several medications used to treat bipolar disorder (e.g., antidepressants). When hypomania occurs from the side effects of medications, usually the health-care provider will discontinue the use of the drug or antidepressant that prompted the episode. In most cases, the use of a stimulant will return the individual to a normal mood. Hypomania has also been linked to narcissistic personality disorder, which is a

personality disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. In this disorder, individuals engage in grandiose behaviors, are preoccupied with power and success, and believe that he or she has a sense of entitlement.

Treatment

In addition to medication treatment, cognitive behavior therapy (CBT) has been shown to be effective for individuals with hypomania. CBT can help individuals control their impulses during hypomanic episodes. Having an individual keep a daily journal of his or her thoughts can be helpful. This technique can assist the individual in taking a realistic look at his or her thoughts and actions. For example, an individual can begin to recognize the negative impact of underestimating risky situations (e.g., sexual indiscretions, shopping sprees). Talking such situations through with someone whom the individual trusts can assist the individual in testing the reality of his or her thoughts and beliefs

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See also: Antidepressants; Bipolar Disorder; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Narcissistic Personality Disorder

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Hypomanic Personality Disorder

Hypomanic personality disorder is a mental disorder characterized by an enduring pattern of hypomania that shapes cognition, attitudes, and identity. This pattern predictably shapes an individual's behavior and relationships with others.

Definitions

- **Cyclothymic disorder** is a mental disorder characterized by alternating cycles of hypomanic and depressive periods with symptoms like those of some depressive disorders but of lesser severity.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt an individual's daily functioning. These disorders include bipolar disorder, major depressive disorder, and persistent depressive disorder.
- **Depressive personality disorder** is a mental disorder characterized by a persistent and pervasive pattern of unhappiness, low self-esteem, pessimism, guilt, and an inability to relax and experience pleasure.
- **Hypomania** is a mental state similar to mania but less intense.
- **Mania** is a mental state of expansive, elevated, or irritable mood with increased energy or activity.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.

Description and Diagnosis

Hypomanic personality disorder is a mental disorder characterized by an enduring pattern of hypomania that shapes cognition, attitudes, and identity, and which significantly influences an individual's behavior and relationships with others. Individuals with this personality are described as cheerful, exuberant, articulate, overly optimistic, and carefree. These individuals tend to be overconfident, self-assured, boastful,

and grandiose. They are also described as extroverted, people-oriented, and energetic. Potentially troubling is their propensity for being uninhibited, thrill seeking, overinvolved, meddlesome, and occasional episodes of rageful anger. While they may show considerable charm and wit, their relations with others tend to be superficial.

This disorder is similar to hypomania and cyclothymic disorder. All three of these disorders are characterized by elevated moods. However, hypomania and cyclothymic disorder are episodic disorders, In contrast, hypomanic personality disorder is a consistent, enduring pattern of elevated mood and energy, movement, and self-inflation. It is noteworthy that hypomanic personality disorder is listed among the personality disorders in the *Psychodynamic Diagnostic Manual* (PDM). However, it is not listed in the *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition*.

According to the PDM, individuals can be diagnosed with this disorder if they exhibit a high energy temperament (biological disposition or pattern). The central tension and preoccupation in their lives is an overriding sense of grief. Their basic emotional state is one of elation, rage, unconscious sadness, and grief. They tend to have a characteristically maladaptive belief about themselves: "If I stop running and get close to someone, I'll be traumatically abandoned, so I'll leave first." Their maladaptive belief about others tends to be, "Others can be charmed into not seeing the qualities that make people inevitably reject me." Their primary ways of defending themselves include denial, self-inflation, and devaluation of others. According to the PDM, this disorder is the converse or polar opposite of the depressive personality disorder (PDM Task Force, 2006).

The exact cause of this personality disorder is not well understood. However, a variety of factors may be causative. These include an energetic temperament, as well as needing and enjoying pleasure while at the same time fearing and being distressed by grief and depression. According to the *Psychodynamic Diagnostic Manual* (2006), this disorder is found in individuals with underlying depressive dynamics, which are obscured by denial of depression. This denial produces a relatively stable state of mood inflation, lack of guilt, and self-inflation.

Treatment

The clinical treatment of this disorder usually involves psychotherapy. Therapists tend to find these individuals initially quite interesting and entertaining but soon feel confused, overstimulated, irritated, and distanced by them. These individuals are typically highly resistant to psychotherapy. They are difficult to engage in the process of therapy because of their tendency to leave relationships in which they are tempted to attach and commit to. Instead, they become unconsciously terrified of being abandoned by the therapist and react to this fear by abandoning the therapist and leaving treatment. Knowledge of the dynamics of this disorder allows therapists to point out the lifetime pattern of abrupt flight from relationships. They can then attempt to preempt a similar flight from therapy by negotiating an agreement that the individual will continue coming for a given number of sessions after any abrupt, unilateral decision by the individual to stop treatment.

Len Sperry, MD, PhD

See also: Cyclothymic Disorder; Depressive Personality Disorder; Hypomania; Personality Disorders

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Ideas of Reference

Ideas of reference are the belief that events, the behaviors, or remarks of others have a particular significance to oneself when, in fact, they do not.

Definitions

- **Bipolar disorders** are a group of mental disorders characterized by changes in mood and in energy (e.g., being highly irritable and impulsive while not needing sleep). These disorders include bipolar I disorder, bipolar II disorder, and cyclothymic disorder.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Delusions of reference** are strongly held belief that events, the behaviors, or remarks of others have a particular and unusual significance to oneself, when, in fact, they do not. Unlike ideas of reference, delusions of reference must disrupt daily functioning.
- **Depressive phase** is a mental state of sad mood, reduced ability to enjoy life, and decreased energy or activity seen in during the course of a bipolar disorder.
- **Manic phase** is a mental state characterized by expansive, elevated, or irritable mood with increased energy or activity seen in during the course of a bipolar disorder.
- **Psychosis and psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations, delusions, and disordered thinking.

Description

Ideas of reference are beliefs that have a particular significance for an individual but are not delusions. In contrast, ideas of delusion are delusions with special personal significance. The terms "ideas of reference" and "delusions of reference" are often used interchangeably. Even though they share some similarities, they are different and it is useful to differentiate them. When ideas of reference reach the point of causing impairment of functioning, they are called delusions of reference. In other words, when a belief is held with delusional conviction, it is a delusion of references (American Psychiatric Association, 2013). In delusion of reference, individuals mistakenly believe that they are the object of remarks, behaviors, or ridicule that is actually benign or has nothing to do with them. These delusions are common in those with bipolar disorder.

Here are some examples of ideas of reference. An adolescent male who has the sense that a radio deejay is talking directly to him even though this is not the case. Or, take the young mother who feels she is not a very good parent. She regularly follows an Internet blog on parenting and believes it has hidden meanings for her. Another example is a nervous teenager who somehow believes that everyone in a small group of students is talking about her when she enters the school cafeteria. But later she is able to acknowledge that is unlikely that the group was talking just about her. This suggests the belief was not strongly held, which makes it an idea of reference rather than an idea of delusion.

By comparison, here are some examples of a delusion of reference. An elderly female would rarely leave her apartment because she came to believe that all the conversation and laughter she would hear when she was outside was directed at her. A wheel chair–bound male insists to his caregiver that secret messages about him are being broadcast in a weekly television program. So, he records each programs and watches them repeatedly. In both examples, there is a disruption in functioning for both individuals. For the elderly female, it is being confined to her apartment to feel safe even though there is no obvious threat. For the male, it is spending hours a week trying to find clues that are not there.

Delusions of reference are common in bipolar disorder. Those with bipolar disorder manifest this type of delusion by projecting themselves into conversations and remarks for which they believe that they are being targeted. Such delusions add to the other paranoid thoughts which further trouble them and impair their daily basis. These delusions tend to deepen as they enter into a manic phase. However, such delusions may also remain in the depressive phase and heighten the psychosis these individuals are already experiencing.

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See also: Delusional Disorder

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Identity and Identity Formation

Identity formation is the psychological concept of how an individual's personality is developed and forms a unique identity from all other people.

Description

Personality and personal identity formation occurs as a developmental process beginning at birth. Erik Erikson (1902–1994) was one of the first psychologists to articulate a comprehensive theory of how an individual's personality is formed. His theory is referred to as Erikson's Theory of Psychosocial Development. Erikson believed that individuals develop throughout their lifespan and that identity and self-awareness form in the unique environment in which a child is raised. Impacted by social, biological, and psychological factors, people are faced with certain age-related task, challenges, and crisis that must be mastered in order for a healthy personality to form. Erikson's "crisis" refers to a time of deep realization, or a turning point, in which lasting change occurs rather than a time of severe emotional distress. Erikson postulated eight distinct age-related challenges that must be mastered in order to successfully move on to the next stage of development. Erikson's fifth stage, Identity versus Role Confusion, is the stage in which a person is challenged with the task of developing a unique sense of personal identity that will help him or her meet the challenges of adulthood or remain confused about who he or she really is and how he or she fits into society.

The stage Identity versus Role Confusion occurs between the ages of 12 and 20 years as adolescents transition from childhood to adulthood. Erikson coined the phrase "identity crisis" to describe a time of particularly deep reflection, confusion, and strife as an adolescent strives to develop a unique and distinct self-identification separate from that of his or her parents. During this time of life, major biological, physical, emotional, cognitive, sexual, and social changes are occurring. It is in this highly active and changing context that the most important question of adolescents is addressed: "Who am I?" Answering this question involves a complex array of social interactions in which feedback and reactions from friends, family, and others become central in the discovery of what is valued and important to the individual. It is a time of intense mental, emotional, and social exploration as the adolescent strives to fit into society and gain acceptance into valued social groups in meaningful and fulfilling ways. This is a time of great exploration in which adolescents explore their independence from their parents, their social roles and what groups to belong to, their own spiritual beliefs and values, occupational and career interest, sexual orientation, ways of expressing oneself, and ways of thinking and behaving. Failure to establish a satisfactory identity results

in role confusion in which the adolescent has no clear understanding of his or her strengths and weaknesses and moves into adulthood without a sense of how he or she fits in or what direction his or her life should take.

Building on Erikson's psychosocial stages, James Marcia, a Canadian developmental psychologist, contended that the level of adolescent identity development was related to the degree to which an individual has explored and committed to an occupational choice, spiritual belief, and political ideology. Marcia defined "crisis" as a period of engagement in choosing between meaningful alternatives and "commitment" as how strongly an individual has identified with the role or value. Marcia identified four possible outcomes, or "statuses," of identity development. "Identity Achievement" consists of a crisis period in which past values are reexamined and present choices evaluated and seriously considered with a clear commitment made to a new role or value. Individuals who experience "Identity Diffusion" may or may not have experienced a crisis period and are undecided, unconcerned, and uncommitted to occupational, spiritual, and ideological choices. There are two statuses that lie somewhere between achievement and diffusion. The first of these is "Identity Moratorium" in which an individual is actively engaged in a crisis and is struggling to make a commitment to a role, value, or ideology. Finally, the "Identity Foreclosure" status is distinguished by individuals who have not experienced a crisis but have expressed a commitment to a role or value. These individuals tend to conform to the expectation of others, such as parents, and have not explored other options.

Identity formation is the process in which an individual develops and establishes a lasting set of personal characteristics distinct from that of his or her parents. Successful identity formation results in a stable sense of belonging to a larger social group with shared values and ideologies.

Steven R. Vensel, PhD

See also: Erikson, Erik (1902–1994); Psychosocial Development, Stages of

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Illness Anxiety Disorder

Illness anxiety disorder is a mental disorder characterized by severe anxiety and a preoccupation of having a serious medical condition. Previously, this disorder was called hypochondriasis

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) beliefs, behaviors, and emotions.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hypochondriasis** is a mental disorder characterized by a preoccupation with having a serious medical condition based on a misinterpretation of bodily symptoms. In DSM-5 this disorder is replaced by illness anxiety disorder.
- **Malingering** is the practice of intentionally exaggerating or faking physical or psychological symptoms for personal gain. It is also referred to as fictitious illness.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Somatic sensitivity** refers to the high level of sensitivity and attentiveness to bodily sensations of emotionally reactive individuals. This sensitivity leads them to overreport physical symptoms.
- **Somatic symptom disorder** is a mental disorder characterized by bodily symptoms that

are very distressing or result in disrupted functioning.

- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description and Diagnosis

Illness anxiety disorder is one of the classes of somatic symptom and related disorders. The characteristic features of this disorder is a high level of anxiety and an unnatural preoccupation with having a serious medical condition but few or no bodily symptoms. Individuals with this disorder tend to misinterpret otherwise insignificant bodily symptoms as evidence of serious or fatal problem. For instance, mild respiratory congestion is interpreted as sign of lung cancer. It is important to note that their misinterpretation is not intentional as it is in malingering. Given their level of concern, individuals with illness anxiety disorder often seek second opinions when no medical findings are present. They may believe that their physician either is incompetent or has overlooked a serious problem. Needless to say, physicians who fail to convince these individuals that they are well can become highly frustrated and end up discounting or dismissing them. This sets the stage for a problematic cycle of hostility and anxiety.

Illness anxiety disorder was previously referred to as hypochondriasis. Both disorders involve excessive worry and preoccupation with one's health. In DSM-5 the two are differentiated. Those with hypochondriasis have bodily symptoms, whereas those with illness anxiety disorder have no (or a few) bodily symptoms but a high level of anxiety about their health (American Psychiatric Association, 2013). With the new DSM-5 diagnosis of somatic symptom disorder, many who formerly would have been diagnosed with hypochondriasis are now more appropriately diagnosed as somatic symptom disorder.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a preoccupation with health in general and a fear of serious illness in particular. This preoccupation occurs despite the fact that there are no or few somatic (somatic) symptoms present. However, those with this disorder experience a high level of anxiety related to their health and believe that they suffer from a serious disease. They engage in excessive behavior such as constantly checking for physical signs of sickness or constantly searching for information or seeking reassurance from others. This constant concern about their health must last for six or more months. This preoccupation is not due to another disorder such as somatic symptom disorder, panic disorder, or generalized anxiety disorder (American Psychiatric Association, 2013).

The cause of this disorder is unknown. It may be that those with illness anxiety disorder are more sensitive to their bodily sensations (somatic sensitivity) than others. They tend to amplify and interpret that these sensations are indicators of physical illness. As a result, when they experience emotional stress, they are likely to interpret it as a physical symptom. From their early years, these somatically sensitive individuals were likely to have been overly concerned about their health. Growing up they learned to distrust those who did not take their health concerns seriously. They came to associate the nonresponsiveness of others to their physical discomfort as physical pain and illness. They also learned that there were advantages to being sick. Faking illness may have been the only way to get the attention of caretakers. They may have also witnessed the attention and caring that others received when they were sick. This impressed them with the value of illness. Still others with this disorder experienced being comforted and validated by overly concerned caregivers who doted over their bruises, fever, or sniffles. All these experiences taught them to be overly impressed by bodily concerns and how to get others to show concern. As a result they learned to worry and be obsessed about their health. They also learned how to they get some physicians and others to focus on their health concerns and to distrust and defeat those who do not take their concerns seriously. In this way, these individuals can remain worried and focused on their health, while demonstrating to others heroic struggle to carry on despite the extent of their perceived illness.

Treatment

Cognitive behavior therapy can be an effective approach with this disorder. Because of their somatic sensitivity and general distrust of health providers, these individuals must be taken seriously. Treatment begins by educating them about their somatic sensitivity and its effects, and ways to reduce are critical to treatment success. As a result they become desensitized to bodily sensations and lessen their preoccupation with heath concerns. Teaching them to accept their symptoms in a nonjudgmental way helps to minimize their impact. Mindfulness practices may also be an additional intervention in reducing and maintaining this reduced sensitivity. It also can help patients to not "fight" their symptoms, which often only makes them feel worse. Moreover, teaching stress management can not only help reframe physical sensations but help give them a sense of self-efficacy in helping themselves feel better.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Hypochondriasis; Somatic Symptom Disorder

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Imagery Rescripting and Reprocessing Therapy (IRRT)

Imagery rescripting and reprocessing therapy (IRRT) is a psychotherapeutic treatment technique utilizing a client's visual memories and imagination to reduce distress from traumatic experiences.

Definitions

- **Mental imagery** includes visual and bodily sensation images that take place within one's mind and imagination.
- **Phobias** are extreme or irrational fears of objects or situations.

Description

Imagery rescripting and reprocessing is used to help transform recurring and distressing mental images into more benign or positive images. Originally developed by American psychologist Mervin R. Smucker in the 1990s for treating adult survivors of child sexual abuse, IRRT has been successfully used to treat a number of mental health disorders, including depression, anxiety, phobias, and personality disorders. IRRT has been most widely used in the treatment of post-traumatic stress disorder and other trauma-based difficulties. IRRT is most effective for individuals who are able to recall or reexperience a traumatic memory; most of the memory is visual along with the painful emotions and most of the emotions are considered non-fear emotions, such as guilt, shame, and self-blame.

Development

Imagery rescripting and reprocessing therapy is based on the theory that mental imagery is deeply connected to emotions and emotional disorders. Mental images evoke powerful emotions, and visual image memories are highly associated with traumatic stress disorder, depression, phobias, and anxiety. Perhaps the most recognized type of mental image is that of a "flashback" in which a person is emotionally overwhelmed by an intrusive and vivid memory of a traumatic event. Flashbacks, and less severe graphic memories, contain much of the original emotional impact of the actual event. Both positive and negative memories that are visual in nature, that is, you can see them in your mind's eye, are more powerfully experienced than are verbal representations of similar events. The goals of IRRT are to decrease physical and emotional upset; eliminate trauma symptoms such as fear, guilt, and shame; transform traumatic imagery into empowering imagery; strengthen the ability for the client to self-calm, self-nurture, and self-regulate emotions; and modify negative self-beliefs (I am bad, I will never be safe, I am unlovable, I am worthless, etc.) that often result from traumatic experiences.

Current Status

Imagery rescripting and reprocessing is considered a brief therapy requiring approximately eight 60- to 90-minute psychotherapy sessions. Treatment includes three phases. Phase one is referred to as "imaginal exposure" or "imaginal reliving." In this phase clients are asked to visualize, imagine, and describe their distressing imagery, including sounds, sensations, smells, and the emotions that accompany the memory. The therapist's role is to provide a supportive safe environment to allow the client to reexperience the painful experience in order to reprocess the associated emotions. Phase two is the rescripting phase in which clients create "master imagery" in which they modify the memory, write a new script so to speak, and picture a new ending. For instance, an adult client who was sexually abused as a child would be instructed to visualize the beginning of the abuse scene but would be instructed to visualize her adult self entering the scene. The therapist would guide the scene by asking the client what she would do as an adult to the perpetrator and how her adult presence changes what happens. The role of the adult in rescripting is to rescue the child, drive out the perpetrator, remove the child from the perpetrator, and protect her from further abuse. The therapist does not tell the client what she should do but facilitate the rescripting to enable the client to choose how best to create the master imagery. Phase three is the development of self-calming and self-nurturing imagery. In this phase clients are encouraged to directly interact with and comfort, nurture, and teach the traumatized child. The therapist may ask, "What would you the adult like to say or do to the child?" and "How does the child feel at this time?" This is a time of deep emotion and healing as clients reprocess the trauma and bring mastery to the memories. As therapy progresses the rescripting and reprocess is repeated, and homework is given in order for clients to gain additional insights and healing from the treatment.

Imagery rescripting and reprocessing therapy is a highly effective tool used by psychotherapists in helping individuals overcome traumatic and debilitating experiences. IRRT is also being studied in the treatment of depression, anxiety, and other mental health disorders.

Steven R. Vensel, PhD

See also: Guided Imagery; Phobias; Post-Traumatic Stress Disorder (PTSD)

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Immigration, Psychological Factors of

Immigration has a social and psychological impact on people specifically when they are disadvantaged by financial, medical, or housing challenges in their nonnative country.

Definitions

- **Acculturation** is the process of blending a person's native culture with another culture.
- **Immigration** occurs when people move and settle into a country outside of their native country.

Description

The cultural and psychological impact of immigration has been a problem both for cultures and individuals throughout history. In our society it is important for mental health professionals to be aware of the scope and dimensions of the problem, as well as how it may affect their diagnostic and therapeutic work with clients. Immigration creates special psychological pressures and anxieties. These can result from differences in climate or geography, social and cultural norms, language differences, different income levels, and other experiences such as education and training.

Many of the issues immigrants experience center around the difficulty of distinguishing between

prejudice and stereotype. Adjusting to a new culture is a challenge for immigrants. Many face the problem of adjustment and the need to find limits and make choices that affect their daily lives, their culture, and traditions when they are suddenly exposed to or unfamiliar with the customs, culture, and expectations of the existing community. The process of adjusting well and achieving mental health is called acculturation. Psychological acculturation is the ability to blend the new and old cultural priorities in a way that doesn't negatively impact the immigrant.

This issue of forced choices between cultures not only affects the whole of the immigrant community; it can tear apart individual immigrant families. This can happen when members of the younger generation, who can acculturate more quickly, make forced choices that may not be in agreement with their elders. Elders may begin to feel that younger children have lost their culture of origin, and both generations suffer through differently based feelings of powerlessness and isolation.

Current Status and Impact (Psychological Influence)

One in five persons currently residing in the United States is a first- or second-generation immigrant. Nearly a quarter of children under the age of 18 have an immigrant parent. Today about 14% of the U.S. population is identified as immigrants.

The immigrant population is diverse and scattered and can vary based on location. There are cities and areas where one or another immigrant group is dominant and has a radical effect on the culture of the area. Still the general impact on society and social structures in terms of education, income, health-care issues, and law enforcement is an ongoing and significant challenge for some immigrants.

Immigrants who find themselves in low- or middle-income levels of society experience more psychological stresses than wealthier immigrants. They also tend to report more negative life events, social problems, and health issues. In addition, immigrants in the preteen years tend to show more distress than immigrants who are either younger or older.

The two immigrant groups who have notably excelled in American schools are Asians and Cubans. These groups seem to have more established contacts in the community and have been able to garner greater social and cultural support. Among those groups that encounter language problems in school, feelings of nonacceptance and prejudice are common. There are many barriers to culturally sensitive and appropriate mental health services for racial or ethnic minorities and immigrant populations. The need for immigrant counseling and services will continue to be important to help immigrants achieve acculturation and success in different areas of their lives.

Alexandra Cunningham, PhD, and
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See also: Ethnicity

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Impaired Professionals

Impaired professionals are individuals with mental or medical condition or substance use disorders adversely affecting their ability to practice their profession.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Dialectical behavioral therapy** is a psychotherapy approach, which focuses on coping with stress, regulating emotions, and improving relationships.
- **Family therapy** is a type of psychotherapy approach that is used to help family members resolve conflicts and improve their communication skills.

- **Group counseling** is a type of psychotherapy approach in which a small group of individuals meet regularly with a therapist.
- **Impairment** is a mental or medical condition that interferes with an individual's ability to engage in tasks of daily living, such as work and personal care.
- **Meditation** is a technique used by individuals for the purpose of focusing upon a sound, object, visualization, and breath movements in order to increase awareness in the present moment.
- **Psychoeducation** is a psychological treatment method that provides individuals with knowledge, about the condition as well as advice and skills for reducing their symptoms and improving their functioning.
- **Relapse prevention group** is a behavioral self-help program that teaches individuals with addiction how to anticipate and cope with the potential for relapse.
- **Spirituality-oriented psychotherapy** is a type of approach that attempts to help an individual understand and experience that he or she is a part of something bigger than himself or herself.
- **Substance use disorder** is a disorder in which one or more mind-altering substances lead to clinically significant distress or impairment in an individual.
- **Twelve-Step Programs** are self-help groups whose members attempt recovery from various addictions based on a plan called the Twelve Steps.

Description

Health-care professionals who are impaired have the inability or imminent inability to practice within their profession according to acceptable standards as a result of mental health problems or substance use disorder (e.g., addiction). An impaired professional (e.g., counselor) cannot function adequately and provide competent care to individuals he or she is working with (e.g., a client). Professionals who have a substance use disorder can result in adverse social and professional consequences. Addiction manifests as physiological and behavioral symptoms related to a dysfunctional pattern of substance abuse. This negatively impacts not only the professional but anyone he or she is are treating or helping. Impaired professionals can cause harmful effects to other individuals. For example, a counselor who is impaired (by a substance use disorder) and is treating a client may provide inadequate and harmful care to the client. The client may not be receiving the appropriate treatment from a counselor and can result in damage to the client. Impaired professionals, who seek help for their difficulties, can have the opportunity to address unique issues specific to their field. For example, an impaired professional will develop the skills of how to tell his or her employer, knowing when to return to work, setting boundaries, establishing work and life balance, and participating in continued care.

There are several causes of impairment. They include burnout, stress, relationship problems, mental health issues, and addiction. Fatigue, vicarious traumatization, and secondary traumatic stress may also cause a professional to become impaired.

Treatment

There are various treatment programs for impaired professionals. Such programs often have a high recovery rate and are designed to help a professional reenter into his or her clinical practice. Usually, these programs involve several modalities. These include group counseling, individual therapy, family therapy, dialectical behavioral therapy, and spirituality-oriented psychotherapy, which can be effective forms of treatment. In addition, Twelve-Step Programs, psychoeducation groups, medication management, relapse prevention groups, and meditation have been found to be effective forms of treatment.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Dialectical Behavior Therapy (DBT); Family Therapy and Family Counseling; Group Counseling; Meditation; Psychoeducational Groups; Rehabilitation Counseling; Relapse and Relapse Prevention; Spiritually Oriented Psychotherapy; Twelve-Step Programs

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Individual Psychology

Individual Psychology is an approach to psychology that understands individuals to be social beings with a need to belong and strive for significance. It is also known as Adlerian psychology.

Definitions

- **Alfred Adler** was an Austrian psychiatrist who created Individual Psychology, also called Adlerian psychology.
- **Early recollections** are a projective therapeutic technique that examines the first memories that an individual can recall. Themes about individuals' personality and their view of themselves and others are hypothesized with this technique.
- **Family constellation** includes information about individuals' relationships with other family members, family values, and the way they found a sense of belonging in their family.
- **Inferiority feelings** are feelings that occur when an individual believes he or she is incompetent or inadequate.
- **Lifestyle and lifestyle convictions** are conclusions an individual makes about his or her inner world based on his or her interpretations of previous experiences.
- **Psychological birth order** is the perceived position or role that an individual takes or is given in a family system.
- **Rudolf Dreikurs, MD,** was an American psychiatrist and educator known for advancing Adlerian psychology through his writings and professional publications.

Description

Individual Psychology, also known as Adlerian psychology, is a psychological approach that assists individuals to increase their sense of belonging to others and to increase their constructive actions toward goals in their lives. Individual Psychology assumes that suffering results from individuals lacking a sense of belonging and from feeling discouraged due to feelings of inferiority. It also assumes that individuals' lifestyle convictions are influenced by their psychological birth order, family constellation, and how they safeguard (protect) themselves from feelings of inferiority.

Human suffering is conceptualized through understanding that discouragement results from inferiority feelings that occur as a result of unhelpful lifestyle convictions. Adlerian psychology techniques assist individuals in modifying their faulty lifestyle convictions and also increasing their sense of belonging. Individual Psychology utilizes four basic principles. Individuals are viewed holistically (body-mind-spirit). Behavior is goal-directed or purposive. Individuals give their own meaning to life experiences. Finally, individuals are social beings who want to belong. In short, this is how personality develops normally and how it becomes dysfunctional.

Developments and Current Status

Alfred Adler (1870–1937) is the founder of Individual Psychology. He was born in Austria and became a physician. Adler had been a colleague of Sigmund Freud (1856–1939) and a member of his Vienna Psychoanalytic Society. In 1911, Adler left the society due to increasing differences in their explanations of human behavior. Freud believed that individuals experience psychological issues due to repressed sexual feelings. However, Adler believed that problems develop from individuals' perceptions of their shortcomings and their difficulties with social belonging. Rudolf Dreikurs (1897–1972) was a student and eventually close colleague of Alfred Adler. After Adler's death in 1937, Dreikurs went on to promote the use of Individual

Psychology around the world. Individual Psychology is considered one of the most influential theories on contemporary counseling theories. While the approach is criticized for having limited empirical research, the approach has thousands of active members in Adlerian societies around the world.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Adlerian Therapy; Dreikurs, Rudolf (1897–1972); Early Recollections; Lifestyle and Lifestyle Convictions; STEP Parenting Program

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Individualized Education Plan (IEP)

An Individualized Education Plan (IEP), also known as an Individual Education Program, is a living document mandated by the Individuals with Disabilities Act (IDEA), which outlines the learning needs, objectives, accommodations, and services that will be provided to a student with a qualifying disability(ies) in a public school setting.

Definitions

- **Free appropriate public education** is an educational right of every child with a disability, as outlined under the Rehabilitation Act of 1973 and IDEA, which ensures that educational programming and services are unique to the child, specific to the child's needs, provide access to the general curriculum, meet grade-level standards, and are of educational benefit.
- **Individuals with Disabilities Education Act (IDEA)**, a federal law reauthorized and signed into law by President George Bush on December 3, 2004, ensures special education programs and support services to children and youth with disabilities.
- **Least restrictive environment (LRE)** is a requirement outlined by IDEA that states that individuals with disabilities be provided the opportunity to be educated with nondisabled peers to the greatest extent possible.

Description

An Individualized Education Plan is a written document developed by a special education team that details, outlines, and monitors the educational services provided to a student with a qualified disability or disabilities. The acronym "IEP" can refer to an Individualized Education Plan, Individualized Education Program, or Individualized Education Program Plan. The purpose of the IEP is to list out the student's unique learning goals and provide information about how the school district plans to support the student's educational success through the services it makes available. Every child who receives special education programming in a public school setting is required to have an IEP on file. Federal regulations established under the Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (2004) ensure the educational rights of disabled youth and require that public schools provide these students with a free and appropriate education in the LRE. When appropriate, students who are disabled should be educated with peers who are nondisabled in a "normal" general education classroom setting. Alternative placement settings may include a resource classroom, a separate classroom, specialized school, or residential facility.

In order to be eligible for special education services and a resulting IEP, an individual must have a documented disability, which impedes his or her learning. To determine this, a full evaluation of the suspected impairment must be conducted by a qualified professional. This impairment must fall under IDEA requirements. Based on the evaluation, an IEP is then

developed by a student support team comprised of the child's parents, at least one regular education teacher, the special education teacher, a school district representative, a psychologist or other qualified individuals who can interpret and relay the child's psychoeducational evaluation results, other support service personnel, the school guidance counselor, and, if deemed appropriate, the child himself or herself. Having the child present is meant to inform the child so he or she is better able to advocate on his or her own behalf once he or she transitions out of high school and into adulthood. Parental attendance and input are critical in the IEP process. School personnel are expected to make every attempt to contact, inform, and obtain consent from parents prior to initiating an IEP plan. Meetings in person are strongly encouraged, and translators should be provided when necessary.

Development (Purpose and History)

The IEP was first developed after the passage of the 1975 Education for All Handicapped Children's Act (EHA), also referred to as Public Law 94-142, ensured equal opportunity to an education for children with disabilities by requiring that special education services be provided to support these students' success. Subsequent reauthorizations of the law further articulated and amended IEP requirements. The 1986 EHA Amendment, Public Law 99-457 included infants and toddlers to those eligible for early intervention services. In 1990, the law was renamed the Individuals with Disabilities Education Act, or Public Law 101-476. In 1997, Public Law 105-017 was introduced to align IDEA requirements with the Elementary and Secondary Education Act and mandate that students with disabilities participate in state and district-wide assessments. In December 2004, President George W. Bush reauthorized the law (Public Law 108-446) and adjusted the name to the Individuals with Disabilities Education Improvement Act, placing more pressure on accountability requirements (i.e., "highly qualified teacher") that resulted from his No Child Left Behind initiative. Several provisions specific to the IEP process resulted from the 2004 reauthorization, attempting to make the process more efficient while placing less stringent demands on IEP team members including reduced paperwork requirements and the need for fewer meetings. On February 17, 2009, President Barak Obama signed into law the American Recovery and Reinvestment Act, a stimulus package meant to increase funding to key areas including education.

Current Status and Results

Specific information is contained in every IEP document: the child's present levels of functioning and academic achievement; the child's specific, measurable annual goals; supplementary services and special education programs available, time devoted to these services and when those will be delivered, how they will be delivered, by whom, and for how long; expected participation, if any, in district and state-wide standardized assessments; and how the student's progress toward his or her annual goals will be measured and reported. IEP team members are required to assemble and document the plan's initiation within 30 days of the establishing the student's eligibility under IDEA. A reevaluation is to be administered every three years. The IEP plan is continually monitored and revised annually based on the child's needs and progress up until his or her graduation from high school or prior to the 22nd birthday. If the student goes on to pursue a postsecondary education, the university's own procedures and system then take over.

Though federal law mandates adherence to IEP protocol, little research has been conducted in this area. Most local and state agencies, however, strongly recommend the use of a standard form in developing the IEP that meets federal requirements. Advances in computer-based technology have allowed for the IEP process to be even faster and more accessible.

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See also: Special Education

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Inhalant-Related Disorders

Inhalant-related disorders are a group of mental disorders characterized by physical dependence on inhalants, drug-seeking behavior, increased tolerance, and social withdrawal.

Definitions

- **Antisocial personality disorder** is a mental disorder characterized by a pattern of disregarding and violating social norms (rights of others). An individual must be 18 years and older for this diagnosis.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Conduct disorder** is a mental disorder characterized by a pattern of disregarding and violating social norms (rights of others). An individual must be under the age of 18 for this diagnosis.
- **DSM** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition is DSM-5.
- **Inhalants** are substances that emit chemical vapors. They are inhaled for their psychoactive effects.
- **Other substance use disorders** include problematic use of substances other than alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, or tobacco. Use must result in clinically significant impairment.
- **Psychoactive** refers to a drug or other substance that produces mood changes and distorted perceptions.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.
- **Tolerance** refers to the need for higher doses of a substance or more frequent engagement in a behavior to achieve the same effect.

Description and Diagnosis

Inhalant-related disorders are one of the DSM-5 substance-related and addictive disorders. Individuals with this disorder intentionally inhale vapors from products or chemical agents to become intoxicated. Vapors may be inhaled straight from a product's container, from a cloth saturated with the substance, or from a bag containing the substance. Inhalants may include, but are not limited to, glue, shoe polish, toluene, gasoline, lighter fluid, and spray paints. There are hundreds of commercial products that can be used as inhalants. Individuals may use one substance or a combination of several substances to achieve the desired psychoactive effects. Intoxication happens very quickly and does not last long. Inhalant abuse of nitrous oxide (laughing gas), amyl nitrite (chemical compound that dilates blood vessels), butyl nitrite (also called poppers that increase sexual desire), and isobutyl nitrite (chemical compound that dilates blood vessels) are not considered to be inhalant-related disorders but rather other substance use disorders.

The occurrence of this disorder is relatively low in the American population. Approximately 4 out of 1,000 teenagers between the ages of 12 and 17 meet the conditions for inhalant-related disorders. In this age group the rate of occurrence is higher among Native Americans and lowest among African Americans. Approximately 1 out of 1,000 individuals between the

ages of 18 and 29 have the disorder. In adults 18 years and older, around 2 out of 10,000 meet the criteria for a diagnosis. Females are rarely diagnosed with this disorder (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they are physically dependent on inhalants. Over the previous year, the individual has increased the substance dose in order to obtain the desired psychoactive effect. Attempts to control use or decrease use have failed. Strong cravings are experienced and excessive amounts of time are spent obtaining inhalants. Use of the substance continues despite negative consequences experienced in occupational, social, and interpersonal areas. Substance use continues despite any psychological or physical problems that have occurred as a result of the substance. The substance is repeatedly used during situations that may result in physical harm. Inhalant-related disorders are not characterized by withdrawal symptoms (American Psychiatric Association, 2013).

The cause of this disorder is linked with the co-occurrence of another substance use disorder (non-inhalant) usually along with conduct disorder or antisocial personality disorder. Other situations that increase the likelihood of inhalant abuse include use of inhalants at an early age, a history of mental health treatment, childhood abuse or trauma, and behavioral disinhibition (tendency to break the rules and take risks).

Treatment

Treatment for inhalant-related disorders is based on the individual's age, extent of drug problem, other addictions, and co-occurring disorders. Treatment can include psychotherapy and medication. Psychotherapy may consist of cognitive behavior therapy. Medication therapy may help reduce the psychotic side effects of inhalants.

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See also: Addiction; Cognitive Behavior Therapy; Psychotherapy; Substance-Related and Addictive Disorders

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Inhalants

Inhalants are ordinary household products that are sniffed or inhaled for their mind-altering effects (getting high).

Definition

- **Gateway drugs** are the first drugs that are used before moving on to other substances such as alcohol, marijuana, cocaine, or oxycodone.

Description

Inhalants are breathable chemical vapors that users intentionally inhale because of the chemicals' mind-altering effects. Inhalants are a class of drugs that include a broad range of chemicals found in hundreds of commonly available products. Such chemicals include volatile solvents (liquids that vaporize at room temperature) and aerosols (sprays that contain solvents and propellants). Examples include glue, gasoline, paint thinner, hair spray, lighter fluid, spray paint, nail polish remover, correction fluid, rubber cement, felt-tip marker fluids, and cleaning fluids such as spot removers, computer keyboard cleaner, and carburetor cleaner. These chemicals can be inhaled directly from a container (sniffing), from the fumes of the substance placed in a bag (bagging), or from a cloth soaked in it (huffing). The mind-altering effect is quickly achieved because the substance enters the bloodstream almost instantaneously via the lungs. High from inhalants is typically brief, necessitating repeated inhalants. This pattern of use and abuse can be dangerous, and can result in unconsciousness or even death.

Inhalant use is more commonly used by younger children than older ones. Estimates are that 10%–20% of youths aged 12 to 17 have tried inhalants. About 6% of the U.S. population of all admits to having tried inhalants prior to fourth grade. The peak time for it is between the seventh and ninth grades. Generally, males use inhalants more frequently than females. Children younger than 12 and adults who use inhalants are more likely to be male (Erickson, 2011). The use of inhalants is often influenced by peers. Typically, inhalants are used in group settings. The solitary use of inhalants is associated with heavy, prolonged use; it may indicate that the individual has a more serious problem with these substances. Furthermore, inhalants may serve as gateway drugs for such users.

Types of Inhalant Use, Precautions, and Side Effects

Inhalant dependence. Inhalant dependence, or inhalant addiction, is a syndrome in which an individual continues to use inhalants despite significant problems caused by, or made worse by, the use of these substances. Those with heavy, recurrent inhalant use may develop tolerance to the drug. This is a positive indicator of physical dependence. Individuals dependent on inhalants may use these chemicals several times per week or every day. They may have problems with unemployment or with family relationships, and/or such physical problems as kidney or liver damage caused by the use of inhalants.

Inhalant abuse. Inhalant abuse is a less serious condition than physical dependence. However, recurrent use of inhalants can have negative consequences. For example, the use of inhalants may contribute to poor grades or school truancy.

Inhalant intoxication. "Intoxication" refers to the behavioral or psychological changes following ingestion of a mind-altering substance. Symptoms of intoxication depend on the type of inhalant, the amount used, and other factors. There is, however, a predictable set of symptoms of inhalant intoxication. Typically, they have a depressant effect on the central nervous system. Similar to the effects of alcohol, they produce feelings of euphoria (feeling good), excitement, dizziness, and slurred speech. In addition, those intoxicated by inhalants may feel as if they are floating, or a sense of increased power. Excessive ingestion or inhalation of the chemical can cause overdose and result in coma or death.

Len Sperry, MD, PhD

See also: Addiction; Inhalant-Related Disorders

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Insanity Defense

The insanity defense is a claim of not being responsible for one's actions because of a mental disorder. It is also referred to as "not guilty by reason of insanity."

Definitions

- **Diminished capacity** is a lesser degree of mental malfunctioning than insanity wherein emotional distress or other factors reduce one's capacity to fully comprehend the nature of the accused criminal act.
- **Incompetent to stand trial** is a court's determination that a defendant's mental condition makes him unable to understand the legal proceedings or to help in his defense.
- **Insanity** is a significant degree of mental malfunctioning considered to be sufficient to relieve the accused of legal responsibility for the criminal act committed.

Description

The insanity defense is a legal defense (reason) in which defendants (accused individuals) claim they are

not responsible for their actions because of a mental condition or disorder. This defense is also referred to as "not guilty by reason of insanity" (NGRI). There are specific requirements for this defense. First, the individual who is charged with a crime must admit to the criminal act. Second, the individual's attorney must claim that the individual lacked the capacity to intend to commit the crime because of significant mental malfunctioning at the time of the crime. Third, it requires that the court set a trial on the issue of insanity. A finding of insanity results in a verdict of NGRI. Assuming the mental condition still exists, the court may order the individual be confined to a mental facility for the criminally insane or a psychiatric hospital. If the insanity no longer exists (was temporary insanity), the judge has the option to require some psychiatric treatment. NGRI differs from incompetence to stand trial. Here the defendant is adjudged to be insane at time of trial. This determination results in a postponement of the trial—often indefinitely—and confinement to a mental facility pending recovery.

Developments and Current Status

Exemption of those determined to be insane from full criminal punishment dates back to the Code of Hammurabi, which is the earliest known legal code. There are different definitions of legal insanity, such as the M'Naghten rules, the Durham rule, and the American Law Institute Formulation. The M'Naghten rule emphasized a "defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know that what he was doing was wrong" (Ewing, 200). The Durham rule emphasized that "an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect." The American Law Institute Formulation's definition is that "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law."

The use of the insanity defense is relatively rare in the United States. Instead factors not eligible for the insanity defense, such as like intoxication or diminished capacity, are used in efforts to reduce charges or to reduce sentences. The diminished capacity plea is primarily raised to remove the element of premeditation or criminal intent. This defense may result in a conviction for a lesser crime, such as manslaughter instead of murder. In other words, a plea of diminished capacity is different from a plea of insanity in that "reason of insanity" is a full defense while "diminished capacity" is simply a plea to a lesser crime.

The insanity defense is based on evaluations by forensic specialists (psychologists or psychiatrists) involving specialized psychological tests. Some jurisdictions (courts) require the evaluation to address the defendant's ability to control his or her behavior at the time of the offense. If successful, the defendant pleading "not guilty by reason of insanity" or "guilty but insane or mentally ill" may be committed to a psychiatric facility for an indeterminate period.

Len Sperry, MD, PhD

See also: Mental Health Laws; Psychological Testing

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Insecure Attachment

Attachments are primarily identified as either secure or insecure, with three breakdowns within the concept of insecure attachments. Attachment styles are rooted in the theory first developed by John Bowlby, with significant contributions from Mary Ainsworth. Insecure attachments develop in infancy and childhood impacts the development throughout the lifespan, as well as how an individual interacts with others. Bowlby's belief was that a child's attachment was connected to his or her interactions and ability to form and maintain emotionally stable relationships later in life.

Definition

- An **insecure attachment** is a lack of trust or consistency in the relationship between a caregiver and child. The caregiver may fail to respond to the infant's needs where the child may become distressed or anxious.

Attachment styles were first explored by John Bowlby and bolstered by key contributions from Mary Ainsworth, notably her strange situation paradigm in which Ainsworth explored infants' responses to being separated from their caregiver as well as their reaction to the return of the caregiver.

Babies who are identified as anxious-ambivalent display high levels of anxiety. These babies struggle with gaining a sense of security even when their caregiver is still present with them. These babies are stressed and distressed when separated from the caregiver. However, what truly identifies these babies is that when their caregiver returns these babies greet him or her angrily and resist efforts to comfort them. These babies rarely explore the room even after their caregiver's return. Children with insecure attachments may refuse to interact with others or may simply avoid others. They may also exaggerate distress as well as have strong displays of anger, anxiety, or fear.

There are three subsets within the concept of insecure attachments. Insecure attachments can be anxious-ambivalent, avoidant, or disorganized-disoriented. Avoidant babies fail to cry when separated from their caregiver. When the caregiver returns, the babies ignore or avoid him or her. These babies are unemotional during both separation and reunification with their mother. They would rather direct their attention toward toys or other objects present in the room.

Disorganized-disoriented babies were initially difficult to identify and categorize and were left out of the inclusion as being classified. These infants display contradictory behaviors. They have a desire to approach their mother when stressed but also avoid her when she approaches them. Children who display this pattern of attachment are more likely to have experienced unstable or difficult home environments, such as filled with abuse or neglect. There is concern that children who display this attachment style may have their learning ability impacted and be at risk academically. This group is also more likely to experience or demonstrate behavior problems such as strong displays of aggression.

When children are insecurely attached, they may be wary of strangers or show no preference for their parents over strangers. They are distressed when their parents or key figures leave and don't appear to be comforted when they return. As adults they are hesitant to become close to others. They worry that their partner doesn't love them and become distraught in relationships. They struggle with intimacy and invest little emotion into their relationships.

Attachment is continuous and can be modified with understanding. In recent years there has been a curiosity in exploring attachments in adulthood and the impacts they have on social and romantic relationships. There have been studies exploring those with insecure attachments as a predictor of depression and anxiety in adolescents and adulthood. Insecure attachments can also lead to lower self-esteem and difficulty with self-regulation and emotional stability, as well as impact social and romantic relationships as an adult.

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See also: Attachment Styles; Secure Attachment

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Insomnia and Insomnia Disorder

"Insomnia" refers to difficulty falling asleep. Insomnia disorder is a sleep disorder characterized by a persistent pattern of difficulty falling asleep and staying asleep.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Polysomnography** is a medical test that records aspects of sleep (circadian rhythms, REM, NREM, number of arousals) as well as breathing patterns, heart rhythms, and limb movements.
- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.
- **Sleep hygiene** refers to the habits, practices, and nonmedical treatments for insomnia and which improve the quality of sleep.

Description and Diagnosis

Insomnia is a sleep disorder characterized by difficulty falling asleep, staying asleep, or both. Often, individuals experiencing this disorder wake up during the night and then have difficulty falling back asleep. Or, they may wake up too early in the morning. In either case, they are likely to be tired upon waking and throughout the day. Insomnia can be short-term (acute) or can last a long time (chronic). It can also come and go, with periods of time when an individual experiences no sleep problems. Acute insomnia can last from one night to a few weeks. Chronic insomnia is longer, lasting at least three nights a week for a month or longer.

It is not uncommon for those with this disorder to be frustrated and distressed about sleep. The longer this continues, the more they are likely to feel hopeless in resolving their inability to sleep. They also experience increased fatigue, lower energy, and significant changes in mood. This further complicates their erratic and maladaptive sleep pattern. The result is increased difficulties with social, work, academic, and other areas of functioning (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a persistent pattern of difficulties and dissatisfaction with falling asleep and or remaining asleep. Individuals may experience sleep-onset insomnia, in which they have difficulty falling asleep. They may have experienced sleep maintenance insomnia in which they have difficulty falling back asleep after awakening. Or, they may experience early morning awakening where they are fall back asleep after awakening early in the morning. This sleep difficulty must have occurred three times per week or more and have lasted for three months or more. They must also cause significant distress for the individual or result in significant level of impaired functioning. In addition, the disorder cannot be the result of a substance, medication, other medical condition, or another sleep disorder (American Psychiatric Association, 2013).

Several factors appear to cause this disorder. Genetic and family factors may be involved since insomnia is more common among first-generation family members. It is more common among females. Insomnia in females often begins with the birth of a child or with the onset of menopause. Psychological and environmental factors are often involved. These include the following: stress caused by a single event, such as giving a speech, or ongoing stress, such as worry about work or a health matter. Depression, anxiety, and other mental or medial conditions may trigger or complicate sleep problems. Lifestyle and environmental factors can also cause or exacerbate (worsen) it. These include poor sleep hygiene habits such as watching television in bed or not having a regular bedtime schedule. It can also include changes in sleep habits and surroundings such as noise, temperature, light, or

sleeping in a different bed. Common environmental factors that might be involved include jet lag or working a late shift.

Treatment

Effective treatment of insomnia requires a multifaceted approach to treatment. Treatment should begin with a medical consultation and sleep study, including polysomnography. The medical consultation should identify any medical conditions and co-occurring psychological disorders that may cause or contribute to insomnia. After the medical evaluation, a treatment plan is established, which usually includes behavior therapy, sleep hygiene, and/or medication.

The National Sleep Foundation recommended behavior therapy and behavior modifications in developing good sleep hygiene. This involves establishing a consistent sleep schedule and exposure to bright light in the morning and avoiding it at night. It also recommends engaging in regular exercise and establishing a bedtime routine. Also, it suggests creating a comfortable sleep environment, keeping stress out of the sleep area, and avoiding caffeine, nicotine, alcohol, and stimulating medication. Initially, medications may be prescribed but usually for only a few weeks since the mainstay of treatment is changing sleep patterns and environments. A natural sleep remedy like melatonin might be considered. Prescription medications such as Ambien, Lunesta, Sonata, or Rozerem may help in bringing on needed sleep while the behavioral interventions and sleep hygiene are being established.

Len Sperry, MD, PhD

See also: Ambien (Zolpidem); Behavior Therapy; Melatonin; Sleep

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Organization

National Sleep Foundation
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Integrative Health

"Integrative health" refers to a system of health care in which behavioral health professionals and interventions are integrated with medical professionals and interventions.

Definitions

- **Behavioral health** is a phrase referring to mental health and substance addictions services and issues.
- **Comorbid** means to have more than one simultaneous medical condition.
- **Primary care** is health care that is provided by nonspecialist physicians such as family doctors and pediatricians.
- **Providers** mean both medical and mental health-care providers.
- **Treatment noncompliance or nonadherence** is the phrases used when individuals fail to follow treatment instructions, regimens, or advice.

Description

Integrative health is an approach to health care that merges and coordinates behavioral health with primary medical care. Integrative health is an emerging service delivery system, which recognizes that physical and behavioral health problems often occur at the same time. In addition, many behavioral health issues are at the root of many physical symptoms. For instance, stress often results in physical symptoms such as headache, stomach upset, fatigue, and insomnia, all common physical complaints frequently treated in primary care settings. A family physician who is not a behavioral health expert may fail to recognize that stress is the underlying cause of the physical symptoms and that cognitive behavior therapy would be indicated for the most effective treatment. The reverse is also true: many physical illnesses have a mental health impact. For example, a person who is newly diagnosed with a chronic disease such as diabetes may succumb to a state of psychological denial and refuse to follow dietary restrictions, resulting in repeated hospitalizations and further health decline. In this case, a behavioral health professional trained in assisting newly diagnosed individuals and their families can assist the patient come to terms with and accept their disease while helping them redevelop a sense of well-being that incorporates the illness into a new lifestyle.

Development

According to the Substance Abuse and Mental Health Services Administration people with mental and substance use disorders may die decades earlier than the average person. These early deaths are most often the result of untreated and preventable chronic illnesses such as hypertension, diabetes, obesity, and heart disease that are aggravated by poor health habits and substance abuse. In addition, approximately 50% of Americans experience chronic medical symptoms and 75% of adults over the age of 65 suffer from more than one chronic illness. Behavioral health interventions that target treatment compliance and health-promoting behaviors can greatly increase the health and well-being of individuals suffering from chronic illness.

Current Status

There are six levels of integrated care, ranging from minimal collaboration to fully integrated and merged systems of care. The key element of levels one and two is that of coordinated communication. Level one involves minimal collaboration between medical and mental health-care providers. Providers work in separate facilities and rarely communicate. Level two is basic collaboration but at a distance. Providers maintain separate service sites but periodically communicate about shared patients, usually by telephone, secure e-mail, or fax.

The key element of levels three and four is colocated physical proximity. Level three is basic onsite collaboration in which providers have separate systems but are in the same facilities, although not necessarily the same offices, and engage in occasional face-to-face interaction. Level four is close collaboration in a partly integrated system. Providers share facilities and office space, have a basic understanding of each other's roles, and share some systems such as scheduling and patient records. There is regular communication between providers who coordinate treatment plans for patients with complex treatment needs.

The key element in levels five and six is that of integrated practice. Level five is close collaboration approaching a fully integrated practice. Providers share the same space and actively work toward shared systems. They communicate frequently in person, collaboration is driven by a desire to be a member of a care provider team, providers have regular team meetings, and they have an in-depth understanding and appreciation of each other's roles. Level six is full collaboration in a transformed and merged integrated practice with completely integrated systems. Providers at this level not only share facilities and systems but also have a shared vision and an in-depth understanding of each other's roles and expertise.

Integrative health is a health delivery system that incorporates behavioral health into primary care settings. The goal of integrated health care is to provide individuals with an increased range and availability of health-enhancing treatment options. Integrating behavioral health care into medical practices presents a clear path to increased health and well-being of all patients.

Steven R. Vensel, PhD

See also: Behavioral Medicine

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Intellectual disability

"Intellectual disability" is the term used to describe people who have below-average intelligence and incomplete skills for daily living.

Definitions

- **Disability** means a physical or mental condition that limits a person's movement, sense perception, or participation in normal physical or mental activities.
- **Intellectual** refers to the ability to think and understand ideas.
- **Intelligence** is the capacity a person has to learn and understand information and solve problems.

Description

"Intellectual disability" (IND) is defined as an impairment that affects a person's ability to function well in daily life. This condition was once diagnosed as mental retardation. IND impacts a person's functioning in three areas of life: cognitive, social, and functional.

The cognitive issues that usually present in people diagnosed with IND are in language, reading, writing, math, and other academic or intellectual areas. Generally, they perform below average in one or several of these areas. The social domain refers to empathy, social judgment, interpersonal communication skills, and similar capabilities. Typically people with IND are socially naïve and do not have a good sense of safety or familiarity with others. The functional domain focuses on areas such as personal care, job responsibilities, money management, recreation, and organization.

The detailed diagnosis of IND is distinct for each person based on how much he or she is affected by the condition. Some are severely impacted and therefore have more trouble, while others are less affected and can function similarly to most others. For a true diagnosis of IND, it must manifest itself sometime during childhood or early adolescence and last throughout a person's lifespan. IND is measured based on intelligence and assessments that identify problems and provide a comprehensive picture of the limits of their capabilities. It is estimated that about 2% of the population in the United States are diagnosed with some form of IND.

Causes and Symptoms

The cause of intellectual disabilities is lined to poorly developed brain functions, but why this occurs is not always clear. In some cases, genetic issues, chromosomal conditions, or problems during pregnancy may be the cause. These instances include the presence of conditions such as Down syndrome and fetal alcohol spectrum disorders. Some of the causes that can contribute to IND are medical in nature. This includes issues such as seizure disorders, unusually low birth weight, or severe illness in early childhood, which directly affect the brain.

Diagnosis and Prognosis

Indications that children have IND may appear during infancy, or they may not be noticeable until a child starts school. It often depends on the severity of the disability. IND is divided into four classifications: mild, moderate, severe, and profound. Levels of classification are determined by intelligence tests, and it is based on a person's test results that he or she is placed into one of these four classifications.

Among the most common signs of IND are physical delays. This includes a child's difficulty to learn how to sit, crawl, or walk when he or she is developmentally

expected to do so. Communication issues are also common for people with IND. This includes difficulty talking and expressing themselves or developing speech much later than expected. Children with intellectual disabilities are also delayed in potty training, dressing, or feeding themselves. Other symptoms include poor memory skills and inability to connect their actions to consequences. Parents and professionals should bear in mind that each child develops at a different pace and no one of these symptoms by itself is conclusive evidence of IND. The diagnosis can only be determined finally by medical professionals who administer assessments of IQ and other tests.

Learning will be a lifelong challenge for those diagnosed with IND. But there are therapeutic and educational interventions that may help to improve the quality of life and capacity for those who are diagnosed with an IND. Many people diagnosed with mild to moderate forms of IND are able to work, socialize, and care for themselves with the support of others. They can benefit from services such as job coaching and training, social skills treatment, and personal care assistants. Unfortunately for those who are classified as profoundly intellectually disabled, lifetime care from family members and professional caregivers may be the only choice.

Treatment

For those who are diagnosed very young and can benefit from early intervention, there is a better prognosis. Parents often seek out professional help to create a treatment plan that will involve family, therapists, and educators. This plan should clearly identify the child's specific needs and what services are likely to help the child develop. Early intervention may include a long list of programs such as speech therapy, occupational therapy, physical therapy, family counseling, training with special assistive devices, or nutritional services.

Children with intellectual disabilities who are able to attend school are eligible for free special education programs through the public school system. The Individuals with Disabilities Education Act mandated by the federal government ensures the provision of these programs. Parents and educators will work together to create an Individualized Education Program that outlines the child's needs and the services the child will receive at school. The point of special education is to make adaptations, accommodations, and modifications that allow a child with an IND to succeed in the academic setting.

When a person with IND exits the school system, the options for assistance and support are limited. Adults with this condition can enroll in job training programs or rehabilitation services to help them gain as much independence as possible. The majority of the programs that place adults with IND into these services are government funded, although private programs also exist. These educational and therapeutic programs often employ counselors, aids, and medical staff in order to properly serve this population. Adult services are often criticized for being difficult to access and unsuccessful in the goal of creating more independence for clients with disabilities.

Alexandra Cunningham, PhD

See also: Down Syndrome; Mental Retardation

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Intelligence

Intelligence is the capacity to learn and understand information and to solve problems.

Definitions

- **Emotional intelligence** is the type of intelligence that assesses the ability to assess, express, and use one's emotions and those of others to determine one's thoughts and actions.
- **Intelligence quotient** is a measure of intellect to determine a person's level of cognitive ability. It is commonly referred to as IQ.

- **Intelligence testing** is a method of evaluating and scoring various aspects of intelligence such as abstract reasoning, verbal and quantitative ability, and processing speed and fluency. It specifies a numerical value to the score to be compared with others.

Description

Intelligence has been defined as an individual's capacity to learn, understand, and acquire knowledge. It also includes the ability to solve problems and to be able to reason. Intelligence and intelligence testing have been an important consideration in school and work settings since the beginning of the 20th century. Since then it has become increasingly clear that ethnicity, social class, and cultural factors influence intelligence and its assessment. Accordingly, efforts have been undertaken to clarify the meaning of intelligence and its assessment. The goals are to reduce cultural bias and develop more accurate measures of it. For example, individuals who do not understand the prevailing language and/or social interactions can be given either a nonverbal test or one in their native language.

Development

In 1983, Howard Gardner's book *Frames of Mind: The Theory of Multiple Intelligences* altered the prevailing view of intelligence. In it he proposes that instead of there being a single type of intelligence, there are many kinds of intelligences. He argued that most of these types of intelligences are neglected by standard intelligence testing and teaching methods. Gardner described eight types of intelligence:musical–rhythmic, visual–spatial,verbal–linguistic,logical–mathematical, bodily–kinesthetic, interpersonal, intrapersonal, and naturalistic. According to Gardner's theory of multiple intelligences, individuals have several different ways of processing information, and these ways are relatively independent of one another.

Another view of intelligence has been proposed by the American psychologist Robert Sternberg (1949–). He describes three main types of intelligence. The first is practical intelligence, which is the ability to do well in informal and formal educational settings. It also involves the ability to adapt to and shape one's environment. This form is often called "street smarts." The second is experiential intelligence, which is the ability to deal with novel situations, the ability to effectively deal with novel situations so they are easily handled in the future, in other words, the ability to think in novel ways. The third is componential intelligence, which is the ability to process information effectively. Sternberg notes that often individuals who are very talented in one type can be less talented in the other two.

Current Status

For the past decade, interest in intelligence has centered largely on emotional intelligence. Emotional intelligence (EQ) is the capacity to recognize, understand, and manage personal emotions and to identify and respond to the emotions of others. It influences how individuals think, behave, interact with others, and make decisions. Emotional intelligence is different from intelligence (IQ) which is the capacity to learn, reason, and problem solve. Intelligence remains relatively stable throughout life, whereas emotional intelligence can be learned and developed.

The term "emotional intelligence" was originally used in 1964 by Michael Beldoch (1931–). However, it became better known because of psychologist Daniel Goleman's (1946–) best-selling book *Emotional Intelligence—Why It Can Matter More Than IQ*. It has been a best seller since its publication in 1995. Goleman contends that emotional intelligence is equally important, if not more important than IQ. A number of measures of EQ have appeared in the past decade. These measure are routinely used in business and the corporate world.

Alexandra Cunningham, PhD, William M. Cunningham, MA, and Len Sperry, MD, PhD

See also: Emotional Intelligence; Intelligence Testing

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Intelligence Testing

Intelligence testing is a method of evaluating and scoring various aspects of intelligence such as abstract reasoning, verbal and quantitative ability, and processing speed and fluency. It specifies a numerical value to the score to be compared with others.

Definition

- **Intelligence quotient**, or IQ, coined by German psychologist William Stern, is an overall score derived from standardized measures of human intelligence.

Description

Assessing aspects of human intelligence has been an area of interest for centuries. The process of intelligence testing seeks to evaluate different components of intellect using standardized measures, which can then be compared between individuals of similar age, ability, and background. The overall score derived from these measures is commonly referred to as one's IQ, or intelligence quotient. Current standardized instruments used to assess IQ have been normed using wide, diverse samples resulting in a median IQ score of 100 with a standard deviation of 15. Thus, an IQ score ranging from 85 to 115 would be considered "normal" or "average." Further, it has been determined that some 95% of the population falls between two standard deviations of the mean, or scores ranging from 70 to 130. There is believed to be a biological or hereditary component to intelligence, though this has been a controversial topic. IQ has been associated with academic achievement, special needs, social behavior, career selection and success, and mortality rates, as well as affective and perceptive indicators of happiness, life satisfaction, and self-esteem.

Development (Purpose and History)

Intelligence testing began in the late 1800s with the work of English statistician Sir Francis Galton. He hypothesized that intelligence had a high genetic component but was unable to prove this assertion. The first standardized intelligence measure, the Binet–Simon Intelligence Scale, was developed by French psychologist Alfred Binet and his student Theodore Simon, which was used to detect mental retardation in school-age children. This work gained popularity throughout the international psychological community, and Binet went on to create the Stanford-Binet Intelligence Scale with Stanford psychologist Lewis M. Terman, a revised version of the Binet–Simon and an instrument still in use today. In 1912, German psychologist William Stern coined the term "Intelligence Quotient" or "IQ" to define an overall, standardized measure of human intelligence, a score that could be determined using the Stanford-Binet. The Stanford-Binet remained the most popular instrument for decades until American psychologist David Wechsler, influenced by the work of Charles Spearman and Alan Kaufman, developed the Wechsler Adult Intelligence Scale in 1939. Wechsler opposed Binet's view of a single score for intelligence and proposed rather that intelligence be divided into two main categories, verbal and nonverbal abilities, each evaluated with different subtests.

Wechsler later went on to publish the Wechsler Intelligence Scale for Children (WISC), a revision; the WISC-III remains a preferred instrument of the day. Wechsler's colleague, Alan S. Kaufman and his wife Nadeen, would later develop the Kaufman Assessment Battery for Children, the Kaufman Test of Educational Achievement, and the Kaufman Brief Intelligence Test during the late 1970s. Around the same time, Richard Woodcock and Mary E. Bonner Johnson released the Woodcock–Johnson Tests of Cognitive Abilities, another assessment that has experienced several revisions and is still in current use.

Current Status

Intelligence testing remains prevalent worldwide though some have suggested alternative theories for how intelligence should be conceptualized. Psychologist Daniel Goleman proposed that an individual's emotional intelligence, or EQ, is a more valuable indicator of future success and happiness. Harvard psychologist Howard Gardner's work offers seven distinct intelligences, which account for variations in student aptitude, learning outcomes, and performance. Current educational policies, programs, and teaching practices seek to incorporate these multiple intelligences. IQ scores also appear to be rising at an average rate of 3 points per decade since the early 20th century, a phenomenon referred to as the Flynn Effect, after researcher James R. Flynn who first documented this trend. Experts have proposed that this may be a result of environmental characteristics, including improved nutrition, schooling and parenting practices, and the increased use of technology. According to the "IQ-achievement discrepancy model," individuals whose achievement scores are one standard deviation or more below their IQ scores are diagnosed as learning disabled. Critics contend that this model fails to provide a comprehensive picture of how a person learns. Concerns have also been raised surrounding whether intelligence instruments accurately account for variations in race, gender, socioeconomic status, and culture as well.

Melissa A. Mariani, PhD

See also: Intelligence; Kaufman Adolescent and Adult Intelligence Test (KAIT); Kaufman Assessment Battery for Children (K-ABC); Wechsler Adult Intelligence Scale (WAIS); Wechsler Intelligence Scale for Children (WISC); Wide Range Achievement Test (WRAT)

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Intermittent Explosive Disorder

Intermittent explosive disorder is a mental disorder characterized by impulsive, aggressive, violent behavior, or angry outbursts.

Definitions

- **Antisocial personality disorder** is a mental disorder characterized by a pattern of disregarding and violating the rights of others.
- **Borderline personality disorder** is a mental disorder characterized by a persistent pattern of instability in interpersonal relationships, self-image, affect, self-harm, and a high degree of impulsivity.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing faulty behaviors, emotions, and thoughts. It is also known as CBT.
- **Disruptive, impulse-control, and conduct disorders** are a group of DSM-5 mental disorders characterized by problems with emotional and behavioral self-control. They include oppositional defiant disorder, conduct disorder, and intermittent explosive disorder.
- **Domestic abuse** is the abuse by one partner against the other in an intimate relationship.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Impulse control** is the degree to which an individual can control the impulse to act or the desire for immediate gratification.
- **Physical abuse** involves inflicting, or threatening to inflict, physical pain or injury on individuals or depriving them of a basic need.
- **Psychodynamic therapy** is a form of psychotherapy that focuses on unconscious processes as they are manifested in an individual's present

behavior. It is also known as insight-oriented therapy.

- **Road rage** is an extreme form of angry or aggressive behavior by a driver of a car or other road vehicle.

Description and Diagnosis

Intermittent explosive disorder is one of the DSM-5 disruptive, impulse-control, and conduct disorders. The core feature of intermittent explosive disorder is a failure in self-control in response to being intentionally provoked by another. It is by impulsive, aggressive, violent, and angry outbursts. The outbursts usually last for nearly 30 minutes and typically occur in response to being provoked by another individual. Outbursts are generally impulsive or anger-based and not premeditated (intended). Aggressive episodes may be accompanied by irritability, rage, increased energy, tremors, and racing thoughts. Some signs of this disorder include road rage, domestic abuse, and throwing or breaking objects. Individuals with intermittent explosive disorder engage in verbal aggression, or assault individuals, objects, and animals. They may feel embarrassment, regret, or remorse following an assault.

The occurrence of this disorder in the United States is approximately 2.7% for the entire population (American Psychiatric Association, 2013). Intermittent explosive disorder is more common among males and more common in individuals younger than 40 years old (American Psychiatric Association, 2013). This disorder is also more common in individuals with a high school education or less (American Psychiatric Association, 2013). Individuals with intermittent explosive disorder are at greater risk of engaging in self-harm, having difficulty in interpersonal relationships, and having trouble at home, work, or school. The disorder may occur from time to time, with repeated periods of impulsive aggressive outbursts. Typically, it tends to be chronic and persistent over the course of many years.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they have a failure to control aggressive impulses as manifested by verbal or physical aggression. The recurrent aggressive outbursts are impulsive, are out of proportion with the precipitating stressor, and cause marked distress with the individual and his or her interpersonal and occupational functioning. The individual must be at least six years old and the disorder must not be better explained by another mental disorder. The individual who engages in verbal aggression or physical aggression toward objects, animals, or other individuals must exhibit this behavior twice weekly for a period of three months. Behavioral outbursts that damage an object or cause physical injury to an animal or other individuals must occur at least three times within a 12-month period (American Psychiatric Association, 2013).

The exact causes of this disorder are unknown. Environmental factors may be involved. For example, individuals who grew up in families where explosive behavior and verbal and physical abuse occurred may be more likely to develop this disorder. Another potential cause is genetic or physiological factors. A genetic component may be an influence. There may also be differences in the way serotonin (a chemical messenger in the brain) works in individuals with intermittent explosive disorder. Depressive disorders, substance use disorders, and anxiety disorders are most commonly associated with this disorder. Also, individuals with borderline disorder, antisocial personality disorder, or a history of disruptive behaviors have a higher risk of being diagnosed with the disorder (American Psychiatric Association, 2013).

Treatment

Treatment for this disorder typically involves psychotherapy in order to help individuals understand and control their thoughts and behaviors. Psychodynamic therapy may be helpful in that it involves having an individual focus on feelings and motivations. This type of therapy may uncover underlying feelings and reasons behind anger and rage and help an individual to develop a better way to think about and control his or her behavior. Cognitive behavior therapy (CBT) may also help individuals with intermittent explosive disorder. CBT focuses on conscious thought and noticeable behaviors, which may help the individual to recognize the urge to explode, to identify triggers, and

to develop ways to prevent explosive behaviors from occurring. Several medications can reduce aggression and prevent angry outbursts. These medications include antidepressants, antianxiety medications, mood stabilizers, and antipsychotic drugs.

Elizabeth Smith Kelsey, PhD, and Len Sperry, MD, PhD

See also: Antianxiety Medications; Antidepressants; Antipsychotic Medications; Antisocial Personality Disorder; Borderline Personality Disorder; Cognitive Behavior Therapy; Conduct Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Road Rage

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International Classification of Diseases

The International Classification of Diseases is the standard diagnostic classification system in the world for the diagnosis, treatment, and reporting of medical and mental conditions. It is also referred to as ICD.

Description

The International Classification of Diseases (ICD) is the standard diagnostic classification system used throughout the world for the diagnosis, treatment, and reporting of human health conditions. In addition to medical disorders, it includes mental and behavioral disorders. ICD is developed and published by the World Health Organization (WHO). Its primary value and utility is that it provides a common diagnostic language across cultures. In this classification system, medical and mental health conditions are organized in a comprehensive taxonomy and coding system. Each disease or disorder entity is identified by a specific diagnostic code. At present, the ICD is in its 10th edition (ICD-10), and revisions are currently under way for ICD-11. The ICD-10 is published in 42 languages, and while print versions are available for sale, it can be downloaded free of charge from the WHO website (WHO, 2004).

Developments and Current Status

In 1893, the International Statistical Institute approved a standardized system for classifying deaths. The list was prepared by a French statistician Jacque Bertillon (1851–1922) and was called the Bertillon Classification. By 1900, 26 countries had implemented the Bertillon Classification. In 1928, a study sponsored by the Health Organization of the League of Nations discussed how the Bertillon Classification could be expanded to include the tracking of diseases. In 1949, the WHO supported the development of a global system for tracking mortality (deaths) and the causes of diseases. The Manual of the International Classification of Diseases, Injuries and Causes of Death (ICD) has served as the foundation for the modern practice of medical coding. Starting with the Bertillon Classification, this list is revised every 10 years. The latest revision is ICD-10.

While most mental health providers in the United States rely on DSM to one degree or another, the official U.S. diagnostic system for mental illness is the ICD. This means that DSM diagnoses must be recoded or translated via computerized "crosswalks" into ICD codes for third-party billing and epidemiological purposes. For example, Medicare requires that claims be submitted with ICD codes and the Health Insurance Portability and Accountability Act requires ICD codes for electronic information transfer. Furthermore, while ICD-10 is the current and most widely used edition of the ICD system, U.S. health care relies on the ICD-9-CM. The ICD-9-CM is an American modification of the ICD-9 developed by the National Center for Health Statistics. It is required for most clinical, billing, and reporting purposes. Presumably, DSM-5 will be more consistent with ICD-11 than previous versions.

While both DSM and ICD systems share commonalities in structure, format, and content, there are noteworthy differences between them. One is that both may use different terms for the same disorders. For

example, attention-deficit hyperactivity disorder in the DSM is hyperkinetic disorder in the ICD. Another is that same disorder can have somewhat different criteria for diagnosis. Basically, the ICD has more flexible and general diagnostic guidelines, while the DSM has stricter and categorically defined diagnostic criteria.

Len Sperry, MD, PhD

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM)

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Internet Addiction Disorder

Internet addiction disorder is a mental disorder characterized by excessive use of a computer that interferes with normal living and causes severe stress on family, friends, and work environment. It is also known as cyber addiction.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Cognitive behavior therapy** is a type of psychological treatment that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Conditions for further study** is the section in the DSM-5 which describes conditions that do not currently meet the criteria for a mental disorder. Further research is required before they can be considered for inclusion in future editions of the DSM.
- **DSM** stands for *Diagnostic and Statistical Manual of Mental Disorders*. It is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.

Description

Internet addiction disorder is extreme computer usage and preoccupation with computer usage that consumes a considerable amount of time and negatively affects personal functioning. Computer usage can include Internet access but does not have to. There are several types of Internet or cyber addiction. Cybersexual addiction entails watching, downloading, or exchanging online pornography. It also includes acting out sexual fantasies in chat rooms. Cyber-relational addiction occurs when online relationships become consuming and take precedence over real relationships. It may also occur when an individual has an online affair. Net compulsion involves excessive online gambling, shopping, or stock market transactions that result in personal, monetary, or work-related distress. Information overload (addiction) is compulsive web searching for the collection of information. Internet gaming disorder is excessive Internet usage to play games. The inability to control or cut down on game time leads to distress in important areas of life. Internet addiction disorder is not a DSM-5 mental disorder. Although Internet gaming disorder is not currently designated as a mental disorder, it can be found in the DSM-5 under the section labeled "conditions for further study" (American Psychiatric Association, 2013).

The cause is not well understood. However, it may be that a combination of biological, psychological, social, and cultural factors play a role in this disorder. Biological influences may involve problems with serotonin and dopamine neurotransmitters. Psychological causes may include maladaptive thoughts, low self-esteem, and low self-efficacy. Additional psychological factors are comorbid psychiatric disorders such as depression, anxiety disorder, or impulse disorders. Inadequate social skills or a lack of social competence may contribute to this disorder. Cultural influences include where an individual lives. Computer and Internet access is readily available in many developed countries. Poor countries have very little, or no, technology availability.

Treatment

A comprehensive assessment is necessary to differentiate problematic computer usage from normal usage. Treatment may consist of cognitive behavior therapy (CBT), self-help groups, and/or medications. CBT is commonly used to treat various addictions, including this disorder. Self-help groups and Twelve-Step Programs can also be helpful and is commonly used in conjunction with CBT. Medications may involve antidepressant and antianxiety medications.

Len Sperry, MD, PhD, and
Christina Ladd, PhD

See also: Addiction; Addiction Counseling; Self-Help Groups; Twelve-Step Programs

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Internet-Based Therapy

Internet-based therapy is a form of psychotherapy accessed via telephone, cellular phone, or the World Wide Web.

Definitions

- **Browsing** means using a web browser such as Internet Explorer, Safari, or Firefox to access the Internet.
- **Internet** is the global communication network that allows almost all computers worldwide to electronically connect and exchange information.
- **Online** means to be on the Internet or to access through the Internet.
- **Protocols** are computer languages used to send and receive information via the Internet, such as the World Wide Web (www) for online browsing, or SMTP for e-mail.
- **Web based** refers to applications that are delivered online via the Internet.
- **Web browsers,** or browsers for short, are computer-based applications that make access to the World Wide Web possible and user friendly through the World Wide Web protocol.
- **World Wide Web** (WWW), or web for short, is most often used as a synonym for the Internet but is actually the protocol a computer uses to access the Internet. The WWW is just one way to use the Internet.

Description

The widespread use of the Internet and the advancement of affordable computer software, hardware, and telecommunications technologies have led to new methods of delivering online psychotherapeutic services. Online mental health services are an emerging form of psychotherapeutic intervention and consist of two broad types of delivered services. The first is web-based interventions, which provide content that may be educational, such as information about a particular mental health disorder, or an interactive application, such as filling out self-assessments that lead to more detailed and specialized information. The second way in which mental health services may be provided

is through real-time interactive online videoconferencing, that is, a video counseling session.

Web-based interventions include self-guided educational, self-guided therapeutic, and human-supported therapeutic interventions. Web-based educational interventions are self-guided online programs accessed through specific websites. The interventions are content focused and provide varying degrees of automated feedback but no human-supported guidance or feedback. These interventions attempt to create positive change by increasing knowledge, awareness, and understanding. For instance, someone suffering from anxiety searches the Internet and finds a website that contains a broad description of the different types of anxiety disorders. The individual fills out an online questionnaire, which indicates he or she may suffer from a social phobia. Upon clicking that link the individual is able to access more detailed information, including treatment options for social phobias. Web-based, self-guided therapeutic interventions add comprehensive, theory-based, highly structured interventions modeled on effective face-to-face treatment. For instance, the individual suffering from a social phobia would be provided a structured learning module focused on understanding cognitive behavioral dynamics, learning how thoughts are related to feelings and behaviors. These interventions can be quite sophisticated in providing automated feedback tailored to specific responses to instructions. Human-supported web-based interventions incorporate a human, usually a mental health professional, to provide support, guidance, and feedback.

Online counseling and therapy is provided by mental health professionals and may include individual or group contact and can be provided in real time or in a nonlinear time frame. Online counseling may be primarily textual, such as a private chartroom, or video conferencing face to face. Real-time video counseling is provided via teleconferencing applications. Nonlinear counseling may be provided via e-mail or text post. There are advantages and limitation to both forms of online counseling. Advantages included flexibility in time and location, and reduced cost. Limitations include the ability for clients to conceal their true identity or impersonate an individual; difficulty providing emergency assistance if needed; difficulty in expressing accurate emotions in text-based therapy; cultural misunderstandings; and difficulties in billing and fee collection.

Current Status

Because Internet-based treatments are still relatively new and therefore have not been standardized, it has been difficult to measure their outcomes with consistency or certainty. However, early research indicates that Internet-based therapy is an effective change agent. Studies have indicated that an empathic and warm therapeutic relationship can be created and maintained and that online counseling sessions have a substantial and positive impact on clients. Research also indicates that Internet-based therapy in the treatment of addictions, mood disorders, and other mental health difficulties results in positive behavioral changes.

Steven R. Vensel, PhD, and Alexandra Cunningham, PhD

See also: Psychotherapy; Self-Help Groups

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Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy (IPT) is a type of insight-oriented talking therapy shown to be effective in the

treatment of a variety of mental health disorders, including depression, anxiety, and eating disorders.

Description

Interpersonal psychotherapy is grounded in attachment theory and communication theory. The focus of IPT is on interpersonal issues that are factors in the creation and maintenance of psychological distress. Targets of intervention include symptom reduction, improved interpersonal functioning, and increased social support. A typical course of treatment is from 6 to 20 weekly psychotherapy sessions.

Development

Interpersonal psychotherapy was developed in the 1970s at Yale University by psychiatrists and researchers Gerald Klerman (1928–1992) and Myrna Weissman (Weissman, 2006). Both Klerman and Weissman treated patients with depression and anxiety disorders. Finding that many patients being treated for depression with tricyclic antidepressants relapse after they stopped taking the medication, the researchers began to investigate the impact of psychotherapy in the prevention of relapse. Research studies of psychotherapy at the time (1970s) were limited in size and scope, and few studies included diagnostic criteria for depression or standardized outcome measures. Their research models addressed these issues and included the development of a standardized form of psychotherapy used in the clinical trials of maintenance treatment. IPT was influenced by psychodynamic, person-centered, and cognitive psychological theories. The psychotherapy they developed was manualized, meaning that the specific process was written down and followed by each of the psychotherapists treating patients in the clinical trial. Manualized treatment assures that all of the patients received the same psychotherapy no matter which psychotherapist provided the treatment. The manualized psychotherapy was initially modeled from supportive psychotherapy as might be delivered by clinical social workers. As the treatment was more fully developed, it was renamed interpersonal psychotherapy. Further clinical trials were conducted and found that a combination of medication and IPT was the most effective treatment for depression. Since those early clinical trials, IPT has been found to be effective in the treatment of a wide variety of mental health disorders, with people of all ages and from diverse populations.

Current Status

Interpersonal psychotherapy is based on the premise that psychological distress and symptoms are associated with a person's social and interpersonal relationships (Weissman, 2006). IPT was developed on a model of psychological distress referred to as the "Interpersonal Triad." The Interpersonal Triad consists of (1) an acute interpersonal crisis or stressor, (2) biopsychosocial vulnerabilities, and (3) social factors.

Interpersonal crises consist of a variety of mood states such as depression, anger, and anxiety, and other psychological distresses. The ability of a person to manage psychological distress is impacted by biopsychosocial vulnerabilities which consist of genetic vulnerability to illness, personality, temperament traits, and attachment style, all of which may contribute to, or diminish, symptoms. Social factors such as marital and family relationships, friendships, work relationships, religious membership, and other social support systems provide the context of the interpersonal psychological distress. In addition, communication patterns between social systems can impact the level of distress.

The linking of psychological distress to interpersonal conflicts and social relationships is a key focus of IPT. Psychotherapeutic elements of IPT include talking about interpersonal incidents, communication analysis, processing emotions, and role-playing. IPT is a here-and-now approach grounded in a strong therapeutic alliance between the client and therapist. Collaboration, consensus on goals, and positive regard expressed toward the client are key therapeutic components. Treatment goals include the identification of emotions, understanding where the emotions come from and why they exist, and the healthy expression of emotion. Treatment also includes linking current emotional functioning to "emotional baggage." Emotional baggage includes unresolved issues from past relationships and learned behavioral responses from childhood. IPT is appealing to clients who may find

psychodynamic therapy confusing and cognitive behavior therapy too demanding.

Interpersonal psychotherapy is an evidence-based practice that has demonstrated effectiveness in the treatment of a variety of mental health disorders. It is also effective in helping individuals recover from distress caused by interpersonal conflicts, grief, role transitions, and lack of social support.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy

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Interpretation of Dreams, The (Book)

A classic work by psychoanalyst Sigmund Freud (1856–1939), *The Interpretation of Dreams*, published in 1900 in German, introduced the theory of the unconscious mind (id, ego, superego) and its impact on behavior.

Definitions

- **Dream analysis** refers to the process of assessing a dream's manifest and latent content to uncover its true meaning; Freud believed dreams to be "the royal road to the unconscious."
- **Oedipus complex** refers to the controversial concept proposed by Freud that describes a child's repressed sexual desire for his or her parent of the opposite sex.
- **Psychoanalysis,** developed by Freud, is both a theory and an approach to treatment that ascertains that people's thoughts, feelings, and behaviors are influenced by unconscious thoughts and the only way to resolve these conflicts and psychological well-being arises from bringing unconscious thoughts into awareness and making them conscious.

Description

The Interpretation of Dreams, literally *Die Traumdeutung* in German, is considered the most famous original work written by psychoanalyst Sigmund Freud. Freud is known to have revised the book at least eight times developing core psychoanalytic concepts, including the unconscious mind, dream analysis, and the foundations of what would later be referred to as the *Oedipus complex*. It was translated from German into English by psychoanalyst A. A. Brill in 1913; later translations by James Strachey and Joyce Crick followed. Though it took a few years to sell 600 copies in its first edition, the text grew in popularity in subsequent editions. Seven editions were published over Freud's lifetime, the final in 1929. Following the 1900 release of *The Interpretation of Dreams*, Freud wrote a more concise version of the book called *On Dreams* published in 1901.

Freud began writing *The Interpretation of Dreams* in 1895 while summering at manor Belle Vue near Grinzing, Austria, and later referred to the importance of the book in a letter to his contemporary Wilhelm Fliess in 1900. Dream interpretation sought to uncover, in Freud's words (1913), "the royal road to the unconscious." Dreams thus contain both manifest (surface) and latent (hidden) content. In Freud's estimation, dreams were forms of wish fulfillment, revealing unresolved conflicts that get pushed down in everyday life yet expose themselves in masked forms when one is in the dream state. Freud reached this conclusion after dreaming his own dream, commonly known as "Irma's Injection" on July 23, 1895. Attributing meaning to dreams, however, requires the careful analysis

of a trained psychoanalyst. Freud regularly conducted dream interpretation on himself as well as others, providing what he believed to be countless examples of this phenomenon. The process consists of a period of free association, listening, and questioning, followed by careful analysis incorporating what is known about the patient's past and present.

Impact (Psychological Influence)

Most people cite *The Interpretation of Dreams* as classic Freudian text that provides the basis for dream interpretation. Though it took several years to gain popularity, it has since been translated into multiple languages and is a common source used in psychology, psychiatry, and counseling courses. Freud, however, has been criticized for his claims as well as for the credibility of the evidence he provided in support of his dream theory; most of the case studies he referenced were his own patients or himself. Furthermore, his views and interpretations have been regarded as misogynistic and highly focused on sexual aspects.

Melissa A. Mariani, PhD

See also: Dreams and Dream Interpretations; Freud, Sigmund (1856–1939)

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Intervention

Intervention is a type of confrontational technique used to persuade someone to seek psychological or medical treatment. The term "intervention" also means a course of action or protocol provided for a person in treatment.

Description

In the mental health field an intervention often refers to a carefully planned process where family, friends, work colleagues, or psychological professionals confront a person struggling with an addiction, most commonly alcohol or drugs. In an intervention an ultimatum or choice is offered the person with an addiction to either seek treatment or that he or she will no longer receive support from loved ones. By talking directly to the person about the consequences of addiction for him or her and for his or her circle of friends and family, it is hoped that he or she will agree to enter a treatment program. Confrontational therapies were once in widespread use by psychologists and other health-care professionals in the United States. Over the past 20 years these techniques have not been as popular as more collaborative therapies. This is due to the harsh nature of the procedures and because research with people abusing substances seems to show that confrontational approaches have been less effective in rehabilitating them than other therapeutic methods.

Development (History and Application)

During the 1940s and 1950s, Dr. Harry Tiebout observed patients in treatment for alcohol abuse. His observations resulted in the recommendation to utilize confrontation and confrontational therapies with this population of patients. Dr. Tiebout believed that an alcoholic was incapable of accurately understanding and perceiving himself or herself. He claimed the defense mechanisms these patients demonstrated led them to justify their alcohol abuse in order to protect their self-esteem. This meant that the task of the therapist or mental health professional would be to help them reconstruct their personality and defense mechanisms. The goal with confrontational therapy was to have the patient surrender to the reality of the disease and then accept the need for the development of a new way of life.

Treatment for alcohol and substance abuse and addiction was spearheaded in Minnesota. In the 1970s the Reverend Vern Johnson developed the idea of family intervention. In this intervention a group of loved ones would confront an addict with the harsh effects of the

addiction on him or her and the community. This served as a reality check and an invitation to seek treatment. Family intervention received positive nationwide publicity when it was used by the Ford family to successfully confront the addiction problems experienced by First Lady Betty Ford. The intervention approach has been criticized for its all or nothing, confrontational approach and for the fact that it many times has not shown effective results. In the past 30 years more gentle approaches have been applied with greater success as evidenced by lower levels of recurring addiction.

Current Status

Intervention and confrontational techniques in therapy, when properly and non-abusively applied, can still be an effective way to reach out to help someone who is suffering. But like many other popular and utilized treatments in substance abuse and addiction, intervention has a low success rate for helping a person abstain from his or her drug of choice. The use of confrontation in intervention and more generally in addiction treatment was not based on any research that showed its effectiveness. Family education about addiction remains important and is an integral part of such family support. More research needs to be done in the area of long-term effectiveness of pretreatment interventions and confrontational therapies when applied to drug and alcohol abusers in order to develop effective alternative treatments.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Addiction; Addiction Counseling; Substance Abuse and Related Disorders; Substance Abuse Treatment

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Intimacy

Intimacy is the experience of emotional and physical closeness with another person.

Description

Intimacy involves activity in close interpersonal relationships. Intimacy is often associated with romantic relationships. However, the idea of intimacy readily applies to any type of relationship, whether it is romantic, family, or friendship. It is considered to be a process since it develops over a period of time. Many believe it to be a deep, biological need. Humans by nature are social beings and have a need for comfort and connection with others. The extent of this need often varies based on the individual.

In relationships, intimacy involves one partner's need to care about and be close to other as well as the fear of being vulnerable. The most critical part of intimacy is the ability and willingness to open oneself up to another. This includes exploring and sharing feelings, thoughts, insecurities, and vulnerabilities. The level of intimacy within a relationship is strongly rooted in trust. The person must have a feeling of safety to share these things with the other. This sharing allows for the person to feel close and connected to the other person in the relationship. On any given day multiple attempts are made by individuals toward achieving or maintaining intimacy at home, school, or even work. The level in which they may be looking to connect varies based on the type of intimacy and the individual.

Intimacy has several major components. These include nonverbal and verbal communication, presence, time, and boundaries. There are also several different types of intimacy, including intellectual, emotional, experiential, and sexual.

Current Status

The topic of intimacy holds importance to multiple fields. In psychology it connects into relationships and even developmental theory. Erik Erikson (1902–1994), an American psychologist, spoke of the importance of intimacy in his psychosocial stages of development. Erikson spoke of the important developmental

component of being able to share oneself with another human being whether it is in a romantic or platonic format. Failure to achieve intimacy in some capacity leads to the risk of isolation for the individual.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Couples Therapy; Erikson, Erik (1902–1994); Psychosocial Development, Stages of

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Introversion

See Extraversion and Introversion and Personality Type

Involuntary Hospitalization

Involuntary hospitalization is the legal process whereby individuals are placed in inpatient mental health treatment against their will because they are a danger to themselves or to others.

Definitions

- **Disability** is a physical or mental impairment that substantially limits one or more of the major life activities of an individual.
- **Mania** is a mental state of expansive, elevated, or irritable mood with increased energy or activity.
- **Psychotic features** are characteristics of psychotic disorders: delusions, hallucinations, disorganized thinking and speech, grossly disorganized or abnormal motor behavior, and negative symptoms, for example, lack of initiative and diminished emotional expression.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

Description

Involuntary hospitalization involves placing individuals in inpatient treatment against their will. This is done through a court order and is sometimes referred to as civil commitment. The process is used for those who are dangerous to themselves or to others. It is also used for individuals who are unable to care for themselves and are without proper judgment. This may be due to a mental disorder, disability, or plans to commit suicide. This includes individuals with substance-related disorders and those who exhibit mania or psychotic features. The assumption behind involuntary hospitalization is that forced treatment is better than no treatment at all. Most states in the United States have some form of involuntary hospitalization law. These vary but generally require that there is proof of individuals' dangerousness and that the risk is immediate. The procedure can be initiated by those close to the individuals, such as a family member, friend, or doctor. Law enforcement officials are commonly called to assess the initial danger. If they determine that the individuals are at risk, then they will take the individuals into custody. This is followed by a psychiatric evaluation by mental health professionals in a hospital. There is generally a court hearing 24 to 72 hours after hospitalization to determine if the individuals are still a risk to themselves or others. This is to make sure that their rights are not violated and they are not unnecessarily detained. A judge may extend the length of the commitment or order a release depending on information provided by the mental health professionals.

Involuntary hospitalization is a controversial practice. Some argue that it goes against basic civil rights and deprives individuals of their freedom. It one of the few ways an individual can be denied liberty in a free society. Others believe that the benefits of this process far outweigh the risks. Supporters of involuntary hospitalization maintain that it is necessary for those who cannot care for themselves. They also hold that it protects society from potential dangers.

George Stoupas, MS, and
Len Sperry, MD, PhD

See also: Disability and Disability Evaluation; Hospitalization; Mania; Substance-Related and Addictive Disorders

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J

James, William (1842–1910)

William James was a major influence on the modern views of cognitive neuroscience. He wrote extensively on many subjects still studied in modern psychology, including attention, emotion, and perception. Though he was one of America's first psychologists, history generally views him as a philosopher.

Description

By the 1890s, James was established as the foremost American philosopher. He popularized pragmatism as a new philosophy. Pragmatism is what allows us to consider the practical effects of an idea when giving it meaning. Through his ideas, James coined the now widely used expression "stream of consciousness." His writings on the subject brought the idea of consciousness into focus. Though James did most of his work in the 19th century, his philosophy was influential and his work is still cited extensively today.

James had many interests and studied many subjects early in his life. He finally decided to pursue medicine and earned his degree in 1869. He taught physiology at Harvard and in 1875 taught the first course in psychology in America. James was a gifted teacher and a good communicator, and his lectures were well attended. Students found him charming and appreciated his friendliness and interest in them as people.

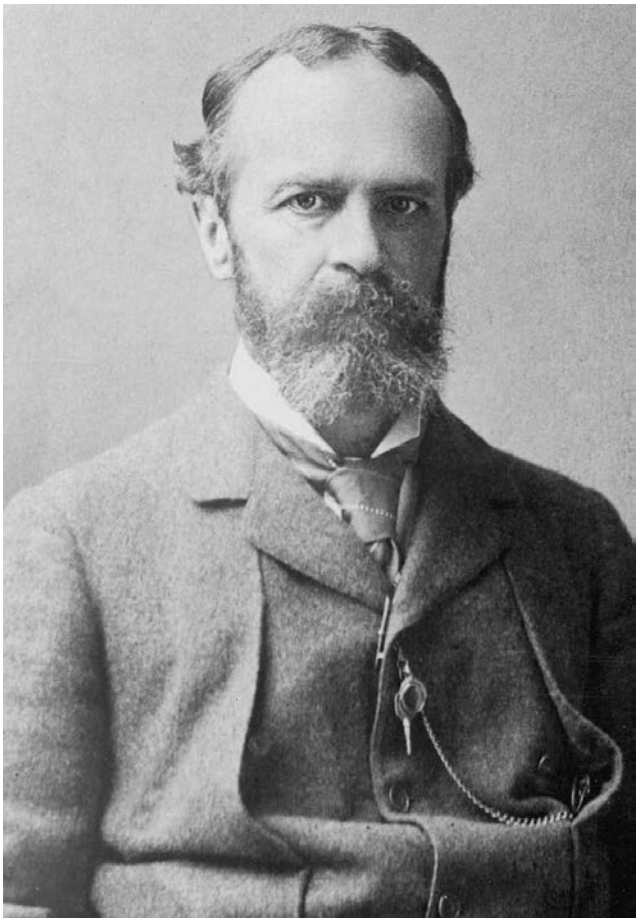
Impact (Psychological Influence)

One of James's major influences was how we look at psychology today. His book *Principles of Psychology* (1890) was one of the first to treat psychology as a science. He had many groundbreaking theories, including the belief that ideas are neither completely true nor completely false, because the universe is open ended and fluid. This principle became part of his functional psychology and philosophy of pragmatism.

Darwin's theory of evolution greatly influenced James's own work. James introduced and made popular the concept of habit as the main governing principle of an individual's mental organization. He wrote that humans, like animals, adapt to their ever-changing environment, and their behavior is controlled by habit. As the world changes, habits begin to break down and people must use consciousness to reestablish their connection to their surrounding environment. This interaction with the environment leads to experience. James's idea about the principle of habit is one of his most important and influential.

His work on brain function pointed to the division between short-term and long-term memory, 50 years before the idea was established as an accepted belief. He defended free will as a concept rather than that of a deterministic principle at work in the universe. Free will allows for the human condition to improve rather than staying locked into repeating the past. His work also established instinct as essential to the study of the human mind. It was his writings that brought instinct to the forefront of psychology.

His philosophy had an influence over other fields, including physics. He put forth that truth is what is experienced by the observer, and because of this, an objective truth is not possible. This concept is still accepted by physicists. In addition, James made a major contribution to education. He believed the study of psychology influences how teachers teach. Psychology itself is a science, while teaching is an art made up of



William James had a major impact on modern views of cognitive neuroscience. He wrote extensively on many subjects still studied in modern psychology, including attention, emotion, and perception. (Paul Thompson/FPG/Getty Images)

many different aspects. Effective teachers know psychology, though there are other skills required as well.

James even had an impact on religious thought. He wrote that religious belief should come from experience and not simply from what the church says. Many New Age churches have incorporated this idea into their teachings. A prolific writer, James's books include *Principles of Psychology* (1890), *Text-book of Psychology* (1892), *The Will to Believe* (1897), *Talks to Teachers on Psychology* (1898), *Human Immortality* (1899), *The Varieties of Religious Experience* (1902), *Pragmatism* (1907), *A Pluralistic Universe* (1908), and *The Meaning of Truth* in 1909.

James's ideas laid the foundation for modern psychology in areas such as emotions and brain function. Today, his conclusions are still stimulating contemporary research and debate in a variety of disciplines.

Mindy Parsons, PhD

See also: Principles of Psychology, The (Book); Psychologist

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Journaling/Journal Therapy

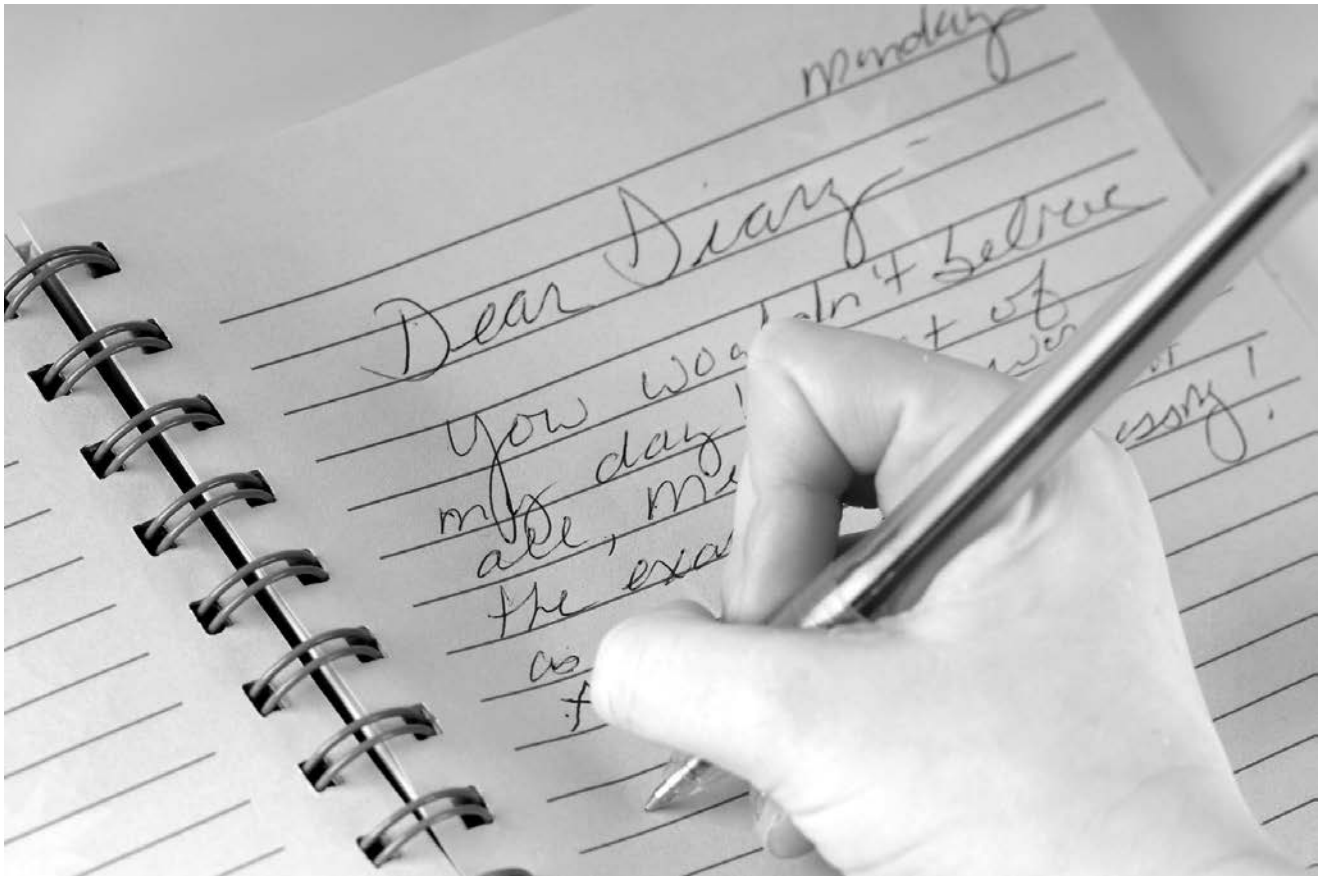
Journaling is a writing process used to openly express one's thoughts and feelings, reduce anxiety, and/or to produce greater self-awareness.

Definition

- **Online journaling** is an expressive writing technique where one accesses a journal via the Internet or other computer program to write about one's thoughts, feelings, ideas, problems, and goals.

Description

Journal therapy, also referred to as "writing therapy" or "reflective therapy," is a particular type of journaling used within the therapist–client relationship in which the counselor provides the client with specific directions, prompts, or guided writing exercises as a means of helping him or her achieve certain therapeutic goals. Journaling describes when an individual writes down his or her ideas, thoughts, and feelings on paper for the purpose of emotional catharsis, gaining clarity, or working through a particular problem. Journal entries are often kept in a recording device referred to as a journal. Journaling can be done individually or in groups. One may begin journaling on one's own, without the direction or urging of another, or one may



Journaling is a writing process used to openly express one's thoughts and feelings, reduce anxiety, and/or produce greater self-awareness. (Cheryl Casey/Dreamstime.com)

be required to journal as part of a teaching or counseling experience. When journaling is used as a means of therapy, it should be done only under the direction of a licensed or certified mental health professional with training or experience in this technique. Journal therapy describes a therapeutic process whereby the counselor instructs his or her client to engage in journaling to help accomplish some of the goals set in therapy. A client may be told to respond to specific prompts within the therapy session itself, or the client may be asked to write about his or her experiences between sessions. Journaling can provide the client with insights or observations about his or her own thoughts, feelings, and behavior patterns. In addition, it can assist the therapist in determining what progress has been made and in gauging what steps to take next. Therapists are cautioned against using journal entries as part of their analysis. Rather, journaling should be used as an additional source of information that can prompt discussion.

Journaling is a positive coping mechanism that can provide one with both mental and physical health benefits. One can use journaling to gain insight and mental clarity, or develop a deeper sense of personal awareness. It can also help to motivate a person to change negative behavior patterns or achieve a goal. The process of physically writing something down makes the goal more tangible and provides a measure of accountability. Keeping a journal can also help relieve stress or anxiety. In addition, journaling can help to repair relationships when it is used in family, couples, or marital counseling.

Development

Though journal writing has been around for centuries, journaling as a therapeutic technique gained

popularity in the 1960s by psychologist Dr. Ira Progoff. His method of intensive journal writing was used to develop a "psychological notebook" documenting his clients' lives over the course of several years. Some key books published during the late 1970s further popularized journal writing in mainstream culture, *At a Journal Workshop* by Dr. Progoff, *One-to-One: Self Understanding through Journal Writing* by Christina Baldwin, and *The New Diary* by Tristine Rainer. Journaling began to be incorporated into education during the 1980s, with many teachers noting the benefits of this practice with increasing students' comprehension, writing, and critical thinking skills. The added benefit of reducing anxiety and stress was also noted. Later studies by Dr. James Pennebaker in Texas confirmed these health benefits. In the late 1980s, psychotherapist Kathleen Adams provided education and workshops on the power of journaling to the general public at the Center for Journal Therapy in Colorado.

Current Status

Journal therapy has been used effectively with individuals suffering from grief and loss, relationship issues, anxiety disorders, coping with health problems and chronic illness, and addiction issues. Certified instructors in journal therapy are now available throughout the United States and several other countries. They typically hold advanced degrees in psychology, mental health counseling, social work, or other related helping professions. Advancements in the area include online journaling, which now allows for this technique to reach a wider range of people.

Melissa A. Mariani, PhD

See also: Psychoeducation; Psychotherapy

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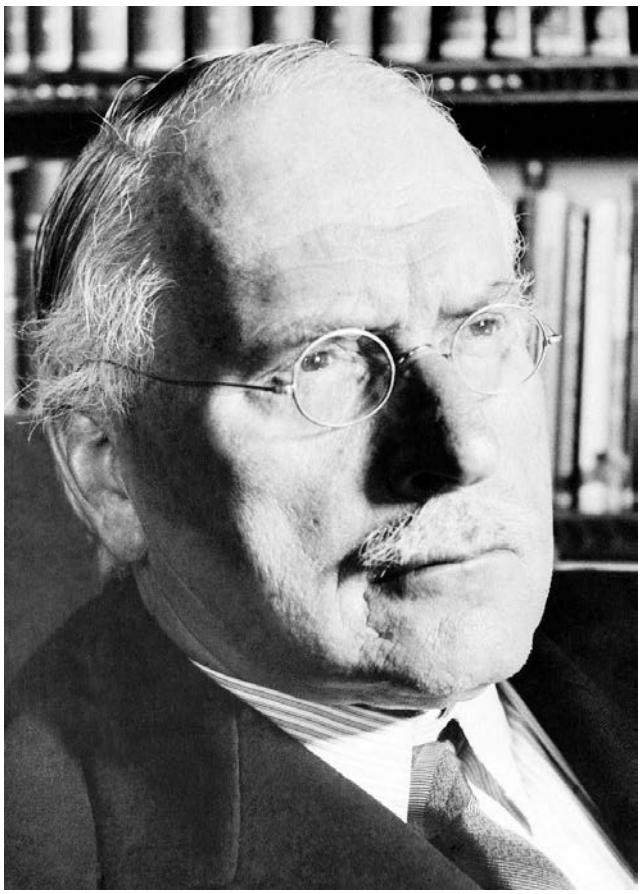
Jung, Carl (1875–1961)

Carl Gustav Jung (1875–1961) was a Swiss-born psychiatrist and psychotherapist who is recognized as the founding father of analytical psychology. A practicing clinician and scientist, Jung focused on spirituality and religiousness. He is most commonly known for proposing and developing many psychological concepts that remain relevant even today. These concepts include extraversion and introversion, archetypes, the collective unconscious, psyche, collective unconscious, anima and animus, complex, individuation, and synchronicity. He also contributed significantly to dream analysis and symbolization, as well as personality typology.

Spirituality and creativity were two deeply held concepts by Jung. In fact, he wrote about the collective patterns of symbolic expressions in his memoir



Carl Gustav Jung was a Swiss-born psychiatrist and psychotherapist who is recognized as analytical psychology's founding father. He is perhaps best remembered in popular culture for his work on archetypes. (AP Photo)

Memories, Dreams, Reflections. He believed that meaning can be expressed by those who are living a symbolic life and a life that is meaningful.

Jung saw the human psyche as religious by nature and so made religiousness the focus of his explorations. He spent considerable time exploring areas such as Eastern and Western philosophy, alchemy, astrology, sociology, literature, and the arts.

Upon entering his university studies, Jung chose to study medicine. During his studies, he stumbled upon a psychiatric textbook, which led to his belief that psychoses are diseases of the personality. Combining the biological and spiritual immediately captured Jung's interest. His training in psychiatry began at the world-renowned Burghölzli clinic in Zurich. This particular medical clinic was known for factoring in social and biological research in the treatment of psychiatric issues. At the clinic, Jung's research focused on the study of the phenomena of conscious as part of a spectrum, including dissociation, trance states, and splitting. Jung's research on the complex behavior patterns that he showed could be revealed through word associations led to his first taste of international fame.

Jung was born the fourth, but only surviving child of a poor rural pastor in the Swiss Reformed Church and the daughter of a wealthy Swiss family. He was a solitary and introverted child who was convinced from childhood that, like his mother, he had two personalities. The first was that of a typical schoolboy living in the era of the time. The second was a dignified, authoritative, and influential man of the past.

In 1903, he published a dissertation on the psychology and pathology of the occult phenomena. In 1906, he published his book *Studies in Word Association*, a copy of which he later sent to Sigmund Freud, sparking a six-year friendship with the famous psychologist. Jung and Freud bonded over their work on dreams and unconscious phenomena. Ultimately, Jung led the development of psychoanalysis and was the first president of the International Psychoanalytic Association, at the request of Freud. After the two split over theoretical differences, Jung again focused on his consciousness research, including the development of individuality through increased self-awareness. However, one of Jung's biographers asserted that Jung never recovered from his traumatic break with Freud. In fact, Jung states in his own words in *Memories, Dreams, Reflections* that the break was traumatic and led to a profound disorientation that was further complicated by psychosis.

In 1908, Jung became an editor of the *Yearbook for Psychoanalytical and Psychopathological Research*. He traveled with Freud and Sandor Ferenczi to the United States in 1909 to speak about psychoanalysis and in 1910 he became chairman for Life of the International Psychoanalytical Association.

In 1912, Jung published *The Theory of Psychoanalysis* and his *Psychology of the Unconscious*. The latter resulted in a theoretical divergence with Freud, which consequently fractured their friendship. He was drafted into the army in World War I.

At the age of 38, Jung experienced what he called a horrible confrontation with the unconscious. He saw visions and heard voices. Deciding it was a valuable experience, he induced hallucinations in private. He recorded everything he felt in small journals. He then transcribed his notes into a large, red, leather-bound book, on which he worked intermittently for 16 years.

In 1925, Jung embarked on the ambitious Bugishu Psychological Expedition to East Africa. Together with a group of three others, he traveled through Kenya and Uganda where Jung hoped to increase his understanding of primitive psychology through conversations with the culturally isolated residents.

In 1937, he took an extensive tour of India where he felt himself under the direct influence of a foreign culture for the first time. Hindu philosophy became an important element in his understanding of the role of symbolism and the life of the unconscious. Jung had a close relationship with the Chinese religions of Buddhism and Taoism. Jung offered several valuable concepts and ideas to Western psychology of spirituality that were based on Chinese religious characteristics.

Jung died at the age of 85 in his home at Keusnacht, Switzerland, after a short illness. He is remembered and still revered in the fields of psychology, psychoanalysis, and psychotherapy. He is remembered as one of the pioneers of contemporary dynamic psychiatry and physiological research in consciousness and self-regulation.

Mindy Parsons, PhD

See also: Jungian Therapy

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Organization

The International Association of Jungian Studies

The IAJS is a multidisciplinary association dedicated to the exploration and exchange of views about all aspects of the broader cultural legacy of Jung's work and the history of analytical psychology.

Website: http://jungianstudies.org

Jungian Therapy

Jungian therapy was developed by Carl Jung (1875–1961). "Jungian therapy" is the common term for analytical psychology, which was the term Jung used to describe his theory and approach to psychology. This term was used to differentiate his theory and practice from Sigmund Freud's form of psychotherapy commonly known as psychoanalysis. Jung and Freud collaborated for several years until a rupture in their relationship over theoretical differences drove Jung to develop his own theory.

"Jungian therapy," "Jungian psychoanalysis," and "Jungian analysis" are terms frequently used interchangeably. Jungian therapy is a form of therapy in which the client ideally progresses toward psychological balance and wholeness. The goal of psychoanalysis is to bring the patient awareness and understanding of what was formerly unconscious. This is achieved by directing therapeutic efforts at bringing the psyche's conscious and unconscious elements into a better alignment and balance. In contrast, the aim of therapy is often symptom relief.

When a client progresses toward psychological balance and wholeness, the result is the creation of new values and purposes. The process can be used to treat a broad range of emotional disorders and can also help anyone who wants to pursue psychological growth. This form of therapy requires intensity and regularity. For example, the frequency of sessions is decided between the analyst and the patient but can range anywhere from one to four or more times a week. Typically, it extends over a period of several years.

Each session focuses on patients' experiences in their daily lives, their memories, their feelings and reflection of such experiences, their dreams, or other forms of expression. The therapy explores a number of aspects of the psyche. The psyche is often defined as the sum total of all psychological processes, including those that are conscious and those that are unconscious. At the center of consciousness is the ego, while the self is at the center of the psyche, which comprises both consciousness and unconsciousness. Jungian analysis and therapy moves beyond the ego to establish a relationship between the ego and the self.

Jung also defined the inner feminine side of a man—the anima—and the inner masculine side of the woman—the animus. These two archetypes in the unconscious often appear in dreams and fantasies. When we become conscious of these inner contra-sexual figures, their energy opens us to new areas of thinking, feeling, and expression. When these figures remain unconscious, they sabotage our efforts for growth and fulfillment. The Jungian therapist works with the patient to identify these archetypes to ensure the person can find balance.

Jungian analysis requires a significant commitment of time and resources as sessions can be once a week or four or more times per week. Each client is different and so the frequency is determined by the analyst and client based on individual needs and presentation. In addition to the frequency, Jungian analysis can extend over a period of several years or more.

Jung was a Swiss-born psychiatrist and psychotherapist who is recognized as the founding father of analytical psychology. A practicing clinician and scientist, Jung focused his attention on spirituality and religiousness. He is most commonly known for proposing

and developing many psychological concepts that remain relevant even today. These concepts include extraversion and introversion, archetypes, the collective unconscious, psyche, collective unconscious, anima and animus, complex, individuation, and synchronicity. He also contributed significantly to dream analysis and symbolization, as well as personality typology.

In 1903, he published a dissertation on the psychology and pathology of the occult phenomena. In 1906 he published his book *Studies in Word Association*, of which he later sent a copy to Sigmund Freud, sparking a six-year friendship with the famous psychologist. In 1912, he published *The Theory of Psychoanalysis* and his *Psychology of the Unconscious*.

Since the 1990s, Jungian therapy has been the focus on many empirical studies aimed at proving its effectiveness in treating emotional disorders and psychoses. As such, there is evidence of the positive effects of this approach. It has been shown to lead not only to a significant reduction of symptoms and of interpersonal and other problems, but also to a restructuring of the personality with the effect that the patients can deal with upcoming problems much better after therapy has ended. The effects of the therapy appear to be long lasting and touch all areas of a patient's life.

Mindy Parsons, PhD

See also: Jung, Carl (1875–1961)

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Website: http://jungianstudies.org/

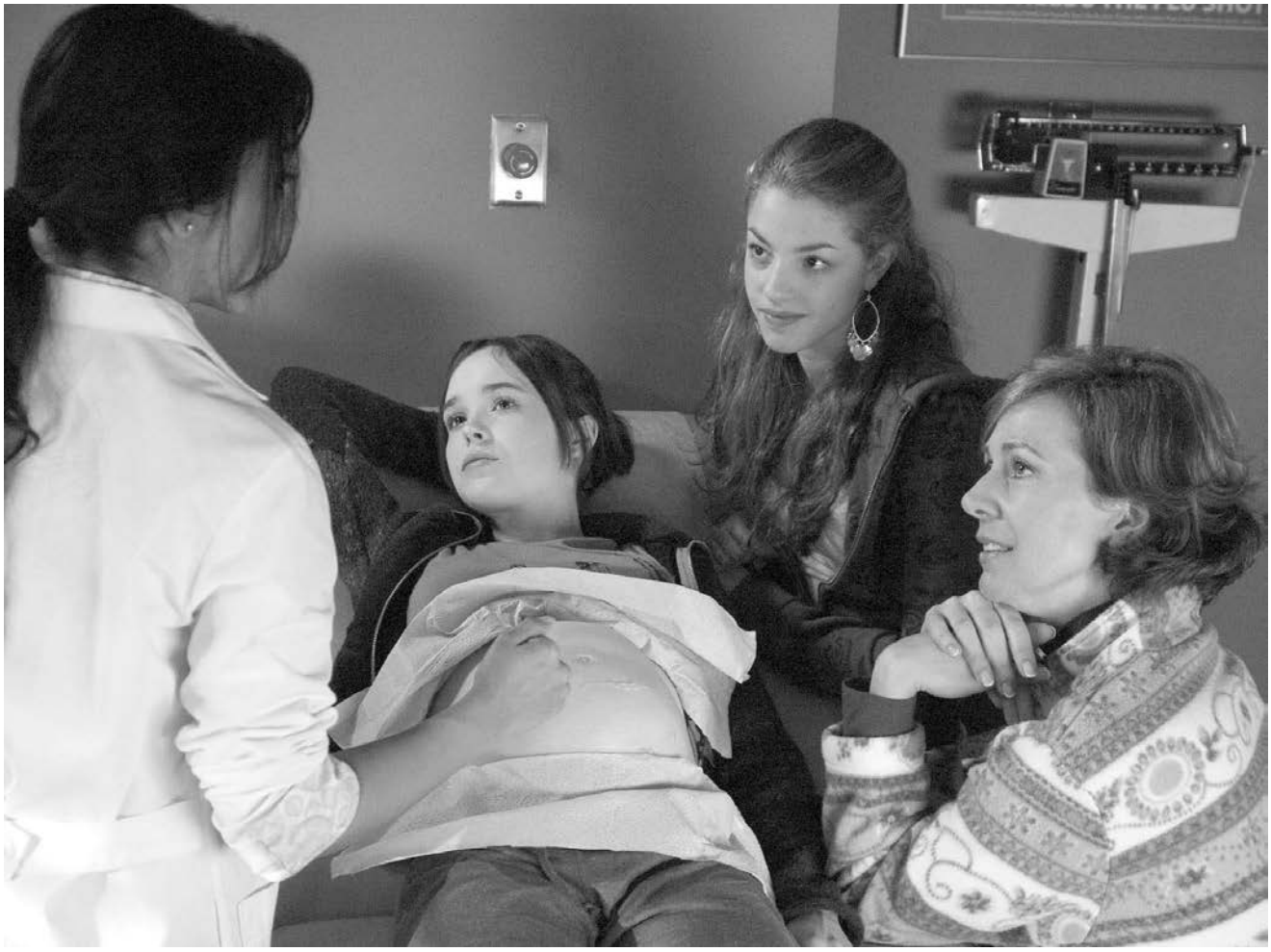
Juno (Movie)

Juno is a Canadian American comedy-drama feature-length movie starring Ellen Page.

Description

Juno is a 2007 Canadian American comedy-drama starring Ellen Page, Michael Cera, Jason Bateman, Jennifer Garner, J. K. Simmons, and Allison Janney. *Juno* was directed by Jason Reitman and written by Diablo Cody. *Juno* is the story of a 16-year-old Minnesota high school girl coping with her unplanned pregnancy. The story follows Juno's relationship with her boyfriend, parents, school friends, and the adoptive parents of the yet-to-be-born child. *Juno* is best known for its depth of writing and characters, Juno's wisecracking and sardonic character, comedic dialogue and one-liners, poignancy, and excellent acting, especially that of Ellen Page. Themes include teen pregnancy, woman's choice, adoption, coming of age, romance, family, and authenticity.

The story opens with Juno (Ellen Page) finding out she is pregnant after having sex with her best friend Paulie Bleeker (Michael Cera), an introverted admirer of Juno. After considering abortion, Juno decides to keep the baby and find a couple for adoption. She tells her father Mac (J. K. Simmons) and stepmother Bren (Allison Janney) who are supportive, wise, earthy, intelligent, and pragmatic of her plan to give the child up for adoption. With the help of her father, Juno finds an adoptive couple, Mark and Vanessa Loring (Jason Bateman and Jennifer Garner), a middle-class couple who live in an expensive neighborhood and are unable to have children of their own. They are stereotypic yuppies, with Vanessa being somewhat materialistic and consumed with being a mother. Mark, pushing 40 years old, is pining over his lost youth and rock and roll days and works from home as a jingle composer for television commercials. Juno enters into an agreement regarding the care and adoption of the child.



Juno is the story of a 16-year-old Minnesota high school girl coping with her unplanned pregnancy. The 2007 film explores important issues such as teen pregnancy and relationships. (Fox Searchlight/Photofest)

The movie follows Juno through all nine months of her pregnancy and focuses on two main storylines: her relationship with Paulie and her relationship with the Lorings. As her pregnancy progresses Juno struggles with her feelings regarding Paulie who is clearly in love with her and will readily acquiesce to whatever Juno wants. Juno is distant and at times rejecting, while Paulie remains loyal and supportive. As Juno struggles with her relationship with Paulie, she makes several unannounced visits to the Lorings where Mark is most often the only one home. Mark and Juno share taste in movies and music and develop an overly close relationship. Mark eventually confesses to both Juno and Vanessa that he is not ready to be a father and intends to divorce Vanessa. Juno is devastated by this news but eventually tells Vanessa that she still wants Vanessa to adopt her child.

Reception and Criticism

Juno was a box office hit grossing over $143 million in the United States and scoring a 94% Rotten Tomatoes rating. *Juno* won numerous nominations and awards, including being nominated for four Academy Awards (including Best Picture and Best Actress for Ellen Page) and winning for Best Original Screenplay. The movie was also praised by critics and appeared on many top 10 lists of best films in 2007. Roger Ebert (2007) wrote "Jason Reitmans's 'Juno' is just about the best movie of the year." *Juno* brought teen pregnancy

into national focus, with both pro-choice and pro-life factions claiming the movie represented their position. *Juno* was also referenced in political debates after Alaska governor and Republican presidential running mate Sarah Palin's teenage daughter announced her unplanned pregnancy.

Steven R. Vensel, PhD

See also: Peer Groups

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Juvenile Offenders

A juvenile offender, also known as a *juvenile delinquent* or *youth offender*, is a minor person under the age of 18 who commits a status offense, engages in delinquent behavior, or commits a violent or other serious crime.

Definition

- **Juvenile delinquency,** otherwise referred to as *juvenile offending* or *youth crime*, defines a violation of the law committed by a person under the age of 18, which would have been prosecuted as a crime if the minor were an adult.

Description

A *juvenile* is a minor person who is younger than the statutory age of majority, 18 years old. "Juvenile offender" is a term used to describe a minor who is found to have violated the law or committed a serious crime. Other terminology used to identify these youngsters includes "juvenile delinquent" and "youth offender." Youth who engage in delinquent, violent, or criminal activities are typically subject to different penalties and punishments than adults who have committed the same crimes. Consequences for violations committed by minors are often less serious and less harsh, and the focus tends to be on rehabilitation, providing these youth with an eventual "second chance" to turn their lives around, as opposed to punishments that are awarded to adult criminals. Minors may not be aware of how their actions impact themselves and others. Adolescents in particular commonly make mistakes, commit errors in judgment, and act impulsively without thinking. Thus, juvenile delinquency may be considered by some to be normal adolescent behavior.

While both males and females engage in youth delinquency and crime, the majority of juvenile criminals are males. Offenders are primarily of African American and Latino decent living in poor socioeconomic communities where lower parental involvement, higher substance abuse rates, and increased gang activity are common. Research indicates that both biological (genetics, chemical makeup, personality) and environmental factors (family dynamics, modeling, exposure to abuse) contribute to the youth crime problem.

Delinquency and criminal behavior can range on a continuum from less severe to more severe. Less severe violations may include status offenses such as underage smoking, drinking, or violating curfews. More serious crimes may involve vandalism, theft, drug trade, and violent behaviors (assault, rape, murder). Depending on the case, the circumstances surrounding it, and those involved in determining the severity of the offense, it is possible for a minor to be charged and tried as an adult.

Impact (Psychological Influence)

Youth violence rates peaked in the early 1990s, but a decrease in aggressive crimes committed by minors has been noted over the past two decades. Statistics indicated, however, that arrest rates for juvenile offenders have risen, though this increase may be attributed to improved law enforcement efforts and stricter, harsher penalties being imposed for first-time offenses. Even though these offenses tend to be primarily nonviolent, concerns have been raised regarding engaging in juvenile delinquent behaviors and one's propensity for future violent behavior and/or criminal involvement. This topic has been studied extensively, with studies showing that the frequency and severity of offending behaviors are critical elements. Delinquency may be viewed as normal adolescent behavior; therefore,

some level of mischief, rule breaking, and opposition to authority should be expected. Most youth who engage in these types of behaviors as minors "grow out" of it as adults and are able to adapt and conform. However, those who consistently and habitually commit offenses, especially violent offenses, during these formative years have a more difficult time breaking the pattern and often end up involved in criminal behavior later on. Youth offending has consistently been linked to at-risk behaviors, including gang involvement, increased dropout rates, experimenting with alcohol and drugs, and sexual promiscuity. Juvenile offenders are also more likely to experience certain psychiatric disorders including post-traumatic stress disorder, conduct disorder, and depression, which may be attributed to increased exposure to violence.

Preventing youth offenses requires comprehensive efforts comprised of educational programming, parental support, and community outreach. School staff may begin by targeting students who display academic, behavioral, or emotional problems and exhibit warning signs including truancy, failing grades, vandalism, and a propensity for violence. Parents of juvenile offenders also need support as they often lack skills needed to deal effectively with their children. Counseling services can be provided for the minor themselves, their parents, and families. Outreach on behalf of community leaders and organizations is also necessary. Churches, state-funded agencies, and other nonprofits entities can assist youth by providing essentials such as food, clothing, and shelter, in addition to offering safe, caring, and positive outlets for adolescents to go. Struggling families need exposure to and assistance from positive, pro-social networks in order to break the cycle of crime and violence.

Melissa A. Mariani, PhD

See also: Gangs

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K

Kaufman Adolescent and Adult Intelligence Test (KAIT)

The Kaufman Adolescent and Adult Intelligence Test (KAIT) is an intelligence test for individuals between the ages of 11 and 85 years.

Definitions

- **Intellectual** refers to the ability to think and understand ideas.
- **Intelligence** is the capacity a person has to learn and understand information and solve problems.

Description

The Kaufman Adolescent and Adult Intelligence Test is designed to assess mental functioning for people beginning at age 11 through late adulthood. The KAIT is one of several intelligence tests developed by Drs. Alan and Nadeen Kaufman. Like several other IQ tests, the KAIT is aimed at measuring both fluid and crystallized intelligence. Fluid intelligence evolves and describes new problem-solving skills people develop to identify and understand patterns of relationships. Crystallized intelligence is the already acquired information and education an individual has based on reasoning with words and numbers. The six subtests of the KAIT core battery are composed of three sections to measure fluid knowledge and three to measure crystallized knowledge. Together they help build a comprehensive picture of an individual's intellectual capability. During the test, a person is asked to respond to randomly chosen samples of behavior. This approach has good results because it targets both how and if a person is able to respond to a situation. The result is a determination of both a person's developmental level and intellectual maturity. The KAIT must be administered according to a strict procedure. It usually takes about an hour to complete. The KAIT also has an extended battery of 10 subtests, which can be used to expand the information about the subject's intelligence especially in regard to delaying a response to tasks.

Development (Purpose and History)

Following the groundbreaking work of Alexander Luria and Jean Piaget, a young Dr. Alan Kaufman had the opportunity to work with Dr. David Wechsler on revisions to the Wechsler Intelligence Scale (WISC). Later while teaching at the University of Georgia and the University of Alabama, he and his wife Nadeen led a team that developed several different kinds of intelligence tests. The first was one for children, the Kaufman Assessment Battery for Children.

This was followed by a series of other tests that provided screening and skills assessments. The Kaufmans were interested in developing an intelligence test which followed the distinctions made by Horn and Cattell about fluid and crystallized intelligence. The Kaufmans wanted to use broader definitions of fluid and crystallized abilities that would especially take into account developmental changes in intelligence.

In 1993, the Kaufmans published the first Kaufman Adolescent and Adult Intelligence Test. The test was validated for a wide population of people beginning with teens and eventually going as far into adulthood as the 90s. The KAIT was intended as an intelligence test which would measure both adolescent

and adult intelligence as well as provide clinical and neuropsychological data on the individual who took the test.

Current Status and Results

The KAIT itself has been tested repeatedly over the years. It shows both strong reliability and validity in the research. One of its strong points is that it includes both visual and auditory formats, which can give more accurate results for different types of learners. It is one of the most widely used tests in educational, clinical, and vocational settings.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Intelligence Testing; Kaufman Assessment Battery for Children (K-ABC)

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Kaufman Assessment Battery for Children (K-ABC)

The Kaufman Assessment Battery for Children (K-ABC) is an intelligence test for children between the ages of 2 and 18 years.

Definitions

- **Intellectual** refers to the ability to think and understand ideas.
- **Intelligence** is the capacity a person has to learn and understand information and solve problems.
- **Intelligence quotient** is a measure of intellect to determine a person's level of cognitive ability.

Description

The Kaufman Assessment Battery for Children was designed to measure the intellectual functioning and processes of children. The K-ABC intelligence test is based on determining how a child solves a problem instead of what kinds of problems he or she can solve. Other intelligence tests focus on what kind of verbal or nonverbal questions children can answer, which means that the K-ABC is a departure from many other intelligence tests. These test results give what is called a general mental processing composite, which is equivalent to an intelligence quotient score.

The K-ABC has been adapted and revised and is now in its second version. The K-ABC-II has four regular scales and one optional scale. The simultaneous tests include such tasks as facial recognition, pattern reasoning, and block counting, while the sequential tests include hand movements, number recall, and word order. The K-ABC-II was normed for an expanded age range, children 3 to 18 years of age. It includes a nonverbal battery option.

Development (Purpose and History)

The K-ABC was developed in the late 1970s by Alan and Nadeen Kaufman. The two were working with a team at the University of Georgia where Alan Kaufman taught. The test was first published in 1983. These tests were developed to be appropriate for use with nonverbal and non-English-speaking children. Therefore, the K-ABC differs from more traditional tests of intelligence because it reduces the emphasis on verbal abilities and knowledge of specific content. It does however also include a brief screening of achievement defined as knowledge acquired through schooling or experience.

Current Status and Results

Originally the K-ABC caused some controversy since it excluded language subtests from the overall intelligence calculations. This does however make it useful for measurement of intelligence in diverse populations. Its construction makes it less susceptible to cultural biases that might be inherent in tests based on language. The K-ABC is also known for not being influenced in

its results by the personality or temperament of the individual taking the test.

The K-ABC is a test that has become widely used in France and Germany. In the 1990s its use in the Democratic Republic of the Congo validated the distinction between sequential processing and simultaneous processing. In the United States, the K-ABC is now a well-accepted alternative or addition to the Wechsler Intelligence Scale for Children (WISC). Because of its reduced dependence on personality factors, it has become a popular choice to test the intelligence of children with disabilities and those who may express their abilities nonverbally.

Alexandra Cunningham, PhD

See also: Intelligence Testing; Kaufman Adolescent and Adult Intelligence Test (KAIT)

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Kava Kava

Kava kava is an herbal remedy used to reduce stress and anxiety. Also called kava, it has many other uses, ranging from promoting sleep to reducing muscle stiffness and menstrual cramps.

Definitions

- **Food and Drug Administration** is a federal agency that is responsible for protecting the public health by assuring the safety and security of drugs, medical devices, food supply, and cosmetics. It is also called the FDA.
- **German Commission E** is a scientific advisory board that evaluates the safety of herbal medicines. It is equivalent of the FDA.

Description

Kava kava, also known as kava, is a natural remedy used to reduce stress, anxiety, and restlessness and a wide range physical symptoms and medical conditions. These include insomnia, sore and stiff muscles, toothache and sore gums, menstrual cramps, epilepsy, jet lag, and attention-deficit hyperactivity disorder. Kava kava is a plant native to the Pacific Islands. Natives prepare kava by pounding or grinding its roots and mixing them with coconut milk or water. Western manufacturers use alcohol or acetate in making liquid kava preparations. It is also available in capsule, tablet, powdered, or crushed forms. The active ingredients in kava are kavalactones and kavapyrones. Kavalactones have antianxiety properties and appear to affect the brain in the same way as benzodiazepines, such as valium. Kavapyrones have anticonvulsant and muscle relaxant properties.

For years, kava has been widely recommended as a mild tranquilizer due to its painkilling properties However, safety warnings have been issued by the U.S. Food and Drug Administration. It had been approved as a nonprescription dietary supplement for the relief of anxiety, stress, and restlessness by the German Commission E. But in fall of 2001 the commission withdrew its approval due to reported health risks associated with it. Kava has been banned from the market in Switzerland, Germany, and Canada. This ban has hurt the economies of Pacific Island countries that export kava. The irony is that while clinical trials have shown it to be unquestionably effective in treating anxiety and in reducing withdrawal symptoms in benzodiazepine users, its safety is questioned.

Precautions and Side Effects

Kava has been linked to several cases of severe liver problems, including hepatitis, cirrhosis, and liver failure. Using kava for as little as one to three months has resulted in the need for liver transplants. Early symptoms of liver damage include fatigue, dark urine, and yellowed eyes and skin (jaundice). If kava is taken despite warnings to the contrary, frequent liver function tests are necessary. Because of its effects on the central nervous system, it should be used with care when driving or operating heavy machinery, and those undergoing surgery should stop taking kava kava two weeks

prior to their procedure. Kava can worsen any existing depression and should not be taken by persons with a history of depression. For these reasons, its use should be medically monitored.

The most common side effects of kava are numbness in the mouth, depression, insomnia, headaches, dizziness, and skin rashes. More serious side effects include liver damage and tremors. It can reduce the effectiveness of levodopa, a drug used in the treatment of Parkinson's disease. Because of serious interaction effects, kava can significantly increase the sedating effect of certain medications. These include benzodiazepines like Xanax, Klonopin, Ativan, and Ambien, and barbiturates like phenobarbital (Donnatal). Individuals should inform their physician that they are taking kava as well as any other supplements.

Len Sperry, MD, PhD

See also: Integrated Health

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Kim Berg, Insoo (1934–2007)

Insoo Kim Berg was an American social worker who was the co-developer of solution-focused brief therapy, a form of psychological treatment that focuses on an individual's strengths and solutions rather than on problems and pathology.

Description

Insoo Kim Berg was born in Korea in 1934 and moved to the United States to attend college at the University of Wisconsin. After completing her master's degree in social work, she received additional postgraduate training at the Family Institute of Chicago. Along with her husband, Steve de Shazer (1940–2005), she is credited with developing and promoting solution-focused brief therapy. Her strengths-based training and positive view of human behavior lead to the creation of this unique therapeutic approach.

Impact (Psychological Influence)

Berg's contributions to contemporary psychotherapy are significant. Her theory focuses on the solutions, not problems or pathology. The therapy is known for techniques such as (1) the miracle question, an assessment strategy from solution-focused brief therapy that examines an individual's desired outcome of therapy; (2) presuppositional questions, or therapeutic questions from solution-focused brief therapy that suggest possibilities or expectations of a positive outcome; for example, "what will be different when you are feeling better?"; and (3) building on strengths. Solution-focused brief therapy focuses on client strengths, their exceptions to the problem, and examines past solutions. Her therapeutic approach is practiced around the world and is a very popular form of brief therapy. She published 10 highly acclaimed books in her lifetime and was known for traveling internationally to train, teach, and consult with other professionals about solution-focused brief therapy. In 1978, Berg and de Shazer founded the Brief Family Therapy Center in Milwaukee, Wisconsin. While the center was closed the year of Berg's death in 2007, her approach continues to be practiced worldwide.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: de Shazer, Steve (1940–2005); Psychotherapy; Solution-Focused Brief Psychotherapy (SFBP)

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Klein, Melanie (1882–1960)

Melanie Klein was an influential pioneer in the psychoanalysis of children. Many list Klein as second only to Freud in her influence on modern psychoanalysis. She took analyzing young children to a level that had never before been seen. As a result of her work, more is understood about the nonverbal communication of children and patients at all ages.

Description

Melanie Klein was born in Austria in 1882, the daughter of a physician-turned dentist. She wanted to be a doctor herself but got married at 21 and never studied medicine. Klein is known for her work with children and her development of child analysis. She discovered that children could express themselves and their fantasies through free play, which allowed analysts to interpret their nonverbal communication.

Melanie Klein was an influential pioneer in the psychoanalysis of children. (Keystone-France/Gamma-Keystone via Getty Image)

Klein sought personal help through psychoanalysis in her 30s. She was analyzed by Ferenczi, who encouraged her to follow through on her desire to understand and help children by analyzing them. She presented her first paper *The Development of the Child* to the Hungarian Psychoanalytic Society in 1919.

She also was analyzed by Karl Abraham, who taught her his theories on oral impulses as a source of mental pain and conflict. She began to take his work further and developed her own technique for child analysis in 1921. Klein helped to develop the object-relations theory in the 1920s, by tracing the origins of anxiety to the baby's first experiences with a part-object, the breast. In 1926 she moved to London, where she made many original contributions to both child and adult analysis and continued her work there until her death in 1960.

She was one of the first psychologists to work with babies and young children, and to understand they may suffer from severe anxiety. Her work with children led to observations that influenced her theory of human emotional development. Working with patients of all ages confirmed to her that normal development depends on the ability to overcome psychotic anxiety.

Her technique for analyzing children was a major breakthrough in psychotherapy. One of the barriers to working with children was their inability to verbalize complex ideas. She got around this by using their natural instinct to play. Klein offered toys to her young patients and observed their play. She noted that all behavior exhibited by children, such as play, drawing, and even silence, conveyed the content of their fantasies. Analysts could then interpret these fantasies the way they did with adults, and children as young as two or three years old could understand the source of their fear. Knowledge of these unconscious fantasies benefits patients of all ages in dealing with their anxiety and environment. Klein's work opened the door not only for analyzing children but also for analysts to use nonverbal communication with other patients who couldn't verbalize, such as those with selective mutism or psychosis.

Another of Klein's theories is that infants divide themselves and their external world into good and bad parts at a young age. This is part of their healthy development. The good part is made up of the sense of

being loved, loving, and gratification, while the bad part is made up of frustrating or hated feelings. Infants initially identify with the good side so they can cope with the bad. When they develop the ego, they are able to combine the bad with the good and deal with conflict.

Klein believed infants feel they are in danger the first few months of life. This can lead to one of two stages of infant anxiety, which she called the paranoid-schizoid position or the depressive position. In paranoid-schizoid position, infants experience paranoia and fear for the self. The depressive position is made up of anxiety of destruction and loss.

Infants form an early, primitive superego in their development that plays a major role in psychoses, manic-depressive illness, and paranoia. They also undergo an omnipotent fantasy she referred to as projective identification, which is part of all normal and pathologic developmental processes.

Another of Klein's breakthroughs was to explain the difference between jealousy and envy. Jealousy is pain suffered from loss of love experienced in a three-person relationship. Envy is found in a two-person relationship, where the patient experiences pain due to inequality. Her theories on early envy are important because they explain how envy can limit success in therapy, which has helped the treatment of difficult patients.

Klein experienced some hostility toward her ideas about infantile anxiety, mainly because they didn't fit with the ideal mother–child relationship that was a popular belief at the time. She saw anxiety in infants as directly related to the infants' own violent oral sadistic fantasy. Babies are terrified of their own aggression that they project outward and are in a state of anxiety because of it. Babies recognize their own behavior as cruel and experience depressive anxiety because of it. Since her ideas didn't agree with those of many other analysts of the day, her work was often criticized.

In 1932, Klein published her first book *The Psycho-Analysis of Children*. Two of her most important papers from her work on infantile anxiety are *A Contribution to the Psychogenesis of Manic-Depressive States* (1935) and *Notes on Some Schizoid Mechanisms* (1946). Her final book *The Narrative of a Child Analysis* was published posthumously in 1961.

Impact (Psychological Influence)

Klein's work and discoveries have stimulated an important school of thought and analysis. Her work is seen as an extension of Freud's psychoanalytic method and has influenced generations of analysts. She was a caring practitioner who was concerned with the well-being of children, and saw patients up until her death at the age of 78.

Mindy Parsons, PhD

See also: Freud, Anna (1895–1982); Object Relations Theory; Psychoanalysis

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Kleptomania

Kleptomania is a mental disorder characterized by the inability to resist the urge to steal things. The items are not stolen for personal use or for their financial worth, but for other reasons.

Definitions

- **Antisocial personality disorder** is a mental disorder characterized by a pattern of disregarding and violating social norms (rights of others).
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Conduct disorder** is a mental disorder characterized by the repeated disregard for the right of others and for rules and laws.

- **Disruptive, impulse-control, and conduct disorders** is a group of disorders that entail difficulties with the regulation of emotions and/or behaviors. These difficulties lead to behaviors that infringe upon the rights of others. They may also lead to legal trouble.
- **Endorphins** are brain chemicals that inhibit sensations of pain and produce feelings of well-being or happiness.
- **Manic episode** is a mental state characterized by expansive, elevated, or irritable mood with increased energy or activity seen in during the course of a bipolar disorder.
- **Opioid antagonists** are medications that block the pleasure receptors in the brain. They inhibit the pleasure response to opiates and endorphins.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Self-help groups** are a group of individuals, sometimes led by a therapist, who provide each other emotional support, information, and advice on problems relating to some shared concern such as an addiction.
- **Twelve-Step Programs** are self-help groups whose members attempt recovery from various addictions based on a plan called the Twelve Steps.

Description and Diagnosis

Kleptomania is one of the DSM-5 disruptive, impulse-control, and conduct disorders. Individuals with this disorder do not plan in advance to steal. Yet they spontaneously experience powerful urges to steal. Such urges create anxiety and tension. The stealing results in relief of these symptoms and feelings of pleasure. Afterward, the individual may feel guilt and remorse. The stolen items are not needed or valued by the individual and are usually stored away or given away. Biological factors may play a significant role in this mental disorder. Decreased levels of neurotransmitters (brain chemicals) have been associated with impulsive behavior. A family history of obsessive-compulsive disorder is also linked with kleptomania.

The occurrence of this disorder is extremely low in the general population (0.3%–0.6%). The rates increase to 4%–24% among individuals who are caught for shoplifting. Females are three times more likely than males to be diagnosed with kleptomania (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they repeatedly give in to the urge to steal. Prior to stealing, tension builds up. During the act of stealing, there is a sense of pleasure, satisfaction, or relief. The items stolen do not have any personal or monetary value. The items are not stolen as a means of expressing anger or for revenge. The individual is not delusional or experiencing hallucinations. The stealing cannot be due to conduct disorder, a manic episode, or antisocial personality disorder (American Psychiatric Association, 2013).

Treatment

Treatment for kleptomania includes psychotherapy, medication, and self-help groups. Cognitive behavior therapy is widely accepted as the best type of psychotherapy for this disorder. Possible medications include antidepressants, mood stabilizers, antiseizure medications, and opioid antagonists. Self-help groups, particularly Twelve-Step Programs, can provide support and a social network.

Christina Ladd, PhD, and
Len Sperry, MD, PhD

See also: Addiction; Cognitive Behavior Therapy; Self-Help Groups; Twelve-Step Programs

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Klonopin (Clonazepam)

Klonopin is a prescribed medication for nervousness, tension, anxiety, and some types of seizures. Its generic name is clonazepam.

Definitions

- **Antabuse** is a medication used to treat alcohol dependence.
- **Anterograde amnesia** is a type of amnesia in which new memories cannot be formed while existing memories remain intact.
- **Benzodiazepines** are a group of central nervous system depressants that are used to relieve anxiety or to induce sleep.
- **Epilepsy** is a medical condition involving episodes of irregular electrical discharge within the brain that causes impairment or loss of consciousness, followed by convulsions.
- **Glaucoma** refers to a group of eye diseases with increased pressure within the eye, significant enough to damage eye tissue and structures. If untreated, glaucoma results in blindness.
- **Seizure** is a sudden convulsion or uncontrolled discharge of nerve cells that may spread to other cells throughout the brain.

Description

Klonopin belongs to a class group of drugs called benzodiazepines. It is used to treat nervousness, tension, symptoms of anxiety, and some types of seizures. Benzodiazepines work by blocking the specific chemical involved in the transmission of nerve impulses in the brain, which decreases the excitability of nerve cells and results in reduced anxiety. Klonopin's primary use is in the treatment of panic disorder and some types of epilepsy. It is also used to treat social anxiety disorder, mania, post-traumatic stress disorder, and medication-induced movement disorders.

When Klonopin is used to treat panic disorder, it is more sedating than Xanax, another benzodiazepine drug used to treat panic disorder. However, unlike Xanax, Klonopin may trigger depressive episodes in patients with a previous history of depression. In those who experience social anxiety disorder, treatment with Klonopin also reduces depressive symptoms.

Precautions and Side Effects

Women who are pregnant should not use Klonopin, because it may harm the developing fetus. Klonopin should never be taken by people who have had an allergic reaction to it or another benzodiazepine drug such as diazepam (Valium). People with narrow-angle glaucoma or severe liver disease should not take Klonopin. People who have kidney disease may need to take a reduced dosage of the drug. Saliva production may increase while taking Klonopin. Because of this, people with respiratory disease or an impaired gag reflex should use Klonopin with close physician supervision.

Because Klonopin is a nervous system depressant, it should not be taken with other such depressants, such as alcohol, other sedatives, sleeping pills, or tranquilizers. People taking Klonopin may feel unusually drowsy and mentally sluggish when they first start taking the drug. They should not drive, operate machinery, or engage in activities that require mental alertness until they see how Klonopin affects them. Because of a loss of coordination, elderly patients are at risk for falls. This excessive sedation usually goes away after a short time on the drug.

Those with an underlying depression should be closely monitored while taking Klonopin, especially if they are at risk for attempting suicide. Klonopin treatment should not be stopped abruptly, as patients may experience withdrawal symptoms, including tremor, insomnia, anxiety, and seizures. Klonopin can be habit-forming.

The main side effects of Klonopin are sedation, dizziness, impaired coordination, depression, and fatigue. Some people experience decreased sex drive while taking Klonopin. The drug may also cause

short-term memory loss or amnesia. A small number of people develop sinus problems and upper respiratory tract infections while taking Klonopin. One of the side effects of Klonopin may be increased salivation. This may cause some people to start coughing while taking Klonopin. Klonopin may also cause anorexia and dry mouth. It may cause either constipation or diarrhea. There are a few reports of Klonopin causing menstrual irregularities or blurred vision.

Klonopin may increase the sedative effects of other drugs that depress the central nervous system, such as certain strong pain medicines (opiates such as codeine, oxycodone, and hydromorphone) and antihistamines (found in many cold and allergy medications).

Len Sperry, MD, PhD

See also: Antabuse (Disulfiram); Antianxiety Medications; Benzodiazepines; Xanax (Alprazolam)

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Kohlberg, Lawrence (1927–1987)

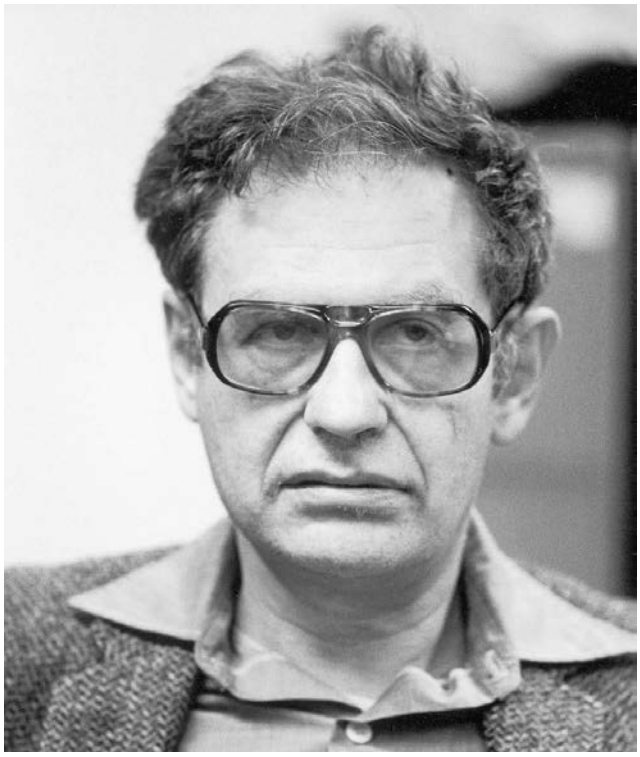
Lawrence Kohlberg was an American psychologist best known for his theory of moral development. He is listed in the top 100 most eminent psychologists of the 20th century.

Description

Lawrence Kohlberg was born in Bronxville, New York, on October 25, 1927. His father, Alfred Kohlberg, was a Jewish German entrepreneur and his mother, Charlotte Albrecht, a Christian German chemist. The youngest of four children, his parents separated when Kohlberg was almost four years old and divorced 10 years later. Kohlberg grew up in an affluent family due to his father's successful import business. He graduated from Phillips Academy, an elite preparatory high school in Andover, Massachusetts. Kohlberg attended high school during World War II and given his Jewish German heritage, as well as his father's involvement in aiding Holocaust victims, he was deeply affected by the plight of European Jews. He was also impacted by incidents of anti-Semitism. At the end of World War II Kohlberg graduated from high school, joined the merchant marines, and traveled to Europe. After completing his tour of duty, Kohlberg became a crewmember on the *S.S. Redemption*, a ship outfitted to smuggle European Jewish refugees into Palestine, a British-controlled territory. Kohlberg was in Palestine during the 1948 Arab–Israeli War, which established the state of Israel. Being in Europe at the end of the war, meeting with Holocaust survivors, and smuggling Jewish refugees through a British blockade raised many questions for Kohlberg regarding how morality develops. Returning to the United States Kohlberg completed an undergraduate degree at the University of Chicago. Given all that he had experienced, he was very interested in social justice and considered becoming a lawyer before deciding to become a clinical psychologist.

Impact (Psychological Influence)

Kohlberg's doctoral dissertation, considered groundbreaking at the time, focused on the moral reasoning and judgment of adolescent boys when presented with a moral dilemma. The dilemma was of a man, Heinz, whose wife was dying of cancer and only one druggist knew how to make the drug that could save her. The druggist charged a very high price and made a lot of profit from the drug. Heinz was able to raise only half of the amount demanded by the druggist, who refused to sell it for less than full price. The boys were asked if Heinz should steal the drug to save his dying wife or obey the law and let his wife die. Kohlberg asked many questions of the boys and discovered distinct age-related differences in the complexity of their moral reasoning and justification for their answers. Kohlberg was the first psychologist to examine how morality develops and his dissertation was highly regarded by his peers. His dissertation work became the basis for his best-known work, the six stages of moral



Lawrence Kohlberg was an American psychologist best known for his theory of moral development. He is listed among the top 100 most eminent psychologists of the 20th century. (Lee Lockwood/The LIFE Images Collection/Getty Images)

development, which continues to be taught in graduate schools throughout the world.

After completing his doctorate in 1958, Kohlberg became assistant professor of psychology at Yale University before joining the psychology and human development department at the University of Chicago in 1961. In 1968 he was appointed professor of education and social psychology at the Harvard Graduate School of Education where he remained until his death. Kohlberg married Lucille Stigberg while working on his dissertation in 1955 and had two sons, David and Steven.

Kohlberg had contracted a parasitic infection while conducting cross-cultural research in Belize on the coast of Central America in 1971. The infection caused chronic physical pain and depression that he lived with for over 16 years. On January 19, 1987, Kohlberg took a one-day leave of absence from the hospital he was being treated at, left identifying documents in his car, and walked into the frigid waters of Boston Harbor and drowned himself. He was 59 years old.

Lawrence Kohlberg wrote several books on his theories of moral development, childhood moral education, and social justice. Perhaps his most important publications were his two-volume collection of "Essays on Moral Development."

Steven R. Vensel, PhD

See also: Moral Development, Stages of

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Kübler-Ross, Elisabeth (1926–2004)

Elisabeth Kübler-Ross was an American psychiatrist and author best known for her groundbreaking work in creating awareness about how society cares for the terminally ill and approaches the grieving process.

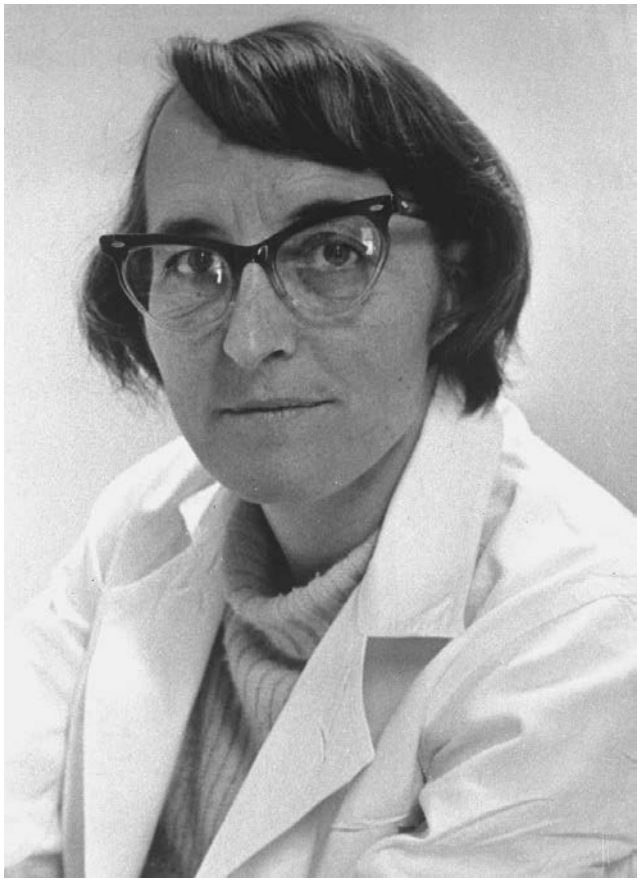
Description

Author and psychiatrist, Elisabeth Kübler-Ross's research was instrumental in changing how the medical community cared for the terminally ill. Physicians have since used her writings as a guide for discussing the topic of death with their patients. Hospice care was also established as a result of Kübler-Ross's work. She

developed the Five Stages Theory, outlining distinct stages that people go through when suffering through the grieving process: denial, anger, bargaining, depression, and acceptance. This model has been applied to the patients diagnosed with terminal disease as well as the survivors of those who have died.

Elisabeth Kübler was born on July 8, 1926, in Zurich, Switzerland. She was one of three triplet girls and weighed only two pounds at birth. Kübler's first experience with death came at age five when she was hospitalized with pneumonia and witnessed the peaceful death of her hospital roommate. Around the same time, a close neighbor of hers passed away after suffering a severe neck injury. These early experiences led Kübler-Ross to begin thinking about how death is simply another stage of life and that people need assistance in dealing with this process. At the onset of World War II, when Elisabeth was just 13 years old she began volunteering at a hospital assisting Polish war victims. By 1945, she had become an activist for the International Voluntary Service for Peace.

Experiencing the bitterness of war firsthand affected Elisabeth immensely. She went on to volunteer rebuilding war-torn communities in France, Poland, and Italy. Another profound experience came during her visit to the Majdanek concentration camp when she met a young girl who showed compassion and forgiveness toward those who had wanted to send her to the gas chambers. Elisabeth decided then to devote her life to helping others. A career in medicine was against her father's wishes, however, Elisabeth decided to enroll in medical school anyway, entering the University at Zurich in 1951 and graduating from there in 1957. It was there that she met her future husband Emanuel Robert Ross, an American medical student. The two married in 1958. They later moved to New York to pursue their internships at Glen Cove Community Hospital in Long Island. Kübler-Ross then went on to specialize in psychiatry and completed her residency at Manhattan State Hospital. She received further training at Montefiore Hospital in the Bronx. After the birth of their first child, the couple accepted teaching positions at the University of Colorado Medical School and relocated to Denver. Kübler-Ross continued researching the topics of death and dying and became increasingly disturbed that the courses in medical school did not address these areas adequately. In 1965, after the birth of their second child, they moved to Chicago where Elisabeth became an instructor at the University of Chicago's medical school. During this time, Elisabeth began a series of seminars about the dying process. The lectures featured candid interviews with terminally ill patients who relayed their innermost fears about their impending death. These experiences offered the basis of her first and most popular book *On Death and Dying*, published in 1969. In this book, Kübler-Ross outlined five stages that terminally ill patients experience: denial, anger, bargaining, depression, and acceptance. Her work raised public awareness and prompted much-needed discussion in the medical community to issues that had previously been



Elisabeth Kübler-Ross's research was instrumental in changing how the medical community cared for the terminally ill. She developed the Five Stages Theory outlining distinct stages that people go through when experiencing the grieving process: denial, anger, bargaining, depression, and acceptance. (AP Photo)

considered taboo. Later writings included *Living with Death and Dying* in 1981 and *The Tunnel and the Light* in 1999. In 1977, she founded "Shanti Nilaya" (Home of Peace) in Escondido, California, which served as a healing center for the dying and their families. The Elisabeth Kübler-Ross Center was also formed around the same time. Kübler-Ross retired after suffering a severe stroke in 1995 which left her partially paralyzed. She died in hospice care on August 24, 2004, in Scottsdale, Arizona, of natural causes, surrounded by those she loved.

Impact (Psychological Influence)

Kübler-Ross's research, though it had a profound impact in the fields of medicine, psychiatry, social work, and counseling, was both praised and criticized. During her career, she authored more than 20 books on death and dying, including her final work *On Grief and Grieving* (2005), which she finished right before her death. Kübler-Ross played an integral role in the start of the hospice care movement, made a significant impact in providing compassion to AIDS patients during the start of that epidemic, and was a cofounder of the American Holistic Medical Association. In 2007, she was inducted into the National Women's Hall of Fame, and throughout her lifetime, she was the recipient of 20 honorary degrees.

Melissa A. Mariani, PhD

See also: Bereavement; Grief

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Language and Thought of the Child, The (Book)

The Language and Thought of the Child is a book about language development in children written by Jean Piaget in 1923.

Description

In *The Language and Thought of the Child*, Piaget addresses two significant challenges. The first is understanding the nature of children's thinking as revealed in their language and the second is understanding the relationship between that and the development of socially important qualities, such as the ability to communicate clearly and truthfully, the power to distinguish romance from reality, and the consideration of other people's point of view. Piaget was the first to apply the insights of social psychology and psychoanalysis to the observation of children, uncovering the ways in which a child actively constructs his or her understanding of the world through language.

Piaget believed that the mind of the child is composed of two levels: a lower plane of subjectivity, which is most important during the child's first years, and a higher plane of objectivity and logical ideas (also known as the plane of reality), which develops slowly during the child's first years. He used psychoanalytic concepts to distinguish two functions of language: egocentric language (not directed toward others, or monologue) and socialized language (directed toward others, or dialogue). The former inevitably disappears with the development of the latter.

Piaget insisted that language cannot be reduced to that of simply communicating one's thoughts. He maintained that there is pleasure and excitement that is derived from talking to oneself, on the magical role of words, and on verbalization. He further believed that the child consciously desires to influence the hearer. Such directed communication is acquired late in the child's development, usually after the age of seven or eight.

Piaget presented these views in a series of clinical pictures in his book *The Language and Thought of the Child*. He carefully studied children playing and talking freely together and found that almost half of the spontaneous talk of children from six to seven years old is completely nonsocial. That is, it doesn't make any real sense. Rather it is a celebration of the self, a playing with sound. Developing the ability to discuss and argue takes time, but the growth of power in this region of the child's mind is not natural or inevitable.

Piaget (1896–1980) started his scientific career at the age of 11, studying mollusks, and was recognized by the scientific community when he was still quite young. During the 1920s, he developed a strong interest in Alfred Binet's theories. In fact, in January 1920, at a conference organized by the Alfred Binet Society, Piaget gave an introductory lecture on the relationship between psychoanalysis and child psychology.

Impact (Psychological Influence)

Piaget's book (and his theories) have widely influenced the concepts of child development and thought. Understanding the child's mind and the role it plays in the development of language is important for teachers, especially those who engaged in teaching language. While Piaget had his critics, his work and particularly

this book is well respected in the realms of psychology, psychoanalysis, and education.

Mindy Parsons, PhD

See also: Piaget, Jean (1896–1980)

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Lavender

Lavender is a natural remedy used as a mild sedative and antispasmodic.

Definitions

- **Antispasmodic** is a drug for controlling muscle spasms.
- **Food and Drug Administration** is a federal agency that is responsible for protecting the public health by assuring the safety and security of drugs, medical devices, food supply, and cosmetics. It is also called the FDA.
- **German Commission E** is a scientific advisory board that evaluates the safety of herbal medicines. It is equivalent of the FDA.
- **Sedative** is a drug that calms and causes sleepiness.

Description

Lavender is from the aromatic plant *Lavandula officinalis*. The essential oil derived from lavender is used primarily as a mild sedative and antispasmodic. It is also used in aromatherapy to treat fatigue, anxiety, difficulty sleeping, nervousness, and restlessness. Lavender is native to the Mediterranean region and has many species and subspecies. The preferred lavender for medicinal use is *L. officinalis* or true lavender. In Europe lavender has been used as a healing herb for centuries. It is used both externally and internally in healing. Externally the essential oil is used in aromatherapy as a relaxant and to improve mood. Aromatherapy can be enhanced through massage, used in the bath, placed in potpourri jars, and burned in specially designed oil burners. Pillows stuffed with lavender have been used as a sleep aid in Europe for many years. Lavender oil applied to the forehead and temples is said to ease headache.

Research has identified the active compounds in lavender. The most important of these is an aromatic volatile oil. Lavender also contains small amounts of coumarins, which are chemicals that dilate the blood vessels and help control spasms. The German Commission E has approved the use of lavender tea or lavender oil to treat restlessness and insomnia. Despite conflicting scientific claims, this organization has also endorsed the internal use of lavender for stomach upsets, loss of appetite, and excess gas.

Precautions and Side Effects

Unlike prescribed medications that are regulated by the U.S. Federal Drug Administration, herbal and dietary supplements are not subjected to rigorous scientific testing for safety and effectiveness. The strength of active ingredients varies from manufacturer to manufacturer, and the label may not accurately reflect the contents. Problems with lavender oil revolve around substitution of oil from species of lavender other than *Lavandula officinalis*, the preferred medicinal lavender. Most often true lavender oil is adulterated with less expensive lavender oil. Although it has a pleasant lavender odor, its chemical composition and healing action are different from true lavender oil. There are no studies on interactions of lavender with prescribed medications. Often, lavender has been used in combination with other herbs such as tea oil and lemon balm without adverse interactions.

Len Sperry, MD, PhD

See also: Nutrition and Mental Health

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Lazarus, Arnold (1932–2013)

Arnold A. Lazarus, PhD, was an internationally known author and therapist who pioneered behavior therapy and brief psychotherapy. Some of his main contributions to the profession include showing that breadth is usually more important than depth for effective psychotherapy, emphasizing the value of technical eclecticism and stressing the dangers of theoretical integration, and developing the multimodal BASIC I.D. model that spawned several unique assessment strategies.

Description

Dr. Lazarus's theoretical underpinnings rest mainly on social and cognitive learning theory. He adapts techniques from several disciplines, without necessarily accepting all the theoretical notions behind them. He is known for having a dynamic and innovative approach to working with clients. He was a firm believer in emphasizing treatments of choice for specific conditions, tied to empirically supported methods.

A prolific writer, Dr. Lazarus authored 17 books and more than 200 professional articles. His books include *Marital Myths* and the updated *Marital Myths Revisited* (2001), *In the Mind's Eye* (1984), and *Brief but Comprehensive Psychotherapy* (2006). His book *Behavior Therapy and Beyond* is one of the first books on what is now known as cognitive behavior therapy, and it humanized the field. His books *Multimodal Behavior Therapy, The Practice of Multimodal Therapy* (1989), and *Brief but Comprehensive Psychotherapy: The Multimodal Way* encouraged clinicians to practice in a humane, yet systematic and broad-spectrum way.

He received the Distinguished Service Award from the American Board of Professional Psychology and two Distinguished Professional Contributions Awards from the American Psychological Association. He was also the first recipient of the meritorious First Annual Cummings PSYCHE Award for exemplary contributions to time-effective psychotherapy. He was a firm believer in being precise about the methods applied in treating patients, otherwise known as manual-based therapy. Rather than falling back on generalizations, stating the specific steps used during a session allows others to see how various techniques can be used and the affect they have on the case at hand.

On several occasions, Dr. Lazarus was accused of crossing client–therapist boundaries because his views on the matter are not as black and white as many others of the profession. In his view, the primary boundary was to do no harm, then to never exploit a patient, and then to never show disrespect. He believed dual relationships with patients can be useful, provided there is no conflict of interest.

Dr. Lazarus was born and educated in Johannesburg, South Africa. He received his master's degree in experimental psychology in 1957 and his PhD in clinical psychology in 1960, after which he ran a full-time private practice for three years in his home city. In 1963, he moved to California, where he taught at Stanford University for one year before returning home to continue his private practice. In 1996, he moved back to California, where he became head of the Behavior Therapy Institute. In 1967, he was appointed a full professor at Temple University Medical School in Philadelphia. Three years later he became the director of clinical training at Yale University, and in 1972 he was awarded the rank of distinguished professor at Rutgers University, where he taught until 1998 in the Graduate School of Applied and Professional Psychology. In 2001, he maintained a private practice in Princeton, New Jersey, and was president of the Center for Multimodal Psychological Services. He died in Princeton in 2013.

At the beginning of his career Dr. Lazarus was heavily involved in testing. Nearly all his clients filled out various questionnaires, including a range of personality, neuroticism, and adjustment inventories. However, he very quickly found such psychometric instruments unhelpful in treatment planning. What he

has found useful is careful history taking, meticulous observation, and corroboration or refutation from the clients' significant others.

Impact (Psychological Influence)

Dr. Lazarus tried to remain current with cutting-edge findings across disciplines. In keeping with the need to find treatments of choice, he kept current with research on empirically supported methods and applied them when feasible. He believed that treatment fidelity is important. That is, for anyone to claim that a treatment method was ineffective, he or she must first show whether said treatment was carried out properly and correctly applied.

Mindy Parsons, PhD

See also: Brief Therapy; Couples Therapy

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Learned Helplessness

Learned helplessness is the state or condition of a human being or animal, where they behave as if they are helpless or have no control over their current situation.

Description

Learned helplessness describes a way that humans or animals behave when they perceive that they have no control over avoiding negative circumstances or hope of gaining positive rewards. This theory has attempted to explain the occurrence of clinical depression and other related mental illnesses. It was based on the foundational experiments conducted back in 1967 by American psychologist Martin Seligman and colleagues at the University of Pennsylvania. Seligman's work using Pavlovian classical conditioning with dogs sought to test the validity of B. F. Skinner's principles of behaviorism, which was a leading theory in the field of psychology at the time. The first of these experiments placed three groups of dogs in various situations. Group 1 was strapped to a harness but later released, Groups 2 and 3 were placed in yoked pairs, with the dogs in Group 2 being subject to electric shocks from which they could escape by pressing a lever, whereas the dogs in Group 3 were subject to the same electric shocks but were not given a means to escape that stressor. Results indicated that the dogs in Groups 1 and 2 exhibited no long-term psychological distress, whereas the dogs in Group 3 were severely impacted, even refusing to escape harm and discomfort when they were placed in situations where they were in fact capable or able to do so. In Part 2 of the experiment, the same three groups of dogs were tested in a shuttle-box apparatus where they could escape the electric shocks simply by jumping over a low partition. The dogs in Groups 1 and 2 easily navigated this task, but the dogs in Group 3 refused to even try and rather lay down and whined. Seligman and his colleagues likened this to a phenomenon known as "retardation of learning," when a human being or an animal instinctively knows and is physically able to react in a given situation but refuses to after being psychologically conditioned to believe that their actions will not affect a resolution. The trauma that the dogs in Group 3 experienced could only be remedied by forcibly reconditioning these dogs to believe that their actions could effectively produce a positive outcome.

Later experiments found similar results. All findings confirmed that a strong predictor of the subject behaving helplessly was its perceived lack of control over aversive stimuli. An experiment conducted by Watson and Ramey in 1969 observed this psychological state in human babies. With group one, a sensory pillow was used so that the babies could control the movement of a mobile by moving their heads, while

the other group of babies had no means to effect the movement of the mobile. Babies in the first group continued to move their heads when placed in a different crib, whereas babies from the other group did not.

Current Status and Impact (Psychological Influence)

Though the phenomenon of learned helplessness has been confirmed in humans, it is not always the case and cannot be generalized to all people in all situations. Much relies on a person's attribution style, meaning what they attribute circumstances and factors to. A person with an external or pessimistic attribution style would perceive himself or herself as having little to no control over determining situational outcomes. An internal or optimistic attribution style would be the opposite, meaning that the person believes that he or she has the power to effect change in the desired direction. Also observed in human beings alone is the salience of modeling, meaning it is not necessary for a person to experience a situation firsthand to be conditioned to respond helplessly; the person can simply observe that behavior in another person and then act the same way.

Learned helplessness has recently been studied from a neurobiological perspective. Researchers have discovered a spike in serotonin levels as well as involvement in certain parts of the amygdala, prefrontal cortex, hippocampus, and hypothalamus during states of learned helplessness. These findings have spawned follow-up studies addressing the role that psychotropic medications, exercise, nutrition, sleep, and stress can play in deterring helpless mind-sets. Though states of learned helplessness can resolve over time, consultation with a health professional along with therapy is recommended.

Melissa A. Mariani, PhD

See also: Depression and Depressive Disorders; Locus of Control; Seligman, Martin (1942–)

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Learning Disorders

"Learning disorders" (LDs) is a general term used to describe several specific categories of problems that people have with learning different subjects.

Description

"Learning disorders" is the phrase used to describe a situation where an individual's achievement on standardized academic tests is significantly below the scores expected for peers of similar age, education, and levels of intelligence. LDs were once referred to as academic skills disorders. As a classification in the DSM, LDs refer specifically to substantially lower scores on individually administered, standardized tests in certain subjects. These include reading, mathematics, and writing as well as being applied to other learning problems that are categorized as unspecified. The diagnoses were previously separated into these subjects, but all now fall under Specific Learning Disorder. Other disabilities include disorders such as dyslexia and developmental coordination disorder.

Learning disorders and their specific subtypes usually arise in childhood. Approximately 25% of children with other disorders (e.g., conduct disorder, oppositional defiant disorder, attention-deficit hyperactivity disorder) may also be diagnosed with a learning disorder. The occurrence of a learning disorder in combination with these other disorders can sometimes be attributed to a child's difficulty coping with his or her learning challenges. Although LDs are usually associated with childhood and adolescence, they may also

persist into adulthood. Adults with LDs may often experience difficulties in finding or keeping jobs and in social relationships.

Causes and Symptoms

Developmental problems, prenatal injury and genetics are all suspected to contribute to the development of LDs. But the presences of these don't always lead a child to be diagnosed with an LD. More closely associated with LDs are medical issues such as lead poisoning, fetal alcohol syndrome and chromosomal defects. In some cases genetic risk of LDs seems to be compensated for by protective environmental factors. Given this variation it seems more appropriate to consider a causal model that is based on multiple cognitive deficits.

Learning disorders mean much more than just difficulty with learning. They indicate neurological process disruptions that affect the brain's ability to receive, process, store, and respond to information in specific ways that vary from individual to individual. The key symptom of LDs are unusually low scores in academic performance. This is usually recognized through age-adjusted standardized testing when no medical issues are present or identifiable. Those who suffer from LDs tend to drop out of school at higher rates. Other symptoms of LDs include emotional problems such as demoralization, low self-esteem, and deficits in social skills.

Diagnosis and Prognosis

The National Center for Learning Disabilities offers links on its website with information about specific LDs. These include reading, writing, and math and can help people assess themselves if they suspect that they have an LD. It is important to be clear that a formal evaluation by a trained and licensed professional is required for accurate diagnosis. Professionals such as clinical or educational psychologists can conduct the necessary tests. It is a good idea to seek a professional who specializes in LD. The initial testing determines the scope of the LD so that appropriate help can be found. Each person's diagnosis and prognosis varies and often depends on whether the diagnosis indicates that the LD is mild, moderate, or severe.

Treatment

The Americans with Disabilities Act (ADA) protects all those who are formally identified as learning impaired, including those diagnosed with LDs. Under ADA, people with LDs have rights and options regarding the support they can receive. This includes tutoring and assistive technology devices to help people with LDs perform as well as possible academically. With proper accommodation, many people with LDs achieve higher levels of education, including college or university.

For those unable to pursue higher education, there are opportunities to enroll in programs that help people who suffer from LDs master the skills needed for employment, socialization, and independent living. Many communities have services through not-for-profit, community-based agencies that help people with disabilities achieve and maintain independent lives within the community. Among the many programs available are such offerings as workplace literacy, social skills development, career counseling and training, and time management, as well as the basics of economics in relation to banking and other financial tasks.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Dyslexia; Mathematics Disorder; Reading Disorder; Specific Learning Disorder

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Lesbian

See Gay, Lesbian, Bisexual, Transgender (GLBT/LGBT)

Lexapro (Escitalopram)

Lexapro is a prescribed medication used to treat a broad range of mood- and stress-related psychiatric illnesses. Its generic name is escitalopram.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Selective serotonin norepinephrine reuptake inhibitors** are medications that act on and increase the levels of serotonin and norepinephrine in the brain that influences mood. They differ from selective serotonin reuptake inhibitors, which act only on serotonin.
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. It occurs when medications that increase serotonin are taken together. Symptoms include high blood pressure, high fever, headache, delirium, shock, and coma.
- **SSRI discontinuation syndrome** results from the abrupt discontinuation of an SSRI medication. It is characterized by withdrawal symptoms such as anxiety, agitation, insomnia, nausea, vomiting, diarrhea, fatigue, vivid or bizarre dream, dizziness, and other sensory disturbances.

Description

Lexapro is an antidepressant medication and one of the selective serotonin reuptake inhibitors (SSRI). Its primary use is to treat anxiety and depression. It is also used in the treatment of premenstrual syndrome disorders, irritable bowel syndrome, and bulimia nervosa (eating disorder). A decrease in serotonin levels, a neurotransmitter (chemical messenger) in the brain, is associated with depression and anxiety disorders. It is believed Lexapro works by increasing serotonin.

Precautions and Side Effects

Lexapro should not be used by those with bipolar disorder since it can trigger manic symptoms. Since it can lead to respiratory problems, gastrointestinal problems, seizures, and feeding problems, it should be used during pregnancy only when clearly needed. Lexapro use during the last three months of pregnancy infrequently results in withdrawal symptoms in newborns. These include seizures, muscle stiffness, or constant crying. Lexapro passes into breast milk. For that reason women should talk with their doctor before breast-feeding. Discontinuing Lexapro requires that the dose be tapered down slowly to avoid withdrawal symptoms known as SSRI discontinuation syndrome. Lexapro overdose may result in a condition known as serotonin syndrome. The risk of gastrointestinal bleeding may be increased when Lexapro is combined with nonsteroidal anti-inflammatory drugs such as Motrin, aspirin, Excedrin, and Aleve. Alcohol should be avoided while taking this drug. Using herbs such as St. John's wort or Yohimbine while taking Lexapro may also cause toxicity.

Like other SSRIs, there can be side effects with taking Lexapro. Less serious side effects may include drowsiness, dizziness, sleep problems, nausea, heartburn, upset stomach, constipation, weight changes, ringing in ears, decreased sex drive, impotence, or difficulty having an orgasm. More serious side effects should be reported immediately to a physician. These include mania, worsened depression, high fever, rigid muscles, tremors, overactive reflexes, loss of coordination, hallucinations, fainting, seizure, aggressiveness, and thoughts about suicide or hurting oneself.

Len Sperry, MD, PhD

See also: Antidepressants; Bipolar Disorder; Depression

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LGBT

See Gay, Lesbian, Bisexual, Transgender (GLBT/LGBT)

Lies and Deceit

Lies and deceit is the central theme in current research on detecting dishonesty through facial expressions.

Definitions

- **Deceit** is the intentional misrepresentation of information for the purpose of misleading another individual.
- **Lies** are untruths that are told with the intent to deceive another individual.
- **Micro expressions** are very brief facial expressions that are involuntary. They are subtle representations of emotions that reflect emotions being experienced.
- **Paralinguistic** refers to the parts of communication that do not involve spoken words. Nonverbal components of speech include inflection, pitch, and tone.

Description

Lies and deceit is the basis of recent research in the recognition of facial micro expressions and detection of lies. Lies can be deliberate or unintentional. A deliberate lie is intended to mislead or deceive an unsuspecting individual. Willfully withholding information is considered a form of lying. Liars make a conscious decision to lie. An unintentional lie can simply be misinformation given by an honest individual.

There are many reasons why individuals may choose to lie. It may be they are attempting to avoid some type of negative consequence or punishment. Or they are trying to prevent another individual from experiencing a negative consequence or getting punished. It may be to get a reward that may not otherwise be within reach. The goal of lying may be to receive approval from others or to avoid embarrassment. Individuals may lie to get out of unwanted or uncomfortable social circumstances. Or they may do it to preserve their privacy. Lies may be a way of exerting power over others by maintaining control of what information is shared with them.

A lie may fail if the liar does not make sufficient advance preparations or if his or her emotions become involved. If the lie is not well rehearsed, the liar may not remember it. Or he or she may have forgotten a previous lie that is inconsistent with the present lie. Earlier lies may contradict the present lie being told. In this case, the target individual the liar intends to deceive may catch the discrepancy in the spoken content. Inadequate preparation may also leave the liar unprepared to respond to unanticipated questions. This may be indicated by long pauses in speech, avoiding eye contact, flattening of tone, changes in speech, and use of more hand gestures. Emotions can also interfere with lying. Emotions that are faked to facilitate a lie may appear phony. On the other hand, real emotions that are felt may need to be hidden to avoid ruining a lie. Emotions such as fear, guilt, and excitement create changes in an individual's behavior that can be noticeable to others. Therefore, a liar experiencing these emotions will show signs in the face, body, voice, and paralinguistic behavior. Discrepancies between verbal content and facial expressions provide clues to potential lies and deceit.

Paul Ekman (1934–) is a pioneer in the detection of emotions through facial expressions. Together with Wallace V. Friesen (1913–1987), he developed Pictures of Facial Affect, an instrument used to record facial micro expressions and to assist in lie detection. Ekman is well known for his forensic work in helping officials catch liars on a national and international level. He has worked for American and foreign

government agencies. He conducts training workshops worldwide on how to detect lies and deceit.

Christina Ladd, PhD, and Len Sperry, MD, PhD

See also: Emotional Intelligence

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Lifestyle and Lifestyle Convictions

Lifestyle and lifestyle convictions are conclusions individuals make about their inner world based on their interpretations of previous experiences.

Definitions

- **Adlerian psychology** is an approach to psychology that understands individuals as social beings with a need to belong and to strive for significance. It is also known as Individual Psychology.
- **Alfred Adler** is the original creator of Individual Psychology. His theory has had significant influence on contemporary counseling approaches.
- **Early recollections** are a projective therapeutic technique that examines the first memories that an individual can recall. Themes about an individual's personality and his or her view of himself or herself and others are hypothesized with this technique.
- **Family constellation** includes information about an individual's relationships with other family members, his or her family values, and the way that he or she found a sense of belonging in his or her family.
- **Family dynamics** are the roles, relationships, structure, and functions of a family system.
- **Life strategies** are behaviors individuals choose as a result of their self and worldview.
- **Ordinal birth order** is the true order that an individual is born in his or her family, for example, being the first born, second born, or only child.
- **Private logic** is the reasoning that an individual creates to justify his or her style of life.
- **Psychological birth order** is the perceived position or role that an individual takes or is given in a family system.
- **Rudolf Dreikurs, MD,** was an American psychiatrist and educator known for advancing Adlerian psychology through his writings and professional publications.
- **Self-view** is the perception an individual has about himself or herself, his or her abilities, and the degree that he or she can be successful in different contexts.
- **Worldview** is an individual's perception about whether the world is dangerous and harmful, or if the world is helpful and safe.

Description

The term "lifestyle" or "lifestyle convictions" was originally used by Austrian psychiatrist Alfred Adler (1870–1937). A student and later a colleague of Adler, Rudolf Dreikurs (1897–1972) advanced the theory and practice of Adler's ideas and also expanded the understanding and practice of using lifestyle convictions in psychotherapy. Adler viewed memories as expressions of an individual's "private logic" and as metaphors of the subjective meaning an individual determines about his or her life. Lifestyle convictions are conclusions an individual makes about his or her inner world based on family constellation, psychological birth order, and early recollections. Individuals interpret events in their lives, and they make subjective meaning of those situations. The private and subjective meaning

that individuals make about their lives becomes their lifestyle. Lifestyle convictions are a cognitive map (mental picture) that guides an individual's perceptions and actions. This includes personalized beliefs about self-view and worldview. In addition, lifestyle convictions influence how individuals go about living their lives based on their beliefs.

Human suffering is conceptualized in Adlerian psychology as discouragement that results from inferiority feelings that occur as a result of unhelpful lifestyle convictions. For example, if an individual has the belief that she should not ask for help and deals with her problems in isolation, she may suffer during times of significant stress. When a therapist understands that individual's lifestyle convictions, the therapist can help her to better understand how her beliefs and perceptions influence her suffering. In addition, Adlerian psychology treats individuals seeking counseling by assisting individuals in modifying their faulty lifestyle convictions and also increasing their sense of belonging.

Lifestyle convictions are conclusions that individuals make about themselves and the world based on their previous life experiences. They represent the individual's basic pattern and life strategies that "drive" the individual's daily thoughts, feelings, and actions. Here is a formula that summarizes life convictions into a pattern:

- I am . . . . (self view)
- Life is . . . . People are . . . . (world view)
- Therefore . . . . (life strategy)

For example, an individual may view himself or herself as dumb, unattractive, and boring, while the individual views others as harsh, critical, and demanding. Their life strategy might be to avoid others because "people are harsh and demanding, so I will avoid them to prevent them from discovering my flaws and criticizing me." Lifestyle convictions come from an individual's interpretations of his or her past experiences; these convictions inform the individual's future behaviors and decisions.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Dreikurs, Rudolf (1897–1972); Early Recollections; Family Constellation; Psychotherapy

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Light Therapy

Light therapy is a type of treatment that uses artificial light exposure to treat individuals who suffer from seasonal patterns of depression and sleep difficulties.

Description

Light therapy, also called phototherapy or bright light therapy (BLT), is a form of therapy used to treat symptoms of depression and some forms of sleep disturbance disorders. Light therapy derives its name from use of artificial bright lights clients are exposed to during treatment.

Development

Light therapy consists of exposure to intense levels of bright light, which affect certain hormones and brain chemicals that can impact mood and sleep patterns. Light therapy has been studied since the 1980s and has been the subject of multiple research studies. BLT has been found to be effective in decreasing depressive symptoms of seasonal pattern depression, sometimes referred to as winter depression, seasonal affective disorder, or seasonal depression. Seasonal depression is a condition that consists of a pattern of depression occurring in the fall and winter but is not present throughout the rest of the year. Light therapy has also been found to diminish symptoms of nonseasonal depression with effects similar to antidepressants.

Light therapy is conducted with specially designed light boxes that reduce glare and filter harmful ultraviolet light. Light boxes produce an intensity of up to 10,000 lux. Lux is a standard measurement of light

intensity and is calculated as equal to the illumination of a surface one meter away from a single candle. For comparison, sunlight ranges from 32,000 to 100,000 lux, and moonlight represents about 1 lux. Research indicates that dosage consists of the combination of the intensity of the light and the duration of exposure. An effective minimum dosage varies depending on this combination. For instance, exposure to 2,500 lux for 2 hours per day, 5000 lux 1 hour per day, or 10000 lux for 30 minutes per day, are equivalent dosages.

Current Status

Bright light therapy has several advantages over psychotherapy and psychopharmacology (the use of medications to treat psychological/psychiatric disorders). BLT produces antidepressant-like benefits faster than medications and psychotherapy. Light therapy is also considerably less expensive than several months of psychotherapy or antidepressant treatment. BLT also has fewer and less severe side effects than antidepressant medications. In spite of these advantages, light therapy has received less research focus on how best to utilize phototherapy than have other forms of more traditional psychotherapy and psychiatric interventions. This research gap may exist due to light therapy not being as financially supported and marketed as pharmacological treatments.

Light therapy is frequently used to treat individuals suffering from sleep difficulties, such as not being able to fall asleep or waking up too early and not being able to fall back asleep. BLT is frequently used in the treatment of phase disorders, which are sleep difficulties due to a disruption in sleep patterns such as occurs with people who work on night shifts and must sleep during the day. Light therapy is also used to assist individuals with circadian rhythm disorders. "Circadian rhythm" is the term used to describe a person's biological internal clock. People who suffer from circadian rhythm disorder have no problem sleeping but are unable to sleep and wake at times required for work or school. In other words their internal clocks are off. The use of artificial bright lights in a therapeutic setting has been found to be a safe and cost-effective method in assisting individuals recover from seasonal depressive disorders and sleep disturbance disorders.

Steven R. Vensel, PhD

See also: Circadian Rhythm Sleep–Wake Disorder; Seasonal Affective Disorder (SAD)

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Linehan, Marsha (1943–)

Marsha M. Linehan, born in 1943, is the driving force behind the development of dialectical behavior therapy (DBT), which *Time* magazine noted as one of the top 100 most important discoveries. Her writings on the treatment is the most cited work in the field of mental health in the past 25 years. She is professor of psychology, adjunct professor of psychiatry and behavioral sciences at the University of Washington, and director of the Behavioral Research and Therapy Clinics.

Description

Marsha Linehan's DBT began as a treatment primarily for suicidal and self-injurious behavior. It has expanded to include many other areas, including addictive and eating disorders, depression, and family conflict. It is now being studied and applied as a skills-based curriculum in classrooms with school-age children and is currently the gold standard treatment for borderline personality disorder. DBT is a comprehensive, multimodal cognitive behavior treatment that Linehan developed in the early 1980s for the comorbid and difficult-to-treat client. It includes principles of acceptance, mindfulness, and validation.

Marsha Linehan is the founder and organizer of the Dialectical Behavior Therapy Strategic Planning Group, which meets annually, and the Suicide

Strategic Planning Group, which meets periodically. Both groups meet at the University of Washington. She is also the founder of the Linehan Institute, which focuses on nurturing psychotherapists and conducts contemplative and Zen mindfulness retreats for caregivers.

Marsha Linehan's DBT has been applied with highly suicidal individuals who meet borderline personality disorder criteria and has been adapted for adults who meet both borderline personality disorder and substance dependence criteria, suicidal adolescents with borderline personality disorder features, suicidal elderly individuals with major depressive disorder, victims of domestic abuse, stalking offenders, families of highly suicidal individuals, and difficult-to-manage correctional populations.

Dialectical behavior therapy is based on three philosophical pillars: dialectics, Zen, and behavioral science. To balance the change needed for a patient's life to improve, he or she is encouraged to let go of attachments to what he or she thinks reality should be like and find the middle path through means of acceptance, self-validation, and tolerance.

Development

Marsha Linehan was born in Tulsa, Oklahoma, the daughter of Marston Linehan, an oil company executive, and Ella Marie (Tita) Linehan, an active participant in the Tulsa community. She is one of six children. When she was 17, she was admitted as a patient at the Institute of Living, where she began her journey through what she refers to as the hell of mental illness and back. She was released at the age of 20.

At age 21 she moved to Chicago, where she worked during the day as a clerk typist for an insurance company and at night as a catechism teacher in her local Catholic church. In 1965, she was accepted as an undergraduate at Loyola University of Chicago, where she was a premed student majoring in psychology. Until her senior year, her plan was to become a psychiatrist and work at a state mental hospital. However, at the last minute, she realized that there were very few interventions that worked for mental disorders, so she changed her focus from being a clinician to becoming a scientist. In 1968, she entered the social psychology program at Loyola University. She then switched to experimental personality psychology and received her doctoral degree in 1971. To get clinical training, she organized a one-year internship with the Suicide Prevention and Crisis Clinic in Buffalo, New York, followed by a postdoctoral fellowship in behavior modification at the State University of New York at Stony Brook.

Linehan started her academic career as an assistant professor at The Catholic University of American in Washington, D.C. She worked in that position between 1973 and 1977. While there, she conducted her first clinical trial targeting suicidal behavior. She also conducted her first component-analysis clinical study evaluating the relative importance of cognitive interventions versus behavioral interventions in assertiveness training. In 1977, she took a position of professor of psychology at the University of Washington.

Impact (Psychological Influence)

Her primary research is in the application of behavioral models to suicidal behaviors, drug abuse, and borderline personality disorder. She developed DBT, which is considered the gold standard of treatment for borderline personality disorder. This research-based approach has also been modified for use with other psychiatric disorders.

Mindy Parsons, PhD

See also: Borderline Personality Disorder; Dialectical Behavior Therapy (DBT)

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Lithium

Lithium is a prescription medication that has long been used to treat bipolar disorder. It has several brand names, including Lithobid and Eskalith.

Definition

- **Antimanic medications** are prescription drugs that are primarily used to treat bipolar disorder (manic depression). They are also called antimanics and mood stabilizers.

Description

Lithium is a naturally occurring element that is classified as an antimanic drug. Lithium has long been used to treat mania and bipolar depression. It has also been used to treat schizoaffective disorder, aggressive behavior, and emotional instability in children and adults. On occasion lithium is used in combination with other antidepressant medications to treat depression in the absence of mania. It is available in the United States under the brand names Lithobid, Lithonate, Lithane, Lithotabs, and Eskalith, as well as under its generic name. The therapeutic benefits of lithium are believed to be related to its effects on balancing electrolytes, such as sodium, potassium, magnesium, and calcium.

Precautions and Side Effects

Because lithium can be toxic and even life threatening, blood levels of lithium are monitored weekly during the first month of treatment and less often after that. Thyroid function must also be monitored. Lithium should be used only under close medical supervision by those with kidney impairment, by those with heart disease, or those who are taking diuretics. Pregnant women should not take lithium in the first trimester. It should be discontinued 24 hours before major surgery, but its use can be continued for minor surgical procedures.

Tremor is the most common neurological side effect. Lithium tremor is an irregular twitching of the arms and legs that varies in both intensity and frequency. Lithium-induced tremors occur in about one half of those taking it. The chance of tremors decreases if the dose is reduced. Acute lithium toxicity (poisoning) can result in neurological side effects, ranging from confusion and coordination impairment to coma, seizures, and death. Other neurological side effects associated with lithium include lethargy, memory impairment, difficulty finding words, and loss of creativity. Lithium increases the chemical messenger called serotonin. Taking lithium along with medications for depression can overly increase serotonin and cause serious side effects, including heart problems, shivering, and anxiety. These antidepressant medications include Prozac, Paxil, Zoloft, Elavil, Anafranil, and Tofranil.

Len Sperry, MD, PhD

See also: Bipolar Disorder

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Locus of Control

Locus of control (LOC) is a psychological concept referring to a personality trait related to how much control individuals feel they have over their lives.

Description

"Locus of control" refers to how individuals experience a sense of personal control over their lives. The word "locus" is Latin, meaning "location." People generally have either an internal or external LOC.

Individuals with an internal LOC believe they can control their own lives and that their actions and choices are most responsible for what happens in their life. In other words, the internal process of how they think, believe, make choices, and behave provides control over their lives. People with an external LOC believe that their lives are more controlled by outside forces such as chance, circumstances, fate, luck, or powerful others. People with high levels of internal LOC, referred to as *internals*, believe they make things happen whereas people with high external LOC, referred to as *externals*, believe other people, forces, or processes are responsible for what happens to them. For instance, take two students who make a poor grade on an exam. The student with an internal LOC thinks: "If I had studied more I could have done better, next exam I'll start studying earlier." A student with an external LOC thinks: "That teacher doesn't know how to teach and doesn't like me, that's why I got graded down."

Current Status and Impact (Psychological Influence)

The concept of LOC was developed Julian Rotter in the 1950s and 1960s. Rotter studied rewards and punishment reinforcements of behavior and the beliefs held by individuals as to whether they, chance, or the experimenter caused the reinforcement to occur. Since Rotter's early research, LOC has been extensively studied across a wide spectrum of psychological, social, educational, and organizational fields of study. LOC has been associated with many aspects of work, personal, and social functioning.

In terms of work, internals are more likely than externals to set challenging goals and persist in attaining those goals regardless of obstacles. In terms of social skills, internals are more considerate of others and are more effective in influencing people. Internals are also more likely to engage in problem-focused coping behaviors such as seeking help from others, or making and following plans to reduce or eliminate stressors. All of these factors contribute to internals being generally more successful than externals. An internal LOC has been repeatedly associated with successful leaders.

Locus of control and its relationship to health factors have also been highly researched. Internal LOC has been linked to health benefits, including seeking health information, smoking cessation, weight control, medical compliance, effective birth control, and dental hygiene. Research into LOC and education has shown that internals earn better grades, work harder, and study longer than do externals. High external LOC has been associated with lack of motivation. Students with high internal LOC are more likely to work harder to improve grades, whereas student with high external LOC are more likely to give up. LOC has also been found to be associated with mental health variables, with external LOC associated with higher levels of psychological distress. External LOC is also associated with higher levels of depression and anxiety compared to internals. It is important to note that an individual's LOC does not predict mental health functioning, success, or ability to achieve. For instance, even though externals may experience higher levels of depression, the fact remains that regardless of a person's LOC, those who are internals can also experience debilitating depression.

Locus of control is a psychological concept referring to how much control individuals feel they have over their lives. LOC has been extensively studied and has broad application in understanding human coping, performance, and motivation.

Steven R. Vensel, PhD

See also: Coping; Motivation

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Logotherapy

Logotherapy is a form of therapy that is based on the meaning-focused, existential philosophy of that which

emphasizes the importance of meaning, faith, hope, and humor.

Description

The word "logotherapy" is derived from the Greek words "logos" (meaning) and "therapy" (treatment). Logotherapy was developed by Viennese psychiatrist Viktor E. Frankl (1905–1997). Frankl introduced the idea of logotherapy and popularized it in his famous 1946 book *Man's Search for Meaning*, which sold more than 10 million copies and has been translated into two dozen languages. At its essence, logotherapy involves healing and the enhancement of one's well-being through changing one's attitude and beliefs. Sometimes logotherapy is referred to as the Third Viennese School of Psychotherapy since it was developed based on the works of two fellow Viennese theorists, Sigmund Freud and Alfred Adler.

The underlying goal of logotherapy treatment is for the therapist to help the patient change his or her attitude or point of view about a particular situation. A central construct of logotherapy is tridimensional ontology, the conceptualization of human beings along three overlapping dimensions: physical, psychological, and spiritual. People often respond with conditioned or automatic reactions in the first two dimensions. The third dimension of spirituality is what distinguishes us from animals. When we neglect that third dimension, an existential vacuum develops, which can lead to disturbances that violate social norms (aggression), create distress symptoms (depression), and lead to addictions. A sense of personal life meaning is critical to logotherapy. Its basic tenets assert that human life has meaning, that people long to experience their own sense of personal life meaning, and that people have the potential to experience life meaning under any and all circumstances.

Development and Current Status

According to Frankl, who spent several years of World War II in four Nazi death camps, including Auschwitz and Dachau, humans are motivated to seek meaning in their lives. They find such meaning in three main ways: (1) through accomplishment or achievement in work or an activity, (2) through experience or loving someone, and (3) by the attitude a person takes when there is unavoidable suffering. He once wrote that during his time in the concentration camps he realized that it was not important what a person expects from life but what life expects from us.

Frankl believed that we all have the uniquely human potential to turn a personal tragedy into triumph. One of his most famous examples is when he worked with a man who was suffering tremendous grief after the loss of his wife. The man looked to Frankl for comfort, solace, and meaning. After listening to the man's story, Frankl asked what would have happened to his wife if he had preceded her in death. The man replied that his wife would have suffered terribly. Frankl asked the man if her dying first had saved his wife from the painful experience of living without him. This helped the man to see the meaning in his experience that by her passing first, she had been spared the grief he was now feeling.

Logotherapists regard their clients as equal human beings. This therapeutic approach involves four main steps: (1) to differentiate the client from his or her symptoms, (2) modify the client's attitude about the symptoms, (3) reduce the symptoms, and (4) maintain mental health. Logotherapeutic techniques include attitude modification (where the therapist asks the client questions to facilitate internal exploration), paradoxical intention (incorporating humor to counteract anxiety), dereflection (reorienting a client's attention away from a preoccupying problem), and logoanalysis (mental and written exercises to help the individual set a life direction and achievable goals based on personal life meaning). Lesser-known techniques include the Mountain Range Exercise, the Movies Exercise, and the Family Shoebox Game. Logotherapy has several psychometric instruments, including the Purpose of Life test, the Life Purpose Questionnaire, and the Seeking of Noetic Goals test.

Research and case studies show that logotherapy is an effective form of psychotherapy. It is also used in cognitive therapy, cognitive behavior therapy, humanist psychotherapy, and existential psychotherapy, and is advocated in appraisal theory. It has also been explored in relation to rational emotive behavior therapy and acceptance and commitment therapy. It is a technique that mental health professionals can readily integrate with those they frequently use. Thus,

logotherapy has much to offer mental health professionals, regardless of their theoretical orientation. In fact, Frankl himself saw logotherapy as an addition to other therapies with the goal of enhancing techniques instead of replacing them.

Logotherapy has proved useful in the treatment of alcohol and drug addiction, depression, anxiety, psychoses, and despair associated with incurable illness. It also has applicability in areas such as rehabilitation, mental retardation, developmental disabilities work, pastoral psychology, aging, family therapy and relationship counseling, and daily work-/life-related issues.

Mindy Parsons, PhD

See also: Frankl, Viktor (1905–1997); *Man's Search for Meaning* (Book); Psychotherapy

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Viktor Frankl Institute in Vienna, Austria. The Viktor Frankl Institute was founded 1992 as a nonprofit scientific society for Logotherapy and Existential Analysis. It is the task of the Viktor Frankl Institute to foster the lifetime work of Viktor Frankl and to provide access to authentic information about logotherapy and existential analysis. For more information, see www.viktorfrankl.org, Prinz Eugen-Strasse 18/12, A 1040 Vienna, Austria, Europe.

Love, Courtney (1964–)

Singer-songwriter, musician, and actress, Courtney Love is known for her rise to fame during the early 1990s as leader of the band Hole. In 1992, she married and had a child with grunge music legend Kurt Cobain, leader of Nirvana. Love also dabbled in acting, finding acclaim for her role in the 1996 film *The People vs. Larry Flynt*. Though Love's musical and artistic talents are noted, she is best known for her bizarre antics off stage.

Description

Courtney Michelle Harrison was born in San Francisco, California, on July 9, 1964, to Linda Carroll, a psychotherapist, and Hank Harrison, a writer and first manager of The Grateful Dead. In 1969 Courtney's parents divorced and her mother was granted full custody after alleging that Harrison had fed Courtney LSD. Life was not typical and the family moved often, traveling from one hippie commune to the next, throughout Oregon. In 1972, Courtney moved with her mother and then-husband to New Zealand. At the age of 16 she became legally emancipated from her mother and traveled through Europe living off a small trust fund left to her by grandparents. (Love later met her mother's birth mother, the noted writer Paula Fox, and therefore Love's grandmother.) Soon after, Courtney returned to Portland to pursue music, seeing minimal success with groups such as Babes in Toyland and Faith No More. She worked intermittently on her acting career during this same time. Alex Cox gave her bit parts in two of his films, *Sid and Nancy* (1986) and *Straight to Hell* (1987). In 1989, Courtney made her big break in the music industry after starting her own band, Hole, and releasing the album *Pretty on the Inside* (1991). While touring, she met and fell in love with Kurt Cobain, the lead singer and songwriter of Nirvana. They married in Hawaii in 1992 and had a daughter, Frances Bean Cobain, that same year (August 18).

The state of Cobain and Love's marriage remained in question, as did the stable care of their daughter, due to the couple's ongoing struggles with drug addiction. This was also a contributing factor in Cobain's 1994 suicide. After Cobain's death, Hole released two more albums, *Live Through This* (1994) and *Celebrity Skin* (1998). In 1996, Love gained

Singer-songwriter, musician, and actress Courtney Love is known for her rise to fame during the early 1990s as leader of the band Hole. (Michael Lunceford/Dreamstime.com)

acting acclaim after receiving a Golden Globe nomination for her portrayal of Althea Flynt in *The People vs. Larry Flynt*. When Hole broke up in the first part of the millennium, Love went on to pursue some minor roles in other films such as *Trapped* (2002). However, her drug use and unpredictable behavior once again surfaced, resulting in further health and legal troubles. After several unsuccessful attempts, Love was finally mandated to a three-month lockdown in rehab by a Los Angeles county court. Upon her release, Love put out a diary recounting her life, *Dirty Blonde: The Diaries of Courtney Love*, and touted her sobriety to the public. In 2009, after losing custody of Frances Bean for unrelated reasons, Love re-formed Hole and the band then released its first album in nearly 10 years, *Nobody's Daughter*.

Impact (Psychological Influence)

Courtney Love's band, Hole, had a significant impact on the "Riot Grrrl" movement of the 1990s. She was voted "Best Female Performer" in the 1994 Metal Edge Reader's Choice Awards, beating out Lita Ford, who had won the title the previous seven years in a row. Love's acting career, though sporadic, has also been a success. She continues to pursue both her music and acting careers.

Melissa A. Mariani, PhD

See also: Cobain, Kurt (1967–1994)

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Loxitane (Loxapine)

Loxitane is a prescription medication used to treat schizophrenia and various other mental disorders. Its generic name is loxapine.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Extrapyramidal symptoms** are a group of side effects associated with antipsychotic medication use, which are characterized by involuntary muscle movements, including rigidity, contraction, and tremor.

Description

Loxitane is an antipsychotic medication that has been licensed to treat schizophrenia. It is also used to treat various other mental disorders, including anxiety, mania, depression, and other psychotic disorders. It belongs to a class of drugs known as "typical antipsychotics." Typical or first-generation antipsychotics first appeared in the 1950s. Although clinically effective, these medications caused severe neurological side effects, including extrapyramidal symptoms similar to those of Parkinson's disease. Second-generation or atypical antipsychotics, such as Clozaril, were claimed to be less likely to cause these extrapyramidal symptoms. However, recent research has demonstrated the side effect profile of both typical and atypical is basically the same. While it is not entirely clear how Loxitane works, it is believed to block or lessen the effects of dopamine, a neurotransmitter or chemical messenger in the brain.

Precautions and Side Effects

Like other antipsychotic medications, Loxitane carries a warning regarding use in elderly people with dementia, who suffer from an increased risk of death from its use. Loxitane should not be used by women who are pregnant, trying to become pregnant, or breast-feeding. Infants born to mothers who had taken Loxitane during pregnancy may develop extrapyramidal symptoms and withdrawal symptoms, including agitation, trouble breathing, and difficulty feeding.

Common side effects associated with Loxitane use include difficulty swallowing, restlessness, stiffness of arms and legs, trembling, and loss of balance. Less common side effects include urination problems, muscle spasms, skin rash, and severe constipation. Rare side effects include uncontrolled twisting and movement of the neck, fever, sore throat, unusual bleeding, yellowing of the eyes or skin, and changes in facial expression. Seizures have also been reported. Overdose symptoms include significant drowsiness, severe dizziness, significant breathing difficulties, severe weakness, trembling muscles, and severe uncontrolled movements. Loxitane should not be combined with other substances that depress the central nervous system, such as antihistamines, alcohol, tranquilizers, sleeping medications, and seizure medications. Loxitane should not be combined with anticholinergic drugs because of the potential of decreased antipsychotic effects. Also, Loxitane should not be combined with lithium or Ativan.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Schizophrenia

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Luvox (Fluvoxamine)

Luvox is a prescribed medication used to treat obsessive-compulsive disorder. Its generic name is fluvoxamine.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Obsessive-compulsive disorder** is a mental condition characterized by obsessions (a persistent idea or image that dominates one's thinking), which cause marked anxiety, and/or by compulsions (strong impulse to repeat an action), which serve to reduce anxiety.
- **Selective serotonin reuptake inhibitors (SSRI)** are medications that act on and increase the levels of serotonin in the brain that influences mood.
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. It occurs when a number of medications that increase serotonin are taken together. Symptoms include high blood pressure, high fever, headache, delirium, shock, and coma.

Description

Luvox is in a class of antidepressant medications known as selective serotonin reuptake inhibitors (SSRIs). Luvox was the first SSRI to be approved for the treatment of treating obsessive-compulsive disorder (OCD) in children, adolescents, and adults. Depression and OCD are thought to be caused by low levels of serotonin, a chemical messenger (neurotransmitter) that is released and transmitted in the brain. Like other SSRI medications such as Prozac, Zoloft, and Paxil, Luvox is believed to work by increasing the level of serotonin in the brain. Increased levels can benefit those with OCD, depression, panic disorder, post-traumatic stress disorder, mood swings, premenstrual tension, alcoholism, and certain kinds of headaches.

Precautions and Side Effects

Those taking Luvox should be monitored closely for insomnia, anxiety, mania, significant weight loss, and seizures. Its use should be also be monitored in children and adults up to age 24 because they are at an increased risk of developing suicidal thoughts. Caution should also be exercised when prescribing Luvox to those with impaired liver or kidney function, those over age 60, children, individuals with known bipolar disorder or a history of seizures, those with diabetes, and individuals expressing ideas of committing suicide. The risks and benefits of Luvox should be considered by women who are or might become pregnant, and those who are breast-feeding. Those with diabetes should monitor their blood or urine sugar carefully, since Luvox can affect blood sugar. Alcohol should not be used while taking Luvox. Care must be taken in driving, operating machinery, or participating in hazardous activities when taking this medication. Luvox use should not be stopped abruptly since it can cause withdrawal symptoms. A group of serious side effects, called serotonin syndrome, has resulted from the combination of SSRI drugs such as Luvox and members of another class of antidepressants known as monoamine oxidase inhibitors.

Common side effects of Luvox include decreased sex drive and diminished sexual performance. Less common side effects are changes in mood, behavior, or thinking; difficulty breathing; difficulty urinating; and twitching or uncontrollable movements of the body or face. Luvox interacts with several other medications. Those considering taking Luvox should review the other medications they are taking with their physician for possible interactions. Also, those who are taking Luvox should inform all their health providers, including dentists. When other medications are taken together with Luvox, the effect of several drugs may be increased. These include benzodiazepines, beta blockers, Clozaril, antiseizure drugs Dilantin and Tegretol, tricyclic antidepressants like Tofranil, and cholesterol-lowering drugs such as Lipitor and Zocor.

Len Sperry, MD, PhD

See also: Obsessive-Compulsive Disorder (OCD); Paxil (Paroxetine); Serotonin

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M

Magnesium

Magnesium is a mineral involved in nerve and muscle functioning, bone formation, and immunity. It is used as both a medical treatment and a natural remedy.

Description

Magnesium is a mineral that is present in relatively large amounts in the body, more than half of which is in the bones. Magnesium is involved in some 350 enzyme (chemical) reactions necessary for optimal functioning. Dietary intake is the primary source of magnesium, and supplements are needed when magnesium levels are too low. Magnesium deficiency is common in about one half of all Americans, particularly in women, African Americans, and in the elderly. Magnesium is a powerful relaxation mineral and stress antidote. It is a life-saving treatment and is a critical medication on crash carts in hospitals and emergency department. Intravenous magnesium is regularly used to treat fatal arrhythmias (irregular heartbeat). Magnesium sulfate is regularly used in the preparation of colonoscopy. As a natural remedy magnesium is used for many conditions. It is used for heart and blood vessel problems, including chest pain, irregular heartbeat, high blood pressure, cholesterol problems, heart valve disease (mitral valve prolapse), and heart attack. Magnesium is also used for treating attention-deficit hyperactivity disorder, anxiety, chronic fatigue syndrome, Lyme disease, fibromyalgia, leg cramps during pregnancy, diabetes, kidney stones, migraine headaches, weak bones (osteoporosis), premenstrual syndrome, altitude sickness, urinary incontinence, restless leg syndrome, asthma, hay fever, and multiple sclerosis, and preventing hearing loss. It is also used as a laxative and as an antacid. The primary action of magnesium is to reduce irritability, spasms, and cramping. It is thought to work by lowering calcium levels in cells, leading to relaxed and more flexible muscles, nerves, and blood vessels.

Precautions and Side Effects

At recommended dose, magnesium appears to be safe for women who are pregnant or breast-feeding. High doses of magnesium should not be given to people with heart block. Taking high doses of magnesium can cause it to build up to dangerous levels in individuals with kidney problems. This could result in kidney failure.

Side effects are rare with magnesium when doses are less than 350 mg per day. Common side effects might include stomach upset, nausea, vomiting, or diarrhea. Higher doses can result in more serious side effects, including an irregular heartbeat, low blood pressure, confusion, slowed breathing, coma, and death.

Magnesium interferes with the absorption of digoxin (a heart medication), some antibiotics, and certain antimalarial drugs, which could potentially reduce their effectiveness. When taking medications used to treat osteoporosis, magnesium should be taken two hours apart so that the absorption of these medications is not inhibited. Magnesium has also been found to reduce the efficacy of Thorazine (a tranquilizer), penicillamine, oral anticoagulants, and tetracycline. High doses of Lasix and some diuretics may result in magnesium depletion. Other medications may also result in renal magnesium loss.

Len Sperry, MD, PhD

See also: Nutrition and Mental Health

Further Reading

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Magnetic Resonance Imaging (MRI)

Magnetic resonance imaging is a medical diagnostic test that uses magnetic field to produce detailed images of the brain and internal organs. It is also referred to as MRI and nuclear magnetic resonance imaging.

Definitions

- **Hydrogen** is the element with one electron (negatively charged particle) circling a nucleus consisting of one proton (positively charged particle). This nuclear proton makes MRI possible by resonating (interacting) with radio waves in a magnetic field.
- **Ionizing radiation** is electromagnetic radiation that can damage living tissue by disrupting and destroying individual cells. Radio waves do not damage organic tissues they pass through.
- **Magnetic field** is the three-dimensional area or field surrounding a magnet, in which its force is active.
- **Radio waves** are electromagnetic energy of the frequency range corresponding to that used in radio communications. They are the same as visible light, x-rays, and other types of electromagnetic radiation but are of a higher frequency.

Description

Magnetic resonance imaging (MRI) is a type of diagnostic imaging that uses electromagnetic radiation and a strong magnetic field to produce detailed images of the brain and internal organs. MRI works by producing a map of hydrogen distribution in the body. Because it can be magnetized, hydrogen will align itself with a strong magnetic field, like the needle of a compass. By using strong magnets and pulses of radio waves to modify the natural magnetic properties in the body, MRI can produce higher-quality images of organs and soft tissues than other scanning techniques.

Once an individual's hydrogen atoms have been aligned in the magnet, pulses of specific radio wave frequencies are used to knock them back out of alignment. The hydrogen atoms alternately absorb and emit radio wave energy, vibrating back and forth between their resting (magnetized) state and their agitated (pulsating) state. This is the "resonance" part of MRI. The MRI device records the duration, strength, and location of the signals emitted by the atoms as they relax, and translates the data into an image on a monitor. This is "imaging" part of MRI. The state of hydrogen in tissue that is diseased differs from that in healthy tissue of the same type. Because of this, the MRI is valuable in identifying tumors and other lesions. A single MRI exposure produces a two-dimensional image of a slice through the target area. This series of closely spaced images (usually less than half an inch) appears as a virtual three-dimensional) view of the area.

MRI is particularly useful for imaging the brain and spine as well as the soft tissues of joints and the interior structure of bones. The entire body is visible to the technique. Because it does not use ionizing radiation, MRI poses no significant health risks. It is being used increasingly during surgical operations, particularly those involving very small structures in the head and neck, as well as for preoperative assessment and planning. Intraoperative MRIs have shown themselves to be safe as well as feasible, and to improve the surgeon's ability to remove the entire tumor or other abnormality. They are valuable because an image can be produced during the procedure so that, for instance, a missed portion of tumor can be removed immediately,

during the initial surgery, rather than having to return for a second procedure.

Developments and Current Status

In 1971, the American inventor Raymond Damadian (1936–) developed the first magnetic resonance scanning machine for safely scanning human tissue. The first MRI image was published in 1973, and the first studies on humans were performed in 1977. In 2003, American chemist Paul Lauterbur (1929–2007) and English physicist Peter Mansfield (1933–) won the Nobel Prize for their discoveries involving magnetic resonance imaging. Since then, there have been several refinements of MRI. One of the most promising has been functional magnetic resonance imaging (fMRI).

fMRI was developed to measure the change in blood flow related to neurological activity in the brain and spinal column. It works by detecting the changes in blood oxygen levels that occur in response to neural activity. When a brain area is more active, it uses more oxygen resulting in increased blood flow. Based on this increased activity, the fMRI produces activation maps, showing which parts of the brain are involved in a particular mental process. The most active areas show up as red and orange, while the least active appear in blue. fMRI has become a favored tool for imaging normal brain function. In the past few years, researchers have used it to increase their understanding of processes involved in the forming of memories, in language acquisition and learning, and in the experience of pain. Unlike other imaging techniques, fMRI does not require individuals to be injected with contrast material or be exposed to radiation. For that reason it has come to be the principal tool in brain mapping research.

Len Sperry, MD, PhD

See also: Electroencephalography (EEG); Single-Photon Emission Computed Tomography (SPECT)

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Major Depressive Disorder

Major depressive disorder is a mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning. It is also referred to as clinical depression.

Definitions

- **Behavioral activation** is a brief, structured treatment approach that activates those who are depressed so they can again experience pleasure and satisfaction.
- **Bipolar and related disorders** are a group of mental disorders characterized by changes in mood and in energy (e.g., being highly irritable and impulsive while not needing sleep). These disorders include bipolar I disorder, bipolar II disorder, and cyclothymic disorder.
- **Depression** is a sad mood or emotional state that is characterized by feelings of low self-worth or guilt and a reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts the individual's daily functioning.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily functioning. These disorders include persistent depressive disorder, premenstrual dysphoric disorder, and major depressive disorder.
- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant

medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain resulting in symptom reduction.

Description and Diagnosis

Major depressive disorder is one of a group of depressive disorders. It is characterized by a depressed mood or anhedonia (loss of pleasure in all or nearly all activities) and other symptoms that are sufficiently severe to interfere significantly with the individual's everyday functioning. Depression is a normal emotional reaction to perceived loss and hopelessness. However, this disorder differs considerably from the occasional "down" feelings or "blues" that are fleeting. It also differs from the normal period of grief or bereavement following the loss of a loved one. Instead, major depressive disorder causes a lengthy period of gloom and hopelessness, and the individual may no longer take pleasure in activities or relationships that were previously enjoyable. Those experiencing this disorder usually cannot "snap out of it" even when something positive happens. In some cases, depressive episodes are triggered by an obviously painful event, but in other instances it can develop without a specific stressor. It is considered a mental disorder only when it is sufficiently severe to disrupt the individual's ability to meet normal demands of life.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a depressed mood or a loss of pleasure in previously enjoyed activities. They must have experienced symptoms such as sadness, emptiness, or hopelessness. Weight loss or weight gain, changes in appetite, and sleep problems are common. Agitation or periods of slowed mental and physical activity may also have been experienced. Fatigue, indecisiveness, and concentration problems can also be present. So can feelings of worthlessness or guilt, and thoughts of death, including thoughts of suicide. Such symptoms must have been experienced for at least two weeks most of each day. These symptoms must be significantly distressing and impair the individual's ability to function in important areas of life. This episode cannot have been caused by substance use or a medical condition or other mental disorder. Finally, to make this diagnosis, there cannot have been a manic or hypomanic episode. Before DSM-5 the depressive disorders and the bipolar disorders were considered mood disorders and described in a single chapter. However, recent research indicates that these disorders are considerably different. For this reason, DSM-5 has separate chapters for the depressive disorders and the bipolar and related disorders (American Psychiatric Association, 2013).

The exact cause of depression is not fully understood. As with many mental disorders, genetic, physiological, biochemical, environmental, and psychological factors may be involved. For example, this disorder seems to run in families, suggesting a genetic basis. Those with this disorder may have physical and other changes in their brains. These include changes in brain chemistry in which there is an imbalance in neurotransmitters (chemicals in the brain), particularly serotonin. Changes in the balance of hormones may also cause or trigger depression. These changes can result from thyroid problems, menopause, or other conditions. Likewise, significant stressors such as the death or loss of a loved one, financial problems, high stress, or childhood traumas can trigger depression in some.

Treatment

The clinical treatment of this disorder usually involves medication, psychotherapy, and lifestyle factors. The longer and more severe, and the more depressive episode, the more difficult this disorder is to treat. In such situations, the more likely all three treatment modalities need to be involved. Treatment often begins with medication that blocks the biological processes that activate the painful and debilitating symptoms. Medications used to treat major depressive disorder include the antidepressants that affect serotonin, called SSRIs, such as Prozac and Celexa. Other antidepressants include Pristiq and Cymbalta.

Once symptoms have been sufficiently reduced by medication, psychotherapy to process psychological issues can begin. Before then it is not uncommon for the individual to be so distracted by debilitating symptoms to effectively engage in therapy. For some, the emotional relief from medication is considerable

and they may decide there is no need for therapy. For others, there is little or no emotional relief, or the side effects of the medication become unbearable. In these situations or when the individual is unable to engage in daily activities, a type of therapy called behavioral activation may be indicated. Other forms of therapy, such as cognitive behavior therapy (CBT), are useful in dealing with current stressors and for providing psychological tools to deal with depressive symptoms and future stressors. Education about depression and underlying psychological issues is also the focus of CBT.

In addition to medication and therapy, lifestyle changes may be necessary for treatment to be successful. Because everyday behaviors can increase or decrease depression symptoms, certain lifestyle changes may be recommended. These might include maintaining a regular daily schedule that includes exercise, a healthy diet, avoiding alcohol, and improving sleep.

Len Sperry, MD, PhD

See also: Celexa (Citalopram); Cognitive Behavior Therapy; Cymbalta (Duloxetine); Depression and Depressive Disorders; Prozac (Fluoxetine); Pristiq (Desvenlafaxine)

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Male Development

"Male development" refers to the psychological concept of how male identity is developed.

Description

Identity development is a multistage process that takes place as adolescents interact with their world in a variety of context. Adolescence is a time that males develop a deepening sense of the qualities, roles, and characteristics associated with masculinity as they seek the answer to the question "Who am I?"

Male development is influenced by many factors. Environmental, media, peer group, social, parental, and family influences are all associated with the development of gender roles and masculinity. Identity formation and masculine development involves developing a sense of self separate from all others while at the same time belonging to a group. Perceptions of gender roles help the adolescent navigate this separate versus belonging dilemma by experimenting with male stereotypes, such as being strong, aggressive, fearless, and emotionally aloof. Positive feedback and group acceptance serve to reinforce the qualities the individual, and group, considers manly.

Peer groups have been identified as major influence on male development. Researchers have noted that adolescents spend more time with friends and classmates than with their families and other adults. Peer groups are comprised of individuals who share common interest and values and who are in the same developmental period. These groups have a strong influence on masculine development as they provide direction, advice, and boundaries for attitudes, behaviors, and emotional expression. These rules establish what it takes to belong and in many ways define the concept of "peer pressure."

Current Status

Male development and its relationship to male privilege and gender inequalities is a topic of intense investigation and concern. "Male privilege" refers to physical, economic, political, and cultural advantages men have over women as a result of being male. "Gender inequalities" refer to unequal treatment of individuals based on gender. Gender inequalities impacting women, sometimes referred to as the "gender gap," have been clearly identified. These inequalities include unequal wages and chance for promotion; less

political representation and policy-making opportunities and power; and a host of other social attitudes that impact women more so than men, such as manner of dress, personal hygiene, and appearance expectations. Significant research has been focused on how male development impacts gender inequalities, with the central question being, is masculinity culturally constructed or biologically determined? The implications are that if male privilege is biologically determined then men have a natural superiority over women. If masculinity is culturally constructed, then male privilege and gender inequalities can be positively impacted through social interventions such as education.

The struggle for gender equality will continue to be a focus of research that will bring greater clarity to how male identity is developed. The importance of men's responsibilities and roles in achieving greater gender equality is essential to this process.

Steven R. Vensel, PhD

See also: Female Development, Stages of; Identity and Identity Formation

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Male Hypoactive Sexual Desire Disorder

Male hypoactive sexual desire disorder is a mental disorder characterized by low or complete absence of erotic thought or fantasy in men.

Definitions

- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Erectile disorder** is a mental disorder characterized by difficulty obtaining or maintaining a rigid erection during sexual activity.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy or therapeutic counseling.
- **Sexual dysfunctions disorders** are a group of mental disorders characterized by significant difficulty in the ability to respond sexually or to experience sexual pleasure. Disorders include delayed ejaculation, and genito-pelvic pain/penetration disorder.

Description and Diagnosis

Male hypoactive sexual desire disorder is one of the DSM-5 sexual dysfunctions disorders. It is characterized by the absence of or decreased interest in sexual thoughts, fantasy, or activity when compared to other men with similar age and cultural influences. Some males may experience the symptoms of this condition with certain partners or in specific circumstance. Others may experience these symptoms at all times. Some may develop this disorder in later life, while others may have the disorder their entire lives. The prevalence of this disorder in the United States varies greatly with age. It is relatively uncommon in younger men, affecting less than 2% of those under the age of 44. However, approximately 41% of men over the age of 44 may experience difficulty with sexual desire (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, for individuals to be diagnosed with this disorder, they must meet certain criteria. Individuals must experience an ongoing absence of thoughts or interest related to sex or sexual activity. This lack of interest must be present for a minimum of six months, although it may have been present throughout their life. Most important, it must cause significant distress and cannot be explained by a medical condition or a different mental disorder. Some individuals may express a discrepancy between their sexual interest and their romantic partners. This alone

is not sufficient for the diagnosis to apply (American Psychiatric Association, 2013).

The cause of this disorder is understood in terms of biological, social, cultural, and psychological factors. One biological factor is that the disorder is the result of aging. If so, the diagnosis can be made if it causes significant distress. Another biological factor is low levels of the hormone testosterone. It is also associated with erectile disorder, which can be the cause of hypoactive desire disorder in some males. Other factors may play a role in the development of this disorder. These include relationship or partner issues, history of abuse, stress, and cultural and religious issues.

Treatment

For this disorder to be treated effectively, a clinician must first ascertain the most applicable cause of this disorder. If the disorder is most likely caused by partner or relationship issues, then joint psychotherapy aimed at resolving the couple's issues is an effective option. If the disorder is lifelong without a biological cause, then it may be very difficult to treat. In such cases, the goal of therapy is to help the couple adapt to the disorder. In contrast, if the disorder has a biological explanation, then some drug or hormone therapies may be employed to improve sexual desire.

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See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Erectile Disorder; Psychotherapy; Sexual Dysfunctions

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Malignant Narcissism

Malignant narcissism is a combination of narcissistic, paranoid, and antisocial personality traits.

Definitions

- **Antisocial personality disorder** is a mental disorder characterized by a pattern of disregarding and violating social norms (rights of others).
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Narcissistic personality disorder** is a mental disorder characterized by a pattern of grandiosity, lack of empathy, and a need to be admired by others.
- **Paranoid personality disorder** is a mental disorder characterized by a pattern of a high level of distrust and suspiciousness of the motives of others.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Personality traits** are stable and consistent behavior patterns that characterize an individual.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.
- ***Psychodynamic Diagnostic Manual*** is a diagnostic framework that characterizes individuals in terms of their psychodynamics (view of self and others). It is also known as PDM.
- **Psychopathic personality** is a mental disorder characterized as amoral (unconcerned with moral standards) behavior, inability to love and understand another's feelings (empathy), extreme self-centeredness, and failure to learn from experience. It is also known as psychopaths.

- **Sadistic** refers to the enjoyment, which may include sexual gratification, gained from causing physical pain or humiliation.
- **Sadistic personality disorder** is a mental disorder characterized by sadistic behavior (enjoyment in being cruel) and domination.

Description

"Malignant narcissism" refers to a cluster of personality traits characteristic of a severe personality disorder. It includes features of the narcissistic personality disorder, paranoid personality disorder, and the antisocial personality disorder. Such individuals are self-centered, grandiose, sadistic, suspicious, and disregard the rights of others. They also lack empathy and seek power through exploitation and abuse. They are sometimes referred to as psychopathic personalities. Malignant narcissists are likely to see themselves as superior, which justifies their harmful treatment of others.

Malignant narcissism is not listed as a personality disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. However, the *Psychodynamic Diagnostic Manual* does describe the sadistic personality disorder which contains certain features of malignant narcissism.

Psychoanalyst Erich Fromm (1900–1980) first described malignant narcissism in his 1964 book *The Heart of Man: Its Genius for Good and Evil*. Fromm characterized this personality trait as "evil." Others expanded on malignant narcissism to include features such as paranoia (suspiciousness) and sadism, or finding pleasure in harming others. The American psychiatrist M. Scott Peck (1936–2005) considers such individuals to be a distinct form of narcissistic personality disorder who exhibit psychological evil. He describes this as the use of "power to destroy others for the purpose of defending or preserving the integrity of one's sick self" (Peck, 1983). He also proposes diagnostic criteria for diagnosing this distinct personality disorder. Many consider Adolph Hitler to be an example of the malignant narcissist. These individuals are also found in everyday life. The fictional main character in the film *American Psycho* has been classified as a malignant narcissist.

The causes of this disorder are not fully understood. Several factors may be involved, including early childhood experience and the way individuals were parented. Their childhood may have involved physical and verbal abuse. The parenting style they experienced growing up was likely to be hostile, cruel, or neglectful. Their parents and siblings may have engaged in and modeled sadistic, suspicious, and antisocial behavior. In addition, these individuals are likely to have characteristic view of themselves and others. They tend to see themselves as being entitled to hurt, humiliate, and cause suffering on others. They are also likely to view others as objects for their domination. As a result they look for situations in which they can express their contempt and inflict pain and suffering. At the same time, they experience immense pleasure and glee watching others suffer.

Treatment for malignant narcissism can involve psychotherapy. Unfortunately, individuals with malignant narcissism are not likely to successfully respond to therapy. The reason is that these individuals have little or no willingness to change.

Len Sperry, MD, PhD, and George Stoupas, MS

See also: Antisocial Personality Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Narcissistic Personality Disorder; Personality Disorders; Psychoanalytic Theory; Psychopathic Personality

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Malingering

Malingering is an act of intentionally faking or exaggerating physical or psychological symptoms for motives involving external incentives.

Definitions

- **Antisocial personality disorder** is a mental health disorder characterized by a pattern

of disregarding and violating social norms (rights of others).

- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing faulty behaviors, emotions, and thoughts. It is also known as CBT.
- **Conversion disorder** is a mental health disorder characterized by paralysis, seizures, or other neurologic symptoms that cannot be explained by medical evaluation. It is also referred to as functional neurological symptom disorder and hysteria.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Factitious disorders** are a group of mental disorders in which individuals intentionally act as if they are physically or mental ill for no obvious benefit.
- **Fatigue** is a feeling of extreme tiredness and has a gradual onset.
- **Histrionic personality style** is characterized by the constant need for approval and praise, attention-seeking behaviors, exaggerated emotional outbursts, and extreme impulsiveness.
- **Hypochondriosis** is a mental disorder characterized by a preoccupation with having a serious medical condition based on a misinterpretation of bodily symptoms. In the DSM-5 this diagnosis has been replaced by illness anxiety disorder.
- **Minnesota Multiphasic Personality Inventory** is an assessment tool commonly used by mental health professionals to assess and diagnose mental illness. It is also referred to as MMPI.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Post-traumatic stress disorder** is a mental health disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. It is also referred to as PTSD.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also referred to as therapeutic counseling.
- **Somatoform disorders** are a group of mental disorders characterized by physical symptoms that cannot be explained by a medical condition. The DSM-5 calls them somatic symptom and related disorders.
- **V codes** are codes listed in the DSM-5, which are used to identify conditions other than a disorder and are used to report significant factors that may adversely affect an individual.

Description and Diagnosis

Malingering is one of the conditions presented as a V code in the DSM-5 "Other Conditions That May Be a Focus of Clinical Attention" section. Malingering is listed under the category of "Nonadherence to Medical Treatment." Malingering is not a mental health disorder although it can occur in the context of other mental illnesses. Malingering is included in the DSM-5 to draw attention to issues that may be of clinical significance (e.g., diagnosis, course, prognosis, and treatment of an individual). Malingering is characterized by intentionally presenting false or exaggerated physical or psychological symptoms, which are motivated by external incentives for personal gain. Some examples of external incentives include avoiding school, work, and military duty, obtaining financial compensation, eluding criminal prosecution, or obtaining narcotics or other drugs (American Psychiatric Association, 2013).

Malingering can be a difficult task for a mental health practitioner to diagnose. Physicians do not want to overlook a treatable disease, yet they also do not want to continue ordering tests and treatment for individuals they believe are faking their symptoms. Some

symptoms individuals often present with on examination include irritable and hostile mood, a vague or evasive attitude toward the examining physician, and preoccupation with the claimed illness or injury. There are not any specific techniques of physical examination that reliably detect malingering. Malingering individuals who are involved in legal cases are often referred for a mental health evaluation. This evaluation is helpful in determining if an individual is faking symptoms. The Minnesota Multiphasic Personality Inventory can be used to detect the presence of malingering. Malingering can be difficult to distinguish from personality disorders, factitious disorder, conversion disorders, hypochondriasis, somatoform disorders, and post-traumatic stress disorder.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, malingering should be strongly suspected if any combination of the following situations or conditions is noted. This includes the presentation of a medicolegal (medical and legal) situation, such as individual being referred to a clinician for an examination by an attorney. If there is a discrepancy between an individual's claimed stress or disability and the findings and observations, then malingering should be suspected. Lack of cooperation by an individual during a diagnostic evaluation and compliance with the prescribed treatment plan is another red flag for suspecting malingering. Malingering is also associated with antisocial personality disorder and histrionic personality style (American Psychiatric Association, 2013).

The occurrence of this disorder is only for personal gain. Motivation for malingering is always external. Mental health practitioners usually become suspicious to the possibility of malingering when factors exist that might help promote a facade. The symptoms individuals typically claim they are experiencing involve chronic pain or chronic fatigue symptoms. One of the reasons an individual states he or she is experiencing these particular symptoms is objective tests (e.g., x-rays) cannot find any physical cause. Many individuals who are faking physical and psychological symptoms engage in dishonest methods. Some of these symptoms include trying to convince a medical professional that one has a disease after learning the details of the symptoms in medical textbooks and on the Internet. Other dishonest methods include an individual taking medications that provoke certain symptoms common to a disease, overexercising to induce muscle strain or other medical ailments, and overdosing on medications.

Treatment

Since the DSM-5 does not recognize malingering as a legitimate disorder, no structured treatment plan exists. Individuals who are intentionally faking symptoms do not want to be cured of their ailment and will often fail to report any improvement with treatment. One possible treatment that may be helpful includes an individual's participating in individual psychotherapy. One particular method of treatment that has been shown to be effective is cognitive behavior therapy (CBT). The goal of CBT is to have an individual focus on and change his or her thoughts and behaviors.

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See also: Antisocial Personality Disorder; Cognitive Behavior Therapy; Conversion Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Factitious Disorders; Fatigue; Hypochondriasis; Minnesota Multiphasic Personality Inventory (MMPI); Personality Disorders; Post-Traumatic Stress Disorder; Psychotherapy; Somatic Symptom Disorder

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Man Who Mistook His Wife for a Hat, The (Book)

The Man Who Mistook His Wife for a Hat and Other Clinical Tales is a best-selling book written by

neurologist Oliver Sacks and published in 1985. The book is a collection of several of Dr. Sacks's case studies that explore the worlds of his patients and offer an interesting look at a series of neurological anomalies.

Description

The book's title is from the case study of "Dr. P." Dr. P. has a visual agnosia, and is unable to recognize common objects around him even though there is nothing wrong with his eyesight. Because of his condition, he mistakes hydrants for children and talks to furniture knobs. He also, as the title suggests, doesn't recognize his wife's head and tries to wear her as a hat. Sacks recounts conversations with Dr. P. and also discusses his artwork. Dr. P.'s artistic style progresses from naturalist to more "geometrical and cubist" over time, charting his pathology through the years.

In the four sections of the book, "Losses," "Excesses," "Transports," and "The World of the Simple," Sacks introduces the reader to several other patients. One is an autistic artist who doesn't talk but can sketch delicate images out of nature. Some of the other case studies in the book include autistic twins who communicate with mathematical computations performed at lightning speed, an amnesiac who can't remember what happened to him five minutes ago, and a woman who can no longer feel her own body.

In the case study of a patient, Jimmie G., with Korsakoff's syndrome, Sacks ponders the human condition. Jimmie G. is unable to remember anything after his 19th birthday in 1945, though he is now 49 years old. Sacks describes the frustration of a man who can't identify with what's currently happening, but who is comforted by his spirituality. This is a reminder that a person is more than just the sum of his memories. Sacks practices medicine in a manner where he and the patient are on equal ground. They learn from each other and work together to gain new understanding of the patient's condition and provide treatment. He appreciates what his patients have contributed to the understanding of their own conditions.

Pointing out the complexity of the human brain, Sacks notes as an organ it processes information similar to a computer. Yet unlike a computer, the brain is capable of doing so much more. He points out that neurologists tend to look at the brain more like a mechanical object rather than part of a complex being. He asserts that it's important that physicians understand how the brain works, not just as a system but also as a part of the whole person. The brain is not just abstract, mechanical, and categorizing, but it's also personal, judging, and feeling.

Impact (Psychological Influence)

In this book, Sacks examines the writings of neurological legends Hughlings Jackson and A.R. Luria, and discusses how neurologists are fond of speaking in terms of deficits. Neurology tends to view patients along the narrow concept of loss or lack. One of Sacks's patients, Rebecca, points out that the focus on deficit is detrimental to what is retained by the patient. A shift in thinking would better serve both the patient and the physician.

The patients whom Sacks works with have come up with unique ways of communicating and coping with their environments with respect to the way their brains function. Sacks notes that whether you look at a prodigy or someone with a mental defect, both are out of step with the rest of society. Sacks believes that normal and abnormal are not mutually exclusive, but rather points on a continuum, and are arbitrary at best.

Mindy Parsons, PhD

See also: Somatic Symptom Disorder

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Manic Episode

A manic episode is a mental state characterized by mania experienced during the course of bipolar disorder.

Definitions

- **Bipolar disorder** is a mental disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more depressive episodes.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life. It is not considered a disorder unless it significantly disrupts one's daily functioning.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Mania** is a mental state of expansive, elated, or irritable mood with increased energy or activity.
- **Psychosis** is a severe mental condition in which an individual loses touch with reality.

Description

A manic episode is a mental state characterized by a period of an abnormally elated mental state. Typically, it includes feelings of euphoria (high spirits), inappropriate enthusiasm, decreased sleep, racing thoughts, talkativeness, impulsivity, risk taking, and irritability. The mood disturbance associated with manic episodes is noticeable to others and is not characteristic of the individual's usual state or behavior. Individuals who experience an overly joyful or overexcited state are usually experiencing a manic episode. The symptoms associated with a manic episode must be severe enough to cause difficulty or impairment in social, occupational, educational, and other important functioning. Symptoms associated with a manic episode cannot be the result of substance use or abuse or other medical conditions. Manic episodes usually occur before the age of 25 (American Psychiatric Association, 2013).

The cause of manic episodes usually occurs as a symptom of bipolar disorder. Bipolar disorder can include both manic and depressive episodes. Bipolar disorders can cause significant shifts in mood, energy, thinking, and behavior. These shifts range from the highs of mania to the lows of depression. The symptoms of a manic episode may last for days, weeks, or months. The mood changes of bipolar disorder (a manic episode) are so intense that they interfere with an individual's ability to function, and individuals may experience hallucinations or psychosis. During a manic episode, an individual may charge large amounts on credit cards or impulsively quit a job. In extreme cases, individuals having a manic episode may experience hallucinations or psychosis. Hospitalization may be required for an individual exhibiting severe symptoms during a manic episode. For individuals who experience one manic episode, 90% will experience at least one more episode in their lifetime (American Psychiatric Association, 2013). Lifelong treatment is required for individuals with bipolar disorder since it is a chronic condition.

Elizabeth Smith Kelsey, PhD, and Len Sperry, MD, PhD

See also: Bipolar Disorder; Depression; Hallucinations; Hypomania; Psychosis

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Man's Search for Meaning (Book)

Meaning-focused existential psychologist and psychiatrist, Viktor E. Frankl (1905–1997) wrote his most popular book *Man's Search for Meaning* over a nine-day period in 1945, shortly after his concentration-camp liberation during World War II. It contains a narrative of concentration camp experiences and outlines some

of the basic elements of logotherapy (healing and enhancing well-being through the changing of one's attitudes and beliefs).

Description

Man's Search for Meaning is a book that emphasizes the importance of meaning, faith, hope, humor, and many other adaptive constructs. Frankl believed that human life has meaning, that people long to experience their own sense of personal life meaning, and that they have the potential to experience that meaning under all circumstances.

Originally published in English in 1959 as *From Death-Camp to Existentialism, Man's Search for Meaning* is a prime example of how people may reduce despair in severe circumstances by incorporating personal meaning through attitudes, experience, and behaviors. The book is divided into two parts. In part one, *Experiences in a Concentration Camp*, Frankl relates his personal story, while also analyzing the dynamics of the camp and its impact on those within. He explored the three stages—transport and arrival, daily camp life, and liberation—of the lives of people in the camp, including the prisoners, the guards, the Capos, and the SS Commanders in charge.

In part two, *Logotherapy in a Nutshell*, he detailed how modern man has focused too much on happiness when he should be focusing on the meaning in his life. Throughout the second part, Frankl deals with neurosis and motivations and the more technical aspect of logotherapy, its need, and its applications.

In 1942, Frankl was sent, with his wife and parents, to Theresienstadt Concentration Camp. He was liberated from Turkheim (near Dachau) in 1945. A psychiatrist before the war, he survived his time in the camps by attempting to treat fellow prisoners and mentally rewriting the manuscript that was taken from him on his imprisonment, incorporating his camp experiences into it. The result of his work, Logotherapy, has been dubbed the "Third Viennese School of Psychotherapy."

Impact (Psychological Influence)

Frankl is credited with writing more than 30 books during his lifetime. Many were published originally in German, but there have been translations into at least 32 languages. He also published over 700 articles. In 1984, a postscript entitled *The Case for a Tragic Optimism* was added to the book, creating a third part. The newest edition of the book (2006) indicates its continued relevance to the fields of psychology, psychotherapy, psychoanalysis, and psychiatry as there are more than 12 million copies in print. The book contains historical significance. It gives a vivid account of what a prisoner in a Nazi concentration camp experienced and what mental state he was in during each phase of his imprisonment. It also details the reasons why some survivors were able to endure such mental, emotional, and physical abuse, and why others did not. It also presented a positive approach to psychological treatment, one that many disciplines within the mental health realm have incorporated into their practices.

Mindy Parsons, PhD

See also: Frankl, Viktor (1905–1997); Logotherapy

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Marijuana

Marijuana is a common recreational drug that is used to heighten perception, affect mood, and relax. It is also known as cannabis and THC.

Definition

- **Drug Enforcement Agency** is the federal agency responsible for enforcing laws and regulations governing narcotics and controlled substances. It is also known as the DEA.

Description

Marijuana is a common street and recreational drug from *Cannabis sativa*, a hemp plant. Its pharmacologically active ingredient is tetrahydrocannabinol (THC). THC is absorbed into the bloodstream where

it activates proteins in the user's brain and spinal cord. This produces short-term psychoactive effects, including euphoria, a heightened state of awareness, and an increased appetite.

There are over 200 slang terms for marijuana, including "pot," "herb," "weed," "Mary Jane," and "grass." Marijuana is usually shredded and rolled into a cigarette or "joint," or is placed in a pipe or a water pipe and smoked. It can be added to food, as in cookies and brownies, or brewed as a tea. Marijuana is the most commonly used illicit drug in the United States, as well as in the world. As with most other illicit drugs, marijuana use disorders appear more often in males and are most common among people between the ages of 18 and 30 years. Statistics indicate that 17.4 million Americans over the age of 12 had used marijuana a minimum of one time in the previous month. One in three admits to having tried marijuana sometime in their lives. Its use has increased consistently in the past decade, and some 5 million Americans use it almost every day. Approximately 60% of illicit drug users use only marijuana. The health implications of marijuana are considerable. Data on emergency room admissions related to substance use, including marijuana, shows that 376,467 people were admitted to U.S. emergency departments in 2009 as a result of marijuana use, with almost a third of patients under the age of 21 (Substance Abuse and Mental Health Services Administration, 2011).

The debate over the use of "medical marijuana" is intense and highly controversial. THC is known to successfully treat nausea caused by cancer treatment drugs. It also stimulates the appetites of those diagnosed with HIV/AIDS and possibly assists in the treatment of glaucoma (eye problem). Its use as a medicinal agent is still questionable, however. A number of states have legalized medical marijuana use. These states include Alaska, Arizona, California, Colorado, District of Columbia, Delaware, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington.

Precautions and Side Effects

Marijuana use is generally perceived as benign, but a number of concerning research studies suggest that it has some potentially serious side effects. In addition to the known side effect of a motivational syndrome (decreased interest and motivation), some research shows an increased risk of psychotic disorders among marijuana users. While these associations have been demonstrated, causality is still unclear. The question remains as to whether individuals with these disorders are more likely to use marijuana, or whether individuals who use marijuana have a potentially higher risk of developing these disorders.

Signs of marijuana use include red eyes, lethargy, and uncoordinated body movements. The long-term effects often include decreased motivation. There are a number of harmful effects on the brain, heart, lungs, and reproductive system. Those who smoke marijuana are at increased risk of developing cancer of the head and neck. For that reason, a synthetic form of marijuana, referred to as medical marijuana, is available. It is a prescription medication called Marinol (trade name: Dronabinol). Marinol contains synthetic THC. Since it is in pill form, Marinol eliminates the harmful and cancer-causing chemicals present when marijuana is smoked. It is used to relieve the nausea and vomiting associated with chemotherapy for cancer patients. Marinol is also used to treat loss of appetite in AIDS patients.

Marijuana has a high potential for addiction and dependency. For that reason it is listed as a Class I controlled substance by the Drug Enforcement Agency. The symptoms of addiction to marijuana are similar to those of any other addictive substance. Abruptly stopping marijuana use typically results in withdrawal. The symptoms of marijuana withdrawal are similar to those of other drugs and include irritability, anger, depression, insomnia, drug craving, and decreased appetite.

Len Sperry, MD, PhD

See also: Addiction; Drug Enforcement Administration (DEA)

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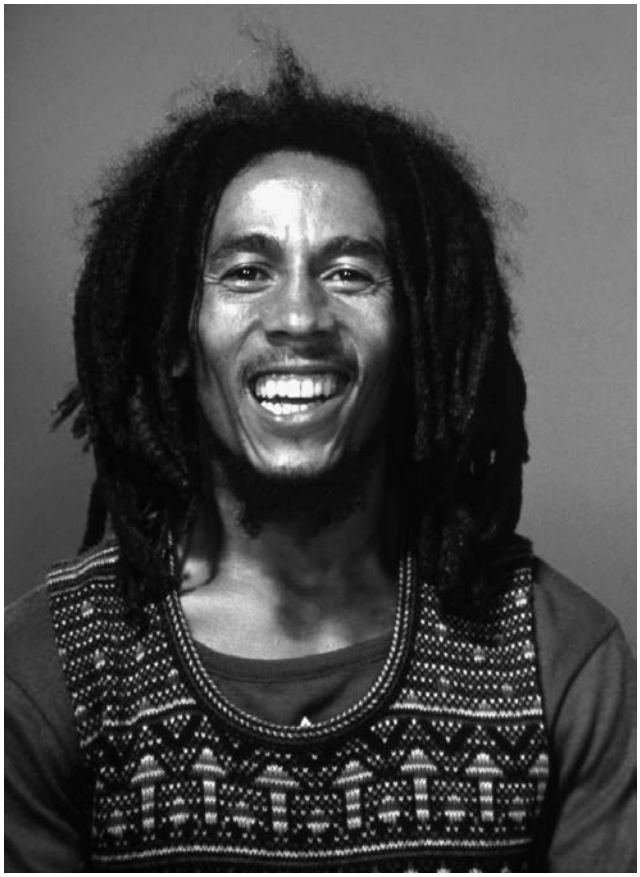
Marley, Bob

Nesta Robert (Bob) Marley (1945–1981) was a Jamaican singer, songwriter, and producer who reached a worldwide audience with his unique style of reggae-based music. Marley was a popular but at times polarizing figure. Treated as an inspiration by many oppressed peoples around the world, he was viewed as a troublemaker by government officials even as he was honored for his music and activism. Since his death in 1981, his image and life have been smoothed over and commercialized with multiple biographies, documentaries, branded products, and feature-length films.



Nesta Robert (Bob) Marley was a Jamaican singer, songwriter, and producer who reached a worldwide audience with his unique style of reggae-based music. (Alamy)

Description

Bob Marley's body of work lifted him out of obscurity in Jamaica to worldwide fame as a singer-songwriter. His career reached its peak in the late 1970s, which coincided with the height of his political power. Controversial during his lifetime, Marley's actions, music, and influence continue to be a powerful but complex cultural force to this day.

At a surface level, Marley has been canonized as a smiling, benevolent Rastafarian figure who assures his followers everything will be all right. However, his smooth reggae beats contain lyrics with edgy, complex integrations of historical events mixed with present-day political and social injustice. Striking deep emotional chords, Marley's music is considered by many oppressed peoples to contain calls to action in the name of freedom, equality, and unity.

Marley was the first to elevate reggae-style music to the world stage. His music touched on the dominant social themes and political issues of his era, particularly the black–white divide and colonialist/imperialist exploitation of emerging nation peoples. As he rose to fame, he was connected with a multitude of social causes around the world, and his influence has continued after his death.

Development

Marley was born in 1945 in Nine Mile, Jamaica, an area noted for its rural poverty. A mixed-race child, Marley's parents never married and his father died when he was 10. His mother moved back and forth between Jamaica and America, allowing him to see different musical styles and cultural norms. From a very young age, Marley sang and performed. He was involved with a

variety of vocal harmony groups and beat-based performers before learning guitar, which would become his signature instrument. His most notable musical collaborators were childhood friends known musically as The Wailers, with whom he had a number of hits.

However, Marley found his greatest success as a solo artist in the mid- to late 1970s. His multiple world tours were often combined with advocacy and activism to support humanitarian and social justice causes. Between his media impact and his musical impact, he was an almost universally recognized voice. A part of what helped his voice stand out was his unique application of the reggae style. Marley's addition of guitar provided a touch of rock-n-roll that made it more accessible to new listeners and extremely popular. This was a surprise to native Jamaicans, especially members of the upper class who considered themselves the custodians of "real" Jamaican culture. Marley's reggae sound was locally considered "rude boy" music, a genre that glorified a certain lawlessness and disrespect for authoritarian figures. Considered second-class or "outlaw" music, those who performed it were often targeted by police and the authorities as troublemakers.

Marley's popularity both puzzled and frightened Jamaican officials, who found his lyrical messages rebellious and countercultural. His Rastafarian beliefs infused his songs and interviews, which troubled traditional religious groups. As a further cultural affront, Marley fathered at least 12 children between his wife and a variety of women and openly smoked an abundance of marijuana. Officials wondered (and worried) at how this man could be an inspiration and hero to anyone, much less revered and sought after. The answer lay with his music. Marley was an extremely talented songwriter. Within a dance chant song, he could embed an uncompromising antiauthoritarian message and skewering of status quo hypocrisies. The energy and intensity of his live performances only added to the power of his verse.

Particularly strong hits for Marley included "No Woman No Cry," "Exodus," and "Redemption Song." The first was a ballad of encouragement to a downtrodden ghetto dweller, while the second was a call for his fellow Rastafarians to leave the tumultuous and dangerous political climate in Jamaica for a better life elsewhere. Both have been broadly adopted as anthems by underprivileged, persecuted, and struggling peoples. "Redemption Song" was inspired by a 1937 speech by Marcus Garvey and Marley's own spreading cancer. Calling on listeners to be the agents of their own liberty, it was released just a year before his death.

Impact (Psychological Influence)

Since his passing, Marley's songs have continued to be popular. However, the edgy antiestablishment element of his image has been commercialized. Some of the "peacemaking" and polishing began before his death. The Jamaican government awarded him the Order of Merit, one of the country's highest honors, and gave Marley a state funeral. His spouse, Rita Marley, worked to secure commercial rights to his image and music. In recent years, Marley has appeared on everything from trading cards to T-shirts. Despite becoming a commodity, Marley's message remains as a voice and a supporter of the black diaspora and underprivileged peoples worldwide. As a result, his music continues to receive heavy play and his image remains an inspiration to those who seek to lift themselves up.

Mindy Parsons, PhD

See also: Reggae Music

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Marriage and Family Therapist

Marriage and family therapists (MFTs) are mental health professionals who specialize in treating couples and families.

Definitions

- **Behavioral health** is an inclusive term referring to both mental health and substance use dynamics.
- **Internships** are required extensive field experiences in which professional knowledge and skills are utilized. Interns are closely supervised as they work directly with client populations.
- **Practicum** is a limited, part-time, field experience in which students are exposed to the "real world" of the profession through direct observation and assisting professionals working in the field. There is limited contact with, and responsibility for, clients.

Description

Marriage and family therapists are mental health professionals who are licensed to diagnose and treat mental health and emotional disorders. MFTs have specialized training in marriage, couples, and family systems theory. MFTs work in private practice, mental health centers, substance abuse centers, nursing homes, and other mental health–related service centers. The Bureau of Labor Statistics estimates the national average salary for MFTs to be $51,690 and projects that employment of MFTs will increase by 31% between 2012 and 2022. Marriage and family therapists have been designated as a core mental health profession by the federal government. Other core mental health professions include psychiatrist, clinical psychologist, clinical social worker, and psychiatric nurse specialist.

Marriage and family therapy is a distinct professional discipline, and all 50 states have regulatory requirements in order to practice as an MFT. Although licensure requirements vary by state, all MFTs are held to strict standards and must have an undergraduate degree and at least a master's degree in a clinical mental health field, such as mental health counseling, social work, psychology, or marriage and family counseling. Accredited graduate programs require up to 60 semester hours of coursework and take a minimum of two years to complete. Coursework includes techniques and theories in counseling, couples counseling, family counseling, and marriage/family systems theory; human development; diagnoses, appraisal, and assessment; substance use theory; treatment planning; psychopathology; ethical and legal standards; and clinical skills instruction. State practicum and/or internship experiences are required in graduate programs and must meet supervisory and clinical requirements.

All states license MFTs, but the regulations vary from state to state. All states require a graduate degree that meets the state's requirements and a passing score on a national licensing exam. All states require post-degree clinical training with ongoing clinical supervision provided by a licensed provider with two or more years of experience, depending on the state. Supervised clinical training requirements vary by state and can be as much as 3,000 hours of supervised clinical experience over a period of no less than two years. A specific percentage of those hours must be in face-to-face counseling, supervision, and case management. All states inquire as to the professional fitness and character of applicants and routinely ask about legal, medical, and behavioral health issues that may impair practice.

The American Association for Marriage and Family Therapy (AAMFT) is a professional membership organization representing over 25,000 members. Founded in 1942, the AAMFT exists to facilitate research, theory development, and education in marriage and family therapy. The AAMFT publishes the *Journal of Marital and Family Therapy* and hosts an annual national training conference. Therapist support services to its members include a wide array of educational materials, job services, online continuing education classes, legal consultation, access to liability insurance, and other services.

The AAMFT accredits graduate programs in Marriage and Family Therapy through the Commission on Accreditation for Marriage and Family therapy Education (COAMFTE). The Association of Marital and Family Therapy Regulatory Boards (AMFTRB)

assists state examiners in evaluating the knowledge of applicants for licensure or certification.

The COAMFTE works with the AMFTRB and state licensing and certification boards to credential marriage and family graduate, doctoral, and post-degree training programs that meet established accreditation standards. COAMFTE accreditation is a voluntary endeavor that once achieved provides the public with assurance that the educational program has been extensively evaluated and meets the standard established by the profession.

Marriage and family therapists are professional mental health practitioners who provide mental health services to individual, couples, and families. MFTs focus on couple and family groups while using the interaction of complex relationships and systems for positive change.

Steven R. Vensel, PhD

See also: Couples Therapy; Family Therapy and Family Counseling

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Marriage Counseling

See Couples Therapy

Maslow, Abraham (1908–1970)

Abraham Maslow (1908–1970) was an American psychologist who is best known for developing Maslow's Hierarchy of Needs, which consists of five steps and are often diagramed in the shape of a pyramid. The five stages are physiological, safety, love/belonging, esteem, and self-actualization. He was also a leading contributor to the movement of humanistic psychology.

Description and History

Abraham Maslow, PhD, was born and raised in Brooklyn, New York. His parents were Russian Jewish immigrants who migrated to the United States in the early 1900s. Maslow was the oldest of seven children. Later in life, Maslow identified his childhood as being unhappy and filled with loneliness, with much of his time being spent primarily in libraries. Maslow became interested in education from early on and he believed that education would improve the world. During his career, he held various academic positions as well as maintained affiliation with numerous professional organizations. He was president of the American Psychological Association in 1967.

Maslow was initially drawn to behaviorism but quickly moved away from it, holding onto only the idea of positivity. It was shortly after the bombing of Pearl Harbor in 1941 that Maslow made the decision that he wanted to dedicate his life to using the field of psychology for peace. As a professor, Maslow discovered students were seeking his advice regarding emotional concerns. At that time counseling did not exist as it is known today. He found himself offering informal therapy to students. This process actually helped him to explore human nature and human motivations. He began focusing on creative outlets, health, and the individual push for fulfillment.

Maslow was focused on positivity and emotional health as opposed to an illness or pathology-based model. Maslow was interested in human potential and the need for growth. He is perhaps best known for creating the Hierarchy of Needs, which consists of five steps and which is often diagramed in the shape of a pyramid. One must start at the bottom and cannot move to the next stage until the first has been fulfilled. The five stages of needs are physiological, safety, love/belonging, esteem, and self-actualization. At the highest level of needs, self-actualization is based on the human desire for self-fulfillment once other, more

Abraham Maslow was an American psychologist who is best known for developing Maslow's Hierarchy of Needs, which consists of five steps and are often diagramed in the shape of a pyramid. (Corbis)

basic needs have been met. The original model was modified later to include cognitive and aesthetic needs before self-actualization.

Impact (Psychological Influence)

Maslow has been viewed as being a passionate visionary. Maslow's influence is seen not only in the fields of psychology but also in the fields of counseling, health care, education, and business. His ideas focused on how to lead a meaningful life and helped create what is called humanistic psychology, system based on the idea that people are inherently good. This theory focuses on the exploration of human potential, while emphasizing wholeness and creativity.

He further explored these ideas through founding the *Journal of Humanistic Psychology* with Tony Sutich.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Humanistic Psychotherapy; Self-Actualization

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Masochistic Personality Disorder

Masochistic personality disorder is a mental disorder characterized by a lifelong pattern of self-defeating and self-destructive behaviors.

Definitions

- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts.
- **Depression** is an emotional state characterized by feelings of sadness, guilt, or reduced ability to enjoy life. It is recognized as a mental disorder when it becomes significantly distressing and disrupts daily life.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is a diagnostic system used to identify mental disorders in terms of specific diagnostic criteria.
- **Masochism** refers to finding pleasure in personal suffering or pain.
- **PDM** stands for the *Psychodynamic Diagnostic Manual* and is a diagnostic framework that characterizes individuals in terms of their psychodynamics (forces influencing thoughts and behaviors).
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.

Description and Diagnosis

Masochistic personality disorder (MPD) is a personality disorder characterized by a lifelong pattern of masochism. Individuals with MPD often reject opportunities that are pleasurable. Rather, they choose situations and others that lead to pain or suffering. They also discourage others from helping them out when in need. As a result, they find themselves continually suffering. This disorder is described in the PDM but is not included in the DSM.

Those with this disorder can present as angry or excessively guilty. They may be overly sensitive to rejection, feel inferior to others, and find difficulty in feeling and expressing anger directed at others. Interestingly, it is has been suggested that narcissism (excessive self-admiration) is a central component of this disorder. This seems contradictory to masochism but may actually be its cause. The suffering and lack of gratification experienced by an individual with this disorder may serve as the rationale for feeling superior to others who do not tolerate their level of suffering. It follows that if they believes this, by not suffering, they cannot be superior.

There are two subtypes of this disorder. The moral masochist describes an individual whose self-image is dependent on his or her suffering. In contrast to normal functioning, individuals with this subtype feel better about themselves when they experience suffering. The second subtype is relational masochist. Individuals with this subtype are dependent on the victimization or suffering that takes place in relationship with another. These individuals may be in abusive relationships with romantic partner or family member. They may believe that they are being altruistic by accepting pain and abuse from their partner (PDM Task Force, 2006).

According to the *Psychodynamic Diagnostic Manual*, MPD is diagnosable by the following criteria. An individual with this personality disorder is preoccupied with self-esteem and the suffering or loss of a relationship. The contributing developmental patterns for this diagnosis are currently unknown. Individuals with MPD exhibit feelings of anger, guilt, and sadness. Their basic belief is that if they are clearly suffering, they can gain moral superiority and have an attachment to others. Their view of others is that individuals pay attention only when one is in trouble. These individuals defend themselves by internalizing various aspects of the world (e.g., particularly aspects of people). They may take a part of another individual they admire and incorporate that part into their own ego to become more like them. Furthermore, they often turn against themselves and reflect on something that is right or wrong especially in a self-righteous way (PDM Task Force, 2006).

Treatment

It is not uncommon for those with this disorder to be misdiagnosed and treated for depression (PDM Task Force, 2006). Medications used for depression are not likely to be effective with MPD. Therefore, when a depressed individual seems more resentful rather than self-critical and sad, further investigation often reveals masochistic traits. The quicker this is recognized, a more accurate diagnosis and treatment plan can be made.

Most individuals with this personality disorder don't want to be helped and may resent anyone who encourages them to seek treatment. If an individual is willing to participate in treatment, psychotherapy, group therapy, and family therapy have been shown to be effective for this personality disorder. Cognitive behavior therapy has been shown to be particularly effective for MPD. This therapeutic approach can assist an individual in taking a realistic look at his or her maladaptive (faulty) thoughts and behaviors in order to bring about positive change.

Len Sperry, MD, PhD, Elizabeth Smith Kelsey, PhD, and Jeremy Connelly, MEd

See also: Cognitive Behavior Therapy; Depression; Family Therapy; Group Therapy; Personality Disorder; *Psychodynamic Diagnostic Manual* (PDM)

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Mass Shootings

Mass shootings are criminal acts of extreme violence in which four or more individuals are murdered by gunshot.

Description

"Mass shootings" are defined as homicides with at least four fatalities. When these horrific events occur, they receive heavy media coverage and commentary from national news anchors, politicians, analysts, and experts from a host of fields. This intense media coverage has led to many misperceptions regarding mass shootings, including the frequency in which they occur, the nature of the perpetrators, what causes people to commit these crimes, and how to prevent them.

One misperception is that mass shootings are on the rise. Research using FBI and state crime statistics indicates that since 1976 the number of mass shootings per year has remained relatively stable. On average, over the past three decades there have been approximately 20 mass shootings a year in the United States. Another misperception is that the number of victims is increasing, but this too has remained relatively stable over the past few decades.

Unlike the public perception that mass shooters are people who suddenly snap, mass murderers are rarely enraged. Survivors of mass shootings describe shooters as being calm. Mass killers spend weeks or months in meticulous planning of where, when, how, and who to kill and then methodically follow their plan remaining focused and controlled.

The most common motive in a mass shooting is revenge. Shooters see themselves as victims and seek to punish those they hold responsible, most often family members or coworkers. The primary target can be a place such as a school or company or an entire category of people such as women, or members of specific religions or races. Random attacks are the rarest type of mass shootings. There is a public perception that violent entertainment, especially video games, is linked to mass shootings, but there is no research that has established causality between game play and violent behavior.

Gun control is perhaps the most frequently proposed prevention strategy. Research indicates that the majority of shooters use semiautomatic handguns that were obtained legally, not assault-style weapons. Although the vast majority of shooters did not have a mental illness on record that would have prevented them from purchasing a firearm, many of the killers in

the most deadly mass shootings in recent years have been found to be mentally ill, including the killer in the Virginia Tech University shootings, the Tucson shootings, the Aurora, Colorado, movie theater shootings, and the shootings in the elementary school in Newtown, Connecticut. No gun control laws currently enacted would have prevented the majority of mass shooting perpetrators from purchasing the firearms used in their murders, something that those who advocate for stricter gun laws have questioned.

Another prevention strategy is to identify the warning signs of potential shooters. Shooters are characteristically Caucasian males, exhibit depressed mood, are socially isolated, are resentful, blame others for their problems, prefer violent entertainment, and enjoy weaponry. Unfortunately, these characteristic warning signs are shared by millions of people who will never become violent.

Impact (Psychological Influence)

Mass shootings have had a deep impact on the American psyche generating profound sorrow, grief, fear, and anxiety. The fact that they have prompted a national discussion about gun control, public safety, school security, and mental health is little solace to the loved ones of victims of these terrible acts of violence, although many of them work hard to engage in national policy about these issues as a result of their losses.

Steven R. Vensel, PhD

See also: Mental Health Violence

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Master Therapist

Master therapists are psychotherapists who are considered by fellow therapists to be "the best of the best" in terms of expertise in psychotherapy.

Definitions

- **Countertransference** is the phenomenon where therapists transfer or redirect feelings and expectations from their own unresolved conflicts to their clients.
- **Expertise** is the special knowledge or skills in a particular subject or area learned from experience or training and a high level of proficiency in utilizing that knowledge or skills.
- **Master** refers to one who practices with a high level of expertise or proficiency.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Transference** is the phenomenon where an individual transfers or redirects feelings and expectations from a particular person in his or her life to others, such as a therapist.

Description

Today, the terms "master" and "expertise" are in vogue. The expectation is that professionals will demonstrate expertise and a high level of proficiency. Typically, those who demonstrate these traits are well compensated and esteemed by others. Such expertise reflects mastery in practice which involves a high level of knowledge and skill sets that can be modeled impressively for others, or used as a basis for supervising the practice of others. A master therapist is one who demonstrates expertise in psychotherapy. Psychotherapeutic expertise is the capacity to know and anticipate what happens moment by moment during a psychotherapy session. Based on that knowledge, it is the skill, precision, and finesse to effect client change in those sessions. It also involves the capacity to guide the development of other therapists.

Developments and Current Status

Over the past three decades, psychologist Thomas M. Skovholt (1944–) and colleagues have conducted several research studies to identify the defining

characteristics of master therapists. These studies have been done in the United States, Canada, Korea, Singapore, and Japan. They have identified the cognitive, emotional, and relational characteristics of master therapists. A major finding is that therapeutic mastery involves considerably more than just accumulating years of experience doing psychotherapy. Rather, mastery involves an ongoing effort in improving skills and competencies, gaining new knowledge, and remaining open to experience and others' feedback. Based on these studies, 11 characteristics represent a composite picture or profile of the master therapist. The research found that most master therapists possess many, if not all, of these characteristics.

The first characteristic is that continuous professional development is a hallmark of these therapists. They are enthusiastic learners, who not only want to fully understand their clients but want to know as much as they can about psychotherapy practice. So, they continually read new literature in the field, are curious about the history of the field, and stay current with the newest developments, techniques, and studies.

Second, these therapists, with an average of nearly 30 years of professional experience, regularly draw on their rich personal and professional experiences in their work with clients. These experiences seem to have increased their depth and competence as persons and psychotherapists. Like others, they have also experienced personal and family problems and professional doubts. Unlike some, these therapists have learned to resolve them. Furthermore, they are not afraid to acknowledge these personal experiences and draw from them to better understand and assist their clients.

Third, master therapists do not simply tolerate complexity and ambiguity; they seek it out. They understand that not everything in the human realm follows linear thinking and logic. Rather, they can understand and appreciate the complexity and ambiguity of subjective emotional experiences. From this deep and broadened understanding, they are able to more effectively help their clients. Cognitive complexity is described in detail later in this chapter.

Fourth, these therapists are emotionally open, self-aware, reflective, and nondefensive, and seek out feedback. This openness includes the capacity to accept any feelings that the client brings up, as well as the capacity to recognize and share their own emotional reactions. They are likely to engage in their own personal therapy, seek supervision, and involve themselves in peer consultation to receive feedback to increase their awareness of themselves and others. They value being in touch with their feelings, deal with them constructively, and communicate them effectively.

Fifth, these therapists are emotionally healthy and mature. They strive to act congruently in their personal and professional lives. They view themselves as honest, authentic, and congruent. Like others, they experience emotional distress and subjective discomfort but are able to process their problems and are able to nurture their own emotional and spiritual well-being. They can continue to meet the emotional needs of others without burnout because they have learned how to care for themselves and meet their own needs. As a result, they are excellent at modeling emotional well-being.

Sixth, these therapists are keenly aware of how their own emotional well-being affects others, particularly in the context of psychotherapy. They are able to recognize and use transference and countertransference reactions as a normal process in therapy. They deal with their own countertransference issues by working through them in their own psychotherapy or by seeking consultation with senior colleagues. They are also very aware of personal and professional boundaries and are careful to avoid boundary violations and unnecessary boundary crossings.

Seventh, master therapists have developed the requisite relational skills of listening, responding, negotiating, and caring for others, often from an early age in their family of origin. These already learned relational skills are then honed and extended over the course of their formal therapy training. Besides using these highly developed skills with clients, these skills are valuable in communicating with family members, colleagues, administrators, and others.

Eighth, these therapists hold positive beliefs about human nature that help in building strong therapeutic relationships. They firmly believe in the value of developing and maintaining a strong therapeutic relationship. They also believe in their clients' capacity to heal and change, and in their clients' right to self-determination. It appears that these beliefs somehow instill hope and activate clients' internal resources and sense of self-efficacy.

Ninth, these therapists have the capacity to engage clients fully in the treatment process. Besides providing support and encouragement, they can therapeutically challenge clients when necessary. They are able to carefully and effectively address difficult and painful issues of their clients. Because of their finely honed therapeutic skills and the strength of their character and a personal power, they can face highly sensitive and troublesome issues with relative ease.

Tenth, master therapists were found to implicitly trust that their clients have sufficient internal resources to make positive change. This finding reflects their positive view of human nature and is related to themes that emphasize the importance of relationships, deep acceptance of self, and their intense desire to learn and grow.

Eleventh, these therapists have sufficient knowledge about the cultural background and possess the requisite cultural competencies to assist clients in effecting change in their lives. They use their cultural knowledge and awareness, conceptual framework, understanding of cultural barriers, and culturally sensitive interventions—or referral for such interventions—to provide services to culturally diverse populations.

Len Sperry, MD, PhD

See also: Deliberate Practice; Psychotherapy

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Mathematics Disorder

Mathematics disorder (MD) is a condition that hinders people from learning age-appropriate mathematical reasoning and calculations.

Definitions

- **Mathematics** is the study of numbers, equations, functions, and geometric shapes and their relationships, as in arithmetic, algebra, geometry, and calculus.

Description

Mathematics disorder, also called dyscalculia, affects a person's ability to learn and apply math. It is included in the category of Specific Learning Disabilities and specified for problems in math. Like most learning disorders, MD is not related to a person's intelligence, as measured by an intelligence quotient. People who have MD may have difficulty in several specific areas. The first is language based since they may find it hard to name and use mathematical terms and concepts. They may struggle with turning word math problems into math problems using numbers and symbols. Second, their ability to recognize mathematical symbols and signs may be limited. A third area of difficulty may be in attention to detail where they find it almost impossible to copy numbers or symbols accurately. In addition, they may not remember to carry over the number when calculating. Finally, they can have great difficulty with mathematical operations, including counting, multiplying, and dividing.

As with other learning disorders, the cause of mathematics disorder is probably genetic but presently the specifics are unknown. In some cases when brain trauma has occurred, MD can be present. Symptoms of the disorder are general difficulty with basic math operations and problems.

There are common issues that surface in the struggle to understand concepts that describe other concepts, for example, the concept of measurement, like the understanding of half, or a relationship, like the meaning of between or instead. The result of a student's confusion will be an inability to tell which parts or details of a mathematical problem are important. Many people with MD also present with symptoms of anxiety and agitation as it pertains to school or academic tasks that they find frustrating. Behavior problems commonly co-occur with learning disorders and MD is no exception.

Diagnosis

Mathematics disorder can be hard to distinguish from associated learning impairments. It is estimated that only about 1% of students warrant a diagnosis of MD. Many more may show evidence of struggling with one or more of the characteristics of MD. The prevalence of MD among children who also have been diagnosed with ADHD is estimated at 18%. MD can be identified through the results of standardized testing, which show that the people tested score substantially below what is expected for their intelligence, age, and level of education.

Treatment

Although the symptoms of learning disorders can change over time, there is no cure for mathematics disorder. Treatments that can help people struggling with MD include special education, tutoring, technology training, and individual therapy. Aside from the educational interventions already mentioned, therapy can be helpful to address the mental health symptoms that may also be present.

Patience and creativity is required to help children deal with the challenges of MD. It is best to consult a specialist in learning disorders for a thorough analysis of the issues involved before developing a treatment plan. In conjunction with math teachers, a program that is tailored to help the child begin to master mathematical concepts, skills, and symbols is important.

Some approaches that have been found useful involve repetition and mnemonic devices to make it easier to memorize formulas. The use of visual approaches such as drawing pictures to illustrate problems has been helpful. Applying mathematical concepts to other subjects they have already learned is also effective. It is also useful to see if there are community or educational services or programs that might benefit children who have MD.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Learning Disorders; Specific Learning Disorder

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May, Rollo (1909–1994)

American psychologist Rollo May is best known for his work in humanistic psychology and promoting existential thought.

Description

Popular American psychologist Rollo Reece May was born on April 21, 1909, in Ada, Ohio, the first son of six children. May experienced a difficult childhood: his parents divorced and his sister, who suffered from schizophrenia, was involuntarily committed after a psychotic breakdown. These early experiences are believed to have influenced May's later interest in psychology. His postsecondary education began at Michigan State University though he was soon expelled for his involvement in a radical student magazine. He then transferred to Oberlin College where he earned his bachelor's degree in English. May later traveled to Greece and spent three years teaching English at Anatolia College. During his travels he became associated with Alfred Adler, who influenced much of his later work. On his return to the United States he earned a bachelor's degree in divinity at Union Theological Seminary in New York in 1938, serving as a minister for only a short time before deciding to pursue a doctoral degree in clinical psychology at Columbia College. While at Union he became friends with philosopher and theologian Paul Tillich, who also had a profound impact on his life and work. In 1942, May was diagnosed with tuberculosis and sent to a sanatorium. Though near death, he spent this time reading, studying, and developing his own philosophical and psychological theory, based on existential and humanistic principles. He recovered and studied and taught at both the William Alanson White Institute and the New School for Social Research in New York City before moving to Tiburon, California, where he spent the remainder of his life with his wife Georgia. Rollo

May died on October 22, 1994, from congestive heart failure.

Impact (Psychological Influence)

Rollo May, along with colleagues Ernest Angel and Henri Ellenberger, developed and introduced existential psychology to the United States with the release of their 1958 book *Existence*. Influenced by the writings and work of Kierkegaard, Abraham Maslow, Alfred Adler, Viktor Frankl, Otto Rank, and Erich Fromm, May's theory emphasized free will, conscious thought, and authenticity as protective forces against human ailments, including anxiety, self-doubt, and loneliness. Rollo May helped to create the concept of existential psychology, which teaches that all people consciously create their own set of beliefs, values, and behaviors, by which they attribute meaning to their life. May authored several well-known books, including *The Meaning of Anxiety* (1950), *Man's Search for Himself* (1953), *The Courage to Create* (1975), and his most popular *Love and Will* (1969). He also founded Saybrook Graduate School and Research Center in San Francisco, California.

Melissa A. Mariani, PhD

See also: Existential Psychotherapy; Humanistic Psychotherapy

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McGoldrick, Monica (1943–)

Monica McGoldrick is a key figure in the research that has studied multigenerational and multicultural families. She is the cofounder and director of the Multicultural Family Institute and has published numerous books on genograms and family development.

Description

Monica McGoldrick, MSW, was born in Brooklyn, New York, and raised in Pennsylvania. McGoldrick originally studied Russian studies and found herself unsure what to do after deciding she didn't want to become a professor. She has frequently spoken of how the day she finished her program she met a man at a coffee shop who happened to be studying psychology and thought that it could be a great field for her. Before returning to school to study she began work at a hospital in an inpatient unit to determine if the field was right for her. This provided the beginning of her realization for her passion for working with families as well as a desire to better understand how families function.

In the early 1970s, McGoldrick was introduced to the work of Murray Bowen who was the pioneer behind what is now known as mainstream family therapy. Bowen's approach was to look at family development over generations and not just immediate family. McGoldrick found his work to be very interesting and influential to her. McGoldrick used his model of family maps to continue the growth and development of genograms as they are currently used by clinicians today. Genograms provide a graphic that tracks usually three or four generations of family members, history, and relationships. McGoldrick emphasizes the importance of exploring several generations of a family as well as the impact of ethnicity and gender. McGoldrick feels that these factors are key in determining and understanding behavior.

Impact (Psychological Influence)

McGoldrick was given an honorary doctorate from Smith College for her extensive contribution to the field of family therapy. She is best known for her contributions to genograms and exploring gender and ethnicity impacts in family dynamics. McGoldrick is considered to be one of the most notable and reliable sources for attending to multicultural and gender issues in family therapy. She has published several books and is highly respected in the field of counseling and family therapy. McGoldrick is currently the director of the Multicultural Family Institute.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Bowen Family Systems Theory; Genograms

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MCMI

See Millon Clinical Multiaxial Inventory

Mean Girls (Movie)

Description

The American teen comedy film *Mean Girls* was released on April 30, 2004, and was an overnight hit ranking number one and grossing over $24 million in its opening weekend. Worldwide it has raked in over $129 million. The movie was based on the nonfiction book *Queen Bees and Wannabees* by Rosalind Wiseman, which reveals how female social cliques operate in high school. Lindsay Lohan stars in the film along with Rachel McAdams, Amanda Seyfried, Lacey Chabert, and Lizzy Caplan. The screenplay was written by Tina Fey, who also stars in the film, and produced by *Saturday Night Live* (*SNL*) creator Lorne Michaels. Several other *SNL* cast members appear in the movie, including Tim Meadows, Ana Gasteyer, and Amy Poehler. *Mean Girls* was directed by Mark Waters, who also collaborated with Lohan on the movie *Freaky Friday* in 2003.

Homeschooled, 16-year-old Cady (Lindsay Lohan) has just returned to the United States after spending 12 years in Africa with her zoologist parents (Ana Gasteyer and Neil Flynn). She begins her first day at public high school feeling intimidated, alone, and unsure of her place. Two students soon befriend her, Janis (Lizzy Caplan) and Damien (Daniel Franzese), and teach her all about the school's cliques, including the top-reigning "Plastics," a trio of popular, pretty, yet exclusive, sophomore girls, led by Queen Bee, Regina George (Rachel McAdams). Janis, in particular, hates the Plastics because they previously spread vicious rumors about questioning her sexuality. She hatches a plan for revenge using Cady to infiltrate the group and take them down from the inside.

The Plastics soon befriend Cady, inviting her to join their lunch table and to go shopping with them. Regina also reveals a secret "Burn Book" that she created containing pictures and gossip about fellow students and even teachers. Slowly, with some coaxing from Janis and Damien, Cady begins to ruin Regina's world. She convinces the other Plastics turn against Regina, destroys her beauty by tricking her into eating Kälteen bars that actually cause her to gain weight, and

Mean Girls was based on the nonfiction book *Queen Bees and Wannabees* by Rosalind Wiseman, which reveals how female social cliques operate in high school. (Paramount Pictures/Photofest)

even falls in love with Regina's ex-boyfriend, Aaron. Cady slowly becomes immersed in the Plastics' world, changing not only her looks but her personality. Janis and Damien learn that their plan has backfired when they see Cady become a Plastic for real. Regina finally figures out that Cady has been plotting and vows to ruin her by telling Principal Duval that Cady is responsible for the "Burn Book." The entire class of girls is now enraged and fights are breaking out right and left as the secrets in the book get revealed. Principal Duval calls a mandatory meeting where all the girls are required to share their feelings and apologize for any wrongs they have caused one another. Cady learns the errors of her ways, especially the values of being true to yourself, your real friends, and taking responsibility for your own actions. In the end of the movie, Cady joins the Mathletes after apologizing to the Math teacher, Ms. Norbury (Tina Fey), for the lies she wrote about her in the Burn Book. She is also elected Spring Fling Queen, makes up with Janis and Damien, reunites with Aaron, and calls a truce with the Plastics. The clique is now disbanded, with each going separate ways and the "Girl World" at school finally being declared drama free.

Impact (Psychological Influence)

The movie *Mean Girls* is considered a teen pop culture megahit. Though Lindsay Lohan had already made a name for herself by its debut, it is still her most successful film at number one and her most memorable role to date. *Mean Girls* also received positive reviews from critics. Rotten Tomatoes rated it 83% ("Certified Fresh") based on 167 reviews. In 2006, it was named the 12th best high school movie of all time by *Entertainment Weekly*. Even though *Mean Girls* is a comedy, it brings to light the reality and cruelties of girl-on-girl bullying during adolescence.

Melissa A. Mariani, PhD

See also: Bullying and Peer Aggression; Cliques

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Media Violence

"Media violence" refers to the impact of violent content in television, film, video games, music, and music videos.

Description

Exposure to depictions of violence in movies, television, video games, music, and music videos has long been recognized as unhealthy for minors as evidenced

"Media violence" refers to the impact of violent content in television, film, video games, music, and music videos on individuals (usually children and adolescents). There is considerable debate about whether violent actions such as school shootings can be attributed to the large amount of violence in the media today. (Alamy)

by restricted access and restricted labeling of these products. A large number of research studies have documented that minors spend a considerable amount of time engaged in media entertainment. Research into media violence has generally focused on its impact on aggression, but effects can be difficult to interpret. Some researchers contend there is clear evidence of harm, while others insist that the effects are minimal at best.

Impact (Psychological Influence)

Research investigating television violence indicates that depictions of violence are frequent and pervasive. There are 20 to 25 violent acts per hour of programing and over 60% of programming contains violence. In over 70% of the violent scenes, there was neither criticism of, nor remorse over, violent behavior. Numerous research studies, including meta-analytic studies, investigating the effects of television violence have found a significant, meaning not random, association between amount of time spent watching television and aggressive behaviors. The effect size, a measure of the magnitude of the effect, of these studies have been overall small to medium. There is similar research investigating the impact of movie violence. What impacts the ability to instantly view movies on just about any electronic platform, including smartphones, is not clear and warrants further investigation.

Video game and music violence have both been highly investigated. Certain genres of music and music videos also been linked to acceptance of violence against women and with rebelliousness, drug use, aggression, and antisocial behaviors. Video games have come under intense scrutiny and have been associated with aggressive behaviors, decreased empathy, and a decrease in helpful behaviors.

In spite of the consistent findings linking media violence to aggression, some researchers have criticized the conclusions as having no causal effect or influence on any real-life behaviors. Researchers who are skeptical of the findings contend that small effect sizes indicate that the true magnitude of the influence is minimal at best. Research skeptics also make note that the interconnected findings across media types should have a cumulative negative impact on society, yet crime, according to FBI statistics, has been steadily decreasing. Research skeptics also argue that background factors such as family and interpersonal dynamics have not been controlled for and may play a part in the actual findings.

Media is a powerful form of entertainment and communication that impacts people on an individual level. Media violence will continue to be the focus of intense research.

Steven R. Vensel, PhD

See also: Hip-Hop Music; Music, Influence of; Video Games

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Medically Unexplained Symptoms

Medically unexplained symptoms are those for which the cause has not been identified. They are also referred to as medically unexplained physical symptoms.

Definitions

- **Anxiety disorders** are a group of mental disorders characterized by anxiety as a central or core symptom. The group includes agoraphobia, specific phobias, and social anxiety disorder.
- **Chronic pain disorder** is a poorly understood medical conditions characterized by the experience of local pain of an unknown cause.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable

mood and other changes that significantly disrupt the individual's daily functioning. These include major depressive disorder and persistent depressive disorder.

- **Fibromyalgia** is a medical condition characterized by widespread, unexplained pain as well as sensitivity to pressure or touch in specific areas of the body.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Somatic symptoms and related disorders** are a group of DSM-5 mental disorders characterized by prominent somatic (physical) symptoms and significant distress and impairment. They include somatic symptom disorder and factitious disorder. Previously it was known as somatoform disorders.

Description

"Medically unexplained symptom(s)" is a medical term for a broad category of abnormal physical symptoms for which the cause has not been identified. This does not mean that the symptoms do not have a cause but rather that there is no scientific consensus as to the cause. Typically, such symptoms involve unexplained pain or sensations. Common examples of medically unexplained symptoms are chronic pain disorder and fibromyalgia. Such unexplained symptoms may be present in the various DSM-5 somatic symptoms and related disorders. Also, such symptoms may co-occur (occur simultaneously) with mental disorders such as the depressive disorders and the anxiety disorders.

Even though a specific diagnosis is not made, medically unexplained symptoms can be and are treated. Treatment varies widely and is usually influenced by a known co-occurring medical or mental condition. Psychotherapy is frequently utilized, even if no additional mental disorders are present. Such therapy typically focuses on helping individuals to cope with their symptoms.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Chronic Pain Syndrome; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Fibromyalgia; Psychotherapy; Somatic Symptom Disorder

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Medication-Induced Movement Disorders

Medication-induced movement disorders are medical conditions that occur as the result of treatment with antipsychotic medications.

Definitions

- **Amphetamines** are a potent central nervous system stimulant of the phenethylamine class that is used primarily in the treatment of attention-deficit hyperactivity disorder and narcolepsy.
- **Antidepressants** are medications that are used primarily to treat depression and depressive disorders. They are also referred to as antidepressant medications.
- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are commonly referred to as neuroleptics.
- **Clozaril** is a second-generation antipsychotic medication used in treating schizophrenia and bipolar disorder, as well as other medical conditions and disorders.

- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Haldol** is a first-generation antipsychotic medication used in treating schizophrenia, short-term psychosis, mania, and delirium, as well as other medical conditions and disorders.
- **Hypothyroidism** is a condition in which an individual's thyroid gland does not produce enough hormones and can cause a number of medical problems, such as obesity, joint pain, and heart disease.
- **Malignant catatonia** is an acute onset of fever, instability, excitement, and delirium caused by a neurogenic motor immobility and behavioral abnormality due to the lack of critical cognitive function and level of consciousness.
- **Movement disorders** are a group of medical conditions affecting the ability to produce and control movement. They include degenerative, hereditary, and medication-induced conditions.
- **Neuroleptic malignant syndrome** is a condition that affects movement and difficulty regulating body heat in individuals who have been treated with antipsychotic medications.
- **Neuroleptics** are antipsychotic medications that block dopamine receptors.
- **Parkinson's disease** is a disease of the nervous system that causes tremor, rigidity, slowness of movement, and unstable posture.
- **Risperdal** is a second-generation antipsychotic medication used to treat schizophrenia, schizoaffective disorder, and bipolar disorder, as well as other medical conditions and disorders.
- **Thorazine** is a first-generation antipsychotic medication used to treat schizophrenia and manic depression, as well as other medical conditions and disorders.

Description and Diagnosis

Medication-induced movement disorders are movement disorders that result from treatment with antipsychotic (neuroleptic) medications. They are not mental disorders but are included in Section II of the DSM-5 because of their importance in medication management of mental disorders or other medical conditions. Since they are not considered mental disorders, they have no diagnostic criteria nor diagnostic codes. Newer antipsychotic medications (e.g., Risperdal and Clozaril) have been found to be less likely to cause some medication-induced movement disorders. However, these disorders do still occur. First-generation antipsychotic medications (e.g., Haldol and Thorazine) are more likely to cause medication-induced movement disorders.

There are several separate classifications of the conditions and problems that fall under medication-induced movement disorders. They include neuroleptic-induced parkinsonism and other medication-induced parkinsonism, neuroleptic malignant syndrome, medication-induced acute dystonia, medication-induced acute akathisia, tardive dyskinesia, tardive dystonia and tardive akathisia, and medication-induced postural tremor. Neuroleptic malignant syndrome and tardive dyskinesia are more fully described in their own entries in this encyclopedia.

Neuroleptic-Induced Parkinsonism and Other Medication-Induced Parkinsonism

Both are conditions that include symptoms such as bodily shaking, muscle inflexibility, and difficulty initiating movement or complete loss of movement. These symptoms usually occur within a few weeks of starting a neuroleptic medication or after increasing the dosage of a neuroleptic medication. Symptoms can also appear after reducing the amount of a neuroleptic medication.

Neuroleptic malignant syndrome. Neuroleptic malignant syndrome (NMS) is a serious condition that can occur at any time during the course of neuroleptic treatment. NMS is easily recognized in its full-blown form and is often different in its onset, presentation, progression, and outcome. One recognizable symptom

of NMS is an individual who experiences abnormally low body temperature on at least two occasions that are accompanied by excessive sweating. This particular feature of NMS sets it apart from other side effects found in other conditions with the use of neuroleptic medications. Some other symptoms of NMS include shaking in the body; fever; loss or impairment of voluntary activity; uncontrollable and repetitive twisting movements; sudden twitching of a muscle or group of muscles; weak or non-movement of the muscles of the face, mouth, and respiratory system; and difficulty swallowing.

Medication-induced acute dystonia. Medication-induced acute dystonia is a condition associated primarily with abnormal bodily positions and muscular spasms. The symptoms usually include abnormal positioning of the neck and head in relation to the body, jaw muscle spasms, and having difficulty swallowing, breathing, or speaking. Individuals with this condition often have slurred speech because of the slow movement of their tongue. Some other symptoms individuals may experience are abnormal or prolonged contractions in the muscles in the eyes and abnormal positioning of their limbs (arms and legs) and trunk (middle section of their body). Symptoms usually occur in individuals within a couple of days of starting or increasing the dosage of a neuroleptic medication. These symptoms may also occur after reducing the amount of the neuroleptic medication.

Medication-induced acute akathisia. Medication-induced acute akathisia is a condition that is due to the use of neuroleptic medications. This condition is not due to excessive worry, substance withdrawal, or unbalanced agitation. Symptoms are characterized by restlessness and the need to be in constant motion. For example, an individual may have fidgety movements of the legs and have an inability to sit still. These symptoms usually occur within the first four weeks of beginning or increasing the dosage of a neuroleptic medication. These symptoms may also occur after reducing the amount of the neuroleptic medication.

Tardive dyskinesia. Tardive dyskinesia is a condition that includes involuntary movements usually in the tongue, lower jaw and face, and arms and legs. These symptoms must be present for at least four weeks. A jerky and rapid, continual and slow, or repeated movements are symptoms present in this condition. Symptoms of this condition usually occur within three months of beginning a neuroleptic medication. Tardive dyskinesia cannot be due to other medical conditions (e.g., Huntington's disease and hypothyroidism).

Tardive dystonia and tardive akathisia. Tardive dystonia and tardive akathisia are conditions involving other types of movement difficulties, such as dystonia and akathisia. Dystonia is a state of abnormal muscle tone, which results in muscular spasms and abnormal bodily positioning. Akathisia is a state of distress, agitation, and restlessness. Tardive dystonia and tardive akathisia are characteristic of their late emergence in the course of treatment. These symptoms may last for months to years, even when the use of neuroleptic medications is discontinued, or the dosage of the medication is reduced.

Medication-induced postural tremor. Medication-induced postural tremor is characterized by a fine tremor (bodily shaking) that occurs during attempts to maintain normal bodily positioning in association with the use of a medication (e.g., antidepressants). This tremor is very similar to tremors seen with anxiety, caffeine, and amphetamine use.

Treatment

Treatment for neuroleptic-induced parkinsonism, other medication-induced parkinsonism, NMS, and medication-induced postural tremor is a change in medication. This may include the reduction of or complete discontinuation of a neuroleptic medication. The average recovery time for individuals who discontinue antipsychotic medications is between 7 and 10 days. There are no effective treatments for tardive dyskinesia, tardive dystonia, or tardive akathisia once the symptoms develop.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Amphetamines; Antidepressants; Antipsychotics; Clozaril (Clozapine); *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Haldol (Haloperidol); Parkinson's Disease; Risperdal (Risperidone); Tardive Dyskinesia; Thorazine (Chlorpromazine)

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Meditation

Meditation is the concentrated focus on a sound, the breath, object, or attention itself to increase awareness of the present moment. Its purpose is to reduce stress, promote relaxation, or increase cognitive capacities and spiritual growth.

Definitions

- **Concentration** is the one-pointed awareness or undivided attention of one's consciousness upon a particular point of focus.
- **Consciousness** is the capability for awareness of one's own existence.
- **Mindfulness** is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Religion** is search for significance through the organized and collective dogma or doctrine that defines the sacred.
- **Spirit** does not have an agreed-upon definition. One way to define spirit is that which is omnipresent, infinite, all-pervading, and all-encompassing.
- **Spirituality** is the personal effort to think, feel, and act in order to find, conserve, or transform the sacred in one's life.
- **Transcendental meditation** is a form of external awareness meditation that takes one's awareness beyond the conventional boundaries of a body-bound self and unites the self with spirit.

Description

Meditation is a spiritual practice that has been described and practiced in various ways. From a mental health prospective, there are two basic forms of meditation. These two forms of meditation are referred to as concentrative meditation and external awareness meditation. The specific techniques or meditative practices associated with these two forms of meditation are infinitely varied. In concentrative meditation attention is focused upon any aspect of reality or imagination. The meditation experience consists of maintaining the concentration and is useful in countering the mind's tendency to wander. As concentration wanes, the goal is to refocus one's efforts to concentrate. Meditation of this kind becomes a sequence of focusing and refocusing one's attention on a preselected object or mental construction. A beginning practitioner of concentrative meditations typically experiences a restless mind. The restless mind is filled with apparently random and uncontrollable mental constructions. This wayward mental experience of novice practitioners is called "monkey-mind" in the Buddhist traditions. It takes will and discipline to train the mind to stay focused. The ability to concentrate develops over time with the deliberate practices associated with concentrative meditation. Concentrative meditation is also known as "object-based" practices. In concentrative meditation there is a distinct experience of duality and separateness between the self that is meditating and the object that one is concentrating upon.

In the second form of meditative practices, external awareness meditation, attention is focused outside of one's self. External awareness meditation is similar to concentrative meditation in that attention is focused on any aspect of reality or imagination. It emphasizes the relationship between the meditator and that which is meditated upon. External awareness meditation focuses on "opening up" one's awareness. The ultimate goal of external awareness meditation is to become totally open to and absorbed in the relationship

between self and other. In this meditative relationship the boundary between self and other is indistinguishable. The self-object duality dissolves into an experience of radical unity.

While different in focus, there is some overlap between these two forms of meditation. In fact, concentrative meditation and external awareness meditation can be viewed on a continuum. The continuum begins with concentrative meditation and self-object duality, and the continuum extends to external awareness meditation and a sense of unification and non-dual self-sacred integration.

Examples of these two forms of meditation are Christianity's Contemplative Prayer, Hinduism's Advaita (Vedanta) meditations, and Zen Buddhism's Dzogchen (Ch'an). These practices are unique because they are object-based concentrative practices to the novice practitioner. Contemplative Prayer, Advaita, and Dzogchen at their rudimentary stages are contemplative or concentrative practices. Through deliberate and steadfast effort, these meditations become objectless external awareness meditations to the advanced practitioner. They are also Transcendental Meditations (TM) at advanced levels of practice. In TM practices, the self and other is not-two or non-dual. "Non-dual" simply means united or yoked sufficiently that the experience of self and other is unintelligible. Contemplative Prayer, Advaita, and Dzogchen are three metaphorical bridges between concentrative meditation and external awareness meditation. Meditation is the practice of eliciting a type of consciousness. Beginning meditators can expect to experience stress reduction and increased relaxation. However, the type of consciousness that meditation ultimately develops is a consciousness united with spirit.

Development and Current Status

Meditative practices outdate recorded history. Meditation was as much a part of prehistory as it is a part of current times. The etiology of meditative practices was passed along through lore until the written word was developed. Various philosophies and religious practices began documenting meditative practices in writing approximately 5,000 years ago. Such writings were first discovered in Egypt, India, China, and Mesoamerica (Mexico and Chile). The earliest forms of written meditation are mantras or rhythmic chants. The oldest forms of modern meditation have their roots in the Hindu traditions of Vedanta. "Vedanta" refers to the scriptural writings of the Vedas. The Vedas are writings devoted to the lore of ancient India. These writings clearly influenced the development of Buddhism in China and Zen Buddhism in Japan. There are theories that claim these same philosophies traveled west as well and influenced the development of Islam and Christianity. In any case, these Eastern "psychologies" have emphasized the cultivation of attention to one's own subjective experience prior to the formal establishment of modern mental health practices. However, meditation is a major aspect of almost all religions and spiritual practices. In other words, meditation is an aspect of human experience and does not belong to any particular ideology. Nevertheless, many of the most popular and effective meditative practices available today originate in the Yogic, Buddhist, and Christian traditions. Students and scholars interested in these meditative traditions might begin with the writings of Adi Shankara (788–820), the Diamond Sutra preserved by Aurel Stein (1862–1943), and the Trappist monk Thomas Keating (1923–), respectively. It is important to note that many forms of meditation are in fact mindfulness practices. These traditions teach that it is most difficult to stay mindful when one is attached to biases, longing for desire, or intensely angry. Many Eastern traditions agree that factors of calmness, tranquility, and balance assist the maintenance of a mindful awareness. Meditation and mindfulness are closely related to loving kindness and compassion.

Layven Reguero, MEd, and Len Sperry, MD, PhD

See also: Contemplative Neuroscience; Mindfulness; Prayer; Religion and Religiosity; Spirituality and Practices; Yoga

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Meichenbaum, Donald (1940–)

Clinical psychologist Donald Meichenbaum is best known for his contributions to cognitive behavior therapy, specifically for developing the cognitive behavioral modification technique that uses self-instruction to identify and correct negative behavior.

Description

Donald H. Meichenbaum was born in the summer of 1940 in New York City. He grew up in a loving family and attended public schools. In 1962, he graduated with his bachelor's degree from City College and went on to pursue a doctoral degree in clinical psychology at the University of Illinois in Champaign. A self-proclaimed "people watcher," Meichenbaum was always interested in observing human behavior. Though he was initially hired as an industrial psychologist to conduct group observations at a veteran's hospital, he soon decided his true passion was for clinical practice. Drawn to the opportunity to work with renowned psychologist Richard Walters, he accepted a position at University of Waterloo in Ontario, Canada, in 1966. It was during his time at Waterloo that he formalized his approach to cognitive behavior therapy (CBT), one that is considered less direct than Albert Ellis's rational emotive behavior therapy approach. CBT is an alternative approach to traditional psychodynamic therapy in that it associates thoughts, beliefs, and feelings with behavior; changing behavior requires a shift in negative thought patterns.

Meichenbaum used a process of self-instruction accompanied by role-playing activities to assist clients in changing destructive thoughts that lead to unwanted behavior. He went on to develop the therapeutic technique known as *cognitive-behavior modification* which is composed of three phases: (1) observing one's inner dialogue, self-talk patterns, and behaviors; (2) recognizing when self-talk patterns begin and replacing them with positive statements; and (3) learning new skills and coping behaviors based on these new restructured thought patterns. His work in the area of stress inoculation training is also well noted.

Dr. Meichenbaum taught and practiced at Waterloo until he formally retired in 1998. He now splits his time between Ontario, where he still maintains a private practice, and Miami where he helped found The Melissa Institute for Violence Prevention and Treatment in 1996. He currently sits on the board of directors and serves as the institute's research director.

Impact (Psychological Influence)

Dr. Meichenbaum has earned the honor of distinguished professor emeritus at the University of Waterloo and distinguished visiting professor at the University of Miami's School of Education. A survey in the *American Psychologist* reported him "one of the 10 most influential psychotherapists of the 20th century" (Smith, 1982). In 2008, he received a Lifetime Achievement Award from the Clinical Division of the American Psychological Association. His expertise spans a wide range of topics, including cognitive behavioral approaches, student learning, anger control, violence prevention, trauma, and post-traumatic stress. Meichenbaum has authored several important works, including *Cognitive-Behavior Modification: An Integrative Approach* (1977), *Coping with Stress* (1983), *Pain and Behavioral Medicine: A Cognitive-Behavioral Perspective* (1983), *A Clinical Handbook/Practical Therapist Manual: For Assessing and Treating Adults with Post-Traumatic Stress Disorder* (*PTSD*) (1984), *Nurturing Independent Learners: Helping Students Take Charge of Their Learning* (1998), *Treatment of Individuals with Anger—Control Problems and Aggressive Behaviors: A Clinical Handbook* (2003), and *Roadmap to Resilience: A Guide for Military, Trauma Victims and Their Families* (2012). He also lectures and consults on these topics both nationally and internationally.

Melissa A. Mariani, PhD

See also: Cognitive Behavioral Modification

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Melatonin

Melatonin is a chemical messenger in the brain, which regulates the sleep–wake cycle and promotes restorative sleep.

Definition

- **Insomnia** is a chronic difficulty in falling asleep and staying asleep.

Description

Melatonin is a neurotransmitter (chemical messenger) in the brain. Melatonin is made from serotonin which is also a neurotransmitter. Serotonin and melatonin work together in relaying signals between neurons in the brain. A primary role of serotonin is to enhance mood and provide energy. Melatonin is produced in response to darkness and results in nightly sleep. Its primary role is to regulate healthy sleep cycles. There is a link between low levels of melatonin and mood disorders due to the disruption of sleep. In addition, low levels of serotonin can cause insomnia by preventing melatonin production.

Synthetic melatonin is a nutritional supplement that is used to treat various sleep problems. One of its most common uses is to adjust the body's internal clock. It is used for jet lag, for adjusting sleep–wake cycles in those whose daily work schedule changes (shift-work disorder), and for helping those who are blind to establish a day and night cycle. Melatonin is also used for the insomnia, delayed sleep phase syndrome, insomnia due to certain high blood pressure medications called beta-blockers, and sleep problems in children with autism, cerebral palsy, and mental retardation. It is also used as a sleep aid after discontinuing the use of benzodiazepine drugs and to reduce the side effects of quitting smoking. Some use melatonin for Alzheimer's disease, tinnitus (ringing in the ears), depression, chronic fatigue syndrome, fibromyalgia, migraine and other headaches, irritable bowel syndrome, osteoporosis (bone loss), and epilepsy, and as an antiaging agent, and menopause. Other uses include breast cancer, brain cancer, lung cancer, prostate cancer, head cancer, neck cancer, and gastrointestinal cancer. Melatonin is also used for some of the side effects of cancer treatment (chemotherapy), including weight loss, nerve pain, and weakness. It is also a potent antioxidant.

Precautions and Side Effects

Melatonin should not be used by women who are or want to be pregnant. Melatonin might also interfere with ovulation, which makes it more difficult to become pregnant. Since little is known about the about the safety of using melatonin when breast-feeding, it is best not to use it. Melatonin should not be used in most children. Because of its effects on other hormones, melatonin might interfere with development during adolescence. Because it can raise blood pressure in those taking certain blood pressure–lowering medications, melatonin should not be used. Melatonin can increase blood sugar in those with diabetes. This necessitates monitoring blood sugar carefully in those taking melatonin. Melatonin can also worsen depression and increase the risk of having a seizure. Because it can cause drowsiness, refrain from driving or using machinery for five hours after taking melatonin.

Generally, melatonin has a positive and quick effect on sleep and it has no negative side effects. If there are side effects they tend to be mild. They include headache, short-term feelings of depression, daytime sleepiness, dizziness, stomach cramps, and irritability.

Melatonin interacts with some medications and over-the-counter preparations. Taking melatonin along with sedative medications can cause significant sleepiness. These sedative medications include Klonopin, Ativan, Donnatal, and Ambien. Taking melatonin along with birth control pills can result in very high levels of melatonin in the body. Such birth control pills include estradiol, Triphasil, Ortho-Novum 1/35, and

Ortho-Novum 7/7/7. Caffeine also interacts with melatonin and may decrease the effectiveness of melatonin supplements. In contrast, Luvox can increase melatonin levels and the main effects (sleep) as well as the side effects of melatonin.

Len Sperry, MD, PhD

See also: Sleep Disorders

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Mental Competency Evaluation

Mental competency evaluation is a medical examination to determine an older adult's capacity (ability) to understand and make decisions about his or her health, living arrangement, finances, and so forth. It is different from a mental evaluation of competence to stand trial for criminal charges.

Definitions

- **Alzheimer's disease** is a progressive neurodegenerative disease in which dementia results from the degeneration and death of brain cells because of plaques and neurofibrillary tangles.
- **Capacity** is the ability to respond to a particular situation with appropriate appreciation and to act in one's own self-interest.
- **Competency** (or competence) refers to the determination that an individual retains the capacity for a specific action.
- **Conservatorship** is the legal status in which a "conservator" is appointed by the court to make decisions concerning a "conservatee," the individual judged to be incompetent.
- **Dementia** is a group of symptoms (syndrome) associated with a progressive loss of memory and other intellectual functions that interfere with one's ability to perform the tasks of daily life. It impairs memory and reasoning ability, causes disorientation, and alters personality.
- **Testamentary capacity** is the capacity to make a will. It means an individual must understand what a will is, and know the extent of his or her estate.

Description

"Competency" is a legal term that means that an individual has the soundness of mind and mental capacity to be qualified to act legally for himself or herself. Capacity is the cognitive ability to receive, process, and perform mentally. More specifically, it is the ability to understand one's options, one's actions, and the effects of one's actions. An individual can lack capacity for many reasons. He or she may have a memory impairment as in Alzheimer's disease. He or she may be unable to read or understand language because of a stroke. He or she may demonstrate poor judgment, planning, or initiative because of a frontal lobe disorder. He or she may feel hopeless and worthless because of depression. Or, an individual with otherwise intact mental faculties may have compromised capacity because of a drug or alcohol (intoxication).

Competency is not an "all or nothing" attribute. An individual may be able to but can make medical decisions about himself or herself or make a will but might not be able to balance his or her checkbook. In other words, some individuals are competent in some areas but not in other areas. An individual might be competent one day and lack competence the next day. However, steady mental decline over-results in increasing degree of incompetence.

Mental decline interferes with quality of life and the details of daily living such as shopping, paying bills, eating, and keeping one's assets safe. When mental decline is severe, the courts, through conservatorship,

may appoint someone act on behalf of and protect the affected individual.

Developments and Current Status

At least four factors are assessed in determining competency: first, the ability to verbalize the reasons behind one's decisions consistent with one's goals; second, the ability to understand relevant information; third, the ability to understand one's situation and the consequences of one's decisions; and fourth, the extent to which a recent decision is consistent with one's other decisions and basic values. The basic criteria in a determination of competency is whether an individual understands the alternatives that are available and whether the individual can make a decision based on the facts and appreciate the consequences of his or her decision.

Determining mental competency generally involves a formal mental competency evaluation done by a physician or psychologist. Such an evaluation includes clinical observation, an interview, and neuropsychological testing. The most often used of such tests is the mini-mental state examination (MMSE). The MMSE is a standardized method to assess cognitive mental status and to quantify cognitive ability. It is also useful in monitoring changes in cognitive status over time. It assesses orientation, attention, immediate and short-term recall, language, and the ability to follow simple verbal and written commands. The MMSE provides a total score that places the individual on a scale of cognitive function (from 0 to 30). MMSE scores of 0–17 suggest severe cognitive impairment, 18–23 suggest mild cognitive impairment, and 24–30 suggest no cognitive impairment. It takes approximately 10 minutes to administer this test.

Len Sperry, MD, PhD

See also: Alzheimer's Disease; Insanity Defense; Mini-Mental State Examination; Neuropsychological Tests

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Mental Health and Violence

"Mental health and violence" refers to the prevalence, frequency, and risk factors associated with violence and individuals suffering from mental illness.

Description

Horrific crimes receive extensive news coverage that link these events to people suffering from severe mental illness (SMI). This has led to the public perception that violence and mental illness are highly associated. The relationship between violence and SMI has important implications affecting not only public opinion but also mental health policy and clinical practice. Stigma and discrimination impacting those who suffer from an SMI is also affected by public opinion. The relationship between SMI and violence has been the subject of investigation for many years and has yielded mixed results. Some studies have indicated a clear linkage, while others have not. Weak research methodology, definitions of mental illness, and ineffective threat assessment tools have been cited as reason for lack of clearly identified risk factors leading to violent behavior by those suffering from an SMI.

Current Status and Impact (Psychological Influence)

Researchers Eric Elbogen and Sally Johnson conducted a national representative investigation of the link between violence and SMI using data from the National Epidemiologic Survey on Alcohol and Related Conditions. Almost 40,000 respondents were interviewed and tracked on two separate occasions. The researchers found that the presence of an SMI such as schizophrenia, bipolar disorder, or major depression alone did not predict future violent behavior. People

with a mental illness who were abusing drugs or alcohol were a strong predictor of violent behavior. The findings also supported other research that identified non-substance abuse risk factors predicting violence in the mentally ill. Risk factors include growing up in an abusive home and/or suffering from parental neglect while growing up; having a history of violent behavior or juvenile detention; suffering from poverty or homelessness; and suffering from stressful life events such as divorce. The strongest predictor of violence is the combination of an SMI, drug abuse, and history of childhood abuse. SMI alone is not a predictor of future violence. Other research indicates that it is far more likely that people suffering from an SMI will be victims of violence not the perpetrators of it.

The relationship between SMI, violence, and public opinion has an impact on mental health policy and funding guidelines in the treatment of mental health disorders. It also has the potential to affect criminal justice policies such as mandatory treatment and mental health court sentencing guidelines in order to protect public safety. Early identification and treatment of substance use disorders would have the greatest impact on violence prevention.

Steven R. Vensel, PhD

See also: Mental Health Courts; Mental Health Laws

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Mental Health Counselor

Mental health counselors (MHCs), also referred to as licensed mental health counselors, licensed professional counselors, and licensed clinical professional counselors, are behavioral health professionals who provide psychotherapeutic services to individuals, couples, and families.

Definitions

- **Behavioral health** is an inclusive term referring to both mental health and substance use disorders.
- **Internships** are extensive educational field experiences in which professional knowledge and skills are utilized in a training setting. Interns are closely supervised as they work directly with client populations.
- **Postgraduate training** refers to training that is acquired after one has earned a graduate degree.
- **Practicum** is a limited part-time field experience in which students are exposed to the "real world" of the profession through direct observation and assisting professionals working in the field. There is limited contact with, and responsibility for, clients.

Description

Mental health counselors are behavioral health professionals who are licensed to diagnose and treat mental health and emotional disorders. MHCs are trained to work with individuals, groups, families, and couples in treating mental, emotional, and behavioral problems and disorders. MHCs work in private practice, mental health centers, substance abuse centers, nursing homes, and other mental health–related service providers. The Bureau of Labor Statistics (BLS) estimates that the 2013 national average salary for MHCs range from $25,840 (10th percentile) to above $67,020 (90th percentile), with an estimated national average of $43,700. The BLS projects that employment of MHCs will grow 29% from 2012 to 2022.

Mental health counseling is a distinct profession with national standards for education, training, and clinical practice. All 50 states have regulatory requirements in order to practice as an MHC. Licensure requirements vary by state, but all MHCs are held to

strict standards and require a minimum of a master's degree in counseling. Licensure standards for MHCs are the equivalent to clinical social workers, and marriage and family therapists, the other master's level behavioral health providers. Graduate counseling education programs require up to 60 semester hours of coursework and take a minimum of two years to complete. Coursework includes techniques and theories in counseling; couples/marital counseling; family counseling; human development; diagnoses, appraisal, and assessment; substance use theory; treatment planning; psychopathology; ethical and legal standards; and clinical skills instruction. State practicum and internship experiences are required in graduate programs that must meet rigorous supervisory and clinical training requirements.

All states license or regulate MHCs, but the regulations vary from state to state. All states require a graduate degree that meet the state's requirements and a passing score on a national licensing exam. All states require postgraduate clinical training with ongoing clinical supervision provided by a clinical professional with two or more years of licensed practice, depending on the state. Supervised postgraduate clinical training require as much as 3,000 hours of supervised clinical experience over a period of no less than two years. A specific percentage of those hours must be in face-to-face counseling, supervision, and case management. All states inquire as to the professional fitness and character of applicants and routinely ask about legal, medical, and behavioral health issues that may impair practice.

The American Counseling Association (ACA) is the largest professional association of counselors. The ACA was founded in 1952 and represents over 55,000 members with 20 separate specialty divisions such as the Association for Multicultural Counseling and Development, the Association for Assessment and Research in Counseling, and the American School Counselors Association. The ACA is very active in advocating and supporting pro-counselor legislation.

The American Mental Health Counselors Association (AMHCA) represents over 7,000 members and works to set standards of education, training, licensing, practice, advocacy, and ethics. The AMHCA created the first educational and training standards for MHCs. The Council for Accreditation of Counseling and Related Educational Programs adopted and adapted the AMHCA standards and established the first accreditation standards for graduate mental health counseling programs.

Mental health counselors are highly trained professionals who provide behavioral health services in a wide range of settings. MHCs work with individuals, couples, and families and are a vital component of the health-care system.

Steven R. Vensel, PhD

See also: American Counseling Association (ACA); American Mental Health Counselors Association (AMHCA), The; Clinical Mental Health Counseling; Counseling and Counseling Psychology

Future Reading

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Mental Health Courts

Mental health courts (MHCs) are specialized courts in which nonviolent offenders who suffer from mental health disorders are mandated for community-based mental health treatment instead of given jail or prison sentences.

Definitions

- **Convicted** means to have been found guilty of a crime.
- **Criminal Justice System** is the set of government agencies, systems, and processes established to control crime and impose penalties on those who violate the law.

- **Defense attorneys** are lawyers who provide legal defense for individuals who are being prosecuted for a crime.
- **District attorneys** are government officials who represent the state or federal government in the prosecution of alleged criminals; they hold the highest office in a jurisdiction's legal department.
- **Incarceration** means to be put in jail or prison.
- **Jurisdiction** refers to the authority to administer justice over a specific area of the law in a specified location or territory.
- **Misdemeanors** are lesser crimes punishable by fine or county jail sentences of less than one year and include crimes such as petty theft, drunk driving without injury to others, various traffic violations, and other non-felony acts.
- **Prosecution** is the act of holding a trail against a person accused of criminal behavior.
- **Recidivism** refers to individuals who relapse back into criminal behavior after having served jail time or some other form of criminal penalty.

Description

Large numbers of offenders in the criminal justice system have underlying serious mental health conditions. Almost 15% of men and 31% of women entering jails have a serious mental health illness. Individuals with mental illnesses, many with co-occurring substance use disorders, cycle repeatedly through courtrooms, jails, and prisons which are not equipped to address their mental health needs, provide treatment, or intervene in the criminal cycle influenced by the mental illness. In addition to the impact on individuals, the influx of large numbers of people with mental illness into the court systems has had a significant impact on court function, use of resources, time, and court staff. Policy makers and behavioral health professionals have sought ways to improve outcomes for offenders suffering from mental illness and break the justice cycle (arrest, conviction, jail, release, rearrests, reconviction, back to jail again). Recognizing that the current system did not address the serious unmet mental health needs that were driving this costly and ineffective cycle, MHCs were created. The Bureau of Justice Assistance (BJA) and the Substance Abuse and Mental Health Services Administration administer the MHC program. More than 150 MHCs exist and more are being planned.

Mental health courts attempt to decriminalize individuals with serious mental health conditions by mandating and supervising community-based mental health services in lieu of jail time or prison sentences. The goals of MHCs are to decrease the frequency of contact with the criminal justice system; provide resources to improve social functioning; provide links to employment, housing, treatment, and support services; improve public safety by reducing criminal recidivism; improve the quality of life for individuals with mental health disorders; increase participation in effective mental health treatment; and reduce cost associated with corrections and incarceration. MHC members include judges, defense attorneys and representatives, the district attorney's prosecution representatives, probation or parole officers, mental health case managers, and other representatives from the mental health system. Defense attorneys, judges, jail personnel, or family members make referrals to MHCs.

Key components of the MHC system include judicial supervision, case management, and periodic review of qualified offenders with mental illness, intellectual disabilities, and co-occurring mental illness with substance use disorders who are charged with misdemeanors or nonviolent offenses. MHCs' delivery of services include specialized training of criminal justice personnel to identify and address mental health needs; development of individualized treatment plans; provision of voluntary outpatient or inpatient mental health treatment in exchange for dismissal of charges or reduced sentencing on successful completion of treatment; and coordination of social services, including life skills training, employment placement, health care, and relapse prevention.

According to BJA existing research indicates that participants in the studied MHCs have significantly lower recidivism rates and are less likely to be arrested for new crimes than are individuals with mental health

conditions who go through traditional courts. Research also indicates that MHCs are more effective at connecting individuals to mental health services than are traditional courts.

Mental health courts are a collaboration between criminal justice systems and community mental health treatment systems. MHCs are successfully providing life-changing services to thousands of offenders who suffer from underlying serious mental health conditions.

Steven R. Vensel, PhD

See also: Mental Health Laws

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Mental Health Laws

"Mental health laws" refer to legal provisions protecting the rights of people suffering from severe mental illness and limiting involuntary commitment to psychiatric treatment facilities.

Definitions

- **Competence** is a legal term designating that a person is capable and able to enter into legally binding contracts, transfer assets, and participate in legal proceedings.
- **Informed consent** means to voluntarily consent in writing, by a competent person, to inpatient or outpatient treatment.
- **Involuntary commitment** is a legal process in which someone suffering from a severe mental disorder can be involuntarily admitted for inpatient psychiatric hospitalization or treatment.
- **Jurisdiction** refers to the authority to administer justice over a specific area of the law in a specified location or territory.

Description

Mental health laws protecting people from involuntary commitment (IC) to psychiatric hospitals or mental health treatment facilities exist in every state in the United States. The states enact these laws, and all jurisdictions have provisions limiting involuntary psychiatric admissions. IC is restricted to those who pose a danger or a risk of harm to themselves or others. Some states require evidence of imminent danger, while others require proof beyond reasonable doubt.

State mental health laws are referred to by different names but share many of the same provisions. An example is Florida's *Baker Act* law that allows for the involuntary examination of individuals who are suffering from a mental illness, are likely to suffer substantial harm, or pose a threat of serious bodily harm to self or others. A person is considered incompetent when he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning treatment due to his or her mental illness. A person may not be held in IC for longer than 72 hours at which point they must be released, provide informed consent, or be ordered by a court for involuntary placement.

Professionals authorized to perform examinations varies by state. In Florida, physicians, psychiatrists, licensed clinical psychologists, clinical social workers, mental health counselors, marriage and family therapists, and some qualified psychiatric nurses are recognized mental health professionals who have the required credentials to diagnose and treat mental health disorders.

Impact (Psychological Influence)

Prior to 1970 the presence of a psychiatric illness, with or without threat to self or others, was sufficient grounds for an IC. This led to the possibility for

individuals to essentially be incarcerated with no legal due process. Beginning in the 1970s laws were enacted throughout the United States, restricting IC to those who posed a danger or risk to themselves or to others. As a protective measure mental health laws have saved an untold number of lives of those suffering from severe mental illness.

Steven R. Vensel, PhD

See also: Involuntary Hospitalization; Mental Health Court

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Mental Measurements Yearbook, The

The Mental Measurements Yearbook (MMY) is a continually updated reference collection of commercially available standardized tests and assessments for use in social research.

Description

It would be difficult to overstate the importance and impact that social research has had on people's lives. Standardized tests and measures, often referred to as "instruments," are essential tools that researchers use in order to explore all aspects of social phenomena. The overall quality of an instrument is associated with how valid and reliable it is and whether it is standardized. Instruments are standardized when all test-takers are required to answer the same questions in the same way and are scored in a consistent or "standard" manner. "Validity" refers to how well an instrument measures what it is designed to measure. For instance, if someone who is very outgoing completes a measure that indicates he or she is shy, that instrument has very low validity. Reliability is a measure of how consistently the instrument measures what it is designed for. For instance, if the outgoing person takes the same personality assessment on two different days and on one day it indicates he or she is outgoing and on the other day he or she is shy, that instrument has poor reliability. Validity and reliability are independent of each other. For instance, if you weigh the same every time you use a bathroom scale, it is reliable. But if the scale is inaccurate, say it measures your weight 5 pounds low every time you use it, it is reliable but invalid. Only if the scale were both consistent and accurate would it be considered to have high levels of both reliability and validity. Researchers use several methods of calculating levels of reliability and validity.

Development and Current Status

The Mental Measurements Yearbook is a widely used reference publication that is designed to assist professionals in selecting and using reliable and valid standardized tests and assessments. Founded in 1938 by Oscar Krisen Buros (1905–1978), the Buros Institute of Mental Measurements is located in the Department of Educational Psychology at the University of Nebraska-Lincoln. The MMY provides factual information, critical reviews, and comprehensive references on the construction, use, reliability, and validity of all standardized tests published in English. It also provides descriptions of the purpose, target population, administration, scoring, price, author, and publisher for all listed instruments. The objectives of the MMY are to provide accurate and factual information of all known tests published in the English-speaking countries of the world; provide candid and critical test reviews written by professionals; and to continually add to earlier editions by providing supplemental, or additional, information, on previously published tests as it becomes available, as well as the inclusion of new testing instruments. The MMY offers evaluations of instruments in the fields of education, psychology, business, law, health care, counseling, and management.

Steven R. Vensel, PhD

See also: Behavioral Assessment; Neuropsychological Tests

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Mental Retardation

Mental retardation (MR) is a disorder that describes people with well below average level of intelligence, an intelligence quotient (IQ) of 70 or below, and who have major limitations in the skills needed for daily living.

Definition

- **Retardation** means the act, process, or condition of being delayed or impaired from an expected course of development.

Description

In the United States about 7 million people are diagnosed with MR. Mental retardation, now known as intellectual disability, is identified by a lower-than-average level of intelligence or IQ. The term "retarded" has been the subject of rejection and shame in our society and therefore makes this diagnosis controversial. Although a below-average intelligence quotient (IQ) contributes to the diagnosis of MR, it is limitations in adaptive skills that characterize most people with MR. This means they have a limited ability to deal with the demands of daily living and self-care. It is this limit that causes them to stand out most obviously from their peers. An estimated 2.5%–3% of the population is diagnosed with some form of MR. It is classified as a disability that begins in childhood and lasts throughout life.

In recent years, due to a stigma related to the word "retarded," there has been a movement away from the diagnosis. Many people in the community who are affected by MR have rejected its application to themselves. The community and professional organizations have changed their terminology from MR to intellectually and developmentally disabled.

There are four degrees of severity that are used to categorize those with MR. Mild MR identifies those with IQ scores between 50 or 55 and 70. This group represents the largest proportion of the four categories of MR at 85% of the population. In addition, it is this group that can be helped most through education and therapy. This is not as true of the other three groups of MR. Those include moderate MR with IQ scores between 35 and 50 or 55, which is about 10% of the MR population. Severe MR represents those with IQ scores between 20 or 25 and 35 or 40 and is 3%–4% of the population. Lastly, there is profound MR with IQ scores below 20 or 25, representing 1%–2% of those diagnosed with MR (American Psychiatric Association, 2000).

Causes and Symptoms

Mental retardation can arise from many different causes. Some of the identified causes are biological, including sickness, such as encephalitis or meningitis, but also accidents that may cause brain damage. Other causes may be psychosocial, but the reasons are nearly impossible to assign in some cases. Common to all MR is some impairment of the functioning of the brain and central nervous system.

Symptoms may appear very early in childhood and vary from person to person. Most individuals have both intellectual and adaptive impairment. Also common are issues and delays in motor and language skills. Some of those with MR are peaceful and passive in personality, while others can be aggressive and impulsive. Sometimes mild MR is not identified until a child enters school and undergoes standardized testing.

Diagnosis and Prognosis

Traditionally, three things are needed for a diagnosis of MR or intellectual disability. The first is that the onset of the condition must occur before the person is 18 years old. The second is that intellectual functioning is below the norm for the population as defined by standard IQ scores. The third is that there are significant limitations in daily living skills such as communication, self-care, social skills, academic skills, work, health, and safety. The condition is lifelong, but the

awareness and treatment for those with MR have improved, which makes for a better quality of life.

Treatment

Mild MR can be treated through special education, which may result in the acquisition of enough knowledge and skills to complete several years of school and eventually to hold employment. People with moderate MR are often trainable but will be limited in educational and work opportunities. Those with severe MR tend to do better in group homes and in situations of structure where their daily living needs can be met. People with profound MR will require extensive care and supervision their whole lives.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Intellectual Disability

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Mental Status Examination

The mental status examination (MSE) is a structured assessment of an individual's level of cognitive (intellectual) and behavioral functioning, appearance, mood, speech, alertness, and judgment and insight at the time of evaluation.

Definitions

- **Cognitive** refers to mental activities associated with thinking, learning, and memory.
- **Delusion** is a belief that is resistant to reason or contrary to actual fact.
- **Dementia** is an overall decline in an individual's level of cognitive (intellectual) functioning, including memory loss, difficulties with language, simple calculations, planning, decision making, and motor skills.
- **Dissociation** is the splitting off of certain mental processes from conscious awareness characterized by feelings of unreality or confusion about one's identity.
- **Hallucination** is a sensory (sight or hearing) experience of something that does not exist outside the mind.
- **Organic brain disorder** refers to impaired brain function resulting from damage or deterioration of brain tissue.
- **Thought disorder** is a condition characterized by incomprehensible language (written or spoken).

Description

A mental status examination is a structured assessment of behavioral and cognitive functioning at the time of evaluation. It includes descriptions of the individual's appearance and general behavior, alertness and level of consciousness, motor and speech activity, mood and affect, thought and perception, attitude and insight, and judgment and insight, as well as the reaction evoked in the examiner. Of these factors, the most clinically relevant are alertness, language, memory, abstract reasoning, and judgment. The MSE is the heart of the psychiatric (psychological) evaluation. The purpose of MSE is to assess the presence and extent of an individual's mental impairment. The MSE is an essential part of the diagnosis of dementia and other psychiatric disorders, and is routinely administered to those being evaluated for dementia. It can be regularly administered to monitor and document changes in an individual's condition. MSE results may suggest specific areas for further testing. The most commonly used MSE in North America is the Mini-Mental State Examination (MMSE).

While the MMSE evaluates five areas of mental status or functioning—orientation, registration memory, attention and calculation, recall, and language—the MSE is more comprehensive. It evaluates 10 areas of functioning: appearance, movement and behavior, affect, mood, speech, thought content, thought process, cognition, judgment, and insight. Administration time of the MSE varies depending on the individual's condition, ranging from 5 minutes or less with healthy individuals to 20 minutes to those with speech problems or intellectual impairments, dementia, or other organic brain disorders.

Normal results for an MSE depend to some extent on the individual's history, level of education, and recent life events. Accordingly, a depressed mood is appropriate in the context of a recent death or other sad event in the individual's personal life, but it would be inappropriate following a recent promotion or pay raise. Generally, a normal MSE involves the absence of obvious delusions, hallucinations, or thought disorders as well as the presence of insight, good judgment, and socially appropriate appearance and behavior. Abnormal results for an MSE would include any evidence of organic brain damage, dissociative symptoms, delusions or hallucinations, or thought disorders. It could also include a mood or affect that is clearly inappropriate, thoughts of suicide, or disturbed speech patterns.

Developments and Current Status

The development of the MSE can be traced to descriptive psychopathology and phenomenology, which is based on the work of philosopher and psychiatrist Karl Jaspers (1883–1969). He assumed that an accurate comprehension of an individual's experience requires his or her own description which is elicited through an empathic and nontheoretical enquiry. This contrasts with an interpretive or psychoanalytic approach, which assumes the analyst might understand experiences or processes of which the patient is unaware, such as defense mechanisms or unconscious drives. Rather, the MSE is a blend of empathic, descriptive phenomenology and empirical clinical observation. The most commonly used MSE in North America is the Folstein MMSE, which is much shorter and provides an easily calculated score.

Len Sperry, MD, PhD

See also: Mini-Mental State Examination

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Methadone

Methadone is a synthetically derived prescription drug (an opioid) used in the treatment of opiate and opioid addiction. It is used to ease detoxification and as a maintenance therapy.

Definitions

- **Drug Enforcement Agency** is the federal agency responsible for enforcing laws and regulations governing narcotics and controlled substances. It is also known as the DEA.
- **Opiates** are a class of naturally derived drugs from opium.
- **Opioids** are synthetically derived drugs and are used as opiate substitutes. The term "opioid" is sometimes used to refer to both opiates and opioids. Both are known as narcotics.
- **Heroin** is a highly addictive and illicit drug derived from morphine, which is used to produce euphoria (feeling of excitement and happiness).

Description

Methadone is an addicting substance commonly used in addiction treatment, particularly opioid addiction. While it can produce a slight high, it works by blocking

narcotics like heroin from producing a powerful drug high. Though methadone treatment has its drawbacks, it remains one of the most effective tools that addiction specialists have to help ease addicts off of illicit opiates like heroin.

Even though methadone maintenance treatment became widespread, it remained controversial. Many wanted those on methadone maintenance to eventually be weaned off the drug. However, research showed that once begun on maintenance treatment, it needed to be taken for life. Treatment centers found that it was very difficult to get individuals off of methadone once it was started. There was also concern that methadone would be diverted to the black market. In the 1980s attitudes toward drug abuse hardened. The federal government placed limits on the amount of federal funding for drug programs used for methadone. This led to many programs being cut. When antidrug sentiment reached its zenith under President Ronald Reagan, many in the federal government opposed it as an overly "soft" response to the drug problem. Research in the 1980s, however, found that methadone was effective not only in treating addiction itself but also in addressing the public health problem of HIV/AIDS. It was found it helped heroin users to stop injecting drugs intravenously and sharing needles—a practice that spread the disease. In the 1990s, the federal government began to support methadone maintenance as an important tool in the battle against drug addiction. By 2000, there were nearly 150,000 individuals on methadone maintenance treatments in the United States.

The use of methadone treatments still remains controversial in the addiction community since addicts are prone to develop dependency on the drug. This means that methadone addition replaces heroin (or another opiate) addition. Research shows that less than 20% of individuals who go on methadone are able to stop taking it. Supporters believe it is the best treatment since it stabilizes addicts as they go off of street drugs, helps reduce withdrawal symptoms, and provides a safe, legal environment where they can receive services to help them overcome their addiction. It also reduces their involvement in the black market for drugs, a hallmark of heroin addiction. The Drug Enforcement Administration lists methadone and oxycodone as a Schedule II controlled substance, while heroin is listed as a Schedule I controlled substance.

Len Sperry, MD, PhD

See also: Detoxification; Drug Enforcement Administration (DEA); Opioid Use Disorder;

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Microaggression

Microaggressions are insensitive acts such as comments, insinuations, or slights that are primarily directed toward marginalized groups, either intentionally or unintentionally.

Description

The term "microaggression" is an umbrella term used to describe actions or words that are dismissive and hurtful toward marginalized groups of people. These types of interactions are not physically aggressive but are rather evidenced verbally, behaviorally, or environmentally. They communicate feelings of hostility, negativity, or insensitivity toward certain types of people. Members of marginalized groups may be subject to microaggression because of race, ethnicity, gender, sexual orientation, ability, and/or religious affiliation. Perpetrators of these offenses are often unaware of committing them or may become defensive when challenged about these abusive messages. Microaggressions can contribute to inequities in the legal system, education, and health care.

People of color commonly report experiences of microaggression. An example of this may be when a white woman clutches tight to her purse when passing by an African American male on the street (hidden message is that you are a criminal). Another example would be expressing frustration or anger toward Latinos who

converse in Spanish with one another (hidden message is that they are not real Americans and should leave their old traditions/language behind now that they are in America). The implications derived from microaggressions such as this are that the member or members of the marginalized group are not part of the larger majority, are lesser human beings, or are not due the same rights or respect as the majority group. They result in the marginalized member feeling demeaned, disregarded, felt of as less than, or inadequate. Research indicates that microaggressions can cause emotional and psychological harm and that acknowledging their existence and discussing them openly in order to promote understanding and growth is encouraged. Persons committing these acts may not even realize that they are saying or doing something offensive as most people consider themselves fair-minded, non-biased, respectful, and good; therefore, accepting that they may have perpetrated hidden slights, insults, or misgivings is difficult. Defensiveness is a normal response when a person is questioned about a transgression.

Three types of microaggressions exist: (1) microassaults—conscious and intentional discriminatory actions, (2) microinsults—verbal, nonverbal, and environmental communications that more subtly express insensitivity or demean a person's racial heritage or identity, and (3) microinvalidations—communications that exclude, negate, or nullify the thoughts, feelings, or realities of a person with color.

The term "microaggression" was coined by psychiatrist Chester M. Pierce in 1970, but others added significantly to this concept. In 1973, Mary Rowe of the Massachusetts Institute of Technology discussed microinequities specifically related to gender. Landmark research later conducted by Stanford University psychology professor Claude Steele indicated that African Americans and women performed worse on academic tests after being subjected to racial and gender stereotyping. Subsequently, numerous experiments by social psychologists, Jack Dovidio and Samuel L. Gaertner, found patterns of aversive racism among whites and blacks. Most recently, psychologist Derald Wing Sue of Columbia University has been developing a theory and classification system for measuring acts of microaggression to help educate and address these issues.

Current Status and Impact (Psychological Influence)

Microaggressions reflect active manifestations of oppression and readily contribute to the marginalization of many groups of people. No one is immune to their existence. Evidence suggests that incidents of microaggression can have a significant emotional and psychological impact on victims, so acknowledging their existence and effectively counteracting them is critical in promoting social harmony.

Melissa A. Mariani, PhD

See also: Cultural Competence; Culture

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Milgram, Stanley (1933–1984)

Social psychologist Stanley Milgram, is famous and best known for conducting controversial studies on obedience (Milgram's Experiments) during the 1960s.

Description

Stanley Milgram was born in New York City on August 15, 1933, to Jewish immigrants. His mother, Adele, was born in Romania and his father, Samuel, was born in Hungary. Both moved to the United States before Hitler's rise to power. Stanley was the second of three children. His sister Marjorie was the oldest

Social psychologist Stanley Milgram is best known for conducting influential studies on obedience to authority during the 1960s. The protocol and procedures he used for conducting research with human participants has since guided standards set forth by the American Psychological Association and other bodies. (Jan Rieckhoff/ullstein bild via Getty Images)

and brother Joel the youngest. Stanley had a modest upbringing as his father worked as a baker until his death in 1953. Adele was a homemaker but assumed work in the bakery after her husband's passing. Stanley displayed academic excellence from an early age, showing a particular interest in science. His leadership skills were also evident. He graduated from James Monroe High School in just three years and went on to attend Queens College, near home, primarily due to the family's financial constraints. Graduating with a bachelor's degree in political science, Milgram went on to apply to Harvard's Social Psychology program, where he was initially rejected. After enrolling in Harvard's Office of Special Students, he was then formally accepted into the program in 1954, working under the guidance of Gordan Allport, and received his PhD in 1960. His research interests focused on social issues affecting the average man or woman; a cross-cultural comparison in conformity between people in Norway and Paris was the focus of his dissertation. He spent a year at the Institute for Advanced Study at Princeton working with Solomon Asch, who was famous for his studies on conformity. This influence prompted him to continue researching social issues such as these. In 1961, he began his obedience studies, also referred to as Milgram's Experiment. During this year, Milgram also met his wife Alexandra, a dancer and social worker, and went on to have two children. Milgram's first teaching position was at Yale, where he became an assistant professor in 1962. He then returned to Harvard's Department of Social Relations from 1963 until 1966 and was hired as a lecturer during 1967. Denied tenure, most likely due to the controversy surrounding his obedience study, Milgram left Harvard, accepting a full professor position at the City University of New York. He was also asked to head up their social psychology program in the Graduate Center. While at CUNY in 1974, he published his book *Obedience to Authority*, which was a compilation of the results of his obedience studies. He went on to publish many other works, record several films based on his research, secure additional grant funding, and serve as a mentor on dissertation committees. Stanley Milgram died of a heart attack at the age of 51 on December 20, 1984, in New York City.

Though Milgram conducted several social experiments throughout his career, he is best known for his groundbreaking studies on obedience, also referred to as "Milgram's Experiments." Following along the lines of Asch's work on conformity, Milgram sought to expand his research to areas of greater interest to the everyday person. An additional component, and not one common in studies at the time, was the fact that Milgram also debriefed his subjects and asked for their input regarding the ethical practices of the study itself. After gaining the approval of the National Science Foundation in 1961, Milgram began his obedience studies. It is believed that these studies were inspired by the 1961 trial of Adolf Eichmann, a high-ranking official of the Nazi party. Milgram sought to understand why human beings blindly conform to those in

authority. The series of obedience studies consisted of pairs of subjects (a teacher and a learner) and the experimenter. The experimenter leads both participants into a room and proceeds to strap one, the designated learner, to a chair and hook up an electrode which the participants are told will administer a shock to the person's arm. The other participant, the teacher, is then taken to a separate room adjacent to the learner's and told to read a list of two word pairs and then instruct the learner to say them back. If the learner answers wrong, the teacher is to push a button administering a 15-volt shock to the learner. Each time the learner answers incorrectly, the teacher administers another shock, increasing 15 volts for every wrong answer, with the highest being 450 volts. The learners were never actually harmed in the experiment but pretended to be. The results indicated that the majority of teachers, two-thirds (26 out of 40), administered the full range of shocks up to the 450 volts and were deemed "obedient subjects." Simply put, the findings of the studies suggested that a majority of people would go against their own moral judgment and, for no personal gain nor malice, harm another human being simply because they were instructed by a perceived person in authority to do so, the key piece being that they were able to shift their perceived personal responsibility in the matter because they were told to perform the act by a person in charge. Milgram related these findings to real life in that people often view themselves as having no personal power or choice and do not view themselves as culpable if they are simply doing what they were told to do.

Impact (Psychological Influence)

The groundbreaking obedience experiments conducted by Stanley Milgram are well-known and incorporated nowadays into nearly every introductory psychology course. His work has been referenced in popular music, movies, television shows, and publications. He is also known for the "Small World" experiment in 1967, which sought to test the concept of "six degrees of separation," positing that any two random strangers in the United States can be linked together by an average of six intermediate acquaintances.

CUNY named him Distinguished Professor of Psychology in 1980. In 1983, he was selected to be a fellow of the American Academy of Arts and Sciences. He also received a Ford Foundation Fellowship, an American Association for Advancement of Science Socio-Psychological Prize, and a Guggenheim Fellowship. In addition to these accolades, the protocol and procedures he used for conducting research with human participants has since guided the standards set forth by the American Psychological Association and the mandating of Internal Review Boards.

Melissa A. Mariani, PhD

See also: Obedience Studies; *Obedience to Authority: An Experimental View* (Book)

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Military Mental Health

"Military mental health" refers to the mental health needs and provision of services to military personnel and their families.

Description

Approximately 20% of activity duty service members and as many as 37% of veterans experience symptoms of serious mental health disorders. Rates of post-traumatic stress disorder and anxiety are disproportionately high among veterans, as compared to the civilian population, as are rates of marital distress, domestic violence, divorce, and drug and alcohol abuse. Most alarming is the high rate of depression and suicide among veterans. According to the National Alliance on Mental Illness, one active duty soldier takes

his or her life every 36 hours and one veteran every 80 minutes.

The mental health needs of military spouses and children are equally challenging. As many as 37% of military spouses suffer from at least one mental health disorder, with anxiety, depression, and sleep disorders being the most prevalent. Although most children of active duty personnel adapt to the deployment of a parent, one-third suffer from psychological distress such as depression, anxiety, acute stress reactions, and behavioral disorders.

There are four principal health-care systems available to active duty and veteran military personnel and their families. The Department of Defense (DoD) offers "In Theater" support and mental health services to deployed personnel through chaplains and embedded mental health specialist. The DoD also offers stateside community-based and inpatient mental health care at military installations. Tricare, the military health insurance program, provides online information and referral services through a national network of mental health providers. The U.S. Department of Veteran Affairs (VA) provides inpatient and outpatient mental health services through VA hospitals as well as individual, marital, group, and grief counseling through community-based clinics. Military personnel and their families may also choose to receive services through the civilian health-care system.

Impact (Psychological Influence)

Military personnel are faced with multiple barriers to receiving adequate mental health care. Eligibility requirements for services and benefits, inadequate private health-care coverage that restricts provision of mental health services, and too few qualified practitioners prevent many from receiving needed care. The VA has come under heavy public and governmental criticism for its failure to provide adequate and timely care for veterans. Access to care is another barrier affecting those who live outside of the major cities where most VA service centers are located. Military culture can serve as a deterrent as many active duty personnel and their spouses fear receiving mental health services will hurt their military careers. Both the DoD and VA are addressing the mental health needs of military personnel and veterans by investigating service failures, increasing service capacity, making changes to delivery systems, and developing new service programs.

Steven R. Vensel, PhD

See also: Post-Traumatic Stress Disorder (PTSD)

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Millennials

"Millennials" refers to the generation of people born between the early 1980s and the early 2000s. They now surpass baby boomers (born between 1945 and 1964) as the largest generation in the United States, due to deaths among baby boomers and immigration boosting numbers of millennials (Raphelson, 2014).

Description

The exact beginning and ending birth years of the millennial generation is a point of debate. Millennials number approximately 80 million individuals residing in the United States. Millennials have unique characteristics compared to other generations. Authors William Strauss and Neil Howe are most often credited with naming the millennial generation. They wrote the first book about the millennial generation titled *Millennials Rising: The Next Great Generation*. Since the publication of that book, millennials have continued to be studied, researched, and frequently written about.

Millennials have many different names. They are also known as Generation Y because they came after Generation X (Gen X), who were born from the early 1960s to the early 1980s. Millennials are also known as the Peter Pan or Boomerang Generation due to the large number of millennials who return home after college and delay getting a career-oriented job and/or put

off getting married. They have been referred to as echo boomers, the me generation, generation we, generation next, and the net generation, among others.

Millennials have unique values, attitudes, behaviors, and demographic characteristics compared to other generations. The Pew Research Center (PRC) has conducted extensive research into millennials. According to the PRC, millennials are made up of 61% white, 19% Hispanic, 14% black, and 5% Asian. Millennials are confident, self-expressive, tend to be more liberal than GenX, are upbeat, and open to change. They are more ethnically and racially diverse than are GenXers and are on track to becoming the most educated generation in American history. Millennials are less religious and less likely to serve in the military. Self-expression is valued by millennials. About three-quarters of those surveyed in the PRC study of millennials have created a profile on a social networking site. About 40% have a tattoo, with about half of those having two or more tattoos. Nearly 25% have a piercing in a body part other than the earlobe.

Sixty percent of millennials were raised by both parents and place parenthood and marriage above financial success and career. As a group millennials get along well with their parents and respect their elders. Millennials believe that families have a responsibility to care for older parents and would allow an older parent to live with them. Approximately 21% of millennials are married and 34% live in their parent's home (Fry). About a third of all millennials are parents.

The economy has contributed to the uniqueness of the millennial generation. According to the Millennial Civic Health Index, millennials have been particularly impacted by the economic recession of the late 2000s, with only 63% of millennials working. Of that group 31% were working on a part-time basis. Despite the difficulties in finding work, 90% of millennials in the 2010 Pew report said they have enough money or that they will meet their financial goals. The job market influenced household formation, with those millennials holding jobs much more likely to establish independent households. Forty percent of employed millennials are the head of their own households compared to 25% who are not employed.

Millennials are more open and accepting of diversity than are previous generations, with 58% believing that immigrants strengthen the country. They are also more tolerant than previous generations, being far more receptive of interracial marriages and nontraditional family arrangements, mothers working outside of the home, and adults living together without being married.

The millennial generation is the most educated and connected generation of all time. Within their generation, they are the first to not remember a time without computers, cable television, smartphones, and the Internet. Each generation brings a unique combination of values, attitudes, and behaviors to society.

Steven R. Vensel, PhD

See also: Baby Boomers

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Millon, Theodore (1928–2014)

Theodore Millon was an American Psychologist known for his research and publication on personality disorders.

Description

Theodore Millon was born in New York in 1928. An only child, his parents had immigrated to the United States in the 1920s. Millon's mother Mollie experienced bouts of mood instability and would have been "diagnosed" bipolar had the *Diagnostic and Statistical Manual* (DSM), which mental health professions use to diagnose mental disorders, existed at that time. Bipolar disorder is a mental disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more major depressive episodes.

A bright student, Millon attended a "gifted program" at Hunter College in New York, prior to graduating from high school in 1945. He completed his bachelor's degrees in psychology, physics, and philosophy at the City College of New York. He obtained his PhD at the University of Connecticut in 1953, and his dissertation focused on assessment of authoritarian personalities.

Impact (Psychological Influence)

Millon is known as "the grandfather of personality disorders," disorders that feature a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture. He also created a widely used diagnostic assessment, the Millon Clinical Multiaxial Inventory (MCMI). The MCMI is an objective personality test that was first published in 1977. It included 175 true–false questions. This test was designed to quickly categorize patients on more than 20 different scales. It screened for clinical conditions such as depression, drug problems, and personality disorders. A key feature of the computer-generated report of this test is a DSM diagnosis. It is an objective test, because it yields scores that are independent of the opinion or judgment of the examiner. The MCMI is the second most used personality inventory in the world and is now in its third edition, MCMI-III.

Millon was a very influential figure in the field of psychology. He published 50 academic papers and 25 books. Millon was the founding coeditor of the *Journal of Personality Disorders* and was also the president of the International Society for the Study of the Personality Disorders (1988–1992). The American Psychiatric Association gave him a lifetime achievement award in 2008. He continued to publish and research up until his death in 2014, at age 85.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Personality Disorders; Personality Tests

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Millon Clinical Multiaxial Inventory (MCMI)

The Millon Clinical Multiaxial Inventory (MCMI) is a psychological test used to assess personality and psychopathology. It is also referred to as the MCMI, MCMI-III, and the Millon.

Definitions

- **Objective personality inventory** is a type of psychological test designed to assess personality traits and behavioral patterns using structured questions. It contrasts with projective personality tests, which uses unstructured stimuli such as the Rorschach Inkblot Test.
- **Personality** is an individual's unique consistent pattern of thinking, feeling, and acting.
- **Psychopathology** is the study of the conditions and processes of a mental disorder and dysfunctional behavior.
- **Scale** is a subset of test items from a multi-item test.

Description

The Millon Clinical Multiaxial Inventory is an objective personality inventory that assesses personality

traits and psychopathology. The third edition of the Millon Clinical Multiaxial Inventory-III (MCMI-III) instrument provides a measure of 24 personality disorders and clinical syndromes for adults undergoing psychological assessment or treatment. The MCMI was designed to assess both Axis I (symptom disorders) and Axis II (personality disorders) and to assist clinicians in making *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnoses. In addition, it is helpful in developing a treatment approach based on the individual's personality style and coping behavior, and guiding treatment decisions based on those dynamics. The MCMI-III is composed of 175 true–false questions that take about 25 to 30 minutes to complete. After the test is scored, it produces 24 personality and clinical scales, and 5 correction scales that verify how the individual approached and took the test. Three facet scales have been added for each MCMI-III personality scale to facilitate treatment planning. These scales help therapists pinpoint specific personality dynamics such as self-image, interpersonal conduct, and cognitive style as treatment targets.

The MCMI-III is brief in comparison to other personality inventories, such as the Minnesota Multiphasic Personality Inventory (MMPI-2), and has a strong theoretical basis. Administering and scoring it are simple whether in paper and pencil or computer formats. An interpretive report includes a treatment guide for focusing treatment interventions. It also provides a capsule summary of test results.

Developments and Current Status

The first version of the MCMI was published in 1977 by psychologist Theodore Millon (1928–2014). It was on Millon's evolutionary theory of personality and psychopathology and was keyed to DSM-III. It had 11 personality scales and 9 clinical syndrome scales. The second version, MCMI-II, was published in 1987. It was keyed to DSM-III-R and had 13 personality scales and 9 clinical syndrome scales. The current version, MCMI-III, was published in 1994 and developed by Millon in collaboration with Roger Davis, Carrie Millon, and Seth Grossman. It is keyed to DSM-IV and has 14 personality scales, 10 clinical syndrome scales, and 5 correction scales. A new version that is keyed to DSM-5, MCMI-IV, was introduced in 2015. Overall, the MCMI is a highly regarded objective personality inventory for identifying both personality dynamics and psychopathology.

Len Sperry, MD, PhD

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Minnesota Multiphasic Personality Inventory (MMPI); Rorschach Inkblot Test

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Mind-Body Medicine

Mind-body medicine is a contemporary form of medicine that emphasizes interactions among physiological, psychological, sociological, and spiritual factors in the diagnosis, prevention, and treatment of medical conditions.

Definitions

- **Behavioral medicine** is an interdisciplinary form of modern medicine that integrates the behavioral, biomedical, and social sciences.
- **Biopsychosocial model** is a way of conceptualizing (thinking about) health and illness in terms of biological, psychological, and social factors rather than purely in biological terms.
- **Consciousness** is the capability for awareness of one's own existence.
- **Meditation** is the concentrated focus on a sound, the breath, object, or attention itself to increase awareness of the present moment. Its purpose is to reduce stress, promote relaxation, or increase spiritual growth.

- **Mind-body psychotherapies** are forms of psychotherapy that emphasize the interrelations among biological, psychological, sociological, and spiritual factors in the diagnosis, prevention, and treatment of mental disorders.
- **Mindfulness** is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.
- **Mindfulness practices** are intentional activities that foster mindfulness.
- **Psychoanalytic psychology** is the form of psychology largely developed by the work of Sigmund Freud, which emphasizes the conflicts and compromises between the unconscious and conscious mind.
- **Psychosomatic** refers to the belief that the mind (psyche) influences diseases affecting the body (soma). Psychosomatic medicine is the branch of medicine that emphasizes the role of psychological factors in causing and treating medical conditions.
- **Psychosomatic illness or disorder** refers to a condition characterized by physical symptoms that result from psychological factors.
- **Psychosomatic model** is a way of conceptualizing (thinking about) certain medical conditions as caused by or resulting from psychological factors.
- **Somatoform** is a group of psychopathologies marked by physical symptoms that suggest a general medical condition but do not manifest in an actual physiological disease.

Description

Mind-body medicine is a form of contemporary medicine that is influenced by ancient philosophies. It assumes that human persons are composed of integrated systems. Thus, it emphasizes the interrelationships of physiological, psychological, sociological, and spiritual factors in the diagnosis, prevention, and treatment of medical conditions. Like mind-body psychotherapies, mind-body medicine is informed by the biopsychosocial model. While both utilizes holistic treatment methods, mind-body medicine emphasizes somatic treatments.

The immune system is of special interest in mind-body medicine. It can be significantly effected by extreme emotion or psychopathology. For example, a depressed immune system can compromise mental health. Mind-body medicine includes psychosomatic and somatoform conceptualizations. Mind-body medicine, like psychosomatic medicine, maintains the belief that the mind (psyche) influences diseases affecting the body (soma). Psychosomatic disorders are similar to but very different from somatoform disorders. The primary difference is that psychosomatic diseases are diagnosable by medical testing. In contrast, in somatoform disorders the presenting symptoms are not due to general medical condition. However, unlike the limited stance of psychosomatic medicine, mind-body medicine also believes that the soma influences the psyche. This belief is especially significant in the treatment of chronic and terminal medical conditions where comfort and well-being are of primary importance. Just as psychological factors may initiate, worsen, or maintain psychosomatic illnesses, so too can physiological factors influence psychological factors of health and well-being. Mind-body medicine prescribes alternative adjunctive treatments to modern medical treatments. For example, prescriptions may include mindfulness, meditation, contemplative prayer, yoga, tai chi, hypnosis, and relaxation. An individual's consciousness and awareness of well-being has been scientifically demonstrated to enhance medical treatment of disease. In other words, the subjective experience of the patient influences the prevention and treatment of medical conditions.

Development and Current Status

Since the middle ages, Christianity's view of human nature has influenced both the philosophy of mind-body dualism and the practice of Western medicine based on it. Mind-body dualism views illness as either a medical condition caused by biological dysfunction,

such as an infection, or a psychological dysfunction caused by trauma or evil spirits. The philosophical distinction between mind and body has been an ongoing discussion beginning with the Greek philosophers. But it was René Descartes (1596–1650), the French philosopher and physiologist, who provided the first systematic account of the mind-body relationship. He proposed that the immaterial mind and the material body are distinct substances (entities) but interact causally with each other. This means that mental events can cause physical events, just as physical events can cause mental events. Unfortunately, Descartes was unable to convincingly explain exactly how the mind can cause changes in the body, and vice versa. Mind-body medicine uses modern science to support Descartes's theory.

Starting in the 1940s, Franz Alexander (1891–1964), a Hungarian American physician and psychoanalyst, is credited with advocating psychosomatic medicine. His view was largely a psychological explanation that emphasized the power of the mind over the body. For example, Alexander believed that asthma was the body's response to unresolved dependency. Duodenal (stomach) ulcers were believed to be caused by frustration and emotional stress. Also, the belief was that rheumatoid arthritis was caused by repressed rebellion, while migraine headaches were caused by repressed hostility. This view of psychosomatic model began to wane as research determined that there was, in fact, both biological *and* psychological factors involved. For instance, research identified an infection with the *Helicobacter pylori* (*H. pylori*) bacteria along with psychological stress as causative factors in duodenal ulcers. Around this time, the psychiatrist George L. Engel (1913–1999) wrote about the need for a new medical model in a landmark article in *Science* in 1977. Engel proposed the biopsychosocial model, which could integrate such an early psychosomatic model with the biomedical model. The biopsychosocial model supported the development of mind-body medicine.

Currently, there are several psychological conceptualizations of the mind-body relationship. Each theory maintains its own ideas of contributive factors of psychosomatic illnesses. The psychoanalytic theory suggests that unconscious conflicts are the reason for psychosomatic conditions. The type of unconscious conflict will predict the type of physiological illness that is psychosomatically manifested. The psychodynamic theory suggests that various personality characteristics and traits react to stressful life events differently. Different life stressors interacting with different personality types lead to different physical diseases. In addition, certain personalities are more likely to develop certain physical illnesses. Psychosocial family systems theories state that dysfunctional families create emotional trauma for children and this is the cause for psychosomatic disease. The biological theories of psychosomatic disease suggest that there are genetic predispositions for psychological influence in illness. A more recent psychosomatic viewpoint views human beings as psychosomatic wholes. It integrates mind with body with a more unified view of life that encompasses polarities (opposing but attracting influences). For instance, in the being versus nonbeing polarity, while individuals are continually threatened by illness and nonbeing, they can constantly reasserting their being by engaging in healthy behaviors. Health problems arise when the polarities become unbalanced. Such an understanding appears to avoid mind-body dualism and the overemphasis of the mind over the body in Alexander's viewpoint.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Mind-Body Psychotherapies; Mindfulness; Psychosomatic Disorder and Psychosomatic Medicine

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Mind-Body Psychotherapies

Mind-body psychotherapies are forms of psychotherapy that emphasize the interrelations among biological, psychological, sociological, and spiritual factors in the diagnosis, prevention, and treatment of mental disorders.

Definitions

- **Biopsychosocial model** is a way of conceptualizing (thinking about) health and illness in terms of biological, psychological, and social factors rather than purely in biological terms.
- **Consciousness** is the capability for awareness of one's own existence.
- **Evidence-based treatments** are therapeutic interventions (techniques) that scientific research demonstrates to be effective in facilitating therapeutic change. It is also known as empirically supported treatments.
- **Expressive psychotherapy** is a form of therapeutic counseling that emphasizes externalizing to process and understand or increase awareness of impulses, trauma, psychopathology, or unrealized growth potentials.
- **Meditation** is the concentrated focus on a sound, the breath, object, or attention itself to increase awareness of the present moment. Its purpose is reduce stress, promote relaxation, or increase spiritual growth.
- **Mindfulness** is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.
- **Psychosomatic** refers to the belief that the mind (psyche) influences diseases affecting the body (soma). Psychosomatic medicine is the branch of medicine that emphasizes the role of psychological factors in causing and treating medical conditions.
- **Somatic psychotherapy** is an alternative form of psychotherapy composed of many approaches, all of which are body centered and emphasize body posture, movement, and the experience of bodily function.
- **Spiritually oriented psychotherapy** is a form of therapeutic counseling informed by spirituality and psychology.

Description

Mind-body psychotherapies are holistic forms of psychotherapy. They are informed by the biopsychosocial model in the diagnosis, prevention, and treatment of mental disorders. Like mind-body medicine, mind-body psychotherapies are informed by the biopsychosocial model. Mind-body psychotherapies, like the biopsychosocial model, emphasize ways in which biological, psychological, sociological, and spiritual factors interact. The biopsychosocial model is suitable for use in various conceptualization of (way of thinking about) a client's presentation. Mind-body psychotherapies utilizes a number of psychotherapeutic interventions that are evidence-based practices which are congruent with client preference, clinician competence, and the goals of treatment.

Mind-body psychotherapies are also akin to but different from somatic or body-centered psychotherapies. Mind-body psychotherapies are larger in scope than somatic psychotherapies and may include their use. Body-centered psychotherapies are focused on intervening in the client's relationship to his or her body, its function and influence on psychological functioning.

Mind-body psychotherapies both include and go beyond somatic interventions. Mind-body psychotherapies emphasize optimal human development in all aspects of human existence, including biological, psychological, sociological, and spiritual dimensions. The clinical practice of mind-body psychotherapies is based on the underlying assumption that human beings are composed of integrated systems. Optimal human functioning is comprised of the healthy functioning of all related systems. Pathology (disease or illness) in one system can compromise the functioning of other interrelated systems. Human consciousness is composed of the sum of its systems functioning.

Mind-body psychotherapies aim to reduce psychopathology through the promotion of health in all mind-body systems. Mind-body psychotherapies often utilize alternative treatments to popular (widely used) therapeutic counseling interventions. Mind-body psychotherapies may include mindfulness, meditation, contemplative prayer, yoga, tai chi, hypnosis, relaxation, nutrition, exercise, dance, art, drama, writing, or play. It may also include culturally sensitive variants of these, such as shamanic healing. An individual's consciousness and awareness of well-being has been scientifically demonstrated to be improved through the use of mind-body psychotherapies.

Development and Current Status

Since the middle ages, Christianity's view of human nature has influenced both the philosophy of mind-body dualism and the practice of Western medicine based on it. Mind-body dualism views illness as either a medical condition caused by biological dysfunction, such as an infection, or a psychological dysfunction caused by trauma or evil spirits. The philosophical distinction between mind and body has been an ongoing discussion beginning with the Greek philosophers. But it was René Descartes (1596–1650), the French philosopher and physiologist, who provided the first systematic account of the mind-body relationship. He proposed that the immaterial mind and the material body are distinct substances (entities) but interact causally with each other. This means that mental events can cause physical events, just as physical events can cause mental events. Unfortunately, Descartes was unable to convincingly explain exactly how the mind can cause changes in the body, and vice versa.

Starting in the 1940s, Franz Alexander (1891–1964), a Hungarian American physician and psychoanalyst, is credited with advocating psychosomatic medicine. His view was largely a psychological explanation that emphasized the power of the mind over the body. This view of psychosomatic model began to wane as research determined that there was, in fact, both biological *and* psychological factors involved. Around this time, psychiatrist George L. Engel (1913–1999) wrote about the need for a new medical model in a landmark article in *Science* in 1977. Engel proposed the biopsychosocial model, which could integrate such an early psychosomatic model with the biomedical model. The biopsychosocial model supported the development of mind-body psychotherapy. Currently, there are many mind-body-based psychotherapeutic interventions. Many of these are based on ancient practices. Each intervention maintains its own emphasis of therapeutic contribution. Different life stressors interacting with an individual's unique biological, psychological, sociological, and spiritual systems lead to different types of disorders or diseases. The following three mind-body psychotherapies are common examples of interventions designed to heal aspects of the integrative human system.

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) was conceptualized by Francine Shapiro (1950–). In 1987, Shapiro noticed that moving her eyes from side to side as she walked in a park in San Francisco reduced discomfort associated with negative thoughts and memories. The theory of EMDR concludes that trauma and psychopathology change the neurological structure of the brain. Through the implementation of a structured eight-step EMDR protocol, the brain and the negative experience of trauma and psychopathology may be healed. The eight-step process to EMDR includes history and treatment planning, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation.

Mindfulness-Based Stress Reduction

Mindfulness-based stress reduction (MBSR) was developed by Jon Kabat-Zinn (1944–) at the University of Massachusetts Medical Center for treatment of medical patients. Since then, MBSR has evolved into a common medical and psychological treatment for various health problems. MBSR is a structured group program lasting 2.5 hours and scheduled over 8 to 10 weeks. Each session covers specific exercises and topics that are examined within the context of mindfulness. These include various forms of mindfulness meditation practice, mindful awareness during yoga postures, and mindfulness during stressful situations

and social interactions. Because an individual's development of mindfulness requires regular and repeated practice, participants are expected to practice 45 minutes of homework assignments each day. This involves meditation, mindful yoga, and applying mindfulness to situations in everyday life.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) was developed Marsha Linehan (1943–) for the treatment of borderline personality disorder. Recently, it has been modified and extended for use with other personality disorders as well as psychiatric disorders such as mood disorders, anxiety disorders, eating disorders, and substance use disorders. Four primary modes of treatment are noted in DBT: individual therapy, skills training in a group, telephone contact, and therapist consultation. The core strategies in DBT are "validation" and "problem solving." Attempts to facilitate change are surrounded by interventions that validate the client's behavior and responses in relation to the client's current life situation, and demonstrate an understanding of his or her difficulties and suffering. Problem solving focuses on the establishment of necessary skills. Mindfulness is an essential skill set in this approach. Learning to be more aware of feelings and internal states is learned through the core mindfulness "what" and "how" skills. The "what" skills of core mindfulness are to observe, describe, and participate in each moment of our lives. The "how" skills are to be nonjudgmental, one-mindful, and effective. The main objective in learning both sets of mindfulness skills is to develop awareness and insight in order to behave in ways that achieve the individual's treatment goals.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Contemplative Neuroscience; Evidence-Based Practice; Meditation; Mindfulness; Psychosomatic

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Mindfulness

Mindfulness is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.

Definitions

- **Consciousness** is the capability for awareness of one's own existence.
- **Meditation** is the concentrated focus on a sound, the breath, object, or attention itself to increase awareness of the present moment. Its purpose is reduce stress, promote relaxation, or increase spiritual growth.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.

Description

Mindfulness is a type of consciousness. It is the ability to be aware (conscious) of the present moment with sustained attention. Mindfulness is an experience of awareness. Mindful awareness involves intimately knowing the present experience. As an individual recalls a past event or experience, the memory, or re-experiencing, actually exists in the present moment. That means that it is possible to be mindful of memories as they occur in the present moment. Fantasies and expectations about possible future occurrences are mental projections that occur in the present moment. So, it is possible to be mindful of fantasies and expectations about possible future occurrences. Also,

an individual can be mindful of his or her own patterns of thought and behavior. Mindfulness leads to an acceptance of the experience as it is. It increases the ability to intentionally make choices about one's own actions. Mindfulness itself is passive, but one can be mindful of one's own movement in the world. Such a mindful awareness may include knowledge of taking a deep and relaxing breath, washing dishes, or doing any other activity. Finally, mindfulness is a lifestyle of awareness. It is a way of being.

Mindful practices are the systematic rehearsal of intentionally attending to aspects of the present moment. Mindfulness practices, including mindfulness-based psychotherapies, enhance the awareness of experience. Those practicing mindfulness learn to pay attention to particular aspects of the present moment. Through practice it is possible to develop the capacity to stay mindful longer. Becoming more mindfully aware is a practice of altering the relationship between one's consciousness and the present moment. Mindful practice includes staying present with one's own moment-to-moment experience. As individuals' ability to "stay present" develops, they might learn to relax their concentration and witness the dynamic moment that is always changing in the here and now. Some forms of mindfulness-based practices aim to include positive affect such as love, compassion, or forgiveness into mindful awareness.

Development and Current Status

Mindfulness is commonly associated with Eastern meditative traditions, such as Buddhism or, less frequently, yoga. Yoga documented various mindfulness-based practices over 5,000 years ago. Similarly, Buddhism has a 2,500-year-old tradition of mindfulness-based practices. These Eastern "psychologies" have emphasized the cultivation of attention to one's own subjective experience prior to the formal establishment of modern science. However, mindfulness is a major aspect of almost all religions and spiritual practices. For example, ancient Greek philosophers documented discussions of principles commonly associated with mindfulness today. In other words, mindfulness is an aspect of human experience and does not belong to any particular ideology. Yet many of the most popular and effective mindful practices available today originate in the Buddhist tradition.

Thich Nhat Hanh (1926–), a Zen Buddhist monk and teacher, conducted a retreat on mindfulness in the United States. One of attendees was the American psychologist Jon Kabat-Zinn (1944–). In 1979, Kabat-Zinn adapted Hanh's teachings on mindfulness into his eight-week Mindfulness-Based Stress Reduction course. This course and its emphasis on mindfulness has since spread throughout North America and to other Western countries. Still, there are differences in Eastern and Western views of mindfulness. For example, conventional Western medicine defines health as the absence of pathology. In contrast, Tibetan-Buddhist medicine defines health as the perpetual presence of mindfulness. This tradition teaches that it is most difficult to stay mindful when one is attached to biases, longing for desire, or intensely angry. Many Eastern traditions agree that factors of calmness, tranquility, and balance assist the maintenance of a mindful awareness.

Unfortunately, the term "mindfulness" is misused or too broad in the West. Here, mindfulness can refer to meditation, love, kindness, compassion, or even insight. In Western psychology the term "acceptance" is often used synonymously with mindfulness. "One-pointed concentration" has become another common synonym of mindfulness. Western psychologies often use mindfulness-based practices as interventions designed to disrupt harmful patterns of thinking or behaving. The essence of these interventions is that mindfulness allows the client to witness his or her cognitive and behavioral processes. Such pure witnessing often leads to the insight and motivation required to utilize available resources to promote change.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Contemplative Neuroscience; Evidence-Based Practice; Meditation; Mindfulness-Based Psychotherapies; Yoga

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Mindfulness-Based Psychotherapies

Mindfulness-based psychotherapies are forms of therapeutic counseling whose primary intention is to increase a client's capacity for an awareness or attention that is nonjudgmental, accepting, and engaged in experiencing the present moment.

Definitions

- **Common factors** are the similarities among theories of psychotherapy and the belief that these common factors are the real therapeutic factors.
- **Mindfulness** is an awareness or attention that is nonjudgmental, accepting, and engaged in experiencing the present moment.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

Mindfulness-based psychotherapies are therapeutic interventions centered in consciousness and awareness. Mindfulness-based psychotherapies operate on the theory that the subjective experience of human suffering will be reduced, or become more tolerable, through sustained attention on the present moment. Mindfulness and psychotherapy have different traditions and conceptualizations of the nature of human suffering. They also have different methods of intervening, promoting health, and achieving well-being. Mindfulness and psychotherapy do, however, have much in common. Mindfulness-based psychotherapies are composed of these commonalities. Mindfulness-based psychotherapies assist clients through the utilization of psychoeducational techniques and related interventions that enhance the awareness of experience. Therapists engage clients in mindfulness through instructional processes. Clients learn to pay attention to particular aspects of the present moment. As individuals' ability to "stay present" develops, they learn to relax their concentration and witness the dynamic moment that is always changing in the here and now. This relaxed and mindful witnessing of the present moment optimally occurs without bias or judgment. Some forms of mindfulness-based psychotherapies aim to include positive affects such as love, compassion, or forgiveness in the client's mindful awareness.

Development and Current Status

Mindfulness-based psychotherapies are often discussed in terms of Eastern meditative traditions, such as Buddhism or, less frequently, yoga. Yoga documented various mindfulness-based practices over 5,000 years ago. Similarly, Buddhism has a 2,500-year-old tradition of mindfulness-based practices. In Eastern traditions mental health is defined as a mind that has been cultivated through the practice of mindfulness. In 1979, the American psychologist Jon Kabat-Zinn (1944–) participated in a retreat on mindfulness given by Thich Nhat Hanh (1926–), a Zen Buddhist monk and teacher. Struck by the potential clinical value of mindfulness with medical and psychiatric conditions. Kabat-Zinn adapted Hanh's teachings on mindfulness into what was to become the first mindfulness-based psychotherapies. Four such common mindfulness-based psychotherapies are described here.

Mindfulness-based stress reduction. Mindfulness-based stress reduction (MBSR) was developed by Jon Kabat-Zinn (1944–) at the University of Massachusetts Medical Center for treatment of medical patients. Since then, MBSR has evolved into a common medical and psychological treatment for various health problems. MBSR is a structured group program lasting 2.5 hours and scheduled over 8 to 10 weeks. Each session covers specific exercises and topics that are examined within the context of mindfulness. These include

various forms of mindfulness meditation practice, mindful awareness during yoga postures, and mindfulness during stressful situations and social interactions. Because an individual's development of mindfulness requires regular and repeated practice, participants are expected to practice 45 minutes of homework assignments each day. This involves meditation and mindful yoga, and applying mindfulness to situations in everyday life.

Mindfulness-based cognitive therapy. Mindfulness-based cognitive therapy (MBCT) was developed by psychologists Zindel Segal (n.d.), Mark Williams (n.d.), and John Teasdale (n.d.). It is a form of MBSR that includes information about depression as well as cognitive therapy–based exercises linking thinking and its resulting impact on feeling. MBCT demonstrates how participants can best work with these thoughts and feelings when depression threatens to overwhelm them and how to recognize depressive moods that can bring on negative thought patterns. MBCT is an adjunctive or standalone form of treatment that emphasizes changing the awareness of, and relation to, thoughts, rather than changing thought content. It offers clients a different way of living with and experiencing emotional pain and distress. The assumption is that cultivating a detached attitude toward negative thinking provides one with the skills to prevent escalation of negative thinking at times of potential relapse. Clients engage in various formal meditation practices designed to increase moment-by-moment nonjudgmental awareness of physical sensations, thoughts, and feelings. Assigned homework includes practicing these exercises along with exercises designed to integrate application of awareness skills into daily life. Specific prevention strategies derived from traditional cognitive therapy methods are incorporated in the later weeks of the program.

Dialectical behavior therapy. Dialectical behavior therapy (DBT) was developed by Marsha Linehan (1943–) for the treatment of borderline personality disorder but has recently been modified and extended for use with other personality disorders as well as psychiatric disorders such as mood disorders, anxiety disorders, eating disorders, and substance use disorders. Four primary modes of treatment are noted in DBT: individual therapy, skills training in a group, telephone contact, and therapist consultation. The core strategies in DBT are "validation" and "problem solving." Attempts to facilitate change are surrounded by interventions that validate the client's behavior and responses in relation to the client's current life situation, and demonstrate an understanding of his or her difficulties and suffering. Problem solving focuses on the establishment of necessary skills. Mindfulness is an essential skill set in this approach. Learning to be more aware of feelings and internal states are learned through the core mindfulness "what" and "how" skills. The "what" skills of core mindfulness are to observe, describe, and participate in each moment of life. The "how" skills are to be nonjudgmental, one-mindful, and effective. The main objective in learning both sets of mindfulness skills is to develop awareness and insight in order to behave in ways that achieve the individual's treatment goals.

Acceptance and commitment therapy. Acceptance and commitment therapy (ACT) was developed by psychologist Steven C. Hayes (1948–). It is a form of therapy that uses mindfulness skills to develop psychological flexibility and helps the individual clarify and focus on life-giving behaviors. ACT is a directive and experiential form of therapy that does not view clients as damaged or sick. The aim of ACT is to experience life fully, which includes the full range of human experience, including pain. Acceptance of life as it is, without evaluation or attempts to change it, is a skill that is developed through mindfulness. Mindfulness is taught in a series of exercises in and out of treatment session. Being present means being in direct contact with the present moment and getting in touch with the observing self, the part that is aware of, but separate from, the thinking self. Mindfulness techniques are taught to experience the observing self—firsthand. This means awareness through the five senses, thoughts, and emotions. Opening up is the ability to detach from thoughts and making space for and dropping the struggle with painful feelings, and urges. Acceptance is the ability to allow what is to be as it is instead of fighting or avoiding it.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Acceptance and Commitment Therapy (ACT); Dialectical Behavior Therapy (DBT); Meditation

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Mini-Mental State Examination

The mini-mental state examination (MMSE) is a brief psychological test to screen for cognitive impairment. It is also referred to as the Folson Mini-Mental Status Examination and the Folson.

Definitions

- **Alzheimer's disease** is a type of dementia that involves brain disease and progressive degradation of the brain, which involves memory loss and an eventual inability to think and function.
- **Cognitive** refers to mental activities associated with thinking, learning, and memory.
- **Delirium** is a state of mental confusion that develops quickly and can fluctuate in intensity.
- **Delusion** is a belief that is resistant to reason or contrary to actual fact.
- **Dementia** is a medical condition characterized by an overall decline in cognitive (intellectual) functioning, including memory loss, difficulties with language, simple calculations, planning, decision making, and motor skills.
- **Dissociation** is the splitting off of certain mental processes from conscious awareness characterized by feelings of unreality or confusion about one's identity.

Description

The mini-mental state examination is a brief test that screens for cognitive impairment in adults from 18 to 100 years of age. It consists of 11 questions that assess six areas of cognitive functioning: orientation, attention, immediate recall, short-term recall, language, and the capacity to follow simple verbal and written commands. It is particularly useful in identifying delirium and dementia. Besides detecting the severity of cognitive impairment, it can be used to measure decline in cognitive function, to follow the course of the individual's illness, and to monitor responses to treatment. It differs from the mental status exam, which includes questions about the mood and other abnormal experiences such as dissociation. Instead, the MMSE concentrates on the cognitive aspects of mental functioning.

The MMSE is divided into two sections, together taking from 10 to 15 minutes to administer. The first part requires vocal responses to the examiner's questions, which test the individual's orientation, memory, and attention. The second part requires the individual to follow verbal and written instructions, including copying a complex geometric figure. Administration time is approximately 10 minutes. A total score of 30 is possible. Scores greater than or equal to 25 points suggest normal cognitive functioning. Below this, scores can indicate severe (less than 9 points), moderate (10–20 points), or mild (21–24 points) cognitive impairment.

Developments and Current Status

The MMSE appeared in 1975 and was developed by psychiatrist Marshall Folstein and colleagues. It was designed to quickly assess elderly individuals whose capacity to sustain an optimum level of engagement with an examination was limited to a few minutes. While the second edition, MMSE-2, is similar to the first edition, it provides more precise evaluations of individuals with less severe forms of cognitive impairment, such as subcortical dementia. Norms were established from sample of over 1,500 individuals with Alzheimer's disease and subcortical dementia. Reliability and validity were also established. Recently, the MMSE was approved as

a measurement of an individual's ability to complete an advance directive or living will.

Len Sperry, MD, PhD

See also: Mental Status Examination

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Minnesota Multiphasic Personality Inventory (MMPI)

The Minnesota Multiphasic Personality Inventory is a psychological test used to assess personality and psychopathology. It is also known as MMPI.

Definitions

- **Objective personality inventory** is a type of psychological test designed to assess personality traits and behavioral patterns using structured questions. It contrasts with projective personality tests which use unstructured stimuli such as the Rorschach Inkblot Test.
- **Personality** is an individual's unique consistent pattern of thinking, feeling, and acting.
- **Psychopathology** is the study of the conditions and processes of a mental disorder and dysfunctional behavior.
- **Scale** is a subset of test items from a multi-item test.
- **T-scores** are derived scores on a test which have a fixed mean (average) of 50 and a fixed standard deviation (deviation of a set of data from its mean).

Description

The Minnesota Multiphasic Personality Inventory (MMPI) is an objective personality inventory that assesses personality traits and psychopathology. It is primarily intended to test individuals presumed to have mental health or other clinical issues. The MMPI is currently administered in one of two forms. The first is MMPI-2, which has 567 true–false questions. The second is the newer MMPI-2-RF, which is considerably shorter with 338 items. The MMPI-2-RF takes only 30 to 50 minutes to complete. Nevertheless, the MMPI-2 is still the more widely used test because of its existing large research base and familiarity with psychologists. The MMPI-2 is intended for use with adults, 18 and up. A similar test, the MMPI-A, is intended for use with adolescents. The MMPI-2 has English and Spanish versions.

The MMPI-2 is designed with 10 clinical scales, which assess the major categories of abnormal human behavior. It also includes four validity scales, which assess the individuals' general test-taking attitude and truthfulness and accuracy in answering the questions. After the test is taken and scored, an interpretive report is constructed. Scores are converted to "T scores" on a scale ranging from 30 to 120. The normal range of T scores is from 50 to 65. Scores above 65 and those below 50 are considered clinically significant and may result in a psychiatric diagnosis.

A set of standard clinical profiles are used in interpreting the MMPI-2. They are called "codetypes," reflecting two scales where one has a high T score and the other is higher than the other. For example, a 2-3 codetype (both Scales 2 and 3 are significantly elevated) suggests significant depression, lowered activity levels, helplessness, and often physical complaints.

Developments and Current Status

The original MMPI was developed and published in 1939 by psychologist Starke R. Hathaway (1903–1984) and psychiatrist J.C. McKinley. They used the

empirical keying process to develop the MMPI. This involved writing several true–false statements, many of which were not psychiatric (psychological) in nature. These items were given to various groups (college students, medical and psychiatric inpatients, hospital visitors, etc.) and then analyzed to determine which items consistently differentiated psychiatric patients and diagnoses from others. These items were grouped into sets which were named clinical scales.

Several additions and changes to the measure have been made over time, including the addition of supplemental, validity, and other content scales to improve interpretability of the original clinical scales, changes in the number of items in the measure, and other adjustments. The MMPI became the MMPI-2 in 1989 as a result of a major restandardization effort to develop a new set of norms that were more representative of population characteristics 50 years after the original version. In 2003, the Restructured Clinical (RC) scales were added to the MMPI-2. It addressed psychometric flaws in the original clinical scales that complicated their interpretability. The MMPI-2-RF (Restructured Form) was published in 2008. Based on RC scales, it is a streamlined version that retains 338 of the original 567 items. Two new Validity Scales were added as well as new scales for somatic complaints. The MMPI-2-RF's scales now demonstrate increased validity compared to their MMPI-2 counterparts. Overall, the MMPI is the most widely used personality inventory tests in the world and has remained the gold standard in personality testing ever since its inception.

Len Sperry, MD, PhD

See also: Personality; Rorschach Inkblot Test

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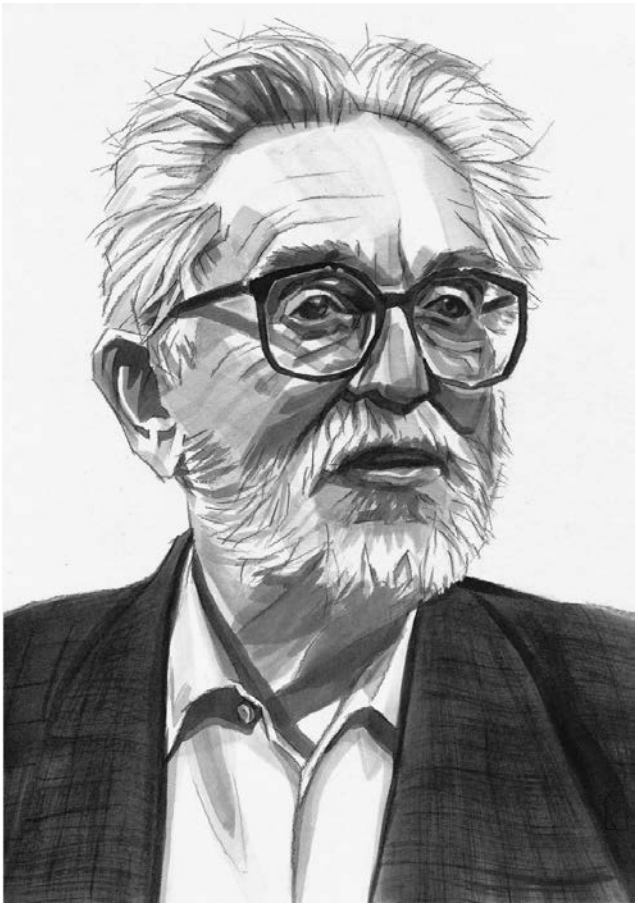
Minuchin, Salvador (1921–)

Salvador Minuchin is an Argentinian psychiatrist best known for his work in creating structural family therapy.

Description

Salvador Minuchin, MD, was born and raised in Argentina. Minuchin's family had emigrated from Russia, and Minuchin was the oldest of three siblings. Minuchin reported being influenced by his large extended family in Argentina as all of his activities growing up included family. As a Jewish male, Minuchin found himself compelled to head to Israel in 1948 after



Salvador Minuchin is an Argentinian psychiatrist best known for his work in creating structural family therapy. He also developed treatment methods for anorexia nervosa and established the Family Studies Institute in New York City. (Jan Rieckhoff/ullstein bild via Getty Images)

Israel declared itself a state. Minuchin has long held an interest in social issues and decided to serve as a physician in the Israeli military before moving to the United States to study psychiatry.

During the 1950s, Minuchin went back to Israel where he worked with children from numerous countries. On his return to the United States, he began working with boys who were identified as juvenile delinquents. In his work he started looking into the impact of family dynamics and functioning as he determined that working solely with boys was insufficient. Guided by experience and practice, instead of theory, he learned and developed structural family therapy in the 1960s. Minuchin focused on the structure of the family as he feels the symptoms or dysfunction the boys expressed can be addressed by restructuring the family interactions and patterns.

Minuchin was fascinated by the social world in which families are connected and the impact of the relationships, structures, and boundaries as well as the impact. Because of the experience he had with the boys he was working with, he recognized a need for a focus on doing—as opposed to talking—and utilized techniques such as role playing and enactments. Minuchin felt it was important to study the family and join as a leader challenging their interactions and roles so that they can be modified to use healthier patterns.

Impact (Psychological Influence)

Stanley Minuchin is considered to be a large contributor to the development of family therapy as a whole, as well as helping create the branch of family therapy known as structural family therapy. He also created treatment methods for anorexia nervosa as he felt the eating disorder had its origin in dysfunction within the family unit. Minuchin has authored several books and journal articles focusing on working with families. In 1981, he established the Family Studies Institute in New York City, which was later renamed the Minuchin Center for the Family. This is currently a nonprofit training and consultation organization focused on structural family therapy. Salvador Minuchin retired in 1996.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Structural Family Therapy

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Mixed Features

Mixed features is a specifier applied to major depression, mania, and hypomania.

Definitions

- **Antidepressants** are prescription drugs that are primarily used to treat depression and depressive disorders.
- **Bipolar disorder** is a mental health disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more depressive episodes.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life. It is not considered a disorder unless it significantly disrupts one's daily functioning.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health

professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5, while the previous was known as the DSM-IV-TR.

- **Features** are prominent or conspicuous parts or characteristics. They are considered as an important part, quality, or ability, and something offered as a special attraction.
- **Hypomania** is a mental state similar to mania but less intense.
- **Major depressive disorder** is a mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning. It is also referred to as clinical depression.
- **Mania** is a mental state of expansive, elated, or irritable mood with increased energy or activity.
- **Mixed episode** is a distinct period during which an individual experiences nearly daily fluctuations in mood to meet the diagnosis of manic episode and major depressive episode.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description

Mixed features is a new specifier included for certain diagnoses in *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (DSM-5). This specifier replaced "mixed episode" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR). It can be applied to major depression, mania, or hypomania. The change from mixed episodes to mixed features reflects the way the behaviors intersect and will benefit diagnosis and treatment. There are several reasons this specifier was changed. In *DSM-IV-TR* a diagnosis of mixed episode required an individual to concurrently meet all criteria for an episode of major depression and mania.

Individuals rarely meet the full criteria of both episode types at the same time. The requirements for individuals to be diagnosed with the new specifier in the case of major depression are that individuals will require the presence of at least three hypomanic/manic symptoms. The symptoms cannot overlap with symptoms of major depression. For example, symptoms such as irritability, distractibility, indecisiveness, and insomnia are common to both moods and are not included in the criteria for mixed mood. The requirements for individuals to be diagnosed with the new specifier for hypomania or mania are that the presence of at least three symptoms of depression in combination with the episode of mania/hypomania must be present.

To the contrary, in individuals who are predominantly depressed with some hypomanic and manic symptoms, the mixed features specifier should also be considered. The hypomanic and manic symptoms may include decreased need for sleep, elevated mood, an increase in energy, and an inflated self-esteem. At least three of these symptoms must be present nearly every day during the two most recent weeks of the major depressive episode.

The mixed features specifier allows mental health professionals to more accurately diagnose individuals who may be suffering from concurrent symptoms of depression and hypomania/mania. This will help mental health professionals to provide more effective treatments for the individual's behaviors. This may be particularly important since many patients with mixed features may have a poor response to a particular medication or become less stable when taking other medications, such as antidepressants. As mental health professionals are able to more accurately identify these simultaneous behaviors, this may allow them to recognize individuals with a unipolar disorder who are at an increased risk of progression to another mental health disorder, such as bipolar disorder.

Elizabeth Smith Kelsey, PhD,
and Len Sperry, MD, PhD

See also: Antidepressants; Bipolar Disorder; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Hypomania; Mania

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Mixed Receptive-Expressive Language Disorder (MRELD)

Mixed receptive-expressive language disorder (MRELD) is a deficit in the ability to both turn thoughts into speech and understand communication received from others.

Description

Difficulties in both understanding and using language to communicate with others are characteristic of people diagnosed with MRELD. It differs from expressive language disorder because those who are diagnosed with MRELD have difficulty processing verbal instruction from others. MRELD is present when persons have problems both with expressing themselves using verbal language and with understanding what people around them say. Expressive language disorder, MRELD may be either acquired or developmental. MRELD can be acquired, usually the result of an accident or illness that causes brain damage. In the developmental type, deficits are the result of some kind of genetic or neurological problem. Many times it is of unknown origin since the disorder is evident from a very early age. Studies suggest that developmental MRELD may occur in up to 5% of preschool children. It also seems to be more prevalent in boys than in girls.

Those who suffer from MRELD often find it difficult to express themselves in such a way that others can understand. Their meaning is often lost due to limited vocabulary, difficulty in using words they know, wrong use of words, and tense confusion. Visual learning in those with MRELD is often unaffected and can show normal development.

Since children with MRELD find it difficult to communicate as well as their peers, they may feel isolated and exhibit some behavior problems. Add to this the fact that they also have problems understanding what is being said to them by others and it becomes clear why they often do not respond to requests or why they respond inappropriately. Others may assume that they are being stubborn or deliberately uncooperative when they simply do not understand what is being said to them.

Diagnosis

Mixed receptive-expressive language disorder is now classified under the diagnosis of speech sound disorder. Standardized testing can help establish a diagnosis of MRELD. It is important to bear in mind that the ability to communicate may be much more complex for children growing up in bilingual households and testing must take that into account. It has been estimated that 30%–60% of children with MRELD also have attention-deficit disorder.

Prognosis for those with MRELD varies depending on the type. Many children with the developmental type of MRELD will improve substantially over time with help. For those with the acquired type of MRELD, the outcome is entirely dependent on the nature, location, and severity of the injuries.

Treatment

For children diagnosed with the developmental type of MRELD the key to success is early intervention. Speech-language therapy is one of the recommended treatments for children and adults with both types of MRELD. Any treatments should involve all the individual's caregivers and should focus on reading and language skills that can be reinforced during interaction with their peers.

Alexandra Cunningham, PhD,
and William M. Cunningham, MA

See also: Expressive Language Disorder; Speech Sound Disorder; Speech-Language Pathology

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MMPI

See Minnesota Multiphasic Personality Inventory (MMPI)

Mobbing

Mobbing is harassment of a coworker by a group of others in a workplace to force the targeted individual out of the workplace.

Definitions

- **Bullying** is an act of repeated aggressive behavior in order to intentionally harm another individual.
- **Target** is the individual who is the recipient or victim of bullying or mobbing.

Description

Mobbing involves a "ganging up" by a coworker, boss, or subordinate who rallies others in a work organization to engage in "mob-like" behavior. The purpose is to cause injury—physical or mental distress or illness, and even expulsion from the organization. Because the organization ignores, condones, or even provokes the behavior, the target may be helpless against this "mob." Instead of understanding mobbing as a reversion to a more primitive aggressive state common to all animals, the individual who has been mobbed most often has received little to no support, has been isolated, and has constructed the meaning of the experience as that of shameful personal failure. The emotional, financial, career, and health consequences of both can be devastating for individual victims and their families. In a 2014 survey by the Workplace Bullying Institute, 27% of Americans have suffered abusive conduct at work, while another 21% have witnessed it. In addition, 72% say they are aware that such workplace abuse happens.

Bullying and mobbing are phenomena that are used interchangeably by many. While both share some similarities, there are some significant differences. In *Mobbing: Causes, Consequence and Solutions*, "mobbing" is defined as the nonsexual harassment of a coworker by a group of other members of an organization for the purpose of removing the targeted individual(s) from the organization or at least a particular unit of the organization. Mobbing involves individual, group, and organizational dynamics. It predictably results in humiliation, devaluation, discrediting, and degradation; loss of professional reputation; and, often, removal of the target from the organization through termination, extended medical leave, or quitting. The results of this typically protracted traumatizing experience are significant financial, career, health, and psychosocial losses or other negative consequences.

In contrast to mobbing, bullying is abusive and harmful behavior directed at a specific target or targets by a single offender. Behaviors may include name calling, verbal or written abuse, exclusion from activities, exclusion from social situations, physical abuse, or coercion. The bully may be a peer or supervisor, but others in the organization are not involved. Unlike mobbing, there is little or no direct organizational involvement in the abusive behavior. As a result, the consequences of bullying tend to be less severe than mobbing.

Workplace mobbing and bullying can be understood on a continuum ranging from health to severe abusiveness. On this continuum, bullying is a less severe and encompassing form of abusiveness than mobbing. In the United States the term "bullying" is used more often than mobbing, whereas in Europe, the term "mobbing" is preferred.

Len Sperry, MD, PhD

See also: Bullying and Peer Aggression

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Modeling

Modeling is a form of teaching where individuals learn how to act or perform by observing other individuals.

Definition

- **Behavior** is an observable action demonstrated by a human or animal caused by either internal or external occurrences.

Description

Over time it has become clear that human beings have learned basic and advanced skills by studying and then imitating the behavior of others. Social learning, as modeling is often called, is the foundation of many therapeutic approaches, especially in behavior therapy. In a therapeutic setting, the therapist is often the one modeling desired behavior. More generally parents and peers also play an important role in demonstrating desired skills, behaviors, or activities. There are several important steps of modeling, all of which impact the effectiveness of treatment.

First, there is the observation of the behavior of the person modeling. If the individual is to learn something new, then paying close attention to what is being modeled is essential. Second, the learner must be able to retain a clear sense of what has been modeled. This may be dependent on learners understanding verbal cues and directions that they can turn into mental images and apply to themselves. This includes understanding the results of what has been modeled, which reinforces the motivation to learn. The last step involves the learner's ability to reproduce the modeled behavior, which will often include repetition and practice before it is mastered.

Modeling is used in a variety of situations, from teaching children with developmental disabilities to self-feed to the more complex social skills required for shy or withdrawn adolescents to interact with others effectively. A primary component of modeling is identifying what the learner is motivated by so that he or she can learn effectively. As a behavioral technique, modeling is a well-researched and effective therapeutic tool.

Development

The leading champion of the concept of modeling is the Canadian-born psychologist Albert Bandura. His studies of social learning have shown the process of how skills are learned by children through watching each other. These skills include sharing, aggression, cooperation, social interaction, and delayed gratification. One of his most famous studies involving Bobo dolls is taught in mainstream psychology as a clear example of social learning theory.

Bandura focuses social learning and social cognition theories on motivating factors and self-regulatory mechanisms that contribute to a person's behavior. This focus on cognition is what differentiates social cognitive theory from B.F. Skinner's more purely behavioral viewpoint. Bandura believed that people can control their behavior through a cognitive process of regulation based on awareness, judgment, and self-response.

Current Status

Recently researchers have demonstrated that modeling, like many other therapeutic approaches, is most effective when it is combined with other complementary procedures. For example, it has been found that a combination of modeling and guided participation is generally more effective than modeling alone in reducing fears during covert desensitization. Modeling is also often a major component in assertiveness training. Assertiveness training also includes other components such as learning communication skills, behavioral

rehearsal, feedback, and coaching. Other current areas that integrate modeling through social cognitive theory are neurolinguistic programming and counseling. The idea of self-regulation has been incorporated into social cognitive approaches and has been used with success in dealing with trauma, smoking, drinking, and gambling.

Alexandra Cunningham, PhD

See also: Behavior Therapy; Behavior Therapy with Children; Social Learning Theory; Social Skills Training

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Mood

Mood is an individual's subjective emotional experience and expression.

Definitions

- **Affect** is an observable pattern of behavior that describes an individual's subjective emotional experience and expression.
- **Bipolar and related disorders** is a category of diagnosis characterized by an individual's alternating between states of extremely expansive moods and significant dysphoric moods. This category includes bipolar I and II, cyclothymic disorder, and substance/medication-induced bipolar disorder.
- **Depressive disorders** is a category of diagnosis characterized by significant and enduring dysphoric moods as a central symptom. This category includes disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, and premenstrual dysphoric disorder.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Emotion** is a feeling state of consciousness (awareness) in which an emotion like joy, sorrow, or fear is experienced, as distinguished from cognitive (mental) states of consciousness.
- **Subjective** is the description of one's personal and distinct experience of an outer or inner event. It contrasts with an objective or third-party description.

Description

Mood describes an individual's subjective emotional experience and expression. Common examples are anger, elation, anxiousness, and sadness. It contrasts with affect which is an objective description, whereas mood is a subjective experience. This subjective–objective perspective on mood and affect differs somewhat from the DSM-5 perspective. DSM-5 views mood as a sustained and pervasive emotional "climate." In contrast, affect is viewed in DSM-5 as emotional "weather," which fluctuates and is shorter in duration.

From either perspective, mood is an emotional experience. However, mood differs from emotion in that mood can lack an object. For instance, the emotion of anger may be aroused by an insult. But an angry mood can arise even when individuals do not know why or what elicited their anger.

The DSM-5 recognizes five common moods:

- **Dysphoric** describes sad or anxious mood.
- **Elevated** describes an increased perception of well-being or excitement.
- **Euthymic** describes a neutral mood.
- **Expansive** describes a magnified sense of self-importance.

- **Irritable** describes a state whereby an individual is perturbed or easily annoyed or angered.

Disturbances in mood are characteristic of mood disorders. It is important to note that an entire category of DSM-4 (former DSM edition) "mood disorders" has been re-categorized in the DSM-5. These diagnoses have been separated into two distinct categories: depressive disorders and bipolar and related disorders. Mood characteristics remain a central part of the diagnostic criteria for both of these new categories (American Psychiatric Association, 2013).

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Affect; Bipolar Disorder; Depressive Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM)

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Mood Disorders

Mood disorders represent a category of mental disorders that all share the main symptom of mood disruptions.

Definitions

- **Affect** is a general and encompassing term that describes emotional experience and expression.
- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Antimanic medications** are prescription drugs that are primarily used to treat bipolar disorder (manic depression). They are also called antimanic and mood stabilizers.
- **Bipolar and related disorders** is a category of diagnosis characterized by an individual's alternating between states of extremely expansive moods and significant dysphoric moods. It includes bipolar I and II, cyclothymic disorder, and substance/medication-induced bipolar disorder.
- **Depressive disorders are** a category of diagnosis characterized by significant and enduring dysphoric moods as a central symptom. It includes disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, and premenstrual dysphoric disorder.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria. It is currently in its fifth edition (DSM-5).
- **Emotion** is a perceived and brief state of feeling, often in response to a stimulus.
- **Mood** is an individual's subjective emotional experience and expression.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotropic medications** are prescribed drugs that affect thinking, feeling, and behavior. They include antipsychotic, antianxiety, antidepressant, and antimanic drugs.

Description

Mood disorders is a category of mental disorders characterized by significant long-term, frequent, or severe disruptions in mood. This category of disorders includes bipolar disorder, cyclothymic disorder, disruptive mood dysregulation disorder, major depressive disorder, and persistent depressive disorder. Sometimes the mood disruptions are ongoing and long-term, as in the case of persistent depressive disorder. Other

times, mood may swing between extremes, as in the case of the bipolar disorders. Generally, these disorders tend to affect a higher proportion of women than men.

Mood disorders were a separate category in the DSM-4. However, in DSM-5 these disorders have been separated into two distinct categories: depressive disorders and bipolar and related disorders. Despite this change, mood characteristics remain the focus of the diagnostic criteria for both of these new categories. A short description of each of these disorders follows.

Bipolar disorder. Bipolar disorder is a mood disorder characterized by the experience of fluctuations between extremely heightened and lowered mood. Heightened moods are characterized by either hypomanic episodes or a manic episode. During these episodes, individuals feel excessively grand or expansive, experience less sleep, and are abnormally active. Individuals who experience hypomanic episodes are given the diagnosis of bipolar II disorder, while individuals who experience manic episodes are diagnosed with bipolar I disorder. Also, individuals with a bipolar I diagnosis may or may not experience a major depressive (extremely lowered mood) episode. In contrast, individuals with a bipolar II diagnosis have experiences at least one major depressive episode.

The occurrence of this disorder is estimated to be less than 1% of the population in the United States (American Psychiatric Association, 2013). This disorder affects slightly more women than men. The specific cause of this disorder is unknown, but it is believed that genetics, brain functions, and the environment play a role in the manifestation of this disorder. Treatment of this disorder most often includes a combination of psychotherapy and psychotropic medications. These include antimanic drugs like lithium, as well as some antidepressants. It is important to note that there are a number of other disorders listed in the category of bipolar disorders. See the entry Bipolar Disorder for more information.

Cyclothymic disorder. Cyclothymic disorder is a mood disorder characterized by alternating cycles of hypomanic and depressive periods. This disorder is similar to bipolar disorder but is less severe. Similarly, the hypomanic and depressive symptoms are also less pervasive and shorter in duration in cyclothymic disorder. The occurrence of this disorder is also similar to bipolar disorder, affecting less than 1% of the population (American Psychiatric Association, 2013). Also, the cause of the disorder is unknown but believed to be the interaction of genetics, brain function, and the individual's environment. Treatment for this disorder may include both psychotherapy and psychotropic medications similar to those employed in the treatment of bipolar disorder.

Disruptive mood dysregulation disorder. Disruptive mood dysregulation disorder is a mood disorder in children characterized by severe and frequent temper tantrums that interfere with daily functioning. These outbursts exceed the normal outbursts that occur in many children in that they occur more frequently, in more places, and more severe than in normal-functioning children of the same age. This diagnosis was developed in the newest revision of the DSM because it was believed that children were being overdiagnosed with bipolar disorder according to the previous criteria. The occurrence of this disorder is estimated to be between 2% and 5% (American Psychiatric Association, 2013). However, this is a newly formed diagnosis, so very little data is available so far. Treatment for this disorder may include psychotherapy and psychotropic medications.

Major depressive disorder. Also referred to as clinical depression, major depressive disorder is a mood disorder characterized by depressed mood that lasts at least two weeks. Individuals who suffer from major depressive disorder are likely to express one of the principal features of the disorder, feelings of significant sadness, emptiness, or bleakness. They may have lost or may be losing weight and be unable to experience normal sleep. Individuals with this disorder may also experience stunted physical movement and difficulty thinking. Some individuals who experience grief, such as loss of a loved one, will experience these symptoms. However, for this diagnosis to apply, the individual cannot be in the process of grief. The occurrence of this disorder is estimated to be 7% (American Psychiatric Association, 2013). This disorder affects females considerably more than males. The cause of this disorder is still debated. However, it is believed that chemical imbalances in the brain may play a role for many individuals. Also, a person's beliefs or predispositions may also affect manifestation. Treatment for this disorder may include psychotherapy and/or antidepressant

medications. This disorder as well as other depressive disorders commonly co-occur with both anxiety and substance abuse disorders.

Persistent depressive disorder. Persistent depressive disorder is a mood disorder characterized by a chronic depressed mood for at least two years. It contrasts with major depressive disorder, which requires only two weeks to be applicable. The depressed mood is less severe than major depressive disorder but is also characterized by symptoms of sadness, hopelessness, or meaninglessness. The occurrence of this disorder in the United States is estimated to be between .05% and 1.5% of the population (American Psychiatric Association, 2013). Treatment for this disorder may include psychotherapy and/or antidepressant or other psychotropic medications.

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See also: Affect; Bipolar Disorder; Cyclothymic Disorder; Depressive Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Disruptive Mood Dysregulation Disorder; Emotion; Major Depressive Disorder; Mood; Lithium; Psychotherapy

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Moral Development, Stages of

First studied by psychologist Jean Piaget and then expanded upon in models proposed by Lawrence Kohlberg and Carol Gilligan, the stages of moral development describe a sequence of moral reasoning that people progress through from early childhood on into adulthood.

Definition

- **Heinz dilemma** is a frequently used case example presented to individuals to assess their moral reasoning and stage of moral development; this dilemma was readily used in foundational research on this topic conducted by psychologist Lawrence Kohlberg.

Description

Moral reasoning has been of interest to psychologists, sociologists, philosophers, theologians, and educators for centuries; however, the development of defined stages of moral development can mainly be attributed to the work of psychologists Jean Piaget, Lawrence Kohlberg, and Carol Gilligan. It is believed that moral reasoning provides the basis for ethical behavior. Moral development is not associated with chronological age; rather it unfolds as a result of each person's own thinking, reasoning, and experience. Assessing a person's stage of moral development, therefore, can provide valuable information about how the individual views the world and navigates through the obstacles he or she encounters, though moral thought is not necessarily indicative of moral action.

In order to determine one's present stage of moral development, an individual is proposed a moral dilemma and then asked to answer how he or she would react in that circumstance and to provide a rationale that justifies his or her choice. The assessor, usually a psychologist, then records the answers and categorizes the individual's responses. Kohlberg used a case example known as the "Heinz dilemma" regularly in his research. The story describes a husband's choice to steal an expensive and rare medication needed for his ailing wife from a pharmacist who refuses to sell the drug for less than market price.

Development

Credited as the first psychologist to investigate moral development in children, Swiss psychologist Jean

Piaget extended his research on how young children learn and process information and applied his theory to moral decision making, publishing *The Moral Judgment of the Child* in 1932. He proposed two distinct stages of moral development: *Stage 1: Heteronomous Morality* and *Stage 2: Autonomous Reality*. In Stage 1, younger children, not far along in their cognitive development, are typically obedient to authority, strictly adhere to rules, and are inflexible in their moral reasoning. However, in Stage 2, children progress both in their cognitive and moral development and begin to critically evaluate rules and apply them to varying situations and circumstances. At this stage, respect, cooperation, empathy, and perspective taking are more likely to occur.

Piaget laid the foundation for this research on moral thinking in children, but his follower, American psychologist Lawrence Kohlberg, later expanded on this area. Kohlberg set forth a series of distinct, constructive stages that individuals move through as they develop moral reasoning. Alignment with Piaget's ideas is evident in the first three stages. Progression through Kohlberg's stages is sequential, meaning that one cannot skip stages and it is extremely rare to move backward in them; each is necessary and the moral reasoning skills gained at each level allow for the individual to progress to the next. The six stages can be divided into three levels: *Preconventional, Conventional*, and *Postconventional*. The Preconventional level is comprised of Stage 1—*obedience and punishment*, whereby young children strictly adhere to rules in order to avoid punishment and/or please authority, and Stage 2—*individualism and moral reciprocity*, in which children start to separate their own wants, needs, and viewpoints from those in authority and begin to pursue their own interests. The *Conventional* level contains Stage 3—*mutual interpersonal expectations*, when the person shifts away from himself or herself and begins to value relationships and the interests of others, and Stage 4—*social system and conscience maintenance*, which describes a developmental shift where the individual learns to consider the viewpoint of the larger social system when making decisions. Finally, at the *Postconventional* level, an individual at Stage 5—*social contract and individual rights*, would be concerned with upholding the laws, ethics, and values of society of each and every person and safeguarding those over particular group interests, and at Stage 6—*universal ethical principles*, the individual's moral reasoning is defined by principles that would be agreed upon as just by the majority of people. At every stage in Kohlberg's model, the primary concern is justice.

A later model of moral development was proposed by one of Kohlberg's associates, Carol Gilligan in the 1980s. Gilligan noted that the majority of Kohlberg's study participants were male, essentially resulting in incomplete or biased conclusions. Given the high value they generally place on connections, interpersonal relationships, and caring for others, females may be categorized at a lower stage of moral development (Stage 3) than males when using Kohlberg's model. Gilligan suggested a revised set of stages that more accurately reflected the female orientation in moral development, incorporating what she referred to as the "ethic of caring." Her three-stage model includes Stage 1—*orientation to individual survival*, Stage 2—*goodness of self-sacrifice*, and Stage 3—*morality and nonviolence*. Gilligan's contribution to the assessment of moral reasoning is important in that she offered that moral development might not be a "one-size-fits-all" process.

Current Status and Results

Kohlberg's six-stage model of moral development is the most popular and widely referenced model to date. Proponents offer that these stages are derived from sound studies that produced qualitative and quantitative support, assessed both rater and inter-rater reliability, were extended to include longitudinal data, and resulted in consistent findings across cultures. Evidence suggests that an individual's stage of moral development is usually consistent with his or her behavior, though this is not universal. Piaget, Kohlberg, and Gilligan's work on assessing moral thought has been applied in counseling and educational settings. Parents, teachers, and authority figures can aid youngsters in their moral development by providing them with opportunities to practice problem-solving and conflict resolution skills by engaging in open discussion and role-playing activities.

In doing so, children learn to navigate through life in a democratic and accepting manner.

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See also: Kohlberg, Lawrence (1927–1987); Piaget, Jean (1896–1980)

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Moreno, Jacob (1889–1974)

Jacob Levy Moreno was an influential psychiatrist who pioneered the concept of group psychotherapy and the technique of psychodrama.

Description

Jacob Moreno (1889–1974) was born in Bucharest, Romania, but as a young child moved to Vienna, Austria, where he received his education. He graduated from medical school and began to practice psychiatry at the end of World War I. While a student he grew dissatisfied with the strict Freudian approach to the treatment of mental illness because of what he considered Freud's too narrow focus or concentration on a client's history.

He would later tell stories about confronting Freud himself about these limitations. He felt a more open and inclusive approach was needed to include creativity and humor as an important balance to help clients achieve psychological health. He would later assert that he was the psychiatrist who had brought laughter into psychiatry.

While in medical school Moreno had the experience of working in Viennese parks with children on theatrical productions where he learned the field of drama. Then, in 1913 he got the opportunity to facilitate a group session for prostitutes who were seeking to escape their profession. He was impressed that the members of the group seemed able to function as therapists to one another.

From these experiences in the community, Moreno came to feel that group psychotherapy and the use of element from drama could be more powerful and dynamic than individual talk therapy alone. Because of his own love of theater it was natural that he would develop ways to dramatize interpersonal relationships in psychotherapy. He noted that it was important for group work to involve elements of spontaneity and creativity. The group setting seemed to aid in letting clients lower emotional barriers and explore their issues in the context of a supportive environment.

The most famous therapeutic technique Moreno developed was psychodrama. In psychodrama a group of people in therapy concentrate on one person at a time who is called the protagonist. While the protagonist is encouraged to express and act out his or her feelings, the other members of the group respond with spontaneity. They use tools such as mirroring behavior or role reversal to help the protagonist become aware of their behaviors and feelings as well as its effects on them and others.

The Austrian psychiatric community remained closed off to such new and different ideas. In 1925, Moreno immigrated to New York City. The United States was far more accepting of Moreno's ideas and techniques. Moreno always felt that coming to America had given him a golden opportunity to experiment with and develop his ideas.

Soon after setting up his psychiatric practice in New York City, he got the opportunity to use group therapy in diverse settings. He did so in schools and prisons across the country, including in the famous Sing Sing prison in New York State. By 1934, he published his theories and the results he had achieved in a book titled *Who Shall Survive? Foundations of Sociometry, Group Psychotherapy, and Sociodrama*. The psychological community began to accept and use the terms he had coined through his work in group therapy and group psychotherapy. Moreno coined the words "sociatry" and "sociometry." He defined sociatry as healthy social

Jacob Levy Moreno was an influential psychiatrist who pioneered the concept of group psychotherapy and the technique of psychodrama. (Bill Peters/The Denver Post via Getty Images)

relationships. Sociometry meant the scientific study or measurement of relationships between individuals.

He founded a number of psychiatric journals and also taught at several universities. In 1942 his collaborator and wife, Zerka Toeman Moreno, joined Jacob in his work. He was considered the visionary and she became the therapist who showed how his theories could work in practical clinical settings.

Jacob Moreno died in 1974 and since then this wife has continued the work he founded. Zerka Moreno has been called "The Mother of Psychodrama" for her intimate collaboration with him in its development. She has not only continued his work through writing, but she has personally trained people all over the world in the understanding and application of psychodrama.

Impact (Psychological Influence)

Moreno was directly responsible for the American Psychiatric Association's recognition of group

psychotherapy as a credible and viable form of treatment. In addition to group psychotherapy, he is recognized as one of the developers of social network analysis, a branch of sociology that quantifies an individual's role in a group through analysis of connections to others. These are represented in various ways but the sociogram is one of the best known. Today there are still psychodrama certification programs and centers across the United States, and the approach remains popular in both group and individual therapy settings.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Group Counseling; Group Therapy; Psychodrama

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Motivation

Motivation is the process or desire that causes one to act on a certain behavior, the reason for the behavior be it biological, social, emotional, or cognitive in nature.

Description

Motivation is the force or drive used to explain the reasoning behind an organism's goal-oriented behavior. It is the underlying cause or stimulus that activates the organism's behavior (biological, emotional, social, or cognitive). The term is commonly used to describe why a person does what he or she does. An individual may be motivated by an impulse to minimize pain or discomfort, maximize pleasure, or optimize his or her well-being. Physical needs such as eating, sleeping, and sex are examples of stimuli that may motivate one to act. Motivation is made up of three major components: activation, persistence, and intensity. Activation refers to what initiates the behavior, persistence refers to maintaining the behavior with effort despite obstacles that may exist, and intensity describes the level of concentration and focus that one puts forth in that behavior.

There are two different types of motivation, extrinsic and intrinsic. "Extrinsic motivation" refers to behavior that is prompted by an outside force, something not within the individual. One may be extrinsically motivated by tangible rewards like food, money, power, awards, recognition, and social status. "Intrinsic motivation" refers to reasons for behavior that are within the person, those that provide internal benefits such as pride, self-worth, a sense of doing what's right, personal accomplishment, or self-satisfaction. A person who is intrinsically motivated acts out of enjoyment or fulfillment of the task itself rather than from external benefits. Motivation can be either conscious or unconscious as well, meaning people may be either aware or unaware of why they engage in certain behaviors.

A number of different theories have been developed to explain motivation, though no one theory is comprehensive. The Instinct Theory of Motivation posits that organisms behave in certain ways due to their evolutionary nature or biological makeup. Several examples of animal behavior can be attributed to instincts, which include hibernation, migration, and predatory reactions. Humans, however, also react instinctively. Attachment, love, anger, fear, protection, modesty, and shame are examples of human instincts. Psychologists William McDougall, Sigmund Freud, and William James wrote extensively about motivation based on human instincts. The principles of behaviorism and the work of B. F. Skinner provide the basis for the next theory, the Incentive Theory of Motivation. This theory suggests that people behave in response to external reinforcers and/or punishers. Drive Theory is another theory of motivation that proposes that people are prompted to act in order to reduce inner tensions derived from unmet needs, primarily physiological. The Arousal Theory maintains that people act in order to maintain an optimal level of arousal. When levels are too low they may engage in activities to increase arousal, and when

levels are too high one may engage in other behaviors meant to decrease arousal states. These states vary from individual to individual and by situation. Lastly, the Humanistic Theory or Motivation, based on Abraham Maslow's hierarchy of needs, suggests that human behavior also has a cognitive component. At lower levels one behaves to meet one's most basic, biological needs including food and shelter, while at higher levels one may act in order to fulfill a sense of love, esteem, or self-actualization. Later theories of motivation have been derived from these core models.

Current Status and Impact (Psychological Influence)

Extensive research has been conducted on motivation attempting to explain why human beings do what they do. Problematic behaviors including procrastination, obesity, substance abuse, and laziness can be explained by lack of motivation. Motivation principles have been applied toward improvements in the areas of education, business, performance, recreation, and relationships. Temporal Motivation Theory, introduced in the *Academy of Management Review* in 2006, is a recent approach at developing an integrative model to explain motivation. The journal article "The Nature of Procrastination," incorporating foundations of Temporal Motivation Theory, received the American Psychological Association's George A. Miller award for outstanding contribution to general science.

Melissa A. Mariani, PhD

See also: Freud, Sigmund (1856–1939); James, William (1842–1910); Motivational Interviewing

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Motivational Interviewing

Motivational interviewing is a counseling strategy for helping individuals to discover and resolve their ambivalence to change. It is also referred to as MI.

Definitions

- **Ambivalence** is a form of a conflict between two courses of action (e.g., indulgence versus restraint) in which each course of action has perceived benefits and costs associated with it.
- **Client-centered counseling** is a counseling approach that requires the client to take an active role in his or her treatment while the therapist's role is nondirective and supportive. It is also known as person-centered, nondirective, or Rogerian therapy.
- **Directive counseling** is a counseling approach in which the therapist directs or leads the therapeutic process, while the client's role is to respond to and collaborate with the therapist.
- **Empathy** is the capacity to recognize and respond to another's expression of emotion.
- **Noncompliance** is the degree to which an individual correctly follows medical advice whether it is medication usage, diet, exercises, or therapy sessions. It is also known as nonadherence.
- **Nondirective counseling** is a counseling approach in which the therapist directly influences the course and direction of treatment.
- **Readiness for change** is the degree of preparedness of the conditions, attitudes, and resources needed for change to happen successfully. It is also referred to as stages of change.
- **Resistance** is a form of ambivalence. It is relational behavior that reflects a lack of collaboration. It includes arguing, interrupting, denying, missing or being late to appointments, and talking too much.

- **Self-efficacy** is an individual's self-evaluation of his or her own ability to accomplish a particular task or engage in a particular process.

Description

Motivational interviewing (MI) is a directive, client-centered counseling strategy to promote behavior change. The purpose of MI is to help clients to explore and resolve their ambivalence and to increase their readiness for change. Compared with nondirective counseling, it is more focused and goal directed. The examination and resolution of ambivalence is the main application of MI. Reducing noncompliance is another application of MI. With rates of noncompliance as high as 80%, it is a problem with significant consequences for patients and their families. MI has been found to be an effective strategy treatment in dealing with noncompliance issues.

The basic assumptions of MI—called the spirit of MI—are collaboration (working in partnership with the client), evocation (drawing out ideas and solutions from the client), and autonomy (decision making is left to the client). The essential features of MI are captured in the acronym (word formed from the first letters of other words) OARS. MI begins with a focused use of open-ended questions (O), providing affirmations (A) (favorable comments on a specific trait or strength of the person), listening reflectively (R), and summarizing (S) the client's responses. It also involves the following five strategies: avoid argumentation, express empathy, support self-efficacy, roll with resistance, and develop discrepancies.

Avoid argumentation. MI refrains from using argumentation to confront an individual's denial or minimize his or her substance-related difficulties. The reason is that argumentation and confrontation are counterproductive. They lead to an individual's feeling attacked and less motivated to participate in treatment, and dropout or relapse.

Express empathy. Expression of empathy is critical in MI because it facilitates change. When individuals feel that they are understood, they are more able to open up to their own experiences and share those experiences with others. They become more comfortable fully examining their ambivalence about change and less likely to defend ideas like their denial of problems.

Support self-efficacy. The individual's belief in his or her ability to accomplish a specific change also facilitates the change process. Accordingly, MI encourages individuals to remain motivated and supports their sense of self-efficacy.

Roll with resistance. Resistance is a signal that something is amiss in the relationship between two individuals. Instead of "fighting" against the individual's resistance, MI advocates "rolling with it." That means instead of challenging the individual's resistive comments, the counselor uses the individual's "momentum" to further explore the client's views. The result is that resistance is decreased since the individual is not reinforced for being resistive.

Develop discrepancy. When a discrepancy is perceived between where individuals are and where they want to be, change is fostered. MI helps individuals examine the discrepancies between their current behavior and future goals. When they perceive that their current behaviors are not leading toward some important future goal, individuals become increasingly motivated to make needed changes.

Developments and Current Status

MI was originally developed in the 1980s by the American psychologist William R. Miller (1943–) and Stephen Rollnick (1952–) to help clinicians address client's problematic alcohol and substance use issues. Essentially, MI is a strategy for helping clinicians change what they say so that clients can change what they do. Evidence continues to mount that MI is a clinically effective and economically efficient intervention guiding clients toward change across a wide spectrum of health-related behaviors ranging from substance treatment, diet, medication compliance, and risky sexual practices to self-management of chronic medical conditions.

Since the late 1980s MI was originally taught to those working in substance abuse programs. Since the late 1990s it has been taught and utilized in a variety of medical and psychotherapy settings. Currently, it is being taught to nurses, dieticians, and medical students to increase motivation for change and reduce noncompliance. Research and clinical experience indicate that

intensive training and follow-up supervision or coaching is essential in achieving proficiency in MI skills. For this reason, initial MI training is best learned over two sessions that involve direct coaching. Learners must practice skills between sessions and utilize a learning process that includes reflection, feedback, and additional skill practice. Additional coaching can promote further skill refinement.

Len Sperry, MD, PhD

See also: Self-Efficacy; Stages of Change

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Multicultural Counseling

"Multicultural counseling" (MC) refers to the integration of multicultural and culture-specific awareness, knowledge, and skills into counselor interactions, training, and practices.

Description

America is an increasingly diverse nation and is rapidly becoming a multiracial, multicultural, and multilingual society. Race, ethnicity, and culture have a powerful influence on individuals, groups, and communities. Multicultural counseling emphasizes the need for counselors to approach helping from the context of the personal culture of the client and to avoid allowing the counselor's own cultural values and biases to override that of the client.

Development

In 1992 psychologists Derald Wing Sue, Patricia Arredondo, and Roderick J. McDavis published "Multicultural Counseling Competencies and Standards: A Call to the Profession." The competencies set forth in this publication have served as the standard model for multicultural counseling. Multicultural counseling competencies (MCC) include counselor awareness of own assumptions, values, and biases; understanding the worldview of the culturally different client; and developing appropriate intervention strategies and techniques.

Competent multicultural counselors (MCs) are aware of their own cultural beliefs, biases, and values and how these influence their definitions of normality and how they impact the counseling process. Competent counselors are able to recognize the impact of oppression, racism, discrimination, and stereotyping while acknowledging their own racist attitudes, beliefs, and feelings. Competent MCs seek out educational, consultative, and training experiences to increase their MCC, and to actively seek a nonracist identity. They are able to contrast their own beliefs and attitude in a nonjudgmental fashion and are knowledgeable of the culture of their clients and how sociopolitical influences impact them. MCs are respectful of their client's spiritual and religious beliefs, family structures, and other values. They value bilingualism and appreciate cultural differences. Competent MCs are aware of institutional barriers that prevent minorities from using mental health services as well as relevant discriminatory practices in the community that impact the psychological welfare of their clients. Culturally skilled counselors are sensitive to language issues and are willing to have a translator or refer to an outside source. Competent MCs are familiar with relevant cultural research and expand their perspective of minorities by active involvement with minority individuals in their personal life.

Current Status

Since the establishment of MCC standards and practices in the 1990s, the mental health community, scholars, and educators have resoundingly embraced multicultural counseling. More recently multicultural counseling has led to the development of social justice counseling that incorporates social advocacy and activism to assist those impacted by systemic social inequalities and racism.

Steven R. Vensel, PhD

See also: Ethnicity; Prejudice; Racial Identity Development; Social Justice Counseling

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Multimodal Therapy

Multimodal therapy is a form of psychotherapy that attends to seven modalities of human functioning, whereas other approaches such as rational emotive behavioral therapy attend to only three modalities: cognitions, emotions, and behaviors.

Definitions

- **BASIC ID** is an acronym in multimodal therapy that represents the therapeutic modalities of Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, and Drugs/Biological processes.
- **Bridging** is a therapeutic procedure in which the therapist identifies issues that the client wants to discuss but then gently guides the discussion into more productive areas.
- **Firing order** is the unique sequence of modalities that are activated when an individual experiences a symptom or conflict.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Second-Order BASIC ID** is a multimodal therapy technique for focus on a specific problem in the BASIC ID in order to flesh out more information; it can be useful for breaking impasses in therapy.
- **Social learning theory** is a psychological theory that combines classical conditioning, operant conditioning, and cognitive factors to explain the development, maintenance, and modification of behavior.
- **Structural Profile Inventory** is a 35-item questionnaire used in multimodal therapy to assess a client's functioning and concerns.
- **Technical eclecticism** is a type of psychotherapy integration in which techniques from various sources are used without adhering to the approaches from which they came.
- **Tracking** is a method for sequencing treatment procedures based on the firing order of the BASIC ID modalities.

Description

Multimodal therapy is the approach to psychotherapy based on the premise that individuals are biological beings that experience life in several dimensions or modalities. These include thinking, feeling, acting, sensing, imagining, and interacting. Individuals are affected in different ways and to different degrees by each dimension of their personality. Multimodal therapists believe that identifying and addressing these modalities are essential for successful psychotherapy.

In multimodal therapy the acronym "BASIC ID" refers to the seven dimensions of personality. In this form of therapy each dimension is considered. "B" stands for behavior, which is manifest in inappropriate actions, habits, gestures, or deficits. "A" represents affect, which is negative feelings or emotions. "S" stands for sensation, which is negative bodily sensations or symptoms such as pain, tension, sweating, or nausea. "I" represents imagery, which are negative images or mental pictures. "C" stands for cognition, which are negative attitudes, beliefs, or thoughts. The second "I" is for interpersonal relationships, specifically the ability to form and maintain healthy relationships. "D" stands for drugs and other biological

factors, like exercise and diet that affect the individual's health status, physical health, drug use, and other lifestyle choices.

Because of individual differences, some individuals are influenced by some modalities more than others. This means that certain individuals will respond to their problems by themselves, cognitively, some will seek support from others, interpersonally, and others will use drugs and other biological means to deal with problems, like smoking. An individual's response pattern is a combination of how these seven personality dimensions work together. Once the pattern is identified, psychological treatment can be used to focus on those specific dimensions.

The Structural Profile Inventory is a questionnaire helpful in identifying this pattern and dimensions. It is included in the Multimodal Life History Inventory, which is a 15-page survey which is assigned as homework for the client to fill out and bring to the next session. This detailed inventory gives a complete picture of the client's problems and style. It has six sections. They are general information, personal and social history, description of the presenting problems, expectations regarding therapy, modality analysis, and the structural profile. The Second-Order BASIC ID can also be useful in developing a complete multimodal assessment.

Based on this multimodal assessment, a treatment plan is devised and will include interventions in all relevant modalities. These interventions may include effective techniques from other psychotherapeutic approaches. For example, for a client who is able to functioning adequately but is passive and dependent in relating to others, the plan will likely include assertiveness training. For clients who are depressed that they are missing work, their treatment plan may be more detailed. For example, for staying in bed most of the day (B), activity schedule and meeting with friends is prescribed. For feelings of sadness and guilt (A), engaging in positive activities is recommended. For using alcohol to feel better (D), monitoring reducing alcohol use and increasing physical activity are prescribed.

Many therapists find that the interventions called bridging and tracking are very clinically useful. Often, tracking a client's firing order can lead to the abrupt cessation of symptoms. For example, take a client whose firing order is to first experience the sensation of tightness in the chest (S), followed by frightening images (I), to which they attach negative cognitions (C), leading to avoidant behavior (B). This S-I-C-B firing order is likely to require a different treatment strategy than for a client whose firing order is C-I-S-B. A useful intervention for the S-I-C-B sequence may be to instruct the client to override the chest tightness but taking three deep breaths. This simple strategy may be sufficient to deactivate the rest of sequence and reduce or eliminate symptoms.

Developments and Current Status

Arnold Lazarus (1932–2013) was a South African psychologist who immigrated to the United States. In 1958 he was the first to introduce the terms "behavior therapy" and "behavior therapist" into the professional literature. He made several contribution to behavior therapy and cognitive behavior therapy (CBT). Among these was developing multimodal therapy. While Lazarus retained the basic premises of CBT in his multimodal therapy, he believed that since personality is multidimensional, therapy should include these various modalities to be more effective.

Multimodal therapy originated with CBT, which combines cognitive therapy and behavioral therapy. It is also grounded in Social Learning Theory. Because of these theoretical influences, a basic premise of multimodal therapy is that most problems arise from deficient or faulty social learning. Another is that individuals respond to their perceived environment rather than to their actual environment. Lazarus contended that clients cannot change unless they have new experiences. Accordingly, multimodal therapists encourage their clients to "do different things and do things differently."

Lazarus was the one of the first to propose that therapists integrate techniques and methods from various approaches rather than utilize methods from a single approach. He viewed multimodal therapy as an example of this integration, and referred to it as technical eclecticism. In 1990 psychologist Donald Keat (1929–) applied the BASIC ID model to his work with children and adolescents. Because school and other environmental factors were not part of BASIC ID, Keat

expanded the model to BASIC IDEAL. Three letters were added to the acronym to represent education (E), adults in the child's life (A), and learning (L), school, and culture.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Rational Emotive Behavior Therapy (REBT)

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Multisystemic Therapy (MST)

Multisystemic therapy (MST) is a community-based treatment model for adolescents presenting with serious clinical problems who are at risk for out-of-home placement.

Description

Multisystemic therapy is a community-based intensive treatment model developed by psychologist Scott Henggeler to decrease crime, violence, and substance use. MST programs focus on youth, aged 12 through 17, who present with serious clinical problems such as violence, drug abuse, and other antisocial behaviors. MST is grounded in the belief that an individual's behavior can best be understood within the context of the multiple systems impacting them, including the person's home and family, school and teachers, neighborhood and friends. In-the-home services are an essential component of MST. Services are also offered at school and in the community.

MST programs are located in communities where juvenile justice, mental health, social welfare, schools, family courts and other service systems work with funders to provide trained MST providers. Two or three teams of three therapists are most often housed within existing mental health services locations. MST programs are primarily funded through Medicaid reimbursement, government sources, and managed care insurance providers.

The organization "MST Services" was established in 1996 and operates through the University of South Carolina. MST Services provides program start-up assistance, initial and ongoing clinical training, and program quality assurance support services. The organization also grants license agreements and program development to ongoing MST programs.

Development

MST was first developed in the 1970s by psychologist Scott Henggeler who found treating juveniles through traditional psychotherapy methods ineffective. Henggeler realized that treating individuals in an office setting far removed from where life was taking place for them would not promote change. He decided to take therapy to the clients in order to see how they lived and began to visit clients' homes, schools, and neighborhoods. He began to view behavior as multi-determined and interactive across these multiple systems. For treatment to be effective, interventions must address a broad range of contributing factors across individual, family, peer, school, and community systems.

Current Status

There are over 500 MST teams operating in 34 states, in 15 countries providing services to more than 23,000 youth a year. Clinical research has been conducted on MST, which has been found to be effective in the treatment of emotional and behavioral problems in juveniles. MST has also been found to improve family relations, increase school attendance, decrease time in out-of-home placements such as residential treatment centers and psychiatric inpatient units, and a decrease in repeat offensives.

Steven R. Vensel, PhD

See also: Family Therapy and Family Counseling

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Music, Influence of

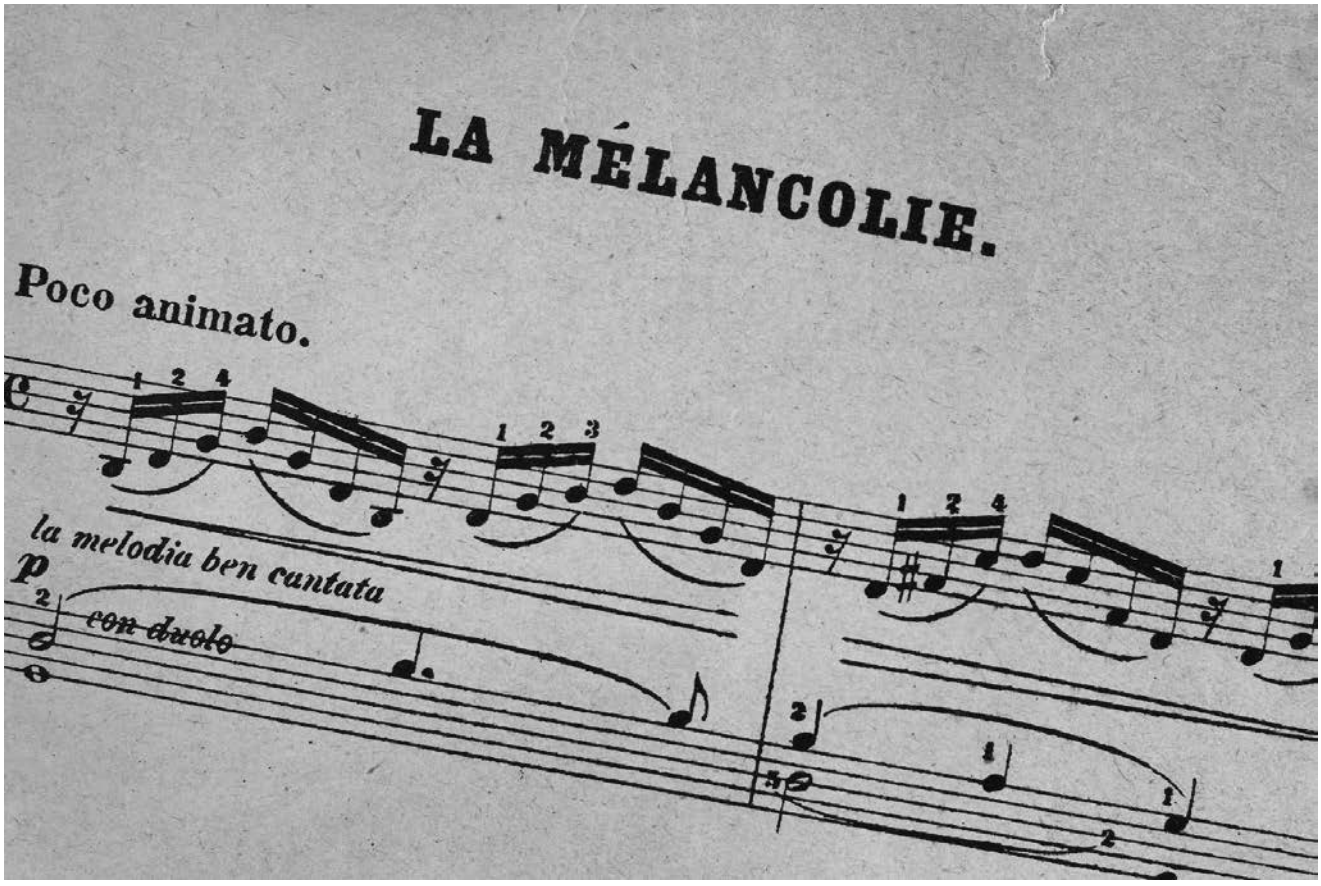
Music is the artistic combination of vocal and instrumental sounds and rhythms to express and communicate emotion, content, and ideas.

Description

Music has been referred to as the universal language and is a significant part of a shared social experience, especially among adolescents and young adults. Popular music is a way of communicating shared values and meaning; experiencing and expressing emotions; and celebrating events, milestones, and relationships. Technological advances have increased the social nature of music, allowing quick access to shared music files, expressing opinions with others, and watching music videos, all in a cyber community accessed via smart phones.

Impact (Psychological Influence)

Personal identity with music and music video genres, performers, lyrics, and content has been a frequent focus of research. Musicians lead highly desirable lifestyles in the minds of adolescents, and performers communicate attitudes and values, knowingly and unknowingly, through their lyrics and performances.



Music is the artistic combination of vocal and instrumental sounds and rhythms to express and communicate emotion, content, and ideas. Music can be an important component of an individual's self-concept, and music can also be a valuable therapy tool for those dealing with emotional or psychological issues. (Marsia16/Dreamstime.com)

Individuals frequently adopt the clothing and attitudes of performers as a way of expressing personal identity and the kind of image they wish to convey. The influence of music content (lyrics) and musician lifestyle, as portrayed in video performances, on attitudes and behavior has received a great deal of focus. Studies have indicated that music with violent sexual content is associated with acceptance of violence against women. Music genres also have influence: heavy metal is associated with belief in the paranormal, rap music with aggression, and defiant rock music with rebelliousness. Academic success, drug use, aggressiveness, antisocial behaviors, and delinquent behaviors such as vandalism and substance use have all been associated with certain types of music that have violent and antisocial content such as rock, heavy metal, and rap. Although there is general agreement that music has some influence on adolescent attitudes and behavior, there is debate over the magnitude and duration of the impact. Given that music represents just one of a myriad of influences on adolescents, how deeply these behaviors are reinforced in the wider social community impacts the overall effects.

Music can reinforce, change, induce, and express a wide range of emotional states. Perhaps the best examples are found in the movie industry where music is powerfully used to induce fear by foreshadowing the presence of sinister characters (e.g., Darth Vader) or heroes (e.g., Superman), or set emotional tones such as fear (e.g., Jaws), and just about any other emotion.

Music is a powerful medium. It influences attitudes and behaviors, expresses emotion, communicates aspects of personal identity, and provides a means of social connection.

Steven R. Vensel, PhD

See also: Expressive Arts Therapy; Music Therapy

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Music Therapy

Music therapy is a therapeutic approach that uses music as a means to accomplish individual treatment goals.

Description

Music therapy is a clinical approach to using music interventions with clients. Music is used as a specific intervention that must be used appropriately in order to offer a therapeutic benefit to the client. Music therapy can be used to explore physical, psychological, cognitive, and social functioning and impairments. The music is utilized as a form of expression and communication, which is important as not every client who comes for therapy is able to express fully using only spoken words.

While music is often enjoyed by many different people in nearly every culture, utilizing it as a therapeutic technique means using it with a distinct purpose to impact positive change for the individual. It consists of five key elements. The first is that it is prescribed and done with purpose and intent. It uses music or music activities such as singing, using instruments, writing music, listening to music, or discussing lyrics. It is provided by a trained professional in the field of music therapy. Music therapy has been well received among clients of all ages—from very young children to the elderly. This form of therapy often is focused on achieving a specific goal.

Music therapists create music with their clients, listen to music, and discuss it to help gain an understanding of the client, as well as to allow the client to express his or her thoughts and feelings. Music therapy can also be used in collaboration with other creative measures such as poetry, dance, movement, storytelling, and play.

Development and Current Status

Music therapy is considered to be beneficial for all ages, genders, ethnicities, and cultures. The key is that it must be individualized to the client. The music is then used to help drive the therapeutic process and provide another opportunity of expression for the client.

Music has long been viewed as having healing properties dating back to ancient times. Early

civilizations found music to help increase health and well-being. The role that music played in nurturing and healing is well documented. Currently, music is used in hospitals to help promote positive health.

Despite music being present throughout history, music as a therapy is still a relatively young field as a profession. Research is continually done to show it as a clinical and evidence-based practice.

Music therapists must pass a national examination after graduating from an approved music therapy program. The exam is given by the Certification Board for Music Therapists. The therapist is then able to become a registered, certified, or advanced certified music therapist. These credentials are required to provide this therapy.

There is a national organization, the American Music Therapy Association. This organization merged two preexisting organizations that were founded in 1950 and 1971. This association is committed to supporting its members and providing continuing education and training to its members.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Dance Therapy; Expressive Arts Therapy; Music, Influence of

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Naltrexone (Naltrexone Hydrochloride)

Naltrexone is a prescription medication used in the treatment of opioid dependence and for alcohol dependence. It is also available under the trade names ReVia and Depade.

Definitions

- **Opiate antagonists** are medications that block opiate receptors, which in turn lead to a blocking of the opiates' effects.
- **Opiates** are a class of naturally derived drugs from opium.
- **Opioids** are synthetically derived drugs and are used as opiate substitutes. The term "opioid" is sometimes used to refer to both opiates and opioids. Both are referred to as narcotics.

Description

Naltrexone belongs to a class of medication known as opiate antagonists. It is used to prevent those who have been addicted to opiates from taking them again. Since it can cause sudden withdrawal symptoms, it should not be given to those who are actively using opiates, including methadone. Naltrexone is thought to work by preventing opiate effects, particularly feelings of well-being and pain relief. It also decreases the desire to take opiates. Naltrexone is also used in the treatment of alcohol dependence. It can help individuals drink less, stop drinking, and decreases the desire for alcohol.

Naltrexone is thought to work by blocking and reversing the physical effects of drugs such as Demerol, morphine, heroin, codeine, oxycodone, and other narcotics. Naltrexone works best when it is an integral part of a comprehensive treatment program that includes behavioral contracts, compliance monitoring, counseling, support, and lifestyle changes When given to those who have been successfully treated for opiate addiction, it helps prevent re-addiction by decreasing cravings and the euphoria associated with opiates. Even though naltrexone is not an alcohol antagonist, it can be an effective treatment for alcohol dependence. When it is an integral part of a comprehensive treatment program that includes behavioral contracts, counseling, support, and lifestyle changes, naltrexone helps decrease cravings, prevent relapse, or decrease the severity of relapse.

Precautions and Side Effects

Because naltrexone can cause liver damage, liver function tests should be done before starting this medication, and then monthly. Individuals should be free of all opiates for 7 to 10 days before starting naltrexone. This reduces the likelihood of opiate withdrawal in those whose bodies are not free from opiates. Individuals should be observed for opiate withdrawal immediately following the first dose of naltrexone. Individuals can mistakenly believe that talking naltrexone makes them immune from the effects of opiates. Actually, these individuals are more sensitive to the effects of opiates. Therefore, those taking naltrexone who continue to use opiates should be monitored for symptoms of opiate overdose. Naltrexone should not be confused with naloxone, which is used for opioid

overdose. Unless there are contraindications, Naltrexone can be used during pregnancy since its benefits outweigh the risks. It is not known whether this medication passes into breast milk.

The most common side effects of naltrexone are cramps, depression, dizziness, diarrhea, headache, irritability, nausea, insomnia, joint and muscle pain, rash, and vomiting. Sudden opiate withdrawal symptoms can occur within minutes after taking naltrexone. Withdrawal symptoms include abdominal cramps, diarrhea, muscle aches, bone pain, nausea and vomiting, anxiety, confusion, extreme sleepiness, visual hallucinations, and a runny nose.

Naltrexone does interact with some medications. Exercise caution in combining naltrexone and Antabuse since it may cause liver damage. Since naltrexone is an opiate antagonist, prescribed and over-the-counter medicines for cough, diarrhea, and pain that are opiate derivatives such as Imodium may no longer be effective.

Len Sperry, MD, PhD

See also: Opioid Use Disorder

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Namenda (Memantine)

Namenda is a prescribed medication used to treat moderate to severe Alzheimer's disease. Its generic name is memantine.

Definitions

- **Alzheimer's disease** is a progressive neurodegenerative disease in which dementia results from the degeneration and death of brain cells because of plaques and neurofibrillary tangles.
- **Dementia** is a group of symptoms (syndrome) associated with a progressive loss of memory and other intellectual functions that interfere with one's ability to perform the tasks of daily life. It impairs memory and reasoning ability, causes disorientation, and alters personality.
- **Glutamate** is a chemical messenger in the brain that promotes learning and memory by binding to N-methyl-D-aspartate (NMDA) receptors. This triggers influx of calcium ions in the brain cells. Calcium ions are important for memory functions, but overstimulation of NMDA receptors by glutamate leads to large influx of calcium ions causing the death of brain cells.

Description

Namenda is used to treat moderate to severe confusion and memory problems associated with Alzheimer's disease. It is believed that high levels of glutamate lead to overstimulation of NMDA receptors, which may be linked to symptoms of Alzheimer's disease. Glutamate also is involved in the development and progression of this disease. Namenda appears to work by blocking these NMDA receptors. While Namenda can improve memory, awareness, and the ability to perform daily functions, it cannot cure Alzheimer's disease. Neither does it prevent or slow the degeneration of brain cells in this progressive neurological disease.

Precautions and Side Effects

Individuals with histories of kidney problems, severe urinary tract infections, and recent dietary change, such as switching from a high-protein diet to a vegetarian diet, should exercise caution in using this medication. Since Namenda can cause dizziness, it is advised to limit driving, using machinery, or engaging in tasks that require alertness until the individual is sure he or she can perform such activities safely. Before having surgery or a dental procedure, inform the surgeon or dentist about Namenda use. Since there may be risks associated with Namenda use during pregnancy and breast-feeding, the risks and benefits should be discussed with the physician.

Namenda is a relatively safe and well-tolerated medication. Side effects with its use are relatively rare. Those reported are body aches, dizziness, constipation, headache, agitation, falling, and accidental injury. Studies on Namenda have relatively few negative interaction with other drugs. Namenda is sometimes combined with Aricept, another Alzheimer's medication. There is some evidence that this "combination therapy" results in greater cognitive, functional, global, and behavioral benefits to those with moderate to severe Alzheimer's disease than in treatment with either medication alone.

Len Sperry, MD, PhD

See also: Alzheimer's Disease; Aricept (Donepezil)

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Narcissistic Personality Disorder

Narcissistic personality disorder is a mental disorder characterized by a pattern of grandiosity, lack of empathy, and a need to be admired by others.

Definitions

- **Anger management** is a method of increasing temper control and the skill of remaining calm.
- **Cognitive restructuring** is a psychotherapy technique for identifying maladaptive (unhealthy) thoughts and changing them to present a more accurate view of a situation.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Empathy** is the capacity to recognize and respond to another's expression of emotion.
- **Empathy training** is a method of increasing skills of recognizing and responding to another's expression of emotion.
- **Narcissistic injury** is the perceived threat to a narcissist's self-esteem or self-worth. It occurs after experiencing a defeat or criticism and results in feelings of emptiness, degradation, or humiliation.
- **Narcissistic rage** is a reaction to narcissistic injury and can range from aloofness to mild irritation or annoyance to serious outbursts, including violent attacks.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

The narcissistic personality disorder is a personality disorder characterized by a pervasive pattern of grandiosity, specialness, unrealistic self-expectations, lack of empathy, and a constant need for admiration. They are the center of their worlds, showoffs, name droppers, and legends in their own minds. They are arrogant, high-handed, and superior, and expect and demand that others will show them deference and admiration. They tend to maintain superficial, and sometimes exploitative, interpersonal relationships. Typically, they are symptom-free and well functioning. But when their impossibly high expectations are not met or they experience narcissistic injury, they become quickly dissatisfied with others and may become depressed, develop somatic symptoms, or manifest narcissistic rage.

Narcissistic personality disorder is increasingly common today. It appears that a number of social trends have fueled this increase. In *The Culture of Narcissism*, historian Christopher Lasch (1932–1994) described some of these trends that he believed showed that Americans were becoming increasingly self-preoccupied and narcissistic. This change reflects a major shift in American values, which was from hard work, a high work ethic, and delayed gratification to pleasure, to a reduced work ethic, and to immediate gratification. More recently, an increasing focus on self-esteem, self-actualization, and entitlement has also fueled this shift to narcissism. Researchers such as Twenge and Campbell (2010) contend that a significant change in parenting has occurred in the past three decades. The shift has been from parents setting firm limits on their children toward letting children get and do whatever they wanted. This change is credited with significantly fueling the narcissism epidemic.

The cause of this disorder is not well understood. However, these individuals tend to have characteristic view of themselves, the world, and others, and a basic life strategy. These individuals tend to view themselves as special and unique, and entitled to rights and privileges whether they have earned them or not. They are likely to view the world as a banquet table to be sampled at will. They view others as owing them admiration and privilege. Their basic life strategy is to expect and demand specialness.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of self-centeredness and grandiosity. More specifically, they have an exaggerated sense of their own abilities and achievements. They may have a constant need for attention, affirmation, and praise. Typically, they believe they are unique or special and should only associate with others of the same status. They are likely to have persistent fantasies about attaining success and power. These individuals can exploit others for personal gain. A sense of entitlement and the expectation of special treatment is common. They may appear to others as snobbish or arrogant. They appear to be incapable of showing empathy for others. In addition, they can be envious or think that others are envious of them (American Psychiatric Association, 2013).

Treatment

The clinical treatment of this disorder usually involves psychotherapy. In terms of treatment goals, a decision needs to be made as to whether the treatment is short term and crisis oriented or long term. Crisis-oriented psychotherapy usually focuses on reducing symptoms such as anxiety, depression, or somatic symptoms associated with the narcissistic injury. The goal of longer-term therapy involves the restructuring of personality. These goals include increasing empathy, decreasing narcissistic rage and cognitive distortions, and increasing the individual's capacity to mourn losses. Treatment methods and strategies include anger management, cognitive restructuring, and empathy training. When marital issues are involved, couples therapy has been shown to be a useful treatment modality. Medication may also be used when symptoms of depression or anxiety are prominent.

Len Sperry, MD, PhD

See also: Personality Disorders

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Narcolepsy

Narcolepsy is a sleep disorder involving daytime sleepiness and uncontrollable episodes of falling asleep during the day.

Definitions

- **Cataplexy** is a medical condition characterized by loss of muscle tone, resulting in slurred speech and complete weakness of most muscles. It can last for up to a few minutes.
- **Hypnagogic hallucination** is a vivid, dream-like sensation that occurs at or near the onset of sleep.
- **Hypocretin** is a brain chemical that regulates wakefulness and REM sleep and is associated with some symptoms of narcolepsy.
- **Parasomnias** are a group of sleep disorders characterized by abnormal events that occur during sleep, such as sleepwalking, talking, or limb movement.
- **Polysomnography** is a medical test that records aspects of sleep (REM, NREM, and number of arousals) as well as breathing patterns, heart rhythms, and limb movements.
- **REM sleep** is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain activity. REM occurs about 90 minutes after the cycle begins. It is also known as rapid eye movement and REM sleep.
- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.
- **Sleep paralysis** is a condition in which individuals are aware of the surroundings but are unable to move when they awaken from sleep.

Description and Diagnosis

Narcolepsy is a sleep disorder characterized by brief attacks of four symptoms: excessive sleep, cataplexy, sleep paralysis, and hypnagogic hallucinations. This disorder affects the control of sleep and wakefulness with uncontrollable episodes of falling asleep during the day. These episodes can occur at any time of the day. While REM normally occurs about 90 minutes into the sleep cycle, in narcolepsy REM sleep occurs almost immediately. It continues to occur periodically during the waking hours, which leads to the symptoms of narcolepsy.

Individuals experiencing this disorder experience uncontrollable sleepiness during daytime activities. The sudden paralysis associated with narcolepsy can lead to physical harm as they may uncontrollably collapse and fall down resulting in injury. As a result, they may be restricted from driving a car or operating machinery. This disorder commonly involves changes in mood and increased anxiety. Also, individuals with this disorder may engage in unintended eating as well as sudden paralysis or loss of muscle tone when they experience emotions like laughter, sadness, or intense anger. This disorder peaks between the ages of 15 and 25 and then again at 30 to 35. It is also quite rare (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit recurrent episodes of sudden, uncontrollable moments of sleep. These must occur at least three or more times per week over a period of three months. There must also be episodes of cataplexy, or hypocretin deficiency, or polysomnography data showing REM sleep segments are less than 15 minutes. Several specifiers can be made (American Psychiatric Association, 2013).

The cause of narcolepsy is not well understood. Genetics may play a role, and infections can contribute to the development of this disorder. It appears that hypocretin deficiencies may also be a factor. Those with narcolepsy, particularly those who experience cataplexy, can have low levels of it in their spinal fluid. Sleepwalking, teeth-grinding, and bed-wetting are comorbid conditions with narcolepsy. Left untreated, individuals may be at risk for injury to themselves or others as well as the loss of driver's license and ability to work (American Psychiatric Association, 2013).

Treatment

As with other sleep disorders, the treatment of narcolepsy may involve various methods, including lifestyle changes. A formal evaluation study should be

conducted by a sleep medicine specialist, which should include screening for hypocretin deficiency and a polysomnography. While there is no known cure for narcolepsy, the symptoms of narcolepsy can be effectively managed. Avoiding alcohol and heavy meals, while maintaining a regular sleep schedule with regular naps, has proven to be beneficial to many enduring narcolepsy. The National Sleep Foundation recommends counseling or psychotherapy since individuals with this disorder may experience depression and anxiety or feel alienated since the symptoms associated with this disorder are not widely understood. Therapy can also be helpful with the family and social relationship issues that they may also experience.

Len Sperry, MD, PhD

See also: Behavior Therapy; Hypersomnia and Hypersomnolence Disorders; Insomnia and Insomnia Disorder; Sleep Disorders

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Narrative Therapy

Narrative therapy is a collaborative treatment approach that looks at the meaning associated with an individual's perception of his or her life and experiences.

Definitions

- **Externalization** is the process of separating an idea from oneself and looking at it from a different view.
- **Modernism** is the view that reasons and science provides accurate and objective knowledge about life and individuals.
- **Postmodern psychotherapy** is the name for psychotherapies that reject modernism and holds that reason and science are ideologies or beliefs that are constructed (created) by people, and that a goal of therapy is to deconstruct such beliefs.

Description

Narrative therapy is a collaborative approach to counseling. It identifies the individual as being the expert of his or her own life. It distinguishes the person's problems as being separate from his or her identity. It looks to understand the person's life from varying points, including his or her socioeconomic status, race, sexual identity, and sexual orientation.

Narrative theory looks at personal narratives or stories that externalize the problem from the person. Narrative therapists believe that the individual creates meaning from his or her own experiences, which in turn creates a person's stories or narratives. They identify how the person perceives himself or herself and his or her problems.

The primary goal of narrative therapy is for the clinician to work collaboratively with the client to rewrite his or her story. As opposed to interpreting events in a client's life, the therapist is more concerned with helping the client to identify new meaning. One way this is done is by having the client tell his or her story from different views. Questions are asked such as if another person is present in the narrative asking how that person viewed the situation and how it differed from the client. Another goal is to assist the client in realizing that he or she is not the problem but rather that the problem is the problem. This is done through externalizing the problem and joining the client in the externalization. To do this, the therapist may ask a client with depression as to how depression has taken over his or her life.

Other key aspects to narrative therapy include inviting significant people in the individual's life to see and hear the new narrative as well as document the

new narrative and knowledge that supports it. This is done through creating a landscape that helps identify the description of the new narrative.

Narrative therapy was developed by Michael White (1948–2008) and David Epston (1944–). They first published on the theory in 1990. The theory originated as a result of White's therapeutic work with young children. He focused on their language to understand their presenting concerns and used this as a tool to explore the problems.

Current Status

Narrative therapy is considered a postmodern psychotherapy. It is one of the more widely used contemporary therapy approaches in English-speaking countries, particularly among family therapists in Australia and the United States. There are criticisms that narrative therapy is based on opinion and lacks scientific or empirical evidence to support its effectiveness with clients.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: White, Michael (1948–2008)

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National Institute of Mental Health (NIMH)

The National Institute of Mental Health (NIMH) is a federal agency whose goal is to prevent and cure mental illness.

Description

The NIMH is one of 27 components of the National Institutes of Health. The mission of the NIMH is to transform the understanding and treatment of mental illness through basic and clinical research and in so doing aims to pave the way for the prevention, recovery, and cure of the mental illness. As a governmental agency, it holds a great deal of authority and credibility on mental health issues.

According to data from the National Comorbidity Survey Replication, during any 12-month period, one in four American adults experience a mental disorder. About 60% of those with a mental disorder suffer moderate to serious symptoms. Despite this high percentage and public education efforts to increase understanding about mental disorders to reduce the stigma associated with them, many people still lack useful knowledge about these conditions. Clearly there is a need to provide reliable and easy-to-understand mental health information online. The NIMH produces such a resource through its website.

In terms of the NIMH's mission, it clearly states that those illnesses that comprise the greatest overall burden of suffering, and those that absorb the greatest amount of human and financial resources in providing care, are its current priorities. These include psychotic disorders, mood and anxiety disorders, and autism spectrum disorders.

Impact (Psychological Influence)

The institute's website contains a wealth of information on mental health disorders and health information by age, gender, and treatment. It is designed to help health consumers find authoritative, reliable information about the most common mental disorders. Highlights of the site include the ability to browse by certain topics and populations, as well as the availability of many publications for online viewing or downloading. Sections include Consumer Health, which offers a mix of educational content about common mental disorders and news based on recent scientific research related to the condition, and Educational Resources, which is targeted toward classroom instruction and provides teachers with lesson plans and manuals for students.

Also available on the website is an outreach program that aims to pave the way toward prevention, recovery, and cure by ensuring interventions, and information can be used by patients, families, health-care providers, and the wider community. Based on the Criteria for Assessing the Quality of Health Information on the Internet of the Health Summit Working Group, the institute's website is listed as one of the top 100 websites for consumer health.

In 2008, the NIMH, for research purposes, implemented a strategic plan to develop new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures. It did this because research in psychopathology has increasingly identified problems with the current diagnostic system.

The institute's mission is to reduce the burden of suffering from mental disorders through research and education. One of its challenges is to target its research priorities in the face of budget constraints and cutbacks.

For the NIMH to continue fulfilling its vital public health mission, it fosters innovative thinking and ensures that a full array of novel scientific perspectives are used to further discover the evolving science of brain, behavior, and experience. In this way, it aims for breakthroughs in science to become breakthroughs for all people with mental illness.

Mindy Parsons, PhD

See also: American Psychiatric Association (APA); American Psychological Association (APA)

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"Nature of Love, The"

"The Nature of Love" is the scientific paper written by Harry Harlow about his experiments with monkeys.

Definition

- **Attachment** is the type of connection or relationship that creates a bond.

Description

"The Nature of Love" is a highly celebrated paper that drew a great deal of attention from those in the psychology field. It was written by Harry Harlow (1905–1981) as an interpretation of the research he had been conducting on monkeys. During that time, most experimentation was done with lab rats to help demonstrate the impact of environment. Harlow chose monkeys as he felt it gave a better understanding and connection to humans. This was a time in psychology controlled by the study of behavior, which was viewed to be driven by primary drives of hunger, pain, and sex—whereas love was viewed as secondary. Harlow refused to follow this line of thought and felt that love should not be considered only as a secondary drive. "The Nature of Love" identified and explained the research he conducted and his findings.

In studying the monkeys raised in the lab, he noticed with the lack of contact with a mother, they grew attached to cloth pads that were in their cages. When the pads were removed, even just to put new ones in, the monkeys became very distressed. Harlow

compared this attachment to what a human baby may experience with a specific pillow, blanket or toy. The monkeys who had no pads rarely survived past five days. Harlow began to question the impact of the pads on the monkeys. The traditional behaviorist view was that the monkeys loved mothers because they provided food since it was believed that hunger is a primary need. However, Harlow's experimentation began his questioning of if the love for a mother was based on more than simply meeting the hunger drive but rather also the need for warmth, love, and comfort.

Harlow created surrogate mothers with wood covered in soft cloth and one made of wire that provided milk. His experiment provided results that showed the preference was for the soft cloth mother. When provided with fear or danger, the monkeys also retreated to the soft cloth mother. He determined that the monkey just needed a basic mother figure. However, as adults the monkeys struggled with appropriate behavior and connections due to their lack of community with other monkeys.

"The Nature of Love" and Harlow's experiments provided insight into the intelligence and ability to experience emotions in animals. It also provided a foundation for changing how children's homes were run giving more insight into the need for emotional attachment.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Harlow, Harry (1905–1981); Insecure Attachment; Secure Attachment

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Nature versus Nurture

"Nature versus nurture" describes the ongoing debate among professionals as to which factors contribute most to the variance among individual human traits, biological makeup/genetics or environment/socialization.

Definitions

- **Behaviorism** is a theory developed by psychologists John B. Watson and B.F. Skinner, which is concerned with measureable, observable behavior rather than inner processes such as thoughts and feelings.
- **Determinism** is a philosophical belief that every event that exists is inevitable, predetermined, and established by preceding events.
- **Empiricism** is a theory of thought that posits that human knowledge arises from experiencing and interacting with environmental stimuli.
- **Epigenesis** is a biological term that refers to the development or unfolding of a particular organism.
- **Heritability** is the degree of genetic or biological variation between people on any given trait.
- **Reductionism** is a philosophical and psychological theory that proposes that even the most complex systems can be understood by breaking them down to analyze their simplest parts.
- **Socialization** refers to the process by which an individual becomes acclimated to their current environmental and cultural surroundings by acting in ways that reflect the society's accepted norms, ideals, and behaviors.

Description

The debate over which factor has the largest impact on individual differences, nature (biology) or nurture (environment), is a long-standing one among psychologists, sociologists, biologists, and educators. Nature is viewed from an epigenetic or deterministic perspective, while nurture is based on the principles of behaviorism and empiricism. Those who argue that nature is the most salient factor in determining a person's unique makeup hold that innate qualities are predetermined or imbedded in one's genetic code. From this perspective an individual's physical and

behavioral traits are essentially hardwired and cannot be changed. Arguments in support of the nurture perspective propose that regardless of heredity, one's environment can significantly shape, mold, and change who a person becomes. Environmental factors include child-rearing and care practices, parenting styles, socialization, peer interactions, cultural influences, gender roles, societal norms, and prejudice.

English writer, philosopher, and scientist, Sir Francis Galton was the first to coin the phrase "nature versus nurture" back in the 1860s. A staunch eugenicist, Galton believed that selecting and reproducing the most desirable traits could improve the human race. He was strongly influenced by the work of his half-cousin, Charles Darwin, specifically his 1859 book *On the Origin of Species*, which discussed how the evolution of any organism was reliant on the process of natural selection. Alternatively, Enlightenment philosopher and empiricist John Locke favored the nurture view proposing that every human being enters the world as a "blank slate," or *tabula rasa*, with environmental factors playing the more significant role in the traits, characteristics, and qualities that a person develops. Scientists, theorists, writers, educators, and practitioners have since added to this ongoing debate over salience.

Research has been conducted on the effects of *heritability*, the degree of genetic variation between people on any given trait, by examining differences between siblings, adoptive siblings, and identical/fraternal twins. Studies have been completed on siblings from the same parents and different parents (adoptive situations) as well as situations where the siblings were reared together or apart. Findings were consistent in suggesting that genetics play a substantial role in determining the traits of personality and intelligence; however, much variation is seen among other characteristics, supporting the significance of environmental factors as well. Generalizability of the findings has been questioned however, as these studies were primarily conducted in Western cultures. Making the assumption of "equal environments" is a faulty one in that familial situations cannot be controlled for in a consistent and reliable manner.

Current Status and Impact (Psychological Influence)

Presently, the majority of scientists, researchers, and practitioners agree that the contribution of both nature and nurture factors influences individual differences. Neither nature nor nurture acts independently. Even with traits that are known to be highly heritable, such as personality and IQ, distinctions can vary according to certain environmental factors. Genetics and environment therefore must work together and remain in sync, in order for normal, productive development to occur.

The question of nature or nurture is important for scientists, doctors, mental health professionals, educators, and lay people to understand as most want answers when something goes array in terms of normal human development. The onset of certain diseases, genetic mutations, mental illnesses, learning disabilities, substance abuse issues, antisocial/conduct disorders, and other special needs are topics of continued interest. Whether there is a genetic cause or if socialization is the contributing factor, determining the why is often critical to care providers, loved ones, and the community at large.

Of recent concern is the issue of self-selecting or predetermining genetic characteristics such as sex/gender through medical intervention. Scientific experimentation with cloning raises additional medical and moral dilemmas. Intervening versus allowing nature to take its course remains a highly debated topic.

Melissa A. Mariani, PhD

See also: Epigenetics

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Neglect

Neglect is a type of harm that is inflicted on a person by another, typically on a child from an adult caregiver.

Description

Neglect involves refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable child or elder. It is the most common form of child maltreatment. Sadly, it often goes unreported and receives less attention than other forms of child maltreatment such as that of physical abuse. The problem is that with physical abuse there is conclusive evidence such as bruises or broken bones that support the claims made by a child.

Neglect is often difficult to prove, leaving the person suffering without help or assistance. The definition of neglect typically varies from state to state, and it is therefore important to check state laws and refer to the child protective agency specific to that state for clear information.

With different definitions across states and trouble proving neglect, it has been troublesome to study it. Neglect is typically broken down to mild, moderate, or severe. Mild neglect may be something such as parents not putting a child in their car seat. This would call for intervention but not necessarily to the level of involving government child welfare agencies. The severity of the neglect is based on how much harm or risk there is, as well as how regularly the neglect occurs.

Along with the severity, there are different types of neglect. Physical neglect tends to be the most recognized as this would include abandoning the child, such as leaving young children unattended in home or even leaving them for extended periods and not arranging reasonable care for them. Expulsion is where the parent or guardian refuses custody of the child without arranging for care. Under the category of physical neglect is also nutritional neglect where the child is undernourished; clothing neglect is where the child lacks seasonal appropriate clothes, such as shoes in the winter, and there is other physical neglect such as driving while intoxicated with the child in the vehicle.

Medical neglect can at times be controversial. This form of neglect includes the denial or delay of health care when the guardian does not allow needed health care or does not seek the care in a timely manner. Another form of neglect is inadequate supervision, where this child is left without an appropriate caregiver for several hours, or environmental neglect, where the child is exposed to potentially hazardous materials.

Emotional neglect tends to be a difficult form to prove as it focuses on the emotional health and nurturing provided to the child. In comparison, educational neglect can be fairly simple to prove since it focuses on the failure of a child being enrolled in school, attention to special education needs, or chronic permitted absence from school.

Despite the physical signs of neglect, the impact is detrimental to a child. The potential longlasting effects of neglect are harmful and can impact health, physical development, intellectual development, emotional development, social development, and behavioral development. The effects can vary based on the child's age, the frequency, duration, type of neglect, and the relationship with the caregiver as well as resiliency or protective factors.

It is important to mention that neglect impacts the elderly as they are considered to be a vulnerable population. The first reports of elder abuse and neglect surfaced in medical literature a little more than 30 years ago, making this a relatively new area of study. The same types of neglect occur, as do the struggles with identification. Those who are neglected tend to die earlier than their peers. Elder neglect often happens in the family home as opposed to in nursing homes as is commonly thought. In the elderly population, neglect may be seen as a lack of medical aid, such as glasses, a lack of assistance in walking, or a lack of adequate food, or confinement to a bed for long periods of time without any assistance.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Abandonment; Adoption; Child Abuse; Foster Care

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Neo-Freudian Psychotherapies

Neo-Freudian psychotherapies are psychotherapy approaches that extend the theory and practice of psychoanalysis.

Definitions

- **Ambivalent movement** is when an individual moves in several directions in a social context: moving against others, moving away from others, and moving toward others.
- **Defense mechanisms** are a psychodynamic understanding of behaviors and thoughts that individuals engage in to protect themselves or to reduce anxiety.
- **Feminist psychology** is a psychological treatment that emphasizes social structures and gender. This approach focuses on the principles and values of feminism.
- **Moving against others** is when an individual resists a situation and becomes aggressive, revengeful, and exploitive toward others, to seek power or to seek recognition.
- **Moving away from others** is when an individual withdraws from others to protect himself or herself from perceived harm or criticism.
- **Moving toward others** is when an individual accepts a situation and becomes pleasing and approval seeking from others to feel loved, seek attention, or be helpful.
- **Neopsychoanalyse** is the first psychological approach to depart from Freud's classical psychodynamic approach by including social and cultural factors.
- **Psychoanalysis** is a theory of human behavior and form of psychotherapy that focuses on conflicts and compromises between the unconscious (internal) and the conscious mind. It was developed by Sigmund Freud.
- **Psychodynamic** refers to a way of explaining thoughts, feelings, and behaviors as the manifestation of unconscious (inner) drives and processes.
- **Psychosexual stages** are sexual developmental stages identified by Sigmund Freud that lead to the development of a healthy or unhealthy personality.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

Description

Neo-Freudian psychotherapy approaches are therapeutic approaches that were originally influenced by Sigmund Freud's theories. These approaches went beyond Freud's biological and unconscious explanation of human behavior, and added sociological and cultural factors. Several examples of Neo-Freudian approaches include Individual Psychology, Jungian psychology, and ego psychology. For example, Alfred Adler (1870–1937) believed that individuals seek belonging and significance in the world. This social and cultural conceptualization of human suffering extended beyond Freud's psychodynamic explanation which emphasized an individual's biology, unconscious mind, libido, and psychosexual development. While Freud's theory provided a foundation for psychology, Neo-Freudian psychotherapy approaches added new explanations and understandings of human behavior, which led to corresponding treatment interventions.

Alfred Adler was the first to explore and develop a comprehensive social theory that went beyond Freud's classical psychodynamic conceptualization. Another Neo-Freudian approach that augmented Freud's theory is called neopsychoanalyse and was created in 1945 by the German psychiatrist Harald Schultz-Hencke (1892–1953). Other known Neo-Freudian theorists include Carl Jung (1875–1961),

Carl Rogers (1902–1987), Erik Erikson (1902–1994), Harry Stack Sullivan (1892–1949), and Karen Horney (1885–1952). After Adler's death, Horney created feminist psychology and also suggested that individuals deal with anxiety in a social context; they move in the various directions: (1) move away from others, (2) move toward others, (3) move against others, and (4) move ambivalently. Horney's conceptualization of movement provided a comprehensive understanding and explanation of human behavior that paved the way for different theoretical explanations of human behavior. Neo-Freudian psychotherapy approaches advanced the field of psychology by furthering the theories of Sigmund Freud.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Adler, Alfred (1870–1937); Brief Dynamic Psychotherapy; Freud, Sigmund (1856–1939); Psychotherapy

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Neuroleptic Malignant Syndrome (NMS)

Neuroleptic malignant syndrome is a rare but potentially fatal condition in individuals taking neuroleptic medications. It is also known as NMS.

Definitions

- **Antagonist** is a substance that inhibits or interferes with the physiological action of another.
- **Benzodiazepines** are a class of drugs that slow the nervous system and are prescribed to relieve nervousness and tension, induce sleep, and treat other symptoms. They are highly addictive.
- **Delusional disorder** is a mental disorder characterized by delusions, which are fixed or false beliefs that persist despite contrary evidence.
- **Dopamine** is the chemical messenger in the brain responsible for the coordinating of movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hypothermia** is a condition in which the body's core temperature falls below what is required for normal body functions.
- **Movement disorders** are a group of neurological conditions that cause an individual to have abnormal involuntary or voluntary movements. These movements may be slow or reduced.
- **Neuroleptic medications** are a class of drugs used to treat schizophrenia, mania, and other types of mental disorders. They are also referred to as antipsychotic medications.
- **Parkinson's disease** is a disease of the nervous system that causes tremor, rigidity, slowness of movement, and unstable posture.
- **Receptor** is a molecule that responds to and receives a neurotransmitter or other substance.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description

Neuroleptic malignant syndrome (NMS) is a complication of therapy for individuals who use antipsychotic (neuroleptic) medications. NMS is associated with dopamine, which is a neurotransmitter that sends messages between nerve cells and the brain, and helps

regulate emotion, mood, motivation, and movement. Antipsychotic medications act as antagonists and prevent dopamine from attaching to receptors. Often, blocking the receptors can result in difficulty regulating body temperature and movement disorders. The onset of symptoms of NMS usually begins within 24 hours to 30 days after an individual has begun taking an antipsychotic medication or when an individual is prescribed a higher dose of the antipsychotic medication (American Psychiatric Association, 2013).

NMS is most commonly associated with the use of first-generation (older) antipsychotic medications such as Haldol and Thorazine. Newer antipsychotic medications such as Risperdal and Clozaril have also been linked to symptoms of NMS, although they pose less of a risk. NMS is easily recognizable due to its onset, presentation, progression, and outcome. For example, hypothermia on at least two occasions with profuse sweating is one recognizable symptom of NMS. This particular feature of NMS sets it apart from other neurological side effects of antipsychotic medications. NMS is characterized by motor dysfunction, changes in consciousness, agitation, exhaustion, dehydration, difficulty breathing, inability to regulate body pressure, muscle rigidity, and fever. It is also associated with symptoms such as tremors; loss or impairment of voluntary activity; uncontrollable and repetitive twisting movements; sudden twitching or jerking of a muscle or group of muscles; weak or non-movement of the muscles of the face, mouth, and respiratory system; and difficulty swallowing. NMS often occurs in individuals who take antipsychotic medications to treat schizophrenia, mania, delusional disorder, and other types of mental illnesses. Individuals with Parkinson's disease who have had their medications abruptly withdrawn also experience symptoms of NMS. NMS has decreased over the years due to changes in prescribing first-generation antipsychotics to individuals. However, NMS is still a danger to individuals who are still being prescribed other antipsychotic medications.

The precise cause of NMS is unknown. One potential risk factor associated with NMS includes genetic factors and is known to run in families. Genetic factors have also been associated with NMS (American Psychiatric Association, 2013). For example, changes in certain genes can affect how antipsychotic medications are absorbed in the liver, and this may result in higher blood concentrations.

Treatment

Treatment for NMS usually begins with discontinuation of the medication that is believed to be causing the problem. Once the medication is stopped, symptoms will usually improve within two weeks. Benzodiazepines and muscle relaxants are usually prescribed during this two-week period to help control symptoms. Typically, after a two-week period, a physician will prescribe a newer (atypical) generation of an antipsychotic medication as it poses a lower risk of NMS. Supportive care and proper nutrition are also helpful forms of treatment.

Elizabeth Smith Kelsey, PhD, and Len Sperry, MD, PhD

See also: Benzodiazepines; Brain; Clozaril (Clozapine); *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Dopamine; Haldol (Haloperidol); Mania; Parkinson's Disease; Risperdal (Risperidone); Schizophrenia; Thorazine (Chlorpromazine)

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Neurontin (Gabapentin)

Neurontin is a prescribed medication used to treat seizures and nerve pain caused by the herpes virus. Its generic name is gabapentin.

Definitions

- **Antiseizure medications** are prescription drugs used to treat epilepsy (seizures) as well as burning, stabbing, and shooting pain. It is also called anticonvulsant medications.

- **Diabetic neuropathy** is a medical condition in which the nerve endings, usually in the legs and feet, become less sensitive. This leads to a lack of feeling in the leg or foot and the increased likelihood of infection and other serious problems.
- **Epilepsy** is a medical condition when seizures reoccur. It is also known as seizure disorder.
- **Fibromyalgia** is a medical condition characterized by widespread, unexplained pain and sensitivity to pressure or touch.
- **Multiple sclerosis** is a disease characterized by patches of hardened tissue in the brain or spinal cord, paralysis, and/or muscle tremors.
- **Neuralgia** refers to pain that extends along the course of a nerve.
- **Seizures** are episodes of abnormal electrical activity in the brain that results in changes in the brain and in behavior.
- **Shingles** is a painful skin rash caused by the varicella zoster virus, the same virus that causes chicken pox.

Description

Neurontin is an antiseizure medication that is used for preventing seizures and for treating neuralgia associated with shingles. Neurontin is often used in combination with other anticonvulsants to manage partial seizures with or without generalization in individuals over the age of 12. Sometimes it is used to treat partial seizures in children as young as three years of age. Other uses include treating multiple sclerosis, neuralgia, restless leg syndrome, alcohol withdrawal, cocaine withdrawal, headaches, diabetic neuropathy, and fibromyalgia. The generic version of gabapentin is similar in structure to the chemical messenger (neurotransmitter), gamma aminobutyric acid (GABA). It believed that this similarity is related to Neurontin's mechanism of action, which is to increase GABA in the brain and reduce excited or overstimulated nerve cells which result in seizure activity and pain.

Precautions and Side Effects

Women who are or wish to become pregnant require a careful assessment of the risks and benefits of Neurontin. Women who are breast-feeding and those with kidney problems also need to talk with their physician about the use of this medication. Suddenly discontinuing Neurontin can increase the risk of seizures. If the medication needs to be discontinued, it should be reduced gradually over a week. Using Neurontin can cause problem with driving and operating machinery. The use of alcohol should be avoided while taking Neurontin. The use of this medication has resulted in suicidal thoughts and behavior, so any changes in mood or behavior should be reported to the physician.

A number of side effects can occur when beginning Neurontin. These include blurred or double vision, muscle weakness or pain, trembling or shaking, increased fatigue or weakness, and unsteadiness. Less common side effects include back pain, constipation, decreased sexual drive, diarrhea, dry mouth, frequent urination, headache, indigestion, low blood pressure, nausea, ringing in the ears, runny nose, slurred speech, difficulty thinking and sleeping, weight gain, twitching, nausea and/or vomiting, weakness, depression, irritability, and decreased memory. Rare side effects include pain in the lower back or side, difficulty urinating, fever and/or chills, cough, or hoarseness. Usually, these side effects go away on their own. Antacids can decrease Neurontin levels in the blood and should be used at least two hours before taking Neurontin.

Len Sperry, MD, PhD

See also: GABA (Gamma-Aminobutyric Acid)

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Neuropsychiatry

Neuropsychiatry is the field of medicine that focuses on mental disorders related to the brain and nervous system. It is also called behavioral neurology.

Definitions

- **Brain** is the organ at the center of the nervous system. It is responsible for a wide range of functions, including learning, movement, and regulation of the body.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily functioning.
- **Neurocognitive disorders** are a group of disorders in DSM-5 that are characterized by a decline from a previous level of neurocognitive (mental) function.
- **Parkinson's disease** is a disease of the nervous system that causes tremor, rigidity, slowness of movement, and unstable posture. When cognitive impairment is also present, this disease can is known as Neurocognitive Disorder Due to Parkinson's Disease in DSM-5.
- **Psychiatry** is the medical specialty that focuses on the diagnosis and treatment of mental and emotional disorders with biological and psychological methods.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.
- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain resulting in symptom reduction.
- **Stroke** is damage or death of brain cells due to insufficient blood flow. There are four types of strokes.
- **Traumatic brain injury** is an insult or injury to the brain from an external force. In DSM-5, this disorder is known as Neurocognitive Disorder Due to Traumatic Brain Injury.

Description

Neuropsychiatry is an area of medical practice and a subspecialty of psychiatry. It focuses on mental disorders related to the brain and nervous system and is also called behavioral neurology. This discipline combines neurology (study of the brain and nervous system) and psychiatry. In the past, neurology and psychiatry were seen as distinct areas. This was because most individuals considered the mind and the brain to be two separate entities. Psychiatrists traditionally treated mental disorders such as schizophrenia, anxiety, and depression. These were believed to be problems in the mind (mental). Since they could not be seen or measured, it was assumed that these problems were caused by factors outside of the physical body. These factors included personality traits and unhealthy family environments. Treatments for these disorders involved using psychotherapy to address emotions, thoughts, and behaviors. Neurocognitive disorders related to Parkinson's disease, stroke, and traumatic brain injury were more clearly viewed as physical problems involving the brain. Treatments for these disorders involved medical procedures and medication. They were considered to be different from psychological disorders and were commonly treated by neurologists.

This division changed with advances in neuroscience in the second half of the 20th century. New technologies like magnetic resonance imaging and positron emission tomography revealed a biological (neurological) basis for many mental disorders. This includes those disorders that were previously

considered to be caused by factors outside the individual. For example, research has shown that there are abnormalities in the brain functioning of individuals with schizophrenia. In addition, medications like SSRIs were found to be effective in the treatment of depression. There is also now more focus on the psychological aspects of neurological disorders. For example, Parkinson's disease often results in emotional symptoms like depression. The emerging field of neuropsychiatry is based on the assumption that treatment for mental disorders should include both biological and psychological elements. Mental disorders should not be seen as different from other medical disorders. The American Neuropsychiatric Association is the professional organization for this specialty.

Len Sperry, MD, PhD, and George Stoupas, MS

See also: Brain; Depressive Disorders; Magnetic Resonance Imaging (MRI); Neurocognitive Disorders; Parkinson's Disease; Positron Emission Tomography (PET); Psychotherapy; Schizophrenia; SSRI; Stroke; Traumatic Brain Injury

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Neuropsychological Tests

Neuropsychological tests are a type of psychological testing for assessing brain functioning.

Definitions

- **Dementia** is the progressive deterioration of intellectual functions, such as memory, within the brain. Alzheimer's disease is a type of dementia.
- **Executive functions** are high-level cognitive abilities that influence more basic abilities such as attention, memory, and motor skills.
- **Neuropsychologists** are psychologists with specialized training and experience in administering, scoring, and interpreting of tests of cognitive abilities and brain functioning.
- **Neuropsychology** is a branch of psychology that studies the structure and function of the brain involving specific psychological processes and behaviors.
- **Psychometric** is a branch of psychology that deals with measurement of mental capacities, processes, and traits.
- **Visual-motor** is the ability to coordinate vision and bodily movements.
- **Visual-spatial** is the ability to manipulate multidimensional figures mentally.

Description

Neuropsychological tests are used to evaluate brain functioning with formal assessment instruments and systematic behavioral observation. These tests are specifically designed to evaluate cognitive abilities, including attention, working memory, short-term and long-term memory, processing speed, reasoning and problem-solving ability, ability to understand and express language, visual-spatial organization, visual-motor coordination, and planning and organizational abilities. By testing a range of cognitive abilities and examining patterns of performance in different cognitive areas, neuropsychologists can make inferences about underlying brain function. Neuropsychological testing is used in the assessment and treatment of traumatic brain injury, attention deficits, dementia, neurological conditions, psychiatric disorders, and drug or alcohol abuse. It is also used in research to determine the effects of toxic substances and medical conditions on brain functioning.

Neuropsychological tests are helpful in identifying syndromes associated with problems in a particular area of the brain. For example, an individual who

performs well on tests of attention, memory, and language but performs poorly on tests that require visual spatial skills, such as making designs with colored blocks, may have dysfunction in the right parietal lobe. That is the region of the brain involved in complex processing of visual information. Following a stroke, an individual may complain of difficulty with pronouncing words. Neuropsychological tests can identify the location of the stroke and help in planning the most appropriate rehabilitation.

In addition, neuropsychological testing of older adults complaining of memory problems can help distinguish those who are at risk for dementia from those experiencing normal age-related memory loss.

Developments and Current Status

Neuropsychology is a branch of psychology with origins in both psychology and neurology. Its primary focus is on brain-behavior relationships. The Russian neuropsychologist Alexander Luria (1902–1977) greatly influenced the development of neuropsychology as it is practiced today. He proposed that the role of neuropsychology was to localize brain lesions and analyze psychological activities arising from brain function through behavioral observation. More recently, American neuropsychologist Ralph M. Reitan (1922–2014) emphasized the value of standardized psychometric tests in evaluating brain-behavior relationships. Along with Ward Halstead, Reitan developed the Halstead-Reitan Battery, which is used to evaluate brain and nervous system function in individuals over the age of 15.

Before the development of brain imaging methods like computed tomography, magnetic resonance imaging, and positron emission tomography, neuropsychological testing was the only method for evaluating brain-behavior functioning. These brain imaging methods provide a direct assessment of brain lesions or structural abnormalities, specifically in localization of brain dysfunction. For a while, it appeared that these imaging methods would eliminate the need for neuropsychological testing. However, neuropsychologists found new uses for their skills and knowledge. They made the case that neuropsychological testing that indirectly assesses brain function complements brain imaging. For instance, neuropsychological testing can clarify if the specific cognitive abilities are impaired or preserved in patients with brain injury. Brain imaging cannot do this. In fact, neuropsychological testing can accurately predict how well individuals will respond to different forms of treatment or rehabilitation. Today, neuropsychological testing and brain imaging methods are used together to determine which part of the brain is affected in a given individual.

Commonly, a neuropsychological evaluation includes tests of sensation and perception, gross and fine motor skills, basic and complex attention, visual spatial skills, receptive and productive language abilities, recall and recognition memory, and cognitive flexibility and abstraction, and other aspects of executive function. Motivation and personality are often assessed as well, particularly in disability evaluations when an individual is seeking monetary compensation for cognitive complaints that may stem from head injuries.

The neuropsychological examination might include a standard test battery such as the Halstead-Reitan Battery or the Luria-Nebraska Battery. These test batteries include tests of a wide range of cognitive functions and are favored by those who believe that all brain functions must be assessed in everyone to avoid diagnostic bias or failure. It is even more likely that the neuropsychological examination will be tailored to the individual being evaluated. That means a customized battery of tests—which may include some subtests from the standard batteries—are chosen based on clinical hunches generated through a clinical interview, observation of the individual, and review of medical records. This more flexible approach to neuropsychological testing has one shortcoming. It is more prone to bias than a standard battery. On the other hand, it has the advantage of preventing unnecessary testing. Because individuals often experience neuropsychological testing as lengthy, stressful, and fatiguing, a flexible battery approach is shorter and less fatiguing. Shorter batteries are also more likely to be reimbursed by insurance companies.

A number of neuropsychological tests are currently available. These include Ammon's Quick Test, Clinical Dementia Rating, Cognitive Assessment Screening Instrument, Continuous Performance Task, Finger Tapping Test, Halstead-Reitan Battery, Kaufman

Assessment Battery for Children, Luria-Nebraska Battery, Repeatable Battery for the Assessment of Neuropsychological Status, Shipley Institute of Living Scale, Test of Memory and Learning, Wechsler Adult Intelligence Scale and Wechsler Intelligence Scale for Children, Wide Range Achievement Test, Wonderlic Personnel Test, and Word Memory Test

Len Sperry, MD, PhD

See also: Psychological Tests

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Neurosis

Neurosis is an outdated but still used term for various mental disorders characterized by considerable anxiety, irrational fears, depression, or obsessive thoughts. It is also called psychoneurosis.

Definitions

- **Anxiety disorders** are a group of mental disorders characterized by anxiety that tends to be intermittent instead of persistent. It includes panic disorder, phobias, and generalized anxiety disorder.
- **Defense mechanisms** are unconscious strategies for self-protection against anxiety and other negative emotions that accompany stress.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Five Factor Personality Model** is a model of personality in which five factors—extraversion, consciousness, agreeableness, openness, and neuroticism—are viewed as core personality structures.
- **Neuroticism** is a mild condition of neurosis. As one of the dimensions of the Five Factor Personality Model, it is characterized by a chronic level of emotional instability and proneness to psychological distress.
- **Personality** describes an individual's pattern of behaving, thinking, feeling, and relating.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. Sigmund Freud developed this original theory.
- **Psychosis** is a severe mental condition in which individuals lose touch with reality and experience severe disruptions in perceiving, thinking, and acting.
- **Unconscious** is part of the personality that contains emotional conflicts, wishes, memories, and repressed impulses to which one is not aware but that influence thinking and behavior.

Description

"Neurosis" or "neurotic" is an outdated term that is used to describe individuals who experience mental disorders that are not psychotic (loss of touch with reality). Neurosis is characterized by distressing symptoms such as significant anxiety, persistent irrational fears, somatic and depressive reactions, obsessive thoughts, and compulsive acts. Today, the term "disorder" is used instead of the term "neurotic." That means that the once-called psychoneuroses are now classified as anxiety disorders in DSM-5.

Originally, the term "neurosis" was used to describe medical conditions related to the nervous system. However, Sigmund Freud (1856–1939), the developer of psychoanalytic theory, refashioned the

term to describe symptoms that resulted from unconscious conflicts. For example, an individual may experience an unbearable trauma in childhood that he or she does not consciously acknowledge. This is called repression, which is one of the ego defense mechanisms. Repression results in neurosis and neurotic symptoms. This conflict was Freud's definition of anxiety. For Freud, treatment of such conflicts involved helping individuals reexperience these traumas and reduce the unconscious conflicts. If successful, the result was a reduction of neurotic symptoms.

Neurosis and neurotic symptoms can be distinguished from psychotic states and symptoms. Individuals who experience neurotic symptoms do experience an impairment of functioning but maintain full awareness of reality. This differs from the loss of reality, which characterizes psychoses. Whereas both neurosis and psychosis result in distress and impaired functioning, neurosis is much less severe.

"Neuroticism" is also a term used to describe a factor of personality in what is called the Five Factor Personality Model (FFM). Also called the Five Factor Model, this model of personality was created by psychologists Robert McCrae (1949–) and Paul Costa. In FFM, neuroticism is a measure of how likely an individual is to experience negative states such as anger, anxiety, and depression. Individuals who measure high in this dimension are often worrisome, irritable, and/or moody. By contrast, individuals who measure low in neuroticism are considered to be emotionally stable, secure, and relatively untroubled.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Anxiety Disorders; Defense Mechanisms; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Freud, Sigmund (1856–1939); Obsessive-Compulsive Disorder; Personality; Psychoanalytic Theory

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Nicotine-Related Disorders

Nicotine-related disorders are mental disorders characterized by the problematic use of tobacco, resulting in considerable distress or disruption of daily life. It is also called tobacco-related disorders.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Dependence** is the need for a drug to function normally. Dependence can be psychological and/or physical. Psychological dependence is dependence on a psychoactive substance for the reward it provides. "Physical dependence" refers to the unpleasant physiological symptoms if the drug is stopped.
- **Dopamine** is a chemical substance in the brain that influences emotion, mood, thoughts, motivation, and movement.
- **DSM** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition is DSM-5, which was published in 2013, and replaced DSM-IV-TR.
- **Nicotine addiction** is a mental condition characterized by physical dependence on tobacco.
- **Self-help groups** are a group of individuals, sometimes led by a therapist, who provide each other emotional support, information, and advice on problems relating to some shared concern such as an addiction. Alcoholics Anonymous is such a group.

Description

Nicotine-related disorders were a group mental disorders in DSM-IV-TR. Common to these disorders was the use of all forms of tobacco. The main disorder in this group was nicotine dependence. A major change in DSM-5 was eliminating the concept of "dependence" from all categories of substance disorders. Another change involved renaming nicotine-related disorders to "tobacco-related disorders."

Nicotine is a highly addictive chemical substance derived from the tobacco plant. It increases dopamine levels in the brain. High levels of dopamine trigger the reward system in the brain. This leads to feelings of pleasure and relaxation. The reward mechanism in the brain plays a significant role in addiction. Nicotine's effects may also result in various mental disorders like depression and neurological disorders such as migraine headaches.

Nicotine can be inhaled from cigarette smoke. It may also be ingested by chewing tobacco, inhaling smokeless tobacco in powder form, or smoking tobacco in pipes and cigars. Regardless of the route of administration, nicotine is very addictive. It is physically addictive because it creates brain chemical changes that produce cravings. It is also mentally addictive because it creates a persistent desire for the stimulating effects it produces.

Nicotine is found in tobacco products, which are known to cause severe health problems. They contain chemicals that can cause lung cancer, leukemia, heart disease, emphysema, stroke, and diabetes. Other health issues include a compromised immune system, respiratory infections, and gum disease.

Nicotine addiction and related disorders are caused by inhaling the smoke of cigarettes, pipes, or cigars. It is also caused by chewing tobacco or nasally inhaling smokeless tobacco.

Treatment

Treatment for nicotine addiction includes cognitive behavior therapy (CBT), medication, and self-help groups. CBT is useful for helping an individual identify and replace maladaptive thoughts and change behaviors. Antidepressant medications can be used to increase dopamine levels and boost mood. Nicotine replacement patches, gums, lozenges, nasal sprays, and inhalers can help reduce cravings. Self-help groups can provide social support and may reinforce coping skills learned during CBT or other forms of counseling.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Addiction; Cognitive Behavior Therapy; Dopamine

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Nightmare and Nightmare Disorder

Nightmare is a dream that results in feelings of terror, fear, or extreme anxiety. A nightmare disorder is a sleep disorder that is characterized by recurrent troubling dreams.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Mindfulness practices** are techniques for increasing one's capacity to live in the present moment.
- **Parasomnias** are a group of sleep disorders characterized by abnormal events that occur during sleep, such as sleepwalking, talking, or limb movement.
- **REM sleep** is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain

activity. It is also known as rapid eye movement and REM sleep.

- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.
- **Stress management** is a set of techniques and intervention to assist individuals to more effectively cope with stress.

Description and Diagnosis

A nightmare involves a dream that occurs during REM sleep and results in feelings of terror, fear, or intense anxiety. Nightmares tend to occur in the latter part of the night and usually awakens the sleeper. Usually, the content of the dream can be recalled. On the other hand, a nightmare disorder is a sleep disorder characterized by troubling dreams that repeatedly occur. These dreams involve threats to survival, security, or self-esteem. On awakening from the frightening dreams, the individual rapidly becomes oriented and alert. The awakenings generally occur during the second half of the sleep period.

Those experiencing this disorder often report recurrent, past, unpleasant events and display unfavorable changes in personality. Changes in typical sleeping schedules and sleep deprivation may contribute to increased risk for experiencing this sleep disorder. While disturbing dreams involve distress, they are less likely to cause social or work-related occupational impairment. However, if the persistence of dreams results in fear of falling asleep, individuals may experience excessive sleepiness during waking hours. This can result in difficulty with concentration, increased anxiousness, sadness, and irritability that affect work and relationships (American Psychiatric Association, 2013). Nightmare is a parasomnia, a sleep disorder that occurs during arousals from REM sleep or partial arousals from non-REM sleep. Other parasomnias include sleep terror disorder, sleepwalking disorder, and restless leg syndrome in addition to nightmare disorder.

Nightmare disorder should be differentiated from sleep terror disorder. While both disorders include being aroused from sleep, individuals who suffer with nightmare disorder can clearly and vividly recall the dream. Nightmares usually occur later in the night than sleep terrors. Also, individuals usually wake up completely once the nightmare has occurred, whereas they do not in sleep terror disorder (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pattern of repetitive, discomforting, and frightening dreams which they remember for which they retain full memory of the dream. Content of the disturbing dreams often involves efforts to evade or cope with perceived danger. Individuals who experience a traumatic event may have distressing dreams that possess elements of the event. Clients report feeling increased fear and anxiousness associated with the dream, even after fully awakening from the dream. On awakening from the distressing dream, individuals report rapidly regaining orientation and alertness. To diagnose this disorder, there must also be clinically significant distress or impaired social, work, or relational functioning. In addition, the nightmares are not part of another mental disorder nor are they due to a medication, a drug of abuse, or a medical condition (American Psychiatric Association, 2013).

The cause of nightmare disorder is not well understood. However, it appears that various factors can contribute to it. These include fatigue, sleep loss, eating immediately before bedtime, and irregular sleep. Stressful life events such as divorce, moving, and starting school or a new job can trigger nightmares. Other sleep disorders like sleep apnea and restless legs syndrome and mental conditions like clinical depression and post-traumatic stress disorder can also trigger it. Withdrawal from alcohol and certain medications can also cause nightmares.

Treatment

Treatment for nightmare disorder differs depending on the age of the individual. In adults, treatment usually involves counseling or psychotherapy that addresses the underlying causes of the nightmare such as a traumatic

event. Stress management and mindfulness practices can be helpful in reducing tension and anxiety Medications are generally not used in the treatment of this disorder. Children can also be treated with stress management. It is helpful for parents to be involved in the treatment. The more they understand the disorder and what they can do, the more likely the treatment will be effective. Parents are instructed to ensure that their child gets regular sleep and does not become overly fatigued. They are helped to establish regular bedtime hours and rituals. They are also urged to wake the child during the nightmare and reassure and support their child through the episodes. Gently distracting them from the nightmare will help them relax and fall back asleep.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Hypersomnia and Hypersomnolence Disorders; Insomnia and Insomnia Disorder; Narcolepsy; Sleep Terror Disorder

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Nondirective Therapies

Nondirective therapies are a clinical approach to treatment where the therapist allows the client to set the pace and content of therapy. This is also referred to as client-centered treatment.

Definition

- **Nondirective** refers to a clinical approach to treatment where the therapist allows the client to set the pace and content of therapeutic counseling sessions.

Description

Nondirective therapy began with the person-centered or client-centered therapy developed by Carl Rogers (1902–1985). The basis of the nondirective approach is a belief that people have an innate desire to fulfill their own potential, to improve themselves. It takes the power based on educational expertise out of the hands of the therapist and gives it to the client. It is the client's insights, feelings, values, and behaviors that will drive the scope, depth, and timing of therapy.

In nondirective therapies the role of the therapist or counselor is important because the therapist establishes the therapeutic relationship and safe environment. The goal for these therapists is to create an open environment in which the client can feel important, valued, and in control of his or her own mental health. The therapist has the task of listening intently to the client in order to be able to reflect back to the client his or her own expressed anxieties, fears, and actions. Through nondirective therapy, the therapist facilitates the client's concerns and desires so that the client can see himself or herself and his or her behavior more clearly in order to change and improve.

The term "nondirective" has been labeled naïve and misleading since the influential role of the therapist is still key to the success of the therapeutic experience. It is criticized and questioned for its overuse of simply repeating what the client expresses, which by some has been deemed ineffective. In the purest form of nondirective therapy, a counselor would not indicate his or her opinions or preferences to the client. Some have argued that removing the therapist's opinion is nearly impossible and that most end up giving subtle direction in any case. Rogers himself recognized the limitation and he came to use and prefer the terms "client-centered" and "person-centered" to better define his treatment approach.

Development

Nondirective therapy arose mainly due to the inspiration, experience, and teaching of American psychologist Carl Rogers beginning in the 1940s. Because of

this, nondirective therapies are often called Rogerian approaches to counseling and therapy. But Rogers himself had been influenced greatly by the Viennese psychiatrist Otto Rank. Rank was one of Freud's closest coworkers but ended up leaving his work with Freud because of what he considered Freud's single-minded focus on the examination of a patient's past. Rogers credited Rank with inspiring many of his ideas, especially client-centered therapy.

The respect for and influence of Carl Rogers led to the extension of nondirective therapy into many therapeutic specialities. For example, Virginia Axline developed nondirective play therapy for children. Play therapy began to be extended from children to adolescents and later even in formats that were found effective for therapeutic work with adults. The success of the nondirective approach to therapy has influenced many in the psychiatric and psychotherapeutic fields. Another nondirective therapy approach is experiential therapy, an offshoot that was developed by Eugene Gendlin.

Current Status

Today nondirective therapy is widely practiced in a variety of forms. The intent to focus on the client and empower him or her through therapy that is his or her own is very common. As already noted, there are those who suggest that "nondirective" is a misleading word and therefore the term is not used as widely as it had been in the past. Master therapists who believe in respecting a client's strengths and abilities apply nondirective therapies effectively. They do so by allowing the client to identify his or her own treatment goals and are able to work within a client–therapist relationship that encourages insight and growth.

Alexandra Cunningham, PhD

See also: Person-Centered Therapy; Rogers, Carl (1902–1987)

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Nonverbal Communication

Nonverbal communication is expressed in ways other than with words, mostly through visual, auditory, and spatial cues.

Definitions

- **Chronemics** describes the study of how one communicates nonverbally using time.
- **Haptics** is the study of nonverbal communication through touch.
- **Kinesics** refers to body language, including posture, gaze, stance, and face/body movements.
- **Oculesics** describes nonverbal communication that is expressed through the eyes, including eye contact, gaze patterns, pupil dilation, and blinking.
- **Paralanguage** refers to the nonverbal elements of the words communicated orally, including a person's voice quality, tone, pitch, volume, rate, and speaking style.
- **Proxemics** is the study of nonverbal communication through personal space and distance (proximity).

Description

"Nonverbal communication," oftentimes mistakenly referred to as body language, refers to the process of communicating information (thoughts, feelings, opinions, mood) through visual, auditory, spatial, body, and timing cues. Simply defined, it is what is relayed and perceived between sender and receiver through the five senses: sight, hearing, smell, touch, and taste. Nonverbal communication encompasses all aspects of communication other than what is expressed in words. Much is communicated between people through the

qualities of voice (paralanguage), eye movements (oculesics), touch (haptics), bodily movements (kinesics), space and distance (proxemics), and time (chronemics). Nonverbal behavior is thus responsible for five primary functions in human communication: expressing emotions, expressing attitudes between people, accompanying what is spoken to manage the cues of the interaction between speaker and listener, helping to relay aspects of an individual's personality, and communicating rituals. Prior to developing the use of language or writing, young children learn to interact with those around them through nonverbal means. A caregiver's facial expressions and body language often relay his or her emotional state, preclude certain actions or reactions, and model expectations he or she holds for the child.

It is estimated that two-thirds of all communication is expressed nonverbally, indicating that what is said or written in word form is not always what is communicated. Clear communication is defined as interaction patterns in which both nonverbal and verbal messages match. Nonverbal messages are meaningless unless there is a person there to interpret those messages; therefore, nonverbal communication is made up of both encoding and decoding processes. "Encoding" refers to the act of generating a message via one's facial expressions, voice quality, gestures, eye movements, distance, spatial relationship, and touch, as well as other cues. The encoding process is generated by the sender. "Decoding" refers to how those messages are interpreted by the receiver. Both encoding and decoding of nonverbal processes are affected by one's personality, innate qualities, and life experiences, opening up the likelihood of misunderstandings and misinterpretations.

Nonverbal communication is of primary importance upon initial encounters, which can take less than one-tenth of a second for someone to make. Often what is expressed through nonverbal means can either increase or decrease the likelihood of future interactions between parties. Situations including potential romantic interests or work-related interviews can be made or broken based on first impressions.

Charles Darwin was the first scientist to write about what was later termed "nonverbal communication." His 1872 book *The Expression of the Emotions in Man and Animals* focused primarily on how humans and animals communicate their emotions through facial expressions. Behaviorists were the next researchers to look at concepts related to nonverbal communication, observing actions such as visual responses, touch, closeness, and other body movements. Formally speaking, the first investigation of nonverbal communication was conducted in 1955 by experimental psychologists and anthropologists Adam Kendon, Robert Scheflen, and Ray Birdwhistell. They used context analysis to code various patterns surrounding common social interactions like greeting rituals and the behavior of people at larger recreational engagements like parties. Research in the 1960s delved deeper into other aspects of nonverbal communication, those related to proxemics and oculesics. Later study investigated the effects of nonverbal behaviors on various relationships, including those with intimate partners, between student and teacher, peer friendships, and among coworkers. The literature on nonverbal communication was abounding by the early 1980s with several books published by various authors on the topic and the founding of the scholarly work the *Journal of Environmental Psychology and Nonverbal Behavior* in 1978. Since that time investigation has continued to further examine the intricacies of nonverbal interactions among various people.

Current Status and Impact (Psychological Influence)

There are commonly agreed-upon behaviors associated with positive and negative nonverbal communication. Positive indicators typically include steady eye contact, confident posture, nodding one's head, smiling, allowing for an appropriate amount of personal space, normal and consistent voice tone and volume, and using acceptable forms of touch. Negative indicators commonly include lack of eye contact, frowning or giving a blank stare, being too close or too far in terms of proximity, using either extremely soft or loud voice tone and/or volume, and engaging in inappropriate or unwelcomed forms of touch. Though these assumptions exist, they are not consistently held across every group or for every individual. Age, gender, power differentials, cultural background, and clothing/dress, as well as emotional, cognitive, or behavioral differences

can further complicate how each individual interprets nonverbal communication. Educating oneself about various subgroups and their accepted cultural/societal norms and expectations is advised. Assumptions, misunderstandings, and/or miscues can lead to resentment, offense, and hurt, which can be prevented.

Melissa A. Mariani, PhD

See also: Multicultural Counseling; Social Communication Disorder; Social Skills Training

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Nutrition and Mental Health

Nutrition and mental health is an integrative approach that can improve an individual's health and well-being with nutrition.

Definitions

- **Attention-deficit hyperactivity disorder** is a mental health disorder characterized by a pattern of inattention or overly active behavior.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **Melatonin** is a chemical messenger in the brain, which regulates the sleep–wake cycle and promotes restorative sleep.
- **Nutritional neuroscience** is an emerging discipline that examines the role that nutrition and dietary habits have on an individual's emotions, cognitions, and behaviors.
- **Psychopharmacology** is the study of drugs that affect thinking, feeling, and behavior. It includes antipsychotic, antianxiety, antidepressant, and antimanic medications.
- **Serotonin** is derived from tryptophan and can be found in the gastrointestinal tract and central nervous system and is associated with happiness and feelings of well-being.
- **Tryptophan** is a standard amino acid found in most protein-based foods that also triggers the release of serotonin, a neurotransmitter in the brain.
- **Well-being** is the state of being happy, healthy, prosperous, or successful.

Description

Nutrition and mental health is an approach for improving an individual's health and well-being. It involves holistic (broad) assessment of diet, eating habits, social support networks, physical activity, stressors, family history, medication, and environmental exposure. Based on this assessment, change in diet and eating habits are prescribed.

The relationship between mental health and food is often underestimated. The foods that individuals eat are broken down in the body and influence functions in the brain that regulate mood and overall mental health functioning. Unhealthy, imbalanced, or deficient diets are known to cause long-term physical and mental health issues.

Nutritional neuroscience research continues to examine mental health conditions such as depression that are exacerbated or in some cases are even caused by poor dietary habits. The general population practices dietary habits that are deficient in the amount of vitamins, minerals, and omega-3 fatty acids. Studies have found that vitamin supplements can actually reduce several of the symptoms of some mental health conditions and ultimately improve overall well-being. They

have examined the link between mental health and carbohydrates, protein, omega-3 fatty acids, and vitamins, minerals such as calcium, chromium, iodine, iron, selenium, and zinc.

Healthy dietary habits include the following: fruits, vegetables, whole grains, seafood (if not vegetarian), low-glycemic foods, and non-processed foods. Carbohydrates cause insulin to be released in the body, which then triggers tryptophan to enter the brain. Tryptophan then impacts neurotransmitters in the brain, which also increases serotonin in the brain that is associated with well-being and pleasure. Professionals recommend that individuals should eat foods low in carbohydrates such as vegetables and pasts but avoid foods that are high in sugar.

Various foods contain components that can influence mental health functioning in both positive and negative ways. Proteins are made up of amino acids and are found in dairy products such as milk, meat, and eggs, but they are also found in plant protein such as grains, peas, and beans. While as many as 12 amino acids are produced in the human body, 8 essential amino acids are supplied through specifics foods. The neurotransmitter called dopamine is made from amino acids. Individuals low in certain amino acids can experience low moods or aggression. Omega-3 fatty acids have mood-stabilizing effects and can reduce symptoms among some who are depressed or who experience attention-deficit hyperactivity disorder. Omega-3 fatty acids can be found in walnuts, green leaf vegetables, oily fish such as salmon, and olive oil. Individuals who add vitamins such as B-12 or folate to their diet have enhanced cognitive functioning and experience fewer issues with mood regulation. Minerals such as iodine, iron, and chromium are known to play a role in mental health functioning.

Besides maintaining a balanced diet, it is also recommended that individuals drink enough water, avoid processed foods, seek organic food options when possible, and avoid high-sugar and sodium foods. Although further research needs to be completed in the area of nutrition and mental health, the link between the two is significant.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Magnesium; Melatonin; Nutrition and Mental Health

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Obedience Studies

The obedience studies were conducted by social psychologist Stanley Milgram between 1961 and 1962 and sought to determine how far human beings were willing to go when instructed to carry out harmful tasks by an authority figure.

Definition

- "**Milgram's Experiments**" is another term used to describe Stanley Milgram's groundbreaking obedience studies, as they are the research he is most famous for conducting.

Description

Between 1961 and 1962, social psychologist Stanley Milgram conducted a series of experiments on obedience to authority. These have since been referred to collectively as the "obedience studies" or "Milgram's Experiments." Controversy initially surrounded this research as participants were subjected to extremely stressful situations and were not made fully aware of the studies' protocol prior to their consent. Findings suggested that the majority of subjects were willing to administer the most severe level of harm to fellow participants because they were instructed to do so by the experimenter (a perceived person of authority). Milgram published his book *Obedience to Authority* in 1974, which compiled the procedures, results, and implications of these studies. Milgram's Experiments have had a lasting impact being incorporated into most introductory psychology courses and guiding the subsequent practices of research with human subjects.

History

Milgram's obedience studies consisted of inviting several pairs of people into a psychology laboratory to participate in a study about memory and learning. One person was designated the teacher and the other the learner. The experimenter then explained to the pair that the purpose of study was to determine the effects of punishment on learning. A panel of 30 switches was then introduced, ranging from 15 volts to 450 volts. The panel also had written designations, ranging from "SLIGHT SHOCK" to "DANGER-SEVERE SHOCK." The teacher was then instructed by the experimenter to administer a test to the learner, who was placed in an adjacent room where his or her arm was hooked up to an electric shock (the learner was actually an actor and never exposed to any harm). When the learner responded correctly, the teacher was instructed to move on to the next item; however, when an incorrect response was given, the teacher was instructed to give the learner an electric shock. The shocks began at 15 volts, the lowest level, and increased in 15-volt increments, with each incorrect response, all the way to 450 volts. The true purpose of the experiment was to find out how far a person will go in inflicting harm on another if instructed to do so by a perceived authority figure. With each increment increase in voltage, the actor is directed to respond more emotionally, eventually screaming and pleading with the teacher to stop. The results of these experiments indicated that 26 of the 40 participants, or two-thirds, were willing to proceed with the highest level of shock (450 volts). The explanation for these obedient subjects' behavior was that they were able to shift the personal responsibility they felt for their actions to another person,

in this case the experimenter, and blame that person instead. Though the learners were never exposed to any shocks, the experiment and tactics used by Milgram were deemed highly unethical in that they caused stress to the participants.

Current Status

The findings of the studies suggested that under controlled conditions most people would go against their own moral judgment and for no personal gain nor malice harm another human being simply because they were instructed to by an authority figure. These people were able to shift their personal responsibility onto the person in charge of them. It did not occur to most of these participants to go against instructions, refuse, or simply refrain. Milgram related these findings to larger-scale events, including the Holocaust and the Mai Lai Massacre. Those that were executing heinous crimes reported doing so because their superiors told them to. Milgram's groundbreaking obedience experiments are commonly cited by professionals in the field and have been incorporated into most introductory psychology courses. These studies have also been referred to in popular culture, including music, movies, television shows, and publications.

Melissa A. Mariani, PhD

See also: Milgram, Stanley (1933–1984); *Obedience to Authority: An Experimental View* (Book)

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Obedience to Authority: An Experimental View (Book)

Obedience to Authority is the most famous work written by American social psychologist Stanley Milgram, published in 1974, which covers the experimental conditions of his obedience studies as well as possible explanations for his participants' behavior.

Definition

- **Obedience studies** ("Milgram's Experiments"), led by psychologist Stanley Milgram during the early 1960s, articulated the salience of real or perceived authority at influencing a human being's thoughts, values, and actions.

Description

Published in 1974, Stanley Milgram's book *Obedience to Authority* was written compiling the experimental methods, conditions, results, and implications of Milgram's renowned studies on obedience to authority. Milgram conducted a series of studies between 1961 and 1962 to determine to what extent people will obey orders from a person in authority regardless of their consequences. The experiments received harsh criticism from the scientific community because of the tactics employed to mislead participants. Currently, these studies are viewed as a cornerstone of basic psychology courses, and some of the procedures Milgram put in place during his research have since contributed to the creation of internal review boards and the overall practice of engaging in research with human participants.

Milgram became interested in the social phenomenon of obedience to authority early on in his professional career. Born to Jewish immigrants, Milgram was deeply impacted by the effects of the Holocaust and was curious about how human beings rationalize their behavior even when instructed to perform the most heinous acts. He was particularly interested in the 1961 trial of Adolf Eichmann, a high-ranking official in the Nazi party. Milgram's dissertation research examined cross-cultural differences in conformity and he went on to study this topic under Solomon Asch at Princeton. While Asch's research examined low-stakes situations from an academic perspective (having subjects select lines judged to be the same length under the influence of the conflicting opinions of an authority figure), Milgram was more interested

in higher-stakes social situations for the average person. His experiments sought to test the effects of punishment on learning and invited pairs of subjects, one designated the teacher and the other the learner, to participate in a memory test. The two were moved into separate, adjacent rooms and the teacher was instructed to ask a series of questions to the learner. If the learner answered correctly, then the teacher moved onto the next question; if the learner answered incorrectly, then the teacher was to administer an electric shock to the learner in increasing increments of 15 volts, with the highest possible being 450 volts. The learners were never in true danger as they were merely acting, unbeknownst to the teachers. The results of these found that the majority of teachers were obedient subjects in that they were willing to administer the most severe shock to the learners simply because the experimenter instructed them to do so. Even though the consequences of their actions often went against their own personal and moral judgment, most proceeded with inflicting harm to the other participant. Milgram posited from these results that most people rationalized their behavior by displacing their responsibility on the person in authority. Most felt that they were simply doing their job and had no choice but to keep going as they were told. This phenomenon has been used to explain peoples' rationale for compliance even in the most grave of situations. The experiment itself and the tactics used by Milgram came under strict scrutiny from the scientific community and were deemed highly unethical in that they caused stress to the participants. Subsequently, stricter guidelines have been enforced for research practices with human subjects.

Impact (Psychological Influence)

One year after its release (1975), Milgram's *Obedience to Authority* was nominated for a National Book Award after being translated into seven different languages, making it available for international distribution. Milgram went on to make his own film about his experiments, titled *Obedience*. "Milgram's Experiments" have also been referenced in later works, including movies, television shows, and songs. In 2005, the short film *Atrocity* won an award for featuring a reenactment of Milgram's *Obedience to Authority* experiment. The American Association for the Advancement of Science awarded Milgram and in particular his works on obedience the annual social psychology award. The obedience to authority phenomenon has been used to explain the Holocaust, the 1968 Mai Lai Massacre in Vietnam, and other heinous acts of genocide and terrorism. Milgram's experiments have also contributed to the creation of the American Psychological Association's guidelines for conducting research with human participants and the subsequent requirement of an institutional review board.

Melissa A. Mariani, PhD

See also: Milgram, Stanley (1933–1984); Obedience Studies

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Obesity

Obesity is a medical condition involving excessive body fat that can lead to an increase in health problems.

Definitions

- **Antidepressants** are prescription drugs that are primarily used to treat depression and depressive disorders.
- **Antipsychotics** are prescription drugs that are primarily used to treat psychotic disorders.
- **Behavioral therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Body mass index** is a medical index for differentiating obesity from non-obesity. The index is calculated from an individual's weight (mass) and height.

- **Calories** are energy that fuels the body. Exceeding the number of calories the body requires leads to weight gain. For example, an excess of 3,500 calories leads to a gain of one pound of fat.
- **Diabetes** is a disease in which there are high levels of sugar in an individual's blood. It is usually a lifelong condition.
- **Dietician** is a professional who promotes good health through proper diet and with the therapeutic use of diet in the treatment of medical conditions like obesity. Registered dieticians are certified by the American Dietetic Association.
- **Prader-Willi syndrome** is a rare genetic disorder that causes constant feelings of hunger, poor muscle tone, and low levels of sex hormones.
- **Thyroid** is a gland in the body that controls how the body uses energy, makes proteins, and controls other hormones.

Description

Obesity is increased body fat in an individual that has built up to the point that it may cause significant health problems. Obesity may also reduce an individual's life expectancy. Obesity, usually, occurs when an individual takes in more calories than he or she burns. Calories are burned through exercise and normal daily activities. The surplus of calories is then saved as fat. Obese individuals have a great risk of developing health problems and diseases (e.g., diabetes, high blood pressure, and heart disease). An individual can calculate body mass index (BMI) to determine if he or she is obese. When an individual has a BMI of 30 or higher, he or she is considered to have obesity.

Obesity increased to a widespread occurrence in the United States. Over two-thirds of adults in the United States are either overweight or obese, and one in three Americans is obese (Haslam and James, 2005). There has been a great increase in obesity among children in the past several years, and nearly 20%–25% of children are either overweight or obese (Haslam and James, 2005). However, it is preventable if an individual seeks help for this condition. It is estimated that in the United States, obesity causes between 111,909 and 365,000 deaths per year (Haslam and James, 2005).

Obesity can be caused by several factors. Some of these factors include inactivity, lack of sleep, family history of obesity (genetics), and an unhealthy diet. For example, diets that are high in calories and lack fruits and vegetables can lead to obesity. Some medications, such as antidepressants and antipsychotics, can lead to weight gain and obesity. In addition, some medical problems, such as Prader-Willi syndrome and low thyroid function, can lead to obesity.

Treatment

The main goal of treatment for obesity is to achieve and maintain a healthy weight. An individual who works with a professional who specialized in behavioral therapy can be an effective form of treatment. The professional (therapist) can assist the individual in addressing behavioral and emotional issues related to eating. In addition, an individual may come to an understanding of why he or she overeats. Working with a dietician and an obesity specialist has been shown to be helpful forms of treatment. The goal is to help the individual understand his or her health condition and alter his or her eating and activity habits. Other forms of treatment include prescription weight loss medications and weight loss surgery.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Antidepressants; Antipsychotics; Behavior Therapy; Nutrition and Mental Health

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Object Relations Theory

Object relations theory is a form of psychoanalytic psychology based on the premise that close relationships are the basic human need. This theory emphasizes the central role of mental representations of such relationships.

Definitions

- **Attachment theory** is a concept of developmental psychology which emphasizes the types of bonds developed between parent and child and their effect on future psychosocial interactions.
- **Identification** is the merging of mental representations of self and internal objects.
- **Introjection** is a lack of differentiation between an internal object and an external object.
- **Object** is actual person, place, or thing that an individual has an interest in or emotional reaction to. It is also known as an "external object."
- **Psychoanalysis** is a form of therapy based on psychoanalytic psychology. In psychoanalysis clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams.
- **Psychoanalytic psychology** is the form of psychology largely developed from the work of Sigmund Freud, which emphasizes the conflicts and compromises between the unconscious and conscious mind.
- **Representation** is an individual's mental construction of a person, place, thing, idea, or fantasy that elicits interest or emotional reactivity. It is also known as an "internal object."
- **Separation-individuation** is the developmental process of learning to differentiate between self, internal objects, and external objects.

Description

Object relations theory is a psychological theory of relationships. It is a psychology of relating to reality or to the mental representations of reality. Specifically, object relations theory explains the influence of early life experiences on present relational dynamics. It is a developmental theory. The capacity for relationships evolves in stages over time as mental representations of self and others are formed. It is important to note that there is a difference between mental representations of self and internal objects. The self has many definitions in the literature; however, it is often referred to as the witness of objects, or the mental representations of one's own consciousness. Object relations theory explains that an infant's representation of self initially is not different than their representation of the other. For example, as the baby gains life experience, it will learn the difference between mother and not-mother. The capacity to differentiate between objects develops over time.

The majority of this developmental process occurs within the first 36 months of life. Later in life, object relations therapies assist individuals to further differentiate between objects and integrate disparate representations of self. The development of mental representations of self and objects is explained through the process of separation-individuation. The first two months are dominated by reflexive living. There is no differentiation between self and other. Between two and six months babies begin to understand that there is a difference between their self and the other that satisfies their needs. The capacity for separation and individuation primarily occurs between 6 and 24 months. In this developmental phase the child will gain a refined understanding of his or her separateness from both internal and external objects. The final stage of development is called object constancy. In this stage a child develops the capacity to maintain a mental representation of an object for extended periods of times. Early experiences related to separation-individuation create pervasive mental representations that influence the individual's pattern of relating to objects. The development of object relations is largely influenced by the predictability of need satisfaction in the formative years.

Development and Current Status

In the early 1900s, Sigmund Freud (1856–1939), the founding father of psychoanalysis, introduced object relations when writing about ways in which individuals identify with others. Freud primarily focused on sex drives and aggression. The Scottish psychoanalyst Ronald Fairbairn (1889–1964) is considered to be the founder of object relations theory and therapy. Instead of the ego and id, Fairbairn described dynamic (relational) structures. Melanie Klein (1882–1960) furthered the work of object relations theory. Fairbairn's major contributions included novel conceptualizations of the self (ego). Other important figures of object relations theory since the 1940s include Wilfred Bion, Otto Kernberg, Margaret Mahler, and Donald Winnicott. The current status of object relations theory is that while the theory has developed considerably, many of its major tenats have remained consistent. John Bowlby's attachment theory is an example of one such developments. Psychoanalytic psychology in general has evolved over the years to offer more pragmatic psychological explanations that are supported by clinical experience and research.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Klein, Melanie (1882–1960); Object Relations Therapies; Psychoanalysis; Schemas and Maladaptive Schemas

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Object Relations Therapies

Object relations therapies are forms of psychoanalytic psychotherapy in which the basic goal is to modify pathological representations of self and others.

Definitions

- **Attachment theory** is a concept of developmental psychology which emphasizes the types of bonds developed between parent and child and their effect on future psychosocial interactions.
- **Identification** is the merging of mental representations of self and internal objects.
- **Introjection** is a lack of differentiation between an internal object and an external object.
- **Object** is actual person, place, or thing that an individual has an interest in or emotional reaction to. It is also known as an "external object."
- **Object relations theory** is a form of psychoanalytic psychology based on the premise that close relationships are the basic human need. Mental representations of self and others determine an individual's motivations and behaviors and fulfill this basic need.
- **Psychoanalysis** is a form of therapy based on psychoanalytic psychology. In psychoanalysis clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams.
- **Psychoanalytic psychology** is the form of psychology largely developed by the work of Sigmund Freud, which emphasizes the conflicts and compromises between the unconscious and conscious mind.
- **Psychoanalytic psychotherapy** is a psychotherapy approach that assumes dysfunctional behavior is caused by unconscious, internal conflicts and focuses on gaining insight into these conflicts.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Representation** is an individual's mental construction of a person, place, thing, idea, or

fantasy that elicits interest or emotional reactivity. It is also known as an "internal object."

- **Separation-individuation** is the developmental process of learning to differentiate between self, internal objects, and external objects.
- **Transference** is the unconscious redirection of feelings and expectations from one individual in the past to another in the present.
- **Transference enactments** is the acting out of transference with a particular individual in the present.

Description

Object relations therapies are based on the theory of object relations. This theory assumes that that all individuals have a fundamental need to relate. Relationships can be the function of an intimate and honest experiencing of real objects. Alternatively, relationships can be the function of a fictional relationship with self-created internal objects and representations. Object relations therapies assist clients to relate to reality (external objects) through a process of separation and individuation. This alters the influence of mental representations on one's present relational dynamics.

Intervention begins with the development of a therapeutic alliance (bond) between the psychotherapist and the client. The working relationship between psychotherapist and client is important to almost all psychotherapeutic interventions. However, it is of marked importance in object relations therapies. The type of attachment or bond that develops between client and psychotherapist is a real-time example of how mental representations effect client interactions. It is not uncommon that a client will maintain and express completely unreasonable beliefs about his or her psychotherapist. These unwarranted feelings, thoughts, perceptions, and fantasies are primarily based on the mental representations from past experiences. A highly skilled object relations therapist will focus the intervention on the client's distorted experience of reality. The psychotherapist will also manage the interaction through the clear and firm establishment of professional boundaries. The client's distorted experience of the therapist is called transference. A client's transference enactments, and other pervasive mental representations, are key processes in the object relations therapies.

A client seeks therapy to reduce the problems (symptoms) associated with his or her maladaptive relationships. Object relations therapies link the client's presenting problem with the client's internal object dynamics. This means that both the symptoms and the underlying dynamics are focused upon. Object relations therapies have a tendency to explore a client's early development and childhood history to discover the root cause of maladaptive representations. Object relations therapies allow the client to guide the content of psychotherapeutic sessions. Therapists accept and explore client disclosures to identify and alter maladaptive representations and patterns of relating. Object relations therapies utilize nonjudgmental listening. Psychoanalytic therapists are interested in using the content of dreams and fantasies to understand the patterns of the unconscious mind. One goal of object relations therapies is to make a client's unconscious patterns of relating available to his or her conscious mind. This awareness is conceptualized as an entry point to authentic change. Object relations therapies assist clients to witness their pervasive patterns of relating to internal objects. Clients often need assistance from the therapist to gain this insight. The object relations therapeutic technique formulated by Henry Ezriel in the 1950s called "the because clause" can facilitate this awareness. The because clause is a behavioral interpretation a psychotherapist will use to point out a client's internal object dynamics. It is a statement that concisely summarizes the relationship among the client's sense of self, the client's past relationships, and the client's current relationships. Object relations therapies utilize clarification, confrontation, and interpretation in many different forms. Object relations therapies also include forms of couples and family therapies. In object relations couples therapy (ORCT), for example, each individual's representation of the other is directly dealt with and modified in session. The object "couple" is cocreated by the interaction of the two representations of the relationship. ORCT assists each member of the couple to be nurturing and appropriately responsive to the other. It helps couples see each other in terms of

real people instead of in terms of past relationships or internal objects (e.g., fantasies).

Development and Current Status

Sigmund Freud (1856–1939) is considered to be the founding father of psychoanalysis. In the early 1900s, Freud alluded to objects when writing about ways in which individuals identify with others. However, Freud's work focused primarily on instinctual drives and tripartite structural theory (id, ego, and superego). The Scottish psychoanalyst Ronald Fairbairn (1889–1964) is considered to be the founder of object relations theory and therapy. Instead of the ego and id, Fairbairn described dynamic (relational) structures. Melanie Klein (1882–1960) further developed and popularized object relations theory. Other important figures of object relations since the 1940s include Wilfred Bion, Otto Kernberg, Margaret Mahler, and Donald Winnicott.

The current status of object relations is that its theory and practice have continued to develop, while many of its major tenats have remained consistent. John Bowlby's attachment theory is an example of one such developments. Psychoanalytic psychology has evolved over the years to offer more pragmatic psychological explanations that are supported by clinical experience and research. Another example of a therapeutic model informed by empirically supported object relations is Murray Bowen's family systems therapy. Object relations therapies are currently being integrated into novel psychotherapeutic models. For instance, cognitive analytic therapy is the integration of cognitive psychology, cognitive therapy, and object relations therapies.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Neo-Freudian Psychotherapies; Object Relations Theory; Psychoanalysis

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Obsession

Obsession is a persistent and intrusive, thought, image, or impulse that creates considerable distress or discomfort.

Definitions

- **Compulsions** are habitual behaviors, practices, or rituals that are impulsively engaged in to defend against perceived threats, to reduce fears, or otherwise to minimize distress.
- **Delusions** are fixed, false beliefs that persist despite contrary evidence.
- **Obsessive-compulsive disorder** is a mental disorder that is distressful to the individual and is characterized by unreasonable obsessions or compulsions that are inappropriately time consuming or cause marked distress or impairment.
- **Obsessive-compulsive personality disorder** is a personality disorder that is defined by a pervasive pattern of preoccupation with control, perfectionism, and meticulousness at the expense of flexibility, openness, and efficiency.

Description

An obsession is a persistent and recurrent thought, belief, image, urge, or impulse that is experienced as intrusive or unwanted and that causes marked distress or anxiety. As a result, the individual attempts to suppress or ignore the thought, belief, image, urge, or impulse. Or, the individual attempts to neutralize them with other thought or behaviors, such as a compulsion (American Psychiatric Association, 2013). Obsessions are common in obsessive compulsive disorder. While obsessions can also occur in obsessive-compulsive personality disorder, they are less common. Although

obsessive thoughts seem unnatural to those who have them, they are recognized as originating from within the individual. In contrast to delusions, they are not experienced as originating outside the individual.

It should be noted that obsessions differ from reasonable and legitimate worries about everyday concerns. Reasonable concerns include keeping a job, paying bills, studying for exams, and maintaining personal relationships. Such concerns are not obsessions. Even though they may be carried to obsessive lengths at times, these concerns can change with circumstances and are usually controlled by planning, effort, and action. In contrast, obsessions involve problems or concerns that most consider quite different than normal, everyday concerns.

Here are some examples of obsessions. These might involve thoughts about fear of contamination from doorknobs or handshakes. They may involve the inability to decide whether to keep or to discard things, fear of losing things, doubts about whether the stove was left on, perverse sexual thoughts or images, or scary images of violent acts. They could involve urges to harm someone or to steal something, or fear of blurting out obscenities or insults. Some individuals with such persistent thoughts, images, or impulses often may find themselves acting in compulsive ways in futile attempts to relieve their discomfort. Other individuals with such obsessions will attempt to control them, while others will attempt to ignore them.

Len Sperry, MD, PhD

See also: Compulsions; Obsessive-Compulsive Disorder (OCD); Obsessive-Compulsive Personality Disorder

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Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive disorder is a mental disorder characterized by persistent thoughts and compulsive actions, such as cleaning, checking, counting, or hoarding. It is also called OCD.

Definitions

- **Cognitive behavior therapy** is a form of counseling and psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Compulsions** are repetitive behaviors or mental acts that an individual feels compelled to perform in response to an obsession or to rules that must be followed rigidly.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure and response prevention therapy** is the cognitive behavior therapy method that involves exposure to the anxiety that is provoked by the obsession and then preventing the use of compulsive behaviors to reduce the anxiety. This cycle of exposure and response prevention is repeated until the obsessions are less distressing and compulsions are reduced.
- **Obsessions** are unwanted, repeated, persistent thoughts, images, or urges that the individual cannot ignore and that produce some level of anxiety or distress.
- **Obsessive-compulsive personality disorder** is a type of mental disorder called a personality disorder that is characterized by a preoccupation with perfectionism, orderliness, and control.

Description and Diagnosis

Obsessive-compulsive disorder (OCD) is characterized by persistent thoughts and compulsive actions, such as cleaning, checking, counting, or hoarding. OCD is one of a group of disorders called obsessive-compulsive and related disorders in DSM-5. Common to all these disorders is recurrent and persistent thoughts, mental acts, or behaviors that individuals feel compelled to enact. Basically, these disorders are efforts to reduce anxiety by engaging in repeated thoughts and acts that can then be addressed and controlled. While males are more likely to be affected by this disorder in childhood, females are more affected by this disorder in adulthood (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience either obsessions or compulsions or both. In addition, the individual must be making an attempt to ignore the obsessions and/or reduce the anxiety, often by enacting the compulsion. The compulsion, however, is not realistically designed to handle or prevent the distress or the compulsive behaviors are clearly excessive. The diagnosis requires that obsessions and compulsions be time consuming, take up more than an hour per day, and cause significant distress or impairment in social, occupational, or other forms of functioning (American Psychiatric Association, 2013). OCD is sometimes confused with obsessive-compulsive personality disorder. While both disorders have some similarities, they have different criteria for diagnosis.

The cause of this disorder is not well understood. However, genetic, psychological, and social factors are associated with it. It may be genetic in origin and tends to run in families where obsessive-compulsive disorder is diagnosed. It is associated with childhood abuse and neglect. Those with the disorder may have not "fit in" within their family, school, or neighborhood peers. As children, they may have developed repetitive patterns of evasion in response to their parent's expectations. Psychologically, obsessions and compulsions tend to reflect negativity and a need for order and control. Both obsessions and compulsion divert an insecure individual from dealing with the responsibilities of friendship, family, and school or work. By engaging in these more manageable processes, the individual retreats from these responsibilities and is instead preoccupied with dealing with his or her symptoms.

Treatment

The clinical treatment of this disorder usually involves counseling or psychotherapy and medication. Depending on the severity of symptoms, treatment could begin with either medication or psychotherapy. For those who are severely affected and are unable to function in a job, in school, or in social situations because of their symptoms, medication usually is tried first before counseling or psychotherapy. Exposure and ritual prevention therapy is an effective CBT intervention for OCD. It is the treatment of choice. Therapists may also combine exposure and response prevention therapy with other cognitive behavior therapy methods which focus on changing faulty beliefs such as fear of contamination. In severe cases of anxiety associated with obsessions or compulsions, medications can also be added. These include antidepressants like Prozac and Luvox.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Luvox (Fluvoxamine); Obsessive-Compulsive Personality Disorder; Paxil (Paroxetine); Prozac (Fluoxetine)

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Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder is a mental disorder characterized by a pattern of preoccupation with perfectionism, orderliness, and control.

Definitions

- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Obsessive-compulsive disorder** is a mental disorder characterized by unwanted and repeated thoughts and feelings (obsessions), or behaviors that one feel driven to perform (compulsions). It is commonly referred to as OCD.
- **Perfectionism** is the belief that perfection is worth striving for and achieving. In its unhealthy form, it is the belief that it is unacceptable to accept anything less than perfection.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

The obsessive-compulsive personality disorder is a personality disorder characterized by a pervasive pattern of being perfectionistic, controlling, inflexible, judgmental, and overly conscientious. Individuals with this disorder are controlled by rules, schedules, and rigid routines and are seen by others as cold and reserved. They must get every last detail correct and cannot delegate tasks because others cannot be trusted to do things well enough. They also tend to be stingy with money, emotions, and affection. As a result, they avoid intimacy and experience little pleasure from life. While they can be successful in a career, at the same time they can be indecisive and demanding. This disorder is often confused with obsessive-compulsive disorder (OCD). However, compulsions and obsessions do not characterize this personality disorder. Confusing this personality disorder with OCD dates back to one of Freud's most famous cases: the "Rat Man" who presumably would have met DSM-5 criteria for both OCD and obsessive-compulsive personality disorder. Today, relatively few individuals (less than 20%) are diagnosed with both disorders.

The clinical presentation of the obsessive-compulsive personality disorder can be recognized by the following behavior style, interpersonal style, thinking style, and feeling style. The behavior style of this disorder is characterized by perfectionism, and individuals with it are likely to be workaholics. In addition to dependability, these individuals are likely to be stubborn, possessive, indecisive, and procrastinating. Interpersonally, they are overly conscious of social rank and status. As a result, they are likely to be deferential to superiors and autocratic to subordinates and peers. They will insist that others do things their way, without awareness of how others react to their insistence. Yet they are polite and loyal to the organizations to which they belong and ideals they espouse. Their thinking style can be characterized as constricted and rule based. They have difficulty establishing priorities and perspective. Because they focus on details, they tend to lose sight of the larger project. Their indecisiveness and doubts make decision making difficult. In addition to their mental inflexibility, they have a restricted fantasy life. Furthermore, they are continually conflicted between assertiveness and defiance, and pleasing and obedience. Their feeling style is best described as grim and cheerless. While they are more comfortable expressing feelings like anger, frustration, and irritability, they avoid positive and intimate feelings like warmth and tenderness.

The cause of this disorder is not well understood. However, these individuals tend to have a characteristic view of themselves, the world, and others and a basic life strategy. Those with this disorder tend to view themselves as competent, righteous, and responsible. They are likely to view the world as unpredictable and out of control, while viewing others as critical, nonaccepting, and overly demanding. Accordingly, their basic life strategy and pattern is to take control, work hard, strive for perfection, and be right and proper at all times.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of perfectionism, orderliness, and control instead of flexibility, openness, and efficiency. They are overly preoccupied with details, rules, and schedules. Their perfectionism interferes with completing tasks due to their overly strict standards. They are overly devoted to work and productivity to the exclusion of leisure activities and friendships. When it comes to matters of values, morality, or ethics, these individuals are inflexible, scrupulous, and overconscientious. Often, they are unable to discard worn-out or worthless objects that have no sentimental value. They will not delegate tasks to or work with others unless it can be on their terms. Not surprisingly, these individuals are also rigid and stubborn. Finally, they are misers with money, and it is hoarded in the event of future catastrophes (American Psychiatric Association, 2013).

Treatment

The clinical treatment of this disorder usually involves psychotherapy. The goals of treatment include decreasing perfectionism and constricted thinking while increasing the expression of positive and intimate feeling. The expected treatment outcome is a reasonable balance between thoughts and feelings. Treatment strategies useful with this disorder usually involve long-term psychotherapy. Unlike OCD, where medication and psychotherapy can greatly reduce obsessions and compulsions in a relatively short period of time, the obsessive-compulsive personality disorder does not lend itself to short-term treatment. When both disorders are present together, treatment has been shown to be much more challenging than if only OCD is present.

Len Sperry, MD, PhD

See also: Freud's Famous Cases; Obsessive-Compulsive Disorder (OCD); Personality Disorders

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Occupational Information

The general term, "occupational information," applies to data and facts about vocational areas of interest, necessary skills and abilities, educational and training requirements, and potential salary ranges that people can use to help them determine potential future employment.

Definitions

- **Career assessment** is the process of using tools such as surveys, inventories, and questionnaires to gather information about a person's aptitudes, interests, and abilities to assist in determining his or her potential success in a certain career.
- **Career counseling,** also referred to as career coaching or career guidance, involves working with a professional counselor or trained coach, who assists the client in exploring his or her job interests and potential matches.
- **Career development** defines the lifelong process of how individuals manage and navigate along their vocational paths.
- ***Dictionary of Occupational Titles*** is the former print publication put out during the late 1930s to 1990s by the United States Department of Labor that sought to match job seekers to jobs; it was replaced by an online computer system, the Occupational Information Network, or O*NET.

The general term "occupational information" applies to data and facts about vocational areas of interest, necessary skills and abilities, educational and training requirements, and potential salary ranges that people can use to help them determine potential future employment. (Rawpixelimages/Dreamstime.com)

Description

"Occupational information" refers to facts related to specific jobs that can assist students, job seekers, career counselors, business leaders, and other professionals to understand the current world of work and how to navigate it. Additional information may include descriptors of various occupations, needed skill sets, schooling, licensing, or certification requirements, and projected pay rates. People can seek this information out independently or be assisted by a career counselor or advisor. Career advisors and counselors use occupational information to assist clients in planning for future employment. Several sources are available that provide career-related information, including print publications and other literature, the Internet, computer software and systems, career centers, audio and video tapes, and professional career associations.

Impact (Psychological Influence)

Career counselors should assess their client's comfort level with accessing, discussing, writing about, and following through on the occupational information they gather. Deficient reading, writing, or computer skills may inhibit a client's ability to obtain career information. For instance, the Occupational Information Network, or O*NET, requires both computer access and skills. Career advisors must be practical, knowledgeable, and respectful of their client's aptitudes, interests, and preferences. In addition to adequate advising and counseling skills, counselors must practice cultural competence. A person's gender, ethnicity, race, socioeconomic status, education level, and life experiences can all impact his or her occupational pursuits. Proper career assessment, planning, and advising are all key components in delineating the right work-person-environment fit.

Melissa A. Mariani, PhD

See also: Career Assessment; Career Counseling; Career Development; *Dictionary of Occupational Titles* (Book)

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Occupational Stress

Occupational stress is the physical and psychological reaction to stress within the workplace and a worker's job. It is also called job stress.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about imagined danger.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Eating disorder** is a class of mental disorders that are characterized by difficulties with too much, too little, or unhealthy food intake, and may include distorted body image.
- **Job strain** is the perception of little control over one's work while facing high job demands. Such strain increases an individual's risk for psychological and medical conditions.
- **Stress** is a state of emotional or mental tension or strain, which results from very unfavorable or demanding circumstances.
- **Substance abuse** is a pattern abuse in which an individual consumes substance(s) in amounts or with methods that are harmful to himself or herself or others.

Description

Occupational stress is the response to demands and pressures that challenge a worker's ability to cope in a normal way. Occupational stress can negatively impact an individual's health when stress in the workplace exceeds an individual's ability to have control over the situation or the ability to cope in an effective way. For example, an individual (employee) may be assigned a very heavy workload and as a result the individual's heart rate may increase and he or she may experience feelings of anxiety. Some other symptoms individuals experience as a result of occupation stress include excessive tiredness, depression, headaches, difficulty sleeping, and stomach problems. Some individuals who experience occupation stress may develop an eating disorder and substance abuse.

Job strain is similar to but different from job stress. While job stress involves job demands at work that are experienced as stressful, job strain involves the negative medical and psychological toll that job stress takes when job demands are high and workers have little decision-making power. Demand and decisional control are two of the main risk factors for various medical conditions such as high blood pressure and heart attacks as well as depression. The key factor in determining negative health consequences is the worker's perceived capacity to control job demands.

Occupational stress is classified in DSM-5 under the section "Other Problem Related to Employment." This category is used when an individual has an occupational problem and is the focal point of attention or has an effect on the individual's prognosis and treatment. Some specific examples that can be classified under this section include threat of job loss, stressful work schedule, sexual harassment on the job, and a hostile work environment.

There can be several causes of occupational stress. Some of them include working long hours, a hostile work environment, increased workloads, and lack of job security within a company. Some other potential causes include working conditions, economic factors, bullying, and workplace conflict.

Treatment

One form of treatment for occupational stress is for an individual to participate in an employee assistance program (EAP). These programs offer ways to assist individuals in stress reduction and offer professional advice. Typically, the EAP will offer suggestions such as reducing work, implementing a program change, and expressing unpleasant feelings about his or her work stress. Some programs may offer individuals vacation time or a leave of absence.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Anxiety; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Eating Disorders; Stress; Substance Abuse Treatment

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On Becoming a Person (Book)

On Becoming a Person is a book published in 1961 by Carl Rogers, who was the founder of person-centered therapy.

Description

In 1961 Carl R. Rogers (1902–1987) was a professor at the University of Wisconsin, where he completed and published *On Becoming a Person*. This book is a collection of essays, papers, and insights based on his 30-year-long career. Rogers ended up writing a total of 16 books and many articles over the course of his career.

Rogers was an influential psychologist who believed that the aim of life is to be a happy and healthy functioning human being. He also believed that people want to be able to live up to their potential by living in the moment. Rogers was an existentialist. For him this meant that each person's concept of himself or herself should grow out of his or her own experience and that every person should trust his or her own judgment above all else. This kind of freedom of choice is the foundation of a sense of responsibility for someone's own behavior. Such a responsible person will be free to adapt his or her behavior to circumstances without feeling the burden of conforming to false external norms. Awareness of the individual's own needs will lead him or her to seek helpful solutions that balance his or her own conflicted feelings and desires.

In this book, Rogers describes a happy and healthy life as an experience of the full range of emotions and events. This includes joy and pain, love and heartbreak, fear and courage. It involves stretching and growing to meet your own potential. Rogers called it the courage to be, which was living life to the fullest or seizing the day. In this book he wrote about how people are constantly changing and evolving to be their best and achieve happiness.

In therapy Rogers believed that the client should lead treatment. Rogers's approach was *nondirective*, a clinical approach to treatment where the therapist allows the client to set the pace and content of therapeutic counseling sessions. In his essays he documents his belief that therapists should be safe and understanding persons in the life of their clients. He claims that the very presence of such a therapist in another's life is helpful. He also observed that the presenting issue, emotion or problem the client first mentions, is usually a symptom of an underlying struggle of the person to discover who he or she is, or what he or she needs. Therefore, each client is inevitably looking for how to become a better person. It is the job of the therapist to guide the client by mirroring what has been said and gently questioning to open the dialogue further.

Impact (Psychological Influence)

The ideas that appear in *On Becoming a Person* have become a part of mainstream psychology, and therefore, the basic concepts of his work have been fully integrated into the field. Rogers's work has given rise to the creation of organizations, institutes, and journals dedicated to person-centered therapy. Recent research has validated the importance of several of Rogers's core ideas for effective psychotherapy. Chief among the effective elements of psychotherapy are empathy and unconditional and positive regard from the therapist for the client.

A study done in 2002 found that Rogers was the second-most prominent psychological clinician after Sigmund Freud. His client-centered approach to therapy revolutionized psychology and the world of counseling in general. His success leading conflict resolution with groups in both South Africa and Northern Ireland led him to be nominated for the Nobel Peace Prize.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Nondirective Therapies; Person-Centered Therapy; Rogers, Carl (1902–1987)

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One Flew over the Cuckoo's Nest (Book and Movie)

One Flew over the Cuckoo's Nest was a best-selling book by Ken Kesey (1935–2001) published in 1962 and was later made into a movie in 1975. The movie was nominated for nine Oscars and managed to bring home five Academy Awards, including best picture.

Description

The impact of both the book and the movie was believed to have caused lasting harm to the image of ECT

One Flew over the Cuckoo's Nest was a best-selling book by Ken Kesey published in 1962 and later made into a movie in 1975. Its depictions of the inhumane treatment of the mentally ill led to a strong backlash against electroconvulsive therapy (ECT). (United Artists/Photofest)

(electroconvulsive therapy), ultimately creating a backlash against the entire psychiatric profession. Even decades later, a small resurgence of ECT in the early 1990s had to battle public sentiment that this form of therapy is potentially dangerous and used too often. Unfortunately, it also had the unintended effect of individuals with a mental illness being viewed in a harsher and more negative light. However, the book and movie offer tremendous insights regarding stereotypes of those with mental illness.

The story follows a man named Randle Patrick McMurphy, who is played brilliantly by Jack Nicholson in the film version. McMurphy is a criminal convicted of gambling, who feigns insanity to avoid hard labor in prison. He arrives at the hospital full of bravado and fun-loving swagger. However, in the end, he is unable to avoid ECT, much like many of the patients in the facility. The movie chronicles his interactions with other patients as they face their arch nemesis, Nurse Ratched, a woman who rules the facility with an iron fist. The highlight is the interactions between McMurphy and Nurse Ratched as they engage in a power struggle over his life, which ultimately leads to the climax of the film.

Impact (Psychological Influence)

Even more than 50 years after its initial release, the book, as well as the film, continues to be considered classics. Kesey's novel had a considerable and lasting impact on the field of psychiatry like few other books or movies have done.

Mindy Parsons, PhD

See also: Electroconvulsive Therapy (ECT)

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Opioid Use Disorder

Opioid use disorder is a mental disorder characterized by a pattern of opioid use, which leads to significant problems for the user.

Definitions

- **Addiction** is a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Motivational interviewing** is a counseling strategy for helping individuals to discover and resolve their ambivalence to change. It is also referred to as MI.
- **Opiates** are a class of naturally derived drugs from opium.
- **Opioids** are synthetically derived drugs and are used as opiate substitutes. The term "opioid" is sometimes used to refer to both opiates and opioids and are known as narcotics.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions and compulsions based on a plan called the Twelve Steps.

Description and Diagnosis

Opioid use disorder is one of the substance-related and addictive disorders. It is characterized by a problematic pattern of opioid use, which leads to significant distress or disrupted daily functioning. Opiates are appealing because they are effective pain killers. In addition to making physical pain manageable, opiates numb psychological pain. Opioid addiction results from prescription drug use or the use of cocaine or heroin. Prescription drugs include Oxycontin, Percocet,

Percodan, and Vicodin. These drugs are prescribed to relieve moderate to severe pain. They are very effective, and a vast majority of those prescribed these drugs do not become addicted. Yet illicit (illegal) use of these prescription drugs is increasing and problematic.

The addiction rate for all opiates, including heroin, is approximately 1% of the adult population of the United States (American Psychiatric Association, 2013). Recently, greater use of prescribed opioids appears to be increasing the addiction rate for opiates. The ratio of heroin users to illicit prescription drug users is 1:6, suggesting that illicit prescription drug use is quite common (SAMHSA, 2006). There are similarities and differences between illicit prescription drug use and heroin use. Heroin is a highly addictive drug, and it is estimated that 23% of those who use heroin, even once, will become addicted to it (American Psychiatric Association, 2013). With heroin there is an initial rush that has been described as so intense that those who experience it spend a lifetime attempting to feel it again. This powerful, initial rush is followed by a euphoric dreamlike state of drowsiness. There is also an increase in self-esteem and decreased concern with problems and concerns. Except for the powerful initial rush, prescription drug use provides many of the same feelings and experience. As a result these drugs have a high potential for addiction. However, chronic use of these prescription drugs often leads to loss of energy, tolerance, physical addiction, and lack of ambition and drive.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a problematic pattern of opioid use, leading to significant impairment or distress. This must occur within a 12-month period. This includes taking the substance in larger amounts or for longer than intended. It means wanting to cut down or stop using the substance but not achieving this goal. It involves spending much time getting, using, or recovering from use of the substance. This disorder also involves cravings and urges to use the substance, and continuing to use, even when it causes problems in relationships. It involves failure to meet obligations at home, work, or school because of substance use. It also means reducing or stopping important social, work, or recreational activities because of substance use. This disorder involves repeated substance use even when it is physically dangerous. Despite knowing the risks of the physical and psychological problems that are caused or made worse by the substance, use of it continues. It means develop tolerance (needing more of it to get the desired effect). Finally, it involves withdrawal symptoms, which can be relieved by taking more of the substance (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, social and psychological factors may be involved. For instance, heroin users tend to come from families where alcohol or drug use is common. Or, it might be that a family member has a mental disorder like bipolar disorder or antisocial personality disorder. Heroin users may have had health problems or behavioral problems in childhood. Being impulsive and thrill seeking may also be contributing factors. Opioid abuse often begins with a legitimately prescribed medication like Vicodin. The user experiences a desirable psychological feeling that leads to seek more of the drug for this need. Adolescent abuse of this drug often begins by experimenting with unused portion of a prescription found in the home.

Treatment

Treatment of this disorder involves various stages. It begins with physical withdrawal from the opioid. Usually, this takes place in a hospital or treatment center. Over a three- to five-day period of detoxification the drug is withdrawn. Depression is common for several days or weeks after the acute withdrawal. Medications may be given to help individuals cope with withdrawal symptoms. Next, individuals are helped to deal with the problems their addiction has caused and learn to live soberly. Motivational interviewing is useful in identifying reasons to stop using and to increase motivation and readiness for treatment. As treatment begins, these reasons may be as simple as not wanting to experience the negative effects of the drug. As treatment progresses, individuals will usually identify important life goals they would like to achieve. Once these broader goals are identified, they are encouraged to develop short-term and intermediate goals. Then, cognitive behavior therapy can be used to identify the

beliefs, behaviors, and situations that trigger use and cravings. From these they can develop a plan to reduce the likelihood of relapse. Because opioid addiction is considered a chronic condition, long-term treatment to maintain sobriety and prevent relapse is necessary. This often includes continuing in therapy and/or a Twelve-Step Program and possibly methadone.

Len Sperry, MD, PhD

See also: Addiction; Addictive Personality; Cognitive Behavior Therapy; Methadone; Motivational Interviewing; Twelve-Step Program

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Opioid Withdrawal Disorder

Opioid withdrawal disorder is a mental disorder characterized by withdrawal symptoms after an individual reduces or completely abstains from heavy and prolonged opioid use.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward and relief with substance use or other compulsive behaviors.
- **Alcoholics Anonymous** is a nonprofit fellowship of men and women for whom alcohol has become a significant problem. It was founded by Bill Wilson and Dr. Bob Smith in 1935 to help people struggling with addiction.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Narcotics Anonymous** is a nonprofit fellowship of men and women for whom drugs have become a significant problem. It uses the Twelve-Step model and it's the second-largest Twelve-Step Program, next to Alcoholics Anonymous.
- **Opioid antagonist** is a receptor antagonist that acts on opioid receptors preventing the body from responding to opioids.
- **Opioids** are a class of narcotic drugs used to treat moderate to severe pain. The classes include both natural and synthetic substances.
- **Sponsor** is another recovering addict who offers guidance and support in a one-on-one relationship.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders characterized by the continued use of addictive substances or behaviors despite significant impairment or distress.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions and compulsions based on a plan called the Twelve Steps.

Description and Diagnosis

Opioid withdrawal disorder is one of the DSM-5 substance-related and addictive disorders. It is characterized by withdrawal symptoms after the discontinuation or reduction of heavy and prolonged opioid use. Opioids are a type of narcotic pain medication and are prescribed to individuals who have moderate to severe pain. Some examples of opioids include morphine, heroin, codeine, oxycodone, and hydrocodone. The withdrawal symptoms can also be precipitated by the use of an opioid antagonist (e.g., naltrexone), which help prevent the body from responding to opioids. Opioids are often misused (taken in larger amounts)

and over a longer period than intended, and lead to addiction.

Anxiety, restlessness, insomnia, fever, vomiting, negative mood, and muscle aches are some symptoms of opioid withdrawal. An individual's quality of life and the ability to function normally may be severely impacted if he or she is experiencing symptoms of opioid withdrawal. For example, symptoms may be so uncomfortable that an individual may have to miss work, school, social events, or other important engagements. Typically, symptoms of withdrawal from opioids usually begin immediately after discontinuation or reduction and can last anywhere from one week to months. The length of time withdrawal symptoms persist depends on the opioid being used and the amount and duration of use. Withdrawal symptoms can continue even if an individual is in a substance abuse treatment facility, using opioid antagonist therapy, or in a medical management setting.

The occurrence of this disorder is more common in males. The onset of problems related to opioid use usually occurs during adolescence, although it may begin during any period of one's life. Opioid withdrawal occurred in 60% of individuals who had used heroin at least once in the previous 12 months (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they have had a reduction in or discontinuation of opioid use that has been prolonged and heavy or has been administered an opioid antagonist. In order to make this diagnosis, individuals must have three or more of the following symptoms. They include nausea or vomiting, diarrhea, muscle aches, dysphoric mood, tearing of the eyes or runny nose, dilated pupils, sweating, yawning, fever, or insomnia. The symptoms must cause significant distress and impairment in occupational, social, or other areas of functioning that are important, and may not be attributed to another medical condition or better explained by another mental disorder (American Psychiatric Association, 2013).

The cause of opioid withdrawal disorder is believed to be the misuse of opioids. The misuse may occur over a short period or more commonly over the course of the individual's lifetime. Individuals often rely on opioids to avoid symptoms of withdrawal. However, over time an individual will need to increase the amount of the drug in order to produce the same effect and not experience symptoms of withdrawal. When an individual stops taking opioids, the body needs time to recover, and the result is withdrawal symptoms.

Treatment

Treatment for this disorder typically involves medications and supportive care from family, friends, and medical providers. Medications are used to reduce withdrawal symptoms. Suboxone is a medication prescribed for relieving symptoms of opioid withdrawal. It can shorten the length of detoxification from opioids. Support groups, such as Narcotics Anonymous and Alcoholics Anonymous, can be very helpful for individuals addicted to opioids. Benefits for recovery are greatest for individuals who participate in a long-term substance abuse treatment program, work a Twelve-Step Program with a sponsor, take part in aftercare sessions, and participate in individual or group counseling.

Elizabeth Smith Kelsey, PhD, and
Len Sperry, MD, PhD

See also: Addiction; Alcoholics Anonymous (AA); *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Substance Abuse Treatment; Twelve-Step Programs

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Oppositional Defiant Disorder (ODD)

Oppositional defiant disorder (ODD) occurs when a child or teen has a persistent pattern of tantrums, arguing, and angry or disruptive behavior toward authority figures.

Definitions

- **Defiant** is an adjective used to describe resistance or objection.
- **Oppositional** is the act of displaying anger or hostility toward a person or group of people.

Description

It may be difficult at times to recognize the difference between a strong-willed or emotional child and one with ODD. It's normal for a child to exhibit oppositional behavior at certain stages of his or her development. But there is a range between the usual independence-seeking behavior of children and that of ODD.

Signs of ODD generally begin before a child is eight years old. Sometimes ODD may develop later but almost always before the early teen years. When ODD behaviors develop, the signs tend to begin gradually and then worsen over months or years. A child may be displaying signs of ODD instead of normal moodiness if the behaviors are persistent for more than six months and disrupt the home or school life.

Causes and Symptoms

There's no known clear cause of ODD. Most scientists and researchers believe that ODD occurs due to inherited and environmental factors. These can include a child's natural disposition and lack of or abusive adult supervision. Physical limitations or developmental delays in a child's ability to process thoughts and feelings could also be a reason that ODD occurs in some children. There has also been research into brain chemicals and differences in serotonin levels.

A child or teen who is diagnosed with ODD exhibits symptoms such as a negative attitude, disobedience, and hostility directed toward authority figures. These behaviors could cause a child to regularly and consistently have temper tantrums or be argumentative with adults in various situations.

In addition to these symptoms, children often refuse to comply with adult requests or rules and annoy other people on purpose. Some children with ODD blame others for mistakes or misbehavior and can be touchy or annoyed when they are accused of wrongdoing. Additional symptoms include feelings of anger and resentment, spite and aggression toward peers. This can cause difficulty performing academically and keeping social friendships, resulting in low self-esteem.

Diagnosis and Prognosis

To be diagnosed with ODD, a child must meet specific criteria. First a child requires a specific pattern of behavior that needs to have lasted at least half a year. During this time period, the child must demonstrate arguments with adults, temper tantrums, disobeying rules, annoying others on purpose, and blaming others. Also important to observe in a child with ODD are the emotional states of anger, resentment, being bothered by others, and often seeking revenge. Finally, it is important that these behaviors must happen more often and more intensively than with other children of the same age. The behaviors also need to cause problems in various places where the child spends time, especially school and home.

It can be difficult for doctors and mental health professionals to sort out and exclude this disorder from others with overlapping symptoms. For example, attention-deficit hyperactivity disorder (ADHD) and disruptive mood dysregulation disorder are sometimes hard to distinguish from ODD. Many times these disorders are provided as multiple diagnoses for one child.

Treatment

Treating ODD generally involves several types of therapy and training for the child and family. Treatment often lasts several months or longer. If a child has coexisting conditions, particularly ADHD, medications may help improve symptoms. However, medications alone generally aren't used for ODD unless another disorder coexists.

There are five cornerstones of treatments for ODD, which usually include individual and family therapy, problem solving, social skills, and parent training. Individual counseling for the child may help him or her to learn better ways of self-expression. Family counseling may help improve communication and relationships, and help members of the family learn how to work together. This can include parent–child interaction therapy (PCIT) which is effective for treating ODD. In PCIT, therapists coach parents while they

interact with their children. This helps parents learn effective parenting techniques and has proven to improve the family relationships and decrease the child's problem behaviors.

Problem solving and social skills training have benefits for children with ODD. During training children learn to identify and alter problematic behaviors that lead to bad decisions and poor relationships with their peers. Finally, parent training gives family members a chance to learn how to encourage positive behaviors while eliminating problem behaviors. Parents learn specific strategies like giving effective timeouts, remaining neutral in times of struggle, and taking care of themselves.

Changes to the environment can help children with ODD and their families. These kinds of changes include having more structure in daily life. One example of this is to create a schedule for the family that includes specific meals that will be eaten at home together. This could also mean that they plan to engage in specific activities where one or both parents can follow the child's lead. With a combination of effective therapy, sometimes with the addition of medication, skills training, and parent involvement, the outcomes for children with ODD can be positive.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Conduct Disorder

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Our Inner Conflicts: A Constructive Theory of Neuroses (Book)

Our Inner Conflicts: A Constructive Theory of Neuroses is a book written by Karen Horney about how childhood experiences shape adult neuroses. It was first published in 1945.

Definitions

- **Movement** describes an individual's style of interactions with others, which may be toward, against, or away.
- **Neurosis** is an outdated but still used psychoanalytic term for unconscious anxiety expressed in physical or psychological symptoms.
- **Psychoanalysis** is a theory of human behavior and a form of therapy based on psychoanalytic theory. In psychoanalysis clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams. It was initially developed by Sigmund Freud.
- **Psychoanalyst** is a practitioner of psychoanalysis.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.

Description

Karen Horney (pronounced "Horn-eye"), MD, PhD (1885–1952), was a psychoanalyst who made some significant changes to traditional psychoanalytic theory in her work. She disagreed with the idea that individuals are only motivated by their unconscious drives. She also highlighted the role of gender and unrealistic cultural expectations, and is considered to be the first female psychoanalyst. Like other psychoanalysts, she believed that the past was important in explaining the causes of problems. However, Horney also focused on dealing with problems in the present and thought people were capable of solving many issues on their own.

Our Inner Conflicts is a book with broad appeal. The basic theme of this text is that symptoms are caused by unresolved psychological conflicts within a person that developed during childhood. Horney viewed these

conflicts as inconsistencies. An example is a child who wants acceptance from his or her teacher but acts out in class and is always in trouble. He or she may unconsciously doubt his or her ability to be liked or may have feelings of anger toward authority figures. Horney believed that this kind of conflict (called neurosis) occurred when individuals had competing ideas about what they wanted. She viewed neuroses as the result of childhood experiences such as neglect, smothering, instability, and abuse.

According to Horney, these inner conflicts lead people to develop three basic types of "movement" in relation to others: toward, against, and away. One's early childhood experiences lead to the type of movement they develop. Those who experience isolation or fear as children may try to please others in order to feel safe and in control. They learn to move *toward* others. As adults, they can become passive, dependent, and fearful. While they seek to be around people, they are primarily concerned with being taken care of and not with the specific people themselves. Children who experience hostile or abusive family environments learn to see the world and other people as threatening and untrustworthy. They move *against* others with the goal of staying in control. This may be accomplished through open hostility or with subtle charm. In any case, they view relationships as win-or-lose contests. Finally, children who experience too much closeness learn to withdraw into themselves. They move *away from* others in an attempt to achieve separation. These people often feel superior to others and will do anything to avoid being forced to socialize and leave their inner world.

Horney believed that healthy children could display all of these movements at different times. It was only when people are unable to engage in different types of movement and their behaviors become compulsive that problems arise. Horney coined the term "tendency to dependency" to describe the consequence of these neuroses. She believed that people actually became more dependent on others because they are no longer aware of themselves and need validation. According to Horney, modern society encourages this process because of its emphasis on success and competition. In the end, individuals become healthy by integrating the different parts of themselves and achieving wholeness. This leads to meaningful and satisfying self-expression in relationships with others.

George Stoupas, MS, and
Len Sperry, MD, PhD

See also: Neurosis; Psychoanalysis; Psychoanalytic Theory

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Pain and Suffering

Pain is the unpleasant sensory and emotional experience, whereas suffering is the meaning one attributes (gives) to that experience. Suffering is the subjective experience of pain.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Biofeedback** is a technique used to help control one's body functions and can enable individuals to focus on making changes, such as relaxing certain muscles to reduce pain.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life. It is not characterized as a disorder unless it significantly affects one's daily functioning.
- **Fatigue** is a feeling of tiredness that can have mental or physical causes.
- **Pain behaviors** are things that an individual says or does in response to pain.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also referred to as therapeutic counseling.
- **Relaxation therapy** is any process, method, or activity that helps an individual to relax in order to attain a state of calmness.

Description

"Pain" and "suffering" are two terms that are often used interchangeably. While they share some similarities, they also are quite different. Pain is an unpleasant sensation and emotional experience of actual or potential bodily damage. Pain can range from mild discomfort to severe agony. Some pain behaviors include moaning, asking for help, taking medications, and seeking medical treatment. Often, pain keeps an individual focused on distress for the purpose of relieving it. It motivates behavior that will help repair, improve, and heal. For example, a blister on the foot will usually motivate an individual to take his or her shoe off and put a bandage on it.

In contrast, suffering reflects the meaning individuals give to their pain. In a sense it is the story they tell themselves and others about their pain. In a very real sense, suffering is the subjective experience of pain. Effective health professionals are usually good at inquiring into an individual's suffering. It may be difficult to resolve pain issues because suffering cannot be found by examining an individual's body alone. Suffering exists only in the mind. It is essential for a physician to listen to an individual's narrative to find out if suffering is occurring. Those who are suffering need help, sometimes even more so than the pain they are experiencing.

Pain behaviors are real and are influenced by environmental consequences. Pain behaviors are triggered either by suffering or by events in the environment that influence an individual. Pain can significantly interfere with the general function of an individual and his or her quality of life. It can limit an individual's ability to concentrate, enjoy social interactions, and participate in physical activities. One common reason individuals seek medical treatment from a physician is for the physical pain and suffering they are experiencing. Pain is a major symptom of several medical conditions. Pain can be classified as either acute or chronic. Acute pain is usually sharp in intensity and begins suddenly. It may be mild and last for just a moment or may persist for months. When the underlying cause of the pain is treated, the pain goes away. Some examples of acute pain include dental problems, broken bones, and cuts and bruises. Chronic pain is pain that persists despite treatment and healing of a medical condition. Chronic pain can last for months or years. Some physical effects of chronic pain include limited mobility, lack of energy, and muscle tension. Emotional effects of chronic pain may include depression, anxiety, frustration, and anger. Some examples of chronic pain include back headaches, back pain, and nerve pain.

The cause of physical pain is from a disease, injury, or something that hurts the body. The cause of physical suffering is the failure to act successfully on the motivation of pain. Continually thinking about pain and how unlucky or unfair it is usually serves to worsen suffering. Suffering usually takes the form of guilt, anxiety, shame, resentment, blame, or anger. Often, an individual who is suffering may expect others to relieve his or her pain, rather than taking action himself or herself.

Treatment

Treatment for pain differs from treatment for suffering. An individual with physical pain usually consults with his or her family physician for a complete assessment and treatment plan. Medications may be prescribed for moderate to severe pain. Biofeedback and relaxation therapy may be effective in reducing physical pain by teaching the individual how to release tension and anxiety that often make painful conditions more intense. Psychotherapy is the usual treatment for suffering. Cognitive behavior therapy is effective in helping individuals focus on changing the meaning individuals have attributed to their pain.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Anxiety; Biofeedback; Cognitive Behavioral Therapy; Depression; Fatigue; Psychotherapy; Relaxation Therapy

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Palliative Care

Palliative care is treatment for symptoms, discomfort, stress, and pain in individuals with medical conditions for which there is no cure.

Definitions

- **Disease** is an objective medical condition that can be acute or chronic.
- **Hospice care** is a form of multidisciplinary treatment that aims to enhance the quality of life and reduce pain of an individual who has been determined to die within six months.
- **Illness** is an individual's subjective experience to a disease.
- **Opioids** are a group of drugs that reduce pain. They are highly addictive and include both prescription drugs like Percocet and illegal drugs like heroin.
- **Psychotropic** medications are prescribed drugs that affect thinking, feeling, and behavior. They include antipsychotic, antianxiety, antidepressant, and antimanic medications.

Description

Palliative care is a kind of medical care used to improve the quality of life among individuals. Usually, it is provided to individuals who are experiencing significant symptoms from medical conditions for which there is no cure. It aims to provide relief from painful symptoms. Some common diseases that are treated in palliative care include congestive heart failure, Alzheimer's, AIDS, kidney failure, various forms of cancer, and renal disease. Symptoms often treated with this type of care include pain, depression, physical discomfort, medication side effects, fatigue, nausea, problems with sleep, and constipation.

Additional goals of palliative care include reducing distressing symptoms, increasing an individual's support system, linking an individual to needed resources, providing spiritual and emotional support, and assistance with rehabilitating an individual back to his or her previous functioning. A palliative care team can consist of a medical doctor, nurse, religious clergy, dietician, occupational therapist, social worker, counselor, and many other health-care workers. Palliative interventions can include pain medication management such as opioids or psychotropic medications, talk therapy, linkage to resources, assistance with daily functions such as bathing, and many more services. Palliative care can also be used with hospice care patients who are near the end of their lives, but palliative care can be used during any stage of an illness.

Palliative care was originally developed in the hospice care setting but is now being used to relieve symptoms and discomfort of individuals among various stages of an illness. Hospice care was originally created out of a hospice care facility in 1967, called St. Christopher's Hospice in the United Kingdom. The founder, Cicely Saunder (1918–2005), is known as the main proponent in the hospice movement.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Bereavement; Bereavement Counseling; Opioid Use Disorder

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Panic Attack

A panic attack is an episode of a sudden, intense, and debilitating sense of fear that is short lived.

Definitions

- **Agoraphobia** is extreme fear of public spaces, crowds, or areas from which escape may be difficult and results in intense anxiety.
- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Fear** is an emotional response to a known danger.
- **Panic** is an intense sense of fear.
- **Panic disorder** is a mental disorder characterized by severe panic attacks that occur frequently and produce significant distress and/or impaired functioning.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

A panic attack is a sudden sense of extreme fear that is associated with both mental and physical symptoms. The experience of these attacks may contain numerous physical symptoms that may include heart

palpitations (pounding heart), sweaty palms, narrowing of vision, shortness of breath, and tingling in the fingers. Because of these symptoms, individuals may conclude that they are having a heart attack. They may feel detached from their experience (called derealization). In addition, they may sense that that are dying or going crazy. It should be noted that a panic attack is just one of the criteria necessary for the diagnosis of panic disorder.

The physical experience of panic (e.g., tightness in chest, shortness of breath, trembling) is associated with the human fear response. In normal functioning, a fearful stimulus registers and the body responds with the fight or flight response. The response is considered to be an evolutionary development that allows us to fight threats or escape from them (flight). The body does this by shutting down nonessential functions such as digestion and directs physiological resources to more necessary systems such as muscles. It is this redirection of resources in preparation for fighting or fleeing that results in the physical symptoms associated with panic attack. Individuals who suffer from recurrent panic attack are thought to have an overly sensitive fear response and therefore experience the fight or flight response as a result of mental activity as opposed to a truly dangerous stimulus.

The prevalence of panic attacks is relatively common in the United Sates, affecting approximately 11% of the population. Panic attacks affect more women than men. Typically, no treatment is needed for isolated episodes of panic. However, treatment is warranted for those who experience panic attacks as part of panic disorder.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Antianxiety Medications; Antidepressant Medications; Anxiety; Panic Disorder; Psychotherapy

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Panic Disorder

Panic disorder is a mental disorder characterized by severe panic attacks that occur frequently and produce significant distress and/or impaired functioning.

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- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Fear** is an emotional response to a known danger.
- **Panic** is an intense sense of fear.
- **Panic attack** is an episode of a sudden, intense, and debilitating fear that is short lived.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

- **Psychotropic medications** are prescribed drugs that affect thinking, feeling, and behavior. They include antipsychotic, antianxiety, antidepressant, and antimanic drugs.

Description and Diagnosis

Individuals with panic disorder experience recurring panic attacks that cause significant levels of distress. It is one of the anxiety disorders in the DSM-5. These attacks can include numerous physical symptoms such as heart palpitations (pounding heart), sweaty palms, narrowing of vision, shortness of breath, trembling, and tingling in the fingers. Because of these symptoms, those with this disorder may fear that they are having a heart attack. They may also sense that they are detached from their experience (called derealization). In addition, they may have a sense that that are dying or going crazy. An important component of panic attack is that there is usually no obvious, plausible cause of their acute fear. For example, an individual experiencing a panic attack may think he or she will choke while having no physical obstruction of his or her airway. The duration of a panic attack is usually only a few minutes but in extreme cases may last an hour. Not only do individuals experience distress during the attacks, but they may also experience distress between attacks. This is called anticipatory anxiety as they anticipate experiencing another episode at any time. The experience of this disorder may be so severe that it is completely debilitating and may result in varying levels of disability.

Panic disorder is one of the less common anxiety disorder. Approximately 2.5% of the population is diagnosed with panic disorder (American Psychiatric Association, 2013). Also unlike the other anxiety disorders, it seems that panic disorder occurs in similar proportions to both sexes. This disorder may be accompanied by other anxiety symptoms or disorders, particularly agoraphobia. However, agoraphobia that occurs without panic attacks is a distinctly different presentation than agoraphobia that follows the onset of panic disorders. Those with only agoraphobia tend to fear public spaces because the environment is somehow dangerous to them. Individuals who develop agoraphobia following panic disorder often fear public spaces because they fear suffering a panic attack without a secure environment to readily escape to. Some also fear the embarrassment of being observed by others as having a panic attack.

To be diagnosed with this disorder, individuals must meet a number of specific criteria. They must experience recurring panic attacks, including various physical symptoms. They must also experience significant concern about future attacks or have changed their behavior so as to actively avoid situations that may result in future panic attacks (e.g., avoiding public spaces). In addition, this diagnosis can only be made when other mental disorders or physiological causes have been ruled out (eliminated) (American Psychiatric Association, 2013).

The precise cause of this disorder is not known and may vary from individual to individual. However, certain aspects of this disorder are known. The physical experience of panic (e.g., tightness in chest, shortness of breath, trembling) is associated with the human fear response. In normal functioning, a fearful stimulus is registered and the body responds with the fight or flight response. The response is thought to be an evolutionary response that allows one to fight threats or escape from them (flight). The body does this by shutting down nonessential functions such as digestion while directing the majority of resources to more useful systems such as muscles. It is this redirection of resources in preparation for fighting or fleeing that causes the majority of physical symptoms associated with panic attack. Individuals who suffer from panic attack are thought to have an overly sensitive fear response and therefore experience the fight or flight as a result of mental activity as opposed to a truly dangerous stimulus. Also, this disorder occurs more frequently in individuals who have other mental conditions, have been abused, have a family history of anxiety or panic, or have recently experienced extreme stress.

Treatment

Treatment for this disorder may include psychotropic medications, psychotherapy, or both. Both antidepressant medication and antianxiety medication may be utilized but serve fundamentally different purposes. Antidepressants such as Lexapro are typically

prescribed to reduce the frequency and severity of panic attacks. Antianxiety medication such as Ativan and Klonopin are prescribed to reduce the acute symptoms of an anxiety attack. These medications may be used together where the antidepressant reduces the frequency of the panic attacks and the antianxiety drug is taken at the onset of a panic attack to reduce the symptoms. Although the medications are useful, they are not the preferred long-term solutions. This is because antidepressants are often accompanied by unwanted side effects and because individuals often build a tolerance to the antianxiety medications and can be addictive.

Psychotherapy is the treatment of choice for this disorder. The most commonly utilized and most effective therapy for panic disorder is cognitive behavior therapy. The aim of this therapy is to help the individual understand his or her faulty beliefs, especially those concerning his or her physical symptoms. Also, individuals are taught relaxation and coping techniques to help them experience their physical symptoms in a more calm state. Often, both medications and cognitive behavior therapy are used in conjunction. The medications reduce frequency and intensity of attacks in the short term while the individual's maladaptive beliefs and behaviors are altered in therapy. This disorder is not likely to resolve without intervention. Self-help books and workbooks can be used along or in conjunction with psychotherapy.

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See also: Agoraphobia; Antianxiety Medication; Antidepressant Medications; Anxiety; Ativan; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Fear; Klonopin (Clonazepam); Lexapro (Escitalopram); Panic Attack; Psychotherapy

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Paradoxical Intention

Paradoxical intention is a psychotherapy technique developed by psychiatrist Viktor Frankl, where the client is instructed to deliberately focus on a negative state, habit, or thought in order to identify it and alleviate its effects.

Definition

- **Logotherapy** is a directive type of therapy developed by Frankl aimed at helping clients who are lacking purpose or exhibiting problem behaviors find meaning; it literally means "therapy through meaning."

Description

Paradoxical intention is a therapeutic method used by practitioners wherein they instruct clients to intentionally exacerbate their aversive emotional states in order to alleviate negative symptomatology. The purpose is to have the client recognize the irrationality of his or her reaction and relinquish control over it, thereby relieving oneself of unpleasantness. Austrian psychiatrist, Viktor Frankl, developed the technique while he was imprisoned in the Nazi concentration camps during World War II. He wrote about this and other methods at the end of his book *Man's Search for Meaning*, where he discussed how humans are able to overcome dire circumstances. Frankl refers to his therapeutic approach as logotherapy, which helps people find meaning and direction in their lives.

Therapists use paradoxical intention to counteract a variety of conditions. It is considered a cognitive behavioral strategy in that it focuses the client on both the intellectual (mental/cognitive) and the behavioral (feelings/actions) aspects of the problem. In practice, the client is directed to turn on or engage in the negative symptom and even to intensify it. This process allows the client to

realize he or she is in control of the worry, fear, or discomfort he or she is experiencing. Engaging in an anxious state does not help the client solve the problem, and therefore, it serves no purpose. By letting go of this, the client is then able to tackle the issue head-on.

Current Status and Impact (Psychological Influence)

Over the past decade, therapists have incorporated paradoxical intention more readily into their clinical practice. It has been used as an effective treatment for certain emotional, behavioral, and psychological disorders. Specifically, paradoxical intention has been used to treat generalized anxiety disorder and obsessive-compulsive disorder. It can help alleviate symptoms associated with insomnia, migraines, eating disorders, and phobic behaviors. Though paradoxical intention has proven effective in addressing conditions such as these, it should not be used to treat people suffering from more severe issues, including suicidal ideation and schizophrenia.

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See also: Cognitive Behavior Therapy; Frankl, Viktor (1905–1997)

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Paranoia

Paranoia is a mental condition involving suspicion or distrust that is unfounded or exaggerated.

Definitions

- **Alzheimer's disease** is a medical and mental disorder that causes dementia particularly late in life. It is also referred to as Neurocognitive Disorder Due to Alzheimer's Disease.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive behaviors, emotions, and thoughts. It is also known as CBT.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Dementia** is a group of symptoms including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of nerve cells in the brain.
- **Huntington's disease** is a neurodegenerative disorder that affects the nerve cells in the brain to degenerate. It is characterized by muscle coordination where individuals have uncontrolled movements; clumsiness; and inability to walk, talk, and swallow.
- **Multiple sclerosis** is an inflammatory disease, which involves an immune-mediated process of abnormal response of the body's immune system and is directed against the central nervous system. The central nervous system is made up of the brain, spinal cord, and optic nerves.
- **Parkinson's disease** is a disease of the nervous system that causes tremor, rigidity, slowness of movement, and unstable posture.
- **Social skills training** is a treatment method that assists individuals to learn specific skills that are missing or those that will compensate for the missing ones.
- **Thought broadcasting** is the delusional belief that individuals can hear or are aware of another individual's thoughts and these thoughts are being broadcast to the environment.

Description

Paranoia is a mental condition characterized by an unfounded or exaggerated distrust or suspiciousness of others. Sometimes, paranoid individuals exhibit

feelings of persecution and an exaggerated sense of self-importance. Those who are often paranoid may believe that others are out to get them or are talking behind their backs. As a result, they respond defensively to what they view as personally threatening (e.g., a relationship, a job, the world). Paranoia can lead to intense feelings of distrust and hostility.

While minor feelings of paranoia are common, severe paranoia can cause significant fear and anxiety and noticeably effect social functioning. In fact, paranoia is a feature of several mental health disorders. It is often a symptom of schizophrenia. Individuals with schizophrenia are often preoccupied with delusions where the individual holds the belief that the world is against him or her. Paranoia also occurs as a symptom of other neurological diseases (e.g., Alzheimer's disease, brain injuries, strokes, Huntington's disease, Parkinson's disease, as well as various types of dementia). Another symptom of a paranoid individual includes the sense that others can read his or her mind. This is referred to as thought broadcasting. Individuals with paranoia also believe that they have the capability to use their thoughts to impact others' thoughts and actions. Paranoid individuals may believe that others are putting thoughts into their minds. They may be convinced that programs on television or radio are specifically talking to them. Other symptoms of paranoia include rage, hatred, and betrayal as a result of their intense and irrational suspicion of others, difficulty with forgiveness, taking offense easily, inability to relax, argumentative, stubborn, and self-righteousness.

In Greek the term "paranoia" means "madness beside or by the mind." The term was used to describe a mental illness in which a delusion was the only and most important feature. The delusion did not have to be oppressive to be classified as paranoia. Historically, any delusional belief could be classified as paranoia. Currently, there are several delusions besides paranoia.

The cause of paranoia is not fully understood. It may result from physical or chemical changes in the brain. The use of certain medications can cause symptoms of paranoia in an otherwise normal individual. Psychological factors also appear to be involved. For example, paranoia may result from the breakdown of several mental and emotional functions. Symptoms of paranoia may arise from denied, repressed, or projected feelings. For example, an individual with paranoid thoughts and feelings can become a part of a delusion because of a misunderstanding, an accident, or minor injustice.

Treatment

Treatment for individuals with paranoia may be quite challenging due to the distrust of individuals' motivations toward them. Psychotherapy is one option for individuals willing to participate in treatment. Cognitive behavior therapy (CBT) and other forms of therapy may be beneficial for certain individuals with paranoia. CBT attempts to make an individual more aware of his or her actions and motivations. CBT also attempts to help the individual learn more accurately how to interpret cues around him or her in an effort to help the individual change the dysfunctional behavior. Behavior therapy can help reduce sensitivity to the criticism and improve upon his or her social skills through training. Therapy also attempts to break the cycle of suspicion and isolation by using relaxation techniques and anxiety management by helping the individual to change his or her behaviors. Support groups can also be helpful for individuals experiencing paranoia as well as for their family members. Support groups can be very helpful in assisting individuals (e.g., family, friends, caretakers) who must learn to care for and live with a paranoid individual.

Len Sperry, MD, PhD, and
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See also: Alzheimer's Disease; Behavior Therapy; Brain; Cognitive Behavior Therapy; Delusions; Dementia; Parkinson's Disease; Social Skills Training

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Paranoid Personality Disorder

Paranoid personality disorder is a mental disorder characterized by a pattern of a high level of distrust and suspiciousness of the motives of others.

Definitions

- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behaviors, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Social skills training** is treatment method that assists individuals to learn specific skills that are missing or those that will compensate for the missing ones.

Description and Diagnosis

The paranoid personality disorder is a personality disorder characterized by a pervasive pattern of aloofness, emotion coldness, unjustified suspiciousness, jealousy, and hypersensitivity. Individuals with this disorder can also be rigid, contentious, and litigious. Because of their tendency to project blame on others, they are often disliked by others. Anticipating that others will take advantage of them, make fun of them, or plot against them, they remain alert and vigilant and never share what they are thinking or feeling. They never forget a slight but hold grudges and collect injustices. As a result, they lead isolated lives and are disliked by others.

The clinical presentation of the paranoid personality disorder can be described in terms of behavioral and interpersonal style, thinking style, and feeling style. Individuals' behavioral style is characterized by being chronically tense, guarded, defensive, argumentative, and litigious. Interpersonally, they tend to be distrustful and secretive, and avoid intimacy. Their thinking style is characterized by careful scrutiny and scanning the environment for "clues" or "evidence" to confirm their preconceptions. While their perception may be accurate, their judgments often are not because their prejudices influence what they see and hear to fit their preconceptions. Therefore, they will disregard evidence that does not fit their preconceptions. When under stress their thinking can take on a conspiratorial or even delusional tone. Their hypervigilance and need to seek evidence to confirm their beliefs result in their mistrustful outlook on life. Their feeling style tends to be cold, aloof, unemotional, and angry. They seem to lack a deep sense of affection, warmth, and sentimentality. Because of their hypersensitivity to real or imagined slights, and their resulting anger at what they believe to be deceptions and betrayals, they tend to have few, if any, friends. Anger and jealousy are the two emotions they commonly experience and express.

The cause of this disorder is not well understood. However, these individuals tend to have characteristic view of themselves, the world, and others and a basic life strategy. They tend to view themselves as special but different from others but consider themselves better than others. Life and the world tend to be viewed as unfair, unpredictable, and demanding. They anticipate that life will sneak up and harm them when they least expect it. Accordingly, their basic life strategy is to be wary, counterattack, trust no one, and excuse themselves from failure by blaming others.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of distrust and suspicion and interpret others' motives as harmful. Without sufficient basis, they suspect that others are exploiting, harming, or deceiving them. They are obsessed with unfounded doubts about the loyalty of friends and associates. Because of their unfounded fears, they are reluctant to confide in others. They are likely to interpret otherwise benign remarks and situations as threatening and dangerous. Not surprisingly, they are unforgiving of slights, insults, and injuries. These individuals are quick to react angrily or to counterattack when they believe that

their character or reputation is being attacked. They are likely to continually suspect, without justification, that their spouse or sexual partner is unfaithful.

Treatment

The clinical treatment of this disorder usually involves psychotherapy. Until recently, the prognosis for treatment of this disorder was considered guarded. Today, there is more optimism about achieving the basic goals of treatment. These include increasing benign perceptions and interpretations of situations, and increasing trusting behavior. Social skills training is used to change the way they process information. Paranoid individuals are taught how to reduce their perceptual scanning and attention to inappropriate cues and to attend to more appropriate cues. They learn to use logic and make more benign interpretation of cues. In so doing they can learn to interpret feedback, including criticism, as constructive. This social skills intervention approach is usually combined with psychotherapy to achieve positive therapeutic outcomes.

Len Sperry, MD, PhD

See also: Personality Disorders; Psychotherapy

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Paraphilic Disorders

Paraphilic disorders are mental disorders characterized by fantasizing about and engaging in sexual behaviors that are unusual and extreme.

Definitions

- **Cognitive behavior therapy** is a psychotherapy approach that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Noncompliance** is the failure, in whole or part, to follow a prescribed treatment regimen.
- **Paraphilia** is a mental condition in which individuals can only become sexually aroused by inappropriate object, actions, or fantasies.

Description and Diagnosis

Paraphilic disorders are a group of DSM-5 sexual disorders in which an individual's sexual arousal and gratification depend on fantasizing about and engaging in sexual behavior that is unusual and extreme. It involves a particular object, such as underwear, or a particular action, such as exposing oneself. Paraphilias involve a preoccupation on the object or action to the point of being dependent on it for sexual gratification. They are common in men than in women.

According to the American Psychiatric Association (2013), atypical sexual behavior is not in and of itself a mental disorder. Rather, most individuals with atypical sexual interests do not have a mental disorder. To be diagnosed with a paraphilia, an individual must meet one of two criteria. The first criteria is that the individual must experience distress about his or her atypical sexual interest, and not just society's disapproval of his or her sexual behavior. The second criteria is that the atypical sexual interest or behavior must cause psychological distress or injury to another person and is not consensual or illegal.

The DSM-5 includes the following as paraphilic disorders. Symptoms for all these disorders include chronic and extreme sexual arousal.

Voyeuristic disorder. In this disorder sexual arousal is achieved by observing an unsuspecting and non-consenting person who is undressing engaged in

sexual activity. It may involve masturbation by the voyeur. The voyeur does not seek sexual contact with the person he or she is observing. This disorder is also known as "peeping" or "peeping Tom."

Exhibitionistic disorder. In this disorder sexual arousal is achieved with intense, sexually arousing fantasies, urges, or behaviors that result from exposure of one's genitals to an unsuspecting stranger. The condition usually is limited to the act of exposure, and actual sexual contact with the victim is rare. However, it may involve masturbation during the exposure. This disorder is also known as "flashing."

Frotteuristic disorder. In this disorder sexual arousal is achieved with intense touching or rubbing one's genitals against the body of a non-consenting, unfamiliar person. Most commonly, this behavior involves a male rubbing his genital area against a female, often in a crowded public location.

Sexual masochism disorder. In this disorder sexual excitement and climax are achieved through sexual fantasies, urges, or behaviors that involve being humiliated, beaten, or suffering. These acts can be self-inflicted and include cutting, piercing, or burning the skin, themselves. They may involve a partner who enjoys inflicting pain or humiliation and include bondage, spanking, or simulated rape.

Sexual sadism disorder. In this disorder sexual excitement and climax are achieved by inflicting psychological or physical suffering on a sexual partner. It differs from minor acts of aggression in normal sexual activity, for example, rough sex. Sometimes, sexual sadists are able to find willing partners to participate in the sadistic activities.

Pedophilic disorder. In this disorder sexual arousal is achieved with fantasies, urges, or behaviors that involve illegal sexual activity with a child 13 years of age or younger). Such behavior includes undressing the child, making the child watch the abuser masturbate, touching or fondling the child's genitals, or forcefully performing sexual acts on the child.

Fetishistic disorder. In this disorder sexual arousal is achieved by wearing or touching nonliving objects (fetish). The object of a fetish is often underwear, shoes, or lingerie. The fetish may replace sexual activity with a partner or may be integrated into sexual activity with a willing partner.

Transvestic disorder. In this disorder sexual arousal is achieved in heterosexual males by dressing in female clothes. This disorder differs from cross-dressing where the purpose is not to become sexually aroused or experience sexual climax.

The cause of this disorder is not well understood. It may be these disorders are caused or predisposed by childhood trauma. If there is a history of such trauma, it is often sexual abuse. Or, it may be that specific objects or situations have become sexually arousing if they are often and repeatedly associated with a pleasurable sexual activity. In general, individuals diagnosed with a paraphilic disorder have difficulty developing normal intimate and sexual relationships with others. Often, these disorders begin in adolescence and continue into adulthood. The intensity and occurrence of the fantasies associated with these disorders tend to decrease as the individual ages.

Treatment

Most individuals diagnosed with these disorder can be treated with cognitive behavior therapy aimed at modifying their sexual behavior. Medications may help to decrease the compulsiveness associated with paraphilias and reduce the number of deviant sexual fantasies and behaviors. Antidepressant medications and hormone medications like Depo-Provera, Androcur, and Lupron can also be used to lower the sex drive in pedophiles. These medications work by reducing their testosterone levels, which then lowers sex drive. Effective treatment for paraphilias is long term, and unwillingness to comply with treatment can hinder its success. Unfortunately, noncompliance is a problem and, as a result, treatment is less likely to be effective.

Len Sperry, MD, PhD

See also: Antidepressant Medications; Cognitive Behavior Therapy; Pedophilic Disorder; Sexual Masochism Disorder; Sexual Sadism Disorder

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Parent, Loss of

The loss or death of a parent can be a life-changing experience for which few are prepared, especially children. This experience can extend beyond death to include abandonment.

Definition

- **Incomplete grief** is grief that persists and is chronic with no resolution that may include a lack of satisfaction regarding the end of relationship with the deceased parent.

Description

Losing a parent at any age can have a tremendous impact on an individual, whether the person is a child, an adolescent, or an adult. For a child, the loss of a parent can negatively impact his or her emotional development, which may in turn have impact on the individual's adult life. Some studies have suggested that the loss of a parent can make a child susceptible to substance abuse, higher rates of depression, increased likelihood of criminal behavior, underachievement in school, and lower employment rates.

One form of grief referred to as acute grief is considered to be a part of healthy bereavement. With acute grief, there may be some distress related to one's own physical health, goals the person was unable to attain, or there may be a disruption in the daily routine and regular behavior. In addition, there may be feelings of sadness or guilt in regard to the status of the relationship when the parent passed, meaning there could have been unresolved issues between the parent and child.

One area of concern is that the individual may experience incomplete grief. With this there may be persistence to the feelings experienced by the individual. This may include exaggerated and continued depression, denial, and impacts on aspect of daily living such as eating and sleeping. Accompanying this are major changes in behavior and intensified feelings with an excessive focus on the loss.

It is important to recognize that children and adults who lose their parents may have and display different dynamics. For instance, if a child is experiencing incomplete grief, he or she may identify with the deceased parent in what is considered a socially inappropriate way with adopting the parent's attitude and mannerisms. This can lead to social isolation from other children as they reject the child's change. The child's identity is connected to his or her parent–child interactions. Early loss of a parent can have grave impacts on relationships and interactions moving forward.

An important part of loss is constructing the narrative of that loss. A common way of coping with life stress, which includes the loss of a parent, includes sharing parts of the parent's narratives with others. Sharing of feelings is considered to be an essential part of coping and adapting to life after loss.

There are numerous variables that impact the process of grieving, such as personality, the perceived relationship with the lost parent, conflicting memories or experiences with that person, and the way in which the parent died, as well as the preparation time the person had leading up to the death. For instance, suicide tends to be one of the most difficult types of death for children to grieve and process.

It is also important to recognize that loss of a parent is experienced not just through death but also through abandonment of a child. This experience is likely to lead to emotional and behavioral difficulties and distress as an adult. Children who are orphaned or abandoned are more likely to experience additional stressors such as relocation from their home, separation from family or siblings, and movement from unstable living conditions.

Ashley J. Luedke, PhD and
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See also: Adoption, Death, Denial of; Grief; Grief Counseling

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Parental Alienation Syndrome

Parental alienation syndrome (PAS) is a condition that occurs when one parent consciously or unconsciously attempts to negatively affect a child's relationship with the other parent.

Definitions

- **Alienating parent** is the parent who criticizes and belittles the other parent in order to undermine and interfere with the child's relationship.
- **Child–parent relationship problem** is when a child perceives an alienated parent to have negative attribution, hostility, and feelings of estrangement toward the other parent.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Target parent** is the parent who is slandered by the other parent in order to undermine and interfere with the child's relationship.

Description

Parental alienation syndrome is a condition in which there is a preoccupation with a child or children by one parent (the alienating parent), who engages in criticism and slandering of the other parent (the target parent). PAS primarily arises in the context of child-custody disputes. Often times during a divorce with children there are situations where one parent will attempt to damage the relationship between the child and the other parent. Parents can get so involved in conflict with each other during a divorce that they focus more on "winning" than on what is in the best interest of the child or children involved. This may include brainwashing (controlling another's thoughts and beliefs) the child. This may lead to the child's own contributions of making vicious or defamatory statements against the target parent. When a child unites himself or herself with the alienating parent and becomes hateful toward the target parent, parental alienation syndrome has developed. Some signs of parental alienation include the sudden rejection from the child/children without cause or specific event, or a child who refuses to communicate or spend time with the target (rejected) parent. A child with PAS becomes an alienator in his or her own right and actively participates in belittling the target parent in some of the following ways: (1) the child uses foul language and exhibits disobedient and hostile behavior; (2) the child feels the need to support and protect the alienating parent; (3) the child displays anger and hatred toward the target parent; and (4) the child does not show remorse or guilt over the cruelty toward the target parent.

Parental alienation syndrome was first described by Richard A. Gardner (1931–2003) in the 1900s. Gardner was an American child psychiatrist known for researching parental alienation in separated and divorced parents. He stated that one parent (usually the custodial parent) intentionally alienates the child or children form the noncustodial parent. The alienating parent (usually the custodial parent) attempts to damage or sever the child's relationship with the noncustodial parent. During Gardner's observations in private practice, he explained what he considered to be an epidemic of false accusations, particularly child abuse.

To date, the American Psychological Association has yet to formally include parental alienation syndrome in its *Diagnostic and Statistical Manual of Mental Disorders*. Some have suggested that the general concept is included under Parent–Child Relational Problem. Under this diagnosis, the child's perception of the target parent may include negative attributions of the other's intentions, hostility toward the target parent, excessive parental pressure, and inadequate

parental control, supervision, and involvement with the child.

Len Sperry, MD, PhD, and
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See also: Diagnostic and Statistical Manual of Mental Disorders (DSM)

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Parenting Skills Training

Parenting skills training, also referred to as parent training or parent education, is a support service targeted at improving communication, teaching positive discipline styles, and reducing negative interactions between parents and their children.

Definitions

- **Parent education programs** are classes or workshops geared toward informing and teaching parents about child/adolescent development, strategies for effective communication, and alternative approaches to discipline.
- **Positive reinforcement** is an operant conditioning technique used to increase the occurrence of desirable behaviors by providing some reward for those and reducing the likelihood of undesirable ones by ignoring them.

Description

Parenting is considered one of the most difficult jobs, and yet it comes without any formal preparation, training, or instruction. When children display academic, behavioral, psychological, emotional, or social concerns, parents are often the first to be blamed though many lack the education, means, and skills to provide adequate guidance and care. Those parents in need of additional support may seek it out through parenting skills classes or parent education programs. Child welfare services may also order certain parents to participate in education or skills training as a consequence of child/adolescent maltreatment. Courts can require these caregivers to complete skills training courses as a prerequisite to reunification with their children. Education-based programs are meant to impart factual, applicable content, while training-based programs focus on skill building and practice. Both services aim to provide adults with the knowledge and strategies needed to become competent, effective, and caring parents. The goal of parental intervention is to reduce the risk of child abuse, neglect, and dysfunction and increase a family's strength, stability, and sense of connectedness.

A variety of professionals from educators and health-care workers to counselors and therapists can lead parent skills training sessions. Parental interventions can be offered at agencies, clinics, and schools as a supplement to existing programs, though availability can vary from one geographical area to another. Services are provided to individual parents or groups of parents face-to-face, via the Internet, and through recorded or print media. Participants actively acquire new knowledge and skills by engaging in open discussion, modeling, skills practice, and homework.

Development (History and Application)

Clinical psychologist Thomas Gordon developed one of the first parent skills training programs *Parent Effectiveness Training* (PET), in Pasadena, California, in the early 1960s. PET remains a widely used program and has been studied, practiced, and proven effective worldwide. Several additional programs also exist, each with its own guiding principles, approach, and format. These include *Parent Management Training* also founded in the 1960s by the Oregon Social Learning Group; *Systematic Training for Effective Parenting* published by psychologists Don Dinkmeyer and Gary D. McKay in the mid-1970s; *Love and Logic*, also developed around this time; and the *Active Parenting* curriculum released in 1983. These founding programs have since been added, revised, and updated

to incorporate "best practices" in terms of parental intervention. Research investigating programs such as these have sought to link participation with positive outcomes for both parents and children.

Current Status

A meta-analytic review conducted in 2008 indicated that the most effective parent skills training programs not only assisted caregivers in acquiring new skills and behaviors but were also impactful at reducing negative, externalizing behaviors in children. Programs that fared best taught emotional communication skills and positive parent–child interaction skills, and required participants to practice these skills with their own child within the program sessions. These key components encourage empathy, patience, and respect, which in turn foster healthy relational bonds among family members. In addition, by expecting caregivers to demonstrate skills in sessions with their children, mistakes can be corrected and proper skill use reinforced. Practice, repetition, feedback, and consistency allow for growth to occur.

Melissa A. Mariani, PhD

See also: Parenting Styles or Disciplinary Styles

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Parenting Styles or Disciplinary Styles

There are four types of parenting or disciplinary styles, authoritarian, authoritative, permissive, and uninvolved, each offering a unique approach to discipline and perspective on how the relationship between parent and child should best be maintained.

Definitions

- **Authoritarian parenting** describes a disciplinary style that is highly structured, rule-oriented, rigid, and demanding with a low level of responsiveness.
- **Authoritative parenting,** also known as democratic parenting, characterizes parenting that is both demanding and responsive; authoritative parents provide the proper balance of expectations, limits, and support.
- **Permissive parenting,** or indulgent parenting, describes those who are highly responsive to their children but do so with little to no demands, expectations, or boundaries.
- **Uninvolved/unengaged parenting** characterizes a disciplinary style that is low in both responsiveness and demands; parents who operate from this style may be rejecting and neglectful.

Description

Four distinct parenting or disciplinary styles characterize the relationship between parents and their children. Each describes a variation on the relationship dynamic, approach to punishment and rewards, and resulting effect on the child's development. Though one's parenting style may vary depending on the situation, or the child's or parent's current circumstance, a preferred style usually surfaces. Psychologist Diana Blumberg Baumrind conducted 30 years of research, beginning in the 1960s, on child development, socialization, and parenting. She was the first to identify and describe the four major parenting styles, authoritarian, authoritative, permissive/indulgent, and unengaged/uninvolved, that parents use to manage their children's behavior. It is important to note that the various styles, though different, are all characteristic of "normal," non-abusive, non-neglectful parents. Baumrind's research is considered the gold standard on this topic and has been cited and expanded upon by many others in the psychological community. The Baumrind Model proposes that both love and discipline fill the child's need for support and guidance; thus, each of the four styles reflects a different balance between responsiveness (warmth,

responsiveness, reciprocity, attachment) and demandingness (confrontation, monitoring, consistency, discipline strategies). For one, authoritarian parents place high demands on their children but are low in responsiveness. Interactions between this type of parent and their child may be described as overly structured, rigid, strict, and punitive. Therefore, children with authoritarian parents may display anxiety, fear, moodiness, and low self-esteem. Alternatively, the authoritative, or the democratic parenting, style is characterized by high responsiveness and high demandingness. Experts endorse this perspective as optimal in terms of fostering a healthy, balanced relationship between parent and child. Adults who operate from this orientation are described as assertive, communicative, and respectful. They have high, yet realistic, expectations, establish healthy boundaries, but are able to provide an environment of positivity, love, care, and support which allows for the child to explore, discover, and thrive. Next, the permissive parenting style is low on demandingness yet high on responsiveness. Parents who operate from this disciplinary style do not believe in stringent rules, and are more open, accepting, and perhaps indulgent. Children of permissive parents appear friendly, pleasant, social, creative, and confident but may also react in aggressive, controlling, and impulsive ways. Lastly, the unengaged or uninvolved parenting style describes adults who are low in demandingness and low in responsiveness toward their children. On the extreme, unengaged parents may be rejecting and neglectful. Children whose parents are uninvolved have difficulty forming secure attachments. They are also likely to engage in deviant or risky behaviors.

Impact (Psychological Influence)

The professional literature abounds with studies correlating parenting style with positive and negative outcomes. Findings indicate that a parent's disciplinary style can have a dramatic effect on a child's development, impacting not only the parent–child relationship but future relationships, in addition to the child's mood and overall temperament into adulthood, and the manner in which he or she eventually parents his or her own children. Research suggests that children from authoritarian households exhibit lower levels of frustration tolerance and experience anger and aggression more readily. Studies have also found that children with uninvolved parents tend to experience at-risk behaviors, such as substance abuse, dropping out, and teen pregnancy at increased rates. As previously mentioned, the authoritative parenting style has been endorsed by parenting experts as it allows for an appropriate balance between demandingness and responsiveness. A large review investigating the relationship between parenting styles and at-risk behaviors in adolescent health found that youth from authoritative families consistently demonstrate higher protective factors and fewer problem behaviors than those from non-authoritative families. A guardian's ability to relay warmth and care and to communicate effectively while still commanding respect has been associated with gains in academic achievement as well as with positive psychosocial adjustment. More research is needed to address parenting styles with diverse populations as assumptions should not be made across cultures. Programs, services, and interventions that support parental development and growth are needed so that families can learn the skills necessary to function in healthy ways.

Melissa A. Mariani, PhD

See also: Parents, Overinvolved; Parenting Skills Training

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Parents, Overinvolved

Overinvolved parents, commonly referred to as overprotective, invasive, or helicopter, exhibit overly

controlling, stimulating, or hovering behaviors, considered excessive or extreme to the average parent.

Definitions

- **Helicopter parenting,** also referred to as intensive parenting, refers to the actions of parents or guardians who overtly infuse themselves into every aspect of the child's life, not allowing the child to deal, cope, grow, or mature properly on his or her own.
- **Invasive parenting**, also known as hyperparenting or "hothouse parenting," describes a parent–child relationship characterized by pressure, smothering, preoccupation, and excessive attention on the child, his or her relationships, activities, successes, and accomplishments.
- **Overparenting,** or overprotective parenting, is defined by intense worrying, hovering, and protectiveness whereby the parent seeks to shelter his or her child from any source of possible stress, harm, worry, or fear.
- **Snowplow/bulldozer parent,** considered a step up from helicopter parent, is an extreme form of parent who intervenes and interferes in the child's life by attacking, threatening, or eliminating any obstacle that may be in the child's way.

Description

Parents who excessively or intensively attempt to control their child's lives may be characterized as "overinvolved." "Invasive," "overprotective," "hyperparenting," and "overparenting" are also terms used to describe this dysfunctional parenting style. Overinvolved parents wish to insert themselves into every situation involving their child. Subsequently, the child never learns to properly cope, problem solve, navigate, or mature on his or her own. Helicopter parents are known for hovering behavior, paying close attention to their child's safety, well-being, and success. This pejorative term first appeared in psychologist Haim Ginott's 1969 book *Between Parent and Teenager*, quoting a teenager who used the metaphor to describe his mother's smothering nature. More recently, the words "snowplow" or "bulldozer" have been added to the vernacular to define even more extreme parenting styles. As their names denote, these types of parents attempt to extinguish whatever or whomever gets in their child's way.

Impact (Psychological Influence)

Though overinvolved parents may have good intentions and truly care about their child's success, they often do not understand how their excessive involvement deters proper maturation and development. Thus, many children remain dependent on parental supervision in order to complete daily tasks. However, happiness, self-esteem, and personal autonomy result from accomplishing tasks, learning to solve conflicts, and persevere through hardships. By not permitting a youngster to weigh pros and cons, manage disagreements, and make decisions for himself or herself, progression into adulthood is delayed. Psychologists describe this as "extended adolescence," a trend that has been noted in the millennial generation (those born roughly between 1981 and 2000), who consistently report significant levels of stress, anxiety, and apprehension about growing up. Increased rates of depression and suicide have also been noted in this subgroup over the past decade. Researchers attribute this rise in part to parenting as many adolescents have been too sheltered, protected, and managed by their parents. Lack of experience with disappointment, realistic expectations, and constructive criticism has left many young adults ill-prepared to navigate through life's stressors. In contrast to overinvolvement, experts recommend an authoritative parenting style, characterized by balanced expectations and support, collaboration, and responsibility, in promoting healthy, confident, and competent children.

Melissa A. Mariani, PhD

See also: Parenting Skills Training; Parenting Styles or Disciplinary Styles

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Parkinson's Disease

Parkinson's disease is a disease of the nervous system that causes tremor, rigidity, slowness of movement, and unstable posture. When cognitive impairment is also present, this disease is known as Neurocognitive Disorder Due to Parkinson's Disease in DSM-5.

Definitions

- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neurodegenerative disease** is a medical condition in which the nervous system progressively and irreversibly deteriorates.

Description and Diagnosis

Parkinson's disease is a progressive, neurodegenerative disease that occurs when the neurons within the brain that produce dopamine become impaired or dies. When most of the brain's dopamine-producing cells no longer function, the symptoms of Parkinson's disease begin to appear. Common symptoms include tremor or shaking, stiff muscles and achiness, slurred speech, limited movement, continuous "pill-rolling" movement of the thumb and forefinger, shuffling gait, and difficulty with balance. As the Parkinson's disease progresses, individuals begin to shake, tremble, and exhibit severe movement disturbances.

When there is also a decline in cognitive functioning, DSM-5 designates it as Neurocognitive Disorder Due to Parkinson's Disease. This decline comes on unexpectedly and progresses gradually. Symptoms include apathy, anxious and depressed mood, hallucinations, personality changes, and excessive daytime sleepiness.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder when they begin exhibiting the cognitive decline associated with the onset of Parkinson's disease. Also required is an insidious beginning and a slow, steady progression of impairment. The disorder cannot be caused by another medical condition, nor can there be evidence of mixed etiology, and Parkinson's disease must precede the onset of the neurocognitive disorder. Criteria must also be met for either major or mild neurocognitive disorder. This disorder can be coded with or without behavioral disturbance (American Psychiatric Association, 2013).

The cause of this disorder has been established as decreased levels of dopamine. This occurs when neurons (nerve cells) in a part of the brain called the substantia nigra deteriorate and no longer produce dopamine. Other factors that may be causative are genetics, aging, inflammation, and toxins in the environment.

Treatment Considerations

Because there is an obvious biological basis for Parkinson's, treatment is largely biological. Currently, there is no known treatment that can stop or reverse this disease. However, certain medications can relieve many of its symptoms. The goal is to correct the shortage of dopamine. Sinemet (L-dopa) is the most commonly prescribed and most effective drug for controlling the symptoms of Parkinson's disease by increasing dopamine. Surgery can also be an effective treatment for some individuals.

Len Sperry, MD, PhD

See also: Dopamine

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Partial Hospitalization Program

Partial hospitalization programs are intensive mental health or substance treatment programs for individuals who would otherwise require inpatient treatment. It is also called PHP and intensive outpatient treatment.

Definitions

- **Addiction** is a chronic disease of the brain that involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcohol use disorder** is a mental disorder involving a pattern of alcohol use that leads to significant problems for the user.
- **Cannabis use disorder** is a mental disorder characterized by cannabis (marijuana) use, which leads to significant problems for the user.
- **Case management** is a collaborative process between a health professional and an individual and family to assess, plan, coordinate, evaluate, and advocate for the individual's health needs.
- **Drug dependence** is a mental condition characterized by physical dependence. It is similar to but different from addiction.
- **Inpatient treatment** is a mental health or substance treatment provided in a hospital setting.
- **Intensive outpatient treatment** is a mental health or substance treatment group and individual services of that allow individuals to participate in both daily affairs and treatment at an appropriate facility in the early morning or in the evening. It is also called intensive outpatient program or IOP.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

Description

Partial hospitalization programs are intensive mental health or substance treatment centers that treat individuals with mental conditions. These programs allow individuals who would otherwise require inpatient treatment to reside in their own homes. They are also known as intensive outpatient treatment. Such treatment allows individuals to remain with their families and maintain employment while receiving intensive outpatient care. The goal of partial hospitalization programs is to reduce inpatient hospitalization cost and ultimately reduce the cost of long-term care. In the United States, partial hospitalization programs can be housed in a hospital setting or in an individual community mental health center. Programs are often required to pass significant inspection and review from state, national, and insurance bodies. Funding for services can often be covered by insurance companies, private pay, Medicaid, and Medicare.

Treatment administered in such programs includes individual and group counseling, case management, and medication. Examples of substance-related and addictive disorders conditions treated in this setting include alcohol use disorder or cannabis use disorder. Mental health conditions treated in this setting include depression, eating disorders, and many other forms of mental illness. Treatment is typically delivered by psychologists, psychiatrists, mental health counselors, social workers, nutritionists, case manager, physicians, and other health-care workers.

Albert E. Moll, MD (1938–2007), a Canadian psychiatrist, pioneered partial hospitalization programs which he called day hospital treatment. He believed that individuals could be successfully treated while still remaining at home and also remaining employed. This form of substance abuse and mental health care is designed to reduce cost to society and to the individual receiving treatment.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Drug Dependence; Hospitalization; Motivational Interviewing; Psychotherapy; Stimulant Use Disorder; Substance-Related and Addictive Disorders

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Passionflower

Passionflower is an herbal remedy used to treat anxiety and sleep problems.

Definitions

- **Alkaloids** are plant compounds composed of carbon, hydrogen, and nitrogen, which are pharmacologically active. Examples are caffeine, morphine, nicotine, and Yohimbine.
- **Antispasmodic** is a medication or preparation used to relieve muscle or digestive cramps.
- **Flavonoids** are plant compounds that have anti-inflammatory, anticancer, or antioxidant effects.

Description

Passionflower is a plant (*Passiflora incarnata*) whose leaves and flowers are used to make an herbal remedy for anxiety, sleep problems (insomnia), stomach upset related to anxiety or nervousness, and generalized anxiety disorder. It has been used to reduce symptoms related to narcotic drug withdrawal. Other uses include seizures, asthma, symptoms of menopause, attention-deficit hyperactivity disorder, palpitations, irregular heartbeat, high blood pressure, pain relief, hemorrhoids, and fibromyalgia.

Although some studies have shown passionflower to have sedative and antispasmodic effects, it is not clear which compounds in the plant have these properties. Passionflower is known to contain flavonoids and a group of alkaloid compounds that include harman, harmine, harmaline, and harmalol. It is thought that the medicinal effects of passionflower derive from a combination of these substances rather than from any of them in isolation.

Precautions and Side Effects

It should be noted that passionflower had been approved as an over-the-counter sedative and sleep aid in the United States. However, in 1978 it was taken off the market because its safety and effectiveness had not been proven. Passionflower should not be used in doses higher than the recommended levels. Because it has a sedative effect, it should not be combined with alcohol or prescription sedatives. Passionflower should not be used by pregnant or lactating women or for children under six months old. It can increase the effects of anesthesia and other medications during and after surgery. So, those planning major surgery should stop using passionflower at least two weeks before their procedure.

The alkaloids found in passionflower, especially harman and harmaline, may increase the effects of a class of prescription antidepressants called monoamine oxidase inhibitors such as Nardil and Parnate. Passionflower may also increase the effects of sedative medications and should not be used in conjunction with either of these medications. Because passionflower can cause sleepiness and drowsiness, it should not be used with sedative medications. These sedative medications include Nembutal, Luminal, Seconal, Klonopin (Clonazepam), Ativan, and Ambien.

Len Sperry, MD, PhD

See also: Insomnia and Insomnia Disorder

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Passive-Aggressive Personality Disorder

Passive-aggressive personality disorder is a mental disorder characterized by an enduring pattern of negative attitudes and passive-aggressive behaviors. It is also known as negativistic personality disorders.

Definitions

- **Dependent personality disorder** is a mental disorder characterized by pervasive pattern of submissiveness, a lack of self-confidence, and an excessive need to be taken care of by others.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Passive-aggressive behavior** is the indirect expression of hostility characterized by procrastination, stubbornness, forgetfulness, sarcasm, inconsistency, stubbornness, resentment, and repeated failure to accomplish requested tasks for which an individual is responsible.
- **Personality disorder** is a mental disorder characterized by a long-standing pattern of maladaptive (problematic) behaviors, thoughts, and emotions that deviates from the accepted norms of an individual's culture.

Description and Diagnosis

The passive-aggressive personality disorder is a personality disorder characterized by an enduring pattern of negative attitudes and passive resistance in complying with reasonable expectations for adequate performance in school, work, or social settings. It includes passive-aggressive behaviors such as forgetfulness, procrastination, inconsistency, and underachievement. This disorder begins by early adulthood and presents in various situations and contexts. Basically, individuals with this disorder accept others' needs and desires but passively resist them. Instead of asserting their own needs and desires, they become increasingly hostile and angry. Because they identify themselves in opposition to others' goals, it is very difficult for them to pursue their own identity and goals.

Passive-aggressive personality disorder was listed among the other personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised* (DSM-III-R). However, it was moved to an appendix in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) as a diagnosis needing further research support. This disorder is also listed in the *Psychodynamic Diagnostic Manual* (PDM) as a variant of the dependent personality disorder.

The DSM-IV provides research criteria for the passive-aggressive personality disorder. According to the DSM-IV individuals can be diagnosed with this disorder if they passively resist completing routine social and occupational tasks. They tend to complain of being misunderstood and unappreciated by others. They are likely to be sullen and argumentative, and unreasonably criticize and scorn authority. They may also express envy and resentment toward those who appear to be more fortunate than them. They also tend to persist in exaggerating and complaining about their personal misfortunes. In addition, they characteristically alternate between hostile defiance and contrition or submission.

The PDM describes individuals with this disorder as having a characteristic view of others and themselves. They tend to view others as wanting them to conform to their rules. At the same time, they view themselves as only able to achieve a sense of worth and dignity when they sabotage the achievement of others. Accordingly, their basic preoccupation is to get revenge and tolerate misfortune. Their basis affects or feelings are anger, resentment, and taking pleasure in their passive-aggressive behaviors. In short, individuals with this disorder are reactive to others' agendas and goals rather than active in achieving their own goals and agendas.

Treatment

The clinical treatment of this disorder usually involves psychotherapy. The PDM indicates that the main task of therapy is to increase individuals' self-acceptance and identity as agents of their own destinies instead of simply being reactors to others' demands. These individuals need help in naming their negative feelings and distinguishing verbal from behavioral expressions of their anger. In response to the oppositional attitude of these individuals, therapists need to take their inconsistencies and provocations in stride. Effective therapists continually focus therapy on the price these individuals pay for their passive-aggressive behaviors.

Len Sperry, MD, PhD

See also: Personality Disorder

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Pastoral Counseling and Psychotherapy

Pastoral counseling and psychotherapy is a form of counseling that integrates theological, spiritual, and psychological concepts in order to provide faith-based counseling interventions.

Description

Pastoral counseling is a psycho-spiritual approach to helping and is most commonly provided by clergy. Clergy are individuals who are trained and endorsed by their religious organization to provide spiritual leadership and services on behalf of the religious organization. Clergy representing Christianity, Judaism, Islam, and other faith traditions can become pastoral counselors. Many pastoral counselors have also received specialized mental health training, certification, or licensure as mental health practitioners, marriage and family therapists, clinical social workers, or psychologists.

As of 2013 only six states (Arkansas, Kentucky, Maine, New Hampshire, North Carolina, and Tennessee) license the title of "pastoral counselor." In states where there are no licensing requirements, pastoral counseling is unregulated. Although pastoral counseling is largely unregulated in the United States, the American Association of Pastoral Counselors (AAPC) provides certification, sets training standards, and defines ethical practice for pastoral counselors. In unregulated states, pastoral counselors can be legally limited in the counseling or psychotherapeutic services they provide and any fees associated with those services. Pastoral counselors in unregulated states may choose to meet state requirements to become licensed professional counselors or licensed marriage and family therapist.

Development

Throughout human history religious communities have provided social structure, support, comfort, and care to its religiously oriented members. Clergy have traditionally served in a helping role in the lives of individuals and families. Before the development of modern psychology, clergy were one of the few helping relationships people could turn to outside of family.

By the early 1900s the need to integrate psychological concepts into pastoral training began to be recognized by clergy and a new form of training, referred to as Clinical Pastoral Education (CPE), was developed. CPE included training in which theological students were placed in psychiatric hospitals and provided supervised care to patients. Influenced by the rise and popularity of Freudian psychology, a variety of CPE organizations were formed with a focus on the integration of psychology in pastoral training. In the 1930s the Council for Clinical Training of Theological Students and the American Foundation of Religion and Psychiatry were both independently formed. By the 1950s some church denominations began to form their own training certification. The Southern Baptist Association of Clinical Pastoral Education was founded in 1957 and in 1967 merged with other pastoral groups to form the Association for Clinical Pastoral Education. CPE does not provide training in counseling or psychotherapy but focuses on educating and training seminary

students, clergy, chaplains, and laypeople (non-ordained) in the provision of care in hospitals, hospice settings, retirement homes, and other direct care settings.

The American Association of Pastoral Counselors was formed in 1963 with a focus on the establishment of educational training, standards, and professional ethics in pastoral counseling and psychotherapy. Founded as a membership and certification organization, the AAPC has over 2,000 members and sets practice standards for certification as pastoral counselors. The AAPC has 75 pastoral counseling centers. The purpose of the AAPC is to provide spiritually informed and integrated counseling, collaborative community-based services, training, and education in order to enhance the well-being of individuals, families, and communities. The mission of the AAPC is to bring healing, hope, and wholeness to individuals, families, and communities by expanding and equipping spiritually grounded and psychologically informed care, counseling, and psychotherapy.

Certification as a pastoral counselor by the AAPC requires an undergraduate degree, and a graduate masters or doctoral degree in theological/spiritual studies or in pastoral counseling from schools accredited by agencies recognized by the U.S. Department of Education. Additional requirements include endorsement for ministry from a religious organization, active relationship in a religious community, completion of a supervised self-reflective pastoral experience, three years of ministry experience, 375 hours of pastoral counseling, and 125 hours of supervision.

Pastoral counseling and psychotherapy is a unique form of helping provided by clergy from diverse religious perspectives and traditions. The integration of specific theologies and spiritual traditions are essential components of professional practice provided by certified pastoral counselors.

Steven R. Vensel, PhD

See also: Pastoral Counselor; Religion and Religiosity

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Pastoral Counselor

Pastoral counselors are professional counselors with specialized training in theology, pastoral care, and psychology.

Description

Clergy were providing care to people needing help with their personal and mental health problems long before counselors, psychologists, social workers, psychiatrists, or other mental health professionals existed. Recognizing that many congregants suffer from mental health conditions pastors began to seek and receive specialized training in psychology in order to better serve their congregations and communities. In 1963, the American Association of Pastoral Counselors (AAPC) was formed in order to establish standards of educational, training, and ethical practices. The AAPC has approximately 4,000 members and is the largest certification organization for pastoral counselors. In order to become AAPC certified, pastoral counselors must meet the educational and training standards set by the organization. Many clergy choose to integrate a graduate clinical degree in a mental health discipline, such as counseling, marriage and family therapy, social work, or psychology, into their pastoral duties.

The primary goal and function of pastoral counselors is to assist individuals cope with physical, emotional, and moral difficulties. Secondary goals include symptom reduction and problem resolution. Addressing spiritual and religious needs is a fundamental component of pastoral counseling, especially for those needing help in coping with crises and personal problems. There are three forms of pastoral counseling that are practiced. A pastoral counselor may choose to provide a brief, situational focused, single session, for those individuals needing help dealing with a specific

issue. A time-limited form of treatment may be offered to those needing one to five sessions. Pastoral psychotherapy may be provided to those needing long-term treatment relating to personality change. Only clergy who have formal supervised clinical training and who are certified or licensed to practice psychotherapy may provide pastoral psychotherapy.

Pastoral counselors provide care with a unique blend of spiritual, religious, and psychological concepts with therapeutic knowledge and clinical competencies. Pastoral counselors help individuals resolve difficulties, restore their psychological health, and promote positive growth and change. Clients are most often individuals struggling with emotional or relational problems; with life transitions; or because of guilt, addictions, abuse, or low self-esteem.

The process of pastoral counseling is similar to other forms of psychotherapy. A positive therapeutic alliance and relationship between the client and the pastor is an important component that can maximize client change. As with most psychotherapies, maintaining some degree of therapeutic distance can aid in accurate diagnosis and client change. In addition to examining client circumstances, the pastor may assess the client's awareness of God, the role God plays in a client's life, client understanding of repentance and grace, and other spiritual dynamics related to the specific religious affiliation. A client's relationship and involvement in the faith community may also be assessed.

Pastoral counselors engage in a wide variety of therapeutic interventions associated with problem solving or solution-focused counseling models. Interventions include active listening and advice giving regarding spiritual and religious matters. Pastoral counselors who maintain clinical licensure can choose from a wide array of therapies to promote client change. Most pastoral counseling models resemble traditional counseling sessions, with clients being seen individually, with their spouse, or as a family, in an office setting during appointed times. Sessions may or may not be conducted at the church or faith facility.

Current Status

Pastoral counselors are actively engaged in establishing their identity as recognized professionals. Pastoral counseling is largely unregulated and only six states (Arkansas, Kentucky, Maine, New Hampshire, North Carolina, and Tennessee) license the title of "pastoral counselor." The AAPC is a strong member organization that will continue to have the strongest voice on behalf of pastoral counselors. Pastoral counselors provide meaningful and effective mental health services to countless faith communities throughout the United States and the world.

Steven R. Vensel, PhD

See also: Pastoral Counseling; Religion and Religiosity

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Pattern-Focused Psychotherapy

Pattern-focused psychotherapy is a form of psychotherapy for quickly and effectively identifying and replacing maladaptive patterns with more adaptive ones.

Definitions

- **Biopsychosocial therapy** is an integrative approach that incorporates biological, psychological, and sociocultural factors in planning and implementing psychological treatment. It emphasizes pattern identification, pattern change, and pattern maintenance.
- **Cognitive behavior analysis system of psychotherapy** is a psychotherapy approach that focuses on identifying and changing hurtful thoughts and behaviors with more helpful ones. It is also referred to as CBASP.
- **Evidence-based practice** is the integration of the best research evidence with clinical experience and client values to inform clinical decision making.

- **Motivational interviewing** is a counseling strategy for helping individuals discover and resolve their ambivalence to change. It is also referred to as MI.
- **Pattern** is the predictable, consistent, and self-perpetuating style and manner in which individuals think, feel, act, cope, and defend themselves.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description

This form of psychotherapy emphasizes patterns. Patterns can either be maladaptive or adaptive. Maladaptive patterns tend to be inflexible, ineffective, and inappropriate, and cause symptoms, impairment in personal and relational functioning, and chronic dissatisfaction. If such a pattern is sufficiently distressing or impairing, it can be diagnosed as a personality disorder. In contrast, an adaptive pattern reflects a personality style that is flexible, effective, and appropriate.

Pattern-focused psychotherapy is based on four premises. The first is that individuals unwittingly develop a self-perpetuating, maladaptive pattern of functioning and relating to others. Subsequently, this pattern underlies a client's presenting issues. The second premise is that pattern change is an essential component of evidence-based practice. The third premise is that effective treatment involves a change process in which the client and practitioner collaborate to identify the maladaptive pattern, break it, and replace it with a more adaptive pattern. At least two outcomes result from this change process: increased well-being and resolution of the client's presenting issue. The fourth premise is that "replacing" non-productive thinking and behaviors with more productive ones is likely to effectively and quickly lead to therapeutic change than might otherwise occur with directly "restructuring" cognitions or "modifying" behavior.

Pattern-focused psychotherapy begins with establishing a collaborative relationship and educating the client in the basic premises of this approach. Central to it is the case conceptualization process in which maladaptive pattern is identified, and treatment is planned that focuses on pattern change. Key factors considered in treatment planning are level of readiness for change, severity, skill deficits, and strengths and protective factors.

The basic therapeutic strategy of this approach is to analyze problematic situations that clients report in terms of their maladaptive pattern. Clients are first asked to describe the situation and their resulting interpretations (thoughts) and behaviors. Then, they are queried about their expected outcome in contrast to the actual one that resulted. Clients inevitably report that they did not achieve their expected outcome. They are then asked about their interpretation and if each "helped "or "hurt" them in getting what they expected. If not, they are asked what alternative interpretations would have helped them achieve. Their reported behaviors are also analyzed as to whether they helped or hurt in achieving their expected outcome. If not, the focus is on identifying alternative behavior which could achieve that end. Finally, the client's "level of importance" of changing the maladaptive pattern and "level of confidence" in doing so are assessed and therapeutically processed.

Development and Current Status

Pattern-focused psychotherapy was developed by Len Sperry (Sperry, 2016). It is derived from biopsychosocial therapy, the cognitive behavioral analysis system of psychotherapy, and motivational interviewing. Pattern-focused psychotherapy is a focused therapeutic strategy that is effective in identifying and changing a maladaptive pattern to a more adaptive one. It accomplishes this by replacing the non-productive interpretations and behaviors that underlie the maladaptive pattern with more adaptive ones. Other modalities such as cognitive restructuring, exposure, skill training, reframing, and interpretation can be employed as adjunctive treatments. In the current era of accountability in health care, pattern-focused psychotherapy has considerable promise as an evidenced-based practice.

Len Sperry, MD, PhD

See also: Biopsychosocial Therapy; Cognitive Behavior Analysis System of Psychotherapy (CBASP); Motivational Interviewing

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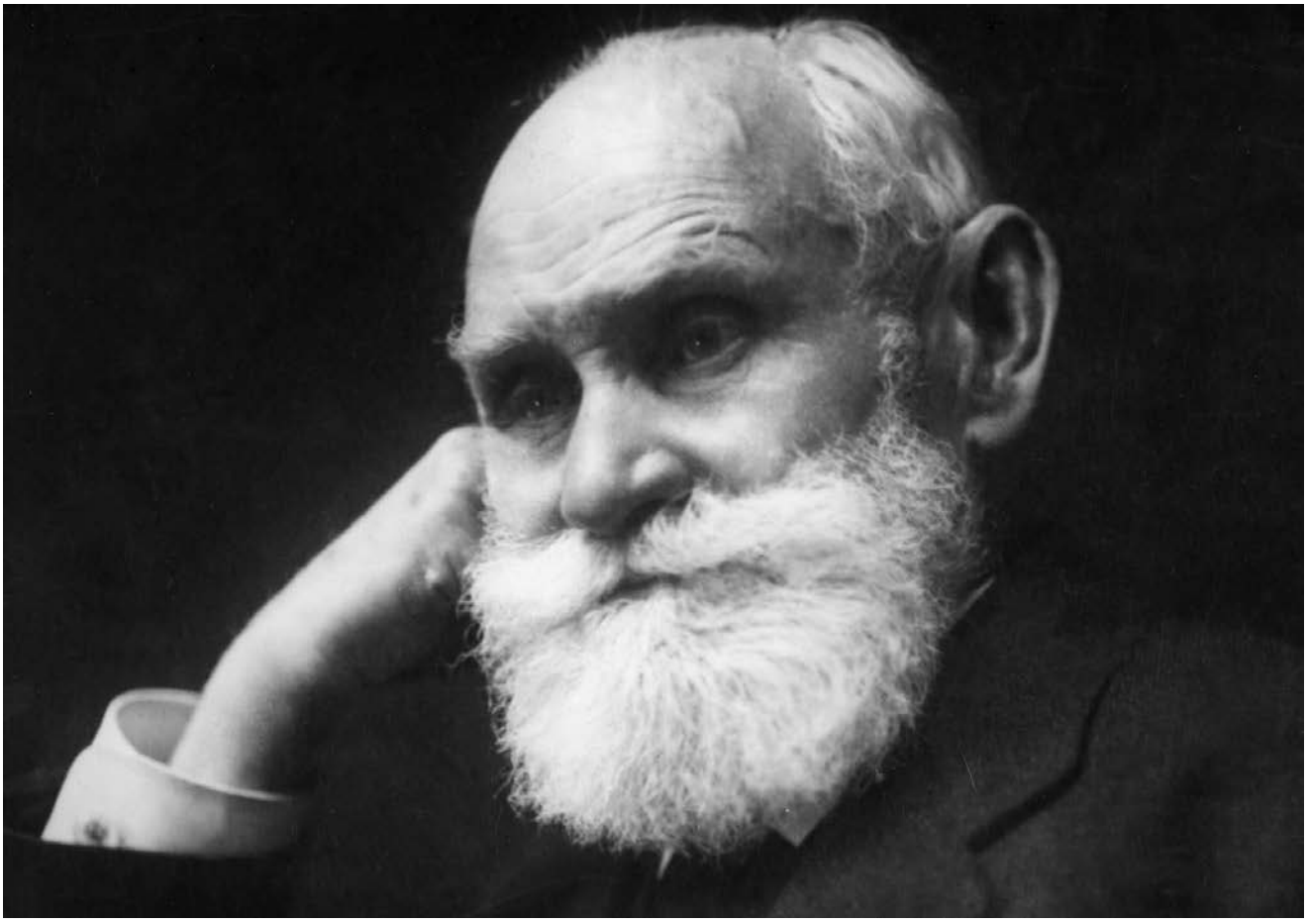
Pavlov, Ivan (1849–1936)

Ivan Petrovich Pavlov was a researcher and psychologist who developed the concept of reflex conditioning based on his experiments with dogs and feeding. Pavlov was able to have dogs associate feeding with the sound of a bell, at which they would begin salivating, even when there was no food present.

Description

Ivan Pavlov is one of the most famous physiologists in history. He lived and worked in Russia for his entire life and career. Pavlov and his studies of classical conditioning became famous from the time of his early work between 1890 and 1930. But he is best known for his discovery of conditioned or learned response. Pavlov established the existence of unconditioned responses by presenting a dog with a bowl of food and measuring its saliva. He did this through a technique he developed to directly observe the salivary glands. Pavlov observed that any object or event that dogs learned to associate with food, such as the entrance of



Ivan Petrovich Pavlov was a researcher and psychologist who developed the concept of reflex conditioning based on his experiments with dogs and feeding. (Sovfoto/UIG via Getty Images)

his lab assistant or the ringing of a bell, would cause the dogs to begin to salivate. At this point he realized that he had made an important scientific discovery. In behavioral terms, the lab assistant was originally a neutral stimulus, which produced no saliva. But after the dogs learned to associate either the assistant entering the room or the bell with the arrival of food, the dogs salivated. Because this response was learned, or conditioned, he termed it a conditioned response.

Impact (Psychological Influence)

By 1905, Pavlov was able to show that almost any external factor could become the conditioned or learned signal, which could initiate the natural response. Classical conditioning involves learning to associate an unconditioned stimulus that already brings about a response, or reflex, with a new or conditioned stimulus. The purpose of classical conditioning is that the new stimulus brings about the same response as the original stimulus.

With his research, Pavlov opened the way for new advances in the theory and practice of psychology and medicine. With extreme clarity he showed that the nervous system played the dominant part in regulating the digestive process. This discovery is in fact the basis of the modern physiology of digestion. He was awarded the Nobel Prize in 1904 for his work in the field of digestive physiology.

But his experiments in the field of conditioned responses or reflexes revolutionized the study of the relationship between learning and responses. This had major implications for the field of human behavior and for the development of behavior therapy, especially because it means not only increasing positive responses but decreasing negative behaviors. The work Pavlov did was the basis for the use of aversion therapy as applied, for example, to smoking cessation.

Alexandra Cunningham, PhD

See also: Behavior Therapy; *Conditioned Reflexes: An Investigation of the Physiological Activity of the Cerebral Cortex* (Book)

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Paxil (Paroxetine)

Paxil is a prescribed medication used to treat depression and anxiety disorders. Its generic name is paroxetine.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety. These include obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).
- **Selective serotonin reuptake inhibitors (SSRI)** are medications that act on and increase the levels of serotonin in the brain that influences mood.
- **Serotonin discontinuation syndrome** results from the abrupt discontinuation of an SSRI medication. It is characterized by withdrawal symptoms such as anxiety, agitation, insomnia, nausea, vomiting, diarrhea, fatigue, vivid or bizarre dream, dizziness, and other sensory disturbances.

Description

Paxil is in the class of antidepressant medications known as selective serotonin reuptake inhibitors (SSRIs). Its primary use is in the treatment of clinical depression and for anxiety disorders: generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, and social anxiety disorder. Depression and anxiety disorders are believed to be caused by low levels of serotonin, a chemical messenger (neurotransmitter) that is released and transmitted in the brain. Like other SSRI

medications such as Luvox, Zoloft, and Prozac, Paxil is believed to work by increasing the level of serotonin in the brain. Increased levels can benefit those with depression and anxiety disorders.

Precautions and Side Effects

Those taking Paxil should be monitored closely for insomnia, anxiety, mania, significant weight loss, and seizures. Like other SSRIs, Paxil carries a warning regarding use in children and adults up to the age of 24. They appear to have an increased risk of developing suicidal thoughts or behaviors while using these medications. Paxil should never be taken with monoamine oxidase inhibitors such as Nardil or Parnate. Caution should also be exercised when prescribing Paxil to those with impaired liver or kidney function, children, those over the age of 60, those with known bipolar disorder or a history of seizures, and those with diabetes. The risks and benefits of Prozac should be considered by women who are or might become pregnant, and those who are breast-feeding. Alcohol should not be used while taking Paxil. Care must be taken in driving, operating machinery, or participating in hazardous activities when taking this medication. Paxil use should not be stopped abruptly since it can cause serotonin discontinuation syndrome.

Common side effects associated with Paxil include headache, weakness, chills, malaise, nausea, and sleepiness. Other complaints included dry mouth, dizziness, tremors, constipation, diarrhea, and problems with ejaculation. Side effects with Paxil use have been reported for all organ systems of the body, but all of these side effects are uncommon. In general, the incidence of side effects increases as the dosage of Paxil increases.

Paxil interacts with a number of medications. Combining Paxil with Mellaril (an antipsychotic) has the potential to cause fatal cardiac arrhythmias (irregular heartbeat). The use of Paxil in combination with tryptophan (a nutrition supplement) may result in unwanted reactions, including agitation, restlessness, and gastrointestinal distress. Paxil may also increase the chance of having a seizure in those with a history of seizure disorders. Those taking anticonvulsants to control seizures should have close medical monitoring. No interactions between Paxil and lithium have been reported, nor are there any reported interactions with the antianxiety medication, Valium. Phenobarbital can decreases the efficacy of Paxil.

Len Sperry, MD, PhD

See also: Anxiety Disorders; Depression

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Pedophilic Disorder

Pedophilic disorder is a sexual disorder in which sexual arousal is achieved with fantasies, urges, or behaviors that involve sexual activity with prepubescent children (13 years of age or younger). It is also referred to as pedophilia.

Definitions

- **Paraphilic disorders** are a group of sexual disorders in which an individual can only become sexually aroused by inappropriate objects, actions, or fantasies. Pedophilic disorder is one of these disorders.
- **Pedophile** is the term given to those who engage in pedophilia.

Description and Diagnosis

Pedophilia is a type of paraphilic disorder in which an individual engages in sexual fantasy or actual sexual behavior with a prepubescent child. It is the individual's preferred or exclusive way of achieving sexual arousal and gratification. It may be directed toward children of the same sex, children of the other sex, or both boys and girls. Some pedophiles are attracted only

to children, while others are attracted to adults as well as to children. In addition to being a mental disorder, pedophilia is a criminal act.

This disorder is more common in males than females, and 3%–5% of the male population meet the criteria for the disorder (American Psychiatric Association, 2013). Pedophiles likely become aware of their sexual interest in children around the time of puberty but may not be diagnosed until they are adults. Many males with this disorder report they were sexually abused as a child. Individuals with this disorder also often present with antisocial personality disorder (American Psychiatric Association, 2013) and as a result may not admit to their sexual behavior harming children.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), individuals can be diagnosed with this disorder if they exhibit intense, reoccurring sexual fantasies, urges, or behaviors toward a prepubescent child (age 13 or younger). The individual must experience significant distress or interpersonal problems as a result of these fantasies, urges, or sexual behaviors. Individuals can only be diagnosed with this disorder if their self-report, legal history, or objective assessment shows they have acted on their sexual impulses with children. If the individual does not express guilt or shame, and it can be proven he has never acted on his fantasies, then the individual has pedophilic sexual orientation but not pedophilic disorder. In contrast, if an individual does not admit to pedophilic urges or sexual behaviors, but it is proven the individual has engaged in these behaviors, he meets criteria for the diagnosis (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, there is some evidence that prenatal (before birth) influences increase the probability of development of this disorder. While there is relatively little published research on the biologic basis for pedophilic disorder, there is considerable research focusing on the psychological and sociological factors that contribute to the disorder.

Those diagnosed with this disorder often have a history of sexual abuse and/or a concurrent diagnosis of antisocial personality disorder. It may be that individuals with both were exposed to an environment and family system that they perceived as unsafe or hostile and offered them little modeling of respect, caring, and cooperation. As a result, such children are likely to develop safeguarding behaviors, which means they learn to hurt others before they are hurt themselves.

Treatment

Because this disorder so negatively impacts children and their families, prevention rather than treatment should be the focus of this disorder. That means working with high-risk parents, that is, those who are abusive and neglectful since their children are at greater risk for developing this disorder. The main treatment intervention for this disorder are incarceration (prison) during which mental health treatment is also provided. Medications can also be used to lower the sex drive in pedophiles by reducing their testosterone levels. In reducing these levels, medications like Depo-Provera, Androcur, and Lupron are referred to as chemical castration. Treating pedophiles is a highly specialized field, with most clinicians needing additional training and supervision in working with such individuals.

Len Sperry, MD, PhD

See also: Child Abuse; Paraphilic Disorders

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Peer Counseling

Peer counseling is a form of counseling provided by an individual who has the same status as the client. An example is a high school student who is trained to counsel fellow students. It is also known as peer helping or peer support.

Definitions

- **Peer facilitator,** peer leader or peer educator, is an individual who either is a volunteer or is

selected and then trained to lead a small group of peers.

- **Peer mediation** is a helping process in which a peer leader facilitates two opposing parties through a conflict resolution or problem-solving model.
- **Peer mentoring** typically occurs in school or work settings and is described as when older, more experienced, or knowledgeable individuals assist younger or struggling individuals by tutoring them and helping them to feel welcome, or to acclimate more easily to their new environment.
- **Self-help group,** or support group, refers to a small network of peers from similar backgrounds and experiences who come together on a regular basis to share issues, concerns, and successes with one another.

Description

Peer counseling is a means of social support provided to individuals struggling with issues commonly experienced in everyday life. The difference between this helping process and others is that the support, or "counseling," is provided by a peer, or equal, rather than by a professional such as a counselor, therapist, or other health practitioner. This model of support has been proven effective as research indicates that people may feel more comfortable, open, and willing to share their problems with peers, those who have experienced similar issues, than with professionals. Being able to relate to a particular situation because one has "been there" is valuable. Thus, peers can provide a distinct level of empathy, understanding, and practical advice. In contrast to working with a mental health professional, peer counseling does not focus on assessment, diagnosis, evaluation, or deficits. Group facilitators and members work to empower, relate to, and uplift their peers. Peer counseling is also a cost- and time-conscious approach to offering help and support. People of any age can participate in peer counseling. Peer counseling can be offered in a variety of settings, including workplaces, churches, and community centers, but is most common in schools. In the school setting this may be referred to as a *peer helper program, peer mentoring, peer tutoring, peer mediation, peer facilitation*, or simply as *peer support*.

Peer counselors usually receive some level of training in order to be considered qualified to lead or facilitate their peers. Levels of training vary and depend on the intervention or program being used. Some training models are specific and manualized, while others may be more open and flexible. Regardless, some core aspects of peer counseling are typically presented. First, participation in peer counseling is voluntary. In addition, the peer counseling environment should be nonjudgmental, empathic, and respectful. Lastly, peer counseling requires honest and direct communication from all parties, both the leader and the participants.

Development (History and Application)

Though people have been helping one another since the beginning of time, the history of the peer counseling dates back to the 1930s with the emergence of the Twelve-Step Model and onset of peer support and self-help groups. Organizations such as Alcoholics Anonymous, Narcotics Anonymous, and Gamblers Anonymous are some of the most common self-help groups still active today. However, the past several decades have given rise to other support groups that address particular issues related to dealing with friends or family members with physical impairments, learning disabilities, behavioral problems, and psychological disorders. Peer counseling in schools soon followed in the 1960s–1970s with the inception of peer tutoring, peer helper programs, and peer mentoring, which took place during the regular school day. Facilitators were trained by teachers or counselors to work with their peers on common student problems. Therefore, the peer counseling movement responded to the shortage of helping professionals in relation to a growing number of people with needs.

Current Status

Peer counseling is a viable intervention for people suffering from a wide range of problems, particularly in times of financial constraint. Research indicates that school-based peer counseling programs provide many benefits to students, schools, and communities.

Programs that are evidence based are more likely to impact student behavior and achievement. Further, it has been documented that both participants and peer leaders report positive outcomes from peer counseling involvement. However, prior to implementing a peer counseling program, one must (1) consider the possible liability of the organization or entity providing the peer counselors, (2) ensure that the proper level of training and supervision is provided, and (3) properly address matters pertaining to confidentiality.

Melissa A. Mariani, PhD

See also: Peer Groups; Self-Help Groups

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Peer Groups

Peer groups are informal associations of people of like age, background, social status, and interests.

Definitions

- **Cliques** are small groups of people (typically the term refers to groups of adolescents) who have similar characteristics and common interests, and who generally socialize exclusively with one another.
- **Peer pressure** describes the positive or negative influence one's peer group, or clique, has on one's attitudes, values, and behaviors.
- **Socialization** refers to the process by which an individual becomes acclimated to his or her current environmental and cultural surroundings by acting in ways that reflect the society's accepted norms, ideals, and behaviors.

Description

One's peer group, or the group of people that an individual associates with, can have a significant impact on his or her development. The term "peer group" refers to a social group as well as the primary group that one is affiliated with. Members of peer groups are typically similar in age, ethnicity, background, views, interests, financial state, and/or social status. Albert Bandura, founder of Social Learning Theory, proposed that the social group one belongs to helps determine what that person views as appropriate behavioral norms. Socialization also contributes to self-concept formation as most people compare themselves to peers whom they have things in common with. A peer group can influence what a person thinks, knows, learns, does, wears, and eats. However, peer groups can also foster one's ability to negotiate, problem solve, prevent conflict, and cope. This is particularly true for adolescents who struggle to find out who they are and what their place is in the world. Renowned psychologist and theorist, Erik Erikson, referred to the adolescent stage of conflict as *Identity vs. Role Confusion* and emphasized the importance of societal influences and peer pressure. The majority of adolescents rely primarily on the feedback they receive from their peers to reflect how they should feel about themselves, whether these judgments/opinions are accurate or not. Therefore, individuation and self-acceptance are ongoing processes that evolve over the course of a person's lifetime.

Peer groups usually have established hierarchies and members have some sense of understanding as to what behavior patterns are considered acceptable or unacceptable. A peer group where the leadership or rules are viewed as excessive or unreasonable may be referred to as a "clique." "Cliques," a word that usually has a negative connotation, are small groups of people who think, act, and dress in similar ways and socialize primarily with one another. Gangs, or groups of youth involved in crime and delinquent behavior, are another example of a negative type of peer group.

Impact (Psychological Influence)

Evidence suggests that an individual's peer group can have a profound effect on his or her likelihood to engage in future destructive behaviors, including committing acts of aggression, dropping out of school, and engaging in criminal activity and substance abuse, and sexual promiscuity. However, there is also data to support that positive peer groups can have the opposite effect. Displaying pro-social behaviors, encouraging others' academic success, making pacts to abstain from drug/alcohol use and risky sexual behavior, and developing healthy relationships with others are examples of these.

Melissa A. Mariani, PhD

See also: Cliques; Gangs; Identity and Identity Formation

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Perfectionism

Perfectionism is the belief that striving for perfection is important because one's self-worth is measured by one's productivity and accomplishments.

Definitions

- **Anorexia nervosa** is an eating disorder characterized by refusal to maintain minimal normal body weight along with a fear of weight gain and a distorted body image.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) beliefs, behaviors, and emotions.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **Five-Factor Personality Model** is a model of personality in which five factors—extraversion, consciousness, agreeableness, openness, and neuroticism—are viewed as core personality structures.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Obsessive-compulsive personality disorder** is a mental disorder characterized by a pattern of preoccupation with extreme perfectionism, orderliness, and control.
- **Personality** is the enduring pattern of perceiving, feeling, relating, and thinking about one's environment and oneself.
- **Personality trait** is an enduring interior characteristic inferred from an individual's trend of actions, feelings, and habits.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy or therapeutic counseling.

Description

Perfectionism is the belief that perfection is worth striving for and achieving. In its unhealthy form, it is the belief that it is unacceptable to accept anything less than perfection. It is a personality trait that is characterized by the belief that achieving very high performance standards is all important. It also involves overly critical self-evaluations and concerns regarding others' evaluations of the extent to which those standards are achieved. Besides very high performance standards, some perfectionists adhere to highly structured routines and make very detailed plans. They may also apply excessive control to the environment in an effort to achieve their expected performance. Some believe their accomplishments are never good enough

despite exceeding what most consider above-average performance.

The term "perfectionism" is best understood on a continuum or range of possible descriptions. On one end of the continuum, there is maladaptive (unhealthy) view of perfectionism. It is characterized by the belief that everything must be completely perfect all the time and it is shameful not to achieve it. On the other end of this continuum is a more adaptive (healthy) view of perfectionism. It is characterized by the belief that pleasure can be derived from one's striving for perfection even if the result it less than perfect.

Those with an unhealthy view of perfectionism may avoid completing a task, anticipating that the results will be less than perfect. Procrastination is not uncommon in those with such a view of perfectionism. Those with this view tend to avoid doing new activities, taking new jobs, or meeting new people for fear of less-than-perfect outcomes. They may also be overly critical of others as a consequence of their perfectionist expectations. In contrast, life tends to be different for those with a healthier view of perfectionism. These individuals are also highly goal oriented and conscientious, but they are able to accomplish tasks. Their drive for perfection serves as a motivator to achieve significant success in a given field such as business, art, and university teaching. However, they can accept less-than-perfect outcomes and they are able to enjoy their accomplishments. They seldom procrastinate or be overly critical of others.

Researchers have identified perfectionism as an aspect of conscientiousness as measured by the five-factor model of personality (McCrae and Costa, 2006). According to the five-factor model, conscientious is a measure of the tendency of an individual to be orderly, structured, disciplined, and goal oriented. Conscientiousness is measured on a continuum ranging from healthy to unhealthy. By identifying this continuum of conscientious and perfectionism, it is clear that perfectionism can be healthy or unhealthy.

There are a number of DSM-5 mental disorders that involve unhealthy perfectionism. Of these, obsessive-compulsive personality disorder is the most common. Individuals with this disorder are more likely to engage in perfectionistic behavior because they believe it is beneficial and necessary. Anorexia nervosa is also associated with perfectionism. Individuals with this disorder often have unreasonable expectation about physical perfections combined with skewed body image.

Although perfectionism is not a standalone diagnosis, it can be very distressing. It follows that perfectionism can be and is treated. For individuals who simply find themselves stressed by their overly perfectionistic strivings, psychotherapy is the preferred treatment. Of the various psychotherapy approaches, cognitive behavior therapy (CBT) is the often used treatment of perfectionism. CBT can be helpful in reducing unreasonable expectations of performance. It accomplishes this by helping the individual identify and modify belief about being perfect. This is combined with behavioral exercises. Such exercises expose the individual to tasks he or she has avoided and to setting more appropriate goals and expectations. Mindfulness practices may be also be a part of treatment.

Len Sperry, MD, PhD, and
Jeremy Connelly, MEd

See also: Anorexia Nervosa; Cognitive Behavior Therapy; Five-Factor Theory; Mindfulness Practices; Obsessive Compulsive Personality; Personality

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Performance-Enhancing Drugs

Performance-enhancing drugs (PEDs) are substances that professional or amateur athletes use to enhance, sustain, or improve their normal performance.

Definitions

- **Doping** is a slang term that describes the act of using substances that enhance athletic performance, endurance, or ability; the word "doping" was derived from the Dutch word "doop," which is an opium concoction that was favored by the Greeks.
- **Steroids,** also known as anabolic androgen or anabolic steroids, is an illegal drug injected into the body usually via syringe that contains a synthetic form of testosterone that aids in quickly increasing muscle mass in a body but has several negative physical and psychological side effects.

Description

People use substances known as performance-enhancing drugs to improve their normal athletic ability. This is also referred to as "doping." PEDs come in several forms, including pills, powders, liquid injections, and topical creams. The use of PEDs has become increasingly prevalent over the past few decades, resulting in a negative impact on sports as a whole. World-doping organizations have therefore imposed stricter regulations to discourage the use of these enhancing substances and to penalize those discovered to have used in their athletic careers. However, PEDs are still used at alarmingly high rates as some athletes, both professional and amateur, believe that their benefits outweigh the costs.

A broad set of substances are deemed performance-enhancing drugs. Categories of PEDs range from prototype performance enhancers like anabolic steroids (synthetic hormones) all the way to substances such as lean muscle builders, diuretics, painkillers, and masking drugs. Proteins and vitamins, though several have been proven to enhance performance and reduce recovery time, are rarely considered PEDs as most are produced naturally by the body. Enforcing standards and laws on the use of performance-enhancing drugs has been difficult to regulate given this wide range.

Professional or personal competition can influence one to begin using performance-enhancing drugs. The yearning to make a team, to prevent being cut from a current position, or to excel to the top of a chosen sport can drive one to use. Several world record holders and/or chasers as well as distinguished professional athletes across a variety of sports have been exposed for using PEDs. Lyle Alzado, Ben Johnson, Marian Jones, Jose Canseco, Lance Armstrong, Mark McGwire, Barry Bonds, and Alex Rodriguez are some of the most recognized names. Some have indicated that the pressure to attain certain goals or a level of ranking in the sport influenced their decision to begin using. However, in addition to damaging their own reputations, these athletes' associations with PED use have resulted in tarnishing the value of awards, trophies, and other sports-related accomplishments. Another reason both professional and amateur athletes report for using performance-enhancing drugs are personal and health-related gains. As cited, PEDs can enhance muscle mass, burn fat, eliminate excess water, and relieve pain. Though there are benefits, the use of performance enhancers can result in serious short-term and long-term physical, psychological, and personal consequences for users. Physical symptoms may include acne, changes in primary and secondary sex characteristics, and hair growth. Physiologically, one can also experience increased heart rates, fluctuations in blood pressure, rapid weight loss, and mood swings. Several other side effects are commonly reported. Prolonged use can damage internal organs and eventually lead to death.

Dating back to the Ancient Greeks and the first Olympic Games (776–339 BC), performance-enhancing substances have been used in sport. The Greeks used herbal medications, wine potions, hallucinogens, and other concoctions to improve their performance. Roman gladiators were also known to ingest a hallucinogenic solution containing strychnine and fed enhancers to their horses. The first documented use of PEDs in the Olympic Games occurred in 1904, with athletes using strychnine, cocaine, heroin, and caffeine combinations to boost their ability. In 1928, the International Association of Athletics Federation became the first international sports federation to ban doping. An increase in performance-enhancer use then came after the Federal Drug Administration approved the sale of anabolic steroids in the United States in 1958. A decade later (1968), the International Olympic

Committee (IOC) instituted compulsory drug testing at the Winter Olympic Games. The IOC added steroids to the list of banned substances in 1975. On September 27, 1988, Canadian runner Ben Johnson was stripped of his Olympic medal after testing positive for the anabolic steroid stanozolol. President Reagan then signed the Anti-Drug Abuse Act of 1988 banning the sale of steroids for nonmedical purposes. On October 5, 1990, Congress passed the Anabolic Steroids Control Act classifying these synthetics as Schedule III narcotics. Former NFL player Lyle Alzedo died of brain cancer in May 1992; Abuse of steroid and human growth hormone for decades was linked to his death.

Impact (Psychological Influence)

On November 10, 1999, the World Anti-Doping Agency was officially established to combat doping in international sports arenas. President Bush signed the Anabolic Steroid Control Act on October 22, 2004, and went on to sign a law banning gene doping in sports in December 2006. A litany of professional athlete names soon came under public scrutiny for their use. Cyclist Floyd Landis was stripped of his Tour de France title on September 20, 2007, as speculation surrounding his sport increased. On December 12, 2007, Marion Jones was stripped of her three gold and two bronze medals from the 2000 Olympics and her world record holding for her use. On January 11, 2009, she was also sentenced to six months in prison for lying. Barry Bonds was then indicted before a grand jury on November 15, 2007, for lying about his steroid use. He was also found guilty on March 21, 2011. Documented use of PEDs in other sports such as soccer, tennis, and swimming was also made public. On May 2, 2009, the winner of Kentucky Derby tested for steroid use for the first time. Former MLB player and home run record holder Mark McGwire admitted to using performance enhancers for nearly a decade on January 11, 2010. On May 19 of the same year, Floyd Landis admitted to using most of his career and went on to accuse other riders, including Lance Armstrong. On August 23, 2012, Armstrong was stripped of his seven Tour de France titles after growing speculation. Finally, on January 17, 2013, after repeated denials of involvement, Armstrong admitted to his using performance-enhancing drugs in an interview with Oprah Winfrey. On August 5, 2013, MLB player Alex Rodriguez was suspended after evidence mounted surrounding his use.

Melissa A. Mariani, PhD

See also: Psychopharmacology

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Perls, Fritz (1893–1970)

Fritz Perls was a German-born American psychiatrist of Jewish descent best known for the development of gestalt therapy, the empty chair technique, and his controversial style of therapy.

Description

Friedrich (Fritz) Salomon Perls was born in Berlin, Germany, on July 8, 1893. Perls grew up in Berlin during the bohemian avant-garde years leading up to World War I. As a teenager he enjoyed poetry and existential philosophy, and was highly involved in theater. He served in the German army and fought in the trenches of World War I. His war experiences were horrific. After the war he studied medicine and began working with veterans who had suffered brain injuries. Being drawn to the work of Sigmund Freud he studied at the Berlin Institute of Psychoanalysis. In 1930, Perls married Lore Posner, later to be known as Laura Perls, and had two children together. Laura Perls, a psychotherapist, was heavily involved in the development of gestalt therapy along with her husband.

Soon after Hitler came to power in 1933, the Perls fled to the Netherlands before immigrating to Johannesburg, South Africa. In South Africa Fritz established

a psychoanalytic training institute. In 1942, during World War II, Fritz became a captain in the South African army, serving as a psychiatrist until 1946. Perls's first book *Ego, Hunger, and Aggression* was published in 1942.

In 1946 the Perls moved to the United States and eventually settled in Manhattan, New York, where he incorporated ideas garnered from psychodrama, posture and movement, and modern dance. Working with American sociologist, poet, and intellectual Paul Goodman, Perls wrote his second book *Gestalt Therapy*, published in 1951. Fritz and Laura Perls founded the Gestalt Institute and began seeing clients in their Manhattan apartment.

Fritz Perls began conducting workshops and seminars on gestalt therapy and traveled throughout the United States. In 1960, Fritz Perls left Laura Perls and moved to California where he further developed his ideas on gestalt. Influenced by humanistic, existential, and Zen philosophies he conducted workshops, and eventually lived, at Esalen Institute in Big Sur, California. Esalen is a residential community, retreat center, and alternative educational institute, which focuses on personal growth, meditation, yoga, spirituality, and other humanistic-oriented practices. Perls lived on Esalen property until 1969 before moving to Vancouver Island, Canada, where he started a gestalt community. Fritz Perls died in 1970 after undergoing heart surgery in Chicago.

Impact (Psychological Influence)

Frits Perls was instrumental in the development of gestalt therapy, a term he coined. The word "gestalt" is defined as something that is made of many parts and is greater than the sum of those parts. Gestalt therapy is an insight-oriented psychotherapy that focuses on the present moment using what is taking place between the therapist and client to develop insight and promote change. Perls believed that as clients increased their awareness and understanding of their perceptions, feelings, and behaviors in the here and now as they interact with the therapist, change automatically occurs.

Perls was known for being a dramatic showman with a confrontational and sometimes hostile style. During the development of gestalt therapy many of Fritz's students emulated his style and this remains a criticism of Perls. Perls was also considered arrogant and dismissive to his family. Laura Perls made significant contributions to the development and establishment of gestalt therapy and is credited with correcting many of the excesses exhibited by Fritz.

Fritz Perls was a controversial pioneer in the development of gestalt therapy. He published three books in his lifetime: *Ego, Hunger and Aggression* (1942), *Gestalt Therapy Verbatim* (1969), and *In and Out the Garbage Pail* (1969).

Steven R. Vensel, PhD

See also: Gestalt Psychotherapy

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Persistent Depressive Disorder

Persistent depressive disorder is a mental disorder characterized by a long-standing depressed mood. Previously it was called dysthymic disorder or chronic depression.

Definitions

- **Acceptance and commitment therapy** is a form of therapy that focuses on helping individuals accept their negative experiences without being critical or judgmental. This is combined with a commitment to set goals. It is also referred to as ACT.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.

- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood. It includes major depressive disorder, disruptive mood dysregulation, and persistent depressive disorder.
- **Dialectical behavior therapy** is a psychotherapy approach that focuses on coping with stress, regulating emotions, and improving relationships.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Major depressive disorder** is a mental illness characterized by depressed mood or loss of interest in formerly pleasurable activities that lasts the most days for two weeks or more.
- **Mood** is an individual's subjective emotional experience and expression.
- **Neurotic** is an outdated but still used term to describe an individual who is somewhat more emotionally unstable than others or is more prone to psychological distress.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotropic medications** are prescribed drugs that affect thinking, feeling, and behavior. They include antipsychotic, antianxiety, antidepressant, and antimanic drugs.

Description and Diagnosis

Persistent depressive disorder is one of the group of depressive disorders that is characterized by chronic depression lasting at least two years. Those with persistent depressive disorder experience symptoms similar to those of major depressive disorder. The main difference is that depressive symptoms in persistent depressive disorder tend to be less severe and last for two years or more.

Estimates of the prevalence of this disorder range from .05% to 1.5% in the United States. This contrasts with major depressive disorder that affects approximately 7% of adults (American Psychiatric Association, 2013). This disorder, as well as other depressive disorders, commonly co-occurs with both anxiety and substance abuse disorders.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, to be diagnosed with this disorder, the individual must meet certain criteria. As stated earlier, the most important criterion is that the depressed mood has been present for at least two years in adults. In children and adolescents, the symptoms need be present only for one year to be considered. In addition, the individual must experience a depressed mood for the majority of days. Also, the individual may experience fluctuations in appetite, inability to sleep or sleep excessively, fatigue, reduced self-esteem, difficulty thinking, or a sense of hopelessness. Individuals may experience any of the symptoms with differing levels of severity. That is to say that some may have a mild form of this disorder while others may have a far more severe form. Like all disorders, it is important to rule out other disorders that may share certain attributes or symptoms (American Psychiatric Association, 2013).

The specific cause of this disorder is unknown, but it is believed that genetics, brain functions, and the environment play a role in the manifestation of this disorder. Specific factors may include a family history of depressive disorders, loss of a parent in childhood, and the existence of other mental disorders.

Treatment

Treatment for this disorder is likely to include psychotherapy and psychotropic medications. Effective forms of psychotherapy include cognitive behavior therapy, dialectical behavior therapy, and acceptance and commitment therapy. Common to these approaches is an emphasis on helping the individual increase coping skills, better understand symptoms, and modify maladaptive (unhealthy) beliefs. Unlike other mental illness, those with persistent depressive disorder are more likely to come to the attention of their primary care physician. Ideally, those physicians would refer

them to a mental health professional for further assessment and possible treatment, as many physicians are not adequately trained to address mental illness.

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See also: Acceptance and Commitment Therapy (ACT); Antidepressants; Cognitive Behavior Therapy; Depression and Depressive Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Dialectical Behavior Therapy (DBT); Major Depressive Disorder; Mood; Psychotherapy

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Personality Change Due to Another Medical Condition

Personality change due to another medical condition is a mental disorder characterized a persistent personality change caused by a medical condition.

Definitions

- **Delirium** is sudden and severe confusion due to changes in brain function that occur in mental and physical illness.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Epilepsy** is a medical condition when seizures reoccur. It is also known as seizure disorder.
- **Huntington's disease** is an inherited disease that causes degeneration of nerve cells in the brain.
- **Opioids** are a class of narcotic drugs used to treat moderate to severe pain. The classes include both natural and synthetic substances.
- **Personality** is a set of enduring mental and behavioral traits that distinguish individuals.
- **Personality disorders** are a group of DSM-5 mental disorders characterized by a long-standing pattern of maladaptive (problematic) behaviors, thoughts, and emotions that deviates from the norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. Psychotherapy is also called therapeutic counseling.
- **Selective serotonin reuptake inhibitors** are the most commonly prescribed antidepressant medication because they generally have few side effects. They are also referred to as SSRIs.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.
- **Stimulant** is a drug that increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity.
- **Stroke** is a medical condition when there is deprivation of oxygen to the brain due to a lack of blood flow.

Description and Diagnosis

Personality change due to another medical condition is one of the DSM-5 personality disorders. It is characterized by symptoms that include poor impulse control, affective instability (e.g., emotions, feelings, perceptions), outbursts of aggression and rage, paranoid thoughts, and suspiciousness. Often, others will notice that an individual is just not himself or herself.

The presentation of an individual with this diagnosis may depend on the features of the disease process. For example, injuries to the frontal lobe (front part) of the brain may cause symptoms of impulsiveness, lack of judgment, and intense feelings of excitement. Strokes have been shown to cause personality changes in individuals. Some of these changes include an individual not being able to perform simple voluntary acts (e.g., keeping eyes closed). In addition, the individual may have the inability to remember things. For example, an individual may be asked to recall a memory of a particular object and draw a picture of it. The individual may only draw half of the object or draw nothing at all.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if an individual exhibits a personality change that is persistent and a change from an individual's previous personality pattern. Children with a personality disturbance must have a noticeable diversion from normal development or exhibit a remarkable change in the child's usual behavior patterns, and must last for at least one year. The personality change must be the direct result of a medical condition. The disturbance cannot be better explained by another mental disorder and cannot occur solely during the course of a delirium. The personality disturbance must cause clinically significant distress in occupational, social, or other important areas of an individual's life. Specifiers must be included when making this diagnosis. According to the DSM-5 manual, these specifiers include the aggressive type, apathetic type, labile type, paranoid type, disinhibited type, combined type, other type, and unspecified type. The aggressive type is a kind of specifier that mainly reveals aggressive behavior. The apathetic type primarily displays disinterested and indifferent behavior. The labile type is a specifier where the main feature is affective lability (e.g., outward emotional expressions). The paranoid type is a kind of specifier where the primary feature is an individual having paranoid thoughts or suspicions. The disinhibited (lack of restraint) type is characterized by poor impulse control (e.g., shopping sprees and sexual indiscretions). The combined type is a kind of specifier that is assigned if more than one feature is present (e.g., apathetic type and aggressive type). The other type is a kind of specifier that is assigned when it is not characteristic of any other subtypes (e.g., paranoid type, labile type). The unspecified type is a kind of specifier that is assigned to this diagnosis when the characteristic feature is unidentified (American Psychiatric Association, 2013).

The occurrence of this disorder includes several medical and neurological conditions. These conditions have been known to cause personality changes in individuals as a result of the symptoms. Some other conditions that cause this disorder include epilepsy, Huntington's disease, and head trauma. Some chronic (long-term) medical conditions are also associated with changes in personality (e.g., pain and disability). This diagnosis can be assigned only if the medical condition is established from the process of examining abnormal conditions.

Treatment

Psychotherapy and medication management have been shown to be effective forms of treatment for individuals diagnosed with this disorder. Some medications prescribed for this disorder include selective serotonin reuptake inhibitor (SSRI) antidepressants. SSRI antidepressants have been shown to be effective in helping individuals with lability (readily undergoing a change). Low-dose stimulants have been shown to be helpful for individuals with impulsivity. Managing environmental factors can also be helpful for managing fatigue and pain. Healthy sleep patterns and avoiding alcohol, caffeine, illicit substances, and opioids for pain can be effective for this disorder. Implementing and maintaining a healthy exercise routine has also been shown to be helpful. Families should participate in the process of therapy. This may help educate families about the disorder and develop an understanding of an individual's inappropriate behaviors.

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See also: Antidepressants; Brain; Delirium; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Fatigue; Psychotherapy; Stroke

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Personality Disorders

Personality disorders are mental disorders characterized by long-standing pattern of problematic behaviors, thoughts, and emotions that deviates from the accepted norms of an individual's culture.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.

Description and Diagnosis

DSM-5 defines a personality disorder as a persisting pattern of inner experience and behavior that differs markedly from the expectations of the individual's culture. The disorder is pervasive and inflexible, and is stable over time. This pattern leads to significant problems and limitations in relationships, work and school, and social situations. Personality disorders have their onset in adolescence or early adulthood (American Psychiatric Association, 2013). Basically, personality disorders are a group of behavioral disorders that are distinct and different from the anxiety, mood, and psychotic disorders.

The majority of those with a personality disorder do not seek or receive mental health services. Those who receive treatment do so in the context of another mental disorder. Or, they may receive services because of a personal crisis such as harming themselves or committing a crime. Still, recognition and diagnosis of personality disorders is important since these disorders predispose individuals to other mental disorders and affect the way these other disorders present and are treated. However, since personality disorders can cause considerable distress and impairment (problems), they can and should also be treated.

Personality disorders are believed to be caused by a combination of genetic and environmental influences. That means that an individual may have a genetic vulnerability to developing a personality disorder and his or her life situation may trigger the development of the disorder. Following is a brief description of the 10 personality disorders described in DSM-5.

Antisocial personality disorder. Antisocial personality disorder is characterized by a callous unconcern for the feelings of others. The individual with this disorder disregards social rules and obligations, is irritable and aggressive, acts impulsively, lacks guilt, and fails to learn from experience. The individual often has no difficulty finding relationships, but they are usually turbulent and short lived. Those with this disorder often have a criminal record or even a history of being in and out of prison. It is more common in men than in women.

Avoidant personality disorder. Individuals with this disorder tend to be persistently tense because they believe that they are socially inept, unappealing, or inferior. They often have a history of actual or perceived rejection by parents or peers during childhood. As a result, they fear being embarrassed, criticized, or rejected. They are likely to avoid meeting others unless they are certain of being liked. They also avoid taking risks. It is not uncommon for those with this disorder to also be afflicted with an anxiety disorder.

Borderline personality disorder. Those with this disorder often lack a cohesive sense of self. As a result, they experience feelings of emptiness and fears of abandonment. This shows in intense, unstable relationships, emotional instability, angry outbursts, and impulsive behavior. Suicidal threats and acts of

self-harm are also common. Many with this disorder have a history of childhood sexual abuse. The disorder is so named because it lies on the "borderline" between the neurotic (anxiety) disorders and psychotic disorders like schizophrenia.

Dependent personality disorder. This disorder is characterized by a lack of self-confidence and an excessive need to be taken care of. These individuals often need others to help them make everyday decisions as well as important life decisions. They greatly fear abandonment and may go to great lengths to secure and maintain relationships. These individuals view themselves as inadequate and helpless. As a result, they tend to shun personal responsibility and put their fate in the hands of others to protect and care for them.

Histrionic personality disorder. Those with this disorder usually lack a sense of self-worth, and so they depend on the attention and approval of others. They can be quite dramatic in their efforts to attract and manipulate attention. They are also very concerned about their physical appearance and behave in a manner that is overly charming or seductive. Because they crave excitement and act on impulse or suggestion, they put themselves at risk of being harmed or exploited. Their relationships with others often seem insincere or superficial. They also tend to be sensitive to criticism and rejection and react badly to failure or loss.

Narcissistic personality disorder. Those with this disorder typically have a grandiose sense of self-importance, a need to be admired, and a sense of entitlement. They lack empathy and readily exploit others to achieve their own needs. To others, they seem to be self-absorbed, controlling, intolerant, insensitive, and selfish. They also tend to be envious of others. If they feel slighted or ridiculed, they will respond with rage and may seek revenge. Their anger and rage can have disastrous consequences for all involved.

Obsessive-compulsive personality disorder. Those with this disorder are characterized by excessive preoccupation with details, rules, lists, order, and schedules. Their perfectionism is so extreme that it prevents them from completing tasks. Their devotion to work and productivity is at the expense of relationships and their well-being. They also tend to be doubting, cautious, humorless, rigid, controlling, and miserly. Their underlying anxiousness is rooted in their perceived lack of control of the individuals and situations. The result is that they have little tolerance for ambiguity and view everything in absolutes (all right or all wrong). Their relationships with friends, colleagues, and family tend to be strained by their unreasonable and inflexible demands. This disorder is not to be confused with obsessive-compulsive disorder.

Paranoid personality disorder. This disorder is characterized by a pervasive pattern of distrust of others. Individuals with this order are often guarded and suspicious. They constantly look for clues to confirm their worst fears. Typically, they have a strong sense of self-importance and personal rights. They are also overly sensitive to setbacks and criticism, and are easily humiliated. They also bear grudges and will lash out when they feel threatened. As a result, they have a tendency to withdraw from others and have difficulty engaging in close relationships.

Schizoid personality disorder. Individuals with this disorder are often detached and aloof, and are prone to introspection and fantasy. Many have little desire for social or sexual relationships. They tend to be indifferent to social norms and conventions, and lack emotional responsiveness. In some situations, they may appear cold and callous. Nevertheless, they are generally able to function well despite their pattern. For those who might desire some level of intimacy, they may find initiating and maintaining relationships are sufficiently difficult or distressing that they give up trying.

Schizotypal personality disorder. This disorder is characterized by a pervasive pattern of oddness or eccentricity in appearance, thinking, speech, and behavior. Their thinking and thought process may include odd or unusual beliefs, magical thinking, suspiciousness, obsessions, and unusual perceptual experiences. They typically view others as potentially harmful and as a result fear relating to those they do not know. On the other hand, they may involve themselves with others or groups who have similar odd or unusual beliefs.

Treatment

Effective treatment depends on the particular personality disorder and its severity. Some personality

disorders are easier to treat (avoidant personality disorder), while others are less responsive to treatment (antisocial personality disorder). Usually, psychotherapy is the mainstay of treatment for these disorders, and its goal is to decrease distress or symptoms and to improve functioning in relationships, work or school, and social situations. Cognitive behavior therapy is a common psychotherapy approach for the various personality disorders. It is often useful in identifying unhealthy and negative beliefs and behaviors and replacing them with more healthy and positive ones. Currently, no medications have been specifically approved by the Food and Drug Administration to treat personality disorders. But various types of medications are used to treat specific personality disorder symptoms. These include antidepressants, antipsychotics, and antianxiety medications.

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See also: Antianxiety Medication; Antidepressants; Antipsychotics; Cognitive Behavior Therapy; Obsessive-Compulsive Disorder

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Personality Tests

Personality tests are psychological measures used to assess various personality characteristics.

Definitions

- **Five-factor model** is a model for describing personality in terms of conscientiousness, extroversion, agreeableness, emotional stability or neuroticism, and intellect or openness to experience.
- **Norms** are standard or range of test scores that represent the typical score of a group and used to determine the relative standing of an individual's test score compared to others in the group.
- **Objective personality test** is a psychological test that usually has a multiple-choice format and yields scores that are independent of the opinion or judgment of the examiner.
- **Projective personality test** is a psychological test where the test-taker responds to ambiguous stimuli that reveal his or her unconscious (hidden) emotions and personality characteristics.
- **Psychometric** refers to the characteristics of a psychological test, particularly its reliability (consistency) and validity (accuracy).

Description

A personality test is a procedure for assessing personality characteristics in a variety of contexts ranging from individual and couples therapy to employee selection and career planning. In a therapy context, personality tests are used for diagnosing, treatment planning, and structuring the therapeutic relations with clients. There are different types of personality tests. The most common uses are the self-report inventory tests. Self-report inventories consist of questions or items to which the test-taker responds by rating the degree to which each item or question reflects his or her behavior or attitude. Because these tests can be scored objectively, they are also known as objective personality tests. An example of an item on a personality test is, "I talk to a lot of different people at parties." Test-takers rate the degree to which they agree with the statement by using a scale of 1 ("strongly disagree") to 5 ("strongly agree"). In contrast, the Minnesota Multiphasic Personality Inventory has a True–False format. In addition to these self-report inventories, there are many other methods for assessing personality, including observational measures, peer-report studies, and projective tests such as the Thematic Apperception Test and the Rorschach Inkblot Test. Today, personality tests have become a

multimillion-dollar industry and are used in a several contexts: individual therapy, couples counseling, employee selection, and career planning.

Developments and Current Status

The first personality tests were developed in the 1920s and were intended to ease the process of personnel selection, particularly in the military during World War I and World War II. The Rorschach Inkblot Test was published in 1921, the Minnesota Multiphasic Personality Inventory appeared in 1939, and the Rotter Sentence Completion Test appeared in 1950. Since then, a wide variety of personality tests have been published. There are two main categories of personality tests: structured or objective personality tests and projective personality tests. The most common are briefly described here.

Objective Personality Tests

Objective personality tests are administered and scored in a standardized fashion. These tests consist of the administration of a designated set of items that are marked and compared against exacting scoring mechanisms that are fully standardized. They are scored and interpreted in a manner that is independent of the examiner's own beliefs and subjective biases. Typically, these tests have norms.

Minnesota Multiphasic Personality Inventory (MMPI). This personality inventory that assesses personality traits and psychopathology used to assess individuals presumed to have mental health or other clinical issues. There are two current forms: the MMPI-2 with 567 true–false items and the lesser used but shorter MMPI-2-RF with 338 items The MMPI-2 is designed with 10 clinical scales that assess the major categories of abnormal human behavior. It also includes four validity scales that assess the individuals' general test-taking attitude and truthfulness and accuracy in answering the questions. After the test is taken and scored, an interpretive report is constructed based on a set of standard clinical profiles called "codetype." For example, a 2–3 codetype (both Scales 2 and 3 are significantly elevated) suggests significant depression, lowered activity levels, helplessness, and often physical complaints.

Millon Clinical Multiaxial Inventory (MCMI). This personality inventory assesses personality traits and psychopathology. Its fourth edition, MCMI-IV, provides a measure of personality disorders and clinical syndromes of adults undergoing psychological assessment or treatment. It is helpful in developing a treatment plan based on the test-taker's personality style and coping behavior. The MCMI-IV is composed of 175 true–false questions and takes about 25 to 30 minutes to complete. It can be hand scored or computer scored and produces 24 personality and clinical scales and 5 correction scales that verify how the test was approached and taken. An interpretive report includes a treatment guide for focusing treatment interventions.

Myers–Briggs Type Indicator (MBTI). This personality inventory test designed to identify an individual's personality type, strengths, and preferences. The test was developed by Isabel Myers and Katherine Briggs and is based on Carl Jung's theory of personality types. It includes 93 forced-choice questions, which means that the test-taker chooses only one of two possible answers to each question. It can be hand scored or computer scored. Based on the response to the MBTI questions, test-takers are identified as having one of 16 personality types. Its purpose is to increase the test-takers' understanding of their likes, dislikes, strengths, weaknesses, possible career preferences, and compatibility with others. Unlike other objective personality tests, the MBTI is not normed. It is commonly used in career counseling, team building, personal and professional development, leadership training, executive coaching, life coaching, and couples counseling.

NEO Personality Inventory-Revised (NEO PI-R). This personality test is based on the five-factor model of personality. It concisely measures five basic domains of personality and the six facets that define each domain. The NEO PI-R provides a detailed assessment of normal personality, for use in human resource development, industrial and organizational psychology, and vocational counseling as well as in clinical practice. It has 240 items and 3 validity items and takes 35 to 45 minutes to complete. It can be hand scored or computer scored. Two report options are available: an individual report for professional development planning and a professional development for management planning. Both identify an individual's strength and limitations in four major areas: problem-solving skills; planning, organizing, and implementation skills; style of relating to others; and personality style.

Projective Personality Tests

The use of projective personality tests is based on the premise that when individuals are exposed to vague or ambiguous stimuli, their interpretation of the stimuli will reflect their motivations, thought processes, and conflicts. Because of their subjective nature of the interpretation of the test-taker's responses, projective tests tend to have poorer psychometric properties than objective personality tests. Most projective personality tests have intricate scoring criteria and guidelines which require extensive training in the proper administration, scoring, and interpretation of these measures.

Rorschach Inkblot Test. The Rorschach is the most widely used and well known of all the projective personality tests. It consists of 10 inkblots present to the test-taker in two phases. In the first or association phase, the examiner holds out one card at a time and asks the test-taker what each might be. The examiner records these responses. In the second or inquiry phase, the examiner goes through each card and asks the test-taker to explain what he saw in each card.

The examiner records these responses verbatim. Scoring is based on the responses and explanations. Over the years, a number of scoring systems have been developed for interpretation. Currently, the most widely used is the Exner Comprehensive System.

Thematic Apperception Test. This test differs from other projective personality tests in that the test-taker is asked to construct a story from a picture shown by the examiner. The story is recorded verbatim and then interpreted using specific scoring criteria. Examples of elements considered in the interpretation are the hero, motives (needs) such as affiliation (belonging), power, and achievement, as well as environmental presses (factors), family relations, and recurring themes.

Rotter Sentence Completion Test. This test presents the test-taker with 40 sentence stems (first part of a sentence) and asked to complete the sentence in writing. Examples of these stems are "Other people _____." and "The happiest time_____." By grouping and evaluating the responses the examiner can postulate and make judgments about the test-taker's personality dynamics. Originally developed by psychologist Julian Rotter in 1950, this test is widely used in a variety of evaluations. Since the original Rotter test was first introduced several, variations on this kind of test format have been developed. This includes versions for children, adolescents, and older adults. Some are specifically geared toward testing sex offenders and other behaviorally disordered individuals.

Expressive Tests

These tests ask the test-taker to engage in drawing. The test-taker is given paper and drawing items (crayons or markers) and given specific directions. For example, in the Draw-A-Person test, the instruction is to draw a person of their choosing. In the House-Tree-Person test, the test-taker is asked to draw a house, a tree, and a person in that order. In the Kinetic-Family-Drawing, the test-taker is asked to draw a picture of their family including themselves engaged in some activity (doing something). The drawings are interpreted through specified guidelines. Conscious and unconscious (hidden) dimensions of personality as well as relational dynamics can be assessed using such expressive tests of personality. For instance, a child's Kinetic-Family-Drawing picture is presumed to elicit the child's attitudes toward his family and the overall family dynamics.

Len Sperry, MD, PhD

See also: Millon Clinical Multiaxial Inventory (MCMI); Minnesota Multiphasic Personality Inventory (MMPI); Rorschach Inkblot Test

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Personalized Medicine

Personalized medicine is medical practice that uses information about an individual's unique genetic makeup and environment to customize medical care to the individual's unique needs.

Definitions

- **Gene expression** is the process by which information from a gene is used to make proteins.
- **Genes** are the carriers of the genetic code present in each cell.
- **Genetic code** is the sequence of genes that reflect biochemical basis of heredity (inherited traits).
- **Genotype** is one's genetic makeup and the potential for unique traits or characteristics to develop.

Description

Personalized medicine is a model of medical practice based on the tailoring treatment to the causes and the unique characteristics of each individual. The basic premise is that treatment is based on causes. This means that all medical decisions and interventions are based on information about an individual's unique genotype and environment. The result of this customized approach is that most individuals get well. This contrasts with the conventional model of medical practice where treatment is based on a diagnosis that is based on symptoms. The basic premise is that treatment is based on symptoms and all individuals who have the same symptoms receive essentially the same treatment. With this "trial-and-error" approach, some get well, while others do not.

Personalized medicine is the use of detailed information about an individual's genotype or level of gene expression and unique and environmental circumstances such as levels of stress, diet, activity level, and exposure to toxins. Such data is considered in selecting a medication, therapy, or preventative measure that is uniquely suited to that individual. The benefits of this approach are its accuracy, efficacy, safety, and speed. The term "personalized medicine" emerged in the late 1990s with progress in the Human Genome Project.

Developments and Current Status

In the past decade, a predictive science has emerged from biomedical research. It is recognized by the shared terminology of "omics." These include genomics, proteomics, metabolomics, cytomics, and nutrigenomics. This new approach focuses on how individuals' unique molecular and genetic profile and environment makes them susceptible to certain diseases. This focus on causes over symptoms increases the level of prediction about which treatments will be safe and effective for an individual and which will not. Because of the increasing precision of diagnostic methods, health-care providers can more confidently select a treatment protocol that will maximize therapeutic effects and minimize harmful side effects. Also, there is mounting evidence that personalized medicine is more cost effective than the "trial-and-error" conventional medical practice. Personalized medicine is changing the way health-care professionals think about, diagnose, and manage health problems. Increasingly, it is already impacting the delivery of medical care. Besides medical conditions, personalized medicine also has applicability to neuropsychiatric and psychiatric conditions.

Len Sperry, MD, PhD

See also: Deplin (Methyl Folate); Functional Medicine

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Person-Centered Therapy

Person-centered therapy is a name for the client-centered, nondirective approach to counseling and psychotherapy developed by psychologist Carl R. Rogers.

Definition

- **Nondirective** refers to a clinical approach to treatment where the therapist allows the client to set the pace and content of therapeutic counseling sessions.

Description

Person-centered therapy is characterized by two main ideas. The first is that human beings have the power to identify and find answers to their psychological problems. The second idea is that the role of the therapist is to help guide and not to direct the treatment process. Hence, person-centered therapy is often also called client-centered and nondirective therapy.

Carl Rogers (1902–1985) was influenced by the revolt of Otto Rank, one of Freud's colleagues, who came to oppose the traditional psychotherapeutic model of the time. In this model, the role of the therapist was to act as an emotionless but critical observer as the client shared his or her feelings and behaviors. According to this model, the therapist would provide superior knowledge and insight into a client's issues and offer an analysis of the meaning of his or her life. In this environment, it is easy to see how many clients would come to depend on their therapists. This was based on the belief that the therapist was the only person who could provide understanding and answers for a client. In this model, it was the therapists who made recommendations for changes and were responsible for the clients making improvements or getting better.

Rogers's firmly rejected Freud's paradigm of psychotherapy and challenged the notion that the therapist was responsible for the success of the treatment. He realized that it was actually the client's needs, feelings, and experiences which should determine the direction and pace of psychotherapy. From this concept Rogers developed person-centered or Rogerian therapy.

Rogers saw the therapist as a kind of supportive facilitator of the process, a knowledgeable and emotionally available guide. But this doesn't mean that he underestimated the role of the therapist. On the contrary he believed that an emotionally open, honest, and nonjudgmental approach on the part of the therapist was the foundation for effective analysis and treatment. The person-centered therapist's goal is to support his or her client who should be the source of the answers that will allow for healing.

This person-centered approach is based on a clear vision about the importance of the client and the secondary role of the therapist. A positive relational climate is the most important factor in creating successful treatment outcomes in this model. This is because it creates a positive clinical environment where the client can explore and discover his or her own truth.

Rogers repeatedly emphasized that the client discovers the truth based on his or her own experience. Person-centered therapists believe that the clients themselves hold the answers to their own questions and that it's the therapist's job to help them in the process of discovering what these answers are based on the clients' reality and experiences. Rogers expressed it this way in one of his most famous books *On Becoming a Person*: "Experience is, for me, the highest authority. The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return again and again, to discover a closer approximation to truth as it is in the process of becoming in me."

Development

Rogers had studied with the influential psychiatrist Alfred Adler in the late 1920s. From Adler, Rogers learned the value of simple and direct communication with his clients. He used this when he began his own formal work in the 1930s where much of his therapeutic work was conducted in a clinical setting with children. In 1939 his first book *Clinical Treatment of the Problem Child* was published. During these years he began to formulate his ideas and recommendations for person-centered therapy.

At the University of Chicago in 1945, Rogers got the chance to put his ideas into practice in a clinical setting attached to the university. He summarized his insights and results in the influential book *Client-Centered Therapy*, published in 1951. The book title is indicative of Rogers's preference to use the word "client" instead of "patient." This signifies a more equal relationship between therapist and the person seeking therapy than the illness-based word "patient."

Rogers never identified one guiding teacher or mentor, but he did admit that Søren Kierkegaard and Martin Buber were enormous influences on his approach to psychotherapy. In Kierkegaard's work he saw the primacy of experience reinforced or of being in the here and now rather than spending time in the past. There was no longer any need for the client to look outside himself or herself for validation,

especially not from the therapist. Instead the client can become his or her best person in and outside of therapy. Buber's work strongly reinforced Rogers's commitment to the person-to-person relationship that should exist between client and therapist. The therapist was more genuinely present and served as a facilitator who showed emotion. Rogers learned through Buber about how communication and language could create intimacy in the therapeutic relationship.

Current Status

Outcome studies over many years have validated the principles and approach that Rogers used by the fact that it demonstrates stable changes in clients' lives. As a result, Rogers's work became so influential that the adjective Rogerian was often applied to any client-centered, nondirective approach to psychotherapy. His prominence was recognized when he was elected president of the American Psychological Association in 1956. In 1961 he published his most famous book *On Becoming a Person*.

Although there will always be those who dislike nondirective therapeutic approaches, the person or client-centered methods that Rogers used continue to be popular not just with therapeutic professionals but with clients as well. Rogers's ideas and person-centered therapy are commonly taught to therapists in training. Client-centered therapy was the inspiration for at least two other variants of nondirective therapies: experiential therapy and process-experiential therapy.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Nondirective Therapies; *On Becoming a Person* (Book); Rogers, Carl (1902–1987)

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Person–Environment Fit

The concept of *person–environment fit* describes the degree of overlap or compatibility between an individual's intrinsic characteristics and his or her extrinsic environment.

Definitions

- **Congruence Model,** developed by Nadler and Tushman in the early 1980s, suggests that organizations thrive when the degree of compatibility between four elements, task, people, structure, and culture, is high.
- **Organizational psychology** is the study of how humans behave in occupational or workplace settings.

Description

Person–environment fit describes how well an individual's characteristics (biological, psychological, emotional, and relational makeup) match up with his or her social and/or work setting. Alignment between these two entities has been an area of interest in organizational psychology and career counseling/assessment for decades. David A. Nadler and M. L. Tushman's Congruence Model, developed in the early 1980s, suggests a link between worker performance and degree of compatibility between the individual's values and those of his or her work environment. A correlation has also been noted regarding degree of compatibility and one's happiness and success.

The concept of person–environment fit can further be broken down into various domains, including person–organization fit, person–job fit, person–group fit, and person–person fit, each of which has been studied by researchers. Person–organization fit is the most commonly investigated, with research indicating that higher levels of congruence between a person's values and the organization in which he or she works result in higher levels of trust, satisfaction, a greater sense of community, connectedness, increased investment, and more productivity.

Current Status and Impact (Psychological Influence)

Determining person–environment fit is a critical element of career counseling and assessment practice. Those entering the workforce, seeking employment, or moving into new fields may undergo a series of assessments, typically in the form of questionnaires/surveys, to help determine the best fit for their individual aptitudes, personality, and characteristics. Organizations themselves have also seen the value of conducting these assessments during interview processes in order to determine if the potential candidate is an appropriate fit and will acclimate well in the company. Research suggests that organizations that invest in training and professional development opportunities can impact the degree of fit between themselves and their employees. Investment in such things increases worker buy-in subsequently resulting in better performance.

Melissa A. Mariani, PhD

See also: Career Assessment; Career Counseling; Professional Identity

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Pervasive Developmental Disorders

Pervasive developmental disorders (PDD) are group of diagnoses that describe impairments in the areas of communication, socialization, and behavior.

Description

Medical professionals often use the term "pervasive developmental disorders" as a synonym for autism spectrum disorders (ASD). PDD is a category of childhood diagnoses that included autistic disorder and Asperger's disorder in former classification systems. The diagnostic category of PDD differs from specific developmental disorders such as language impaired or specific learning disorders. PDD has encompassed a group of five disorders, all of which have in common delays in the development of basic functions around behavior, socialization, and communication. The diagnoses included under the category of PDD are pervasive developmental disorder-not otherwise specified, autistic disorder, Asperger's disorder, Rett syndrome, and childhood disintegrative disorder.

Each of these is explained in further detail in the encyclopedia entry for them. It is important to note that the first three of these disorders are also usually called autism spectrum disorders. However, the last two disorders are regressive in nature and rare. It is estimated that PDD or ASD may affect as many as 1 in 68 children.

Causes and Symptoms

Although medical professionals feel confident that the causes of PDD or ASD arise from deficits in brain functioning, there has been no clear identification of specific origins. The exception is Rett syndrome where it seems almost certain that a defect in the X chromosome is responsible, hence its restriction to girls. Researchers have identified some genetic abnormalities among certain groups of people with PDD or ASD but not one generalizable cause. Some suggest that a combination of genetics or biology and environmental influences during fetal development creates a predisposition to developing PDD or ASD.

Because of misconceptions in the past, it is important to note that parenting behaviors are not the cause of PDD or ASD. In the 1950s and 1960s, when the understanding about PDD or ASD was limited, many parents were informed by their physicians that their child's condition was a result of faulty bonding. This

group of parents were referred to as "refrigerator mothers." Since that time many advancements have been made, and although no one or even a group of causes have been identified, it is clear that parenting methods do not cause PDD or ASD.

The symptoms of PDD can be varied. Among the most commonly cited are difficulty using and understanding language and difficulty relating to people socially. Limited use of facial responses and unusual ways of playing with toys and other objects is often observed. It is common to see difficulty coping with changes in routine or familiar surroundings for people diagnosed with PDD or ASD. Many of them demonstrate repetitive body movements or behavior patterns, such as hand flapping or body rocking. Several symptoms need to be present in order for a child or adult to receive a diagnosis of PDD or ASD.

Diagnosis and Prognosis

In the current diagnostic system, PDD has been replaced with ASD. Both the previous PDD and the current ASD diagnosis depend on the involvement of several physicians. Families who are seeking a diagnosis for their child are usually referred to a neurologist to rule out any physical brain damage that may be causing problems with development. In addition to that a psychologist, psychiatrist, or other mental health professional can conduct standardized behavioral observations to determine if a child or adult meets the criteria for one of the ASD or former PDD diagnoses.

Some medical professions use the diagnosis global developmental disorder or social communication disorder for very young children when they are not yet sure that they are truly suffering from ASD. Since very young children tend to exhibit limited social interaction and communication skills simply because of their age, this makes it more difficult to diagnose milder cases of autism in toddlers.

PDD and ASD are lifelong conditions that do not have a cure. Many individuals with a PDD or ASD diagnosis who receive early intervention therapies make progress and are able to learn skills that they have not naturally acquired. The potential of each person with a PDD varies, and therefore, it is hard to make a prognosis for the population as a whole.

Treatment

As with so many other disorders, effective treatment will be based on the individual, on when they receive help or intervention, and on all of the factors in the child's environment. Once a sufficient diagnosis is reached, it is possible to plan for specific and tailored behavioral therapies and educational programs that can help alleviate some of the symptoms of PDD. Some of the evidence-based therapies approved for treating PDD include speech-language therapy, applied behavior analysis, occupational therapy, and social skills training. All these will help the child to behave and communicate with others in various ways that it is hoped will benefit them.

Education is an important component of treatment for those with PDD. There are programs to teach parents how to help their children through positive reinforcement and the enforcement of limits applied with consistency at home. Most physicians recommend 25 to 40 hours a week of therapy or some kind of active engagement with others. This can be done with family members at home as well as through school programs. Some children with PDD will need special education, while others with less severe symptoms may be able to be in mainstream education. It is not uncommon for individuals with PDD to be under psychiatric care because the use of medications can help treat many of the more severe symptoms of aggression and co-occurring mental health conditions.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Asperger's Syndrome; Autism; Autism Spectrum Disorders

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Phantoms in the Brain: Probing the Mysteries of the Human Mind (Book)

Phantoms in the Brain: Probing the Mysteries of the Human Mind is a best-selling book written in 1998 by V. S. Ramachandran and Sandra Blakeslee about Ramachandran's work with patients who have neurological disorders.

Definitions

- **Anomalies** are something that is different from what is considered normal or expected.
- **Neuroscience** is the scientific study of the nervous system and the brain.
- **Phantom limbs** is the sensation or feeling that a part of the body that is physically missing or has been removed is still present. The feelings are generally painful.

Description

Phantoms in the Brain is a best-selling book exploring the mysteries of the mind. The main author V. S. Ramachandran (1951–) is a prominent neurosurgeon, considered to be one of the best in the world. He has taken on the challenge of exploring medical anomalies. This book explores his cases of rare client disorders that could easily be mistaken for psychological disorders, yet the root of the problem lies within the brain.

Ramachandran is no stereotypical scientist. His work uses influence from the English playwright William Shakespeare and Holistic guru Deepak Chopra, as well as psychologists and references to religion. He takes an approach like that of Sherlock Holmes, thinking outside of the box and questioning everything. The book has some informality to it where Ramachandran's curiosity and wonder can be truly experienced by the reader.

Ramachandran is best known for his work with individuals who experience phantom limbs, meaning the sensation that people who have had limbs or other parts of the body removed feel. This book explains where some of these sensations originate, as well as the impact of damage to different parts of the brain on an individual. The author begins the conversation of hoping to connect an understanding of the brain and the impact and relationship with that of the individual who houses it.

Each of the patients written about suffers from damage of some sort to specific parts of the brain that results in bizarre changes in behavior. Traditionally, when someone was seen to experience behavior changes such as hearing or seeing things that were not present or feeling missing limbs, the assumption was that the person was mentally ill. *Phantoms in the Brain* finds these kinds of behavior changes to be the guide allowing for exploration of the human brain. The book explores the way these disorders are viewed from a psychological standpoint, as well as from a medical view. This leads to the possibility of exploring cases previously viewed as insanity as possibly simply being malfunctions in the brain.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Neurocognitive Disorders

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Phencyclidine-Related Disorders

Phencyclidine-related disorders are mental disorders characterized by the persistent use of phencyclidine or similar drugs (e.g., ketamine).

Definitions

- **Auditory and visual hallucinations** are severely distorted perceptions of what is real.
- **DSM** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders*,

which is the handbook mental health professionals use to diagnose mental disorders. The current edition is DSM-5.

- **Hallucinogen-related disorders** are DSM-5 mental disorders characterized by the use of mind-altering drugs that cause changes in mood, thoughts, perceptions, and consciousness. Unlike other drugs, they cause auditory and visual hallucinations.
- **Ketamine** is a drug that is used in both individuals and animals to treat pain or for sedation.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders characterized by maladaptive thoughts, excessive and repetitive behaviors, and physical symptoms. It includes cannabis use disorder and hallucinogen disorders.

Description and Diagnosis

Phencyclidine-related disorders are one group of the DSM-5 substance-related and addictive disorders. They are further subcategorized under the hallucinogen-related disorders. Phencyclidine is also known as PCP (or by the street name "angel dust"). It is primarily used by veterinarians and less often by physicians. However, it is also illegally used by individuals as a recreational substance. Phencyclidine and similar substances may be used for their pain-reducing, numbing, and/or hallucinogenic effects. They may be ingested orally, injected intravenously, or smoked. These substances affect dopamine and serotonin levels in the brain. Small amounts of phencyclidine drugs may result in euphoric feelings, while larger quantities may lead to aggressive behaviors. Physical side effects may include high blood pressure, increased heart rate, or lack of muscle coordination.

The occurrence of this disorder is not known. Use of phencyclidine and similar substances appears to increase with age. About 0.3% of individuals between the ages of 12 and 17 have taken phencyclidine. Approximately 1.3% of young adults aged 18 to 25 and 2.9% of adults aged 26 and older have used the drug. Males are more likely than females to use phencyclidine (American Psychiatric Association, 2013). African Americans and Hispanics are more likely to use phencyclidine and Caucasians are more likely to use ketamine (phencyclidine-like substance).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if, over a 12-month period, they need higher doses of the drug to achieve the desired effect. They have not been able to reduce usage or stop using. They have strong cravings and spend a lot of time finding, buying, and using the drug. Continued drug use leads to occupational, social, and interpersonal problems. The drug is used during situations that could potentially be dangerous, such as when driving. Phencyclidine-related disorders are not characterized by withdrawal symptoms (American Psychiatric Association, 2013).

The cause of this disorder may be attributed to genetic, biological, and environmental factors. An individual with a first-degree relative with a phencyclidine-related disorder has a higher chance of developing the disorder. Individuals with brain chemical imbalances may use phencyclidine substances to improve mood. Environmental stressors may also contribute to substance use.

Treatment

Treatment can include medication, psychotherapy, psychoeducation, and self-help groups. Once drug usage ceases, antipsychotic drugs may be necessary to manage phencyclidine-induced hallucinations. Antidepressant drugs may be necessary to treat symptoms of depression often associated with cessation of phencyclidine use. At this time, it is important to conduct a suicide assessment and refer individuals who require psychiatric hospitalization. Cognitive behavior therapy is the psychotherapy of choice in the treatment of phencyclidine-related disorders. The individual learns how to identify maladaptive thoughts, feelings, and behaviors and replace them with adaptive thoughts, feelings, and behaviors. Education on addiction, recovery, and coping skills can be very helpful in maintaining sobriety. Self-help groups founded on the Twelve-Step principles may provide a sober social network and support.

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See also: Addiction; Self-Help Groups; Substance-Related and Addictive Disorders; Twelve-Step Program

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Phobic Disorders

Phobic disorders are mental disorders characterized by intense and unreasonable fears of a situation or an object that cause little danger but produce anxiety and avoidance.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger. It is the anticipation of future threat.
- **Anxiety disorders** are a group of DSM-5 mental disorders characterized by excessive fear and anxiety and associated behavioral problems. These include panic disorder, generalized anxiety disorder, and phobic disorder.
- **Benzodiazepines** are a class of drugs that slow the nervous system and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing faulty behaviors, emotions, and thoughts. It is also known as CBT and cognitive behavioral therapy.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure therapy** is a behavioral therapy method in which an individual is exposed to a feared object or situation.
- **Fear** is an emotional response to a known danger.
- **Panic attack** is an episode of sudden, intense, and debilitating sense of fear that is short lived.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.

Description and Diagnosis

Phobic disorders are one of the group of DSM-5 anxiety disorders. They are characterized by a feeling of panic or terror when exposed to the source of an individual's fear. Individuals with a specific fear may do everything possible to avoid what they fear. Often, they are not able to function normally because they experience severe anxiety as a result of the fear. Symptoms of phobic disorders include rapid heartbeat, difficulty breathing, sweating, and a feeling of panic and extreme anxiety. Very often, an individual acknowledges that his or her fears are unreasonable but feels powerless to control them. In some cases, just thinking about a fear (e.g., snakes, spider, elevators) leads to intense anxiety in an individual. Phobias are generally long lasting and cause intense physical and psychological reactions. Phobias can affect an individual's ability to function normally at work, in social settings, and in other important areas of his or her life.

There are three separate disorders that fall under the classification of phobic disorders. They include

agoraphobia, social anxiety disorder (social phobia), and specific phobia. A brief description of each follows and is more fully described in their own entries in this encyclopedia.

Agoraphobia. Agoraphobia is a fear of an actual or anticipated situation, such as being in open or enclosed spaces (e.g., elevators), being in a crowded area (e.g., mall), or being outside of one's home alone. Anxiety usually develops because the individual feels there is not means to escape. Most individuals who have agoraphobia develop panic attacks. Agoraphobia may be so severe that these individuals refuse to leave their home.

Social anxiety disorder. Social anxiety disorder (social phobia) involves a combination of excessive self-consciousness and a fear of humiliation in social situations. Individuals in social situations have a fear of being rejected by others or have a fear of offending others. This disorder was previously called social phobia.

Specific phobia. Specific phobia involves continuous and irrational fears of a specific situation or object that is out of balance to the actual risk. For example, an individual may have a fear of elevators because he or she may think the elevator may malfunction. Some other examples of specific phobias include a fear of animals, thunderstorms, heights, and loud noises. There are several types of specific phobias.

Treatment

If a phobia is affecting individuals' daily life, there are several therapies and medications available that can help them overcome their fears. Psychotherapy has been shown to be effective for individuals with phobic disorders. In particular, desensitization or exposure therapy and cognitive behavior therapy can greatly help individuals overcome phobias. Antidepressant medications and benzodiazepines are commonly used to treat phobias to reduce anxiety.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Agoraphobia; Antidepressants; Benzodiazepines; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Exposure Therapy; Panic Attack; Psychotherapy; Social Anxiety Disorder; Specific Phobia

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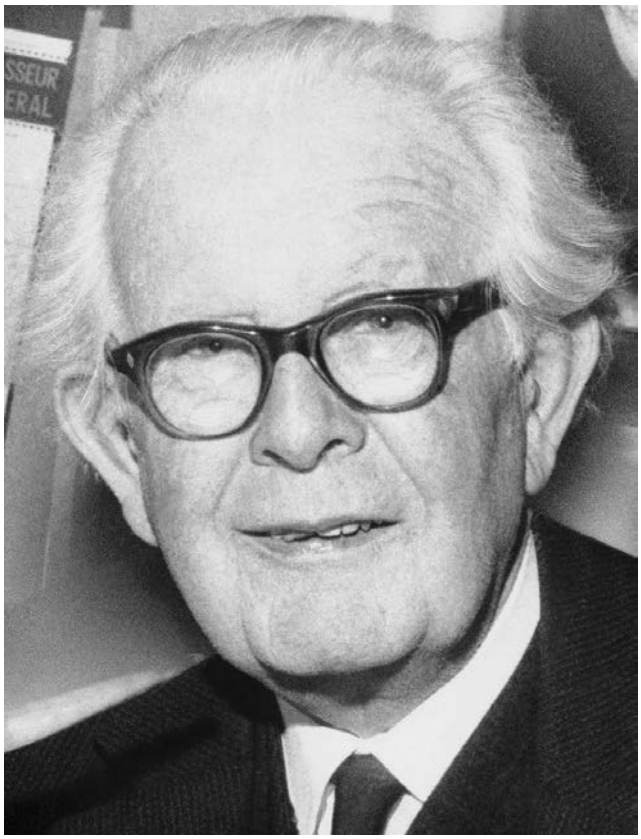
Piaget, Jean (1896–1980)

Jean Piaget was a Swiss-born developmental psychologist best known for his studies on the cognitive development of children.

Description

Jean Piaget, PhD, was born and raised in Switzerland. Piaget was the oldest of three children. His father Arthur was considered to be a highly influential figure



Jean Piaget was a Swiss-born developmental psychologist best known for his studies on the cognitive development of children. (AP Photo)

in science and education in Switzerland. This influence led to an early interest in the sciences and by age 11, Piaget had begun to write educational papers. He had a strong desire to understand how things worked. Piaget found his father's expectations and way of connecting with him a large motivator in his own accomplishments. Piaget was married and had three children of his own. His children would become focus points for his area of study and the basis for his writing and theories.

Early in his career, Piaget worked with Alfred Binet using Binet's intelligence tests. Using these tests he started to notice that children think differently than adults do. This understanding led him to begin studying the development of thought process and intelligence in his own children. Throughout his life, Piaget was invested in revising his theories and staying focused in the fields of psychology, philosophy, sociology, and epistemology (the study of knowledge and understanding, grounded in philosophy). Piaget's theory was influenced by philosophy, specifically that of Jean-Jacques Rousseau who had argued that reasoning and understanding in children happens in stages.

Piaget's theory of cognitive development identified four stages: (1) the sensorimotor stage, (2) the preoperational stage, (3) the concrete operational stage, and (4) the formal operation stage. The sensorimotor stage is identified from birth to about age 2 where babies are taking in sensations but cannot symbolize their experiences. The preoperational stage is from about ages 2 to 7 when thinking is not yet logical and children can focus only on one piece of information. The concrete operational stage is from about ages 7 to 12 where thinking is becoming quicker and more efficient. Logical thinking can be connected to concrete material. The final stage of formal operations is from about age 12 to adulthood and is evidenced when logical thinking is connected to abstract information.

When Piaget was in his 50s, he founded the International Center for Genetic Epistemology in Geneva. He was the director of the center until his passing in 1980. His hope in creating this center was to unify scientists and researchers from various disciplines and connect them to doctoral students or new developmental psychologists.

Impact (Psychological Influence)

Piaget became a key figure in both European and American psychology. His theories are still widely studied and used, especially when looking at human growth and development. His work has been a large contributor to understanding the thinking development of children as opposed to simply thinking of them in terms of adult intelligence. He had an impactful career filled will numerous publications. His theories have been and continue to be a leading presence in the field of development.

Ashley J. Luedke, PhD

See also: Language and Thought of the Child, The

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Pica

Pica is the persistent craving and compulsive eating of nonfood substances, like dirt, paint chips, or ice. It is considered an eating disorder in DSM-5.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **Behavioral analysis** is a type of assessment that focuses on the observable and quantifiable aspects of behavior and excludes subjective phenomena such as emotions and motives.

- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Eating disorder** is a class of mental disorders that are characterized by difficulties with too much, too little, or unhealthy food intake, and may include distorted body image.

Description and Diagnosis

Pica is an eating disorder that is characterized by the persistent craving and compulsive eating of nonfood substances. It is most common among children over the age of two years who have developmental or intellectual delays. Those with this disorder consume various substances, including sand, clay, starch, ice, cigarette butts and ashes, hair, paint chips, soap, wood, coal, chalk, and paper. Although pica can occur in individuals of various backgrounds, it is more likely to be associated with pregnancy, early childhood, mental retardation, autism, anorexia nervosa, poor nutrition, and low blood levels of iron and other minerals. Consuming nonfood substances is seldom done publicly. The reason is that most are embarrassed to admit to this unusual habits and so they hide it from their family and doctors. Or, they may not report the pica to their doctor because of a lack of knowledge of pica's potential medical significance. Pica can lead to health problems such as intestinal obstructions, nutritional deficiency, and parasites.

Pica is also associated with certain religious and cultural traditions. For example, in some cultures, nonfood substances are believed to have positive spiritual and health effects. Among some African Americans eating a particular kind of white clay is believed to promote health and reduce morning sickness during pregnancy. In some cultures eating certain substances is believed to bring good luck or increase fertility.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a persistent pattern of eating nonnutritive, nonfood substances. It requires that the eating of these substances must be developmentally inappropriate and not culturally supported. When pica appears in individuals with autism, schizophrenia or Kleine-Levin syndrome, it is not an additional diagnosis unless the condition is severe (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. Iron deficiency is most commonly associated with pica. While individuals with documented iron deficiency engage in pica, it is not clear whether the iron deficiency was a cause of pica or a result of it. It has been observed that pica cravings in individuals with iron deficiency stop once iron supplements are given. Low blood levels of iron are common in pregnant women and those with poor nutrition. Pica is also common in those diagnosed with hookworm infections. Pica has a higher incidence in populations with mental disorders like autism and conditions such as mental retardation. Because these conditions do not involve iron deficiency, it may well be that psychological factor are involved as a cause. Pica may be the result of a desire for attention, or the avoidance of some task, or a desire for sensory feedback.

Treatment

An examination by a medical practitioner is warranted as a starting point for treatment of pica and/or rumination disorder. Ruling out and then supplying treatment for medical causes and complications is the first step in the treatment of both diseases. When pica presents in infants and toddlers, it may be normal oral exploration unless the presentation is severe; however, the presentation of moderate to severe rumination disorder in infancy can pose a threat to development and even lead to lethal medical conditions. Making sure that a medical team is alert to the presence of these disorders is extremely important.

The second consideration in treatment for pica is the use of psychological interventions. Both school psychologists and special educators provide the first line of diagnosis in children with developmental disorders who may engage in pica. Psychological interventions that have been effective in treating pica include behavioral analysis and behavior therapy. However, identification of the purpose of the behavior is often key to the development of an effective treatment plan. Once a purpose is identified (desire for attention, avoidance of task, desire for sensory feedback), behavioral

interventions can be utilized to extinguish the behavior or substitute more positive oral stimulation for it.

Len Sperry, MD, PhD

See also: Anorexia Nervosa; Behavior Therapy; Eating Disorders

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Pick's Disease

Pick's disease is a rare form of dementia that causes a slow shrinking of cells in specific areas of the brain.

Definitions

- **Alzheimer's disease** is a medical and mental disorder that causes dementia particularly late in life. It is also referred to as Neurocognitive Disorder Due to Alzheimer's Disease.
- **Dementia** is a group of symptoms, including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of neurons (nerve cells) in the brain.
- **Dementia praecox** refers to a chronic, deteriorating psychotic disorder characterized by cognitive disintegration, usually beginning in the late teens or early adulthood.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life. It is not considered a disorder unless it significantly disrupts one's daily functioning.
- **Frontotemporal dementia** is a group of disorders caused by cell degeneration in the brain's frontal lobes (the area behind the forehead) or its temporal lobes (the area behind the ears). It is also referred to as FTD.
- **Paramnesia** is a distortion of memory in which fact and fantasy are confused.
- **Primary progressive aphasia** is a form of cognitive impairment that involves a progressive loss of language function. It is also referred to as PPA.
- **Semantic dementia** is a progressive neurological disorder characterized by loss of semantic memory (general knowledge) where individuals can speak easily but their words convey limited meaning.

Description

Pick's disease is a type of dementia distinguished by progressive degeneration in the frontal and temporal areas of the brain. Pick's disease is similar to Alzheimer's disease; however, it affects only certain areas of the brain, whereas Alzheimer's disease affects all areas of the brain. Pick's disease is also referred to as frontotemporal dementia (FTD). Pick's disease, primary progressive aphasia, and semantic dementia are grouped together and classified as FTD. It is usually diagnosed in individuals under the age of 65 years. Individuals with Pick's disease initially exhibit behavioral and personality changes before they lose the inability to speak coherently. The early stages of Pick's disease are often misdiagnosed as depression or Alzheimer's disease. Some behavioral signs and symptoms of Pick's disease include extreme restlessness, impulsivity and poor judgment, poor personal hygiene, withdrawal or decreased interest in activities, repetitive or obsessive behavior, promiscuity, and a decline in function at work and home. Some emotional signs and symptoms of Pick's disease include apathy, rudeness, impatience, aggression, poor attention span, abrupt changes in mood, and a lack of empathy, warmth, and concern for others. Some language signs and symptoms of Pick's disease include trouble finding the right word, difficulty speaking, loss of vocabulary, decreased ability to write or read, uncoordinated speech sounds, and a complete loss of speech. Some physical signs and

symptoms of Pick's disease include loss of memory, general weakness, difficulty moving around, increased muscle rigidity, lack of coordination, and urinary incontinence.

Arnold Pick (1851–1924) was the psychiatrist who first discovered and described the disease. He is known for identifying the clinical syndrome and the characteristic of this disorder, which are Pick bodies. In 1892, Pick examined brain tissue of several deceased individuals with histories of dementia. The characteristic feature is a protein tangle that appears as a large body in the tissue of neurons, known as a Pick body. Pick headed the Prague neuropathological school which is one of the two neuropathological schools in Europe, which framed Alzheimer's disease through several studies.

The cause of Pick's disease is the result of a buildup of protein in the affected areas of the brain. The accumulation of Pick bodies eventually leads to socially inappropriate behavior, changes in character, and poor decision making. The progression of Pick's disease eventually leads to severe intellectual, memory, and speech impairment. Pick's disease is slightly more common in women than in men and usually affects adults between the ages of 50 and 60 years. Unfortunately, the cause of this buildup of protein is unknown.

Currently, there is no cure for Pick's disease. However, by understanding the unique symptoms, an individual with Pick's disease can better manage the disease and his or her quality of life. Treatment for Pick's disease is similar to that for Alzheimer's disease. The goal of treatment is symptom management that maximizes the quality of life. This may include medications to manage specific symptoms. Treatment should also include emotional support for the caregiver. The prognosis for individuals with Pick's disease is poor. The disease progresses rapidly, ranging from 2 to 10 years for life expectancy. Eventually, some individuals with Pick's disease will need around-the-clock care, whether it be at home or in an institutionalized care setting.

Elizabeth Smith Kelsey, PhD, and
Len Sperry, MD, PhD

See also: American Psychiatric Association (APA); Alzheimer's Disease; Aphasia; Brain; Dementia; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM)

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Placebo Effect

The placebo effect is any genuine psychological or physiological response to an inert substance or procedure.

Description

Historically a placebo is an inert substance, such as a sugar pill, which contains no medication, and is given to subjects of controlled medical studies. In these studies one group of patients is given an experimental treatment and the control group is given a placebo and no treatment. Neither group would know if they were receiving the treatment or the placebo. Researchers have consistently found that both groups, in spite of the fact that only one group received a placebo, would benefit. This phenomenon is known as the placebo effect.

The placebo effect, sometimes referred to as the placebo response, has been a topic of interest in the scientific and medical communities for many years. Originating out of the medical field, the placebo effect has also resulted in both philosophical and psychological inquiry. How something inert, or a fake treatment as some have described certain types of placebo, can have a real effect has been the focus of much inquiry. Research has shown that placebos mimic many characteristics of actual medications. For instance, two placebo pills are more effective than one, and larger pills have a stronger effect than small pills. Placebo injections produce stronger effects than placebo pills. In one study a placebo anesthetic was applied to one index finger of participants. When pain stimulation was applied to both index fingers, the pain was perceived as less on the finger with the placebo anesthetic. Placebos have been shown to improve health but have also been

shown to mimic side effects. Attempts to understand, or explain away, the placebo effect have resulted in a large body of research that indicates the placebo effect is a genuine phenomenon.

Current Status and Impact (Psychological Influence)

Research indicates that placebo effect is related to expectancy and conditioning. Expectancy is related to the belief one has about the positive benefits of the medication or procedure. The stronger the belief, the stronger the effect. Expectancy develops through personal experience, receiving verbal information or suggestion, and observational learning. For instance, positive counseling outcomes have been shown to be related to expectancy. Common factors in counseling such as the quality of the therapeutic relationship (personal experience), normalizing symptoms (verbal information), and provider reputation (observational learning) are associated with positive counseling outcomes separate from technique or expertise.

Placebo effect is also related to conditioning. Classical conditioning teaches that if you experience two events simultaneously and repeatedly you come to expect the same result when only one of the conditions is met. This is called conditioned stimulus-response. For instance, people consistently go to the doctor when they are sick and then get better after the visit. We take pills when we feel ill and then we feel better. These repeated stimulus-response (go to the doctor, feel better; take a pill, feel better) results in positive health outcomes regardless of what the doctor does or what the pill contains.

Placebo effect is considered a pervasive phenomenon, meaning that the response is part of any and all medical intervention. Placebo effect is also known to have an effect on positive counseling and psychotherapeutic outcomes. Placebo effect is a powerful phenomenon that demonstrates the brain's role in physical and psychological health outcomes.

Steven R. Vensel, PhD

See also: Brain; Therapeutic Alliance

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Play Therapy

Play therapy is a therapeutic method used by a play therapist who provides carefully selected play materials in a safe setting for the child to express his or her feelings, emotions, fears, and beliefs.

Description

Play therapy is formally defined (Association for Play Therapy, 2015) as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development."

This important relationship offers a way for the child to explore his or her inner self using the familiar and often symbolic medium of play. Play therapy can include the use of therapeutic games, puppets, role playing, a wide variety of toys, dress-up clothes, bop bags, play doh, dollhouses, musical instruments, or even sand tray, which is an experiential form of play therapy. There are many different theoretical approaches to play therapy, including filial therapy, client-centered play therapy, Adlerian play therapy, and nondirective play therapy.

Development and Current Status

At the beginning of the 20th century, well-known psychoanalysts, including Sigmund Freud, Anna Feud, and Melanie Klein, began advocating play as an important therapeutic approach for children. Play can be therapeutic for individuals, including children, adolescents, adults, and even the elderly. Interestingly, although play therapy is most commonly associated with children, there is a growing demand to use play therapy with adults and geriatric clients. Case studies have shown that using play therapy with elderly clients

can lead to less isolation, reduced stress, more socialization, higher self-esteem, less forgetfulness, lower levels of depression, and increased mental sharpness.

For children, this form of therapy is considered highly effective, especially since they have a limited emotional vocabulary and have yet to master abstract concepts that are necessary for traditional talk therapy. Experts in the field of play therapy believe that play helps to bridge the gap between concrete experience and abstract thought by giving the child (or adult) a familiar medium to express his or her thoughts and feelings. This can be particularly beneficial for individuals who are experiencing emotional or behavioral challenges.

There are many reasons that the use of play therapy has been so effective across a variety of populations and presenting issues. Some of the unique characteristics of play include its voluntary nature in a world of rules and requirements; it is free from evaluation and judgment so it's safe to make mistakes without it being seen as failure; it encourages the use of the imagination; it increases involvement and interest, which can increase social interest and reduce social isolation; and it also promotes self-development. A client who is engaged in play therapy often feels a sense of being able to be in control of his or her world, particularly in ways that are impossible in the real world. Whether child or adult, play therapy offers a medium to symbolically express what is going on in his or her inner world. As with any form of therapy, it is advised to be used with purpose and intent as part of a professional treatment plan.

Much of the basic tenets of play therapy in use today are based on the work of Virginia Axline, whose 1964 book *Dibs: In Search of Self* was considered groundbreaking and still is a must-read for today's play therapists. Axline, who developed nondirective play therapy, was influenced by the person-centered approach of Carl Rogers. Axline, in turn, influenced Violet Oaklander, whose seminal book *Windows to Our Children* on gestalt play therapy is among the most highly read on play therapy and has been translated into 14 different languages. In addition to Axline and Oaklander, many play therapists have contributed to the growth of this form of therapy. Among today's most influential play therapists and play therapist researchers are Garry Landreth, Eliana Gil, Rise VanFleet, Terry Kottman, and Paris Goodyear-Brown.

There are several different theoretical approaches that can be used for play therapy. Filial therapy is also referred to as family play therapy or child relationship enhancement therapy. The basic premise is to teach the parents to play the role of the therapist. The goal with this approach is to create a better relationship between parents and their children. There is also the client-centered or child-centered play therapy model, which is based on the principles of Virginia Axline's work. Adlerian play therapy was developed by Terry Kottman and is led by the child through a supportive and accepting environment that helps target misbehavior and is especially helpful for children who have suffered abuse or trauma. Another modality is nondirective play therapy, which is often used to help children develop their verbal language skills.

Mindy Parsons, PhD

See also: Expressive Arts Therapy; Filial Therapy; Sand Tray Therapy

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Organization

The Association for Play Therapy is a national professional organization created in 1982 to promote the benefits of play therapy and provide credential for play therapists. The organization publishes the peer-reviewed *International Journal of Play Therapy*.

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Polysomnography

Polysomnography is a set of medical tests used to diagnose and evaluate sleep disorders.

Definitions

- **Dyssomnias** are disorders involved in falling asleep or staying asleep.
- **Hypopnea** is breathing that is too shallow to maintain adequate levels of oxygen in the blood.
- **Narcolepsy** is a disorder characterized by frequent and uncontrollable attacks of deep sleep.
- **Parasomnia** is a type of sleep disorder characterized by abnormal changes in behavior or body functions during sleep, specific stages of sleep, or the transition between sleeping and waking.
- **Restless leg syndrome** is a medical condition characterized by unpleasant sensations in the legs that occur at rest or before sleep and is relieved by walking.
- **Sleep apnea** is a brief suspension or interruption of breathing.
- **Sleep disorders** are chronic disturbances in the quantity or quality of sleep that interfere with an individual's ability to function normally.
- **Sleep latency** is the amount of time it takes to fall asleep.

Description

Polysomnography is a set of medical tests performed while an individual sleeps. It examines brain wave patterns, eye movements, and muscle tone. Polysomnography is used to diagnose and evaluate many types of sleep disorders, including dyssomnias, parasomnias, and other medical, psychiatric, and dental disorders that produce symptoms during sleep. Sleep apnea is a dyssomnia that is common in middle-aged and elderly obese men. In sleep apnea the muscles of the soft palate in the back of the throat relax and close off the airway during sleep. This causes the individual to snore loudly and gasp for air at night. This results in the individual becoming excessively sleepy during the day. Narcolepsy is another dyssomnia, which results in excessive daytime sleepiness, sudden attacks of muscle weakness, and hallucinations at sleep onset. Some parasomnias detected using polysomnography include disorders of arousal or rapid-eye-movement (REM) sleep problems, such as nightmares. Medical conditions that can be evaluated by polysomnography include sleep-related asthma, restless leg syndrome, depression, and panic disorder. It is also used to evaluate seizures of sleep-related epilepsy that occur during sleep.

Developments and Current Status

Polysomnography is performed during an overnight stay in a sleep laboratory. While the individual sleeps, a wide variety of tests can be performed. One form of monitoring is electroencephalography (EEG), in which electrodes are attached to the individual's scalp to record his or her brain wave activity. The EEG monitors brain wave activity from different parts of the brain and records them on a graph. It identifies the stage of sleep as well as detects seizures. Another form of monitoring is continuous electrooculography (EOG), which records eye movement and is useful in determining when the patient is going through a stage of REM sleep. Both EEG and EOG are helpful in determining sleep latency, total sleep time, the time spent in each sleep stage, and the number of arousals from sleep. The electrical activity of the patient's heart is also measured using electrocardiography. Electrodes are placed on to the individual's chest to record electrical activity from various areas of the heart. They help detect cardiac arrhythmias (abnormal heart rhythms), which may occur during periods of sleep apnea. Blood pressure is also measured as episodes of sleep apnea sometimes dangerously elevate blood pressure. A final

standard measurement is muscle tone. This is done using electromyography, which involves placing an electrode on the muscle to record its contractions. Depending on the suspected disorder, polysomnography can also include sound monitoring to record snoring, video monitoring to document body positions, core body temperature readings, incident light intensities, penile swelling (tumescence), and pressure at various levels of the esophagus.

Len Sperry, MD, PhD

See also: Sleep Disorders

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Organizations

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Website: http://www.sleepfoundation.org

Positive Psychology

Positive psychology is an approach to psychology that emphasizes strengths and health rather than deficits and illness.

Definitions

- **Values** are principles that govern virtuous behavior. When values are lived or put in action, they are known as virtues.
- **Values in action inventory of strengths** is a psychological inventory that assesses positive psychological traits, strengths, and virtues. It is also called VIA-IS.
- **Well-being** is the state of being happy, healthy, prosperous, or successful.

Description

Positive psychology is the scientific study of strengths and virtues that influence individuals to live meaningful and fulfilling lives. It is a reaction to most other psychological approaches that view human nature in terms of pathology and deficiencies. Instead, positive psychology views human nature in terms of health and strengths. It assists individuals to utilize their strengths and to live meaningful and fulfilling lives. Positive psychology seeks to understand what makes people well rather than what makes them ill. Another basic premise is that human beings are drawn by the future rather than being driven by the past. Mental health is not viewed by the absence of symptoms but by the presence of purpose, happiness, and acceptance.

Positive psychology has a significant research basis. Comprehensive research has explored and continues to examine the nature of human happiness and well-being. This scientific endeavor will lead to a greater understanding of human behavior and corresponding methods of psychological treatment. Positive psychology is considered one of the most recent psychological efforts to study and understand the nature of well-being and happiness. This approach has gained significant international attention in a short amount of time. The International Positive Psychology Association (IPPA) has expanded to over 80 countries with thousands of members. The mission of IPPA is to further the scientific study of positive psychology around the world in various contexts.

Developments and Current Status

As a field of study, positive psychology was developed by psychologist Martin Seligman (1942–) in 1998. However, the term "positive psychology" was used by Abraham Maslow (1908–1970) in 1954. This approach is influenced by the humanistic psychology perspective, which was influenced by the work of Abraham Maslow, Carl Rogers, and Alfred Adler. These approaches focus on promoting mental health rather than the treatment of mental illness. Positive psychology is the basis for positive psychotherapy, which is the psychological treatment of individuals using the principles of positive psychology.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Depression; Positive Psychotherapy; Psychotherapy; Strengths

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Positive Psychotherapy

Positive psychotherapy is a form of psychotherapy that assists individuals to build on their strengths and virtues so they can lead more meaningful and fulfilling lives.

Definitions

- **Positive psychology** is an approach to psychology that emphasizes strengths and health rather than deficits and illness.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Values** are principles that govern virtuous behavior. When values are lived or put in action, they are known as virtues.
- **Values in action inventory of strengths** is a psychological inventory that assesses positive psychological traits, strengths, and virtues. It is also called VIA-IS.
- **Well-being** is the state of being happy, healthy, prosperous, or successful.

Description

Positive psychotherapy is a form of psychotherapy based on positive psychology. It emphasizes the individual's strengths and virtues to ultimately influence living a life of meaning and fulfillment. Instead of targeting symptoms like the majority of other psychological approaches, the goal of positive psychotherapy is to increase positive emotions through various strategies and interventions. Positive psychotherapy was originally developed to treat individuals suffering from depression, but further research and clinical application suggest that this approach can treat a variety of presenting issues.

Positive psychotherapy can be used among individuals, couples, families, groups, and organization settings. Individuals are trained to focus their attention to what is going well in their lives and to focus their attention and memory on positive encounters and experiences. For example, the "three good things" exercise is a daily activity done in the evening in which individuals write down what went well in the day and what they did to make it go well. Another therapeutic strategy includes individuals taking the values in action inventory of strengths (VIA-IS) and to journal about how they can implement their signature strengths in their daily lives.

Developments and Current Status

Positive psychology and psychotherapy was developed by psychologist Martin Seligman (1942–) in 1998. This approach was influenced by the humanistic psychology perspective, which was influenced by the work of Abraham Maslow, Carl Rogers, and Alfred Adler. These approaches focus on promoting mental health rather than the treatment of mental illness. Positive psychotherapy is considered one of the most recent psychological efforts to study and understand the nature of well-being and happiness.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Positive Psychology; Psychotherapy; Strengths

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Positron Emission Tomography (PET)

Positron emission tomography is a diagnostic imaging technique that uses radioactive substances to produce three-dimensional colored images within the body. It is also called the PET scan and PET/CT scan.

Definitions

- **Computed tomography** is a diagnostic imaging device that uses x-rays to produce cross-sectional images (tomographs) of the body.
- **Magnetic resonance imaging** is a diagnostic imaging device that uses electromagnetic radiation and a strong magnetic field to produce images of soft tissues.
- **Positron** is a positively charged particle, which is the antimatter counterpart of the electron.
- **Radioactive** refers to radiation emitted by certain substances.
- **Radiopharmaceutical** is a radioactive drug.

Description

Positron emission tomography (PET) is a medical imaging device that uses short-lived radioactive substances to produce three-dimensional colored images of those substances functioning within the body. These images are called PET scans and the technique is termed PET scanning. Three-dimensional imaging is achieved with a CT x-ray scan performed on the patient during the same session, in the same machine. PET is a highly specialized scanning method that provides information about the body's chemistry not available through other procedures. Unlike CT (computerized tomography) or MRI (magnetic resonance imaging) scans that identify anatomy or body structure, PET studies metabolic activity or body function.

PET uses small amounts of radioactive positrons. These radiopharmaceuticals have a short half-life, which means that the amount of radiation exposure is similar to that of two chest x-rays. The PET scanner uses a special camera and a tracer (glucose and a radioactive chemical) to take images of organs and tissues within the body. The camera records the position of the tracer, and the resulting data is then sent to a computer for analysis. In areas where higher levels of chemical activity occur, the radioactive chemical within the tracer accumulates. These areas show up as brighter spots on a PET scan and aid in diagnosis. The resulting image is used to evaluate for cancer, neurological problems, and heart disease.

The PET scan has been used to assess the benefit of coronary artery bypass surgery, identify causes of childhood seizures and adult dementia, and detect active tumor tissue. It is useful in the diagnosis, staging, and treatment of cancer because it provides information that cannot be obtained by other techniques, such as CT and MRI. It is becoming the scan of choice for head and neck, brain, lymphoma, melanoma, lung, colorectal, breast, prostate, and esophageal cancers. PET scans are also valuable in studying brain activity and how mental illness changes brain activity.

Developments and Current Status

Since the 1950s there have been several developments in imaging which led to the development of PET. One of the most recent of these was the introduction of the PET/CT scanner in 2000. David Townsend, a physicist, and Ronald Nutt, an electrical engineer, are credited with this device, which *Time* magazine named as the medical invention of the year in 2000.

Physicians first used PET to obtain information about brain function and to study brain activity in various neurological diseases and disorders, including stroke, epilepsy, Alzheimer's disease, Parkinson's disease, and Huntington's disease, and in psychiatric disorders such

as schizophrenia, depression, obsessive-compulsive disorder, attention-deficit hyperactivity disorder, and Tourette's syndrome.

PET scans are to differentiate between brains of individuals with and without mental disorders. For instance, because PET detects metabolic activity in the brain activity, PET scans of the brains of depressed and nondepressed individuals, it can localize decreased brain activity in those who are clinically depressed. Similarly, such data has been collected in schizophrenia and Alzheimer's disease. PET scans are also used for individuals suspected of having transient ischemic attack (mini strokes), multiple sclerosis, and other nervous system disorders. Such research can help scientists discover new ways to treat these disorders. PET scans are also used for monitoring the results of treatment. At the present time, PET scans are primarily used in research studies rather than as aids to treatment in psychiatric settings.

PET scans do not show as much detail as CT scans or MRI scans. However, PET scans provide an advantage over CT and MRI because they can determine whether a lesion is malignant. CT and MRI provide images of anatomical structures but are not particularly used in determining malignancy. That is because CT and MRI show structure, while PET shows function. PET has been used in combination with CT (called PET/CT) to identify abnormalities with more precision and indicate areas of most active metabolism. This additional information permits more accurate evaluation of cancer treatment and management.

Len Sperry, MD, PhD

See also: Computed Tomography (CT); Magnetic Resonance Imaging (MRI)

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Postpartum Depression

Postpartum depression is a mental condition that can affect women after childbirth. It is also known as peripartum depression.

Definitions

- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life. It is not considered a disorder unless it significantly disrupts one's daily functioning.
- **Depressive disorders** are a group of DSM-5 mental disorders characterized by sad, irritable, or empty moods along with somatic (bodily) and cognitive (mental) changes that greatly affect everyday functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Major depressive episode** is a period characterized by symptoms of a major depressive disorder.
- **Peripartum onset** is the depressive disorder specifier given for depressive symptoms that occur during pregnancy or in the four weeks following delivery. "Peri" means around the time of, whereas "postpartum" means after.
- **Selective serotonin reuptake inhibitors** are the most commonly prescribed antidepressant

medication because they generally have few side effects. They are also referred to as SSRIs.

- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.
- **Unspecified depressive disorder** is one of the DSM-5 depressive disorders. It is characterized by depressive symptoms that cause significant distress or disrupt daily life but do not meet the full criteria for any disorder in the depressive disorders group.

Description

Depressive symptoms occur in some females who are about to give or have already given birth. "Peri-" means around the time of and includes "before" and "after," whereas "post-" means "after." When depressive symptoms occur in a female after giving birth, the term "postpartum depression" has been used. However, because research shows that at least 50% of the so-called postpartum depressions actually begin before giving birth, the term "postpartum" is not an accurate designation (American Psychiatric Association, 2013).

The DSM-5 does list postpartum depression as a separate diagnosis (American Psychiatric Association, 2013). However, it does recognize unspecified depressive disorder with the peripartum-onset specifier. About 3%–6% of women will likely experience the onset of a major depressive episode during pregnancy or in the weeks to months postpartum. Since most so-called postpartum depressions begin before delivery, the term "peripartum" has become the preferred designation (American Psychiatric Association, 2013).

The cause of peripartum depression is unknown. However, there are some characteristics that are associated risk factors. These include low self-esteem, increased stress, and past or current emotional difficulties. They can also include a family history of depression, a lack of good-quality medical care during pregnancy, or a lack of support from one's partner, friends, and family.

Treatment

There are several treatment options available for women with this type of depression. The combination of medication and psychotherapy is one form of effective treatment. Commonly prescribed medications are SSRIs like Prozac and Lexapro, and other antidepressants. Cognitive behavior therapy (CBT) has been found to be effective for this condition. CBT helps an individual with PPD focus on changing faulty behaviors, emotions, and thoughts.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Cognitive Behavior Therapy; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Fatigue; Lexapro (Escitalopram); Major Depressive Disorder; Mood Disorders; Prozac (Fluoxetine); Selective Serotonin Reuptake Inhibitors

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Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder is a mental disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. It is also referred to as PTSD.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also called CBT.
- **Cognitive processing therapy** is a form of CBT specifically designed for treating PTSD, which teaches skills for recovery from

traumatic events by changings one's view of self, world, and others.

- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing automatic thoughts and maladaptive beliefs.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure therapy** is a behavior therapy intervention (method) in which a client is exposed to a feared object or situation. It is also referred to as flooding.
- **Eye movement desensitization and reprocessing** is a treatment method to reduce trauma-based symptoms by visualization of the traumatic event while concentrating on the rapid lateral movements of the therapist's finger. It is also known as EMDR.

Description and Diagnosis

Post-traumatic stress disorder (PTSD) is one of a group of trauma- and stress-related disorders in DSM-5. PTSD can develop after an individual experiences or witnesses a traumatic or terrifying event in which serious physical harm occurred or was threatened. Symptoms can include recurrent flashbacks of the event, nightmares, irritability, anxiety, emotional numbing, fatigue, forgetfulness, and social withdrawal. Most who experience a traumatic event will react with nervousness, fear, shock, or anger. These reactions are common, and in time, they decrease and go away. However, for those with PTSD, these reactions continue and increase to such an extent that the individual can no longer live a normal life.

Individuals with this disorder are prone to angry outbursts. They may be easily startled when surprised and have difficulty initiating and maintaining sleep. They often feel uncomfortable in social situations, which may lead to social isolation. They may experience depression, shame, and guilt, as well as anger and aggression. They can become enraged with little provocation. Emotional detachment and withdrawal from loved ones is common. Interpersonal conflict is common, which can lead to divorce and separation. In their efforts to avoid reminders of the traumatic event, these individuals tend to avoid those associated with event. They are unlikely to make as they increasingly withdraw from social activities.

Approximately 3.5% of adult Americans suffer from PTSD during the course of a year, and 8.7% of Americans experience PTSD at some point in their lives (American Psychiatric Association, 2013). PTSD can develop at any age, and women are more likely to develop it than men. This difference is probably because women are more likely to be victims of abuse, rape, and domestic violence than men. Rates of PTSD and anxiety are disproportionately high among military veterans, as compared with the civilian population.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience specific symptoms as a result of direct or indirect exposure to traumatic events that could result in death or serious injury. The symptoms can present in one of four categories; reexperiencing, avoidance, negative mood, and arousal. Reexperiencing symptoms include nightmares, intrusive thoughts, flashbacks, and general psychological and physiological distress when confronted with thoughts or experiences associated with the original traumatic event. Avoidance symptoms include attempts at avoiding external and internal reminders of the event. The negative mood symptom cluster includes inability to recall portions of the trauma, distorted cognitions, loss of interest in activities, emotional detachment, unremitting negative emotions, and the inability to experience happiness or joy. They may also show irritable behavior, angry outbursts, recklessness, excessive vigilance, and problems with attention and concentration. The heightened arousal also includes an exaggerated startle response and sleep problems (American Psychiatric Association, 2013).

While the immediate cause of PTSD is exposure to a traumatic event, only a small number of those experiencing trauma actually develop PTSD. Several factors can predispose an individual to developing this disorder. These include a previous experience of trauma,

childhood abuse or neglect, or having other mental health problems, such as anxiety or depression. Other risk or predisposing factors include having a family history of PTSD, alcoholism, anxiety, or depression, having low cortisol levels, or lacking an adequate support system of family and friends.

Treatment

Effective treatment of PTSD usually involves psychotherapy. Some medication may also be useful. The goal of treatment is to decrease symptoms, to better control feelings, and to improve functioning in relationships, work or school, and social situations. Cognitive behavior therapy is the general therapy approach used. There are three specific forms of it that are effective with PTSD. They include cognitive therapy, exposure therapy, and eye movement desensitization and reprocessing (EMDR). Cognitive therapy is useful in changing one's thoughts about the trauma that are not true or that cause stress. Exposure therapy is useful in talking about and reexperiencing the traumatic event safely while the fear of it lessens. EMDR is also useful in lessening the experience of the trauma. A newer approach is called cognitive processing therapy, which is now being used with military personnel to reduce distressing thoughts and foster trauma recovery. Various medications can help reduce the symptoms of PTSD. Chief among these are antidepressants like Zoloft and Paxil.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Cognitive Therapies; Exposure Therapy; Military Mental Health; Paxil (Paroxetine); Post-Traumatic Stress Disorder (PTSD) in Youth; Zoloft (Sertraline)

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Post-Traumatic Stress Disorder (PTSD) in Youth

Post-traumatic stress disorder (PTSD) in youth is about the specific way in which the diagnosis of PTSD is seen within that population.

Definitions

- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Post-traumatic stress disorder** is a mental disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. It is also referred to as PTSD.
- **Trauma** is a singular or recurrent event that is both extraordinary and severely distressing. It is also called traumatic event. This can include abuse, domestic violence, medical trauma, accidents, acts of terror, war experiences, and natural and man-made disasters.

Description

Post-traumatic stress disorder is a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). However, as a mental health disorder, it is seen differently in children and adults and can have some varying impact. It is important to look at how PTSD is a unique experience for youth. Over the past decade there has been an increasing interest in the role that trauma, and specifically post-traumatic stress, has in regard to at-risk behaviors and the mental health of youth. In fact with the increasing interest, Alan Kazdin, PhD, president of the American Psychological Association (APA) in 2008, put together a task force to specifically look at PTSD in children and adolescents. This was the result of the majority of knowledge about PTSD being based on adult studies.

What applies to adults may not necessarily be true to that of youth in regard to symptoms, experience, and presentation of PTSD. Community samples in a study done by APA found that more than two-thirds of children report experiencing a traumatic event by the time they are 16 years. The three main categories of symptoms include reexperiencing the trauma, avoiding reminders, and hyperarousal, which may include being jumpy and quickly reacting to loud noises or overalert to potential dangers, as well as seeming increasingly agitated. However, it is important to note that youth will vary in their responses to trauma with influence from their developmental level, family life, cultural factors, and past trauma experience and exposure. Youth who experience PTSD may develop new fears, have trouble sleeping, experience separation anxiety, have a decline in their school or athletic performances, increase in anger, and increase in physical health complaints.

Unless the caregiver is supportive, the chances of the youth receiving effective treatment are reduced. In fact, most children with trauma-related distress receive little or no mental health treatment. When treatment is provided it may be suboptimal, because of the therapist's lack of expertise in trauma focused methods. In short, youth need to be offered support from the caregiver and expert treatment from professionals.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Anger in Adults; Anxiety Disorders in Youth; Crisis Intervention; Date Rape; Post-Traumatic Stress Disorder (PTSD); Suicide in Youth

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Poverty and Mental Illness

Poverty and mental illness looks at the connection between these two areas and the impact that poverty can have on an individual's mental health.

Description

There is a complicated relationship between mental illness and poverty. This is an area that needs continued research. Poverty has great impact on physical health, as well as mental health. Studies have shown that those who experience poverty or are negatively impacted by unemployment or the lack of affordable housing are far more susceptible to developing a mental health disorder. The exception to this is in the case of those diagnosed with schizophrenia. With patients diagnosed with this disorder typically, the mental illness comes first and as a result leads to a lack of ability to maintain work and/or housing.

Some research has indicated that those with the lowest socioeconomic status have greater likelihood of developing or suffering from a mental health disorder. Despite having the greatest need for mental health services, quality services are not often received. This is due in part to multiple reasons, including access to care and being able to afford mental health services.

A groundbreaking study in the 1950s conducted by psychologist August B. Hollingshead (1907–1980) and psychiatrist Frederick Redlich (1910–2004) looked at the mentally ill population in New Haven, Connecticut. They studied the treatments provided to those who were mentally ill. They compared the types of treatments with social class. They found that those in poverty received treatment typically from institutions. The methods used were also highly intrusive, such as electroshock and lobotomies. This was greatly different from those of higher classes who received far less invasive treatments such as talk therapy. A big difference from this study to current day is that those in poverty instead of receiving treatment in institutions are more likely to receive no treatment at all. The study from Redlich and Hollingshead as well as studies that have come since indict the direct relationship between poverty and prevalence of mental illness.

The lack of mental health services then leads to a vicious cycle preventing those in poverty from moving forward and obtaining employment and affordable housing. Poverty is viewed as a great cause of suffering. It has impacts on social, emotional, behavioral, and psychological development, and problems. With a lack of ability to maintain basic needs of safety and hunger, it makes it even more complicated to attempt to maintain positive mental health.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Homelessness; Socioeconomic Status

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Prayer

Prayer, the act of communicating with a deity in word or thought, is an intervention utilized in spiritually oriented psychotherapy.

Description

Prayer has been an essential spiritual practice for thousands of years and has long been associated with various benefits to psychological well-being. Mental health researchers have investigated how people utilize prayer for personal growth, healing, coping, recovery from life-limiting behavioral patterns, forgiveness of wrongs, and increasing hope. Prayer has been associated with quality of life, lower levels of psychological distress, and more rapid recovery from health-related problems. Prayer allows people to ask for help and guidance; offer praise and thanks; and find comfort, hope, and support.

Survey research indicates that approximately 90% of Americans believe in God or a universal spirit. Experts in the mental health fields have recognized the centrality of spirituality and religion in the lives of most people. Spiritually oriented psychotherapy has become an important way to help the spiritually oriented cope with life's difficulties. Spiritually oriented interventions include prayer. Types of prayer include petitioning or asking God or a higher power for help and resources; meditative prayer that focuses on the nature of God, connecting to God, or finding peace in God's presence; and intercessory prayer, which is praying for, or on behalf of, someone else. Centering and contemplative prayer are types of mindfulness meditation that can be encouraged to strengthen self-esteem and reduce symptoms related to stress, anxiety, and depression.

Prayer can serve as a useful tool for counselors helping those who are spiritually or religiously oriented. Prayer can serve as a way to measure the spiritual and psychosocial functioning of clients; as a way to foster cognitive and behavioral change; or as a tool of reflection, among others. There are several types of prayers utilized by counselors. Clinicians may pray with clients, pray for client healing outside of treatment sessions, pray for guidance regarding treatment issues, and allow clients to pray during psychotherapy sessions. Therapeutic benefits to prayer include extending a sense of comfort beyond the counseling session, expressing clinician care, enhancing client–therapist trust, and decreasing a client's sense of isolation and loneliness.

Prayer must be used with caution in therapeutic settings. Praying with clients can have an unpredictable impact on the therapeutic relationship, and boundary issues can occur as shared prayer can be an unintentionally intimate experience. Prayer can also be upsetting to people who are emotionally unstable.

Current Status

There are currently no studies, professional standards, or professional consensus in the use of prayer in

therapeutic settings. The use of intercessory prayer is classified by the American Psychological Association to be an experimental intervention. Prayer is considered by many professionals to be a controversial practice.

Steven R. Vensel, PhD

See also: Mindfulness; Religion and Religiosity; Religious Coping; Spirituality and Practices

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Prejudice

Prejudice is the preconceived judgment or opinion about a group or class of people based on limited, inaccurate, or assumed information.

Definitions

- **Discrimination** is the unjust treatment of others based on racist beliefs.
- **Genocide** is the large-scale murder of people belonging to a particular racial, political, or social group.
- **Hate crimes** are hostile criminal acts such as assault or vandalism motivated by racial, sexual, or other group prejudices.
- **Oppression** is the unjust exercise of authority or power.
- **Racism** is a socially shared belief that all members of a particular race possess characteristics that are inferior to another race resulting in oppression.

Description

Prejudice involves negative attitudes and beliefs about people that are not based on actual experiences. Feelings of dislike, fearfulness, anxiety, or contempt are often associated with the person or group. The people in question are often thought of, or referred to, as "them" or "they" and represent a group of people who have some kind of feature in common. Prejudices can be based on race, social class, sexuality, gender, age, religion, physical features, or just about any other shared group element.

Prejudices are based on oversimplified stereotypes, for instance, the notion that women with blond hair are less intelligent than women with dark hair; that is, "dumb blonds" is a stereotype without basis. Discrimination occurs when others are treated in a manner based on stereotype. Discrimination can be thought of as the behaviors driven by prejudice. Hiring women with dark hair over women with blond hair, because they have blond hair, would be a discriminatory practice.

Racism occurs when prejudicial beliefs and attitudes permeate the dominant social group so completely that minority groups are perceived as inferior with little thought as to the veracity of the belief. Racism is a pervasive majority group attitude that accepts and reinforces oppression and racial inequalities. The consequences of prejudice are racial inequality that impacts all facets of life, including job availability, hiring practices, wages, education, housing, and access to services. Hate crimes are the ultimate consequences of prejudice and have resulted in vandalism, murder, and genocide.

Impact (Psychological Influence)

Prejudice, discrimination, and racism have been a significant source of social conflict in America, and multiple efforts across diverse fields continue to move toward positive change. Extensive social research continues to explore ways to eliminate racism, and all of the mental health professions have adopted significant multicultural professional competencies and standards. Social justice counseling is a developing method that actively addresses issue of oppression and social inequalities. In addition to the helping professions, lawmakers are actively pursuing ways of eliminating the impact of prejudice through legislation aimed at reducing social inequalities and hate crimes.

Steven R. Vensel, PhD

See also: Multicultural Counseling; Racial Identity Development; Social Justice Counseling

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Premature Ejaculation

Premature ejaculation is a mental disorder in males characterized by ejaculation just before or within one minute of sexual activity.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Sexual dysfunctions** are a group of mental disorders characterized by significant difficulty in the ability to respond sexually or to experience sexual pleasure. These include premature ejaculation and delayed ejaculation.
- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that raise serotonin levels in the brain. The result is a reduction of symptoms.

Description and Diagnosis

Premature ejaculation is a mental disorder whereby a male lacks control of the climax of his sexual response during sexual activity with a partner. Specifically, it refers to the experience of premature (less than one minute) ejaculation during vaginal intercourse or non-vaginal sexual activity. Most individuals with this disorder have experienced symptoms since they began sexual activity. However, some acquire this disorder after experiencing a pattern of normal sexual response. It may be experienced during all sexual activities, while others may experience symptoms in certain situations. Approximately 25% of men in the United States report dissatisfaction with ejaculation. However, if only those individuals who ejaculate in less than one minute are included, only 1%–3% of individuals qualify for this diagnosis (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, for an individual to be diagnosed with this disorder, specific symptoms must be present. The primary symptom is uncontrollable ejaculation that occurs before the individual wants to, typically less than one minute following penetration. This response must occur more often than not and for a minimum of six months. The symptoms must cause the individual distress and cannot be better explained by another mental disorder or medical condition (American Psychiatric Association, 2013).

There are a number of factors that can cause this disorder. Certain medical conditions commonly cause such inflammation of the prostate. Individuals may have a history of sexual or emotional abuse that may contribute to the onset of the disorder. Also, some individuals may experience anxiety about sex, which may contribute to the manifestation of this disorder. As with other sexual dysfunctions, cultural issues are especially important to consider in the diagnosis of this disorder.

Treatment

Treatment for this disorder varies depending on both the type of clinician seen and the willingness of the individual and partner to engage in certain therapies. For example, if an individual reports these symptoms to a medical doctor, the doctor may prescribe an SSRI (selective serotonin reuptake inhibitor). While commonly used to treat depression, SSRIs are also effective in

the treatment of premature ejaculation. Psychotherapy is also used to treat underlying psychological causes, or to help the couple adapt to the disorder. A clinician may also suggest specific exercises designed to learn how to control sexual response and prolong ejaculations. However, these exercises are not always effective because they require regular practice and patience on the part of both partners. Sometimes, a combination of medication, psychotherapy, and exercises is used.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Antidepressant Medications; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Psychotherapy; Sexual Dysfunctions

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Premenstrual Dysphoric Disorder

Premenstrual dysphoric disorder is a mental disorder characterized by a severe form of premenstrual syndrome in which depression, mood swings, irritability, and anxiety disrupt daily functioning.

Definitions

- **Depression** is a sad mood or emotional state that is characterized by feelings of low self-worth or guilt and a reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts the individual's daily functioning.
- **Depressive disorders** are a group of mental disorders characterized by a sad or irritable mood and cognitive and physical changes that significantly disrupt the individual's daily functioning. These disorders include major depressive disorder, persistent depressive disorder, disruptive mood dysregulation, and premenstrual dysphoric disorder.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Premenstrual syndrome** is a medical condition in which cramps, breast tenderness, bloating, irritability, and depression occur prior to a woman's menstrual period and subsides after it.
- **SSRIs** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.
- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description and Diagnosis

Premenstrual dysphoric disorder is one of a group of depressive disorders. It is characterized by a severe form of premenstrual syndrome in which mood swings, depression, irritability, or anxiety significantly impair everyday functioning. Both premenstrual syndrome and premenstrual dysphoric disorder have physical and emotional symptoms. However, premenstrual dysphoric disorder causes extreme mood shifts that can disrupt the individual's work and relationships. In both the syndrome and disorder, symptoms typically begin 7 to 10 days before the menstrual period starts and continue for the first few days of the period. Both can cause fatigue, bloating, breast tenderness, and changes in sleep and eating patterns. However, in the disorder at least one of the following emotional or behavioral symptoms stands out: extreme moodiness, marked irritability or anger, overwhelming sadness or hopelessness, or extreme anxiety or tension.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, women can be diagnosed with this disorder if they exhibit a pattern of symptoms during the final week before the onset of their menstrual cycle, which starts to improve within a

few days after it, and are minimal or absent in the following week. These symptoms include marked mood swings, irritability, anger, or increased interpersonal conflicts. They also include depressed mood, feelings of hopelessness, anxiety, feelings of being "on edge," or decreased interest in usual activities. Other symptoms may include difficulty in concentration, a lack of energy, a change in appetite or sleep patterns, breast tenderness, food cravings, weight gain, or a sense of being overwhelmed. These symptoms must be significantly distressing and impair the individual's ability to function in important areas of life. Finally, this condition cannot have been caused by substance use or a medical condition or other mental disorder (American Psychiatric Association, 2013).

Just as with premenstrual syndrome, the cause of premenstrual dysphoric disorder is not well understood. As with other mental disorders several factors appear to be involved. First among these are hormones. Hormonal changes in the menstrual cycle can trigger some of the symptoms of this disorder. In addition, changes in levels of serotonin, a neurotransmitter (brain chemical) thought to regulate mood, could trigger these symptoms. For instance, low levels of serotonin can cause premenstrual depression, fatigue, and sleep problems. Other factors include stress, which can increase symptom intensity, and poor nutrition. Eating highly salted foods can cause fluid retention, while using alcohol and caffeine can cause moodiness and fatigue. Low levels of vitamins and minerals and a previous history of depression may also increase the likelihood of having this disorder.

Treatment

Medications and counseling or psychotherapy have a place in treating this disorder. Commonly prescribed medications include the SSRIs such as Prozac, Paxil, and Zoloft. They can help with the symptoms of depression, fatigue, sleep problems, and food cravings. Over-the-counter medications like Advil, Motrin, and Aleve can ease cramping and breast tenderness. Diuretics (water pills) can reduce swelling and bloating. Oral contraceptives (the Pill) can stabilize hormonal swings, and Depo-Provera, an injectable hormone, can temporarily stop menstruation and the accompanying pain. Psychotherapy can also help those with this disorder to develop more effective coping strategies. The use of stress management and mindfulness practices can reduce stress and increase relaxation, acceptance, and living in the present.

Len Sperry, MD, PhD

See also: Depression; Mindfulness; Paxil (Paroxetine); Prozac (Fluoxetine); Stress Management; Zoloft (Sertraline)

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Prescription Drug Abuse

Prescription drug abuse occurs when medications are taken in greater amounts or for different reasons than what was prescribed by a physician.

Definitions

- **Benzodiazepines** are tranquillizers used in the treatment of anxiety, panic attacks, depression, and insomnia and other disorders.
- **Central nervous system depressants** are drugs that slow down the normal functions of the brain.
- **Central nervous system stimulants** are drugs that enhance attention.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.

- **Detoxification** is a process of purging the body of the toxic effects of a drug or substance. During this process the symptoms of withdrawal are also treated. Also called detox, it is often the first step in drug treatment.
- **Dopamine** is a chemical substance in the brain that influences emotion, mood, thoughts, motivation, and movement.
- **Epinephrine** is a hormone that is also known as adrenaline.
- **Neurotransmitters** are chemicals in the brain that send messages across synapses from one neuron to another neuron.
- **Norepinephrine** is a chemical produced by the adrenal gland. It takes on the role of both a hormone and a neurotransmitter.
- **Opioids** are drugs that are primarily used to relieve pain.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Self-help groups** are a group of individuals, sometimes led by a therapist, who provide each other emotional support, information, and advice on problems relating to some shared concern such as an addiction. Alcoholics Anonymous is such a group.

Description

Prescription drug abuse is the misuse of medications prescribed by a physician. The medications are not taken for the intended effects but for the feelings that the drug produces. Prescription drug abuse is the use of prescription medications for their mind-altering effects. The most commonly abused prescription drugs are opioids (painkillers), central nervous system depressants (e.g., benzodiazepines), and central nervous system stimulants (e.g., amphetamine). Opioids are typically misused for their euphoric effects. Individuals may abuse central nervous system depressants to reduce anxiety and inhibitions and promote relaxation. Central nervous system stimulants elevate dopamine, norepinephrine, and epinephrine levels and increase alertness and attentiveness. Stimulants may be abused by students to improve focus while studying or simply to get high. Even some over-the-counter cold and cough medicines made with dextromethorphan can be taken in greater doses than recommended to achieve a euphoric effect.

Prescription drug abuse can be caused by using medications that have been prescribed for a family member or friend. It can also be caused by increasing the dosage (without physician approval) of one's own prescription medications. Altering the form of prescribed medications and snorting or injecting them is also considered drug abuse. The misuse of prescription medications may lead to increased tolerance. This means that higher doses of the drug are necessary to achieve the desired effect. Drug dosage is also increased to avoid feeling the negative effects of withdrawal symptoms. Abuse of prescription drugs can lead to addiction.

Treatment

Treatment may consist of detoxification, psychotherapy, self-help groups, and medication. During detoxification, individuals may require medication to decrease the severity of withdrawal symptoms. Cognitive behavior therapy can assist individuals with reframing negative thoughts and beliefs and modifying maladaptive behaviors. Group therapy and self-help groups can provide support and social network opportunities. Family therapy can provide information to family members and help them understand prescription drug abuse. It can also be a great source of support. Medications may also be necessary to reduce drug cravings and long-term withdrawal symptoms.

Christina Ladd, PhD, and
Len Sperry, MD, PhD

See also: Benzodiazepines; Opioid Use Disorder; Opioid Withdrawal Disorder

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Prevention of Mental Illness and Substance Abuse

Prevention of mental health and substance abuse is a strategy implemented to prevent the onset of a mental or substance abuse condition.

Definitions

- **Competence** is the ability to do something efficiently or successfully.
- **Mental disorder** is a bodily or mental condition due to sufficient disorganization of personality, emotions, and mind that seriously impair the normal psychological functioning in an individual.
- **Protective factors** are conditions in individuals, families, and communities that help individuals cope more effectively when stressful events occur and eliminate risk in communities and families.
- **Resilience** is the ability to recover quickly from difficulties.
- **Risk factors** refer to any characteristic, attribute, or exposure of an individual that increases the likelihood of developing an injury or disease.
- **Substance use disorder** is a disorder in which one or more mind-altering substances lead to clinically significant distress or impairment in an individual.
- **Well-being** is the state of being happy, healthy, prosperous, or successful.

Description

Preventing mental illness and substance abuse has been a long-standing concern. Over the past several years, many ideas have been created on how to generate possible strategies to prevent behavioral problems and mental disorders in children and adults. However, it wasn't until 1980 that a multidisciplinary field began focusing on prevention of mental health. This development was facilitated by increasing knowledge on risk and protective factors. Research centers, practitioners, and prevention research centers have been focusing on preventive interventions and mental health promotion that can impact risk and protective factors that reduce the occurrence of some mental disorders. Some examples of risk factors include stressful life conditions, being neglected or abused as a child, and having few healthy relationships. Some examples of protective factors include social participation, self-esteem, resiliency, the ability to cope with stress, parental involvement, and limited availability of illegal drugs. Mental health promotion needs to be an integral part of public health at local and national levels. Promotion and prevention of mental health should be integrated within a public policy approach that embraces action through the environment, different public sectors, housing, social welfare, employment, and education. Mental health promotion intends to promote positive mental health by increasing psychological well-being, resilience, and competence, and creating supportive environments and living conditions. Positive mental health serves as a strong protective factor against mental illness.

Prevention of substance abuse is a process used to deter the onset of substance abuse and to restrict the development of problems associated with using substances of abuse. Prevention from substance abuse attempts to stop the abuse before it begins, by increasing protective factors and reducing risk factors. Some substance abuse risk factors include stress, family problems, health problems, social pressures, and feelings of grief or loss. Some substance abuse protective factors include learning how to solve problems, staying positive, and developing an emotional bond with family and friends. Some other protective factors include parents setting rules for their children and having a belief that the community is important in substance abuse prevention. The process of prevention begins by providing all individuals with skills and information necessary to prevent the problem. Substance abuse

prevention is an effective way to reduce the burden associated with substance use disorders. Promoting mental health and preventing mental health disorders and substance use disorders are fundamental in order to decrease the effects of behavioral health conditions in America.

Elizabeth Smith Kelsey, PhD, and
Len Sperry, MD, PhD

See also: Competency and Competencies; Resilience; Substance-Related and Addictive Disorders; Well-Being

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Principles of Psychology, The (Book)

The Principles of Psychology is an influential psychology textbook written by William James and first published in 1890.

Definitions

- **Nervous system** is the structure inside an animal that performs voluntary and involuntary actions. It sends messages throughout the entire body. It includes the brain, spinal cord, sensory organs, and connecting nerves.
- **Neural pathways** connect different parts of the nervous system with each other. They determine how signals are sent through the nervous system.
- **Physiology** is the scientific study of the normal functioning of all living things. It is how a living organism's various parts work.

Description

The Principles of Psychology is a two-volume book originally published in 1890. The author, William James (1842–1910), was a philosopher and psychologist. He is considered to be the greatest American philosopher and a founding figure of modern psychology. William Wundt (1832–1920) is the other father of modern psychology. James also established the first experimental psychology lab in the United States in 1875. *The Principles of Psychology* emphasizes the individual mind or the personal self. It illustrates how the thoughts, feelings, wants, reasoning, and decisions of an individual are shaped by the physical world in which he or she lives. It is written in technical and philosophical language and includes many difficult concepts. Passages in the book are very long and include physiology of the brain and nervous system.

It took James 12 years to write the 1,400 pages contained in the original two volumes. James also wrote a shorter version called the "Jimmy" for college students. The shorter version has influenced several generations of students. Before the late 1950s, it was used as the core textbook in psychology courses for students in business, science, and liberal arts as well as psychology programs.

Furthermore, individuals are creatures of habit. They have a multitude of needs and wants and must deliberately develop new habits in order to obtain a desired outcome. Individuals have the ability to form positive habits through deliberate and repeated productive responses. Repetitive actions create neural pathways in the brain, thus making it easier for subsequent nerve signals to journey down the same pathway. James stated that each individual's mind is divided into two parts: (1) me and (2) the remaining world and the people in it. Most individuals take interest in the "me" part. James stated that an individual who wants to learn about psychology does so in order to better understand his or her own thoughts and feelings, not necessarily to learn about the general topic of thoughts and emotions.

The book explains that conscious thoughts fluctuate frequently. Physical needs or wants (i.e., hunger or exhaustion) and environmental changes (i.e., nighttime or cold weather) continually impinge on thoughts, constantly changing them. This leads to a continuous

flow or stream of thought. James compared conscious thought to a flowing stream. Individuals never have the same thought twice. One may look at the same thing many times and have differing thoughts on every occasion. The continuous flow of thoughts and feelings is what constitutes consciousness.

Since it was first published, *The Principles of Psychology* is considered the most important book in the history of modern psychology. Generations of leaders in all spheres of life were likely to be influenced by this book in a college psychology course. Since James's book was usually the text for this course, his influences on how these future leaders would come to think about human behavior were profoundly influenced by this book.

Christina Ladd, PhD, and
Len Sperry, MD, PhD

See also: James, William (1842–1910); Psychologist; Self-Esteem

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Pristiq (Desvenlafaxine)

Pristiq is a prescribed medication used to treat depression. Its generic name is desvenlafaxine.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Metabolite** is chemical compound that results from the breakdown or metabolism of a parent drug.
- **Neurotransmitter** is a chemical messenger secreted by a nerve cell (neuron) that transmits a nerve impulse to another nerve cell. Common neurotransmitters are serotonin and norepinephrine.
- **Selective serotonin norepinephrine reuptake inhibitors (SNRI**) are antidepressant medications that act on and increase the levels of serotonin and norepinephrine in the brain that influences mood. They differ from selective serotonin reuptake inhibitors, which act only on serotonin.
- **SNRI discontinuation syndrome** is a condition caused by abrupt discontinuation of an SNRI resulting in withdrawal symptoms. These include flu-like symptoms, anxiety, agitation, vivid or bizarre dreams, insomnia, nausea, diarrhea, dizziness, headache, numbness, and tingling of the extremities. This syndrome can be avoided by dose reduction over time.

Description

Pristiq is an antidepressant medication and is a selective serotonin norepinephrine reuptake inhibitors (SNRIs). It affect the neurotransmitters serotonin and norepinephrine and is used to treat depression. It is believed that a decrease in serotonin and norepinephrine contributes to depression and anxiety disorders. SNRIs works by counteracting this by increasing the actions of both neurotransmitters, although Pristiq increases serotonin more than norepinephrine. Pristiq is a metabolite of Effexor, an SNRI that was developed to have fewer side effects and drug interactions than Effexor.

Precautions and Side Effects

Antidepressant drugs, including Pristiq, have been associated with an increased risk of suicidal thoughts and behaviors in children and adults up to age 24. Any patient taking an antidepressant drug should be monitored for changes in behavior and worsening depression. If treatment with Pristiq is ceased, it should be slowly discontinued to avoid the development of SNRI discontinuation syndrome. Close medical monitoring

is needed if Pristiq is used by those with liver or kidney function impairment, seizure disorder, bleeding disorders, glaucoma, dehydration, and history of alcohol abuse, and in patients younger than 25 years of age or the elderly. Pristiq should be used only for a short time and with careful monitoring in those with bipolar disorder as it can induce mania. Since the safety of Pristiq use during pregnancy and breast-feeding is unknown, its use is not recommended.

In general, SNRIs tend to have fewer side effects than SSRIs and tricyclic antidepressants, but side effects may still occur. Dry mouth, dizziness, and nausea are the most common side effects reported with Pristiq. Side effects that are less common include hot flashes, nosebleeds, and yawning. Most side effects are minor and easily treated. Serious, but rare, side effects include mania, hallucinations, panic attacks, suicidality, seizures, serotonin syndrome, liver damage, and glaucoma. Drug interactions may occur when alcohol, Haldol, or nonsteroidal anti-inflammatory drugs are taken with Pristiq. Other medications that can cause drug interactions with Pristiq include Tagamet, lithium, anticoagulant medicines like aspirin or Aleve, and herbal remedies like Yohimbine, ginkgo biloba, and St. John's wort.

Len Sperry, MD, PhD

See also: Depression; Serotonin

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Privilege and Privileged Communication

"Privilege and privileged communication" refer to the legal rule safeguarding the communication that occurs within certain "protected relationships," including that of patient/health-care professional, attorney/client, clergy/laity, and spouse/spouse.

Definition

- **Confidentiality** defines the keeping private of information that is disclosed by a patient, client, or other protected party within the context of a safe, trusting relationship.

Description

"Privilege," in terms of communication, refers to the legal statute establishing that information discussed between certain protected parties is safeguarded from forced disclosure, except as specified by law. This precedent was set forth in the 1996 U.S. Supreme Court case of *Jaffee v. Redmond* that recognized the evidentiary privilege of mental health-care professionals. Mary Lu Redmond, a police officer who shot and killed Ricky Allen whom she discovered wielding a knife and attempting to harm another man, was sued by Carrie Jaffee, the representative of Allen's estate. Jaffee was seeking damages, arguing that Redmond had used excessive force. After learning that Redmond sought counseling to deal with the situation, Allen wanted access to the case notes recounting the details of her therapy sessions. Both Allen and the social worker she worked with refused to provide these documents citing privileged communication. This resulted in the Federal Court's ruling that information discussed among certain parties be kept confidential and remain safeguarded from disclosure to third parties. State jurisdictions, however, can vary in how they interpret and apply privileged communication in cases.

The words "privileged" and "confidentiality" are sometimes used interchangeably to describe the context of communications among qualified parties. Protected relationships include that of doctor/patient, counselor/counselee, attorney/client, clergy/laity, and spouse/spouse. Patients/clients are granted control over whom their private information is released to, with certain exceptions. In order to qualify as "privileged," there must be the understanding, at the onset of the relationship, that the communication exchanged

between the parties is confidential. This would not be the case if any third party or parties are present at the time. There are exceptions to privileged communication that occur when the patient or client provides his or her consent for disclosure, either verbally or in writing, and other circumstances that do not require consent. Situations involving the abuse or suspected abuse of minors, the elderly, and the disabled, as well as situations involving a duty to warn third parties whose welfare may be threatened, are such exceptions. In addition, privilege may be limited and consent may not be required in cases where a patient's sanity is being called into question.

Impact (Psychological Influence)

The prevalence of technology in today's digital age presents particular challenges to professionals charged with safeguarding client information. Unlike times past where communications were limited to phone calls, paper documents, and faxes, professionals are now afforded multiple means with which to communicate with their clients. However, these professionals must now be even more vigilant to protect privileged communications with their clients. Likewise, patients/clients should be informed, be cautious, and remain thorough in their review of paperwork, policies, and practices, which involve patients' personal information.

Melissa A. Mariani, PhD

See also: Ethics in Mental Health Practice; Tarasoff Decision

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Problem-Solving Therapy

Problem-solving therapy is a brief treatment approach that focuses on helping clients to effectively cope with life's stressors. Problem-solving therapy helps clients to find their own solutions to their current problems, as well as bolster self-efficacy.

Definition

- **Cognitive behavior therapy**, which is also known as CBT, is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts.

Problem-solving therapy is considered to be an intervention under the umbrella of cognitive behavioral approaches. It is a brief therapy that can be completed in approximately four to eight sessions. It is considered to be beneficial for both minor and major stressors and mental health problems.

The goal of problem-solving therapy is to increase the individual's planning in problem solving and minimize his or her negative problem-solving skills, such as avoidance or impulsive reactions. There are two major components that look at the person's general beliefs or attitudes to problems and his or her style in which to solve problems.

Clinical assessment looks at the abilities and attitudes in relation to problem solving, the way in which the individual currently solves problems, and what the problem he or she is experiencing. Problem solving is divided into either five or seven stages depending on the model. The seven-stage model includes the steps of the orientation of the problem or the client's attitude, recognizing and identifying the problem, and selecting and defining the problem where one specific thing is chosen to work on in therapy; solutions are then compiled followed by making decisions as to what to do. This is followed by creating an action plan and finally reviewing the progress made by the individual.

Clients are asked questions such as describing the situation and why it is a problem for them. Clients are also asked to identify their emotional reactions to the problems both at onset and throughout the situation. The clients are then asked how they specifically handled the

problem and what the outcome was. This allows for the clinician to gain insight into the client patterns to help generate potential alternatives going forward.

Problem-solving therapy was explored by Thomas D'Zurilla and Marvin Goldfriend in 1971 when they published a review related to problem solving in real life which was later called social problem solving. Based on this review they developed a model that consisted of problem orientation and problem-solving skills. Their model included four problem-solving skills: problem definition and formulation, creation of alternatives, decision making, and solution implementation.

Contemporary problem-solving therapy was developed by Thomas D'Zurilla, Christine Maguth Nezu, and Arthur Nezu. It is considered a form of brief therapy due to the limited number of sessions that are needed. In the original treatment, clients were encouraged to stop and think to assist in coping with something stressful. However, in the contemporary model, clients are encouraged to use the "SSTA" method, which stands for Stop, Slow Down, Think, and Act.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Cognitive Behavior Therapy; Haley, Jay (1923–2007)

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Process Addiction

Process addiction is a compulsive behavior pattern, not involving substances or chemicals, which interferes with daily living.

Definition

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.

Description

Process addiction, different from substance addiction, has received a lot of publicity due to the unusual compulsive behaviors of public figures. Common process addictions include engaging in compulsive work, sex, spending money, exercise, shopping, gambling activities, and eating disorders. In the addiction counseling field there is some question about whether or not food can be considered a chemical addiction. While many process addictions are not officially diagnosed, the American Psychological Association has otherwise recognized them as valid disorders.

Many process addictions are connected to lifestyle and access, which suggest an environmental influence on the development of such addictions. Process addictions are less researched and can be harder to recognize than substance addictions. However, these compulsive and maladaptive behaviors can be equally destructive to individual well-being and happiness.

Some researchers estimate that almost half of the population in the United States has some kind of addictive behavior. While others suggest that about 53 million people, or about 17%, of the United States are addicts of some kind. In terms of each process addiction, the estimates range from a low of 2% of the population for gambling and as high as 10% estimated to be addicted to work.

Causes and Symptoms

It is nearly impossible to identify a single cause of process addiction. Many factors come into play, including genetics, social status, mental state, and individual experience. What is well established is that certain activities stimulate the brain's reward center in the person, which causes the production of chemicals, such as serotonin, that make the person feel good while engaging in the activity. When something feels good, people want more of it and in the addict's case the obsession can have negative impacts.

The most telling symptom of a process addiction is the fact that the person loses control and no longer has the ability to choose freely whether to stop the behavior. There are many other symptoms as well, including increased tolerance of the activity, withdrawing from

others when the person is not able to pursue the activity, excessive time spent in the activity, and secrecy around the activity. For reasons that are also not clearly identifiable, some people might display one addiction while others seem prone to multiple addictions.

Diagnosis and Prognosis

One of the difficulties in diagnosing process addiction is that the behaviors can, in part, be in the normal range of activities. What is important to identify in diagnosis is when the activity becomes obsessive. A major sign of addiction is when personal health and social relationships suffer. In addition to that when finances are negatively affected and when obvious behavior problems surface, it becomes more clear that the behavior is addictive.

It is important to note that the application of the word "addiction" can have a negative connotation. Individuals with process addictions are likely to be invested in particular behaviors such as exercise or work. Many will strongly deny any suffering or unpleasant consequences or symptoms from the activities they are addicted to.

Many people with process addictions can be helped by learning how to identify all the aspects of a behavior which feed the addiction. This can be difficult due to denial and the secret keeping that many addicts display. The most important factors are that the addict recognizes and then is willing to commit to changing or stopping the behavior.

Treatment

Treatment methods for process addictions vary, but the most effective include long-term behavioral modification therapies. In combination with behavioral techniques, many use medication intervention. But without the individual's own desire to stop the behavior, it will be hard to accomplish any change.

A holistic approach with multiple therapies, both psychological and physical, seems to be helpful in changing the patterns of tension and release, which mark the behaviors of people with addictions. Group therapy including family and friends is a successful option when possible. Addictions tend to be social, and building healthy relationships during treatment can be a powerful tool in helping the person with a process addiction.

Alexandra Cunningham, PhD, and
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See also: Addiction; Addiction Counseling; Addictive Personality; Compulsions

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Profanity

Profanity is a verbal activity involving the use of taboo words.

Description

Profanity, also known as swearing, cursing, and cussing, is a verbal behavior that involves the use of taboo words. The most common taboo word categories include bodily functions, body parts, sex, and religion. Swearing can be broadly grouped into annoyance swearing and social swearing.

Impact (Psychological Influence)

Using profanity as an expression of both positive and negative emotions is one of the most characteristic elements of swearing. Research into profanity has shown that the most frequently expressed emotion is anger and frustration followed by humor, pain, and sarcasm. Expressing negative emotions through swearing can reduce tension and is the most mentioned reason for swearing among students. Swearing has been found to increase pain tolerance, but the effect diminishes for those who cuss frequently.

Because swearing uses taboo language, profanity can be shocking and offensive to others. This behavior can have a negative impact on an individual's social standing and reputation. Swearing can be an indication that a person is unable to manage his or her emotions and can evoke feelings of fear or hostility in others. This can result in others distancing themselves, which may lead to a sense of rejection and social isolation. Swearing intensifies the offensiveness of emotionally abusive language and increases the level of hostility perception. People who engage in out-of-control profanity are often perceived as unstable and dangerous.

The impact of profanity is associated with the social context of the behavior and can serve to strengthen social connectedness and solidarity in different settings. For instance, collective swearing out of shared job frustration or dissatisfaction increases group connectedness and becomes part of a group identity. Nonmembers are usually not accepted into the group culture without conforming to the norms, including the use of profanity. Swearing as a means to group membership holds true across a variety of social groups including athletes, soldiers, sailors, laborers, police, and emergency workers. Swearing is a very common sign of solidarity and belonging among adolescent groups.

Use of profanity may be related to social status and is widespread among lower socioeconomic classes, students, and adolescents. This may be due to these groups having little risk of falling in social status and are thus relatively resistant to the negative reactions of others. Swearing has most often been identified as a masculine behavior. Boys begin swearing at an earlier age than girls, and men know and use more swear words than women. More recent research indicates that gender differences in swearing are decreasing.

Profanity has existed for as long as there has been language. It uses taboo words to express emotion, to gain entry into social groups, or as a warning of hostility. Controlling the use of profanity is an important consideration in all social contexts.

Steven R. Vensel, PhD

See also: Culture

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Professional Identity

"Professional identity" refers to the unique growth process through which an individual defines himself or herself in terms of his or her role, philosophy, and approach to others both within and outside the chosen profession.

Definitions

- **Competency** defines one's ability to demonstrate skill in an efficient and successful manner.
- **Constructivism** is a philosophy that posits that meaning is continually and actively constructed based on the experiences one encounters and the value he or she attributes to his or her experiences.
- **Person–environment fit** is the degree of compatibility between an individual's characteristics and the characteristics of his or her environment.
- **Self-concept,** or self-identity, refers to how individuals perceive themselves or the image they have of themselves.
- **Social identity theory** holds that individuals gain a sense of who they are from the membership and status they hold in certain groups, both personal and professional.

Description

"Professional identity" refers to the sets of beliefs, attitudes, and understanding of roles a person holds about himself or herself related to his or her work. It is both a cognitive/psychological and social process whereby individuals come to integrate their personal attributes,

education, and training into the context of a professional community. The way in which one views oneself professionally is based on one's self-concept and interactions with others both within and outside the work environment; it describes interpersonal and intrapersonal experiences.

One's professional identity is thus one aspect of a one's self-concept, which is continually being constructed and altered. Professional identity consists of the individual's present view of himself or herself (who the person is) and his or her current performance (what the person does) as well as his or her future goals and aspirations (what the person wants to do or hopes to attain). A positive self-concept is typically reflected in a positive professional identity, with the person behaving as competent, able, and successful. Positive professional identity is associated with high levels of collaboration, tenacity, and flexibility. A negative self-concept rather typically results in a negative professional identity as evidenced by inadequate performance, self-doubt, non-assertiveness, and lack of drive. Professional identity can therefore play a large role in predicting success.

Professional identity is a concept grounded in constructivism and social identity theory. From a constructivist perspective, professional identity is based on how individuals attribute meaning to the situations they encounter at work or related to their work environment as well as how they view themselves as professionals. How one constructs meaning is a personal process that varies from person to person. Professional identity is further supported by social identity theory, proposed by psychologist Henri Tajfel in the late 1970s, which holds that people gain a sense of who they are based on their group membership, both personal and professional. One's self-concept can thus be enhanced or diminished by the feedback one receives from others in terms of recognition, rewards, punishment, and status. Researcher Herminia Ibarra's work revealed three basic tasks when transitioning from one role to the next in the professional hierarchy: (1) observing role models that display possible professional identities; (2) experimenting with these possible identities in professional practice; and (3) evaluating experiences in these new roles, weighing them against internal standards and external feedback, and determining which identity to adopt.

Impact (Psychological Influence)

The foundation of one's professional identity is based on one's personal and professional philosophy, moral judgment, ethical decision making, responsible behavior, and internal and external standards. Alignment between one's personal attributes and the environment in which one works is referred to as *person–environment fit*. When the two are matched, job success and satisfaction are more probable than when the two are at odds. Future research is needed to address personal and environmental characteristics that moderate successful alignment between the two. The study of organizational dynamics seeks to determine ways to improve this fit. Career assessment practices also work to match individual characteristics to proper professions to increase levels of personal and professional success.

Melissa A. Mariani, PhD

See also: Person–Environment Fit; Career Assessment; Career Counseling

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Project MATCH

Project MATCH was a major research study that attempted to identify the best alcoholism treatment for each individual involved.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.

- **Alcoholics Anonymous** is a mutual aid or self-help fellowship that was founded by Bill Wilson and Dr. Bob Smith in 1935 to help people struggling with alcoholism.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **Psychotherapist** is a trained professional who uses a psychological method for achieving desired changes in thinking, feeling, and behavior with individuals.
- **Twelve Steps** refer to the 12 guiding principles on which Alcoholics Anonymous is based.

Description

The basic premise of Project MATCH was that the most effective treatment for those with alcoholism was the one that was best matched to the individual. It has been acknowledged and observed by addiction professionals for a long time that no single treatment plan has worked for all individuals with alcoholism. Many have suggested that different treatment approaches for specific types of patients struggling with alcoholism might be more effective than others. During the investigation of Project MATCH, psychotherapists administered three types of treatments. Although Alcoholics Anonymous (AA) meetings were not included in the investigation, Twelve-Step methods were incorporated into the treatment. In order to examine the essence and strength of commonality between the treatment approaches, Project MATCH was financed and supported by the National Institute on Alcohol Abuse and Alcoholism. This project was initiated in 1989 and took over eight years to implement. The cost of the investigation was over $27 million.

Three specific types of treatment were evaluated. They were cognitive behavioral coping skills therapy, motivational enhancement therapy, and twelve-step facilitation therapy. Cognitive behavioral coping skills therapy focuses on correcting low self-esteem, and negative and self-defeated thinking. Motivational enhancement therapy assists individuals in becoming aware of and building on their personal strengths, which can help to encourage an individual to stop drinking alcohol. The twelve-step facilitation therapy was introduced as an independent form of treatment to familiarize individuals with the AA philosophy and encourage participation. The outcome of the study concluded that individual treatment matching is not necessary because all three forms of treatment were equally effective.

There were several criticisms in the methods used in Project MATCH. One in particular is that there was no control group (e.g., a group who did not receive treatment) used in the investigation. Therefore, the investigation could not determine whether any of the treatments was effective versus the natural recovery process. In addition, the psychotherapists who were part of Project MATCH had more training than other addiction counselors in the field. Another criticism was that the main outcome measure was reduced alcohol use. Critics maintain that the outcome measure should have been complete abstinence (no alcohol use).

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Addiction; Alcoholics Anonymous (AA); Psychotherapist

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Prostitution

Prostitution, also referred to as commercial sex, defines the act or practice of engaging in sexual relations in exchange for monetary gain or any other benefit.

Definitions

- **Commercial sex** is a sexual act in which something of value is given to or received by any of the involved parties.
- **Human trafficking** describes the illegal buying, selling, and trading of human beings for the purpose of sexual slavery, exploitation, or forced labor.
- **Sex tourism** is defined as when a person travels nationally or internationally to procure prostitution services.

Description

The word "prostitution," a variation of the word "prostitute," is derived from the Latin word *prostituta*, meaning "to put forward for sale." Prostitution is deemed "the world's oldest profession" and has a long-standing history dating back to the 18th century BC where it was referred to in the Code of Hammurabi. Nearly every civilization has some account of prostitution on record, including Mesopotamia, Greece, Italy, Spain, Japan, Australia, France, India, Sweden, and Norway.

"Prostitution," or commercial sex, refers to the business, activity, or practice of exchanging sexual relations for money or another desired benefit. Terms used to describe a person who works in this field are prostitute, sex worker, hooker, call girl, whore, escort, gigolo, hustler, and streetwalker. Commercial sex is offered in various ways, at specified establishments known as "brothels" (in slang terms "whore houses"), call-out services, and most commonly through street prostitution. The majority of sex workers are female who typically service male clients (called "johns" or "tricks"). However, males may also work as prostitutes. Gay, lesbian, prostitution, though less prevalent, exists as well.

Pricing for prostitution services depends on different factors, including the type of sex act performed, current economic conditions, the location, and simple supply and demand. High-end prostitutes can earn significant amounts of money, thousands of dollars, for acts rendered, while lower-end street workers may make only a few dollars. A portion, often a significant amount, of the sex worker's earnings goes to a pimp, madam, or other procurer/procuress. Prostitutes can be found in both urban and rural communities, though larger cities experience the most problems. Like other criminal activities, prostitution is associated with lower socioeconomic status, higher dropout rates, and increased substance abuse. Clients who engage in sex tourism travel to various locations to seek out prostitution services. Victims of human trafficking are also recruited, coerced, or forced into lives of prostitution against their will. Criminal traffickers demand large sums for young girls and those who are virgins in particular.

The average age of someone who enters into prostitution is 14 years; most sex workers are between the ages of 18 and 29. Many who begin this lifestyle have been victims of physical or sexual abuse and are seeking a way out of their current living situation. The majority of prostitutes end up becoming addicted to alcohol or drugs, a factor that contributes to the cycle. Studies indicate that most prostitutes are aware that their actions are illegal and they desire to leave the sex worker industry; however, most report feeling trapped for one reason or another. Pimps, madams, and procurers/procuresses provide money, shelter, clothing, food, and protection.

Impact (Psychological Influence)

Laws and regulations on prostitution vary from country to country. Presently, prostitution is illegal in every U.S. state except for some parts of Nevada. Traditional law enforcement approaches to combating prostitution consists of arresting the prostitute, incarcerating them for a brief period of time, and subjecting them to a fine. However, further analysis has weighed the effectiveness of this approach as the majority of prostitutes return to the lifestyle almost immediately. Alternative suggestions include rescuing prostitutes from these situations and offering them shelter, support, and a new direction. Regardless, the long-term effects of prostitution are also well documented. Victims are more likely to experience lower self-esteem, adjustment issues, difficulty forming and maintaining relationships, suicidal thoughts and attempts, and substance abuse issues.

Current estimates suggest that the prostitution industry generates over $100 billion per year. There is now ongoing debate as to the pros and cons of legalizing prostitution. Proponents suggest that decriminalizing and regulating commercial sex would reduce the allure, deter the punishment of victims, enforce age and health guidelines, and establish proper monitoring and testing standards to reduce the risk of sexually transmitted diseases.

Melissa A. Mariani, PhD

See also: Human Trafficking

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Prozac (Fluoxetine)

Prozac is a prescribed medication used to treat depression and other medical and mental conditions. Its generic name is fluoxetine.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Food and Drug Administration** is the federal agency responsible for monitoring safety standards for food and prescription medications.
- **Selective serotonin reuptake inhibitors (SSRIs)** are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.

Description

Prozac was the first of antidepressant medication to be known as selective serotonin reuptake inhibitors (SSRIs). It was the first such drug approved by the FDA for the treatment of depression. Depression and some other mental disorders appear to be caused by low levels of serotonin, a chemical messenger (neurotransmitter) that is released and transmitted in the brain. Like other SSRI medications such as Luvox, Zoloft, and Paxil, Prozac is believed to work by increasing the level of serotonin in the brain. Increased levels can benefit those with major depression, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, mood swings, premenstrual tension, alcoholism, and certain kinds of headaches.

Precautions and Side Effects

Those taking Prozac should be monitored closely for insomnia, anxiety, mania, significant weight loss, and seizures. Its use should be also be monitored in children and adults up to age 24 because they are at an increased risk of developing suicidal thoughts. Caution should also be exercised when prescribing Prozac to those with impaired liver or kidney function, those over age 60 years, children, individuals with known bipolar disorder or a history of seizures, and those with diabetes. The risks and benefits of Prozac should be considered by women who are or might become pregnant and those who are breast-feeding. Those with diabetes should monitor their blood or urine sugar carefully, since Prozac can affect blood sugar. Alcohol should not be used while taking Prozac. Care must be taken in driving, operating machinery, or participating in hazardous activities when taking this medication. Prozac use should not be stopped abruptly since it can cause withdrawal symptoms.

Common side effects include decreased sexual drive, restlessness, skin rash, hives, and itching. Less common side effects include fever, chills, and joint or muscle pain. Prozac interacts with many other medications. Those considering taking this medication should review the other medications they are taking with their physician for possible interactions. Also, those who

are taking Prozac should inform all their health providers including dentists.

Len Sperry, MD, PhD

See also: Antidepressants; Bipolar Disorder; Depression

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Pseudocyesis

Pseudocyesis is the false belief of being pregnant. It is also known as false pregnancy, hysterical pregnancy, and phantom pregnancy.

Definitions

- **Anxiety disorders** are a group of mental disorders characterized by anxiety, which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorder.
- **Depressive disorders** are a group of mental disorders characterized by sad or irritable mood and cognitive and physical changes that significantly disrupt an individual's daily functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Endocrine system** is a group of glands that produce hormones to regulate the body's growth and sexual development.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Somatic symptom disorder** is a mental disorder characterized by bodily symptoms that are very distressing or result in disrupted life functioning.

Description

Pseudocyesis is a condition in which signs and symptoms associated with pregnancy occur when an individual is not pregnant. Symptoms of it are very similar to those of a real pregnancy. They can include morning sickness, missing a menstrual period, weight gain, and tenderness in the breasts. The abdomen may be swollen and expands so much that the individual looks pregnant. The swollen abdomen may be due to feces, gas buildup, urine, or fat. Another common physical sign of pseudocyesis is irregularity with menstrual cycles. Also, most women also report feeling the fetus move even though there is no fetus present. The main distinction between a true pregnancy and pseudocyesis is the lack of a fetus. No matter what the symptoms, the unquestioned belief that one is pregnant is necessary to make the diagnosis.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with "Other Specific Somatic Symptom and Related Disorder" if they have pseudocyesis. This category is one of the DSM-5 somatic symptoms and related disorders. This category applies to the appearance of symptoms that are typical of a somatic symptom and related disorder. This condition must cause major impairment and distress in an individual's work, social life, or other important areas of life. However, individuals do not meet the full criteria necessary for any of the other disorders in the somatic symptom and related disorders classifications. Other presentations that are identified under this diagnosis include brief somatic symptom disorder, brief illness anxiety disorder, and illness anxiety disorder without excessive health-related behaviors (American Psychiatric Association, 2013).

There is no known cause for pseudocyesis. One theory is that this condition is due to emotional

conflict. For example, many women have a strong desire to become pregnant or a strong fear of becoming pregnant. This can create changes and internal conflict in the body, particularly within the endocrine system. The endocrine system is responsible for the release of hormones, and this may explain why women experience symptoms related to pregnancy. A second theory is that if a woman desires to become pregnant badly enough, she may perceive that any small change in her body is due to pregnancy. Another theory is that pseudocyesis may be due to chemical changes in the body related to some depressive disorders, which triggers symptoms associated with this condition.

Treatment

Since there is not any underlying medical cause of pseudocyesis, medications are generally not prescribed. However, in some situations an individual may be prescribed a medication for terminating menstruation. Individuals who have underlying psychological problems may benefit from psychotherapy. The use of an ultrasound to reveal to the individual that she is not pregnant may be the best form of treatment.

Len Sperry, MD, PhD, and
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See also: Anxiety Disorders; *Diagnostic and Statistical Manual of Mental Disorders,* (DSM); Psychotherapy; Somatic Symptom Disorder

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Psychedelic Drugs

Psychedelic drugs are a class of mood-altering substances, natural and manufactured, that can cause hallucinations or altered sensory experiences in those who ingest them.

Definition

- **Psychoactive** is a drug or substance that has a significant effect on mental processes. There are five groups of psychoactive drugs: opioids, stimulants, depressants, hallucinogens, and cannabis.

Description

Psychedelic drugs were originally intended to enhance the experience of people going through psychotherapy. British psychiatrist Humphry Osmond first coined the adjective "psychedelic" in the 1950s. There is a wide range of psychedelic or hallucination-causing substances. The most common class of psychedelic drugs is those that affect serotonin or dopamine levels in the brain. The best known of these psychedelic drugs are LSD (lysergic acid diethylamide), and psilocybin, mushrooms or magic mushrooms. The second most widely known drugs associated with psychedelics are cannabis, marijuana, and mescaline. Other examples of psychedelic drugs are DMT (dimethyltryptamine) and MDMA (ecstasy). The list of natural and derived, or synthetic, psychedelic drugs is long, and new drugs continue to be developed every year.

Originally psychedelics were valued therapeutically because they could reduce patients' resistance to accessing painful thoughts and memories. In addition, they enhanced the visual or sensory reality of images and feelings experienced during psychotherapeutic sessions. They also seemed to cause little physical harm, especially in a controlled setting. Their initial use in therapy resulted in mild physical and psychological dependency and were not viewed as harmful.

Although other existing drugs, such as alcohol, heroin, and cocaine, also have the potential to induce hallucinations and powerful disconnections, they have not been used for psychological treatment. This is because they are highly addictive and have strong adverse physical effects on the people ingesting them. For these reasons, they are not generally included in the classification of psychedelic drugs.

Development

For all of recorded history, humans have been using various substances to relieve pain or induce ecstatic experiences. These experiences were used to alter perceptions often in the context of religious or celebratory occasions. Some groups of people have used and continue to use these drugs to get experiences or responses to questions not otherwise accessible to the mind. For example, Native Americans have used peyote as part of their religious practices.

As opposed to traditional drugs, the class of hallucinogens called psychedelics is a modern innovation and arose as a way to aid patients with psychological problems. It was intended to improve the quality and content of their thoughts and feelings during extended therapeutic sessions with the guidance of a professional. The intent was to free patients to explore their inner psychological states without self-judgment and with greater creativity than talk therapy alone could provide. The recreational use, or abuse, of these drugs came after their use in treatment. Eventually their use was classified as a criminal offense since many of these drugs are restricted to be used only under strict medical supervision.

In the 1960s, Harvard psychology professor Timothy Leary became the most famous person to use and advocate that others use LSD. His intent was to create a path to personal fulfillment through expanded or changed consciousness. Leary also believed you could administer psychedelics in treatment only if you yourself had ingested them and experienced the results. Leary's increasing advocacy and use of LSD was an instrument to raise political awareness and activism. But his approach and the use of these drugs in therapy provoked opposition, and his ideas were ultimately discredited. Government support of scientific investigations into psychedelics was halted during the 1970s.

Current Status

Many people assume that all psychedelic drugs are illegal, while in actuality, medical and religious use of psychedelics regulated by law is allowed in the United States. It's legal in other countries as well. It is estimated that about 10% of the U.S. population, an estimated 32 million people, has used LSD, mushrooms, or mescaline. Men are reported to be using these drugs at a higher rate than women. The use of perception and mood-altering drugs is a staple of modern medicine and psychotherapy but not widely in the form of psychedelics.

Use of these psychedelic drugs outside of accepted medical treatments continues to be socially and legally controversial. Nevertheless, it does seem that the voting public feels that there is a false distinction between legally approved traditional mood-altering substances, like alcohol, and previously banned products, such as marijuana. Thus, although currently only two states in the United States (Colorado and Washington) have made the psychedelic drug marijuana legal for public consumption, 23 states have approved the medical use of marijuana. The trend toward legalization of some drugs continues. Beneficial as some of these psychedelic drugs may be, controversy remains as it pertains to preventing them being made available to young people or to people who exhibit mental disorders.

Alexandra Cunningham, PhD

See also: Marijuana

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Psychiatrist

A psychiatrist is a physician who specializes in the diagnosis and treatment of mental disorders; a psychiatrist is also referred to as shrinks.

Definitions

- **Clinical psychologist** is a graduate trained and licensed psychologist who can provide clinical assessment, diagnosis, psychotherapy and other interventions, and consultation.

- **Clinical psychology** is a form of psychology that integrates science, theory, and practice to increase the knowledge of the psyche and its function. It is also concerned with predicting, assessing, diagnosing, and alleviating psychological problems and related disability.
- **Cosmetic psychopharmacology** is the use of psychotropic medications to optimize mood and cognitive functioning in individuals with no diagnosable mental disorder.
- **Health Maintenance Organization** is an organization that provides or manages health-care delivery to control costs (managed care).
- **Neurotransmitters** are chemical messengers that carry signals between neurons (nerve cells) and other cells. Deficits or excesses result in anxiety, depression, and other disorders.
- **Psychotropic medications** are prescribed drugs that are capable of affecting the mind, emotions, and behavior. These include antidepressants such as Prozac and antianxiety medications like Xanax. They are also called psychoactive medications.

Description

Psychiatrists are medical doctors who specialize in the diagnosis and treatment of mental disorders. They treat patients in outpatient settings (clinics or private offices) and in hospital settings through a combination of psychotherapy and medication. The training of a psychiatrist consists of four years of medical school, followed by one year of internship and at least three years of psychiatric residency. Psychiatrists may receive board certification from the American Board of Psychiatry and Neurology. Certification requires two years of clinical experience beyond residency and passing a written and an oral examination. While a medical license is required in order to practice psychiatry, board certification is not required. The general public often confuses clinical psychologists and psychiatrists. Although both treat individuals with mental disorders, clinical psychologists are licensed as psychologists and not as physicians.

Psychiatrists can practice general psychiatry or choose a specialty. These specialties include child and adolescent psychiatry, geriatric (older adults) psychiatry, forensic (legal) psychiatry, emergency psychiatry, and community psychiatry. Those whose work primarily involves the use of psychotropic medication are known as psychopharmacologists. Psychiatrists treat the biological, psychological, and social aspects of mental disorders. Because they are licensed physicians, psychiatrists can prescribe medication; they are also able to admit patients to the hospital. They can also diagnose whether symptoms are due to physical causes, such as a thyroid imbalance, or whether psychological symptoms are contributing to physical conditions, such as high blood pressure.

In addition to their clinical work, psychiatrists can be involved in related professional activities such as teaching, research, and administration. The American Psychiatric Association supports the profession by offering continuing education and research opportunities, keeping members informed about new research and public policy issues, helping to educate the public about mental health issues, and serving as an advocate for people affected by mental illness. It reports a membership of 33,000 psychiatrists.

Developments and Current Status

The history of psychiatry begins about 400 BC, with Hippocrates distinguishing mental from physical disorders. The early practice of psychiatry took place largely in psychiatric hospitals until the end of World War II. Since then, outpatient treatment has displaced the central role of the psychiatric hospital in the practice of psychiatry. Several factors account for this change. These include the inability of state governments to remedy the deteriorating condition of many public psychiatric hospitals. The Community Mental Health Centers Act of 1963 provided federal funds to establish a network of community mental health centers (CMHC), which would provide a variety of services, including outpatient treatment and partial hospitalization. These CMHCs contributed to the growing trend toward the deinstitutionalization (discharging patients to the community) of mental patients. Another key factor was the development of more effective psychotropic

medications that allowed patients to live in the community. Today, the majority of psychiatric patients are treated without hospitalization.

Controversy has surrounded psychiatry, particularly the anti-psychiatry movement. Advocates of this movement insist that psychiatric treatments are more damaging than helpful to patients. Anti-psychiatry advocates point to treatments like electroconvulsive therapy as dangerous. In the 1960s and 1970s radical critics within the profession, such as psychiatrists Thomas Szasz (1920–2012) and R.D. Laing (1927–1989), challenged the medical model of mental illness itself. Psychiatry also came under fire from the feminist movement, which saw it as a vehicle for controlling women. Feminist authors have portrayed psychoanalysis as instrumental in suppressing the original feminist movement of the late 19th and early 20th centuries by labeling women's legitimate dissatisfaction and agitation as hysteria and providing an intellectual theory that aided in legitimizing society's continuing subordination of women. Published in 1972, Phyllis Chesler's (1940–) *Women and Madness* was a landmark in feminist criticism.

Advances in neurobiology, endocrinology, and immunology have greatly impacted the way psychiatry is practiced today. Research on neurotransmitters has led to the development of new medications and in the way psychiatrists think about mood, personality, and behavior. Many of these new drugs have fewer side effects than drugs previously used to treat anxiety and depression. Some have become controversial because of their potential use for cosmetic psychopharmacology. The medical and psychiatric professions, as well as ethicists, must deal with the issue of using drugs as mood enhancers to make already healthy individuals more assertive, energetic, and resilient.

Another issue with wide-ranging implications for psychiatry is the policies of insurance companies and health maintenance organizations (HMOs), whose cost-containment policies have already had a significant effect on the way psychiatry is practiced. Insurers and HMOs generally favor psychiatrists using medication management (use of medication only) over psychotherapy with their patients. So, they are more likely to reimburse for medication management and therefore discourage the practice of therapy by psychiatrists. They also tend to promote the use of generic (cheaper) medications over more expensive brand name medication, even when the brand name offers greater benefits.

Len Sperry, MD, PhD

See also: Clinical Psychology; Psychologist

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Psychoanalysis

Psychoanalysis is a theory of human behavior and form of psychotherapy that focuses on conflicts and compromises between the unconscious (internal) and the conscious mind. It was developed by Sigmund Freud (1856–1939).

Definitions

- **Psychoanalytic psychotherapy** is a form of psychoanalysis that assumes that dysfunctional or unwanted behavior is caused by unconscious, internal conflicts and focuses on gaining insight into these conflicts.
- **Psychoanalytic theory** reflects a psychodynamic view of human behavior which emphasizes the conflicts and compromises between the unconscious (internal) and conscious mind.
- **Psychodynamic** refers to a way of explaining thoughts, feelings, and behaviors as the manifestation of unconscious (inner) drives and processes.
- **Psychodynamic psychotherapies** are a group of psychodynamic approaches that assume that dysfunctional or unwanted behavior is caused by unconscious conflicts, and therapy focuses on resolving conflicts through insight and/or corrective experiences.

Description

Psychoanalysis is both a theory of human behavior and a form of psychotherapy developed by Sigmund Freud. In psychoanalysis, the analysand (patient) is encouraged to talk freely about personal experiences, particularly early childhood experiences and dreams. It is based on psychodynamic theory. Freud viewed personality as having three parts: the id, the ego, and the superego. He developed a model of personality and psychopathology (abnormality) based on it. The id is comprised of instinctual drives for food, sex, and aggression, and these drives are unconscious. The id seeks immediate gratification and anxiety results when it is frustrated. Linked to the id is the ego, which has been socialized. As a result the ego recognizes that gratification of the id's urges cannot always be achieved. The superego acts as an arbiter of right and wrong and moderates the id's urges in terms of a moral code. Freud used this model to demonstrate how instinctual drives are frustrated with social codes (by the ego) and by morality (by the superego). The inevitable conflicts between these three components are the basis of psychoanalytic theory.

In dealing with these conflicts, psychoanalytic theory contends that the human mind constructs three different forms of adaptive mechanisms: defense mechanisms, neurotic symptoms, and dreams. Freud identified several defense mechanisms, such as repression, displacement, denial, rationalization, projection, and identification. Each has its own unique role, but all work to distance an individual from a conflict that is too difficult to confront realistically. Neurotic symptoms are understood to be symbolic actions that represent the repressed longings of the id.

Freud believed dreams were vivid representations of repressed urges. Some neurotic symptoms have both physical and psychological components. For example, a severe headache can result from unfulfilled longings that the individual is unable to confront on a conscious level. Because of this inability, individuals may develop an acceptable symptom (headaches) for which they can seek medical attention. Dreams have two parts, the manifest (obvious) content, the narrative that one is able to remember on waking, and the latent (hidden) content, the underlying, largely symbolic message. Since dreams are understood as representing unfulfilled longings of the id, psychoanalysis deals heavily with dream interpretation.

Such conflicts are believed to originate during one of the four developmental stages. Freud believed that adult neuroses could be traced to frustrated sexual gratification during one of these stages. Four stages were identified: the oral stage (birth to one year), the anal stage (one to three years), the phallic stage (three to five years), and the latency stage (five years to puberty). Each of these stages is in turn divided into substages. In each of the major stages, the infant has sexual needs which, because of social mores, are left largely unfulfilled, causing neuroses to originate. It is during the phallic stage that the Oedipus complex develops. During this stage, the child begins to associate his genitals with sexual pleasure and becomes erotically attracted to the parent of the opposite sex while at the same time developing an intense jealousy of the same-sex parent. Later, Carl Jung (1875–1961) described the Electra complex for women in which the same dynamics of erotic attraction and jealousy is played out from the girl's perspective.

Developments and Current Status

Sigmund Freud noted that many of his patients were suffering from physical symptoms for which he could find no cause. At first he sought to uncover the psychological cause through hypnosis. Because of limited success with it, he instructed patients to talk freely about their problems. This led individuals to reveal the unconscious heart of the problem. Continuing his research of the mind and the unconscious, Freud published *The Interpretation of Dreams* in 1900. This was followed by *The Psychopathology of Everyday Life* in 1904 and *A Case of Hysteria* and *Three Essays on the Theory of Sexuality*, both in 1905. By 1920, Freud had become internationally recognized, and psychoanalysis emerged as a significant intellectual and social development. As a result, entering psychoanalytic treatment became fashionable among the elite.

Classical psychoanalysis is the version of psychoanalysis practiced by Freud and his early followers. It often required years of therapy, sometimes on a daily basis. Not surprisingly, it was criticized for being

time consuming and costly. More recently, a number of modern approaches have been developed that are briefer and more effective. These are broadly labeled psychodynamic psychotherapies. They include psychoanalytic psychotherapy, ego psychology, object relations therapy, self-psychology, and the interpersonal psychoanalysis.

Len Sperry, MD, PhD

See also: Psychodynamic Psychotherapies

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Psychodrama

Psychodrama is a therapy technique that explores psychological issues through guided and creative reenactments.

Description

The developer of psychodrama was Dr. Jacob Moreno (1889–1974), who believed that each person is impacted by the roles that he or she plays. These roles include cultural, social, and psychological expectations. From his perspective, a person is mentally healthy when he or she is able to flexibly act and react with a variety of responses or roles, depending on circumstances. For example, one person could play the role of a father in some circumstances and an employee in others. Conversely, issues and problems are indicated by restrictions in emotional responses and spontaneity when asked to take on certain roles.

Psychodrama is an active and involved method of group and individual psychotherapy. In this technique, people are helped to explore their psychosocial issues by enacting scenes from their lives, their dreams, or their fantasies. This is done in a facilitated setting so that each individual may gain new insights into his or her thoughts and behaviors and be able to access previously unspoken emotions. The power of acting out and getting immediate emotional response from other group members is accomplished through psychodrama. Psychodrama can help to reduce inhibitions and provide the opportunity for surprising breakthroughs in awareness. The goal is that these opportunities fuel their courage to try new roles and new behaviors outside of therapy.

Development

From 1918 to 1925, Dr. Moreno practiced psychiatry and psychodrama in Vienna. His work was an effort to depart from the typical Freudian approach to psychotherapy and its exclusive concentration on individual talk therapy. From theatrical work that he had done with children in the parks of Vienna, he came to realize the healing impact and importance of creativity and spontaneity. Moreno had also worked with a group of prostitutes seeking rehabilitation. During this experience he became aware that working with them together as a group had positive results, in fact results that were greater than might have been achieved with individual one-on-one work because each person was able to function as a kind of therapist and support for the others. This led him to expand on the idea of incorporating group therapy and psychodrama into treatment to effect change. Psychodrama was popularized during the 1930s in New York City by Moreno. He accomplished this through the extensive use of psychodrama in the context of group therapy. The United States proved to be fertile ground for further development and the spread of both group therapy and psychodrama.

Current Status

Psychodrama has become a standard tool that is used in group therapy. Moreno's work has continued for the half century after his death through his wife Zenka Toeman Moreno. Today there are psychodrama certification programs and centers across the United States and the concept of psychodrama is widespread in creative group therapy settings.

Alexandra Cunningham, PhD

See also: Group Counseling; Group Therapy; Moreno, Jacob (1889–1974)

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Psychodynamic

"Psychodynamic" refers to a way of explaining thoughts, feelings, and behaviors as the manifestation of unconscious (internal) drives and processes.

Definitions

- **Ego psychology** is a form of psychoanalysis that emphasizes the role of the ego in managing competing demands.
- **Object relations theory** is a variant of psychoanalytic theory which emphasizes the essential need for close relationships. The attempted fulfillment of this need through mental representations of self and others is believed to determine one's motivations and behaviors.
- **Psychoanalysis** is a form of therapy based on psychoanalytic theory. In psychoanalysis, clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams.
- **Psychodynamic psychotherapies** are a group of psychodynamic approaches that assume that maladaptive or unwanted behavior is caused by unconscious drives and processes, and therapy focuses on fostering insight and/or corrective experiences.
- **Self-psychology** is a form of psychoanalysis that assumes that dysfunctional or unwanted behavior results from unmet or disrupted developmental needs.

Description

The origin of the term "psychodynamic" is from the Greek words "psyche," meaning mind, and "dynamis," meaning power or force in motion. In other words, the mind is made up of powerful forces in motion. Sigmund Freud (1856–1939) used the word "psychodynamic" to describe the mind as an energetic moving system of parts. We are aware of the conscious parts of the mind and unaware of the unconscious parts. From a psychodynamic perspective, maladaptive behaviors are the result of unconscious processes and develop early in life.

The unconscious consists of feelings, memories, self-perceptions, ways of relating to others, conflicts, and beliefs that we are not aware of. All of these processes develop during childhood and are a unique combination of an individual's early experiences, family environment, biological factors, and genetic predispositions. Psychodynamic theory posits that certain thoughts, feelings, and fantasies are forced into the unconscious because they are overwhelming or would give us a sense of disgust or shame.

Psychodynamic theory states that unconscious mental processes affect conscious thoughts, feelings, and behaviors. Becoming aware of how past experiences impact present behavior is a central goal of the psychodynamic psychotherapies. Similar to psychodynamic theory is psychoanalytic theory. While it reflects the psychodynamic view of human behavior, psychoanalytic theory emphasizes the conflicts and compromises between the unconscious and conscious mind. In other words, the psychoanalytic theory holds that individuals' unwanted or maladaptive (problematic) behaviors are the result of internal conflicts and experiences being locked up in the unconscious by way of psychological defense mechanisms such as regression and repression. Once the experiences and internal conflicts are brought into the consciousness of the client, the maladaptive behaviors cease.

Development and Current Status

Psychodynamic theory has its roots in psychoanalysis, being the oldest of the psychodynamic psychotherapies. Freud's ideas about personality, the ego, unconscious

processes, defense mechanisms, and the importance of early childhood experiences have all been further developed by numerous other psychiatrists, psychologists, and theorists over the past century.

Other psychodynamic theories and approaches include ego psychology (Anna Freud), psychosocial development (Erik Erikson), object-relations theory (Otto Rank and Melanie Klein), Individual Psychology (Alfred Adler), Jungian/analytical psychology (Carl Jung), and self-psychology (Heinz Kohut). A more recent theory that has made considerable contributions to psychodynamic psychotherapy is that of attachment theory (John Bowlby), which recognizes the central role of the primary caregiver, most often the mother, in the emotional development of a person.

Steven R. Vensel, PhD, and
Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Erikson, Erik (1902–1994); Freud, Anna (1895–1982); Freud, Sigmund (1856–1939); Klein, Melanie (1882–1960); Psychoanalysis; Psychodynamic Psychotherapies

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Psychodynamic Diagnostic Manual (PDM)

The *Psychodynamic Diagnostic Manual* (PDM) is a diagnostic framework that characterizes individuals in terms of their psychodynamics.

Definitions

- **Psychiatric diagnosis** is a form of diagnosis based on comparing symptoms and impaired functioning with diagnostic criteria for a specific disorder.
- **Psychoanalysis** is a form of psychodynamics therapy in which patients are encouraged to talk freely about personal experiences, particularly about their early childhood and dreams.
- **Psychoanalysts** are therapists who practice therapy from the perspective of psychoanalysis.
- **Psychodynamic** refers to interaction of conscious and unconscious processes as they influence personality, behavior, and attitudes.
- **Psychodynamic diagnosis** is a form of diagnosis that involves an investigation into how individuals acquire their symptoms and the meaning they attribute to their symptoms.

Description

The *Psychodynamic Diagnostic Manual* is a diagnostic framework that characterizes individuals in terms of both their psychodynamics and their emotional, cognitive, and social functioning. The purpose of the PDM is to complement the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) with psychodynamically based descriptions of patterns of personality, global functioning, and symptom formation. The PDM emphasizes motivational factors that commonly underlie the emergence of particular personality disorders and symptom disorders (depressive disorders) and the ways individuals with these disorders are likely to experience them.

Psychodynamic diagnosis differs from psychiatric diagnosis. Whereas a psychiatric diagnosis focuses on symptoms and impairment, the psychodynamic diagnosis focuses on the individual who is experiencing those symptoms and impairment. While a psychiatric diagnosis is a DSM diagnosis that is primarily descriptive (describes a group of symptoms), the psychodynamics diagnosis identifies the causes or etiology of the individual's behavior and feelings.

The PDM provides a diagnostic framework that describes both the deeper and surface levels of an individual's personality, emotional and social functioning, and symptom patterns. A psychodynamics evaluation explores how and why those influences are emerging in the present and causing symptoms, including the

role of early environment, developmental factors, current stressors, and internal psychological factors.

The PDM can complement the more descriptive approach of the DSM diagnosis with an individualized, dimensional, and motivationally based classification system. It accomplishes this by describing individuals in terms of their personality characteristics, the adequacy of their mental functioning, operative patterns of symptom formation, and their experience of these symptoms. Accordingly, each person being evaluated with the PDM is diagnosed on three axes that are labeled S (Symptom Patterns), P (Personality Patterns and Disorders), and M (Profile of Mental Functioning). The PDM diagnosis begins with the P axis, considers next the M axis, and concludes with the S axis. This sequence reflects the belief that symptom disorders are embedded in an individual's personality structure and manifest in ways that vary with the individual's functioning capacities.

The PDM is divided into two parts. Part 1 focuses on adult disorders and closes with three case illustrations of how the P, M, and S codes can be applied. The three individuals in these cases have the same PDM S axis diagnosis of depressive disorder (S304.1), but their P axis and M axis diagnoses differ in ways that have implications for their uniqueness as people and for treatment strategies tailored to their individual needs. Part 2 focuses on child and adolescent disorders. It is organized around the same P, M, and S axes as are used with adults, but in a different sequence. The PDM diagnosis of children and adolescents begins with attention to the adequacy of basic functioning capacities, in the form of an MCA axis that provides guidelines for classifying mental functioning and coping.

Developments and Current Status

The PDM was published in 2006. It was a collaborative effort of five psychoanalytic organizations: the American Psychoanalytic Association, the International Psychoanalytic Association, the Division of Psychoanalysis of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the National Membership Committee on Psychoanalysis in Clinical Social Work. It was authored by a task force consisting of Stanley Greenspan, Nancy McWilliams, Robert Wallenstein, and an interdisciplinary group of 37 other task force members and consultants.

Despite the considerable clinical value of the PDM, it seems unlikely that the PDM will replace the DSM. There are many reasons for this, not the least of which is that the PDM does not yet have the established reliability necessary to warrant its widespread adoption. Overall, the PDM complements DSM by providing a valuable framework for planning and implementing clinical treatment.

Len Sperry, MD, PhD

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM)

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Psychodynamic Psychotherapies

Psychodynamic psychotherapies are a group of psychodynamic approaches that assume that dysfunctional or unwanted behavior is caused by unconscious (internal) conflicts, and therapy focuses on resolving conflicts through insight and/or corrective experiences.

Definitions

- **Object relations theory** is a variant of psychoanalytic theory which emphasizes the essential need for close relationships. The attempted fulfillment of this need through mental representations of self and others is believed to determine one's motivations and behaviors.
- **Object relations therapies** are forms of psychoanalytic psychotherapy in which the basic

goal is to modify pathological representations of self and others.

- **Psychoanalysis** is a form of therapy based on psychoanalytic psychology. In psychoanalysis, clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams.
- **Psychoanalytic psychotherapy** is a form of psychoanalysis that assumes that dysfunctional or unwanted behavior is caused by unconscious, internal conflicts and focuses on gaining insight into these conflicts.
- **Psychoanalytic theory** reflects a psychodynamic view of human behavior which emphasizes the conflicts and compromises between the unconscious (internal) and conscious mind.
- **Psychodynamic** refers to a way of explaining thoughts, feelings, and behaviors as the manifestation of unconscious drives and processes.
- **Relational psychoanalysis** is a form of psychoanalysis that emphasizes the role of real and imagined relationships with others in mental disorder and psychotherapy.
- **Self-psychology** is a form of psychoanalysis that assumes that dysfunctional or unwanted behavior results from unmet or disrupted developmental needs.

Description

Psychodynamic psychotherapies represent a broad category of psychotherapeutic approaches that are based on the principles of psychodynamics and psychoanalytic psychology. Generally, dynamic therapies endeavor to bring unconscious material and processes into full consciousness so individuals can gain more control over their lives. These therapies have their origins in psychoanalysis and stem from the work of Sigmund Freud (1856–1939) and others who have made major contributions and reformulations (variants) to Freud's original theory and therapeutic approach, which is called classic psychoanalysis. These reformulations include psychoanalytic psychotherapy, ego psychology, object relations theory, self-psychology, and the interpersonal psychoanalysis. While there are important differences in both theory and practice among these different approaches, they share certain common principles. These include (1) the unconscious and the belief that much of mental life involves and is influenced by unconscious processes; (2) resistance and the exploration of resistance to change, and defenses as a focus of therapy; (3) transference (reenacting past feelings and expectations) and the exploration of such reenactment of the past in response to the therapist; (4) symptoms and behavior which are determined by complex and usually unconscious forces; and (5) exploration of basic assumptions about self and the world or maladaptive interpersonal patterns rather than simply focusing on symptom relief.

Developments and Current Status

Sigmund Freud (1856–1939) is considered to be the father of psychoanalysis. Freud's work focused primarily on instinctual drives and structural theory (id, ego, and superego). However, psychoanalysis has evolved considerably since Sigmund Freud. Five different phases of this evolution can be identified. Each is briefly described.

Classical psychoanalysis. Classical psychoanalysis is the approach developed and practiced by Freud. In this approach, the analysand (client) verbalizes thoughts, free associations, fantasies, and dreams, from which the analyst (therapist) identifies the unconscious conflicts causing the client's symptoms and related characterological (personality) issues, which includes unconscious aspects of the therapeutic alliance (relationship with the analyst). The analyst's interventions include confrontation, clarification, interpretation, and working through (process of generalizing new awareness to the client's life). Typically, the analyst sits behind the analysand who lies on a couch during sessions.

Psychoanalytic psychotherapy. Another drive-based dynamic approach is psychoanalytic psychotherapy. It is a modified form of classical psychoanalysis, which is more widely practiced than classical psychoanalysis today. It is less intense and less concerned with major changes in the client's personality structure and

focuses on the client's current concerns and the way these concerns relate to early conflicts. Typically, therapist and client face each other in this approach.

Ego psychology. Ego psychology evolved out of Freud's later thinking and was the dominant form of psychoanalysis practiced until the 1970s. Freud's daughter, Anna Freud (1895–1982), played a significant role in its development. It focuses on the ego's normal and pathological development and its adaptation to reality. Unlike the focus on libidinal and aggressive impulses of classical psychoanalysis, ego psychology focuses directly on the ego and its defenses. Through clarifying, confronting, and interpreting the client's commonly used defense mechanisms, the goal is to assist the client in gaining control over these mechanisms.

Object relations. Since the 1970s major reformulations of psychoanalysis have emerged. Among these was object relations theory which emphasizes interpersonal relations, especially between mother and child. Melanie Klein (1882–1960) was a key architect of this approach. "Object" refers to a significant other who is the object of another's feelings or intentions. "Relations" refers to interpersonal relations and refers to the residues of past relationships that affect a person in the present. Object relations therapy focuses on the ways the client projects previous object relationships into the relationship with the therapist. The goal is to assist clients in resolving the pathological qualities of past relationships through the corrective emotional experience. Like other psychodynamic approaches, some interpretation and confrontation may be involved. However, the working through of the original pathological components of the patient's emotional world and the objects is the primary therapeutic strategy.

Self-psychology. Another reformulation initiated by the Hungarian psychiatrist Heinz Kohut (1913–1981) is called self-psychology. This approach emphasizes the development of a stable and cohesive or integrated sense of self through empathic contacts with significant others (selfobjects). These selfobjects meet the developing self's needs and serve to strengthen it. Treatment proceeds through reflection of feelings and interpretations in which the client gradually internalizes the selfobjects' functions provided by the therapist.

Interpersonal psychoanalysis. There is also some reformulation of psychoanalysis based on relational themes. Psychologist and psychoanalyst Stephen A. Mitchell (1946–2000) distinguished between psychoanalytic theories emphasizing biological drives (drive/conflict theories) and theories emphasizing human relationships (*relational/conflict theories*). Mitchell argued that drive and relational theories were conceptually incompatible and that the field must choose between them. He is credited with developing interpersonal psychoanalysis. This approach emphasizes the way in which individuals protect themselves from anxiety by establishing collusive (unhealthy) interactions with others. It emphasizes how the individual's personality is shaped by both real and imagined relationships with others, and how these relationship patterns are reenacted in the interactions between therapist and client.

Time-limited dynamic psychotherapy is a brief form of relational psychoanalysis. It was developed for clients with chronic, pervasive, dysfunctional ways of relating to others by psychologist Hans Strupp (1921–2006). Essentially, this approach assumes that individuals have unintentionally developed self-perpetuating, maladaptive patterns of relating to others and that these patterns underlie their present problems. The therapist's role is to use the therapeutic relationship to facilitate in clients new experience of relating, which allows them to break their maladaptive pattern and thereby resolve their presenting problem. This approach is also called brief dynamic therapy and has become one of the more commonly practiced psychodynamic psychotherapies today.

Len Sperry, MD, PhD

See also: Klein, Melanie (1882–1960); Object Relations Therapies; Psychoanalysis

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Psychoeducation

"Psychoeducation" is a general term used to describe the assessment and therapeutic process involved in identifying an individual's present state of physical health, behavioral, academic, and psychological functioning, determining an accurate diagnosis, and assisting the person and his or her family in dealing with the new diagnosis.

Definitions

- **Psychoeducational groups** are a type of small group therapy that focus on educating people on how to cope with a medical diagnoses, learning disability, and/or psychiatric disorders.
- **Psychoeducational testing** is a form of assessment that is comprised of both psychological and educational components, which seeks to determine what an individual has learned and what capacity the individual has to learn in the future.
- **Psychoeducational therapy** defines the therapeutic treatment, either individually or in small groups, of those with disabilities and medical illnesses so they can learn to manage and cope with their new diagnosis.

Description

"Psychoeducation" refers to the evaluation, education, and treatment of persons diagnosed with various conditions, including learning disabilities, medical illnesses, and psychological disorders. This intervention offers teaching, counseling, and skill-building support. Attention-deficit hyperactivity disorder, reading and processing difficulties, anxiety-related issues, eating disorders, depression, personality disorders, schizophrenia, and health-related concerns including diabetes, epilepsy, and cancer have all been addressed with psychoeducation. Psychoeducation is meant to impart knowledge and skills so that patients and their loved ones become better able to cope with their conditions. New diagnoses can result in feelings of stress, anxiety, and confusion, which can be dissipated with appropriate intervention. The goal of psychoeducation is to promote self-management strategies and prevent relapse by increasing overall well-being.

Psychoeducation is a broad term that includes both the assessment process, *psychoeducational testing*, and the intervention, *psychoeducational therapy*. Proper diagnosis is the first step in the psychoeducational process, typically conducted by a physician, specialist, psychiatrist, or licensed psychologist. Physical illnesses require testing and analysis by a medical doctor who specializes in the area of concern. Learning, behavior, or psychological disabilities are determined through a full psychoeducational evaluation by a psychiatrist or psychologist, which assesses the client's present psychological functioning as well as his or her retention of knowledge and capacity for future academic learning. Once a proper diagnosis has been determined, the client/patient may then be referred for psychoeducation to assist in educating and helping cope with his or her new status. Psychoeducation for physical illnesses may be offered by physicians, nurses, specialists, physical therapists, or home health-care workers, while psychoeducation for learning, behavior, and psychological concerns may be delivered by mental health professionals, behavioral interventionists, or clinical social workers. This treatment intervention can be offered to patients on an individual basis or in small group settings with peers or family members.

Psychoeducation can be implemented in a variety of settings, including hospitals, treatment centers, and schools. Patients who receive psychoeducation benefit by gaining information and increased awareness on their diagnosis. Information regarding client symptomatology, treatment options, outcomes, resources, and support networks available is imparted to clients and their loved ones during psychoeducational sessions. This results in reducing feelings of hopelessness, anger, anxiety, and fear and in raising the client's level of acceptance of, sense of control over, and healthy coping with his or her condition. The effectiveness of psychoeducational groups in particular has been proven as support from peers who are experiencing, or have experienced, similar issues is important. Peers can relay helpful tips and provide firsthand knowledge and support is key. The format of

a psychoeducational session can vary from discussion based to more structured; however, each session typically has specific goals and content. Information can be imparted through lecture, open question–answer, and the reading/writing of print materials, or use of CDs, DVDs, or computer-based learning. The number of sessions can also differ.

Development (History and Application)

Though psychotherapist John E. Donley was the first to refer to the concept of psychoeducation in his article "Psychotherapy and Re-education" in the *Journal of Abnormal Psychology* in 1911, the term "psychoeducation" was actually coined by Brian E. Tomlinson in the 1941 book *The Psychoeducational Clinic*. Psychoeducation as it is presently used, however, is attributed to the work of American researcher C. M. Anderson, who focused on the effectiveness of this intervention approach with patients suffering with schizophrenia. Her work referred to the benefits of educating patients and their families and increasing their emotional and coping skills in order to improve their prognosis and postpone relapse. Psychoeducation has since been applied to treat other psychological conditions, as well as medical illnesses, physical disorders, and learning disabilities.

Current Status

The psychoeducational approach has been proven effective in helping to mitigate the symptoms of various mental illnesses. Most of the research on this intervention notes the benefits of psychoeducation for those suffering with schizophrenia, clinical depression, and bipolar disorder. Recent application has addressed the positives of this treatment with clients suffering from other conditions, including eating disorders, personality disorders, behavioral challenges, and learning needs. There is limited research on the difference between various psychoeducational formats and delivery methods. Much of the benefit one gains from this type of intervention depends on individual characteristics, including the client's willingness to participate, openness to new information, attitude, and mindset toward his or her diagnosis.

Melissa A. Mariani, PhD

See also: Intelligence Testing; Psychoeducational Groups

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Psychoeducational Groups

Psychoeducational groups provide therapeutic support in small group settings to assist members struggling with similar issues or diagnoses and educate them so that they can manage their symptoms and conditions in everyday life.

Definitions

- **Psychoeducation** is a general term that describes the educational and therapeutic process involved in assisting an individual and his or her family in coping with a medical or psychological illness, or physical, behavioral, or learning disability.
- **Psychoeducational therapy** defines the therapeutic treatment, either individually or in small groups, of those with disabilities and medical illnesses so they can learn to manage and cope with their new diagnosis.

Description

Psychoeducational groups are a form of psychoeducational therapy that helps individuals diagnosed with a wide variety of conditions, ranging from medical illnesses, physical impairments, psychological disorders, and learning disabilities, effectively cope with their symptoms and deal with their new diagnoses in healthy, appropriate ways. These groups can be offered to individuals of all ages across a wide range of settings, including hospitals, treatment centers,

churches, and schools. Those diagnosed with autism, ADHD, anxiety-related issues, certain phobias, eating disorders, depression, personality disorders, schizophrenia, substance abuse, eating disorders, diabetes, and cancer have all benefited from psychoeducational groups. Psychoeducational therapy is typically provided by a mental health professional, such as a counselor, therapist, social worker, or psychologist. Group psychoeducation focuses on providing information, support, and strategies. New diagnoses can result in feelings of stress, anxiety, and confusion, all of which can be dissipated with appropriate intervention. The goal of a psychoeducational intervention is to promote self-management strategies and prevent relapse by increasing the participant's overall well-being. Membership is usually comprised of peers who are dealing with similar diagnoses, symptoms, or behaviors. The structure of a psychoeducational group can vary from lecture-based to informal, open discussion. Group leaders may impart information pertaining to the diagnosis itself, including physical symptoms, treatment options, and prognosis. Topics center around particular conditions or diagnoses. In addition, coping strategies and skills may be taught.

Development (History and Application)

Psychoeducational group therapy is considered a holistic intervention that stresses competency, collaboration, strength, empowerment, and choice. Patients/clients who participate are encouraged to focus on the present rather than the past or future. Psychoeducation has been in existence for decades and has developed as an alternative approach to traditional psychotherapy. This therapeutic intervention responds to patient needs by providing a skills-based approach to treatment. Psychoeducational facilitators focus on collaboration and operate from an egalitarian mind-set, respecting the patient's autonomy and arming him or her with information that will allow him or her to feel more control over his or her diagnosis.

Current Status

The effectiveness of psychoeducational group therapy has been well documented. Numerous studies support this intervention as a viable choice in mitigating symptomatology and recurring episodes for those suffering from schizophrenia, depression, and bipolar disorder. Eating disorders and substance abuse issues are also regularly treated with this form of therapy. Alcoholics Anonymous is a popular example of a psychoeducational group that has had much documented success. More recently, psychoeducational groups have been implemented in school settings to assist adolescents in dealing with common problems like teen pregnancy, alcohol and drug use, learning, and behavioral struggles. Little research exists on the degree of effectiveness between different psychoeducational formats and delivery methods. An individual's willingness to participate, interest in learning the information imparted, and commitment to the group process are key.

Melissa A. Mariani, PhD

See also: Psychoeducation

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Psychological Factors Affecting Other Medical Conditions

Psychological factors affecting other medical conditions is a mental disorder characterized by emotional factors that worsen a medical condition.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by

professionals to identify mental disorders with specific diagnostic criteria.

- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Somatic sensitivity** refers to the high level of sensitivity and attentiveness to bodily sensations of emotionally reactive individuals. This often leads to a preoccupation with bodily symptoms.
- **Somatic symptom and related disorders** are a group of DSM-5 mental disorders characterized by prominent somatic symptoms and significant distress and impairment. They include somatic symptom disorder and psychological factors affecting other medical conditions.
- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description and Diagnosis

Psychological factors affecting other medical conditions are one of the somatic symptom and related disorders. They are characterized by one or more emotional or behavioral factors that exacerbate or adversely affect an existing medical condition. Psychological factors can be a contributing or exacerbating factor in several medical disorders. For example, heart disease, diabetes, high blood pressure, and cancer are commonly impacted by psychological factors. Immune and endocrine disorders like hyperthyroidism (overactive thyroid) as well as migraine, irritable bowel syndrome, and pain disorders are also impacted.

There are various ways in which psychological factors can worsen a medical disorder. For example, psychological distress can signal the thyroid gland to increase hormones that in time can result in hyperthyroidism (overactive thyroid gland). Similarly, chronic activation of the stress response can negatively affect the immune system and worsen asthma or allergies. Mood disturbance also plays a role in medical disorders. For example, clinical depression is both a risk factor in heart disease and a factor that negatively influences recovery from a heart attack.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a medical condition or symptom and behavioral or psychological factors adversely affecting that condition. These factors can be shown to influence the course of the medical condition or interfere with its treatment. In addition, these factors can precipitate or worsen its symptoms, or serve as health risks for the condition. Finally, these factors cannot be better explained by another mental condition such as a depressive or a panic disorder (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. It may be that those with it are more sensitive to their own bodily sensations (somatic sensitivity) than others. This means that those with this disorder tend to amplify and interpret these physical sensations as indicators of physical illness even when the cause is emotional. This means that when they experience emotional stress they inevitably interpret it as a physical symptom. In addition, they are likely to view life as threatening and overwhelming. They are also likely to view themselves as unable to control and deal with overwhelming circumstances. These views reflect an external locus of control. It not only confirms and perpetuates their suffering but also explains their reliance and overuse of medical treatment.

Treatment

Effective treatment of this disorder usually involves counseling or psychotherapy. Typically, this requires a team approach in which the psychotherapist collaborates with physicians to reduce symptoms, increase treatment compliance (willing to follow treatment recommendations), and ensure that care is coordinated. Effective psychological treatment results in decreased symptoms and increased functioning. Intervention strategies should target physical functioning by teaching relaxation and other stress management skills. Such interventions can greatly help individuals feel better physically and increase their sense of self-efficacy.

Mindfulness practice can also help in both reducing their preoccupation with and acceptance of physical symptoms. In addition, instructing these individuals to get regular exercise and sufficient sleep is crucial. Finally, helping them increase their support network and connection to others provides them with an effective buffer against stress and also reduces their symptoms.

Len Sperry, MD, PhD

See also: Mindfulness; Somatic Symptom Disorder; Stress Management

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Psychologist

Psychologists are social scientists who study behavior and mental processes, typically in teaching, research, business, or clinical settings.

Definitions

- **Behaviorism** is the psychological theory and scientific approach that emphasized the role of observable, quantifiable facts rather than subjective thoughts and emotions as in structuralism.
- **Clinical psychologist** is a graduate trained and licensed psychologist who can provide clinical assessment, diagnosis, psychotherapy and other interventions, and consultation.
- **Clinical psychology** is a form of psychology that integrates science, theory, and practice to increase the knowledge of the psyche and its function. It is also concerned with predicting, assessing, diagnosing, and alleviating psychological problems and related disability.
- **Clinical social worker** is a graduate trained and licensed professional who provides a broad range of mental health services for individuals, families, and groups.
- **Functionalism** is the psychological school of thought that views mental life and behavior in terms of its functions and active adaptation to external challenges and opportunities.
- **Mental health counselor** is a graduate trained and licensed professional who provides psychotherapy or therapeutic counseling to individuals, families, and groups.
- **Psychiatrist** is a licensed physician who specializes in the diagnosis and treatment of mental disorders usually with medications and/or psychotherapy.
- **Psychoanalysis** is the psychological theory developed by Sigmund Freud in which much of mental activity is considered to be unconscious (not available to the conscious mind).
- **Structuralism** is the psychological school of thought that identifies the components (structure) of the mind to learn about the brain and its functions.

Description

A psychologist is a graduate trained social scientist who studies behavior and mental processes. These professionals work in schools, universities, research settings, and business and corporate settings. Clinical psychologists are likely to practice in clinical settings such as hospitals, clinics, or private practice.

Psychology can be categorized into various subfields or specialties. The two major areas of psychology are basic psychology and applied psychology. Basic psychology encompasses the subfields concerned with the advancement of psychological theory and research. Experimental psychology employs laboratory experiments to study basic behavioral processes shared by different species, including sensation, perception, learning, memory, communication, and motivation. Physiological psychology is concerned with

the ways in which biology shapes behavior and mental processes, and developmental psychology is concerned with behavioral development over the entire life span. Other subfields include social psychology, quantitative psychology, and the psychology of personality.

Applied psychology is the broad area of psychology that applies psychological research and theory to problems posed by everyday life. It includes clinical psychology, which is the largest subfield in psychology. Clinical psychologists account for 40% of all psychologists. Although clinical social workers, psychiatrists, and mental health counselors typically work in mental health settings, their focus, training, and licensure are different. In contrast, counseling psychologists have training that is similar to clinical psychologists. Like clinical psychologists, they apply psychological principles to diagnose and treat individual emotional and behavioral problems. However, counseling psychologists are more likely to focus on career and development issues.

Other subfields of applied psychology include school psychology, educational psychology, industrial and organizational psychology, community psychology, health psychology, and consumer psychology. School psychologists are involved in the evaluation and placement of students in school settings. Educational psychologists investigate the psychological aspects of the learning process. Industrial and organizational psychology study the relationship between individuals and their jobs. Community psychologists study environmental factors that impact mental disorders. Health psychologists investigate the psychological aspects of health behaviors and medical conditions. Consumer psychologists investigate the preferences and buying habits of consumers and reactions to advertisements.

More recent specialization includes environmental psychology, forensic psychology, and sports psychology. Environmental psychologists study the relationship between individuals and their physical surroundings. They address such issues as the effects of noise and overcrowding, and the effects of building design. Forensic psychologists apply psychology to law, particularly to the criminal justice system. They are involved in competency to stand trial evaluations, jury selection, criminal profiling, and custody evaluations. Sports psychologists focus on the psychological and mental factors that influence participation and performance in sport, exercise, and physical activity.

Most psychologists earn the PhD degree. This degree requires four to six years of graduate training in psychology beyond the bachelor's degree. PhD study includes both general and specialized coursework and the completion of a dissertation. For those training for careers in clinical, counseling, and school psychology, an internship is also required. Such PhD training prepares the graduate for teaching and research, and for those in applied psychology programs, clinical practice. Students who intend to practice only applied psychology have the option of obtaining a doctor of psychology (PsyD) degree. The PsyD degree has a limited emphasis on research, and the dissertation or final project does not require an original, empirical research study.

Developments and Current Status

Psychology has grown and changed throughout history. Starting in 400 BC, Greek philosophers have proposed theories to explain human behavior. The emergence of scientific method in the late 19th century shifted psychology's focus from philosophy to science. In 1879, psychologist Wilhelm Wundt (1832–1920) opened the first psychological laboratory ever in Leipzig, Germany. As a result of his research and publications, Wundt helped in establishing psychology as the study of conscious experience. This became known as the school of structuralism. It was surpassed by functionalism. Afterward, psychologist G. Stanley Hall (1844–1924) established the first American experimental psychology lab in the United States at Johns Hopkins University. The American Psychological Association (APA) was founded in 1892. Its purpose was to encourage research, enhance professional competence, and disseminate knowledge about psychology, its research, and its applications to everyday life. Hall was elected the first president of the APA in 1892.

The late 19th and early 20th centuries saw the development of behaviorism and psychoanalysis. Because of psychology researchers like B.F. Skinner (1904–1990), behaviorism became the dominant theory in the United States in the 1950s and 1960s. Since the 1970s, psychology has been influenced by

the cognitive approach. Unlike behaviorism and psychoanalysis, the cognitive approach focuses on how individuals receive, perceive, store, process, and act on information.

Psychology is a flourishing field and for years has been one of the most popular undergraduate majors. Job prospects for those with psychology training are quite bright. Employment of psychologists is expected to increase by 22% from 2010 to 2020. This is above average for all occupations. More jobs will be available to those with doctoral degrees in an applied specialty of psychology. The most jobs are projected for those with a specialist degree or doctoral degree in school psychology.

Len Sperry, MD, PhD

See also: Mental Health Counselor; Psychiatrist; Psychoanalysis; Social Worker

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Psychology of Self Esteem, The (Book)

The Psychology of Self Esteem is a book written by Nathaniel Branden and published in 1969 about how choices and values influence self-esteem.

Definitions

- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **Behaviorism** is a theory of human behavior that limits the study of psychology to measurable or observable behavior.
- **Psychoanalysis** is a theory of human behavior and a form of therapy that explains behaviors as the result of unconscious, sexual, and biological instincts.
- **Self-esteem** is the personal evaluation of one's worth. It can range from high to low and is associated with an individual's emotions and behaviors.

Description

The Psychology of Self Esteem popularized the idea of self-esteem as a focus of psychology. Prior to its publication, this topic was seldom discussed. The author, Nathaniel Branden (1930–2014), was a follower of the famous Russian American philosopher Ayn Rand (1905–1982). *The Psychology of Self Esteem* is written in philosophical language. The book explains that individuals are rational beings in full control of their destiny. Those who take control of their lives are likely to view themselves positively and have high self-esteem. Those who do not take control of their lives are likely to view themselves negatively and have low self-esteem. Branden explains that human beings are different from animals because they need to make sense of their lives. Examples of such concepts include "meaning" and "humanity." While animals can have awareness, only humans have the ability to make conscious choices about how they will live life. *The Psychology of Self Esteem* disagrees with the two main schools of psychology of the time, psychoanalysis and behaviorism. Branden believes that psychoanalysis saw individuals as puppets driven by unconscious drives. He criticizes behaviorism and behavior therapy for treating individuals like robots who just responded to stimuli. Instead, he insists that individuals are able to use concepts and self-awareness to make conscious choices and take control of their lives. If individuals fail to use this ability, they will become unhappy. In order to truly love themselves, individuals must actively use their ability to think.

The Psychology of Self Esteem discusses the difference between emotions and rational (logical) thought. Branden argues that individuals should put their values and intellectual knowledge ahead of their feelings. This is psychological maturity and is the opposite of acting on irrational emotions. He calls that

psychological immaturity and it results in self-doubt, unhappiness, and low self-esteem. Branden believed that happiness was not so much a feeling but rather the result of living according to our values. For example, individuals who seek immediate pleasure or the approval of others will not have much self-esteem and will be unhappy. However, those who are guided by facts and behave rationally will be happy. Branden explains that psychological pain was a sign of unhealthy choices. This is similar to how physical pain is a sign of an unhealthy body. This pain alerts individuals to the need to change. *The Psychology of Self Esteem* makes the case that self-esteem is not a luxury but rather a core need for all individuals.

Len Sperry, MD, PhD, and
George Stoupas, MS

See also: Behavior Therapy; Psychoanalysis; Self-Esteem

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Psychopathic Personality

Psychopathic personality disorder is a mental disorder characterized by amoral behavior, extreme self-centeredness, and the inability to love and understand others' feelings (empathy). It is also referred to as psychopath and psychopathy.

Definitions

- **Antisocial personality disorder** is a mental disorder characterized by a pattern of disregarding and violating social norms (rights of others).
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **PDM** stands for the *Psychodynamic Diagnostic Manual;* it is a diagnostic framework that characterizes individuals in terms of their psychodynamics.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behaviors, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Sociopathic personality** is a form of antisocial personality disorder that manifests as amoral and criminal behavior and lacks a sense of moral responsibility or social conscience. It is also known as sociopathy and sociopath.

Description and Diagnosis

Psychopathic personality disorder is a personality disorder that manifests as amoral behavior, inability to love and be empathic, extreme self-centeredness, and failure to learn from experience. While the PDM uses the original term "psychopathic," the DSM uses the more contemporary term "antisocial" for this personality disorder. However, many individuals with psychopathic personality do not meet DSM-5 criteria for the antisocial personality disorder since they disregard social norms. Conversely, many who meet DSM criteria for antisocial personality do not exhibit some or all of the characteristic features of the psychopathic. Some individuals with psychopathic personality disorder can function well in some jobs and work settings where their psychopathic behavior is considered socially acceptable and even rewarded. Although some psychopathic individuals are held legally accountable for their actions, others are able to evade responsibility for the harm they do to others.

Sociopathic personality has been used interchangeably with psychopathic personality. Currently, clinicians and researchers tend to distinguish them in terms of behavior and etiology (cause). For example, there are specific deficits in psychopaths that distinguish

them from sociopaths. These include interpersonal deficits, such as grandiosity, arrogance, and deceitfulness, as well as affective deficits, such as a lack of guilt. In addition, psychopaths are characterized with global deficits of empathy. In contrast, sociopaths can emotionally attach to others and may feel bad when they hurt those individuals to whom they are attached. Yet sociopaths can lack empathy and attachment toward society in general. As a result, they are not likely to feel guilty in harming a stranger or breaking laws. So while both psychopaths and sociopaths are capable of committing hateful crimes, the psychopath can commit crimes against family members or friends and feel little or no remorse. Also, the etiology of psychopathy appears to be largely inherited, whereas sociopathy results more from environmental factors such as poverty, exposure to violence, and overly permissive or neglectful parenting. For diagnostic purposes, the last three editions of the *Diagnostic and Statistical Manual of Mental Disorders*, including DSM-5, use the designation "antisocial personality disorder" in place of psychopathic or sociopathic personality.

Psychopathic individuals can be charming and are quite good at "reading" others' emotions and needs. While they tend to be sensitive to feelings and social cues, their own expression of emotions is often insincere and intended to manipulate. They will emotionally disconnect and lose interest in others they no longer consider useful to them. Another indication of their lack of empathy is their inability to describe their own emotional reactions in depth. Not surprisingly, these individuals experience anxiety less frequently and intensely than non-psychopathic individuals. Furthermore, these individuals tend to seek out emotional stimulation (thrill-seeking) and so engage in high-risk activities.

According to the *Psychodynamic Diagnostic Manual* the psychopathic personality disorder is diagnosable by the following criteria. Individuals exhibit high threshold for emotional stimulation and aggressiveness. They are preoccupied with manipulating others. Their basic emotions tend to be rage and envy. Their basic belief or view of themselves is that they are omnipotent, the belief that they can make anything happen and control everything. Their basic belief or view of others is that everyone is selfish, manipulative, or dishonorable. Furthermore, their basic way of defending themselves is attempt to control everything around them.

Treatment

Treatment of individuals with this disorder tends to be challenging. Attempts to engage these individuals in therapy with kindness, empathy, and compassionate care are likely to fail. The reason is that psychopaths consider caring and kindness to be ineffective and illusory. So they will devalue therapists who manifest these qualities. In contrast, therapists can effectively engage such individuals if they convey a powerful presence, act with scrupulous integrity, and recognize that these individuals want to be acknowledged as powerful. These individuals tend to be more receptive to therapeutic influence when they have experienced a decline in physical power and influence. Having experienced limits to omnipotence increases their receptivity to engaging in the process of therapy.

Len Sperry, MD, PhD

See also: Antisocial Personality Disorder; Personality Disorders; Sociopathic Personality

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Psychopharmacology

Psychopharmacology is the study of drugs that affect thinking, feeling, and behavior. It includes

antipsychotic, antianxiety, antidepressant, and antimanic medications.

Definitions

- **Antianxiety medications** are prescription drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Antimanic medications** are prescription drugs that are primarily used to treat bipolar disorder (manic depression). They are also called antimanic and mood stabilizers.
- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.

Description

Psychopharmacology is the scientific study of drugs that affect mental and emotional functions. It focuses on the pharmacology (drug functions) of cognition, emotion, and behavior. Because it emphasizes drugs that affect abnormalities in thought, affect, and behavior, it is central to psychiatry practice. Psychopharmacology is primarily concerned with the major classes of drugs that treat four major categories of psychiatric disorder: anxiety, depression, mania, and schizophrenia. Each of these major drug classes are briefly described here.

Antianxiety medications. Antianxiety medications, or "anxiolytics," have a powerful effect on dampening the central nervous system when it is overexcited. This class of medication is prescribed to reduce feelings of tension and anxiety, as well as to induce sleep. Antianxiety medications are usually taken orally, and although they work differently, they all produce a pleasant drowsy or calming effect. When they are used for a long time, tolerance can develop. This means that larger doses are needed to achieve the initial effects. Continued use can lead to physical dependence and withdrawal symptoms when the dosage is reduced or stopped. Common medications in this class are Valium, Librium, Xanax, Halcion, and Seconal.

Antidepressant medications. Antidepressant medications are used primarily to reduce symptoms of depression. They also have been found useful in the treatment of seasonal affective disorder. Some individuals with anxiety disorders, eating disorders, pain syndromes, migraine headache, smoking cessation, fibromyalgia, and sleep disorders have found these medications helpful. The specific antidepressant prescribed depends on the particular array of symptoms. There are several different types, and each works by altering the level or activity of neurotransmitters (chemical messengers) in the brain. The most common type are selective serotonin reuptake inhibitors (SSRIs). These include Celexa, Lexapro, Prozac, Luvox, Paxil, and Zoloft.

Antimanic medications. Antimanic medications are used to balance neurotransmitters (chemical messengers) in the brain that control emotional states and behavior. They are effective in treating and preventing the return of both manic and depressive episodes in bipolar disorder. They are also helpful in treating mood problems associated with schizophrenia. There are several medications in this class of drugs. These include lithium, Tegretol, Lamictal, Neurontin, and Depakote.

Antipsychotic medications. Antipsychotic medications are used to treat psychotic disorders, ranging from schizophrenia, delusional disorder, and psychotic depression. They are also be used to treat the psychosis associated with other medical conditions, such as dementia. These medications work by blocking dopamine (a chemical messenger) in the brain. There are two classes of these drugs: "typical" and "atypical" antipsychotics. The most commonly used typical antipsychotic today is Haldol. The most commonly used atypical antipsychotic today are Clozaril, Risperdal, Zyprexa, and Geodon.

Len Sperry, MD, PhD

See also: Antianxiety Medications; Antidepressant Medications; Antipsychotic Medications

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Psychosexual Development, Stages of

The stages of psychosexual development are based on Sigmund Freud's theory of sexual motivation in the process of development through the life span.

Definitions

- **Oedipus complex** is the desire for sexual involvement with the parent of the opposite sex and a concurrent sense of rivalry with the parent of the same sex. Freud considered the complex a critical stage in normal developmental.
- **Psychoanalysis** is a theory of human behavior and a form of therapy based on psychoanalytic theory. In psychoanalysis clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams. It was initially developed by Sigmund Freud.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.

Description

The psychosexual stages of development is a concept from Sigmund Freud (1856–1939). Freud was a medical doctor who developed psychoanalytic theory. Freud's theories were heavily based on sexual motivation. He believed that even as children there is a connection to sexual motivators. Freud felt it was important to look into the symbolic meanings and not just the actual behavior in order to have a more complete understanding of the person.

Freud felt that early parental interactions strongly shaped the development of a child. Working with clients Freud would analyze his patients and ultimately became convinced that their problems were all results of experiences from early in their life. He felt that as children grow their focus of pleasure shifts through different parts of their body, resulting in the five stages of psychosexual development: oral, anal, phallic, latency, and genital. If conflicts in these stages are unresolved or overindulged, problems will occur later in life.

The first stage is oral, which is considered to be from birth to approximately age one and a half. At this point in their life, infants' pleasure stems from their mouth. Too much or too little stimulation and satisfaction can result in oral fixation later in life, which may be seen in traits either actively such as smoking or symbolically such as being overdependent.

The second stage is anal, which is from about one to three years old. At this stage the anal region provides the greatest pleasure to the toddler. Toilet training that is considered too harsh or indulgent can lead to the idea of anal fixation. As an adult, this can look like being greedy or messy.

The phallic stage is from about age three to six. Here pleasure is achieved through genitalia. Freud felt at this stage the child developed sexual desires toward the opposite-sex parent and jealousy toward the same-sex parent. This is often referenced as the Oedipus complex. If the child struggles with balancing these emotions, it may lead to deviant behavior in adulthood.

The fourth stage is latency, which is from age six to puberty. Here sexual desires are repressed and energy is focused into play and work. The final stage is genital, which is from puberty through adulthood. Here sexual needs become the critical motivator behind behavior. This is considered to be a reawaking of sexual pleasure that the person can reach with someone outside of his or her family.

While this idea originally gained great popularity, it currently receives little attention. Modern research does not support the positions that Freud once took and looks to other theories of development, such as that of Erik Erikson and Jean Piaget.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Freud, Sigmund (1856–1939); Psychosocial Development, Stages of; Sex and Gender; Sexual Orientation

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Psychosis

Psychosis is a severe mental condition in which an individual loses touch with reality.

Definitions

- **Antipsychotic medications** are prescribed drugs that are intended to reduce psychotic symptoms. It is also known as neuroleptics.
- **Catatonia** is disorganized, limited, or complete absence of normal physical behavior.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Neurosis** is an outdated but still used term for various mental disorders characterized by considerable anxiety, irrational fears, depression, or obsessive thoughts.
- **Psychotic symptoms** are a group of severe symptoms that include hallucinations, delusions, disordered thinking, or disorganized movement.
- **Schizophrenia spectrum and other psychotic disorders** are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, delusional disorder, and brief psychotic disorder.

Description

Psychosis is a mental condition whereby an individual's subjective (private) experience is severely disconnected with reality. Psychosis is characterized by psychotic symptoms such as hallucination, delusions, and catatonic behavior. Individuals who are experiencing psychosis may have false perceptions involving any of their five senses (hallucinations). For example, they may hear voices or see things that others don't see. They may be extremely paranoid and convey elaborate stories (delusions). They may be completely incoherent or move erratically and without purpose (catatonia). Although the symptoms of psychosis are variable, they all share the principal attribute of a significant disruption in their normal experience of reality. Psychosis is distinguished from neurosis. With neurosis individuals do experience an impairment of functioning. However, it is less severe than with psychosis and they maintain full awareness of reality.

Psychosis is not a standalone disorder, but a broadly defined condition that is often associated with certain mental disorders, medical illnesses, and drugs. Psychosis is usually experienced as one of the DSM-5 schizophrenia spectrum and other psychotic disorders, which are also referred to as psychotic disorders.

Treatment for psychotic disorders usually involves antipsychotic medications. Psychosis is also associated with a number of medical conditions such as Alzheimer's, stroke, and certain infectious diseases. For individuals with such conditions along with psychotic symptoms, treatment is first aimed at the underlying medical condition in the hope of reducing the symptoms of psychosis. If psychotic symptoms persist, then antipsychotic medication is added. Psychosis is also associated with a number of drugs, including LSD, cocaine, methamphetamine, and alcohol. For individuals with drug- or substance-induced psychoses, symptoms typically subside with the body's breakdown and elimination of the substance. Also, some individuals may manifest psychotic symptoms when under extreme stress. Generally, the appearance of

psychotic symptoms whatever the cause often involves hospitalization.

Jeremy Connelly, MEd, and
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See also: Antipsychotic Medications; Catatonic Disorders; Delusions; Hallucinations; Neurosis; Psychotic Disorders; Schizophrenia Spectrum and Other Psychotic Disorders

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Psychosocial Development, Stages of

The stages of psychosocial development are based on Erik Erikson's concept of personality development throughout the life span.

Description

The stages of psychosocial development is a concept established by Erik Erikson (1902–1994). Erikson was an American development psychologist. He originally studied with Sigmund Freud but then went on to propose his own theory of personality development that differed from the psychosexual stages of development. Erikson's theory put far less emphasis on the sexual motivators. Erikson felt the main motivator for people was that of social desires to connect with others.

Development

The psychosocial stages of development are sometimes referred to as the "Eight Stages of Man." In each of the stages the individual faces a crisis or dilemma to be resolved. The crisis is not necessarily a catastrophe but rather a turning point for the individual. With successful resolution the person will be a more emotionally healthy person.

The first stage of trust versus mistrust occurs in infancy. This stage is largely connected to the caregiver. The second stage is also in infancy and begins at about ages 1 to 3; this is the stage of autonomy versus shame and doubt. The infant is becoming more independent. If infants experience punishment that is too harsh or are restrained too much, they develop an increasing sense of shame or doubt. The third stage is in early childhood from about ages 3 to 6 and is called initiative versus guilt. Children are facing more tasks and getting more responsibility with the hope of achieving purpose. If this is not achieved, children may experience guilt over their actions. The fourth stage of industry versus inferiority occurs at about ages 6 to 12 where the hope is to help instill competence in children. The fifth stage identity versus role confusion is from ages 12 to 20 where they begin making choices about their goals and future with the hope of establishing themselves. The sixth stage is intimacy versus isolation, which occurs in young adulthood. This stage focuses on love and the ability to share oneself with others. The seventh stage of generativity versus stagnation occurs in middle adulthood, which focuses on giving back to the next generation. The final stage of ego integrity versus despair is in late adulthood, with the goal being wisdom where adults come to terms with their success and failures in life.

Erikson felt that even if one of these crises or stages went unresolved, it could be resolved later in life. He was an optimist and his theory is considered to be very appealing to those in the helping professions. However, some theorists have raised concern over Erikson's final stage, especially since he himself had not yet reached that stage in his own life when he wrote it. Later in his life when his health was failing, he and his wife, Joan—a frequent collaborator—began to reconsider the eighth stage. Joan Erikson (1902–1997) created a ninth stage she called transcendence. Here the person confronts all previous eight stages again in hopes of reaching peace.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Erikson, Erik (1902–1994); Psychosexual Development, Stages of

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Psychosomatic Disorder and Psychosomatic Medicine

"Psychosomatic" refers to the belief that the mind (psyche) influences diseases affecting the body (soma). Psychosomatic medicine is the branch of medicine that emphasizes the role of psychological factors in causing and treating medical conditions.

Definitions

- **Behavioral medicine** is an interdisciplinary form of modern medicine that integrates the behavioral, biomedical, and social sciences.
- **Biopsychosocial model** is a way of conceptualizing (thinking about) health and illness in terms of biological, psychological, and social factors rather than purely in biological terms.
- **Psychoanalytic psychology** is the form of psychology largely developed by the work of Sigmund Freud, which emphasizes the conflicts and compromises between the unconscious and conscious mind.
- **Psychosomatic illness or disorder** refers to a condition characterized by physical symptoms that result from psychological factors.
- **Psychosomatic model** is a way of conceptualizing (thinking about) certain medical conditions as caused by or resulting from psychological factors.
- **Somatoform** is a group of psychopathologies marked by physical symptoms that suggest a general medical condition but do not manifest in an actual physiological disease.

Description

"Psychosomatic" describes the belief that the mind (psyche) influences diseases affecting the body (soma). Psychosomatic medicine is the approach to clinical practice based on this belief. The term "psychosomatic" is also used to describe psychological factors that worsen or trigger a medical condition. Psychological factors may initiate, worsen, or maintain psychosomatic illnesses. The underlying assumption of psychosomatic illnesses is that human beings are composed of integrated systems. For example, there is an interrelationship between body and mind. The immune system can be compromised by extreme emotion or psychopathology. Depression and anxiety are common psychological elements that contribute to the manifestation or worsening of physiological illness. It is common for individuals to be minimally afflicted by psychosomatic ailments. A psychosomatic disorder is similar to but very different from somatoform disorders. The primary difference is that psychosomatic diseases are diagnosable by medical testing. In contrast, in somatoform disorders, presenting symptoms are not due to general medical condition.

Psychosomatic presentations may not include detectable toxins, viruses, bacteria, or other medical cause. The psychosomatic illness itself is medically diagnosable, however, even if the cause remains elusive to medical examination. Psychological assessment often offers clues to the root cause of psychosomatic complaints. The emotional state or psychopathology of the ill person may be the only available explanation for his or her presenting physiological complaint. Psychosomatic complaints may include various pain presentations, gastrointestinal problems, sexual dysfunction, skin disturbances, and respiratory and cardiovascular disturbances. Asthma, hypertension, headaches, and skin disturbances such as rashes or hives are common psychosomatic ailments. These psychosomatic symptoms may be dismissed as faking illness to avoid responsibility (malingering). A highly skilled mental health professional will assess for possible contributions of personality and developmental abnormalities.

An individual's constitution and maturational patterns may indicate susceptibility to psychosomatic complaints. Poor ego integrity, poor self-image, and poor emotional awareness or sensitivity may also increase the probability of developing psychosomatic illnesses. Pervasive psychopathological views of self and others (schemas) may also contribute to psychosomatic disease.

Development and Current Status

Since the middle ages, Christianity's view of human nature has influenced both the philosophy of mind-body dualism and the practice of Western medicine based on it. Mind-body dualism views illness as either a medical condition caused by biological dysfunction, such as an infection, or a psychological dysfunction caused by trauma or evil spirits. The philosophical distinction between mind and body has been an ongoing discussion beginning with the Greek philosophers. But it was René Descartes (1596–1650), the French philosopher and physiologist, who provided the first systematic account of the mind-body relationship. He proposed that the immaterial mind and the material body are distinct substances (entities) but interact causally with each other. This means that mental events can cause physical events, just as physical events can cause mental events. Unfortunately, Descartes was unable to convincingly explain exactly how the mind can cause changes in the body, and vice versa.

Starting in the 1940s, an early version of psychosomatic medicine emerged. Franz Alexander (1891–1964) was the Hungarian American physician and psychoanalyst who is credited with advocating for one such psychosomatic viewpoint. His view of psychosomatic medicine was largely a psychological explanation that emphasized the power of the mind over the body. For example, Alexander believed that asthma was the body's response to unresolved dependency. Duodenal (stomach) ulcers were believed to be caused by frustration and emotional stress. Also, the belief was that rheumatoid arthritis was caused by repressed rebellion, while migraine headaches were caused by repressed hostility. This view of psychosomatic model began to wane as research determined that there was, in fact, both biological *and* psychological factors involved. For instance, research identified an infection with the *Helicobacter pylori* bacteria along with psychological stress as causative factors in duodenal ulcers. Around this time, psychiatrist George L. Engel (1913–1999) wrote about the need for a new medical model in a landmark article in *Science* in 1977. Engel proposed the biopsychosocial model that could integrate such an early psychosomatic model with the biomedical model.

Currently, there are several other psychological conceptualizations of the mind-body relationship. Each theory maintains its own ideas of contributive factors of psychosomatic illnesses. The psychoanalytic theory suggests that unconscious conflicts are the reason for psychosomatic conditions. The type of unconscious conflict will predict the type of physiological illness that is psychosomatically manifested. The psychodynamic theory suggests that various personality characteristics and traits react to stressful life events differently. Different life stressors interacting with different personality types lead to different physical diseases. In addition, certain personalities are more likely to develop certain physical illnesses. Psychosocial family systems theories state that dysfunctional families create emotional trauma for children and this is the cause for psychosomatic disease. The biological theories of psychosomatic disease suggest that there are genetic predispositions for psychological influence in illness. A more recent psychosomatic viewpoint views human beings as psychosomatic wholes. It integrates mind and body with a more unified view of life that encompasses polarities (opposing but attracting influences). For instance, in the being versus nonbeing polarity, while individuals are continually threatened by illness and nonbeing, they can constantly reassert their being by engaging in healthy behaviors. Health problems arise when the polarities become unbalanced. Such an understanding appears to avoid mind-body dualism and the overemphasis of the mind over the body in Alexander's viewpoint.

It is noteworthy that psychosomatic medicine became a certified subspecialty of the American Board of Psychiatry and Neurology in 2005. This certification acknowledges the expertise needed to diagnose and treat psychiatric disorders and symptoms in complex medically ill patients. This subspecialty includes

treatment of patients with acute or chronic medical, neurological, obstetrical, or surgical illness in which psychiatric illness is affecting their medical care and/or quality of life such as organ transplantation, heart disease, renal failure, cancer, stroke, traumatic brain injury, and high-risk pregnancy. Patients also may be those who have a psychiatric disorder that is the direct consequence of a primary medical condition, or a somatoform disorder or psychological factors affecting a general medical condition. Psychiatrists specializing in psychosomatic medicine provide services in general medical hospitals, on medical psychiatry inpatient units, and in primary care settings.

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See also: Clinical Health Psychology; Clinical Psychology; Mind–Body Medicine

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Psychotherapist

Psychotherapists offer a form of treatment known as talk therapy with individuals, couples, and families, in order to help clients overcome a wide range of psychological and emotional challenges. They are usually psychologists, mental health counselors, or social workers.

Description

Employing a variety of theoretical approaches, psychotherapists work to build rapport and trust with clients in an effort to help them address maladaptive thought processes, feelings, and behavior. Psychotherapists also help clients to understand and potentially resolve inner conflicts as well as to develop new and healthier ways of coping with life's many challenges. Although many different theoretical approaches are used by therapists today, the roots of psychotherapy are often traced back to the work of Sigmund Freud in the late 1800s in Vienna.

The role of a psychotherapist typically involves working with clients on a weekly or semiweekly basis in sessions lasting between 45 minutes and an hour on a mutually agreed-upon set of goals. Depending on the psychotherapist's training and specialty, clients may include children, adolescents, teens, adults, couples, families, and groups. Psychotherapists use a wide variety of theoretical approaches, such as cognitive behavior therapy, psychoanalysis, psychodynamic therapies, and humanistic therapies. "Psychotherapy" and "counseling" are terms that are often used interchangeably; however, while there is considerable overlap between these two, counseling often refers to shorter-term treatment (weeks or months) of a specific symptom or stressful situation. In contrast, psychotherapy is usually a longer-term treatment (months or even years) that addresses a client's maladaptive thought processes, rather than specific behaviors or problems.

There are a variety of job titles and training for psychotherapists based on their level of education, area of expertise, and their role. Before becoming a licensed therapist, training normally requires a graduate degree—most psychotherapists have a master's or doctoral degree with specialized training in psychological counselling. Psychiatrists, psychologists, licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, and psychiatric nurses are just some of the examples of mental health professionals who can provide psychotherapy. Notably, psychiatrists are medical doctors who are mental health specialists and who can prescribe medications, as well as offer psychotherapy.

Mindy Parsons, PhD

See also: Family Therapy; Freud, Sigmund (1856–1939); Group Counseling; Group Therapy; Psychiatrist; Psychotherapy

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Organizations

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Psychotherapy

Psychotherapy is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

Description

According to the National Institutes for Mental Health, psychotherapy is a form of talk therapy that helps clients with a mental disorder understand their illness. It offers clients strategies and tools to address their maladaptive thoughts and behaviors. The goal is often to help clients cope with their symptoms and improve their levels of coping with everyday life by learning about their moods, feelings, thoughts, and behaviors. A treatment plan is created with an individual or family in order to establish appropriate treatment goals. The treatment plan is like a map that guides the clinician and helps to measure whether or not progress is being made in therapy. Talk therapy is appropriate for many people with mental health diagnoses; however, depending on the mental health issue facing a client, psychotherapy may be combined with medications prescribed by a psychiatrist or other mental health specialist.

Psychotherapy is often an effective way of helping people overcome a mental illness, whether it is a mild disturbance, such as an adjustment disorder, or something more severe, such as a personality disorder. A person who is suffering mentally or emotionally can work with a psychotherapist to improve his or her ability to cope with and manage specific challenges in his or her life. The client normally meets with the therapist weekly to discuss the challenges he or she is having. For example, the client may be experiencing difficulty with bitterness and resentment following a divorce, or parent may bring in a child who is cutting.

To address the presenting issue, the therapist may use a single therapeutic approach, such as cognitive behavior therapy, or multiple modalities based on what the client's concern may be. Psychotherapy can include a wide variety of theoretical approaches, such as cognitive behavior therapy, psychoanalysis, psychodynamic therapies, and humanistic therapies. "Psychotherapy" and "counseling" are terms that are often used interchangeably; however, while there is considerable overlap between these two, counseling often refers to shorter-term treatment (weeks or months) of a specific symptom or stressful situation.

In contrast, psychotherapy is usually a longer-term treatment (months or even years) that addresses a

client's maladaptive thought processes, rather than specific behaviors or problems. However, there is overlap between the two and counseling can often include psychotherapy and psychotherapy can often include counseling. Psychotherapy is often referred to as talk therapy, counseling, or just therapy.

Mindy Parsons, PhD

See also: Family Therapy; Group Counseling; Group Therapy; Psychiatrist; Psychotherapist

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Psychotherapy Integration

Psychotherapy integration is a process that treats individuals by using a combination of psychotherapy techniques.

Description

It is based on the understanding that while there are different approaches to psychotherapy, there are common factors that can be found in nearly every type of treatment. Therapists using psychotherapy integration believe that in order to understand human behavior, it's important to apply a variety of treatment theories. They have a theoretical understanding of various techniques and are aware that each treatment has limitations. However, when they combine techniques, they can create a synergistic effect that leads to a more effective treatment for the patient.

Development and Current Status

Psychotherapy integration was first named by the Society of Psychotherapy Integration (SEPI) when it formed in 1983. SEPI began publishing the *Journal of Psychotherapy Integration* in 1991. The movement, however, has roots going back many years. Publications have been talking about integrating or combining psychotherapy techniques for decades. Even Freud alluded to it in 1905 when he said that there are many ways and means of practicing psychotherapy and that all that lead to recovery are good.

Psychotherapy integration is often compared to eclectic therapy. Integration is a process that places importance on the theories of treatment. By contrast, eclectic therapy chooses methods because they work. Practitioners of eclectic therapy may choose therapies randomly, rather than based on what is likely to benefit their patient. To successfully practice psychotherapy integration, a therapist must have an understanding of a wide range of skills and knowledge, instead of specializing in one type of therapy.

The benefit of psychotherapy integration is that it is unencumbered by the possible limitations of any particular therapeutic approach. This allows the practitioner to be open and explore other therapy options to help their patients change. However, psychotherapy relies more these days on evidence-based practice. Because of this it's important for therapists and researchers to collaborate. However, in psychotherapy integration, most practitioners use the data they collect from their private practices, rather than from research. In fact, there has been little psychotherapy integration research in the past 20 years.

As a result, one of the goals of the psychotherapy integration community is to increase the effectiveness of psychotherapy by increasing research and integrating the findings into clinical practice. Closer ties between research and clinical practice will lead to a greater impact of psychotherapy and an increased understanding. It's also worthwhile to study the differences between individual therapists. Though the preferred approaches of most therapists are not much different from each other, some therapists perform better than others, and nearly all therapists have good results with their treatment specialties.

Research on this element could lead to guidelines to improve therapy. For many practitioners, psychotherapy integration represents the ability to combine the best parts of differing orientations and thereby develop more efficient treatments. Today, psychotherapy integration is internationally accepted and practiced, and is taught to most therapists in training. The objectives of the movement are to develop more effective intervention procedures by providing a greater understanding of the process of change. It is a popular approach to treating patients, which is likely to continue to be used worldwide.

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See also: Psychotherapy

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Psychotherapy Skills and Competency

Psychotherapy skills involve therapeutic techniques, while psychotherapy competency involves the appropriate and effective use of those skills. Both are essential in the practice of evidenced-based psychotherapy.

Definitions

- **Accountability** is the expectation or requirement to conduct evaluations, particularly of outcomes, and to report performance information.
- **Capability** is the attitude to strive to achieve more than the minimal or required level of competency and the capacity to adapt competencies to changing circumstances.
- **Case conceptualization** is a method summarizing case information and an explanation or formulation and a strategy for planning and focusing treatment interventions to increase the likelihood of achieving treatment goals.

- **Competency** is the capacity to integrate technical skills along with knowledge and positive professional attitudes, which is reflected in the quality of clinical practice. It is developed through professional training and reflection and can be evaluated by external standards.
- **Core competencies** are the basic competencies common to the effective practice of all psychotherapeutic approaches. They include the therapeutic relationship, intervention planning, intervention implementation, and intervention evaluation and termination.
- **Evidence-based practice** is a form of practice that is based on integration of the best research evidence with clinical experience and client values.
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Master therapists** are psychotherapists who are considered by fellow therapists to be "the best of the best" in terms of expertise in psychotherapy.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Skill** is a capacity that has been acquired through training.

Description

Psychotherapy skills and competency are required for the practice of highly effective psychotherapy. Both represent the therapist's contribution to positive therapeutic outcomes. Highly effective psychotherapy is competency based and is practiced by those who exhibit capability and can think, act, and reflect much like master therapists.

Core competencies are similar to but different from psychotherapy skills. Competencies are larger in scope than psychotherapy skills. Skills are but one component of a competency. That means it is possible to master a skill and not necessarily develop its related competency. For example, one can master a skill but not know how or when to appropriately and effectively utilize that skill. Competencies require thinking and acting like an effective and ethically and culturally sensitive therapist in addition to the application of a specific clinical skill. Competencies inform the clinician how and when to use each therapeutic skill. A competent psychotherapist is able to put skills into practice with wisdom (knowledge) and compassion (attitude). Four core clinical competencies are briefly described next along with their related skills.

The most basic and important of the core competencies is the establishment of an effective therapeutic alliance (relationship). The therapist–client relationship is the most significant predictor of therapeutic outcomes. Authentic human connection can be therapeutic in and of itself. Intervention planning is a second important core competency. This competency requires assessment skills and a sufficient understanding of client characteristics, such as culture and treatment preference which form the basis of a case conceptualization. Intervention planning is informed by the diagnosis of a client's presentation. Determining a diagnosis requires a specialized set of assessment skill. Another set of treatment planning skills is needed for predicting obstacles to treatment. Understanding the unique obstacles to the treatment of each client facilitates the implementation of interventions. Because therapeutic interventions have better outcomes when they are tailored to the unique culture and preference of the client, specialized skills in planning culturally sensitive treatments are also needed.

Intervention implementation is another core competency. There are several essential skills associated with this competency. Implementing the various interventions requires specific skills for modifying a client's maladaptive thoughts, behaviors, feelings, and interpersonal relationships. In addition, other skills are needed to establish and maintain the treatment focus. To promote successful therapeutic outcomes, the core

competency of monitoring treatment progress and evaluating interventions is essential. The evaluation of the success of therapeutic interventions is a fundamental aspect of the practice of highly effective therapy. This competency allows a psychotherapist to monitor therapeutic progress and alter it as necessary. Evaluation of therapy helps the therapist and client work effectively together to achieve therapeutic goals and prepare for terminating the therapeutic relationship. Even highly effective therapists are able to appraise and enhance their counseling competencies through the use of active and ongoing reflection and guidance offered by a clinical supervisor.

Development and Current Status

The professional understanding of psychotherapy skills and competencies has undergone much development. Several have contributed to this development, including Len Sperry (1943–), an American psychologist and physician. He developed a systematic model of the core competencies that are common to psychiatry, psychology, marital and family therapy, counseling, and social work. This model is a synthesis of the various and sometimes competing clinical competencies. It provides a unified language and a way of categorizing the various competencies into a model that is easily teachable and researchable. The model is particularly relevant in training mental health professionals. There has been a significant paradigm shift in the training and practice of psychotherapy.

Changes to the health-care system effect mental health and psychological services in the United States. Many of these changes are the result of the increasing expectation for accountability. Accountability is maintained in part through the use of evidence-based practices. Evidence-based treatments are largely about the effort to get the best results for less money and in the shortest amount of time. Resources for health-care interventions are limited. This fact has created an effort to conduct medical and psychological practice in the most efficient manner possible. However, all things being equal, the most ethical mental health treatment is one that achieves therapeutic goals in the least amount of time. Managed care was established to increase the efficiency and cost effectiveness of health care. Evidence-based practice has a critical role in managed care. Managed care encourages and often requires health-care professionals to incorporate evidence-based treatments into the health-care process. As a result of this accountability movement, the training and practice of psychotherapy has become more competency based.

Standards of psychotherapy practice have evolved in the recent past. Because of both accountability and psychotherapy research, new psychotherapy skills, competencies, and standards of practice have emerged. There has been a distinct shift away from the previous focus on requirement-based standards and training. Requirement-based standards and training focused primarily on meeting degree requirements, logging supervised hours, and passing written licensure examinations. But meeting requirements does not demonstrate competency in the practice of psychotherapy. This contrasts with competency-based standards and training, which focus on demonstrating mastery of the core competencies of psychotherapy. Competencies require the critical thinking, analysis, professional judgment, and attitudinal stance to effectively implement evidence-based standards of practice. It is predicted that competency-based training will increasingly become the standard of education of therapists. The reason this will happen is the increasing demand for accountability in the guise of evidence-based practice. When treatment is informed by research-based practices and skills, the therapist' expertise, and the client's needs, expectations, and values, effective psychotherapy is likely to result, and everybody wins.

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See also: Case Conceptualization; Evidence-Based Practice; Master Therapist; Therapeutic Alliance

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Psychotherapy Stages and Process

Psychotherapy stages describe the natural progression that occurs within the psychotherapy process. It begins with developing a therapeutic relationship and ends with termination.

Definitions

- **Assimilative integration** occurs when one theoretical orientation primarily informs the psychotherapeutic process and techniques of other theories are deliberately adjunctive.
- **Common factors** are the similarities among theories of psychotherapy and the belief that these common factors are the real therapeutic factors. They are also known as convergence factors.
- **Evidence-based practice** is a form of practice that is based on integration of the best research evidence with clinical experience and client values.
- **Managed care** is a system of health care that controls costs by placing limits on physicians' fees and by restricting access to certain medical procedures and providers.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Technical eclecticism** is the psychotherapeutic use of intervention techniques from various theories without endorsing the theories themselves.
- **Theoretical integration** is the assimilation of two or more theories of psychotherapy.
- **Therapeutic alliance** is the therapeutic relationship between therapist and client that occurs within the context of psychotherapy and is characterized by an affective bond leading to the negotiation of working goals and tasks, as well as explanations of problems and expectations for his or her treatment.
- **Transtheoretical model** is an integrative approach to psychotherapy that identifies the processes of change, the stages of change, and levels of change to tailor treatment to the client.

Description

Psychotherapy stages are a way of conceptualizing (thinking about) the psychotherapy or counseling process. These stages reflect the changing emphasis of psychotherapy over time, which progresses from one stage to the next. Basically, psychotherapy has a beginning, a middle, and an end. Typically, these stages are progressively focused on over time. The first few sessions typically focus on the earlier counseling stages. The therapeutic counseling process works through the remaining stages. The last few psychotherapy sessions usually focus on the last stages or stages of the process. Alternatively, each 50-minute session may run through all six of the stages. The number of sessions required for effective treatment varies based on therapeutic goals, diagnosis, the type of psychotherapeutic interventions utilized, and available resources. Based on these factors, managed care will dictate the number of sessions by limiting their financial contribution. Due to the influence of managed care, the psychotherapy process typically lasts 6 to 12 sessions. Despite these imposed limitations there is a measure of consistency to all psychotherapy processes. The uniformity of the counseling process is maintained despite the varied theoretical orientations utilized by psychotherapists. There are considerable commonalities among the various psychotherapy approaches. These convergence factors characterize the stages of psychotherapy. These stages provide a structure to the therapeutic process. While there is yet to be consensus about the number of

stages of successful psychotherapy, a six-stage process is described here.

Stage one emphasizes developing a therapeutic alliance (relationship) with the client. The establishment of an effective therapeutic alliance is essential for psychotherapy to be successful. That is because the therapeutic relationship is the best predictor of therapeutic outcomes. One of the most valuable therapist-offered conditions is a nonjudgmental and empathetic presence. It is important that the psychotherapist communicate a sense of unconditional positive regard. These therapist-offered conditions help to establish rapport, promote client's sense of acceptance, and increase the chance of developing an effective therapeutic alliance. Stage two is concerned with assessment and diagnosis. Assessment and diagnosis informs all stages of the therapeutic process, including the development and maintenance of a therapeutic alliance. The third stage refers to the formulation of counseling goals. Goals of psychotherapy should be agreed upon by both client and therapist. The goals of psychotherapy provide purpose and direction to the therapeutic relationship. Therapeutic goals foster client motivation for change, provide a contextual framework for psychoeducation, and allow evaluation of therapeutic outcomes.

After the goals of therapeutic counseling have been agreed upon, treatment interventions can be planned. Stage four develops a treatment formulation specifying specific treatment targets that reflect therapeutic goals. Interventions are personalized for the client's needs and therapeutic obstacles are predicted. This stage also is devoted to the problem solving necessary to navigate these therapeutic obstacles. Surmounting obstacles to treatment is a major component of client change and achievement of successful therapeutic outcomes. The last counseling stage dedicated directly to the client–counselor relationship is stage five. Stage five prepares a client for termination and schedules follow-up work as necessary. One of the most preferable outcomes to highly effective therapy is for the client to develop the capacity to function as his or her own therapist. More frequently, a client and therapist will both agree that the client has made sufficient progress toward therapeutic goals. Termination also can refer to a stage of client change that is stable enough to reduce the likelihood of relapse. At this point, psychotherapy can be terminated. There are four components to successful termination of the therapeutic relationship. They are the discussion of the end of psychotherapy, a review of the course of psychotherapy, providing closure to therapist–client relationship, and planning for the future. Highly effective therapy can be very influential in the life of a client. It is critical that therapists allow for processing of the experience and discussions about the client's future goals. Finally, stage six involves evaluation of the process and outcomes of the therapy.

Development and Current Status

"Psychotherapy stages" refer to the art and science of the psychotherapy process. Psychotherapists must undergo a subjective process of implementing the evidence-based knowledge and techniques while remaining interpersonally connected to clients in a meaningful way. Clearly there is an art and a science to the psychotherapy stages. There is also consensus that an effective psychotherapy process is related to positive therapeutic outcomes. While there is some research on topics related to specific aspects of the therapeutic process, there is much less on the overall stages and process of psychotherapy. Instead, research commonly studies one or more static elements of the stages. While useful in some respect, this research has limited clinical value. However, research on "common factors" among the various psychotherapy approaches has been clinically useful. Common factors were first described by psychologist Saul Rosenzweig (1907–2004) in a paper published in 1936. Since then three distinct approaches to common or integrative practice have been identified. They are technical eclecticism, theoretical integration, and assimilative integration. To date, the most clinically useful way of specifying commonalities in the psychotherapy process among all psychotherapy approaches is called the transtheoretical model. It was introduced in 1983. Other models have since been published with varying number of psychotherapy stages. Typically, the content of the stages is similar among different theories. Differences are largely related to the organization and grouping of the stage processes. This research not only informs the clinical practice of

psychotherapy but is also essential in the training of psychotherapists.

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See also: Best Practices; Evidence-Based Practice; Motivational Interviewing; Stages of Change

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Publication Manual of the American Psychological Association

The *Publication Manual of the American Psychological Association* is a reference book that provides standards for academic writing. It is also known as the APA Style Guide.

Definition

- **American Psychological Association** is the largest professional organization of psychologists in the United Stated and Canada. It publishes the *Publication Manual of the American Psychological Association*.

Description

The *Publication Manual of the American Psychological Association* is a reference book that provides specific guidelines for scientific writing. It is intended to be used for those writing about behavioral and social sciences; however, it has become the standard for writing in many other disciplines such as education, business, and nursing. The *Publication Manual* is used by students as well as professionals. Its purpose is to make communication clear so readers understand the information presented. The *Publication Manual* covers topics such as grammar, writing style, spelling, punctuation, word choice, quotations, capitalization, and abbreviations. It also describes how to create bibliography and reference pages. This specific way of writing is commonly referred to as "APA style." The *Publication Manual* includes instructions for preparing manuscripts to submit to academic journals. These instructions cover standards regarding title pages, appendices, page indentation, margins, and numbering. Guidelines are also offered to reduce bias and discrimination with regard to race, gender, sexual orientation, and ethnicity. Also included is information about copyrights, permissions, and reprints for published articles. Many professional organizations, such as the American Counseling Association, use the *Publication Manual* as the standard for publishing in their journals.

The idea for the *Publication Manual* began in a meeting in 1928. Publishing editors from the fields of anthropology and psychology came together to create instructions for writing journal manuscripts. These instructions were initially meant to give authors guidelines to reference. They were not intended to be the strict rules they are often seen as today. The first manual was only seven pages long. It was published in 1929 in the *Psychological Bulletin*, which came before the *Publication Manual*. The first official edition of the *Publication Manual* came out in 1952. It was 60 pages in length. Since that time, the *Publication Manual* has been revised six times. Later revisions occurred in 1957, 1967, 1974, 1983, 1994, and 2001. The most recent sixth edition was published in 2010 and is 272 pages. As new technology and media became available for research, new guidelines were included in the *Publication Manual*. For example, the sixth edition addresses how to cite Internet message boards, podcasts, and wikis. The sixth edition also maintains a companion website.

Len Sperry, MD, PhD, and
George Stoupas, MS

See also: American Counseling Association (ACA); American Psychological Association (APA)

Further Reading

American Psychological Association. *Concise Rules of APA Style*. Washington, DC: American Psychological Association, 2010.

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American Psychological Association. *Publication Manual of the American Psychological Association*, 6th ed. Washington, DC: American Psychological Association, 2010.

Pyromania

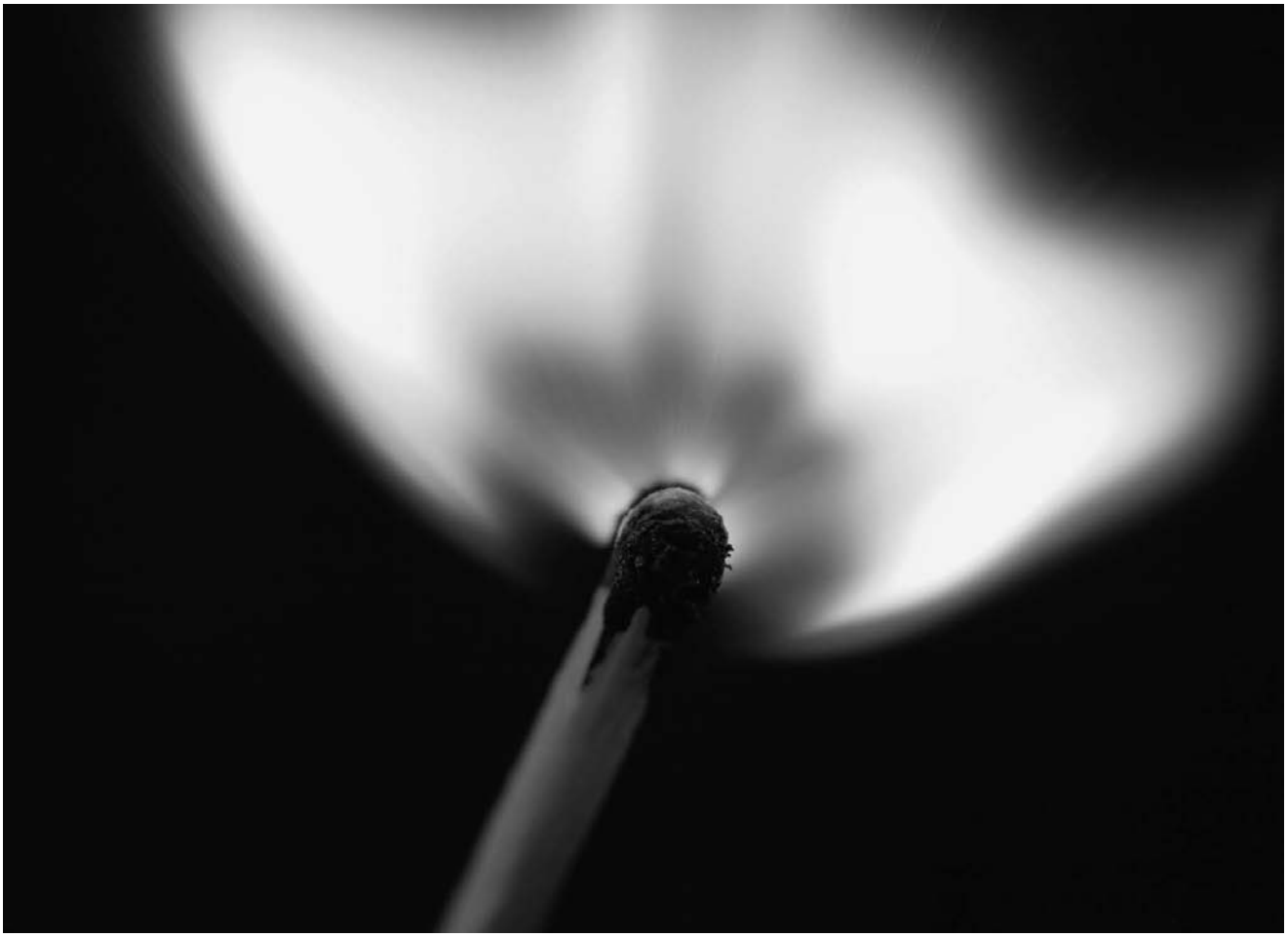
Pyromania is a mental disorder characterized by intentional fire setting for pleasure or satisfaction.

Definitions

- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Cognitive restructuring** is a psychotherapy technique for identifying maladaptive (unhealthy) thoughts and changing them to a more accurate view of a situation.
- **Conduct disorder** is a disorder diagnosed in childhood or adolescence characterized by repeated and persistent pattern of behavior in which the basic rights of others are violated.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life. It is not considered a disorder unless it significantly disrupts one's daily functioning.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than external stimuli.
- **Impulse control** is the degree to which an individual can control the impulse to act or the desire for immediate gratification.
- **Mood disorders** is a group of diagnoses in the DSM-5 classification system where a disturbance in the individual's mood is presumed to be the main underlying feature.
- **Obsessive-compulsive disorder** is a mental health disorder characterized by repeated and unwanted thoughts and feelings (obsessions) or behaviors that one feels driven to perform (compulsions). It is commonly referred to OCD.
- **Paranoia** is an unfounded or exaggerated distrust or suspiciousness of others.
- **Psychotic features** are characteristics of psychotic disorders: delusions, hallucinations, disorganized thinking and speech, grossly disorganized or abnormal motor behavior, and negative symptom (e.g., lack of initiative and diminished emotional expression).
- **Sexual abuse** involves nonconsensual contact of any kind, coercing an elder to witness behaviors.
- **Substance abuse disorders** are characterized by a pattern of continued pathological use of medication, which results in distress and significant impairment in several areas of an individual's life.

Description and Diagnosis

Pyromania is one of the DSM-5 disruptive, impulse-control, and conduct disorders. It is characterized by the inability to resist fire setting. Individuals engage in this behavior to achieve relief of tension and immediate gratification despite potentially negative or harmful consequences. The presence of several episodes



Pyromania is a mental disorder characterized by intentional fire-setting for pleasure or satisfaction. (Dr_harry/Dreamstime .com)

of intentional and purposeful fire setting characterizes this disorder. Individuals with this disorder usually experience emotional arousal and tension prior to the act of setting a fire. They have a fascination with, interest in, or attraction to fire, and may set off fire alarms in stores and schools. They often take pleasure in anything associated with fires (e.g., fire departments and fire equipment). Individuals with this disorder repeatedly fail to resist impulses in intentionally starting fires. Another characteristic of this disorder is to induce euphoria. Often, pyromaniacs observe fires in their neighborhoods. Some may become affiliated with local fire departments and even become fire fighters themselves. Not only do they receive pleasure and relief from setting fires, but they also witness the destruction and participate in the aftermath (American Psychiatric Association, 2013).

Pyromania occurs more often in adolescent males, particularly those with learning disabilities and poor learning skills (American Psychological Association, 2013). Often children between the age of 5 and 10 years of age do not understand the dangers and consequences of playing with fire. Those who are pathological fire setters exhibit the following features. They may set fires as a cry for help. They may be neglected or ignored by their caretakers, suffer from depression, or have been sexually abused. Others may be severely disturbed. They may be diagnosed as either psychotic features or paranoia, and may even engage in fire setting as part of a suicide attempt. Pyromania in adults has a high rate of dual diagnoses with other disorders such as obsessive-compulsive disorders, substance abuse disorders, and mood disorders.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can

be diagnosed with this disorder if they intentionally and purposefully engage in fire setting on more than one occasion. Affective arousal and tension must be present prior to the act of fire setting. They must have an interest, fascination, curiosity, or attraction to fire or when in the presence of witnessing the act or participating in the aftermath of the fire. The act of fire setting must not be due to financial gain, to conceal criminal activity, due to expression of anger, an expression of a sociopolitical ideology, to improve one's living situation, in response to hallucinations or delusions, or a result of blind judgment. In order to make the diagnosis of pyromania, fire setting cannot be better explained by a manic episode, antisocial personality disorder, or conduct disorder (American Psychiatric Association, 2013).

The exact causes of this disorder are unknown. There are several theories that exist for why children and adolescents engage in fire setting. Some individual factors that may be associated with fire setting include antisocial behaviors and attitudes. For example, some adolescents may have committed vandalism of another's property, nonsexual offenses, and forcible rape. Another theory is that individuals set fires due to an attention seeking behavior. They may be bored and not engage in positive recreation. Environmental factors may also be involved. These include a lack of supervision of their parents or other adults. This may include parental neglect or lack of emotional involvement. Stressful life events (e.g., divorce and lack of coping skills with a personal crisis) may be associated with pyromania. Pyromania in adults has been associated with depression, difficulty in interpersonal relationships, and suicidal thoughts.

Treatment

The age in which an individual engages in pyromania will depend on specific treatment options. For children and adolescents cognitive behavior therapy may be an effective form of treatment. An individual's behavior may become apparent during therapy sessions, and as to what may have caused this impulsive behavior (pyromania). Ongoing therapy can help the child or adolescent in his or her recovery. Some other treatments for children and adolescents include parental training, communication skills, problem-solving skills training, relaxation training, individual and family therapy, cognitive restructuring, and medication. Recovery from pyromania is more positive in children and adolescents than in adults (American Psychological Association, 2013). However, it also depends on the environmental and individual factors at play. Pyromania in adults is generally more difficult to treat due to the lack of cooperation by the individual. Treatment usually consists of medication to prevent emotional outbursts and prevent stress. Long-term therapy is recommended for adults with this disorder (American Psychological Association, 2013).

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Conduct Disorder; Delusions; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Family Therapy; Hallucinations; Mood Disorders; Obsessive-Compulsive Disorder (OCD); Paranoia; Sexual Abuse; Substance Abuse Disorders

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Mental Health and Mental Disorders

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Mental Health and Mental Disorders

AN ENCYCLOPEDIA OF CONDITIONS, TREATMENTS, AND WELL-BEING

Volume 3: Q–Z

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This book discusses treatments (including types of medication and mental health therapies), diagnostic tests for various symptoms and mental health disorders, and organizations. The authors have made every effort to present accurate and up-to-date information. However, the information in this book is not intended to recommend or endorse particular treatments or organizations, or substitute for the care or medical advice of a qualified health professional, or used to alter any medical therapy without a medical doctor's advice. Specific situations may require specific therapeutic approaches not included in this book. For those reasons, we recommend that readers follow the advice of qualified health care professionals directly involved in their care. Readers who suspect they may have specific medical problems should consult a physician about any suggestions made in this book.

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Speech-Language Pathology

Preface

The quest to understand mental health and its disorders is first noted in the writings of the ancient Greeks. With today's new technologies and constant research, scientists have uncovered many causes of mental disorders and conditions as well as new treatments to reduce symptoms as well as prevent these conditions. "Mental health" is a broad term that encompasses both dysfunction and well-being from conception through the life span.

The purpose of this encyclopedia is to provide a wide-ranging reference source on mental health and its disorders, written at a level accessible for upper high school and college students as well as for the layperson. The encyclopedia provides insights into the discipline of mental health and covers both healthy functioning and mental disorders or conditions, treatment methods, and factors that promote mental health and well-being.

Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being aims to open the door to mental health research for readers, as well as direct them to accurate and current resources for further investigation.

Scope

This encyclopedia helps the reader understand mental disorders and their treatment as well as normal development and prevention of mental illness. This reference work covers virtually every topic and consideration involving mental health. The reader will find that the 875 entries in this three-volume work comprise six areas of emphases:

- Mental disorders and conditions. These include both common and relatively rare disorders. Also included are diagnostic characterizations that follow the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, commonly known as DSM-5.
- Treatment of these disorders. These include prescribed medications, psychological therapies, and herbs and other natural remedies.
- Tests and assessment methods used in evaluating or diagnosing mental conditions. These include standardized paper and pencil tests as well as biological and brain-imaging methods.
- Common psychological terms and concepts associated with mental and emotional well-being.

- Highly regarded individuals and organizations influential in researching disorders, developing treatments, or fostering professional development.
- Popular and classic books and films as well as high-profile individuals and culture-changing events. These have significantly influenced our understanding of mental health and illness and are also profiled.

To increase readability, technical terms are defined near the beginning of most entries. Terms are also included in the glossary at the end of volume three.

Contributors

The 13 contributors to this encyclopedia are all uniquely qualified to speak with authority regarding at least one aspect of mental health and its disorders. They have formal training and experience in psychiatry, clinical psychology, clinical mental health counseling, or child and adolescent development. Most have specialized in working with children, adolescents, and young adults and recognize the critical role of culture in mental health and illness. The collective expertise of these contributors allows a much broader understanding of mental health issues than a single author could ever provide.

User-Friendly Features

Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being is organized in the customary A–Z encyclopedia format. At the front of each volume is an alphabetical listing of all entry headings ("Alphabetical List of Entries"), allowing the reader to scan the list of all entries. A "Guide to Related Topics" is an additional aid, listing all the entries in the book under broad topics. Readers can look under topics such as "Disorders," "People," and "Social Issues" to quickly see all the entries included for that topic.

All entries have a "See also" section that connects the reader to other relevant topics. For example, in the entry "Anxiety Disorders in Adults" the connecting and cross-references will direct the reader to other entries that discuss similar disorder symptoms (Agoraphobia, Generalized Anxiety Disorder, Panic Attack, Panic Disorder, Social Phobia, Specific Phobia), and various treatment methods and approaches (Antianxiety Medication, Antidepressant Medication, Cognitive Therapy, Exposure Therapy).

Further Reading and Selected Resources

Each entry also includes current, reliable sources for additional statistics, research, or consumer-friendly education. Books, articles, and websites are included, allowing the reader to choose the level of detail and depth for further data and material. "Recommended Resources," a specially chosen short list of good books and online resources that are helpful to the layperson or student, is featured at the end of volume three. That volume also includes the "Glossary" of terms, with succinct definitions or descriptions of concepts, disorders, treatments, tests, and important people. The "List of

Organizations" features more than 120 groups and resource centers, ranging from the Albert Ellis Institute to the Association for Applied Sport Psychology to the Workplace Bullying Institute. The encyclopedia concludes with a comprehensive index.

Where to Start?

Obviously a reader's starting point is individually driven; however, if you are interested in a specific mental disorder, please read that entry first and follow it up with reading the "See also" selections. If you are using this reference for a research paper on a specific topic, simply start at the index or list of entries to guide you through the encyclopedia. Moreover, the further reading sections at the end of every work will provide you with additional references for your investigation. Finally, if you have an inquisitive mind and are a lifelong learner, allow yourself to be immersed in this ever-growing field of mental health as detailed in entries in these three volumes. You will find interesting and valuable information about this ever-developing field that may just pique your interest as it has mine.

Concluding Note

While this encyclopedia broadly overviews the expanding field of mental health in its extensive number of entries, it does not provide complete information on any one topic. The "Recommended Resources" section at the end of volume three provides readers with additional information to explore selected topics more fully. Furthermore, the material in this encyclopedia is not intended to be used for diagnostic purposes or for psychological treatment. While self-knowledge can be very helpful, it is not a substitute for professional help. Finally, because indications for psychological treatments continually change, readers are advised to seek updates from health professionals, professional literature, or authoritative websites.

Acknowledgments

This project was a joy to work on as it allowed me to share my passion about mental health and well-being with everyone. However, this project was enormous and could not have been completed without the help and devotion of my coeditors, Alexandra Cunningham, PhD, Melissa Mariani, PhD, Mindy Parsons, PhD, and Steven Vensel, PhD, and the other contributing authors.

Len Sperry, MD, PhD

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Introduction: Mental Health

Mental health is a continuum, ranging from states of well-being to stressful life experiences to severe mental disorders. We hope that readers of *Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Being* will find it a useful reference source for specific purposes like academic assignments, term papers, job reports, or, more generally, for better understanding themselves and others.

This three-volume encyclopedia is subtitled *An Encyclopedia of Conditions, Treatments, and Well-Being*. The following paragraphs will focus on these three concepts: conditions or mental disorders, treatments, and well-being. Before that let's first look at mental health.

Mental Health

So what is mental health? Mental health can be thought of as successful mental functioning that results in productive activities, fulfilling relationships, and the ability to cope with change and adversity. Another way of saying this is that mental health is indispensable to effective personal functioning, interpersonal and family relationships, and community life.

Change exerts a constant influence on mental health and can be a major source of anxiety for many in their personal and professional lives. Change, by itself, whether for good or not, can be a source of stress and can negatively influence mental health. For example, technological changes continue at an accelerating pace, and while they can be useful to many individuals, they pose a stressful challenge to others.

Advances in health care can positively or negatively affect mental health. For example, older adults today have increased their life and health expectancies compared with Americans 10 years ago. That means that those over the age of 65 have fewer physical health concerns. But a decline in mental faculties among an increasing number of aging adults can create significant mental health concerns. For instance, dementia and Alzheimer's disease were not major health and mental health concerns in the past because relatively few lived past the age of 60. In 1900 there were 120,000 Americans over age 85, while today there are more than 4 million older adults of that age, making them the fastest-growing age group. The U.S. Census Bureau estimates that by 2030 there will be 72 million adults over the age of 65, which represents 20% of the American population. Among those 85 and older it is estimated that 50% will be diagnosed with Alzheimer's disease (Vincent and Velkof, 2010). The point of these examples is that mental health and mental disorders are influenced by various factors.

Mental Disorders

Mental disorders are primarily disorders of the brain. These conditions usually have multiple causes and result from complex interactions between individuals' genes and their environment. Lifestyle factors and health behaviors, like smoking and exercise, and life experiences, such as severe and prolonged stress or a history of abuse, are such factors. Typically, such factors interact with an individual's genetic or biological predisposition to a mental disorder. For example, a traumatic brain injury or a mother's exposure to viruses or toxic chemicals while pregnant may play a part. Other factors that can increase the risk for mental illness are the use of illegal drugs or having a serious medical condition like cancer. Research on the causality of mental illness has convincingly replaced the now-disproved belief that mental illness is a moral failure.

Mental illnesses occur at similar rates around the world, in every culture and in all socioeconomic groups. Statistics reveal that one in five individuals suffer from a mental disorder. This represents at least 20% of Americans. However, only one-fourth of those individuals with disorders are receiving treatment (SAMHSA, 2014). And, currently, only about 4% of America's health-care budget is spent on mental health treatment and prevention.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (called DSM-5), published by the American Psychiatric Association, provides a common language and standard criteria for the classification of mental disorders. It is the most commonly used clarification system in North America. It classifies mental disorders into categories. There are more than 20 categories of which the following are the most common.

- Anxiety disorders are disturbances in brain mechanisms designed to protect you from harm.
- Mood disorders are disturbances in usual mood states.
- Psychotic disorders are disturbances of thinking perception and behavior.
- Personality disorders are maladaptive personal characteristics.
- Eating disorders are disturbances of weight and feeding behavior.
- Substance-related and addiction disorders are disturbances of cravings.
- Neurodevelopmental disorders are early disturbances in usual brain development.
- Trauma- and stressor-related disorders are disturbances related to significant stressful events.

For example, post-traumatic stress disorder (PTSD) is one of the trauma- and stressor-related disorders. It is a common occurrence in those who witnessed or survived traumatic situations. Many veterans of the war in Iraq and Afghanistan suffer from PTSD and experience symptoms of flashbacks, nightmares, feelings of constant vigilance, and depression. But not all who were deployed to Iraq experience PTSD. Rather, it is most likely to occur in those with a biological predisposition.

Depression is a mental disorder experienced by more than 120 million American adults each year. Depression is a leading cause of drug and alcohol use. Sleep difficulties result in nearly 50 million prescriptions being written for sleep medications per year. Many individuals manage their anxieties by overeating or smoking. Over

time, unhealthy ways of coping take their toll on physical as well as mental health, particularly in those who are predisposed to such conditions.

Treatment

Significant advances have been made in the treatment of mental disorders. This increased understanding of the causes of mental health disorders (at least some of them) and increasingly effective treatments allow clinicians to better tailor treatment to those disorders. As a result, many mental health disorders can now be treated almost as effectively as medical conditions.

Generally, treatment for mental health disorders is characterized as either somatic (biological) or psychological. Somatic treatments include drugs, electroconvulsive therapy, and other therapies that stimulate the brain. Psychological treatments include psychotherapy (individual, group, or family and marital), behavior therapy techniques (e.g., relaxation training or exposure therapy), and hypnotherapy. Research suggests that for major mental health disorders like major depressive disorder, a treatment approach involving both drugs and psychotherapy is more effective than either treatment method used alone.

Clinicians who treat mental disorders include psychiatrists, clinical psychologists, mental health counselors, social workers, and psychiatric nurse practitioners. However, in most states, psychiatrists and psychiatric nurse practitioners are the only mental health clinicians licensed to prescribe drugs. Other clinicians practice psychotherapy primarily. Many primary care doctors and other medical specialists also prescribe drugs to treat mental health disorders.

Well-Being

In the past, mental health treatments focused largely on reducing symptoms or returning the individuals to their previous level of functioning. Today, however, treatment may also focus on increasing individuals' functioning, resilience, and prevention. This focus is known as well-being. Well-being is defined as how individuals think about and experience their lives. It is an indicator of how well individuals perceive their lives to be going. It reflects several health, job, family, and social outcomes. Accordingly, higher levels of well-being are associated with decreased risk of disease, illness, and injury. It is associated with faster recovery for illness, better immunity, increased longevity, and better mental health. Those with high levels of well-being are more productive at work, tend to get along better with others, and are more likely to contribute to their communities.

While there is not yet consensus among researchers or clinicians on the definition of well-being, most agree that well-being involves the presence of positive emotions and the absence of negative emotions. Most would agree that it includes satisfaction with life, a sense of personal fulfillment, and positive functioning. In short, it is about judging life positively and feeling good. Furthermore, most agree that well-being is broader and more inclusive than mental health. In fact, several kinds of well-being can be described and are currently being researched. These are physical well-being, economic well-being, social well-being, emotional well-being, and psychological

well-being. Depression, anxieties, addictive behaviors, and severe physical pain make it difficult to attain and maintain well-being. The reason is that these conditions interfere with the ability to see beyond one's immediate negative experience.

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Q

Qualitative Research

Qualitative research describes investigative methodologies that provide more detailed descriptions, explanations, and observations of an individual subject, or smaller, focused samples of subjects, and the related variables that occur in naturalistic settings.

Definitions

- **Ethnography** is a form of qualitative research aimed at the investigation and interpretation of different cultural groups.
- **Positivism** theory posits that everything in the objective world can be confirmed or denied by gathering data and then verifying the validity and reliability of this data through empirical analysis.
- **Quantitative research** is a research methodology that relies on quantities, or numbers, to answer investigative questions.
- **Subjectivism** is a theory that holds that there are a variety of possible explanations or reasons for human behavior, rather than one, universal truth.

Description

Qualitative research is a type of methodology commonly employed in the social sciences that is interested in revealing more in-depth information or a greater understanding of the topic, person, or setting under investigation. It is interested in the quality, essence, or nature of something rather than the quantity. This type of inquiry is based on subjectivism, or the belief that there are many different versions of the truth and/or a variety of possible meanings for occurrences. The opposite of this is positivism, or realism, which is a worldview that holds that a true reality exists and that it can be discovered by maximizing objectivity and the use of rigorous scientific methodology. "Qualitative research" is an umbrella term that encompasses various forms of inquiry that helps investigators explain social phenomenon with as little disruption to the natural setting as possible. Qualitative researchers look for patterns, themes, or trends in the data rather than relying solely on what the numbers indicate, relying on subjective rather than objective data. Findings are specific to the subject under study and should not be generalized to larger populations. However, qualitative findings may also generate new hypotheses for subsequent, larger-scale quantitative studies. These types of studies differ from quantitative studies in that they require smaller sample sizes, focus more on answering the how and why behind the problem, and, thus, take a longer amount of time to conduct. Naturalistic inquiry, participant observations, interpretive research, inductive research, ethnography, focus groups, case studies, and pilot tests are forms of qualitative research. Ethnography is a type of qualitative research that investigates the differences between various cultural groups. Focus groups involve a moderator that leads a group of selected individuals through a discussion on a particular topic to gauge their opinions, thoughts, and feelings. Market research frequently uses this form of qualitative inquiry. Another readily used form for gathering qualitative data is the case study, which is a detailed investigation of an individual, group, or institution.

Case studies often reveal the deep complexities of the subject under study. Methods for collecting qualitative data include observations, interviews, discussions, notes, and pictures. Subjective though they may be, these methods provide the researcher with a vast amount of rich, descriptive information.

When conducting qualitative research, one seeks to gain a complete picture of the problem under investigation. This is referred to as a holistic perspective. There are several advantages to engaging in this type of inquiry such as the richness, depth, and comprehensiveness of the information gathered. The ease of collection methods is another advantage since these are not as rigid in a natural setting as they are in a controlled environment. In addition, the knowledge gained from qualitative means often provides the researcher with a better understanding of the real environment. Qualitative research, however, is not without its limitations. For example, given the subjectivity of the data gathering, reliability and validity of the findings are often questioned. Researcher bias is another limitation. Finally, this type of research often takes a longer amount of time to gather and the information itself can be lengthy and tedious to code and review.

Development

Both psychology and the social sciences have a long history of employing qualitative research methods dating back to the early 1900s. Seven phases or moments have been outlined documenting this progression in the United States. The first of these, referred to as the traditional period, ranged from the first part of the 20th century to World War II and was characterized by Malinowski's research in ethnography and the influence of the Chicago School in sociology. The focus of qualitative inquiry at this time was on understanding those different from mainstream culture or society. Wilhelm Wundt, the founder of scientific psychology, was one of the first psychologists to use qualitative methods in the experiments he conducted from 1900 to 1920. Next came the modernist phase that lasted till the 1970s and was concerned with formalizing qualitative research practices. Many textbooks on qualitative methodology were written during this time. The following phase that lasted up to the mid-1980s, termed "blurred genres," was characterized by the development of alternative paradigms. A crisis of representation then occurred in the mid-1980s with the birth of artificial intelligence. Researchers began to question how the continuous construction of new realities could potentially impact study findings and interpretations. Narratives replaced theories in the next phase, coined the fifth moment, which took place during the 1990s. The sixth moment (up to 2000) focused on post-experimental writing and the seventh moment (2000–2004) on further establishing qualitative research through successful journals. The final phase, or the eighth moment, is characterized by current emphasis on evidence-based practice.

Current Status and Results

The debate over which is more valuable, qualitative (soft) data versus quantitative (hard) data is ongoing. Some researchers argue that qualitative research is not scientific, lacking the structure, rigor, and objectivity of quantitative methods. However, the fields of anthropology, sociology, philosophy, and psychology readily engage in this type of research given the depth and breadth of the information it provides.

Melissa A. Mariani, PhD

See also: Quantitative Research

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Quantitative Research

Quantitative research is a type of investigative research involving the collection of numerical data and subsequent analysis of that data using mathematical, or statistical, methods.

Definitions

- **Mixed-methods research** defines a flexible type of research methodology that makes use of both qualitative and quantitative components.
- **Positivism** theory posits that everything in the objective world can be confirmed or denied by gathering data and then verifying the validity and reliability of this data through empirical analysis.
- **Qualitative research** is a type of research methodology that gathers "soft" data, subjective and non-numerical, for the purpose of gaining insight and in-depth information about a person, thing, setting, or problem in its natural environment.
- **Realism** is a paradigm that proposes that research, the gathering and verifying of data through empirical analysis, can be used to uncover existing realities in the world.
- **Subjectivism** is a theory that holds that there are a variety of possible explanations or reasons for human behavior, rather than one, universal truth.

Description

Quantitative research uses scientific inquiry and descriptive or inferential statistics to investigate and then determine conclusions about real-world problems. Drawing from the paradigms of realism and positivism, quantitative research is grounded in the belief that true realities exist in the world that can be measured objectively and then quantified through the use of empirical analysis. Researchers use quantitative methods to test hypotheses, determine possible cause and effect relationships, and make predictions about something. This type of research is readily used in the social sciences, including psychology, sociology, and political science; however, it is also applied in mathematical sciences such as physics and statistics.

There are apparent differences between qualitative and quantitative methodologies. Foundationally, qualitative processes are grounded in subjectivism, while quantitative studies are rooted in positivism. In addition, qualitative studies identify patterns, features, or themes (subjective), while quantitative studies identify numerical or statistical relationships between variables (objective). Qualitative data types vary from words, pictures, and objects, while quantitative data is of a numerical or statistical nature. Collection of data for qualitative studies can be obtained through the use of open-ended questions, interviews, observations, case notes, and personal reflections. For quantitative studies, data is based on precise measurements derived from standardized, structured, and validated instruments. Final reports of findings for qualitative research typically come in a narrative form, while those for quantitative studies are of a statistical nature. Narratives may include lengthy descriptions of the person, group, or organization under investigation as well as direct quotes or comments from study participants, while statistical reports contain mathematical calculations such as correlations, comparisons of means, indications of statistical significance, and measures of effect size. Though both research methodologies employ steps in the scientific method, qualitative studies are described as exploratory, while quantitative studies are confirmatory. Another difference lies in the role of the researcher. In qualitative designs, the researcher often plays a primary role in collecting data and may interact with the subjects under study; in quantitative research, the researcher's role is limited in order to reduce bias. Next, qualitative researchers study behavior that occurs in a natural environment, while quantitative researchers investigate behavior under controlled conditions. This allows the researcher to generalize his or her findings to other populations. Quantitative studies also focus on larger-scale problems with randomized samples. This allows the researcher to generalize his or her findings to other populations.

As with qualitative designs, quantitative research is not without limitations. First, quantitative research is limited in the information it provides. Though numbers can indicate increases, decreases, trends, and relationships between variables, they are limited in depth and breadth they offer. Next, given their controlled conditions, quantitative studies indicate little about how the subject under study behaves in their natural environment. Finally, quantitative research views human

behavior as regular and predictable; however, this is typically not the case as each individual, organization, and setting is unique and each situation, controlled or not, may be different.

Development

Quantitative inquiry has existed since people began recording events and counting objects; however, quantitative research, in the formal sense, can be attributed to the work of French philosopher Auguste Comte. Comte is credited as the founder of sociology and the theory of modern positivism. In his book *A General View of Positivism*, he detailed the empirical goals of the scientific method in sociology. His work emphasized quantitative, mathematically based decision making, which remains the basis for current practices in statistics and business.

Current Status and Results

Quantitative methods have dominated research practices for the better part of the 20th century on into the 21st century. Though there is apparent value in qualitative designs, quantitative research with its focus on "hard" data is viewed as more salient and the results more powerful. One of the dominant themes in current social science research is an emphasis on evidence-based practices and research-based interventions, with quantitative data playing a central role.

Melissa A. Mariani, PhD

See also: Qualitative Research

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R

Racial Identity Development

Racial identity development describes how individuals achieve an awareness of their self within the social, cultural, and historical context of their race.

Definitions

- **Culture** refers to the knowledge and values; patterns of though, speech and actions; and customary beliefs, social forms, and speech shared by a society.
- **Discrimination** is the unjust treatment of others based on racist beliefs.
- **Ethnicity** refers to a group of people sharing a common and distinctive racial, national, religious, linguistic, and cultural heritage.
- **Heritage** refers to the practices, traditions, or characteristics that are passed down from one generation to the next.
- **Prejudice** is a preconceived opinion about a group or class of people based on limited, inaccurate, or assumed information.
- **Race** refers to a socially constructed system of classifying individuals according to observable characteristics such as physical attributes (skin tone, height, eye shape, etc.) or language.
- **Racism** is a socially shared belief that all members of a particular race possess characteristics that are inferior to another race, resulting in oppression.
- **Stereotype** means to categorize, characterize, or group people into oversimplified and inaccurate classifications.

Description

Racial and ethnic identity is an essential component of an individual's overall self-identity. Racial identity is based on an individual's perception of shared genetic and physical characteristics of a particular racial group. Ethnic identity is based on an individual's identification with the customs, traditions, culture, and values of a shared and embraced heritage.

Racial identity development has received considerable attention in the United States, with much of the research being focused on the unique experience of African Americans. The concept of racial identity has been considered from both biological and social perspectives. Early concepts of racial identity were derived from a biological perspective in which race was seen simply as an individual's physical features and genetic characteristics. Seen from this narrow perspective people were grouped according to physical ability and difference in appearance, most often skin color, leading to social stereotype, racism, and oppression. Today racial identity is viewed from a social perspective, with research focusing on how groups of people develop a sense of collective identity over their lifetime.

There are multiple models of racial identity development, and many of the theories have their roots in the developmental stage models of Erik Erikson. Most theories focus on the psychological and emotional development of individuals within the context of their social environment. One of the most

prevalent and researched models of racial identity is that proposed by William E. Cross, a psychologist and leading researcher in the field of racial identity development. Cross proposed five stages in the development of what he referred to as "the process of becoming black." Cross called his theory "Nigrescence" in which a healthy Afro-American progresses from a non-Afrocentric to an Afrocentric to a multicultural identity. Cross originally identified five stages: Pre-Encounter, Encounter, Immersion-Emersion, Internalization, and Internalization-Commitment. An individual begins in the Pre-Encounter identity stage in which he or she seeks to assimilate and be accepted by whites. The individual has a nonracial perspective and is unaware of race and race issues. At some point there is a racial "Encounter" in which the individual, for the first time, is treated differently because of the color of his or her skin. This encounter with racism results in the individual focusing on his or her identity as a member of the group targeted by racism. The third stage, Immersion-Emersion, is highly emotional and individuals immerse themselves in black culture. They are obsessed with and take pride in their blackness; surround themselves with symbols of their racial identity; disparage white culture and avoid symbols of whiteness; and become more involved with their own racial group and exclude those from different groups. As they emerge from this stage and enter into the Internalization stage, they become less psychologically defensive and more emotionally and cognitively open to analyze and consider their racial worldview. There is an inner security, comfort, and satisfaction with being black as well as an ability to see both positive and negative elements of being black or from another racial group. An individual with an internalized racial identity is willing to establish meaningful relationships with individuals from other racial groups. The final stage of racial identity is Internalized-Commitment in which individuals have internalized a positive racial identity and are able to use their experiences to take action for other oppressed groups. They are committed to social change, political justice, and social equality for all oppressed minorities.

There are multiple theories of racial identity development, and no single model could capture all of the challenges unique to the African American community. As the social environment changes, racial and ethnic identities evolve and change over time. A positive and healthy perception of racial identity is a core component of an individual's sense of self-concept and well-being. Understanding how healthy identities form will continue to be an important area of research.

Steven R. Vensel, PhD

See also: Ethnicity; Identity and Identity Formation; Multicultural Counseling; Social Justice Counseling

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Rage

"Rage" refers to uncontrolled, intense, and often violent fits of anger.

Description

Rage is an intense emotional state of anger that is often experienced as being "out of control." Rage is an intense form of anger. When people are "in a rage," they are unable to control their impulsive aggressive behaviors and become verbally hostile, destructive, and violent toward others.

Causes and Symptoms

Anger includes a wide range of emotional states from minor annoyance and frustration on one end of the spectrum to rage on the other end. Rage occurs in response to helplessness, threat of harm, threat of loss of relationship, perceived or real injustices or disrespect, and real or imagined provocations. Rage is triggered

by how individuals interpret and appraise events. The emotional response is usually so automatic, immediate, and intense that individuals in a rage are unable to access more rational forms of thought in order to control their aggressive impulses. A common explanation given by people who rage is that "something snaps" and they lose control. However, research indicates that rage may, at least at times, include an element of calculation and intentionality as when a person wraps his or her hand in a cloth to avoid injury prior to hitting a window. Nonetheless, individuals who are in a "fit of rage" consistently report an inability to think about anything other than what is angering them. They also report being able to easily find additional evidence of wrong to further feed their rage. Verbal symptoms of rage include yelling, ranting, cussing, and making verbal threats. Physical behaviors include combative and provocative gesturing, destroying objects, vandalizing property, engaging in physical fights, and assaulting others.

Diagnosis and Prognosis

Rage is very damaging and often results in loss of personal relationships, job loss, legal difficulties, arrest, and incarceration. Rage is included as a behavior indicator associated with some mental health disorders, including intermittent explosive disorder. Anger expressions that are out of proportion to events are a frequent focus of counseling. Psychotherapies such as cognitive behavior therapy, rational emotive therapy, and cognitive behavioral analysis system of psychotherapy have been found to be effective by assisting individuals in understanding and changing their anger-related thinking and behaviors. Self-help and professional anger management groups are widely available and provide effective psychoeducational and anger control skills development, including conflict resolution skills, communication skills, mindfulness, reflection, and emotional regulation. Although rage is an emotionally intense and destructive form of anger, it is easily treatable.

Steven R. Vensel, PhD

See also: Anger in Adults; Anger Management; Intermittent Explosive Disorder; Mindfulness; Road Rage

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Rational Emotive Behavior Therapy (REBT)

Rational emotive behavior therapy (REBT) is a form of psychotherapy developed by Albert Ellis (1913–2007).

Description

Ellis first began writing about his theories in 1955 and published his book *Reason and Emotion in Psychotherapy* in 1962. Albert Ellis's book, which was revised in 1994, is still the most important source for practitioners of REBT. Originally called rational psychotherapy, Ellis renamed his theory rational emotive therapy, and then changed the name to REBT. REBT uses an A-B-C model to explain the cause of distress in a patient. In this model, the patient experiences an activating event (A). This event triggers beliefs (B) about the event and emotional consequences (C) happen because of their beliefs.

According to Ellis, people create their own reactions to event. Reactions are natural when they are based on functional, rational beliefs and lead to appropriate, healthy consequences, such as regret, annoyance, or sadness. The problem arises when people instead have dysfunctional or irrational beliefs. These lead to negative or unhealthy consequences, such as guilt, anger, or depression. Where REBT differs from other cognitive behavior therapy approaches is that it points out the distinction between healthy and unhealthy emotions.

Ellis's theories on REBT came about after a 1953 session with a patient. The patient was afraid of men and stated her fear was because her father beat her as a child. Ellis reminded her that her father was dead. The

patient wondered if it wasn't her father causing her fear, then perhaps it was because of what she was saying about what he did in the past. Ellis agreed that her fear came from her own action of telling herself that her father is responsible for the way she thinks now. This patient's interaction led Ellis to the basic principle of REBT, which is the way people think makes them behave in a certain way.

REBT states that it's natural for people to experience emotions in response to events. A therapist can work with a patient to replace unhealthy emotions with helpful, more appropriate ones. The REBT therapist's major job is to point out negative emotions and discuss them with his or her patient. Cognitive intervention is then used to replace the negative emotions with positive, healthy emotions. Therapists see this as one of the major advantages of REBT.

Healthy, positive emotions come from rational beliefs about situations. Positive illusions, like thinking that things are okay when they really are not, are associated with unhealthy, irrational beliefs. Unconditional self-acceptance is a cornerstone of REBT, and patients are urged to love the self unconditionally. Ellis advised patients not to rate or evaluate themselves, but only their roles. For instance, you may judge something you did, but you shouldn't judge yourself.

People struggle between extreme and non-extreme, or dogmatic and non-dogmatic beliefs. For instance, it's unhealthy for a person to believe that an outcome must happen, or "all will be lost." Therapists encourage patients to be passionate about their desires, but not believe that it will be the end of the world if they are unable to obtain them. It's the job of a therapist to help a patient let go of his or her irrational beliefs and instead have a rational belief with an appropriate negative emotion.

Ellis believed problems arise when people have trouble separating feeling from thinking, or vice versa. Inappropriate emotions come not from what has happened to us but from how we interpret these events. Ellis's approach differed from other forms of psychotherapy, especially the nondirective approach, which was popular in the 1950s. It's important to note that REBT is direct, active, provocative, and confrontational. Ellis interrupted patients during therapy sessions, made fun of their irrational beliefs, and pointed out the thoughts that were bothering them. This made for many uncomfortable therapy sessions.

In REBT, the therapist must challenge the patient to think differently. This can save time by not letting a patient ramble on during a therapy session, but by getting to the point and achieving a resolution. However, REBT therapists can find it difficult to be direct. They are not immune from the desire to be liked and may be afraid if they are direct and confrontational, their clients won't like them. Many of Ellis's colleagues dismissed his therapy tactics. However, his patients reported that they were effective and that it was worth any discomfort they experienced at the time.

Development and Current Status

During his career, Ellis documented REBT with 934 articles, books, pamphlets, audiocassettes, and video tapes. He worked hard to keep REBT from being influenced by other approaches and insights. As a result, REBT hasn't absorbed much or merged with other therapies, as is often the case in psychotherapy. To this day, REBT continues to stay true to its non-psychoanalytic beginnings.

That is not to say that REBT has remained stagnant, however. Ellis worked on refining it for 50 years, from 1955 to 2005. He continually tested his ideas in clinical sessions during this time, holding up to 90-patient sessions a week. Changes to REBT were a result of his clinical findings. However, not everyone feels REBT is well documented enough. REBT is viewed by some as too loosely formulated and based too much on anecdotal evidence. Another downside to REBT is that there are few rigid, set rules for practitioners to follow. There is no clear standard for what constitutes REBT and what doesn't, and few educational standards for therapist training. This can be an advantage for therapists, since it allows them the flexibility to develop their own ideas. However, it also means that without standardization, some therapists practice REBT quite differently than others.

Since Ellis continually refined and changed his approach to REBT over the years, but didn't issue strict guidelines, not every practitioner was aware of the changes. Therefore, not everyone followed the same practices. However, what remains is that REBT is an effective cognitive behavior therapy and a way for

therapists to guide their patients into resolving their issues. It has been a major influence on psychotherapy during the last century.

Mindy Parsons, PhD

See also: Cognitive Behavior Therapy; Ellis, Albert (1913–2007)

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Reactive Attachment Disorder

Reactive attachment disorder is a mental disorder in children characterized by disturbed and developmentally inappropriate social relatedness.

Definitions

- **Attachment** is the emotional bond between children and caregivers that provides a secure (healthy) base from which children are able to safely explore their environment and relate to others.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Disinhibited social engagement disorder** is a mental disorder in children characterized by an overly familiar and culturally inappropriate behavior with strangers.
- **Trauma- and stressor-related disorders** are a group of mental disorders characterized by exposure to a traumatic or stressful event. These include post-traumatic stress disorder, reactive attachment disorder, and disinhibited social engagement disorder.

Description and Diagnosis

Reactive attachment disorder is one of the trauma- and stressor-related disorders. It is characterized by disturbed and developmentally inappropriate social relatedness in children. The most obvious and prominent behavioral presentation of children with this disorder is the avoidance of and withdrawal from caregivers, other adults, and peers. When distressed, these children tend to reject attempts at comforting and soothing. Instead they engage in self-calming and soothing behavior, and tend to be calmer when left alone. As young children they seldom smile and do not respond when being hugged or picked up. Typically, they show little interest in playing childhood games like hide-and-seek. Older children avoid social activities and become isolative, and when frustrated, they may engage in aggressive behavior toward adults and peers.

Children with this disorder seldom have any friends. This probably results from their disinterested attitude toward making friends with peers and relating to caregivers. With peers, these children send the message, "I don't want you as a friend." Unfortunately, this becomes a self-fulfilling prophecy as peers stop their efforts to relate to such children. Similarly, these children and their caregivers tend to get caught in a negative cycle. In this cycle both interpret disinterest and avoidance in each other's behavior, which leads to further disinterest and avoidance. It is unknown how common reactive attachment disorder is among children. While found in children placed in intuitions or raised in foster care, it appears in less than 10% of such children (American Psychiatric Association, 2013). In some ways, this disorder is the mirror opposite of disinhibited social engagement disorder. Whereas children with disinhibited social engagement disorder relate indiscriminately to individuals they do not know, those with reactive attachment disorder cannot easily relate to individuals they do know.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, children can be diagnosed with this disorder if they exhibit an ongoing pattern of emotional distance and general inhibition in relating with adult caregivers. Specifically, the child will rarely seek comfort and support from caregivers when distressed, and will rarely respond when comfort and support is provided. This inhibition and lack of emotional responsiveness extends to others within the child's environment. This includes teachers, relatives, and peers. These children have a history of neglect and deprivation or have had several primary caregivers. It is believed that while they have the capacity to form appropriate social attachments, due to significant social neglect and lack of opportunities for receiving developmentally appropriate comfort, affection, and stimulation from caregivers, this capacity is not fully realized. This diagnosis is not made unless the child is at least nine months of age and the symptoms have been present prior to five years of age (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, withdrawal and avoidance seem to be logical responses to an early childhood experience of neglect or trauma. The core feature of this disorder is the failure to form a secure (healthy) attachment to the primary caregiver. Reasons for this include abuse, extreme neglect, abrupt separation from caregivers, or a repeated lack of responsiveness of the caregiver when the child attempted to interact. Or, several of these reasons may have been involved. Accordingly, these children came to believe and feel that they did not belong, were not good enough, or were not accepted. The result was their pattern of avoidance of and withdrawal from others and a failure of a secure attachment. There may also be some genetic factors that contribute to this pattern of behavior, but so far nothing has been determined except that between the infant and the earliest caretakers was not established and further training of the child's social interest was not continued.

Treatment

Treatment of this disorder consists primarily of psychological interventions. First and foremost, it is important that the child be in a secure, safe, and supportive environment. If the child is in a neglectful environment, referral to appropriate state, tribal, or federal agencies should be made. Another essential goal of treatment is to foster the development of a secure (healthy) attachment between the child and caregiver. This can be accomplished directly with the caregiver through parenting classes or in individual psychotherapy. Cognitive behavior therapy can help in reducing stress and negative emotions associated with caring for a child with this disorder.

Len Sperry, MD, PhD

See also: Attachment Style; Cognitive Behavior Therapy; Disinhibited Social Engagement Disorder

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Reading Disorder

Reading disorder, commonly called dyslexia, is a type of learning disability that negatively affects a person's reading ability.

Definition

- **Dyslexia** is a learning disorder that impairs a person's ability to read.

Description

Individuals who exhibit dyslexia typically read at levels significantly lower than expected for their age even though they have average or above-average intelligence. Characteristics vary for each person with dyslexia. This problem occurs when someone is unable to distinguish the significance and specific differences between letters. Some common characteristics are difficulty with basic reading, such as letter and word identification and sounding out letters.

There is dispute about the accuracy of how reading disorder is measured. Reading disorder is generally thought to be two or three times more common in boys than in girls. And while approximately 10% of school-age children struggle to read successfully, only about 4% of these children have dyslexia. For many children dyslexia is also associated with other learning disorders such as mathematics disorder. When it occurs in adults, dyslexia is usually the result of a brain injury or occurs in the context of dementia.

Causes

Reading disorders seem to have a biological basis and run in some families. Studies of brain structure, brain function, and genetics would seem to point to a biological basis in many cases. Recent research suggests that there are environmental factors that can cause reading disorders as well. At the same time, some children who exhibit reading difficulties do so based on poor instruction and negative experiences while reading.

A child's ability to acquire the complex skills necessary for reading is dependent on the development and functioning of various systems. These include coding and memory systems and related processes. Reading difficulties could result either from a deficit in brain development or from a combination of a child's genetic inheritance along with environmental and instructional experiences. In addition, emotional and psychological stressors should also not be ignored when students are being assessed.

Symptoms

Students with reading disorder or dyslexia will struggle with or be unable to master the process of understanding the meaning of written text. Therefore, key symptoms of reading disorder are inability to identify words and to comprehend sentences, paragraphs, or longer forms of written expression. Although reading is primarily a linguistic rather than a visual skill, it is important to ensure that students being assessed for reading disorder are not suffering from vision problems.

Treatment

As in most learning disorders, the creation of a supportive team of parents, family members, and educators is important. This will provide the child with the greatest chance of enhancing his or her reading skills. Great improvement can be made to help children read better through instructional activities that are tailored to the child's specific challenges as well as the child's strengths. The focus should be on the reading process and reading development. The teacher should individualize instruction around what the child is already able to do. Recently, it has been proposed that a combination of evidence-based teaching practices and cognitive neuroscience measures based on plasticity in the brain is the best way to prevent and treat dyslexia in many children.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Dyslexia; Learning Disorders; Specific Learning Disorder

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Reality Television (TV)

Reality television (TV) is a program genre that claims to represent real people, not actors or actresses, in unscripted, "real-life" situations.

Definition

- **Reality shows** are sitcoms, documentaries, talk shows, game shows, and sports shows that feature real people, rather than professional actors, in supposedly unscripted events.

Description

Reality TV is a type of television program that presents everyday people in unscripted, actual events in

their life. Instead of employing professional actors, as in other programming genres, reality shows contain regular people. Different types of reality shows include competition-based reality shows, game shows, documentaries, sports shows, family reality, and talk shows. There has been debate about the reality of reality programming, as it has been revealed that some of these shows are not naturally occurring events and would not naturally occur on their own without some provoking, urging, or script writing from show producers.

Reality programming arguably began in the 1940s and 1950s with game shows such as *Cash and Carry, Beat the Clock*, and *Truth or Consequences*. The hidden camera show *Candid Camera* was another reality hit during this time. Another milestone for this genre was the first *Miss America* pageant where beauty queens competed for the renowned title and crown. A well-known reality series on British television that started in the 1960s was the U.K. documentary *Seven Up!*, which chronicled the lives of 14 seven-year-olds. The series has followed up with almost all of the same children first seven, and then 14 years later, with the shows *7 Plus Seven* "*21 Up*," and so forth, every seven years to the most recent show, *56 Up* (in 2013). In 1966, Andy Warhol's *Chelsea Girls* was released and is supposedly to blame for reality television's craze. The 1970s series *An American Family* was most closely related to reality programming as it is thought of currently. This show followed an upper middle-class American family through their trials and tribulations. The 1970s launched a string of reality game shows, including *The Dating Game, The Newlywed Game*, and *The Gong Show*, all featuring real-life people willing to expose their private lives for sport. The 1980s and 1990s introduced another take on reality TV with shows where people put themselves in dangerous situations. These shows included *That's Incredible*, *Thrill of a Lifetime, Expedition Robinson*, and the crime-fighting reality show *Cops*. It was programming like this that led to the later success of reality shows like *Survivor* and *The Amazing Race*. Another reality program subset featured putting a bunch of strangers together for an extended period of time to record their interactions and reactions. Programs like these included the original, *Nummer 28*, the MTV smash series, *The Real World*, *The Apprentice*, and *Big Brother*. This time period also saw a major development in reality television with the invention of computer-based, nonlinear editing for video, making it possible to record and edit hours of footage with ease.

Impact (Psychological Influence)

Due to the popularity of reality television, some cable channels now comprise mainly this type of programming. Fox Reality, Bravo, E!, TLC, and MTV are some of the most popular. The early 2000s saw another explosion in the popularity of reality TV. Several of these competition series have had continued success with adaptations worldwide. Shows like the *American Idol*, the *X-Factor, Dancing with the Stars, Deal or No Deal*, the *Weakest Link, Who Wants to Be a Millionaire*, and *The Voice* are examples. Family reality shows such as *Jon & Kate Plus 8, The Osbournes, Keeping Up with the Kardashians, Duck Dynasty, Teen Mom*, the *Real Housewives* series, and the *Jersey Shore* have been megahits resulting in fan-craze. Reality television nowadays seems to encompass every area, romantic relationships (*The Bachelor/Bachelorette*), self-improvement (*The Biggest Loser, Intervention, Celebrity Rehab*), culinary arts (*Hell's Kitchen*, *Top Chef*, *Rachael Ray*), and even antiques (*Pawn Stars, Storage Wars*). One of the major criticisms of reality programming is that it is not actually depicting reality, as many shows are fabricated settings and somewhat scripted to provide more drama or entertainment. Furthermore, editing can be used to misrepresent characters or mislead viewers as to the events that really transpired on set. Whether they are viewed as positive or negative, the fact remains that reality show participants are often catapulted into instant celebrity status, which many are unprepared for. Nearly 60% of all TV shows currently running are considered in the reality genre. Viewers tune in to watch in record numbers, and many report it as their guilty pleasure.

Melissa A. Mariani, PhD

See also: Media Violence; Music, Influence of

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Reality Therapy

Reality therapy is a type of counseling developed by William Glasser, which is firmly based on the principles of choice theory and focuses on developing successful connections between people in order to alleviate emotional, behavioral, and psychological problems.

Definition

- **Choice theory,** first termed "control theory," was developed by William Glasser to explain human behavior, which states that all humans choose to behave in ways that satisfy five basic needs, the most important being love and belonging.

Description

Reality therapy (RT) is an approach to counseling that was founded by Dr. William Glasser in the 1960s. It is grounded in choice theory, which emphasizes the power of personal choice in determining life's outcomes. RT is different from other forms of psychotherapy as it focuses on what Glasser termed the three Rs: realism, responsibility, and right-and-wrong. This is in stark contrast to other therapeutic approaches based on a medical model that attribute problems to chemical imbalances or disorders and encourage the use of psychotropic medications to help alleviate symptoms. The goal of RT is to assist the client in building supportive, fulfilling connections with others. The belief is that all human angst is derived from a lack of positive relationships, and if one is assisted in building these connections, one will have better coping skills and have the wherewithal to withstand difficulties that may arise. Five basic needs that all humans strive for are at the heart of RT: (1) power—a sense of self-worth attained from winning or achieving something; (2) love and belonging—connection to one's family, community, or other loved ones; (3) freedom—sense of personal autonomy or independence; (4) fun—sense of enjoyment, pleasure, and satisfaction; and (5) survival—basic physiological needs such as food, drink, shelter, safety, and sexual fulfillment. If one or more of these basic needs are unmet, then discord, unhappiness, and loneliness can result.

Reality therapy begins with a therapeutic alliance. Emphasis is placed on forming a trusting, empathetic, and supportive bond between the counselor and counselee. This relationship is then used as a vehicle to address outward problems. A reality therapist will focus on the present instead of the past; empower the client to make own choices and accept responsibility for those; avoid criticism, blame, and complaints; assist the client in making specific plans and steps toward growth; and use encouragement and support throughout this process. Once a trusting relationship is established between counselor and client, the focus then moves to an action plan taking into account personal choices and reinforcing responsible behavior. The therapist focuses on "getting real" or looking at the objective reality of the client's current situation. Accountability is key as the client moves from blaming and criticizing to accepting change and establishing supportive connections with loved ones. It is from these relationships that people feel safe, cared for, and empowered, and are thus able to create new realities.

Development (History and Application)

Dr. William Glasser and his mentor, Dr. G.L. Harrington, developed RT at the Veterans Administration Hospital in Los Angeles, California, in the early 1960s. His first book on the topic *Reality Therapy: A New Approach to Psychiatry* was published in the United States in 1965. This was a client-centered process that empowered people to recognize how much control they have over the choices they make in life. By the 1970s, he came to refer to his theory as control theory, later changing the name to choice theory in the 1990s. Glasser founded The Institute for Reality Therapy in Tempe, Arizona, in 1967, which he changed to The Institute for Control Theory, Reality Therapy, and Quality Management and finally to The William Glasser Institute in 1996. Branches are now located throughout the United States as well as in several other countries.

Current Status

On August 23, 2013, William Glasser died of respiratory complications at his home in Los Angeles, California. However, the practice of RT remains a foundational approach in the ongoing work of choice theory followers. It has proven to be a successful intervention for addressing a wide range of complicated issues, including anxiety disorders, substance abuse problems, health concerns, and other life-changing events. Furthermore, RT has been effective in assisting clients from different backgrounds and cultures due to its emphasis on personal choice and decision making. RT principles have been applied in educational settings, most recently to school counseling programs, to foster productive relationships between counselors and students.

Melissa A. Mariani, PhD

See also: Glasser, William (1925–2013)

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REBT

See Rational Emotive Behavior Therapy (REBT)

Recovery

Recovery from alcohol and drug addiction involves achieving abstinence and improved health, wellness, and quality of life.

Definitions

- **Abstinence** is the restraint of indulging oneself in bodily activities that typically gives an individual pleasure (e.g., alcohol and drugs).
- **Addiction** is the compulsive, continued, out-of-control use of substances, or engagement in behaviors (e.g., gambling), despite physical harm or negative consequences. Addiction is also the physical state of being dependent on a substance.
- **Alcoholics Anonymous** is a self-help fellowship that was founded by Bill Wilson and Dr. Bob Smith in 1935 to help people struggling with alcoholism. It is also called Twelve-Step Program.
- **Dependency** refers to the body's physical need for continued or increasing use of a substance in order to maintain the effect or to ward off withdrawal symptoms.
- **Mental disorder** is a bodily or mental condition evident by adequate disorganization of mind, personality, and emotions that seriously impairs an individual's normal functioning. Schizophrenia is a serious and debilitating mental disorder.
- **Sobriety** refers to the state of being sober and of not having any mood-altering substances such as drugs or alcohol in one's system.
- **Substance use disorders** are a category of conditions associated with the continued use of substances, such as alcohol or drugs, despite causing significant cognitive, social, behavioral, health, and psychological consequences.
- **Withdrawal** is the body's physical reaction (e.g., cravings, depression, pain, trembling, hallucinations) to a decreased or discontinued use of a substance.

Description

"Recovery" is a broad term meaning recuperation or a return to a previous or higher level of functioning. The recuperation can involve a physical condition, like a broken bone or a mental condition like schizophrenia. Here, it refers specifically to alcohol and drug addiction. In substance abuse treatment the phrase "recovery" or "in recovery" is used to mean someone who is in the process of recovering from a substance use disorder. More explicitly recovery refers to successful

abstinence from alcohol, drugs, and other substances. Recovery and the recovery movement have their roots in Alcoholic Anonymous (AA), which remains the most well-known recovery program. Although there were other approaches to recovery in the 1930s, the founders of AA developed an approach to help alcoholics recover from their addiction.

Recovery approaches share many elements in the recovery process. Typically recovery is a group-oriented, supportive, social approach to sobriety. Most recovery groups such as AA are not led by professionals but rather by people in recovery themselves. Social support is critical to recovery, and mentors, referred to as "sponsors," who have experienced long-term sobriety, play a crucial role in the care, encouragement, accountability, and support to those new to recovery. Common themes include the recognition of powerlessness over their addiction, the need for a higher power to rely upon for help in recovery, and surrendering one's helplessness to that higher power; making amends to people who have been harmed; and attending meetings as often as needed in order to stay sober.

Steven R. Vensel, PhD

See also: Twelve-Step Programs; Wilson, Bill

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Recovery Process

Recovery is a series of steps individuals take beyond an addiction to improve their wellness and health, while living a self-directed (responsible) life and striving to reach their highest potential.

Definitions

- **Abstinence** is the restraint of indulging oneself in bodily activities that typically gives an individual pleasure (e.g., alcohol and drugs).
- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Detoxification** is a process of purging the body of the toxic effects of a drug or substance. During this process the symptoms of withdrawal are also treated. It is also called detox.
- **Sobriety** is the condition of complete abstinence from all mind-altering substances as well as increased mental, physical, and spiritual health.
- **Substance Abuse and Mental Health Services Administration** is a federal agency that promotes health and well-being by reducing the impact of substance abuse and mental illness in communities.
- **Substance use disorder** is a disorder in which one or more mind-altering substances lead to clinically significant distress or impairment in an individual.
- **Twelve-Step Programs** are self-help groups whose members attempt recovery from various addictions based on a plan called the Twelve Steps.
- **Withdrawal** is the body's physical reaction (e.g., cravings, depression, pain, trembling, hallucinations) to a decreased or discontinued use of a substance.

Description

Recovery is a series of steps an individual takes in moving beyond an addiction to health. Abstinence is

the first step and working to achieve sobriety is another step in the recovery process. Recovery and the recovery movement have their roots in Alcoholic Anonymous (AA), which remains the most well-known recovery program. Although there were other approaches to recovery in the 1930s, the founders of AA, Bill Wilson and Bob Smith, developed the approach to help alcoholics recover from their addiction. While the recovery movement has its roots in AA, it is much broader than Twelve-Step Programs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes recovery from mental disorders and substance use disorders as a process of change in which an individual improves his or her wellness and health, and lives a self-directed life, while striving to reach his or her highest potential. SAMHSA describes four major elements that support a life in recovery. The first element includes health, which attends to managing or overcoming an individual's disease(s), in addition to living in an emotionally and physically healthy manner. The second element involves living in a stable and safe place. The third element includes finding purpose in meaningful daily activities (e.g., school, job, and family caretaking). The fourth element involves engaging in relationships and social networks that provide support, love, hope, and friendship (e.g., becoming involved in the community).

In 2011 the Substance Abuse and Mental Health Services Administration developed a working definition of "recovery" in order to assist policy makers, providers, and others to better design, deliver, and measure services to those in need. SAMHSA defined recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMSHA, 2012). SAMHSA also listed the following guiding principles: recovery emerges from hope; is person driven; occurs via many pathways; is holistic; is supported by peers and allies; is supported through relationship and social networks; is culturally based and influenced; is supported by addressing trauma; involves individual, family, and community strengths and responsibility; and is based on respect. SAMHSA also led the "Recovery Support Strategic Initiative" in order to partner with people in recovery from mental and substance use disorder to guide behavioral health systems and promote approaches that foster health and resilience and provide housing, employment, and educational support.

Mental health professionals and individuals in recovery are aware there is hope that is found in recovery. In many cases, individuals with the disease of addiction feel hopeless. However, recovery is available even when an individual perceives there is not any hope for changing his or her behaviors and living a healthy life. Taking care of oneself and having a good support group (e.g., Twelve-Step Programs) are a very important part of recovery. Having peer support and participating in self-help activities can benefit an individual in recovery. Furthermore, it can optimize the health status of the individual and influence positive outcomes in recovery.

Treatment

Addiction that is untreated or treated inadequately can cause disability or premature death. Addiction must be managed and monitored over time in order to decrease the occurrence and intensity of relapses, sustain periods of remission, and optimize an individual's level of functioning during periods of remission. In many cases medication management can improve treatment outcomes. Integrating rehabilitation with medication management has been shown to provide effective outcomes. Furthermore, recovery from addiction can be achieved through a combination of mutual support and professional care provided by trained and certified professionals.

The recovery process has also been adapted to the treatment and management of mental health disorders, including mood, psychotic, and personality disorders. Recovery approaches to treatment have been included in many, if not all, substance use rehabilitation treatment centers. Many other addictive-type problems have also benefited from a recovery approach such as gambling, sex, and food addictions.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Addiction; Sobriety; Twelve-Step Programs

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Reggae Music

Reggae is a musical style built on an irregular, offbeat rhythm accompanied by spoken-song lyrics.

Description

Reggae music is widely considered the sound of countercultural and underprivileged peoples around the world. Emerging in the 1960s in Jamaica, its irregular rhythms and native-slang lyrics contained stinging social commentaries designed to agitate for change. It is almost exclusively performed by mixed race or black singers, who often espouse a Rastafarian worldview.

Reggae is a musical style built on an irregular, offbeat rhythm accompanied by spoken-song lyrics. It has been a conduit of self-expression for many poor, underprivileged, and marginalized individuals around the world. (Bunyos/Dreamstime.com)

As a result, it has been viewed with wariness, disdain, and, in some cases, open hostility by traditional Eurocentric ruling classes.

Official hostility has not diminished the power or popularity of reggae. On the contrary, for many performers, upsetting and annoying the status quo is the whole point. For others, the revolutionary elements of the music serve as a force of unification and a way for marginalized groups to share a feeling of solidarity between countries, languages, and continents.

Reggae was born in the 1960s, growing out of ska, jazz, and R&B traditions. At the time, it was treated as a dangerous, ethnic, countercultural sound that highlighted the lower-class experience. Jamaican performers such as Bob Marley—perhaps reggae's best-known voice—lifted the style to the world stage. In this way, Marley and others like him brought the discussion of modern racial identity to the forefront and provided a platform for voices outside the Eurocentric power structure.

Early reggae stars came primarily from Jamaica, but reggae is now performed worldwide. Songs often focus on social issues with a view toward illuminating injustices and inspiring marginalized peoples (particularly of African heritage) to take action and make changes. While reggae is not inherently religious, it is often associated with and performed by those with a Rastafarian worldview.

The unique rhythmic sound of Reggae seems more suited for a relaxed party than a revolution. However, traditional reggae music was intended as a vehicle for expressing what could not be openly said, particularly with regard to black/white power imbalances, economic injustices, and rejections of colonial/imperial power structures. As it spread, it was a way for performers to advocate unification of peoples—particularly traditionally oppressed black and mixed-race peoples—and deliver sharp political takedowns disguised as catchy dancehall music.

Development and Current Status

As the sound spread, key style points emerged. For example, reggae was to use as much of the local slang as possible, pushing back against power structures who tried to stamp out native dialects in the islands, Africa, and Central America. This also gave reggae a touch of "in-group" cachet, as outsiders (cultural or economic) would miss the real meaning of many verses.

Songs were to contain a social message. This might be a celebration of a cultural experience unique to pan-African or mixed-race peoples or a cautionary tale about the workings of "the man" in the country. Often, songs were an exhortation to listeners to band together as brothers in a common experience of oppression/repression and work for peace, unity, and love among mankind.

Finally, and perhaps most controversially, reggae songs were to feature Rastafarian ideologies. This belief system had become associated with "pure" reggae, since many early genre pioneers were Rastafarians. However, marijuana use, dreadlocks, and orthodoxy of Rasta sometimes served as a barrier to the spread of the music, particularly in strong Catholic countries, and this style point is inconsistently applied in modern, commercialized reggae.

Yet even with varied stylistic elements, modern reggae builds on the original drive to inspire underprivileged peoples from all backgrounds. Even as it influences and blends into rap, *reggaeton*, and punk movements, reggae retains its traditional association with the marginalized, independent, and countercultural forces in society. This association does fade in some of the most commercialized forms of reggae. These newer songs are more highly sexualized with only light touches of social commentary or Rastafarian beliefs. As a result, there is some tension between "original" reggae artists focused on raising awareness of the "inferior" classes who continue to be exploited and artists who focus on *reggaeton* club hits that often receive lucrative mainstream radio play.

Impact (Psychological Influence)

Despite the tension between ideology and financial success among artists, as reggae matures it continues to build on its popularity. Its evolution does not diminish its role as a voice for revolution, racial awareness, and respect for all peoples.

Mindy Parsons, PhD

See also: Marley, Bob

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Rehabilitation Counseling

Rehabilitation counseling is a type of counseling that focuses on helping individuals who have disabilities to achieve their career, personal, and independent living goals.

Definitions

- **Rehabilitation** is the process of restoring to good health or improved quality of life through therapy or education.
- **Rehabilitation counselors** are certified counseling professionals who help people with emotional and physical disabilities live independently.

Description

The practice of rehabilitation counseling aims to improve the lives of people with physical, mental, and emotional disabilities. The counseling process is interested in helping clients achieve independence in their work and personal life. Rehabilitation counselors apply communication, behavioral goals, social integration, and vocational therapy to help meet their client's goals.

Rehabilitation counseling also focuses on the use of assessment, diagnosis, and treatment planning like counselors in other fields. What makes them different is that they are often focused on case management and advocating for their clients. Advocacy is used to make changes in the environment to remove barriers and use policy to create more access to help for their clients. Counselors may focus on rehabilitation work in private practice, hospitals, colleges, universities, government agencies, and more.

Development

At its start, rehabilitation counseling was focused on adults with disabilities. In the 1940s programs in education began to focus on helping people with disabilities. But it wasn't until 1954 that the federal government provided funds to establish rehabilitation programs. At this time federal and state vocational rehabilitation programs were funded and regulated by different governing bodies. These programs help place people with disabilities in jobs and careers. The creation of professional associations for rehabilitation counselors, such as the Commission on Rehabilitation Counselor Certification and the Council on Rehabilitation Education, has solidified the field of rehabilitation counseling.

Current Status

The Bureau of Labor Statistics predicts that jobs in rehabilitation counseling are expected to grow at a rate that is greater than the average career. In the United States, many rehabilitation counselors currently work in different arenas. Rehabilitation counselors work most commonly in state rehabilitation programs, in social service agencies, and in colleges as disability or career counselors.

The biggest need for rehabilitation counselors is within federal- and state-funded vocational rehabilitation programs. Rehabilitation counselors can work in the not-for-profit corporate sector through career counseling or at the administration level in supervising staff or directing programs for people with disabilities. Some may supervise staff in case management programs that serve people with disabilities.

In addition to this, rehabilitation counselors may work with independent living centers doing community engagement, advocacy, and referrals for people

with disabilities. Rehabilitation counselors who have a business or corporate focus also work as consultants, establishing their own private service agencies. Counselors working with corporations focus on community relations or corporate service, serving as liaisons between companies and charities or service programs.

Legally, colleges and universities are required to make accommodations for students with disabilities. This occurred as a result of the Americans with Disabilities Act. Most academic settings have an office and staff dedicated to helping students with disabilities. Services offered in college disability services usually include counseling, technology assistance, referral services, note taking, and tutoring. The help they provide is usually to ensure that students achieve academic, social, and emotional success in college.

Alexandra Cunningham, PhD

See also: Certified Rehabilitation Counselor (CRC); Rehabilitation Counseling; Vocational Counseling

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Reinforcement

In psychology, the term "reinforcement" is used to describe any stimulus that increases or strengthens the likelihood of a certain response or behavior.

Definitions

- **Behaviorism** is a theory developed by psychologists John B. Watson and B.F. Skinner that is concerned with measureable, observable behavior rather than inner processes such as thoughts and feelings.
- **Extinction** refers to the diminishing of a conditioned response, which occurs when a stimulus no longer has an effect on behavior.
- **Operant conditioning,** a theory of learning proposed by B.F. Skinner, teaches that behavior can be modified through the use of positive and negative reinforcements.
- **Punishment** is a consequence imposed following an operant response that decreases, or is meant to decrease, the likelihood of the same response occurring again.

Description

Reinforcement, or any stimulus that prompts behavior to increase or strengthen, is a principal component of behaviorism. When actions are reinforced, they are more likely to occur again. Reinforcement can be categorized as either primary or secondary. Primary, also known as unconditional reinforcement, is naturally occurring and does not require any learning to take place. Air, water, food, sleep, and sex would be examples of primary reinforcers. Secondary reinforcers, those dependent on conditioned reinforcement, can be both positive and negative.

Based on the theory of operant conditioning, coined by behaviorist B.F. Skinner, the introduction or removal of positive and negative reinforcers is responsible for behavior change. "Positive reinforcement" refers to the adding of stimulus (i.e., praise, tangible rewards such as toys, prizes, tokens, money) in hopes of increasing the desired behavior; "negative reinforcement" refers to the removal of a stimulus (i.e., time out, ignoring, removing privileges) in order to increase the desired action. Negative reinforcement differs from punishment, or a consequence that when introduced is likely to result in a decrease or disappearance in the behavior. When a conditioned response is extinguished, due to an ineffective stimulus, this is referred to as extinction. Reinforcement can be dispensed continuously or at variable schedules, and at fixed times or at set intervals. The schedule at which the reinforcement is delivered typically correlates with differing rates (in terms of duration, frequency, and magnitude) of the desired behavior. Once a behavior is acquired, it is advised to change this schedule in order to prevent the behavior from extinction.

Current Status and Impact (Psychological Influence)

In contrast to psychoanalytic and cognitive-based theories, the founding fathers of behavioral research, Ivan Pavlov, Edward Thorndike, John B. Watson, and B. F. Skinner, proposed that behavior change occurs in response to external stimuli rather than internal processes (thoughts and feelings). Countless experiments have been conducted since in support of this theory. The salience of positive reinforcement in particular has been well studied, and its concepts have been applied to the fields of psychology, sociology, politics, and education. Behavior modification programs, token economies, and learning communities have all derived from positive reinforcement concepts. Parents and teachers who employ these types of strategies report positive effects related to behavior, affect, motivation levels, self-concept, relationships, and achievement. Negative reinforcement, though also proven effective, is more susceptible to extinction if not delivered consistently.

Melissa A. Mariani, PhD

See also: Applied Behavior Analysis; Behavior Therapy

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Relapse and Relapse Prevention

Relapse is the recurrence of symptoms after a period of improvement or recovery. Relapse prevention is the effort to maintain health and prevent the recurrence of relapse.

Definitions

- **Addiction** is a chronic disease of the brain that involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Addiction recovery** is the state of abstinence from addictive behaviors, usually achieved through self-reflection and spiritual exploration.

Description

Although the original use of the terms "relapse" and "relapse prevention" was strictly medical, both words have come to be used in the field of mental health in an extended way. Relapse was first extended to those combating addiction, especially to alcoholics and drug users. It is today often applied to the behavior of those suffering from severe personality disorders when treatments they have been using, whether drugs or cognitive behavioral interventions, fail. For example, this can happen for people experiencing psychosis who might not be properly medicated.

While there are different measures of relapse rate, two widely accepted criteria are a significant worsening of symptoms after a more stable period and the need for rehospitalization within a few years of first hospitalization. Not adhering to medication is a principal cause of relapse, especially in schizophrenic or bipolar patients.

Relapse is a constant and difficult challenge in the treatment of mental disorders. Success in changing or controlling problematic behaviors depends on many individual, social, and medical conditions. When a person with behavioral issues is confronted with the elements that encourage or provoke his or her dysfunctional behavior, there is always a risk that the person's ability to respond with appropriate coping mechanisms may fail. The factors that cause relapse can vary but might include the availability of a drug, the presence of a person who is threatening, or simply the terror of being out of control in a social situation.

Relapse prevention is an activity of vital interest to the person suffering from behavioral issues. It is also important to the person's family and friends, as well as professionals for both humane and economic reasons since hospitalization and treatment can be expensive. Comprehensive treatment plans need to include the

identification of high-risk situations. Identifying key relapse triggers and emergency interventions that may go from the most critical, such as hospitalization, to a simple low-impact therapy highlights the dangers and reinforces the patient's effective coping strategies. Educating the patient about the dangers and possibilities of behavioral relapse also lays the groundwork for the possibility of a more cooperative intervention if one should be needed.

A holistic approach to relapse prevention should include regular interactions with counselors and medical professionals. This includes supervising and updating drug protocols and a range of healthy living activities. Meditation and mindfulness exercises have been shown to have positive results in the treatment of such behavioral disorders as depression and anxiety. Learning to control the stressors in daily life, regular exercise, and a healthful diet are activities that reinforce calm and balance in those being treated both with drugs and with cognitive behavioral activities.

Current Status and Impact (Psychological Influence)

Since the 1990s many studies have been done on the effectiveness of a variety of relapse prevention programs. This is partly because it has become clear that antipsychotic drugs do not completely resolve hallucinations and delusions in some patients. In addition cognitive behavior therapy has been shown to be effective in controlling symptoms in such diverse behavioral dysfunctions as depression, obsessive-compulsive disorder, bipolar disorder, and schizophrenia.

Recent studies indicate that family intervention and family involvement with the patient significantly decrease the relapse rate. In clients diagnosed with schizophrenia, the involvement of relatives in the treatment protocols was seen to reduce the relapse rate by as much as 20%. This seems to support a movement away from sole dependence on medications to control symptoms and reinforces the importance of psychosocial interventions for more effective relapse prevention.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Alcohol Use Disorder; Substance abuse Treatment

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Relaxation Therapy

Relaxation therapy is a practice by which anxiety or tension in the mind is released in order to improve physical and mental health.

Definitions

- **Mindfulness** is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.
- **Relaxation** is the state of being free from tension and anxiety or the restoration of equilibrium following emotional disturbance.
- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description

During the 20th century, a group of famous yogis brought eastern meditative approaches to the West. These approaches were an alternative and a challenge to some of the practices of Western medicine. Therefore, groups began to develop a plan to legitimize relaxation and meditative practices through scientific study.

When research on meditation was conducted by medical practitioners at many universities, it turned out that quieting the mind and body helped subjects in achieving a state of physical and mental relaxation. These states of relaxation led to faster and better healing, both physically and psychologically. With scientific research to support its effectiveness, relaxation, meditation, and mindfulness therapies are now proven

therapeutic approaches and recommendations for those with mental and physical disorders. It is now practiced in many clinical settings under a variety of different names and with slightly different approaches.

Development

Dr. Edmund Jacobson was the first American physician to become widely known for using relaxation therapy as a therapeutic technique. He began using it especially to release tension from muscle groups. His seminal work *Progressive Relaxation* was published in 1938. In the 1950s, Dr. Joseph Wolpe, a behavior therapist, used similar ideas and therapeutic techniques to help treat anxiety and other behavioral disorders. Progressive relaxation became an effective method of stress management.

One of the most famous American physicians and advocates of relaxation therapy is Dr. Herbert Benson. He first published his popular book *The Relaxation Response* in 1976. It was based on the teachings of Maharishi Mahesh Yogi and his transcendental meditation that became very popular as a cultural phenomenon in the early 1970s. Cultural icons such as the Beatles went to India and learned from the Maharishi. In part, this helped popularize meditation and relaxation approaches among young people.

Dr. Benson's success was partly based on his ability to clearly explain the benefits of meditative relaxation. He could scientifically describe and show how the regular practice of relaxation therapy, with or without spiritual roots, could help treat a wide range of stress-related disorders. Dr. Benson went on to found Harvard University's Mind Body Medical Institute to study the methods and effects of meditation, mindfulness, and similar therapies on healing.

Current Status

Today many hospitals and clinical settings regularly use or recommend the use of meditation or relaxation techniques. These recommendations are made to decrease tension as a key factor in the promotion of recovery and better health. In clinical trials, patients suffering a diverse range of problems, from cardiac and cancer patients to those suffering from depression and anxiety disorders, all showed significant improvement through the use of relaxation therapy. With these results, it is no wonder that at least 20 million Americans practice meditation, yoga, and other methods of relaxation as a systematic treatment to prevent problems experienced by the mind and body.

Alexandra Cunningham, PhD

See also: Mindfulness; Mindfulness-Based Psychotherapies; Stress Management; Yoga

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Religion and Religiosity

"Religion" refers to the beliefs, doctrines, theology, and practices associated with specific religious institutions.

Definitions

- **Adherents** are people who are followers or members of a religion, cause, movement, or belief.
- **Fundamentalism** refers to strict, narrow, and demanding religious beliefs and practices.
- **Intrinsic** means to genuinely and deeply value something as if it's a natural part of who you are.
- **Sacred** is defined as those things that are holy, "set apart," and include objects, rites, and rituals.
- **Theology** refers to the study and concepts of the nature of God.
- **The Transcendent** refers to a spiritual force or entity that exists beyond the physical realm of ordinary consciousness.

Description

Americans' self-reported belief in God, or a universal spirit, has remained relatively constant since the 1940s. According to a 2011 Gallup poll, 91% of Americans sampled stated they believe in God or a universal spirit. Religion deals with important questions about life, relationships, morality, meaning, purpose, life after death, and how people should live their lives. Religious beliefs and practices evoke considerable passion for adherents, and few people, even atheists, remain neutral when it comes to their beliefs. Given the significance of religion in people's lives, mental health researchers have long been interested in the role religion plays in a person's mental, emotional, and psychological health. Researchers investigating the value of religion, religiosity, and religious practices have reached opposing conclusions. Religion has been described as a source of wholeness, balance, harmony, and peace—a pathway to healing, wisdom, maturity, and the highest of human potentials. It has also been criticized as being punitive, exploitive, irrational, pathological, dangerous, and opposed to the goals of mental health.

In the past the terms "religion" and "spirituality" were used interchangeably but are now used to characterize different aspects of the spiritual experience. Religion is distinguished as having an institutional dimension connected to specific faith traditions. The term "spirituality" has yet to be clearly defined and is most often used to describe a wide array of personal spiritual experiences that may, or may not, be associated with any specific religion. Researchers define religion in different ways but most agree on its basic elements, which include an organized communal belief system with shared doctrine, rituals, and practices.

Psychologist Kenneth Pargament (1950–), one of the leading scholars of religion and religiosity, broadly defines religion as a search for significance in ways related to the sacred. This definition is broad enough to be inclusive of many forms of organized religious traditions, some of which are very positive and some very negative. Religion is experienced through various ways of thinking, behaving, feeling, and relating. Thinking includes a person's beliefs, theology, and ideologies. Behaving includes rituals and practices such as singing, prayer, and participating in sacred rites. Feeling involves emotional states such as awe, peace, fear, and guilt. Relating includes social bonding through shared practices and interactions in congregations or fellowships.

People turn to religion for a variety of reasons. Some embrace religion for personal reasons such as finding meaning or peace or developing self-control. Others enjoy religion through social dynamics, such as developing connection with others. Many embrace religion as a way to know God, to connect with the transcendent, and to live according to a sacred set of values. The definition stated earlier also includes some very destructive aspects of religion, such as terrorism, hate speech against marginalized groups, and self-glorification.

Current Status and Impact (Psychological Influence)

Pargament analyzed the empirical research literature and drew several conclusions about religion and its impact on individuals. Some forms of religion are more helpful than others. Religion that is intrinsic and built on a secure relationship with God accompanied with a sense of connectedness to others is positively associated with a sense of well-being, higher self-esteem, greater tolerance, and positive religious coping. Religion that is imposed, built on fear and guilt, or unexamined does not have these benefits. How people cope with stressful experiences is related to their conceptions of divine power and can have a positive or negative impact on their mental health. Positive religious coping is associated with a sense of a loving and supportive relationship with God, spiritual connectedness to others, support of clergy and congregation members, and a belief that there is meaning and purpose connected to the experience. Positive religious coping is beneficial and has been linked to less depression and anxiety, greater stress-related personal growth, and better quality of life. Negative religious coping is associated with an unstable relationship with God, questioning the power of God, anger toward God, discontent with clergy and congregation members, attributing troubles to demonic forces, and an ominous view of the world. Negative religious coping has been linked to anxious and depressed mood,

greater psychological distress in disaster, poorer physical health, and more trauma symptoms.

There are advantages and disadvantages to all religions, even controversial ones. For instance, religious fundamentalism found in many of the world's religions has been associated with greater prejudice and bigotry toward blacks, women, Jews, and homosexuals, as well as narrow mindedness and willingness to support torture. In spite of these criticisms, strict belief systems offer some benefits to its adherents, including an unambiguous sense of right and wrong with clear rules for living; a distinct identity; social closeness, community, and belonging with like-minded believers; and a strong sense that they are supported and sanctioned by God.

Religiousness is more helpful to marginalized groups such as the elderly, the poor, the less educated, women, and minority groups. This may be due to positive social dynamics linked with religious communities, such as access to emotional support and resources. Religious beliefs and practices are more helpful during stressful situations that push people to the limits of their personal and social resources, such as the death of a loved one or job loss. Levels of religiosity vary a great deal, and those who more fully integrate religion into their daily lives benefit most. Individuals whose faith includes a larger supportive social group and blend their beliefs, practices, and motivations in a shared social context benefit most.

America is becoming increasingly diverse in its religious and spiritual affiliations, and traditional forms of worship, membership, and religious practices are significantly changing. Interest in how these changes are impacting American society will continue to be of great interest to mental health and social researchers.

Steven R. Vensel, PhD

See also: Pastoral Counseling and Psychotherapy; Prayer; Religious Coping; Spiritual Identity; Spirituality and Practices

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Religious Coping

Religious coping describes how individuals utilize their faith to evaluate problems and cope with stressful events.

Description

Religion plays an important role for religiously oriented people in coping with stressful life events by offering guidance, support, and hope. Religious beliefs can be a source of meaningful explanations for difficult events and provide a basis for defining and resolving problems. Kenneth Pargament, a leading researcher in religious coping, has conducted extensive research into how religious beliefs and practices may guide individuals in the coping process.

Pargament proposed that individuals whose religious beliefs and practices are a large part of their general orientation to the world utilize religious coping methods in response to stressful events. Building on Richard Lazarus's comprehensive theories of stress, appraisal, and coping, Pargament identified three religious coping styles: deferring, collaborative, and self-directing religious coping styles. These three styles represent consistent patterns of coping response and vary on two key dimensions underlying the individual's relationship with God. The first dimension focuses on who is primarily responsible to solve the problem: God or the individual. The second

dimension focuses on the level of individual activity in the problem-solving process: the individual is highly active and God is passive or the individual is passive and God is active.

The individual who takes an active stance in the problem-solving process and is solely responsible to resolve the problem characterizes a self-directing style. God is passive and not directly involved. This style stresses the power of the person rather than the power of God. This is not an antireligious stance but rather God is viewed as giving people the freedom and resources to direct their own lives. Although it is active, a self-directing style relies on personal rather than religious resources to resolve problems.

A deferring coping style is characterized by the individual who waits for solutions to emerge through the active efforts of God, thus deferring the responsibility of problem solving to God. From this perspective God is the source of solutions, rather than the person. This style stresses the omnipotence of the deity and relative insignificance of the individual who is submissive to God's power.

In a collaborative coping style, the responsibility for problem solving is held jointly by the individual and God. Neither is seen as a passive participant as God is active in the problem-solving process by prompting the person to do what is right through the inner voice of the Holy Spirit. A collaborative style relies on practices, which facilitate and maintain a personal relationship with god.

Building on Pargament's work Anna Wong-McDonald and Richard Gorsuch proposed surrender to God as a fourth coping style. Surrender represents the concept of self-relinquishment and differs from a deferring style in that it is not passively waiting for God to solve problems but rather an active choice to surrender one's will over to God's rule. The authors note that surrender may be more related to collaborative coping in that both the individual and God are active. However, surrender style differs from collaborative style in that when an individual's solution differs from God's solution the individual chooses to follow God's way. Surrendering to God requires self-sacrifice and obedience while the believer lets go of personal desires to follow God's way.

Steven R. Vensel, PhD

See also: Coping; Pastoral Counseling and Psychotherapy; Prayer; Religion and Religiosity; Spiritual Identity; Spirituality; Stress

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Resilience

Resilience describes an individual's ability to overcome challenges, adapt to new situations, and cope well when faced with adversity or stressful life events.

Definitions

- **Learned helplessness** is a psychological phenomenon that occurs when an organism, repeatedly subjected to aversive or painful stimuli in the past, continues to endure that stimuli in the present circumstance even though it has the means to escape it.
- **Learned optimism,** contrasted with learned helplessness, is a concept from positive psychology that teaches individuals the transformative power of replacing negative self-talk with optimistic thinking.

Description

Those who respond well to life-changing events including stress, trauma, loss, and adversity are characterized as resilient. Resilience is defined as one's ability to preserve adaptive capacity or "bounce back" when faced with challenges. Those who are resilient maintain healthy thoughts, feelings, and behaviors, which serve as "protective factors" to stress. Resilience is viewed as a process, or something that one does, rather than as a stable personality trait that one

either has or does not have. Findings suggest that a host of factors contribute to promoting resilience, the most salient being the existence of positive social support. Additional factors include possessing a healthy self-concept and adequate communication skills, as well as being able to self-regulate, problem solve, and set realistic goals.

Though it may seem to come more naturally to some, resilience can be taught and developed in anyone. Optimists, those who tend to have a positive outlook on the world, are likely to be more resilient than pessimists, or those who view the world through a negative lens. Positive psychologist Martin Seligman's research into learned helplessness resulted in a new concept he termed "learned optimism," which holds that replacing negative thinking with optimistic thought patterns results in psychological, emotional, relational, and physiological benefits.

Current Status and Impact (Psychological Influence)

Drawing on principles from positive psychology, choice theory, social learning theory, and cognitive behaviorism, resiliency research began in the early 1970s with the seminal work of clinical psychologist Norm Garmezy, deemed the "grandfather of resilience theory." Other researchers followed applying this concept to the areas of health, wellness, medicine, education, criminology, anthropology, and sociology. Ann S. Masten's work has been particularly influential in demonstrating how resiliency can impact student behavior and achievement.

There is evidence to support that resilience is commonly displayed by people all over the world of various ages, abilities, intellectual capacities, health, and economic circumstances. However, differences can exist based on one's culture as certain factors associated with resiliency, such as communication skills, degree of openness, and the value placed on relationships, can vary. Research indicates that resilient behavior can protect against further psychological harm, emotional distress, or health-related problems.

Melissa A. Mariani, PhD

See also: Learned Helplessness; Positive Psychology

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Resistance

In psychological terminology, resistance is a client's opposition, direct or indirect, to making change in psychotherapy.

Definitions

- **Ambivalence** is a form of a conflict between two courses of action (e.g., indulgence versus restraint) in which each course of action has perceived benefits and costs associated with it.
- **Motivational interviewing** is a counseling strategy for helping individuals to discover and resolve their ambivalence to change.
- **Psychoanalysis** is a theory of human behavior and a form of therapy based on psychoanalytic psychology. In psychoanalysis clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams.
- **Readiness for change** is the degree of preparedness of the conditions, attitudes, and resources needed for change to happen successfully. It is also referred to as stages of change.

Description

Many seek out counseling or psychotherapy and invest time and money for it. Yet not all will experience changes in their lives as a result of therapy. Some will

experience partial change, while others will experience none at all. Some even appear to sabotage efforts to change. Therapists expect clients to change and when they do not, it is not unusual for therapists to attribute this lack of change to a client's lack of cooperation. Signs of such noncooperation include missing or being late to appointments, not expressing feelings, talking too much, arguing, interrupting, and failing to complete homework.

Resistance to change is a problem that can complicate an individual's personal life and relationships. Understanding why individuals don't change is a complex issue since it can have several determinants, many of which are outside of conscious awareness. Because it is associated with a sense of unpredictability and uncontrollability, change is often resisted, whereas non-change is perceived as relatively safe. It should be noted that outright refusal by a client is not common. Rather, most instances of what is called either resistance or noncompliance may be better understood as ambivalence.

Developments and Current Status

Sigmund Freud (1856–1939) is credited with discovering resistance. It would become a central tenet of psychoanalysis. In fact, Freud considered that psychoanalysis should be a re-education in overcoming clients' resistances. Over the years, a number of other theories and models of resistance have been proposed. Most of these view resistance as failure of the client to cooperate with the therapist and the therapeutic process. However, in solution-focused therapy these behaviors would be considered an individual's unique way of cooperating. What is viewed as resistance may actually be an individual's natural protective mechanism and realistic caution about changing to quickly (Quick, 2008). From the solution-focused therapy perspective, it is the therapist's responsibility to discover and follow the client's unique way of cooperating.

Recently, psychologists Hal Arkowitz (1941–) and David E. Engle have proposed an integrative approach to understanding and working with resistance. In their book *Ambivalence in Psychotherapy* (Engle and Arkowitz, 2006), they emphasize that most resistance is a form of ambivalence, which they call "resistant ambivalence." Resistant ambivalence reflects discrepancies among beliefs relevant to change (beliefs associated with movement toward change and those associated with movement away from change). Most often clients are not fully aware of their beliefs and the discrepancies among them that cause resistant ambivalence. Because it is also an interpersonal phenomenon, it is best understood in the interpersonal context in which it occurs. When it occurs in a therapeutic setting, it is essential that the therapist recognize it as a temporary state rather than a personality trait.

Motivational interviewing (MI) has been found to be effective in resolving ambivalence. MI is focused on increasing the client's readiness for change. It utilizes a number of interventions to resolve ambivalent resistance by fostering change talk. There are four types of change talk that clients make and which therapists should recognize and effectively respond to. They are disadvantages of the status quo, advantages of change, optimism for change, and intentions to change. While MI is not the only strategy for dealing with resistance and resistant ambivalence, it is a powerful intervention that is commonly taught in psychotherapy training programs.

Len Sperry, MD, PhD

See also: Motivational Interviewing; Solution-Focused Brief Psychotherapy (SFBP); Stages of Change

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Restless Leg Syndrome

Restless leg syndrome is a sleep disorder characterized by an irresistible urge to move one's legs while attempting to rest.

Definitions

- **Non-REM sleep** is one of the two basic states of sleep consisting of stages 1, 2 (light sleep) and 3, 4 (deep sleep). It is also known as non-rapid eye movement and NREM sleep.
- **Parasomnias** are a group of sleep disorders characterized by abnormal events that occur during sleep, such as sleepwalking, talking, or limb movement.
- **Periodic limb movement in sleep** is a medical condition characterized by involuntary, jerking movements of the legs or arms.
- **REM sleep** is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain activity. It is also known as rapid eye movement and REM sleep.

Description and Diagnosis

Restless leg syndrome is a sleep disorder characterized by an irresistible urge to move because of uncomfortable or painful sensations in the legs when attempting to rest and causing a compelling urge to move the legs. The movement makes it difficult or impossible to sleep restfully. Symptoms usually begin within 15 minutes and usually result in significant sleep loss, fatigue, and problems with daily functioning. If asleep these involuntary leg movements, called periodic limb movements in sleep, begin and interrupt sleep.

Restless leg syndrome belongs to a group of sleep disorders called parasomnias. Common to all parasomnias are problems during arousals from REM sleep or partial arousals from non-REM sleep. The parasomnias include nightmare disorder, sleep terror disorder, sleepwalking disorder, and restless leg syndrome.

The likelihood of developing this disorder in one's lifetime is about 4%, a rate that increases until the age of 60. Females are 1.5 to 2 times more likely to develop this disorder than men. Approximately 90% of those with this disorder have periodic movements of sleep involving their legs (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit the urge to move their legs in response to uncomfortable and unpleasant sensations. This urge to move the legs begins or worsens during times of inactivity or rest. In addition, the urge is relieved by movement, is worse at night than during the day, and occurs only at night. These symptoms have occurred three times per week or more and have lasted for three months or more. The episodes must also cause significant distress for the individual or result in significant level of impaired functioning. In addition, the disorder is not the result of a substance, medication, other medical condition, or another mental disorder (American Psychiatric Association, 2013).

The cause of this disorder is not fully understood. However, it appears that iron deficiency and low levels of dopamine may bring on this disorder. Genetic factors also appear to be causative since this disorder commonly runs in family particularly when it is severe and begins early in life. Environmental factors and other medical problems are also associated with this disorder. Restless leg syndrome may begin or be exacerbated during pregnancy. It can also be caused or exacerbated by kidney failure and back problems, and in those with peripheral neuropathy (damaged nerves endings) common in those with advanced diabetes.

Treatment

Treatment of this disorder is based on the cause and severity of symptoms. Regular exercise, stretching, and sufficient sleep may relieve mild symptoms. Also, taking a hot or cold bath, using massage, losing weight, if one is overweight, and eliminating smoking and caffeine could reduce or control symptoms. If symptoms are being caused by iron deficiency or another medical condition, that condition is treated first. It the disorder starts during pregnancy, regular exercise and stretching may be prescribed to relieve symptoms. If symptoms do not improve, medications may be considered when symptoms are severe and interfere with sleep and daily functioning. Medication can be quite useful to both control the urge to move and improve sleep. Commonly used medications include anticonvulsants like Neurontin or sleep medications like Valium, Ambien, or Lunesta.

Len Sperry, MD, PhD

See also: Ambien (Zolpidem); Dopamine; Insomnia and Insomnia Disorder; Neurontin (Gabapentin); Sleep Disorders

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Retirement

Retirement is a phase of life and developmental period in which individuals are no longer working.

Description

America has often been considered a youth-oriented nation; however, with increasing life expectancies and lower birth rates, there is an increase in the aging population. This trend will have an impact on the culture to accommodate the needs of an aging population. Retirement is something that most Americans will face as a reality at some point in their life. Currently, the retirement age to receive benefits from Social Security is age 65; however, many people are extending their work years far beyond that age, whereas others are looking forward to early retirement.

With the aging baby boomer population, there has been an increasing awareness that retirement will be something different than it was for previous generations. Baby boomers are anticipating working either for enjoyment or out of financial necessity. It is imperative that in working with those preparing for retirement or just joining the workforce that the idea of financial awareness be explored.

For most people retirement is simply having the assets accumulated to provide income as opposed to going to work to earn income. However, with retirement comes financial concerns such as medical expenses, final expenses, and long-term care. Some of these people are able to plan for to some extent so that they can enjoy leisure time to the fullest during their retirement years.

The decision to retire can come as a personal decision or be recommended from one's employment or be due to health concerns. As the decision to leave one's occupation can carry a large impact, it is imperative that counselors are prepared to acknowledge this major life transition for that individual. The transition to retirement is a developmental phase that provides a shift in one's activity at home, work, and the community. It is also a time when the individual must consider his or her financial status looking at investments and future health-care access. It is a time for mindful planning to ensure security, especially with increasing averages of life expectancy. Retirement has moved from simply a description of moving away from the workforce to include new life opportunities. In preparation for retirement it is important to explore and be cognizant of the individual needs and expectations for life as a retiree.

While retirement has been commonly accepted as an absence of paid employment, it may also indicate a move from one form of employment to another or a new chapter of exploration for that individual. The social aspect of retirement must also be an area of exploration. What is this individual hoping to do or accomplish with his or her time? Who will be the active supports in his or her life? It is imperative that individuals be aware of these potential impacts.

Other considerations to be aware of are marital issues, mood changes, grief, caregiving demands, and life decisions. As previously mentioned, this is a developmental phase and the experiences of that are unique to each individual. Retirement counselors must be prepared to potentially address these issues. Returning home after working allows for changes in relationships. There is a period of "getting to know each other" that occurs again. The person may experience anxiety or depression connected to changes experienced from retirement. Generally, retiring is connected to aging and with aging comes health concerns. These health

concerns can be demanding and life altering based on how the individual would like to carry on with his or her remaining days.

Mindy Parsons, PhD

See also: Retirement, Psychological Factors

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Retirement, Psychological Factors

The psychological factors surrounding retirement are defined as mental and emotional factors that impact an individual who is considering retiring or has retired from his or her occupation.

Description

When one chooses to start considering retirement, numerous factors are considered and must be noted as potential impacts. These factors include those of psychological factors such as well-being, self-worth, social supports and networking, goals, and financial stability. A person's individual perception of retirement can largely impact his or her ability to participate or enjoy in separating from the work environment.

The notion of retirement is based on social and organizational policies. Some look at retirement as though it should be a process of transition from one phase of life to the next. In the United States, Americans generally start considering this transition as they approach mid-life, with retirement being considered generally around age 65. Knowing this it is imperative to reflect on some of the psychological factors present.

One argument has been made that when people retire there is a decrease in their cognitive functioning and that there is a connection between drop in employment rate and decrease of cognitive functioning. This argument has been supported by a hypothesis that those who are working are actively engaged in cognitive exercises. The recommendation is then that retirees engage in activities that stimulate the brain (e.g., puzzles) and an active lifestyle to allow for cognitive functioning to remain intact. However, there is also an argument that jobs that have high cognitive demands could lead to an earlier retirement because of the stressors connected to the position.

While we know that factors such as income, security, age, and health weigh in on decisions regarding retirement, there are other factors that carry an impact, such as psychological factors and psychosocial variables. The attitudes and expectations of working as well as life as a retiree have an impact on people. It has been hypothesized that those who expect retirement to be a positive experience are more likely to be interested in retiring early, whereas those who expect it to be negative are more likely to consider a later retirement. For instance, some measure their self-worth based on their job or career. Retiring for that person could be psychologically damaging. For some, retirement is considered a new beginning where they can engage in leisure activities, whereas for others it can bring anxiety due to potential decrease in social contacts, loss of structure, and confusion as to how to spend one's day as well as a fear of financial security.

The psychological resources found in sense of control and adaptation play significant roles. It has been suggested that three factors are connected to expectations of retirement. The first is the perceived self-efficacy of adjustment to retirement. Self-efficacy explores one's ability to effectively cope with changes to one's life that would be experienced in retirement. The second is anticipated social interaction after retirement, and the final factor is attitudes toward leisure.

Differences toward work itself can have an impact on retirement. This would include exploring the impact that working has had on a person and how his or her occupation has defined him or her and been connected to his or her self-identity. Along with this, it's important to consider the potential impacts on health.

With the continued aging of baby boomers, increase in life expectancy, and the rising depletion of social security, there is concern over the ability to maintain these functions that provide health-care support to retirees. The connection between work and health cannot be ignored. The ability to maintain health insurance is often a determinate for potential retirees. Changes to the current Social Security and Medicare system would no doubt influence and impact retirement behavior.

Another important consideration is simply that of happiness and exploring what the individual needs to maintain or increase happiness. Not everyone transitions successfully to retirement and so it's important to explore how an individual is impacted by retirement. The resources that help increase well-being and happiness are connected to social networks and supports such as closeness to a spouse and interactions with friends and family; and financial stability, resources, and goal-directed behavior. A key factor is continuing to find new opportunities and engaging in a fulfilling life per that individual.

Mindy Parsons, PhD

See also: Retirement

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Rett Syndrome

Rett syndrome is a neurodevelopmental disorder in children characterized by extreme difficulty with learning, communication, and movements. It is also known as Rett disorder.

Definitions

- **Autism spectrum disorder** is a neurodevelopmental disorder characterized by difficulty learning, communicating, and repetitive bodily movements.
- **Developmental disorders** are a group of mental disorders characterized by abnormal deficits or impairment in the development of learning, language, and coordination.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neurodevelopmental disorders** are a group of physiological disorders characterized by abnormal growth or functioning of the developing brain or nervous system.

Description

Rett syndrome is a neurodevelopment disorder that manifests at a very young age. Individuals with this disorder develop normally in the early childhood but experience a loss of previously learned ability between the ages of five months and four years. The occurrence of this disorder is rare and almost exclusively females. Rett syndrome is considered to be a lifelong, incurable disorder. It was named for the doctor who first described the disorder, Dr. Andreas Rett (1924–1997). This disorder is often confused with autism and autism spectrum disorders, but is distinctly different.

This disorder was previously included as a formal diagnosis in the previous edition of the DSM. It has been excluded in the new DSM-5 because it is considered a different etiology (cause) than the developmental disorders it was previously grouped with, such as autism. This disorder is caused by a specific mutation of the MECP2 gene. Also, this disorder differs from autism in that Rett syndrome affects primarily females, has a specific time frame of onset preceded by normal development, and has some other specific patterns. The first physical symptom to appear is typically a slowing in the growth of the head. This is followed

by a loss of ability in controlling one's hand and then abnormal walking movements. One of the distinct differences between this disorder and others is that much of the development in these areas is reversed. An individual who was once able to walk, talk, and use his or her hand just like others of the same age loses these abilities. Those with this disorder seldom are able to regain their functioning nor can they learn any significant new skills. They may also experience seizures. Commonly, individuals with this disorder often die in middle age.

There is no effective treatment for the reductions or elimination of this disorder. Treatment is focused on helping the individual and family cope with disorder and navigate the tasks of daily life such as toileting and dressing.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Autism Spectrum Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Developmental Disabilities

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Risk Management

Risk management is the identification, assessment, and management of potential and actual adverse events. Its purpose is to ensure the safety and/or well-being of all involved.

Definitions

- **Involuntary hospitalization** is the legal process whereby individuals are placed in inpatient mental health treatment against their will because they are a danger to themselves or to others. It is also called involuntary commitment.
- **Self-harm** refers to intentional acts of injury to one's own body, such as cutting or burning. It also includes causing self-harm through neglect. It is a maladaptive means for coping with emotional pain, rage, or irritation.

Description

Risk management is the identification, evaluation, and management of situations that may have possible or actual negative events. The events have potential for causing harm to one's self or others. Mental illness increases the possibility of risky and harmful behavior. In mental health clinical practice, the most common risk involves self-harm, violence toward others, or suicide. In such cases involuntary hospitalization may be necessary. Mental illness such as depression may lead to suicidal ideation and completed suicide. Individuals may become violent when they are involuntarily committed or mandated to treatment against their will. These individuals may be also at risk for running away from treatment or leaving against medical advice. Sometimes there is the potential for external violence from family members toward a mentally ill individual. Risk management also includes controlling for treatment errors such as misdiagnoses, inappropriate clinician behavior (e.g., sexual misconduct), and medication misuse or abuse by clients. The delivery of clinical services may help to reduce or eliminate potential risks and maximize client strengths.

Risk management protocol is beneficial not only to individuals (i.e., keeping them safe) but also to the agency or clinical practice. It assists in maximizing the organization's performance and ensuring the safety of staff members. The goal is to achieve a balance between managing risk posed by clients and maintaining a positive therapeutic alliance. A strong therapeutic relationship can help clients assume responsibility for their illness and treatment and manage risky behavior. Clinicians must know how to assess and manage risk and combine this knowledge with clinical judgment. They must assess the risk individuals pose to themselves or others while taking into account potential

threats to the individual caused by the clinician. Clinicians must be aware of risks to clients' autonomy, consumer rights, and self-esteem. Clinicians may need formal training to learn how to assess risk and use risk management tools.

The term "risk management" was originally used by Robert Irwin Mehr (1917–) and Robert Atkinson Hedges (1919–) in their book *Risk Management in the Business Enterprise* written in 1963. This was the first book to be written on the subject of risk management.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Crisis Intervention; Involuntary Hospitalization; Suicide

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Risky Business (Movie)

Risky Business is an iconic movie released in 1983, starring Tom Cruise and Rebecca De Mornay.

Description

Risky Business, written and directed by Paul Brickman, was launched amid a flurry of teen-coming-of-age sex comedies that were wildly popular in the 1980s. This film offers a satirical look at the basic human obsessions of guilt, lust, secrecy, and especially greed. The movie tells the story of Joel Goodson, an affluent high school senior left alone by his vacationing parents. Bowing to peer pressure to not enter college as a virgin, Joel uses his allowance for the services of a hooker.

After a frightening encounter with a transvestite, Joel is given the number of Lana (played by Rebecca De Mornay), who comes to his home and, following a night of teenage boys' dreams, refuses to leave as she's being pursued by Guido the Killer Pimp (played by Joe Pantoliano). Lana soon surveys her surroundings and realizes that with Joel providing a supply of affluent boys for her hooker colleagues, the two have the potential to make serious money with the spacious home currently unoccupied by his vacationing parents.

Perhaps one of the enduring qualities of the film is that *Risky Business* goes beyond raunchy sex humor to address the interplay of sex and intimacy. This movie is both intimate and sexy without sacrificing humor. It also offered one of the most iconic scenes in which Tom Cruise's character comes sliding across the floor in his pressed white dress shirt, underwear, socks, and black wayfarer sunglasses singing Bob Seger's "Old Time Rock and Roll." A search on YouTube shows hundreds of homages to and parodies of this classic scene.

Risky Business offered moviegoers insight into the many advantages of making money through any means necessary, whether it be legally or illegally and regardless of the consequences to you, your family, or friends. In this movie, the message is that money talks and it buys you happiness, including a Porsche, a mansion, and a blonde bombshell. In fact, one line in the movie blithely states that money may not be able to buy you happiness, but it can buy you things that make you happy.

At one point in the movie, Cruise's character asks his friends what their goals are for their lives. One friend succinctly replies, "Make money." His next friend adds, "Make a lot of money." This telling interaction among high school boys in this film helped to glorify the culture of greed and instant gratification so prevalent in American culture starting to unfold in the 1980s and 1990s.

Mindy Parsons, PhD

See also: Sixteen Candles (Movie)

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Risky Business is an iconic movie released in 1983 starring Tom Cruise and Rebecca De Mornay. The film helped to glorify the concepts of greed and instant gratification. (Warner Bros./Photofest)

Risperdal (Risperidone)

Risperdal is a prescription medication used to treat the symptoms of schizophrenia and bipolar disorder. Its generic name is risperidone.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Atypical antipsychotics** are a class of newer (second) generation antipsychotic medications that are useful in treating schizophrenia and other psychotic disorders.
- **Neuroleptic malignant syndrome** is a potentially fatal condition resulting from antipsychotic use characterized by severe muscle rigidity (stiffening), fever, sweating, high blood pressure, delirium, and sometimes coma.
- **Schizophrenia** is a mental disorder in which there is difficulty distinguishing real from unreal experiences. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description

Risperdal is in the class of antipsychotic medications known as "atypical antipsychotics" or second-generation antipsychotics. It is used is to treat the symptoms of schizophrenia, bipolar disorder, and irritability associated with autism. Although it is sometimes used in Alzheimer's diseases, Risperdal has not been approved for the treatment of behavior problems in older adults with dementia. Older antipsychotic medications work by blocking dopamine. In contrast, Risperdal is thought to work by maintaining a balance between dopamine and serotonin neurotransmitters (chemical messengers) in the brain. This difference may account for its lower side effect profile and having fewer medication interactions than older antipsychotics.

Precautions and Side Effects

Risperdal should not be used in older adults with dementia because of the increased risk of stroke and heart failure. Those with a history of cardiovascular disease, abnormal heart rhythm, seizures, or low blood pressure should take Risperdal only after discussing the risks and benefits with their doctor. Women who are pregnant should not take Risperdal and should alert their physicians if they become pregnant while on Risperdal. Infants born to mothers who took Risperdal during pregnancy may develop extrapyramidal symptoms and withdrawal symptoms, including agitation, trouble breathing, and difficulty feeding. Breast-feeding is not recommended while taking this medication. Risperdal has been associated with the risk of developing hyperprolactinemia, a blood disorder caused by heightened levels of the hormone prolactin. Symptoms include amenorrhea and lactation in women, and breast development and erectile dysfunction in men.

The most common side effects of Risperdal use include are drowsiness, dizziness, lightheadedness, drooling, nausea, weight gain, and tiredness. More serious side effects include severe dizziness, fast and irregular heartbeat, fainting, and seizures. Rarely, Risperdal can cause a serious condition called neuroleptic malignant syndrome. Risperdal does interact with some other medications. Using Risperdal with blood pressure medications can lead to lowered blood pressure while standing. Risperdal does interact with medications for heart burn and acid reflux such as Reglan. It also increases the sedative effect of alcohol, antihistamines such as Benadryl, medications for sleep or anxiety such as Xanax, Valium, and Ambien, muscle relaxants, and narcotic pain relievers like codeine.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Schizophrenia

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Ritalin (Methylphenidate)

Ritalin is a stimulant medication prescribed for the treatment of attention-deficit hyperactivity disorder. Its generic name is methylphenidate.

Definitions

- **Attention-deficit hyperactivity disorder** is a mental condition characterized by a lack of concentration, impulsive or inappropriate behavior, and hyperactivity.
- **Stimulants** are psychoactive substances that increase wakefulness or alertness. They may be prescribed to treat ADHD and autism; they are also illegally abused.

Description

Ritalin is used primarily in the treatment of attention-deficit hyperactivity disorder (ADHD) in children and adults. It is best used as part of an ADHD treatment program that includes psychological, educational,

and social interventions. Ritalin can help those with ADHD increase attention, focus on activities, organize tasks, and improve listening skills. It is also used to treat a sleep disorder (narcolepsy) and sometimes used to decrease sedation and lethargy from opioid pain medications.

Ritalin is a mild stimulant that is believed to work by activating the brain's arousal system and produce a stimulant effect. This increases levels of electrical activity in the brain resulting in the seemingly paradox response of increasing alertness and attention span while decreasing motor restlessness in ADHD children. It is also believed to work by increasing dopamine levels in the brain.

Precautions and Side Effects

Ritalin use can produce physical and mental dependence. Withdrawal symptoms are common when Ritalin is stopped abruptly. These include anxiety, agitation, paranoid feelings, suicidal thoughts, depression, and sleep disturbances. Ritalin should not be given to those with high levels of anxiety, agitation, severe depression, emotional instability, or a history of alcohol or drug abuse. Nor should it be used by those with Tourette's syndrome, tic disorders, glaucoma, or alcohol or other drug dependence. Ritalin should be used cautiously by those with high blood pressure, those with a history of seizures, and women who are pregnant or are breast-feeding.

The most common side effects of Ritalin are nervousness, difficulties with sleep, tachycardia, and increased blood pressure. It may also cause dizziness, irritability, vision changes, drowsiness, and a poor appetite. Less common side effects include chest pain, palpitations, joint pain, skin rash, and uncontrolled movements or speech. Other side effects may also include a rapid or irregular heartbeat, stomach upset, nausea, headache, blood in the urine or stool, and muscle cramps. Reducing the dose or changing the time the medication is taken can reduce some side effects. Individuals taking Ritalin should have regular blood pressure and pulse checks.

Several drugs may interact adversely with Ritalin, including anticoagulants and drugs to prevent seizures, reduce depression, and treat high blood pressure. Physicians may reduce the dosages of these medications when taken simultaneously with Ritalin.

Len Sperry, MD, PhD

See also: Attention-Deficit Hyperactivity Disorder; Dopamine

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Road Rage

Road rage is an extreme form of angry or aggressive behavior by a driver of a car or other road vehicle.

Definitions

- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **Impulse control** is the degree to which an individual can control the impulse to act or the desire for immediate gratification.
- **Intermittent explosive disorder** is a mental disorder in DSM-5 characterized by impulsive, aggressive, violent behavior, or angry outbursts.
- **Psychological factors** are mental and emotional factors that affect behavior.

Description

Road rage is a violent criminal act involving the intention of a driver to cause physical harm to another human being. Road rage is aggressive driving that

involves a wide variety of negative behaviors. Some behaviors include tailgating, speeding, cutting off another vehicle, making rude gestures and verbal insults, hitting other vehicles, chasing other motorists, and intentionally driving in an unsafe and threatening manner. Road rage can even lead to more harmful and threatening behaviors and actions, such as altercations, assaults, shootings, and vehicular accidents. The result may be death.

Individuals who engage in road rage have been classified as selfish, vindictive, power hungry, and angry. Road rage may be caused by mental and behavioral impairments. It could involve driver frustration and anger, environmental factors (e.g., heavy traffic), and psychological factors (e.g., displaced aggression, the desire to blame others). Alcohol and substance abuse may also be contributing factors. Those who engage in road rage may also be violent in other areas of their life, particularly family or friends. It may also be a symptom of intermittent explosive disorder. In this disorder individuals may lack impulse control and act on their impulses in a destructive way.

Road rage is a real threat and a major concern to the safety of all road users. A study performed by the Road Safety Unit of the American Automobile Association (AAA, 1995) found in the United States alone more than 1,200 cases of reported road rage. In addition, more than 300 cases of road rage are reported annually that have ended in serious injuries or fatalities. Males with an average age of 33 years are more likely individuals to engage in road rage than females. The National Institutes of Health (DMV, 2015) reported that 5%–7% of nearly 10,000 drivers studied engaged in road rage. The study identified Intermittent Explosive Disorder as a possible cause of road rage. They also reported that the average offender engaged in road rage at least 27 times.

Len Sperry, MD, PhD,
and Elizabeth Smith Kelsey, PhD

See also: Intermittent Explosive Disorder; Rage

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Rogers, Carl R. (1902–1987)

Carl R. Rogers was an American psychologist best known as the originator of the client-centered approach to counseling and psychotherapy.

Description

Rogers's client-centered approach emphasized a person-to-person relationship between the therapist and the client. Rogers insisted that it was the client's role—not the therapist's—to determine the course and duration of therapy. Not surprisingly, this approach has come to be known as person-centered or client-centered therapy. Throughout his career, Rogers also made significant contributions to humanistic psychology, focusing on the worth and dignity of the individual and the human potential for personal growth, awareness, creativity, choice, and self-direction, as well as to humanistic approaches to counseling, which are those that focus on the worth and dignity of the individual and of the human potential for personal growth, awareness, creativity, choice, and self-direction.

Humanistic psychology is an orientation to psychology that assumes that persons are inherently good and that focuses on the exploration of human potential, while emphasizing wholeness and creativity.

Development

Rogers was born, raised, and schooled in a strict, religious environment beginning in Oak Park, Illinois. He then attended the University of Wisconsin where he studied agriculture. However, his interest in psychology was piqued while studying for the ministry at Union Theological Seminary in New York City. After two years he left the seminary and transferred to

Carl Ransom Rogers was an American psychologist who advocated for client-centered therapy. (Everett Collection Historical/Alamy)

Columbia University where he completed his PhD in clinical psychology in 1931.

While finishing his doctoral work, Rogers became involved in research and clinical work with youth at the Society for the Prevention of Cruelty to Children in Rochester, New York. He also lectured at the University of Rochester. Based on his work with troubled youth, he published his first book *The Clinical Treatment of the Problem Child*, in 1939. He then took the position of professor of clinical psychology at Ohio State University in 1940. There he published *Counseling and Psychotherapy* in 1942. In 1945 he became professor of psychology at the University of Chicago. Here he started researching his client-centered approach at the university counseling center that he helped establish. The initial findings appeared in two influential books: *Client-Centered Therapy* and *Psychotherapy and Personality Change*. He moved on to University of Wisconsin–Madison in 1957 where he published his best-known book *On Becoming a Person*. From there he moved to La Jolla, California, where he helped establish the Center for Studies of the Person. During that time he published *Carl Rogers on Personal Power* in 1977 and *Freedom to Learn* in 1983.

Impact (Psychological Influence)

Rogers's client-centered/person-centered approach to therapy has widespread acceptance and has been applied to education, nursing, social work, management, interpersonal relations, and international relations. Rogers's approach has significantly influenced other psychotherapy approaches. He was one of the first psychotherapy researchers to study therapy outcomes and treatment effectiveness, and pioneered the use of recording and transcribing therapy sessions.

Rogers was also a leader in the humanistic psychology movement which was a distinct counterpoint to psychoanalysis and behaviorism, the two reigning orientations in psychology at that time. He is widely regarded as one of the most influential forces in psychology. In a survey of professional psychologists, Rogers was ranked as the sixth most eminent psychologist of the 20th century (Haggbloom et al., 2002).

Len Sperry, MD, PhD

See also: Humanistic Psychotherapy; Person-Centered Therapy

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Role-Playing

Role-playing is a therapeutic technique that is designed to reduce the fear or discomfort that people experience in various social situations.

Definition

- **Social skills training** is a form of therapy used by teachers, therapists, and mental health professionals to help people with social challenges.

Description

Role-playing is accomplished by having clients act out scenarios where they represent the behaviors of themselves or of others. For example, a problematic relationship between a client and one of his or her parents could be dramatized by having the client assume the role of his or her parent. Clients are encouraged to do this with as much detail possible and play it out to gain insight or understanding. Reenactment of past traumatic events through role-play can provide therapeutic value.

Likewise, the experience of acting out feared or avoided social situations may give clients a greater degree of comfort in dealing with these situations in real life. The opportunity to practice and rehearse situations through role-playing is helpful. One of the ways it helps clients is to practice social skills and rehearse them in a simulated situation. Examples of feared or problematic situations might be giving a speech, engaging in small talk, or asking someone out on a date.

The focus during a role-play session is on the acting out of different scenarios, rather than simply talking through them. Different elements of theater are involved in role-play and more specifically in psychodrama. This can include the use of props or scene setting, which enhances and heightens the feeling of reality in the experience. Elements of psychodrama, including role-playing, indicate that the process is more important than the content. This means that the situations and the interactions are often more important than the words or ideas.

Development (History and Application)

Role-playing can be traced back to the work of the influential psychiatrist Jacob Moreno. He first introduced the idea of group psychotherapy to the United States in the 1920s. He developed and refined the theories and tools for role-playing and psychodrama.

Research has examined the advantages and disadvantages of role-playing. One argument is that under most circumstances role-playing is not a legitimate substitute for other psychological methods. Nevertheless, it is this kind of work that laid the foundations for interactive group therapy, which in turn is a key tool for work with different conditions and populations. Role-playing is often used in therapy with children, clients diagnosed with substance use disorders, and those who are socially challenged.

Current Status

Role-play has become a standard and accepted feature of psychological treatment and popular culture. It has been effective enough that it will continue to be used both for general social improvements and in therapeutic applications. When used effectively, role-play can greatly enhance a person's ability to handle situations that were previously difficult for him or her. But like many practices or tools that become commonplace in our culture, it can also be ineffective or even counterproductive. This happens when it is used in too casual or haphazard a manner. Carelessness and lack of fidelity to effective practices will diminish the potential effectiveness of role-playing. Whatever the original social skill capabilities of the participants may be, those skills can usually be improved with the opportunity to practice, which role-playing can help provide. Even small gains in understanding or comfort in dealing with unpleasant or problematic situations can improve the quality of one's social relationships and life overall.

Alexandra Cunningham, PhD

See also: Moreno, Jacob (1889–1974); Psychodrama; Social Skills Training

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Rorschach Inkblot Test

The Rorschach inkblot test is a psychological test of underlying personality structure revealed through an individual's responses to 10 inkblot designs. It is also known as the Rorschach psychodiagnostic test, the Rorschach test, and the Inkblot test.

Definitions

- **Projective personality test** is a psychological test where the test-taker responds to ambiguous stimuli that reveal his or her unconscious (hidden) emotions and personality characteristics.
- **Psychodiagnostic** refers to methods used to examine and analyze the factors that form human behavior, particularly abnormal behavior.

Description

The Rorschach inkblot test is a projective personality assessment based on the test-taker's reactions to a series of 10 standardized unstructured images or "inkblots." As a projective test, the Rorschach test assumes that individuals will interject their own personalities into neutral-appearing images. By so doing, they reveal their personality characteristics, hidden emotions, unconscious (hidden) conflicts, illogical thinking, reactions to others and the environment, and underlying motivations. It has been used in clinical settings to assess personality structure, to identify emotional problems, and to detect underlying thought disorders, especially in individuals who are reluctant to describe their thinking processes openly.

The Rorschach test is one of the most widely used projective test even though its influence has declined somewhat over the past several decades. It is commonly included in a battery (series) of tests used to assess personality and diagnose psychiatric problems and disorders, including depression, schizophrenia, and anxiety disorders in clinical settings. It is also used in forensic settings such as evaluations of an individual's competency to stand trial and in child custody evaluations. This untimed test is generally administered on an individual basis to adolescents and adults, but has been used with children as young as three years of age.

The test consists of the test-taker being shown inkblots on separate white cards and then being asked a set of standard questions about what he or she sees. Responses are tabulated, placed in summary form, and scored according to a set of criteria. Of the 10 original inkblots, 5 consist entirely of black ink on a white background, while 2 use black and red ink and 3 consist of several colors of ink.

The scoring of the Rorschach test is based on several factors, such as the content of the subject's response. The content observed by the subject is usually classified by the evaluator in one of such groupings as humans, animals, nature, clothing, or abstract. Based on the test-taker's responses and actions, the evaluator should be able to reveal certain underlying characteristics of the individual, such as any conflicts residing within the individual and any perceptions of the world or others. Because the evaluator must interpret the responses and actions of the subject, the interpretations of the subject by different evaluators may vary.

Developments and Current Status

Hermann Rorschach, MD (1884–1922), developed the Rorschach test. While he intended to publish the test with the 15 inkblot cards he regularly used, the only publisher who agreed to publish the test would only include 10 of his inkblots. Rorschach reworked his manuscript to include only 10 inkblots. The test was finally published in 1921. Rorschach did not provide a comprehensive scoring system.

Before the 1970s, five primary scoring systems were used and the evaluator was free to use any of them. In 1969, John E. Exner published the first comparison of these five systems entitled *The Rorschach Systems*. In it he introduced a comprehensive scoring system that has become the standard for scoring the test. The Exner system, as it has come to be called, uses clusters of Rorschach variables as the basis for evaluating responses. It utilizes a standardized procedure to assure unbiased scoring. It is considered to be an objective and reliable method with high reliability among different evaluators. The Exner system uses a computer-based scoring system, which provides

score summaries and personality descriptions of the test-taker.

Len Sperry, MD, PhD

See also: Minnesota Multiphasic Personality Inventory (MMPI)

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Rumination Disorder

Rumination disorder is a mental disorder characterized by repeated regurgitation (bringing up swallowed food), which is then re-chewed, swallowed, or spit out. It is also referred to as merycism.

Definitions

- **Aversive conditioning** is a treatment method of pairing specific behaviors with a negative or undesirable stimuli (behavior or sensation). It is also called aversive techniques.
- **Behavioral therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Bulimia nervosa** is a mental disorder characterized by recurrent binge eating with loss of control over one's eating and compensation for eating.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Feeding and eating disorders** are a category of DSM-5 mental disorder characterized by recurring disturbances in an individual's eating patterns and behaviors.

Description and Diagnosis

Rumination disorder is a mental disorder characterized by repeated episodes of regurgitating partially digested food. Following the initial regurgitation, individuals with this disorder then re-chew the food and either spit it out or swallow it again. Typically, those with this disorder do not experience nausea or other bodily symptoms that precede vomiting. Rumination disorder usually follows a pattern of regular feeding behaviors and is most common in infants and young children. It is one of the feeding and eating disorders in DSM-5. The prevalence of this disorder is unknown (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they regurgitate their food frequently for a period of at least one month. This regurgitation must not be caused by a medical condition known to cause vomiting, such as acid reflux. Also, the behavior cannot be the direct consequence of an alternative feeding and eating disorder such as bulimia. It is important to note that bulimia differs from rumination disorder in that individuals with bulimia exhibit a pattern of uncontrolled binge eating followed by purposeful vomiting in an effort to prevent weight gain (American Psychiatric Association, 2013).

The cause of this disorder is not well understood but is believed to vary between individuals. For some, this disorder manifests following a period of stress or trauma. For others, this disorder may occur with other feeding and eating disorders or medical conditions, including changes in medication regimens. The disorder can cause a number of adverse bodily conditions, including malnutrition, tooth decay, and other digestive conditions.

Treatment

Children with this disorder often outgrow regurgitation. However, treatment is preferred over waiting for behavior to change and is necessary in adults. Treatment for this disorder usually involves behavioral therapy. The aim of this therapy is two-fold. First, the

individual is taught behavioral techniques such as relaxation and diaphragmatic breathing (deep breathing from the lower abdomen). Second, mild aversive conditioning techniques are used. Specifically, regurgitation may be paired with a sour-tasting spray. The more the unwanted behavior (regurgitation) is associated with the aversive stimuli (the sour taste), the less likely the individual is to continue the behavior.

Jeremy Connelly, MEd, and
Len Sperry, MD, PhD

See also: Bulimia Nervosa; Feeding Disorder of Infancy or Early Childhood

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Sadistic Personality Disorder

Sadistic personality disorder (SPD) is a mental disorder characterized by a lifelong pattern of getting pleasure and power from inflicting pain and humiliation on others.

Definitions

- **PDM** stands for the *Psychodynamic Diagnostic Manual* and is a diagnostic framework that characterizes individuals in terms of their psychodynamics.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.
- **Sadism** is the act of gaining pleasure from inflicting physical or psychological pain on another.
- **Therapeutic alliance** refers to the relationship between a therapist and client that is a necessary component of effective psychotherapy.

Description and Diagnosis

Sadistic personality disorder (SPD) is a personality disorder characterized by sadism. Those with this disorder are focused on dominating and harming others. Common behaviors of individuals with SPD include emotional cruelty, intentionally manipulating others through the use of fear, and being preoccupied with aggressive and violent behavior. Besides deriving pleasure from imposing pain and suffering, these individuals mistreat and humiliate others to achieve a sense of power over them. Only small numbers of individuals with SPD engage in physical violence. Sadistic individuals tend to inflict mistreatment of others with unemotional calm. This distinctive feature is a form of detaching emotionally or expressing enthusiasm without guilt. This influences an individual with SPD to engage in domination and control (PDM Task Force, 2006).

According to the *Psychodynamic Diagnostic Manual*, SPD is diagnosable by the following criteria. Individuals with SPD are often preoccupied with the suffering and humiliation of others. The contributing developmental patterns for this diagnosis are currently unknown. Individuals with SPD take pleasure in their contempt and hatred for others. Their basic belief is they are entitled to hurt or humiliate others. Their view of others is that they exist as objects to be dominated. Furthermore, the primary way individuals with this disorder defend themselves is by detaching from others and believing they have supreme powers (PDM Task Force, 2006).

Treatment

Psychotherapy has not been shown to be an effective form of treatment for SPD. In part, this is because a therapeutic alliance is rarely developed. Individuals with SPD see human beings as objects that can be tinkered with, rather than developing a respectful relationship (PDM Task Force, 2006). But the main reason

why psychotherapy is not effective is such individuals do not want to change.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Personality Disorders; *Psychodynamic Diagnostic Manual* (PDM); Psychotherapy; Sexual Sadism Disorder; Therapeutic Alliance

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SAMe (S-Adenosyl-Methionine)

SAMe is a naturally occurring compound important in normal bodily functioning. It is also a nutritional supplement used to treat depression, osteoporosis, and other conditions.

Definitions

- **Amino acids** are organic compounds that combine to form proteins. Amino acids and proteins are the building blocks of life.
- **Antioxidant** is a substance that protects the body from damaging reactive oxygen molecules.
- **Glutathione** is a peptide made from amino acids (cysteine, glycine, glutamate) and sulfur. It functions as a powerful antioxidant and detoxifies the body of toxins like mercury and lead.
- **Homocysteine** is a sulfur-containing amino acid that can be recycled into methionine or converted into cysteine. High levels of homocysteine increase the risk of heart disease, stroke, Alzheimer's disease, and osteoporosis.
- **Methionine** is an amino acid that supplies sulfur and methyl groups needed for normal metabolism and growth. In the liver, methionine is converted into SAMe.
- **Methylation** is a chemical reaction where methyl groups are added to proteins, DNA, and other molecules to keep them functioning. For example, unless serotonin is methylated it becomes inactive and may result in depressive symptoms.
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. It occurs when medications that increase serotonin are taken together. Symptoms include high blood pressure, high fever, headache, delirium, shock, and coma.

Description

SAMe (S-adenosyl-methionine) is a natural substance synthesized (made) from methionine (an amino acid). When methionine is not fully converted to SAMe, homocysteine accumulates and can cause serious health problems. SAMe is involved in over 40 biochemical reactions in the body and plays a key role in the methylation process. As a methyl donor, SAMe is involved in regulating gene expression and the production of neurotransmitters important in regulating mood. It is also an antioxidant and helps to maintain cell membranes and levels of acetylcholine and glutathione, all of which enhance cognitive functioning and reduce neurodegeneration. As SAMe becomes depleted with illness and aging, it must be replaced by diet and supplementation. SAMe is thought to work by inhibiting the actions of serotonin, dopamine, and norepinephrine.

SAMe is used for treating attention-deficit hyperactivity disorder, anxiety, and depression, and for improving intellectual performance. Several studies have indicated that SAMe is effective in treating depression. It can improve symptoms of depression within two weeks, which is much shorter than for antidepressant medications. Other research suggests that SAMe can lessen attention-deficit disorder symptoms in adults. SAMe is also used for Alzheimer's disease, bursitis, chronic fatigue syndrome, chronic pain, dementia,

fibromyalgia, headache, heart disease, lead poisoning, liver disease, multiple sclerosis, spinal cord injury, seizures, migraine, osteoarthritis, Parkinson's disease, slowing the aging process, and tendonitis. Research shows it is particularly effective in relieving symptoms of osteoarthritis.

Precautions and Side Effects

Increased anxiety has occurred in those with depression when taking SAMe. SAMe should be used carefully by those with a history of bipolar disorder since it may aggravate symptoms of mania. When used with prescription antidepressant medications, life-threatening symptoms may occur. It should be used with prescription antidepressant drugs only under close medical supervision. Individuals should not begin taking SAMe until one week or more after stopping an antidepressant medicine, and two weeks or more after taking monoamine oxidase inhibitors such as Nardil or Parnate. Women who are pregnant or breast-feeding should use extreme caution when using it. To reduce the risk of withdrawal symptoms, SAMe should not be suddenly stopped, but rather discontinued. In addition, alcohol should not be consumed with SAMe. Those with Parkinson's disease have frequently reported a worsening of symptoms while taking it.

Side effects associated with SAMe include stomach upset, gas, vomiting, diarrhea or soft stool, constipation, and nausea. SAMe can also cause dry mouth, headache, mild insomnia, anorexia, sweating, increased thirst, blurred vision, restlessness, dizziness, and nervousness.

The use of SAMe with antidepressant drugs such as Elavil, Prozac, Celexa, and Parnate may cause serotonin syndrome. The combination can also cause insomnia. Individuals should not take it if they are also taking Robitussin DM and other cold medications, levodopa, Demerol, Talwin, or Ultram. SAMe should not be taken with other herbs and supplements that also increase serotonin levels, such as 5-HTP, L-tryptophan, and St. John's wort. On the other hand, SAMe may actually protect the liver from damage caused by some medications, including Tylenol, alcohol, estrogens, steroids, and several other prescription medications.

Len Sperry, MD, PhD

See also: Depression

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Sand Tray Therapy

Sand tray therapy is an expressive and projective therapeutic form of treatment that helps clients with mental health challenges by using sand tray materials (e.g., sand, a sand tray, and a collection of miniature figures).

Description

Sand tray therapy is a nonverbal form of communicating thoughts, feelings, emotions, and worldviews through the use of specific materials, such as sand, a sand tray, and a collection of miniatures, symbols, and figurines all guided by a trained therapist. It is a projective technique that helps a client better understand, process, and hopefully resolve intra- and interpersonal issues that have led to mental and emotional challenges. Sand tray, which is considered a form of play therapy, offers an effective therapeutic modality for a wide variety of diverse populations and for clients of all ages. Depending on the clinician's theoretical orientation, the tray can be processed and interpreted with the client or simply completed without interpretation and processing. Both have been shown to be effective for intrapsychic healing.

Sand tray is considered a cross-theoretical form of therapy, meaning that it is not simply used by clinicians trained in a specific theory. Processing sand trays can vary based on a therapist's theoretical orientation. Some use the term "sandplay," which refers to a specific form of sand tray therapy that was originated and developed in Jungian circles and processed based on Jungian theory. The common approach for sand tray is to explain the concept to the client and ask him or her to symbolically create his or her world in the sand using a selection of miniature objects and symbols. The client

creates the tray, while the therapist witnesses the process. When the client is finished, he or she is asked to explain the meanings of the symbols used in the tray. It is then photographed and the tray is dismantled.

The equipment needed for sand tray includes a shallow rectangular sand tray filled halfway with sand and painted blue on the inside so that when moving the sand away from an area, the client gets the impression of water below. The client is allowed to choose from hundreds of miniatures, figurines, and small objects that are displayed on open shelves to create a picture or story in the sand. These figures that are made available should include people representing a variety of historical periods, careers, and functions, as well as animals, houses, buildings, trees, religious symbols, bridges, cars, and mythical creatures.

The use of this therapeutic medium has been shown to serve as a transitional object that creates independence and also a sense of safety and security. It is a modality that offers a calming and soothing experience because it offers a voice to the part of the inner self that doesn't normally have a voice—essentially giving a voice to the inner workings of the unconscious. Most studies on sand tray have found that this method of play therapy is considered to be highly productive. It is a unique therapeutic approach that allows a client to express lost memories and unconsciousness fantasies, as well as promote health and healing.

The use of sand tray therapy is a unique therapeutic tool and arguably the most powerful for creating a metaphoric dialogue as well as for stimulating the visual and kinesthetic areas of the psyche by allowing the psyche to visually express itself. The kinesthetic experience associated with sand tray creates a mind-body dialogue unlike any other form of therapy. Through this form of therapy, it is possible, to be cross the mind and body threshold. The beauty of sand tray includes the ability to access and express this autobiographical memory, which offers a failure-free modality with a high likelihood of success and satisfaction.

Part of the powerful healing qualities of sand tray therapy is the use of miniatures. When these living symbols are used in the sand tray, there is a spontaneous healing in the collective unconscious within the client, which creates a stronger connection between the conscious and the unconscious. Although it may appear to be a chance selection, a client's choice of symbols carries both the personal meaning to the individual and the universally accepted meaning.

The use of sand tray therapy is an active psychological intervention that combines elements of play therapy and analytical work. There are times that clients, no matter what their age, simply don't have words to describe their feelings. Using the symbolic expression of sand tray helps the client find new solutions to his or her challenges. Even a small number of sandplay sessions can be therapeutic. A minimum of 5 to 10 sessions are ideal, but even one session has been found to offer therapeutic benefits. Notably, sand tray offers a failure-free intervention that requires no skill or creative talents, unlike drawing, painting, or writing.

Development and Current Status

Many credit the evolution of sand tray to writings by H. G. Wells, the author of the 1911 classic *Floor Games*, as he observed his sons playing with small toys on the floor. As he watched his boys, he discovered they actually were processing challenges with each other and other members of the family. Two decades later, Margaret Lowenfeld, a pediatrician based in London, remembered reading Wells's account of his sons' play and was able to adapt it to her own practice. She later founded the Institute for Child Psychology in London, where her sand therapy techniques were further refined and researched.

Lowenfeld believed that verbal language offered a limited means of communication, which led to her introducing miniatures in her playroom to be used symbolically as a means of expression of a child's inner world—without the need for verbalization. Within the sand tray, Lowenfeld found a projective tool that allowed for thoughts and feelings to be expressed on a symbolic level without the need for verbal communication and rational/conscious thought. Lowenfeld believed that this unique therapy was compatible with any theoretical orientation. Thus, today sand tray as a therapeutic intervention is used by many professionals with diverse theoretical backgrounds.

Mindy Parsons, PhD

See also: Expressive Arts Therapy; Play Therapy

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Organization

The Sandplay Therapists of America (STA) (www.sandplay.org) is a nonprofit professional organization, whose purpose is to promote education, training and research in sandplay therapy. STA is an affiliate of the International Society for Sandplay Therapy, which offers an international meeting ground for the exchange of knowledge and experience in sandplay.

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Satir, Virginia (1916–1988)

Virginia Satir was a pioneer in the family therapy movement. She was one of the first therapists to work with the entire family, instead of just individuals, and many of her methods are still in use today.

Description

Virginia Satir is best known for her contributions to family therapy. Virginia Satir is also remembered for her theories on family systems and how they affect individuals. According to Satir, family behavior was a result of the search for homeostasis, or a sense of balance. All actions were designed to achieve balance in the family. Families had predictable, repetitive patterns, and family members were affected by these patterns.

Satir graduated from the University of Wisconsin in 1936 and taught at a small rural school. She moved to a career in therapy in 1948 after attending the University of Chicago and earning a master's degree in social work.

At the time, it was common practice in psychotherapy to see only one member of a family at a time. However, Satir had discovered while teaching that her students were affected by her relationship with their families. She drew upon this experience and in 1951 she began seeing families together as a group, instead of just individual patients.

In 1959, she partnered with Don Jackson and Jules Riskin, and cofounded the Mental Research Institute (MRI) in Menlo Park, California. Satir began teaching family therapy courses at MRI in 1959 and focused her work on clinical practice and training. She became MRI's director of training. Under her, MRI received a grant from the National Institute of Mental Health in 1962 that enabled the Institute to offer a formal training program in family therapy.

She began teaching month-long training programs in family therapy at MRI in 1969 and continued to do so until her death in 1988. She also gave family therapy training and workshops around the world throughout her career. Satir was always deeply committed to working with patients, teaching, and sharing her belief in the potential of humans. Because of this focus on her practice, she never formally published her theories on family therapy.

Instead, Satir published a number of books about her experiences. The first was *Conjoint Family Therapy*, published in 1964. A collection of notes and essays about her work, this book also discussed her views on the importance of working with families, and how the family dynamic affects the individuals within. Satir published other books during her career, including *Peoplemaking* in 1972, *Satir Step by Step* (with M. Baldwin) in 1983, *The New PeopleMaking* in 1988, and *The Satir Model: The Family and Beyond* (with J. Banmen, J. Gerber, and M. Gomori), published in 1991, three years after her death.

Those who have studied her family therapy model found it to be based on four major components: a set

Virginia Satir was a pioneer in the family therapy movement. One of the first therapists to work with the entire family instead of individuals alone, she wrote in a commonsense style, and her psychotherapy methods are still used today. (Ed Maker/The Denver Post via Getty Images)

of presuppositions, basic constructs, the therapeutic process, and her methods. One of Satir's main presuppositions was that every family was trying to reach homeostasis, or balance. This makes family members behave in a way that maintains balance within the family relationship. Satir believed family members act and communicate predictably. Any disruption in the family dynamic creates conflict and causes the family to try to get back into balance. This conflict and rebalancing is normal. However, problems come up when these attempts to balance don't work or are blocked.

Satir placed great importance on the family in the process of therapy. In her sessions, Satir focused her efforts on the patterns in the family, instead of the events themselves that led to the problem. She felt issues were more likely to be resolved if the patterns of behavior were addressed and changed, rather than the event that caused the patterns.

Her work was also heavily influenced by the belief that all people have the potential to be good. She felt everyone had the capability to change and grow and that change is not just natural but essential.

Impact (Psychological Influence)

Satir was a dedicated teacher and trained other therapists during more than 430 workshops during her career. Charismatic and engaging, she wrote in a nontechnical style with commonsense advice, in a way that appealed to both professionals and laypeople. In 1987 the American Psychological Association made Satir an honorary member of its Division of Family Psychology.

The Satir model of family therapy continues to be taught and practiced by therapists working with individuals and families. At its core is the mission of therapists to help a client set positive goals in line with his or her whole self, as well as create a deep level of change, instead of just altering feelings or actions.

Satir and her teachings influenced the practice of family therapy around the world. Many therapists today draw from her teachings for their own family practices. As a result of her methods, patients can spend less time in therapy while achieving greater positive changes in their relationships and lives.

Mindy Parsons, PhD

See also: Family Therapy

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Savant Syndrome

Savant syndrome is a rare mental condition characterized by mental retardation but with very special abilities in memory, calculation, music, or art.

Definitions

- **Autism spectrum disorder** is a neurodevelopmental disorder characterized by difficulty learning, communicating, and repetitive bodily movements.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Traumatic brain injury** is an insult or injury to the brain from an external force. In DSM-5, this disorder is known as Neurocognitive Disorder Due to Traumatic Brain Injury.

Description

Savant syndrome is a rare condition in some individuals with severe mental retardation. Individuals with this syndrome exhibit many of the same inabilities in social skills, communications, and other arenas of functioning that are shared by others with the same mental disorders or injuries. However, they also exhibit a remarkable ability that is limited to a specific and narrow domain. These abilities may include incredible abilities to calculate numbers, recall facts, compose music, or create art. The savant's ability is referred to as an island of genius. It is an accurate description since their abilities are similar of those who are considered a genius or prodigy in a given field. One of the most common special abilities involves memory, with a high degree of idiographic (photographic) memory. While savants have considerable memory in a specific area, they tend to have limited memory in other areas.

Although this condition is rare, it is widely known in the United States. This recognition is in large part due to the popular 1989 movie *Rain Man*, starring Tom Cruise and Dustin Hoffman. The cause of savant syndrome is unknown. It occurs relatively frequently, but to differing degrees, in individuals with autism spectrum disorder. It is believed that up to 10% of individuals with autism spectrum disorder exhibit savant capability. This condition affects more males than it does females. However, this may be due to a similar disproportion in the number of males with autism spectrum disorder as compared to females. In addition, this condition has been diagnosed in individuals with other mental disorders and traumatic brain injuries. It should be noted that this syndrome is not a formal diagnosis in DSM-5.

Jeremy Connelly, MEd, and
Len Sperry MD, PhD

See also: Autism Spectrum Disorders; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Traumatic Brain Injury

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Schema-Focused Therapy

Schema-focused therapy is a type of psychotherapy whose aim is to modify a client's maladaptive schemas, coping styles, and modes of being by addressing basic unmet emotional needs.

Definitions

- **Attachment theory** is a concept of developmental psychology which emphasizes the types of bonds developed between parent and child and their effect on future psychosocial interactions.
- **Behavioral psychology** is a form of psychology whose aim is to study behavioral adaptation to an environment and its stimuli.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.

- **Cognitive psychology** is a form of psychology whose aim is to study thought and distorted patterns of thinking.
- **Cognitive therapy** is form of psychotherapy that focuses on changing maladaptive (faulty) cognitions and thinking patterns that lead to maladaptive behaviors.
- **Coping styles** are the behavioral reactions to schemas and maladaptive schemas.
- **Gestalt therapy** is a form of psychotherapy whose aim is to reduce cognitive distortions and increase a client's awareness of and centering in the present moment.
- **Maladaptive schemas** are self-defeating patterns of thought, beliefs, and values about self, others, and the world, which inform a person's negative observations and evaluations of life.
- **Modes of being** are the various states of consciousness, subjective emotional experience, or mind-set resulting from schemas and maladaptive schemas.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Schemas** are long-standing patterns of thought, beliefs, and values about self, others, and the world, which inform a person's observations and evaluations of life.

Description

Schema-focused therapy is a form of psychotherapy that can be utilized when other more common interventions are, or are predicted to be, ineffective. Typically, this involves severe and chronic mental conditions such as enduring depression and/or personality disorders. Schema-focused therapy addresses a client's maladaptive schemas, resultant maladaptive coping styles, and modes of being. Schema-focused therapy analyzes the client's essential themes of thought, affect, and behavior. Typically, these pathological themes are a result of years of unmet emotional needs. Schema-focused therapy utilizes practices from many theoretical orientations. Schema-focused therapy integrates the theories of behavioral psychology, cognitive psychology, cognitive behavioral therapy, object relations, attachment theory, and gestalt therapy. This integrative (combined) form of psychotherapy aims to create schema change in clients suffering from dysfunctional and pervasive patterns of being. It attempts to facilitate this change through empowering a client to honestly stay present with his or her feelings, and set limits to behavioral reactivity to these feelings. Schema-focused therapy also assists clients in identifying their central emotional needs and working with clients to plan ways to meet their core needs. It focuses systematically on problematic emotions, early childhood experiences, and the therapeutic relationship.

Development and Current Status

Schema-focused therapy was developed by psychologist Jeffrey Young (1950–) in the 1990s. It resulted from his experience treating clients with long-standing maladaptive thinking, feeling, behavior, and relational patterns. The primary roots of schema-focused therapy are in the cognitive therapy approach of psychiatrist Aaron Beck. Young has demonstrated that clients with pervasive pathologies experience more positive therapeutic outcomes when schema change, or even personality change, occurs. Over time, schema-focused therapy has been developed and refined. In 2003, research was published that identifies 18 different "early maladaptive schemas," each of which is paired with a proposed cause or origin and a typical presentation. In brief, the 18 early maladaptive schemas are Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation, Dependence/Incompetence, Vulnerability to Harm or Illness, Enmeshment/Underdeveloped Self, Failure,

Entitlement/Grandiosity, Insufficient Self-Control/Self-Discipline, Subjugation, Self-Sacrifice, Approval-Seeking/Recognition-Seeking, Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards/Hypercriticalness, and Punitiveness.

Layven Reguero, MEd, and
Len Sperry, MD, PhD

See also: Schemas and Maladaptive Schemas

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Schemas and Maladaptive Schemas

Schemas and maladaptive schemas are long-standing patterns of thought, beliefs, and values about self, others, and the world, which inform a person's observations and evaluations of life.

Definitions

- **Attachment theory** is a concept of developmental psychology which emphasizes the types of bonds developed between parent and child and their effect on future psychosocial interactions.
- **Behavioral psychology** is a form of psychology whose aim is to study behavioral adaptation to an environment and its stimuli.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **Cognitive psychology** is a form of psychology whose aim is to study thought and distorted patterns of thinking.
- **Cognitive therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) cognitions and thinking patterns that lead to maladaptive behaviors.
- **Coping styles** are the behavioral reactions to schemas and maladaptive schemas.
- **Gestalt therapy** is a form of psychotherapy whose aim is to reduce cognitive distortions and increase a client's awareness of and centering in the present moment.
- **Modes of being** are the various states of consciousness, subjective emotional experience, or mind-set resulting from schemas and maladaptive schemas.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Schema-focused therapy** is a type of integrative therapy whose aim is to modify a client's maladaptive schemas, coping styles, and modes of being, by addressing basic unmet emotional needs.

Description

Schemas and maladaptive schemas are enduring patterns of thought. They are generalizations about the self, others, and the world. Schemas and maladaptive schemas assist people in making real or imagined meaning out of the enormous amount of information encountered in life. Only a fraction of the information available to the senses is integrated into an individual's consciousness. Schemas are preconceived notions about what information is important and what is to be ignored. The preconceived notions of the self, others, and the world are established early in life, often

childhood or infancy. Repetitive or intense experiences establish enduring configurations of thoughts, beliefs, and values that a person uses later in life to make meaning out of stimuli. Schemas are cognitive templates that shape experiences. They filter and distort information into biased and predictable patterns of experiencing and relating. Through schematic processing (patterns of thinking) reality is repetitively distorted into preconceived notions of what an individual believes reality to be. These distortions of perception effectively alter the way in which individuals experience themselves, others, and the world. Schemas do not only operate upon information that an individual is exposed to. They also affect how information is retrieved from memory. In fact, schemas govern nearly all human thinking and perceiving. A schema is the mental representation of a simple object or event and can even be the basis for a complex value system. Schemas are stereotypic thinking that prevent the honest experiencing of novel information. New information instead is compared against what has been previously learned. Then only the schema is experienced and the novel information is largely ignored. This schematic processing or stereotyping can be understood as a type of jumping to conclusions about the nature of reality. In other words, these patterns of thought called schemas selectively abstract (filter) information that a person is exposed to or remembers. Schemas tend to be effective across multiple situations and persist despite the presence of evidence that challenges the schemas. Schemas are core beliefs and are not easily altered.

Schemas are adaptive or maladaptive. Adaptive schemas are patterns of thinking that assist an individual in achieving health and well-being. An example of an adaptive schema might be, "I can overcome this." Adaptive schemas allow an individual to selectively ignore information that does not assist him or her in living a meaningful life. In contrast, maladaptive schemas are self-defeating patterns of viewing self, others, and the world. Maladaptive schemas often cause and perpetuate unhealthy patterns of living. An example of a maladaptive schema might be, "I can never do anything right." There are 18 categories of maladaptive schemas, each of which is developed as a result of unmet emotional needs in early childhood. In brief, the 18 early maladaptive schemas are Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation, Dependence/Incompetence, Vulnerability to Harm or Illness, Enmeshment/Underdeveloped Self, Failure, Entitlement/Grandiosity, Insufficient Self-Control/Self-Discipline, Subjugation, Self-Sacrifice, Approval-Seeking/Recognition-Seeking, Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards/Hypercriticalness, and Punitiveness.

Development and Current Status

"Schema" is a term that was first used by the developmental psychologist Jean Piaget (1896–1980) in 1926. The concept was simultaneously being used by the educational and gestalt psychologists of the time. In the early 1930s, Frederic Bartlett conducted a series of psychological experiments which helped further the understanding of schema dynamics. His work with memory and memory recollections indicates that a person's memories are stored and subsequently altered according to the schemas that the individual maintains. Many years later, in the 1980s, researchers conducted similar studies that demonstrated that fake memories could be created as a result of schemas. These studies suggest that reality may be misperceived as a result of the individual's expectations and schemas. Schema-focused therapy was developed by psychologist Jeffrey Young in the mid-1990s. The most prominent influence of schema-focused therapy is the cognitive therapy approach developed by psychiatrist Aaron Beck and cognitive behavior therapy. The cognitive-based psychotherapies primarily help clients modify their distorted patterns of thinking. However, many clients with long-standing patterns of maladaptive thought, affect, and behavior, which include dysfunctional interpersonal relationships, are not responsive to simple thought or behavior change. Young demonstrated that clients with pervasive pathologies experience more positive therapeutic outcomes when schema change occurs.

Layven Reguero, MEd, and
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See also: Schema-Focused Therapy

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Schizoaffective Disorder

Schizoaffective disorder is a mental disorder characterized by psychotic symptoms such as hallucinations or delusions along with a severe mood disturbance.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.
- **Antimanic medications** are prescription drugs that are primarily used to treat bipolar disorder (manic depression). They are also called antimanics and mood stabilizers.
- **Antipsychotic medications** are prescribed drugs that are intended to reduce psychotic symptoms. They are also known as neuroleptics.
- **Bipolar disorder** is a mental disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more major depressive episodes.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Depressive episode** is a mental state characterized by sad mood, reduced ability to enjoy life, and decreased energy or activity occurring during the course of a bipolar disorder.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Family therapy** is a type of psychotherapy for families that focuses on improving relationships among family members.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Manic episode** is a mental state of expansive, elevated, or irritable mood with increased energy or activity. It is also called mania.
- **Mood disturbance** refers to various symptoms ranging from excessively happy (manic) to extremely sad (depressive) that are distressing or disruptive to daily life.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Psychotic symptoms** are a group of severe symptoms that include hallucinations, delusions, disordered thinking, or disorganized movement.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.
- **Schizophrenia spectrum and other psychotic disorders** are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, delusional disorder, and schizoaffective disorder.

Description and Diagnosis

Schizoaffective disorder is one of the schizophrenia spectrum and other psychotic disorders. Basically, schizoaffective disorder is a cross between schizophrenia (hallucinations or delusions) and a disturbance in mood (depressive or manic episodes). Both psychotic and mood symptoms occur simultaneously. But schizoaffective disorder is not schizophrenia, nor is it a depressive disorder or a bipolar disorder. Neither is schizoaffective disorder a depressive or a bipolar disorder with psychotic symptoms. DSM-5 criteria distinguish schizoaffective disorder from these other disorders.

The occurrence of this disorder is estimated to be relatively rare, affecting less the one-third of 1% of the U.S. population. It is considered to be more common in females than males, and it usually appears in late adolescence or early adulthood (American Psychiatric Association, 2013). For those with disorder, psychotic symptoms typically precede the mood disturbance.

According to the *Diagnostic and Statistical Manual, Fifth Edition*, individuals can be diagnosed with this disorder if they meet the following criteria. They must experience a long-standing, uninterrupted period of hallucinations or delusions along with a depressive or a manic episode. To distinguish schizoaffective disorder from a depressive or bipolar disorder with psychotic symptoms, the delusions or hallucination must last for at least two weeks in the absence of the depressive or manic episode at some time during the lifetime of the disorder. In addition, these symptoms cannot be attributed to substance use. There are two main specifiers of this disorder: bipolar type and depressive type (American Psychiatric Association, 2013).

The cause of this disorder is not fully understood. However, it is believed to be a combination of genetic and environmental factors. The genetic component has been suggested as a vulnerability to psychotic or mood disorders, as opposed to a single cause.

Treatment

Effective treatment of this disorder usually incorporates both medications and psychotherapy. Because of the presence of both psychotic symptoms and mood symptoms, medications are directed at both sets of symptoms. Antipsychotics are used to reduce psychotic symptoms. Antimanic medications are prescribed to treat manic symptoms. Antidepressants are used to treat depressive symptoms. Cognitive behavior therapy is often used with this disorder. It is focused on faulty beliefs and behaviors that underlie this disorder. Also, family therapy is used to help a family adjust to living with those with this disorder.

Len Sperry, MD, PhD, and
Jeremy Connelly, MEd

See also: Antipsychotic Medications; Bipolar Disorder; Delusions; Family Therapy; Hallucinations; Psychotic Disorders; Psychosis; Schizophrenia Spectrum and Other Psychotic Disorders

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Schizoid Personality Disorder

Schizoid personality disorder is a mental disorder characterized by a pattern of detachment from social relationships and a limited range of emotional expression. It is also referred to as schizoids and schizoid personality.

Definitions

- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.

- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.
- **Schizophrenia** is a chronic psychotic disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description and Diagnosis

The schizoid personality disorder is a personality disorder characterized by a pervasive pattern of detachment and social isolation from others, a limited capacity for interpersonal relationships, and a minimal range of emotional expression. Basically, individuals with this disorder prefer to be alone and derive little or no pleasure, support, or meaning from relating to others. Accordingly, they gravitate to solitary occupations (like night watchmen and security guards), live alone, avoid dating, and have no real friends. Others find them to be awkward, distant, cold, and formal in all social contacts. Nevertheless, they can perform tasks well if left alone. They seem humorless and aloof, and they daydream excessively.

The clinical presentation of the schizoid personality disorder is characterized by the following: behavioral style, interpersonal style, thinking style, and feeling style. The behavioral pattern of schizoids can be described as lethargic, inattentive, and occasionally eccentric. They exhibit slow and monotone speech and are generally non-spontaneous in both their behavior and speech. Interpersonally, they appear to be content to remain socially aloof and alone. These individuals prefer to engage in solitary pursuits, are reserved and reclusive, and rarely respond to others' feelings and actions. They tend to fade into the social backdrop and appear to others as "cold fish." They do not involve themselves in group or team activity. In short, they appear inept and awkward in social situations. Their thinking style can be characterized as cognitively distracted. That is, their thinking and communication can easily become derailed through internal or external distraction. This is noted in clinical interviews when these patients have difficulty organizing their thoughts, are vague, or wander into irrelevance such as the shoes certain people prefer. They appear to have little ability for introspection, nor ability to articulate important aspects of interpersonal relationships. Their goals are vague and appear to be indecisive. Their feeling style is characterized as being humorless, cold, aloof, and unemotional. They appear to be indifferent to praise and criticism, and they lack spontaneity. Not surprisingly, their rapport and ability to empathize with others is poor. In short, they have a constricted range of affective response.

The cause of this disorder is not well understood. However, these individuals tend to have a characteristic view of themselves, the world, and others, and a basic life strategy. They tend to view themselves as misfit from life and indifferent to everything, and so they they tend to view the world as a difficult place and that relating to others can be harmful. Accordingly, their basic life strategy and pattern is to trust no one and to maintain physical and emotional distance from others.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of detachment from others and restricted emotional expression. They do not desire nor enjoy close relationships, including family relationships. Except for first-degree relatives, they are unlikely to have close friends or confidants. These individuals typically choose solitary activities and have little, if any, interest in sexual relations. Not surprisingly, they seem indifferent to the feedback, including criticism, of others. They experience little, if any, pleasure in most activities. Instead, they exhibit emotional coldness, detachment, or flat affect.

Treatment

Unlike other personality disorders in which psychotherapy can be effective, the schizoid personality

disorder is less amenable to such treatment. Because of their relational style, these individuals rarely volunteer for treatment unless they begin to decompensate (get worse). Nevertheless, they may accept treatment if a family member demands it. Treatment goals are focused on symptom reduction rather than on restructuring of personality. Effective treatment interventions are those that focus on crisis resolution and provide consistency and support. Medications, such as antipsychotic drugs, are not useful with this disorder and should be avoided unless psychotic decompensation is noted.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Personality Disorders; Psychotherapy; Schizophrenia

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Schizophrenia

Schizophrenia is a chronic psychotic disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Definitions

- **Antipsychotics** are prescription medications used to treat psychotic disorders, including schizophrenia, schizoaffective disorder, and psychotic depression.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Psychoeducation** is a psychological treatment method that provides individuals with knowledge about the condition as well as advice and skills for reducing their symptoms and improving their functioning.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations, delusions, and disordered thinking.

Description and Diagnosis

As a diagnostic label, schizophrenia includes a wide variety of clinical presentations. Symptoms can vary so greatly from one individual to another that to present a classic textbook picture of the disorder is difficult. For example, the diagnostic presentation could be that of a hypervigilant accountant who suspects that others are plotting against him, or the housewife who believes she is controlled by her dead mother's voice. Or, it could be that of a withdrawn and apathetic college student who broods incessantly about the reality of existence. Symptoms also can vary within the same individual over time so that the individual may be floridly psychotic and totally unable to function one week, and then be capable of adequate reality testing and reasonable performance in the workplace the following week.

Three phases of this disorder can be described. The first is the *prodromal phase*. It begins with a noticeable deterioration of functioning prior to the active phase and involves the presence of specific symptoms. The *active phase* is recognized by the presence of certain characteristic symptoms combined with gross impairment in the tasks of life: work, love, and friendship. These include primarily "positive" psychotic symptoms. The *residual phase* gradually follows from the active phase. It is manifested by the same symptoms already described for the prodromal phase along with "negative" psychotic symptoms. An individual with a diagnosis of schizophrenia who recovers fully is usually considered to be "in remission." If no recurrences intervene over a period of five years without medication, the diagnosis is then changed to that of "no mental disorder." Those in remission frequently experience an acute exacerbation of their symptoms, possibly requiring hospitalization. The so-called rule of thirds describes the course of this disorder and its treatment. According to this rule, approximately one-third of all those who meet the criteria for the diagnosis of schizophrenia will recover fully after a single episode. Another one-third will experience periodic exacerbations of symptoms and periods of remission. The remaining one-third will experience an ongoing, chronic form of the disorder.

Arriving at a diagnosis of schizophrenia can be challenging. The symptom pattern of this disorder consists of some combination of "positive symptoms" (delusions, hallucinations, disorganized thinking, or bizarre behavior) and "negative symptoms" (flat affect, reduced motivation, and limited relationships). But these symptoms are not necessarily specific to schizophrenia, since they can occur in other mental disorders. That means none of these symptoms are pathognomonic (specific and always present) for schizophrenia. Some individuals will be present with all or most of these diagnostic features, while most others will present with only some of them.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit the positive and negative symptoms and three phases: prodromal, active, and residual phases. Individuals who meet criteria for this diagnosis exhibit characteristic symptoms during the active phase. Positive symptoms include delusions, hallucinations, disorganized speech, and grossly disorganized behavior. Negative symptoms include flattened affect and avolition. Symptoms are experienced continuously over a period of at least six months. During this time, approximately one month involves active phase symptoms, while prodromal and residual symptoms are experienced the rest of the time. Negative symptoms are more likely to be exhibited in the prodromal or residual phases of this disorder. Besides displaying such symptoms, the individual's functioning is also greatly affected. This is noted by markedly impaired functioning in interpersonal relations, work, and/or self-care. The diagnosis of schizophrenia is not given if schizoaffective disorder, depressive disorder, or bipolar disorder with psychotic features is present. Nor can the diagnosis be made if there is evidence of the direct physiological effects of a medication, a drug of abuse, or a medical condition. When there is a history of a communication disorder beginning in childhood or autistic spectrum disorder, the diagnosis of schizophrenia can be added only if prominent delusions or hallucinations have been present for at least one month. Previously, the DSM had listed schizophrenia subtypes: paranoid, disorganized, catatonic, undifferentiated, and residual type. But these subtypes have been removed from DSM-5 because of limited diagnostic reliability and poor validity (American Psychiatric Association, 2013).

Treatment

Since the mid-1950s antipsychotic medications have been the treatment of choice for schizophrenics, particularly in the active phase. The introduction of these medications has had a powerful influence on the management of schizophrenia. Some believe that antipsychotic medication is the only proven mode of treatment and that psychotherapeutic interventions are of little use. On the other hand, advocates of psychotherapy for schizophrenia argue that medication alone is not sufficient and that the effectiveness of medication depends on the psychosocial context in which it is given. They also contend that medication only reduces psychotic symptoms but does not affect the patient's social or personality functioning. For all practical purposes,

talking about a single "correct" treatment is not useful since schizophrenia is a syndrome consisting of a number of disorders. The range of treatments and combinations of treatments used reflect the variability inherent in this disorder. Usually, the most effective treatment regimens combined psychopharmacology and psychosocial therapies. However, those with severe symptoms or who are at risk of harming themselves or others may also require hospitalization.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Psychotherapy; Schizophreniform Disorder

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Schizophrenia in Youth

Schizophrenia in youth is a brain disorder in which children experience hallucinations, delusions, paranoid thoughts, and other psychotic symptoms.

Definitions

- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Psychotic disorder** is a severe mental disorder in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description

Schizophrenia is a condition where those who are diagnosed experience a break between their perceptions and the perceptions of others. To people with schizophrenia, hallucinations or delusions are persistent. They often see people and things, hear sounds and voices, or even smell things that are not experienced by others. It can at times be a mysterious and terrifying experience both for the person with schizophrenia and for their friends and family.

The younger the onset of schizophrenia, the more the person's cognitive or intellectual functions will be impaired. Fortunately, schizophrenia is rare in children but becomes more common with the onset of adolescence. It often manifests itself more clearly between the mid-teenage years and the mid-20s. It is estimated that about 1% of people around the world may suffer from schizophrenia. Slightly more men than women have been identified as experiencing the symptoms of schizophrenia.

Causes and Symptoms

The exact circumstances that cause schizophrenia are not clear. There is some research that genetics, environment, or a combination of both may give rise to the increased likelihood of a child being diagnosed with schizophrenia. Certainly a family history of schizophrenia increases the chances that a young person will suffer from it. But the question of why one family member gets it while another does not remains a mystery. Magnetic resonance imaging studies of the brain have shown that gray matter reductions in the

prefrontal area may indicate a familial risk for schizophrenia. Other factors that are being researched as possible causes of schizophrenia include prenatal exposure to viruses or toxins, inflammation or autoimmune diseases in childhood, having an older father, and experiencing certain traumatic head injuries.

Among the most common symptoms of schizophrenia are hallucinations. Hallucinations are defined as false sensory information, for example, seeing, hearing, or smelling things that others do not experience. The second warning symptom is delusions. Delusions are beliefs in things for which there is no evidence, for example, that your relatives are all aliens or that people want to poison you. Directly connected to delusions is the symptom of paranoia. This includes the belief that people are watching you, spying on you, or are out to get you.

The other major symptoms are radical changes in behavior, especially antisocial ones. Examples are refusing to bathe or brush teeth, hiding, refusing contact, adopting strange or new compulsive habits. When these behaviors are tied to strange and unverifiable ideas about themselves or people close to them, individuals should undergo clinical psychological examination.

Diagnosis and Prognosis

As a general rule, schizophrenia in youth can be reliably diagnosed using the same criteria employed with adults. But great care should be taken when examining teenagers for signs of schizophrenia because in adolescence young people typically experience emotional traumas and the struggles of making the transition to physical, social, and sexual maturity. Physicians need to be mindful of the difference between behaviors which may be considered acting out and something much more serious that may be a sign of possible schizophrenia and that should not be ignored.

Schizophrenia is a chronic mental disease, and therefore lifetime support and treatment is required for a child with the disorder to be successful later in life. A child's prognosis will depend on the early identification and management of symptoms through medication and therapy. People with schizophrenia who are able to manage their symptoms successfully can lead productive and successful lives.

Treatment

Schizophrenia is a complex mental disorder, and therefore, treating it requires a battery of different approaches. Those approaches include medication and psychosocial treatments. Certainly medication, principally antipsychotic medication, is an invaluable tool in helping the person with schizophrenia to effectively manage his or her delusions and hallucinations. At the present time, most people with schizophrenia are not institutionalized, and ensuring that schizophrenics get the necessary regular dosage of their medications can be a struggle and responsibility that falls on the shoulder of the family members or caregivers of a child with schizophrenia.

Families who have a young child with schizophrenia should develop a comprehensive plan for their family member. This needs to be done with the help and guidance of medical professionals, educators, and other caregivers. An effective plan will include not only medications but other treatment options such as cognitive behavior therapy, self-help and support groups, and family educational opportunities. These opportunities should be available over the course of the person's life in order to maximize positive behavioral outcomes and manage negative side effects.

Alexandra Cunningham, PhD

See also: Antipsychotics; Schizophrenia

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Schizophreniform Disorder

Schizophreniform disorder is a psychotic disorder with the signs and symptoms of schizophrenia but with a total duration of less than six months.

Definitions

- **Antipsychotics** are prescription medications used to treat psychotic disorders, including schizophrenia, schizoaffective disorder, and psychotic depression.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations, delusions, and disordered thinking.
- **Schizophrenia** is a chronic psychotic disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult.

Description and Diagnosis

Schizophreniform disorder and schizophrenia are exactly the same in presentation and differ only in duration, with schizophreniform disorder presentation lasting less than six months. In contrast, schizophrenia is a lifelong illness. The main reason for differentiating the two disorders is that those who are able to recover more quickly have a better lifetime prognosis (prediction of the course of the disorder). Indicators of good prognosis are an acute onset, the absence of prior episodes, the absence of bizarre behavior, the presence of specific stressors, or the presence of mood symptoms. The cause of schizophreniform disorder is not clear. However, it appears to involve genetic, imbalance brain chemistry, and environmental factors such as poor social interactions or highly stressful events that trigger the disorder in those with an inherited vulnerability to it. About 1 in 1,000 individuals develops this disorder, which occurs equally in men and women.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit the positive and negative symptoms and three phases: prodromal, active, and residual phases. Individuals who meet criteria for this diagnosis exhibit characteristic symptoms during the active phase. Positive symptoms include delusions, hallucinations, disorganized speech, and grossly disorganized behavior. Negative symptoms include flattened affect and avolition. Symptoms are experienced at least one month but no more than six months. Besides displaying such symptoms, the individual's functioning is also greatly affected. This is noted by markedly impaired functioning in interpersonal relations, work, and/or self-care. The diagnosis is not given if there is evidence of the direct physiological effects of a medication, a drug of abuse, or a medical condition.

Treatment

Treatment for schizophreniform disorder usually consists of antipsychotic medication and psychotherapy. Those with severe symptoms or who are at risk of harming themselves or others may need to be hospitalized. The goal of treatment is reduction of symptoms and return to one's previous level of functioning. If the symptoms do not improve within six months, the individual is likely to have schizophrenia. Unfortunately, about two-thirds of individuals with this disorder go on to develop schizophrenia.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Psychotherapy; Schizophrenia

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Schizotypal Personality Disorder

Schizotypal personality disorder is a mental disorder characterized by a pattern of acute discomfort in close

relationships, eccentric behaviors, and distorted thinking and feeling. It is also referred to as schizotypal and schizotypal personality.

Definitions

- **Asperger's disorder** is a mental disorder characterized by severely impaired social skills, repetitive behaviors, and narrow interests. In DSM-5 it is known as autism spectrum disorder without language or intellectual impairment.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychoeducation** is a psychological treatment method that provides individuals with knowledge about the condition as well as advice and skills for reducing their symptoms and improving their functioning.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.
- **Schizoid personality disorder** is a mental disorder characterized by a pattern of detachment from social relationships and a limited range of emotional expression.
- **Schizophrenia** is a chronic psychotic disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description and Diagnosis

The schizotypal personality disorder is a personality disorder characterized by a pervasive pattern of disorganized speech, disorganized behavior, and emotional blunting. While similar to the diagnosis of schizophrenia, individuals with this disorder do not experience delusions or hallucinations. However, they do demonstrate eccentric thinking and behavior, weird beliefs, and strange perceptual experiences. These symptoms and behaviors are recognized early in life and remain stable throughout life. Sometimes, individuals with schizoid personality disorder are misdiagnosed as having Asperger's disorder because of some similarities between the two disorders.

This disorder shares some features with the schizoid personality disorder, but those with the schizoid personality disorder do not exhibit eccentric behavior and peculiar thought content. Rather, those with the schizotypal disorder describe strange intrapsychic experiences, think in odd and unusual ways, and are difficult to engage. Yet none of these features reach psychotic proportions. It has been suggested that the schizotypal personality is part of the schizophrenic spectrum since schizophrenia occurs with increased frequency in family members of the schizotypal.

The clinical presentation of the schizotypal personality disorder is characterized by the following: behavioral style, interpersonal style, thinking style, and feeling style. Behaviorally, schizotypals are noted for their eccentric, erratic, and bizarre mode of functioning. Their speech is markedly peculiar without being incoherent. Holding a job is difficult for those with this disorder. They tend to quit or are fired from jobs after short periods of time. As a result, they may become drifters and move from job to job and town to town. They tend to avoid long-term responsibilities and in the process lose touch with common social expectations. Interpersonally, they are loners with few, if any, friends. Their solitary pursuits and social isolation may be the result of intense social anxiety, which

may be expressed with apprehensiveness. If married, their manner of relating tends to be superficial and peripheral and leads to separation and divorce in a short period of time. Their thinking style is described as scattered and ruminative, and is characterized by cognitive slippage (disconnected thoughts). Talking about superstitions, telepathy, conspiracies, and bizarre fantasies is common. Their way of thinking and self-expression is strange and vague but does not reach the level of delusions or auditory or visual hallucinations. Their feeling style is described as cold, aloof, and unemotional with constricted affect. They can be humorless and difficult individuals to engage in conversation probably because of their general suspicious and mistrustful nature. In addition, they are hypersensitive to real or imagined slights.

The cause of this disorder is not well understood. However, these individuals tend to have a characteristic view of themselves, the world, and others, and a basic life strategy. They tend to view themselves as on a different wavelength than others. They commonly experience being as estranged and disconnected from the rest of life. They then view the world as strange and unusual and that some have special powers. Accordingly, their basic life strategy and pattern is to be cautious while also being curious about these special magical intentions and powers of others.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a pervasive pattern of social and interpersonal deficits with significant discomfort and limited capacity for relationships as well as by perceptual distortions and eccentric behavior. They experience ideas of reference as well as unusual beliefs and thinking that influence their behavior, and which is inconsistent with their subculture. They also experience unusual perception, such as bodily illusions, and odd speech thinking. These individuals are prone to suspiciousness and paranoid ideation. They exhibit inappropriate or constricted emotions, and behavior that is odd, peculiar, or eccentric. With few exceptions, they lack close friends or confidants except for first-degree relatives. When they are around others, they experience excessive social anxiety that is not diminished by familiarity and is associated with suspicion and fears.

Treatment

Unlike other personality disorders in which psychotherapy can be effective, the schizotypal personality disorder is less amenable to such treatment. Because of their thinking and relational style, these individuals often find it very difficult to engage and remain in psychotherapeutic relationship. Typically, they are on medication and may be referred for psychotherapy that focuses on dealing with daily life issues. A realistic treatment goal for the schizotypal personality is to increase the individual's ability to function more consistently even though on the periphery of society. Specifically, successful management will likely incorporate psychoeducation. If these individuals can remain in long-term treatment, they may be able to increase their ability to function more consistently and with less dysfunction. In terms of medication, low-dose antipsychotic drugs have been found to be useful for the schizotypal personality even in the absence of psychotic features.

Len Sperry, MD, PhD

See also: Antipsychotics; Autism Spectrum Disorders; Personality Disorders; Psychotherapy; Schizophrenia

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School Phobia (School Refusal)

School phobia, also referred to as *school avoidance* and more recently as *school refusal*, is characterized

by an aversion to attending school due to excessive worry, fear, or anxiety.

Definitions

- **Absenteeism** defines either an excused or unexcused absence from school.
- **Psychoneurotic truancy** refers to school absenteeism characterized by negative affectivity or symptomatology related to worry, anxiety, fear, panic, hysteria, depression, or compulsive behavior.
- **School anxiety** defines when students experience feelings of worry, fear, or anxiousness brought on by the act of going to school, being at school, or separating from parents in order to attend school.
- **School refusal,** an umbrella term now used in lieu of the term "school phobia," describes child-motivated noncompliance in attending school, remaining in class for the entire school day, or both.
- **School resistance** is a phenomenon that occurs when a child or adolescent reacts to what he or she perceives to be injustices or excessive demands placed on them at school.
- **Separation anxiety** describes experiencing significant worry or distress from having to part from a significant person or people, usually a parent or guardian, for a given period of time.
- **Truancy** refers to excessive absentee behavior due to choice, not associated with fear, anxiety, or distress at school.

Description

Absenteeism associated with a student's negative experiences, symptoms, or feelings with previous attendance is commonly referred to as "school refusal." This was previously termed "school phobia," or "psychoneurotic truancy," though this phrase usually accompanies severe worry, paranoia, or distress, as with separation anxiety, post-traumatic stress, or social phobia. School phobia and school refusal are different from regular absenteeism or truancy. Absenteeism is simply not attending school for any excused or unexcused purpose, but not necessarily because of any adverse experience. Students who are truant would be more accurately characterized as "school resistant" and often miss school excessively out of choice, typically because they don't like going or have found something better to do with their time.

School phobia or refusal is characterized by certain physical, psychosomatic, and emotional ailments. Students may complain of stomachaches, headaches, or "feeling sick" in order to escape school. Relaying dislikes or fears pertaining to teachers, peers, or subject areas is also possible. Screaming, crying, pleading, and temper tantrums are likely to occur if the child is pressed to attend. Parents may struggle to get their child up in the morning, out the door, out of the car, and into the school building. If parents are successful in getting their child to school, the child may be unable or unwilling to attend the full school day. Frequent trips to the nurse's office are common as are calls home.

Development

School phobia and/or refusal are not part of normal childhood or adolescent development. Most students who report school refusal behaviors are between the ages of 5 and 14. This problem can impact both males and females. Those living in urban areas are more likely to have this issue as well. Transition periods have been linked to school refusal. Students entering kindergarten for the first time, those moving from elementary to middle school, or those moving from middle to high school may start displaying nonattendance patterns, usually out of anxiousness or fear of the unknown. Having to separate from a parent/guardian, leave familiar settings, or make new friends can prompt negative feelings. Likewise, changes in routine or schedule can prompt school refusal. Weekends, holidays, and summer vacations can bring on school refusal as children become over-accustomed to life at home, a place that often represents comfort and safety. School nonattendance may also arise after a stressful life event such as a move, illness, or death of a loved one.

Current Status and Results

Though many youth struggle with school compliance related to attendance at one time or another in their school-age lives, true school refusal affects only a small number; however, it can have a significant impact on a child's emotional, psychological, and academic well-being. School refusal can result in academic struggles, retention, or dropping out. Students with attendance issues are also more likely to have social difficulties. This is of concern as research indicated that forming positive relationships with peers and teachers plays a critical role in school success. Generalized anxiety disorder, post-traumatic stress disorder, conduct disorder, and depression have all been linked to school refusal patterns. It is imperative that parents and school staff address attendance issues immediately in order to prevent long-term consequences.

Melissa A. Mariani, PhD

See also: Phobic Disorders; Separation Anxiety Disorder

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School-Based Therapy

"School-based therapy" is a general term referring to a range of services, most commonly occupational and speech therapy, that are offered by certified or licensed professionals on school-based sites.

Definitions

- **Individualized Education Program/Plan (IEP)** is a written statement that outlines the present learning needs of a student who qualifies under the IDEA guidelines and addresses specific measurable academic goals to be attained annually given the accommodations, modifications, and services provided by a school in conjunction with outside support staff.
- **Individuals with Disabilities Education Act (IDEA)**, a federal law reauthorized and signed into law by President George Bush on December 3, 2004, ensures special education programs and support services to children and youth with disabilities.
- **Occupational therapy (OT)** refers to the treatment interventions that OT professionals employ with patients aimed at fine and gross motor skill development as well as improving overall physical, sensory, emotional, social, and academic challenges.
- **Speech-language therapy/speech-language pathology** is comprised of evaluation and treatment procedures to address communication disorders related to articulation, pronunciation, phonation, and intonation.

Description

"School-based therapy" is a broad term that covers the supplemental services offered to children with identified needs at local, educational settings during the regularly scheduled school day. Offering these services to students at school allows for treatment to be more consistently monitored and maintained. Though occupational therapy and speech-language pathology are the most common forms of school-based therapy, other services such as physical therapy and counseling support may also be provided. Occupational therapy focuses on improving fine and gross motor skills; handwriting difficulties are commonly referred to occupational therapists. Speech-language therapy assists students with communication problems. Supplemental services require that the student be properly identified

and evaluated and that proper consents be obtained prior to beginning treatment. Certified/licensed professionals who are contracted with school districts or specific schools schedule session times with students to work on skills both individually and in small groups. Students with disabilities are most commonly referred for these types of services, though students who are displaying difficulties in these areas who do not have a diagnosis might also be referred for treatment. For those diagnosed, the duration, frequency, and goals for treatment are typically outlined in the student's Individualized Educational Program/Plan, discussed and agreed upon by the school-based team comprised of administrators, teachers, counselors, Exceptional Student Education (ESE) coordinators, and support service professionals. This is a written, signed document that outlines the student's current level of functioning, the services that will be provided along with any additional accommodations/modifications to the general curriculum, and measurable goals to be attained. Students who qualify under Section 504 of the Rehabilitation Act of 1973 are also eligible for school-based therapies. Students with a 504 Plan do not require specialized instruction but do qualify for special services and accommodations that meet their specific circumstances.

Development (History and Application)

The Individuals with Disabilities Education Act (IDEA) was first enacted by Congress in 1975 to provide all students, including those with disabilities, a free and appropriate education. IDEA ensured that students who qualified for support services and required variations to the regular curriculum in order to be successful in school received them. On December 4, 2004, President George W. Bush signed a reauthorization of IDEA, the majority of regulations became effective July 1, 2005, and the final regulations were published on August 14, 2006. The new regulations include information related to identification, evaluation, notification and transfer of rights, monitoring and providing appropriate interventions, and transition. Students who would benefit from school-based therapies, regardless of diagnosis, were now eligible for services under the reauthorization.

Current Status

School-based therapies are regularly provided in K-12 educational settings. Students who require support services in order to be successful in school benefit from occupational therapy, speech-language therapy, physical therapy, and counseling support. Evidence suggests that early intervention is key in resolving difficulties that can impact a student's physical, cognitive, social, academic, and emotional development.

Melissa A. Mariani, PhD

See also: Individualized Education Plan (IEP)

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Seasonal Affective Disorder (SAD)

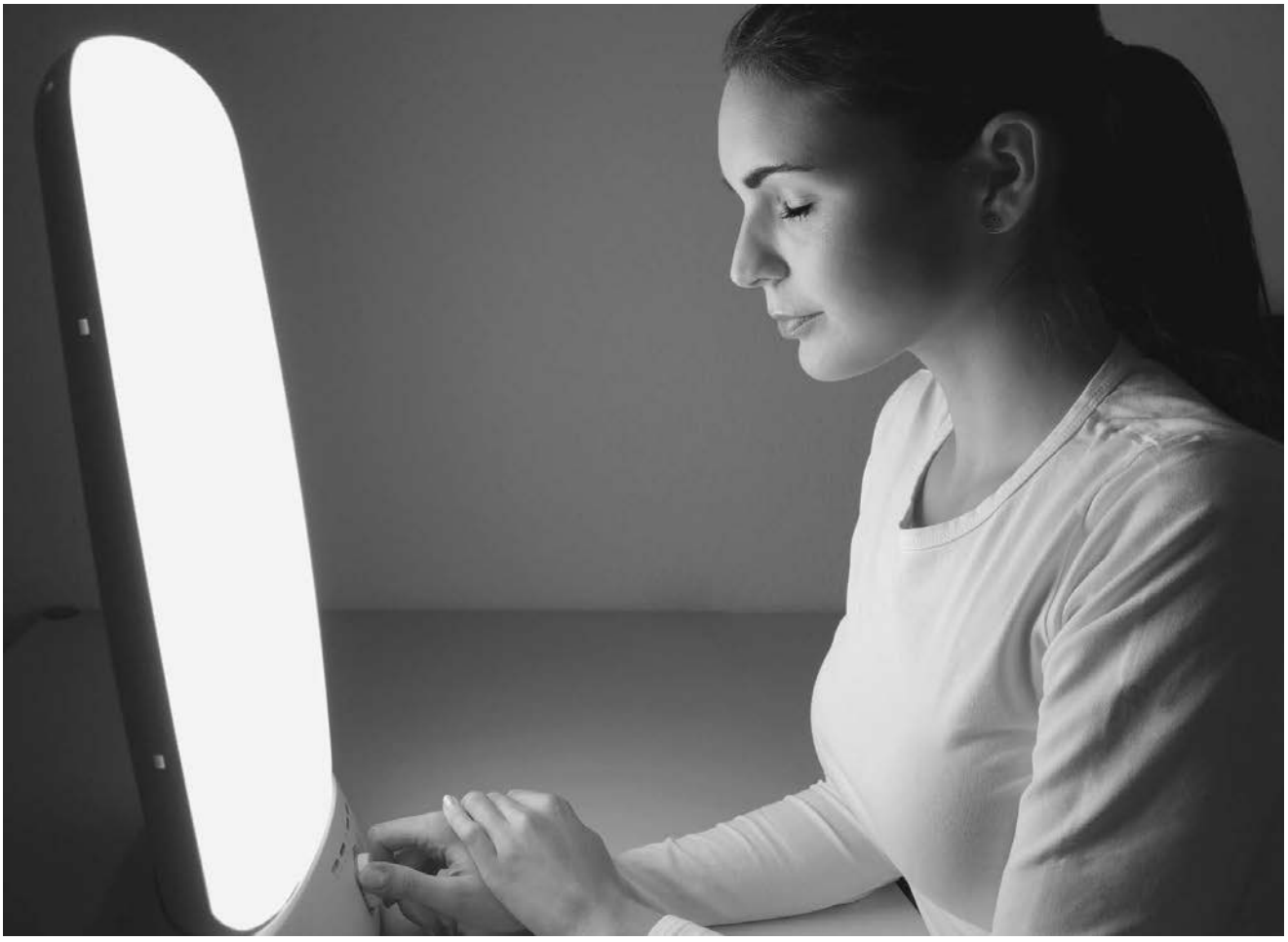
Seasonal affective disorder is a mental disorder in which depression comes on during the late fall and winter and begin to lift during spring and summer. It is also called SAD, winter depression, and winter blues.

Definitions

- **Circadian rhythms** are variations in biological activities that repeat during 24-hour intervals, which influence the amount and quality of sleep. It is also called a biological or internal clock.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Depression** is a sad mood or emotional state that is characterized by feelings of low

self-worth or guilt and a reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts the individual's daily functioning.

- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Light therapy** is a medical treatment in which doses of bright light are administered to normalize the body's internal clock and treat depression. It is also called phototherapy.
- **Major depressive disorder** is a mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning.
- **Melatonin** is a chemical messenger in the brain which regulates the sleep–wake cycle and promotes restorative sleep.
- **Serotonin** is a chemical messenger in the brain that regulates learning, sleep, mood, and appetite. It is involved in disorders such as depression and anxiety.
- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain resulting in symptom reduction.



Seasonal affective disorder (SAD) is a disorder in which depression sets in during the late fall and winter and then lifts during spring and summer. Exposure to light therapy can be an effective treatment. (Rocky89/istockphoto.com)

Description and Diagnosis

Seasonal affective disorder (SAD) is a type of depression characterized by the onset of depressive symptoms during fall and winter when there is less natural sunlight. Symptoms generally lift during spring and summer as sunlight increases. Those with this disorder usually experience sadness, moodiness, irritability, and loss of interest in usual activities. They may eat more and crave carbohydrates, gain weight, sleep more, or have daytime drowsiness. These symptoms usually begin in September or October and end in April or May. Less often, SAD may cause depression in the spring or early summer.

This disorder is more common among those living in northern states. Women are twice to three times more likely to suffer from the winter blues than men. DSM-5 does not consider SAD to be a separate disorder. Rather, it is a specifier, "with seasonal pattern," for major depressive disorder (American Psychiatric Association, 2013).

The specific cause of SAD remains unknown. However, it is likely that circadian rhythms (biological clock) and brain chemistry are factors. The reduced level of sunlight in fall and winter appears to disrupt an individual's circadian rhythms that govern sleep and energy levels. This disruption can lead to depressive symptoms. An imbalance in two brain chemicals, serotonin and melatonin, also appears to be involved. Reduced sunlight can cause a drop in serotonin levels that may trigger depression. Also, a change in seasons can lead to lower melatonin levels, which can disrupt sleep patterns and mood.

Treatment

Treatment for this disorder can include light therapy, medication, and psychotherapy. Light therapy mimics natural sunlight and can increase brain chemicals and improve mood. Light therapy usually begins working in two to four days and causes few side effects. While it works for many, some do not get better with light therapy alone. For that reason, medication and cognitive behavior therapy (CBT) are used alone or in combination with light therapy. Antidepressants can be helpful, particularly if depressive symptoms are severe. These include Paxil, Zoloft, Prozac, and Effexor. Such medications may take several weeks to reduce most or all symptoms. CBT can be helpful in identifying and changing negative thoughts and behaviors that may be making you feel worse. It can also increase skills to better cope with SAD.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Effexor (Venlafaxine); Light Therapy; Major Depressive Disorder; Melatonin; Paxil (Paroxetine); Prozac (Fluoxetine); Serotonin; Sleep; Zoloft (Sertraline)

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Second-Order Change

Second-order change involves changing a maladaptive pattern to a more adaptive pattern.

Description

Second-order change in psychotherapy involves assisting clients to change maladaptive patterns of thinking, feeling, and acting to a more adaptive pattern of thinking, feeling, and acting. Psychotherapy in its fullest sense is a psychological strategy designed to effect deep and enduring change. To appreciate the potential impact of psychotherapy, it is useful to conceptualize it in terms of orders of change. Three orders of change have been identified. "First-order change" refers to therapeutic efforts that resolve symptoms or situations without changing the causes of the problem. Here clients are assisted in making small changes, reduce symptoms, or achieve stability. Generally, career

counseling, crisis counseling, personal counseling, coaching, and case management can assist a client in achieving either symptom relief or resolution of a current life problem. This kind of change effects stability but does not result in transformation of the personality. In contrast, second-order change is transformative and results in a resolution of the causes of the problem. It is therapist-assisted pattern change wherein the therapist assists clients to alter their patterned thinking, feeling, and behaving within the situation in which their maladaptive pattern is occurring. The heart of second-order change is transformation, and specifically a transformation of pattern. In this order of change, a new and more adaptive pattern transforms or replaces the maladaptive pattern. In third-order change clients change patterns on their own without the assistance of a therapist. In essence, clients become their own therapists. This represents the ultimate goal of therapy wherein clients function "as their own therapists."

For example, an unemployed client with the diagnosis of social anxiety disorder might take medication that effectively reduces his anxiety symptoms but does not replace his maladaptive pattern of fearfulness and avoidance. Thus, he might fill out a job application online but out of fear decides he cannot tolerate the prospect of a job interview when it is offered. If medication reduces his symptoms, a degree of stability has been achieved. This represents first-order change. However, if the client is helped by a therapist to learn to face his fears and avoidance behavior directly so that he can be interviewed, offered, and starts the job, a more adaptive pattern is achieved. Such positive actions reflect a more adaptive pattern and constitute second-order change. If this same client is then able to disengage from excessive fearful and anxious feelings on his own, without the assistance of a therapist, he has achieved third-order change.

Developments and Current Status

The orders of change originated in the early family therapy literature. In the 1990s the orders of change were applied to change in organizational and institutional settings. More recently, the orders of change have entered the psychotherapy literature. The basic premise of psychotherapy is that when psychotherapy is truly effective, a transformation of current efforts is needed to effect change, called second-order change. This contrasts with psychotherapy that only produces stability or a return to baseline functioning, called first-order change. Deep, lasting change is not possible with first-order change. Rather, such change is the domain of second- and third-order change. Of these three, the first two are to be the focus of most therapists.

Len Sperry, MD, PhD

See also: Psychotherapy

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Secure Attachment

A secure attachment is an emotional bond between children and caregivers. Children with secure attachments trust their caregivers to meet their needs. These children also show minimal distress when separated and seek comfort when needed.

Description

Secure attachment is one of the two primary forms of attachment style—insecure and secure. A secure attachment is an emotional bond between children and caregivers. Children with secure attachments trust their caregivers to meet their needs. These children also show minimal distress when separated and seek comfort when needed.

Attachment styles are rooted in the theory first developed by John Bowlby, who also had significant contributions from Mary Ainsworth. Secure attachments developed in infancy, and childhood impacts the development throughout the life span, as well as how an individual interacts with others. John Bowlby was a key explorer of the concept of attachments, both insecure and secure. His belief was that a child's attachment to his or her mother was an indication for later

relationships and the child's ability to establish and maintain emotional stability. While there are four types of attachment styles, only one is secure in nature, with the others being various forms of insecure attachment.

The majority of babies are securely attached. Babies who are identified as securely attached display distress when they are separated from their mother. This results in crying and their attempts to go after her. When their mother returns they greet her happily and actively reach for her. Once securely attached babies are reassured by the presence of their mother, they are happy and comfortable to explore the room they are in. Mary Ainsworth did work where she identified that babies who are securely attached utilize their mother as a secure base for activity.

Attachment relates to the quality of the relationship between the child and the caregiver. It includes the interactions and the child's preference toward his or her caregiver. Attachment has been assessed using the strange situation paradigm, which was developed by Ainsworth. Children who are classified as securely attached have been explored and researched the most, especially since the majority of infants are identified as securely attached.

Secure babies are confident that the caregiver will return after an absence and meet their needs. The caregiver allows for safety to explore environments and to return to them when they are distressed. These infants are easily comforted by their caregiver when upset.

Secure attachments are formed when the caregiver is sensitive to the child's needs and appropriately responds to his or her needs. When children are securely attached, they can be separated from their parent. They can also comfortably seek support from their parents when frightened as well as utilize positive emotions when greeting their caregivers. As adults they can develop trusting relationships with others. They also have higher self-esteem and are comfortable with sharing their feelings with others and can seek out social support from others.

Secure attachments are identified by an individual being flexible with his or her interpersonal relationships. It allows for adaptive self-regulation and is key in continued positive psychology. The early experiences become internal models of the self and mold the individual's future social experiences, interactions, and relationships.

It is important to understand attachment styles as it impacts relationships in adulthood as well as development throughout the life span. Those who are securely attached tend to be more satisfied in relationships with others. In romantic relationships they feel connected to their partner but allow for movement within the relationship without experiencing great distress. They can actively provide and offer support to others and ask and seek comfort when distressed themselves. Someone who is securely attached can work well alone or with others. They have positive, flexible, reciprocal relationships with others. It allows for development of reliable social supports that they can utilize in times of need. With the confidence they have they can develop healthier coping mechanisms.

Current Status

Attachment styles are actively studied in psychology, counseling, and social work programs. About 60% of the population is identified as having secure attachments. This concept is important to be aware of due to its implications and impact throughout the lifetime on relationships and ability to maintain emotional stability.

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See also: Attachment Styles; Insecure Attachment

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Sedative, Hypnotic, or Anxiolytic Use Disorder

Sedative, hypnotic, or anxiolytic use disorder is a mental disorder characterized by stimulant use, which leads to significant problems for the user.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **Anxiolytics** are medications that relieve anxiety symptoms. They are also called antianxiety medications or tranquilizers.
- **Barbiturates** are a class of prescribed drugs that slow the nervous system and are prescribed primarily for sedation, general anesthesia, and for treating some types of epilepsy.
- **Benzodiazepines** are a class of drugs that slow the nervous system and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms. They are highly addictive.
- **Depressants** are a group of drugs that are prescribed to reduce the symptoms of anxiety. They are addictive and can be abused. Benzodiazepines are a very common depressant.
- **Hypnotics** are substances that induce or cause sleep.
- **Sedatives** are substances that have a soothing, calming, or tranquilizing effect.
- **Stimulant** is a drug that increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity, or suppresses appetite. Examples are cocaine, amphetamines, and Ritalin.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

Description and Diagnosis

Sedative, hypnotic, or anxiolytic use disorder is one of the substance-related and addictive disorders. It is characterized by a problematic pattern of sedative, hypnotic, and anxiolytic use, which leads to significant distress or disrupted daily functioning. These drugs include barbiturates like Seconal and benzodiazepines like Xanax. Both are prescribed drugs used to control anxiety and aid in sleep. While effective in relieving anxiety in the short term, they become problematic for long-term use, or when used for every disappointment or frustration.

Benzodiazepines were introduced in the 1960s as a safer alternative to barbiturates. Since benzodiazepines are safer, this drug is much more common and has a tendency of being abused. The use of this drug leads to mild sedation, muscle relaxation, and lowered anxiety, and even when it is not abused, physiological addiction for this class of drug is common when used over several months. Problematic use of this drug occurs when it is combined with depressant drugs to counter the effect of stimulant drugs. Individuals have also been known to use these drugs during working hours when drinking alcohol would be too easily detected. Like alcohol, the effect of these drugs includes slurring of speech, difficulty with coordination, and poor judgment.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a problematic pattern of sedative, hypnotic, or anxiolytic use, leading to significant impairment or distress. This must occur within a 12-month period. This includes taking the substance in larger amounts or for longer than intended. It means wanting to cut down or stop using the substance but not achieving this goal. It involves spending much time getting, using, or recovering from use of the substance. This disorder also involves cravings and urges to use the substance, and continuing to

Sedative, hypnotic, or anxiolytic use disorder is characterized by a problematic pattern of use of these substances, which can lead to significant distress or disrupted daily functioning. (istockphoto.com/James Brey)

use, even when it causes problems in relationships. It involves failure to meet obligations at home, work, or school because of substance use. It also means reducing or stopping important social, work, or recreational activities because of substance use. This disorder involves repeated substance use even when it is physically dangerous. Despite knowing the risks of the physical and psychological problems that are caused or made worse by the substance, use of it continues. It means develop tolerance (needing more of it to get the desired effect). Finally, it involves withdrawal symptoms, which can be relieved by taking more of the substance (American Psychiatric Association, 2013).

This disorder has some of the same root causes as other substance disorders. However, specific social and psychological factors may also be involved. Typically, those who will go on to develop this disorder begin use of this drug in their adolescent years or in their 20s. Their pattern of use escalates to the point at which they develop problems sufficient to meet criteria for the diagnosis. This pattern is particularly likely among those with other substance disorders. While use began intermittently, such as at parties, it progresses to daily use and increased levels of tolerance. Besides interpersonal difficulties, these individuals experience severe physiological withdrawal and difficulties with cognitive functioning. A less frequent pattern involves those who begin with a legitimately prescribed benzodiazepine for anxiety or sleep problems. Use is increased as tolerance develops, which they justify by their anxiety symptoms or sleep problems. It also happens that adolescents develop this disorder by experimenting with unused portion of a prescription found in the home.

Treatment

While it is rare for individuals to be addicted only to a single benzodiazepine, it does occur. More commonly, individuals are also addicted to another benzodiazepine or other central nervous system depressants such as alcohol, or opiates. When these drugs are used in combination with others, detoxification is complicated. Treatment for this disorder is similar to the treatment of other substance disorders. The goal of treatment is abstinence. Treatment approaches range from inpatient hospitalization and drug rehabilitation centers for detoxification to outpatient programs. Motivational interviewing is useful in identifying reasons to stop using and to increase motivation and readiness for treatment. Then, cognitive behavior therapy can be used to

identify the beliefs, behaviors, and situations that trigger use. From these they can develop a plan to reduce the likelihood of relapse. Treatment may also include a Twelve-Step Program like Narcotics Anonymous.

Len Sperry, MD, PhD

See also: Addiction; Barbiturates; Benzodiazepines; Cognitive Behavior Therapy; Twelve-Step Program

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Seizures

A seizure is an episode of abnormal electrical activity in the brain that results in changes in the brain and in behavior.

Definitions

- **Computed tomography** is a medical diagnostic test in which computer-processed x-rays produced tomographs (cross-sectional images) of body areas. It is also referred to as CT scans.
- **Convulsions** are a medical condition during which time an individual's body shakes uncontrollably and rapidly.
- **Electroencephalography** is a medical diagnostic test that records electrical activity on the scalp to evaluate various brain functions and psychological disorders. It is also referred to as an EEG or brain wave test.
- **Epilepsy** is a medical condition when seizures reoccur. It is also known as seizure disorder.
- **Stroke** is a medical condition when there is deprivation of oxygen to the brain due to a lack of blood flow.

Description

A seizure occurs when sudden and disorganized electrical activity affects the brain. Seizures can come on unexpectedly and may be a one-time event or a series of multiple events. They vary in duration and severity. The symptoms that may occur include a brief blackout followed by a period of when an individual cannot remember a certain period of time. Other symptoms include drooling, body shaking, falling, mood changes, and twitching and uncontrollable muscle spasms. During such twitching and spasms, individuals lose control of their limbs. Symptoms may last from a few seconds to 15 minutes. The part of the brain that is involved will depend on the symptoms that occur.

Often an individual may exhibit some warning signs before a seizure occurs. Some of these warning signs include fear, nausea, anxiety, and visual problems. Some individuals may not be aware they have had a seizure and therefore it may go unnoticed. Others may go through such a significant change and lose consciousness. Those who lose consciousness may exhibit involuntary muscle spasms called convulsions. There are many different types of seizures. Some have mild symptoms and some have very severe symptoms.

Based on the type of behavior and brain activity, seizures are divided into two broad categories: partial and generalized. Partial seizures occur in a relatively small part of the brain. The most common symptoms of a partial seizure include muscle rigidity, spasms, head turning, unusual sensations affecting one or more of the five senses, memory or emotional disturbances, fidgeting, and other repetitive, involuntary but coordinated movements. Generalized seizures occur throughout the entire brain. The most common symptoms of a generalized seizure include convulsions, short loss of consciousness, jerking movements on both sides of the body simultaneously, stiffening of the muscles, and sudden loss of muscle tone.

There are many causes of seizures. These include drug abuse and dependency, alcohol use disorders, and withdrawal from certain drugs and alcohol. They can also include low blood sugar, head injury, heart disease, stroke, and brain infection. Sometimes a cause cannot be found. By the age of 80, about 5%–10% of

all individuals will have experienced a seizure, and 40%–50% of these individuals are likely to have a second seizure. If a second seizure occurs, the individual has developed epilepsy. Currently, epilepsy affects about 1% of the population. Men are more likely to develop epilepsy than women (Engel, 2013).

In most cases, seizures are not life threatening and generally easy to treat. If a seizure lasts for more than five minutes, the individual should seek medical treatment immediately. The medical care provider will attempt to diagnose the type of seizure the individual has had based on symptoms and medical tests that will be performed. Tests may be ordered to rule out other medical conditions that cause seizures or similar symptoms (e.g., stroke). Computed tomography and electroencephalography are two methods used when treating an individual who has had a seizure. Blood and urine tests may also be ordered. Treatment will vary depending on the type of seizure (e.g., first time seizure, epilepsy). For individuals who have been diagnosed with epilepsy, it will be important for the health-care provider to access the medication individuals are currently taking, as well as the dosage prescribed.

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See also: Alcohol Use Disorder; Brain; Computed Tomography (CT); Drug Dependence; Electroencephalography (EEG); Stroke

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Selective Mutism

Selective mutism is a mental disorder in which children or adolescents fail to speak in some social situations although they have the ability to talk normally at other times. Previously it was called elective mutism.

Definitions

- **Anxiety disorders** are a group of mental disorders characterized by anxiety as a central or core symptom. The group includes specific phobias, social anxiety disorder, and generalized anxiety disorder.
- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Separation anxiety disorder** is an anxiety disorder characterized by excessive anxiety resulting from separation from those to whom a child is attached.
- **Social anxiety disorder** is an anxiety disorder characterized by excessive and unreasonable fear in social situations of being judged or evaluated by others. Previously it was referred to as social phobia.
- **Specific phobia** is an anxiety disorder characterized by a marked and enduring fear of specific situations or objects.

Description and Diagnosis

Selective mutism is an anxiety disorder in which a child who is capable of speaking does not speak in specific situations. It must be distinguished from mutism in which the child cannot speak. Instead, those with selective mutism are fully capable of speaking and understanding language; they fail to meet the expectation to speak and respond. For example, a child with this disorder may be silent at school for years but speaks freely at home. It appears that the refusal to speak serves to control others and situations that the child fears. While the disorder may develop in early childhood at home, it is seldom diagnosed until the child is in school. This refusal to speak can lead to

impairment in school, work, or other areas of life. It is a rare disorder affecting less than 1% of children. It is most common in children under age five but not diagnosed until they begin school.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, children can be diagnosed with this disorder if they exhibit consistent failure to speak in specific social situations despite the capacity to speak in other situations. It interferes with school, work, or social communication. This failure to speak is not the result of not knowing the spoken language, and it must continue for at least one month. Finally, it is not the result of stuttering or other communication disorder or a developmental disorder like autism (American Psychiatric Association, 2013). In addition, selective mutism is not diagnosed if there is a neurological problem with the child's speech or if the child has recently emigrated from a place where people speak a different language.

The cause or causes of this disorder are not well understood. Children with this disorder may inherit a tendency to be anxious and inhibited. Some have a family history of selective mutism, extreme shyness, or anxiety disorders, which may increase their risk for similar problems. Most children with selective mutism also have social anxiety disorder, separation anxiety disorder, or a specific phobia. Parents of children who use selective mutism are often overprotective and more controlling than the parents of children who have other anxiety. It may be that selective mutism is a purposeful choice made by a child to control anxiety or to control others who are placing demands on the child that are unwanted.

Treatment

Behavior therapy can be effective with this disorder. The goal of treatment is to increase speech. Treatment begins with the therapist performing an assessment that identifies the child and the settings in which the child refuses to speak. Then, a behavior change plan based on a reinforcement (reward) system is established. Its purpose is to reward appropriate behavior (efforts to speak). The behavior plan typically uses tokens (tickets) which the child receives for desirable behaviors. The child can then trade the tokens for toys, candy, or privileges. Working with the child's parents and teachers is another treatment approach. They learn about the disorder and how to address the child's power-control strategy for controlling individuals and situations by refusal to speak. They are helped to defuse this strategy and become calm and supportive encouragers. They learn that neither speaking for the child nor demanding that the child talk is effective. Instead, they can help the child by asking questions once and then allowing consequences to occur. For example, if a child likes a particular treat, the parent could ask if the child would like the treat in a situation where the child had not been talking. Getting the treat requires that the child speak or lose out on the opportunity. Or, a teacher can tell a child that she has a gift which the child can have if the child asks for it in a clear voice.

Len Sperry, MD, PhD

See also: Anxiety Disorders; Behavior Therapy; Separation Anxiety Disorder; Social Anxiety Disorder; Specific Phobia

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Self-Actualization

Self-actualization is a psychological concept referring to both the human desire and ability to fulfill one's potential.

Description

"Self-actualization" is a term used by a number of developmental psychologists over the years to describe the condition when human beings are able to strive toward and fulfill their highest potential. Abraham Maslow (1908–1970) and Carl Rogers (1902–1987),

both listed in the top 10 most eminent psychologists of the 20th century, considered self-actualization to be the highest level of human development. Maslow used the term to describe a motivating desire. Rogers described it as a fundamental driving force. Both Maslow and Rogers believed that to become self-actualized an individual needed to have several internal characteristics or attributes. These include being vulnerable to others, being willing to learn from painful experiences, desiring to be one's true self, and being fully human.

Maslow placed self-actualization at the top of his "hierarchy of needs." He theorized five levels of needs, which must be met before a person is able to move up to the level above until reaching self-actualization. The five needs are (1) physiological, which includes what is needed to sustain life such as food, water, and sleep; (2) safety, which includes physical and economic security; (3) love and belonging, which includes friendship, family, and intimacy; (4) esteem, which includes self-esteem, the need to be accepted and valued by others; and (5) self-actualization, which is the realization of a person's full potential.

Rogers believed that people were self-actualized when their view of themselves, their sense of self-worth, and their ideal self (what they wish they were like) were congruent, or in harmony. He considered self-actualized individuals to be "fully functioning persons" who were well adjusted, well balanced, and interesting people to know. Rogers identified five characteristics of self-actualized or fully functioning persons: (1) open to experience, able to accept and handle both positive and negative emotions; (2) existential living, able to live in and appreciate the experience of the present moment, not being judgmental of others; (3) trust feelings, able to trust one's own emotional experience and trust that people can make the right decision for themselves; (4) creativity, creative thinking and taking risk in life, able to seek out new experiences; and (5) fulfilled life, the person is happy and satisfied with life and seeks out new challenges.

Steven R. Vensel, PhD

See also: Maslow, Abraham (1908–1970); Rogers, Carl (1902–1987); Self-Concept; Self-Esteem

Future Reading

Haggbloom, Steven, Renee Warnick, Jason E. Warnick, Vinessa K. Jones, Gary L. Yarbrough, Tenea M. Russell, Chris M. Borecky, Reagan McGahhey, John L. Powell III, Jamie Beavers, and Emmanuelle Monte. "The 100 Most Eminent Psychologists of the 20th Century." *Review of General Psychology* 6, no. 2 (2002): 139–152.

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Self-Concept

"Self-concept" is a psychological term referring to a person's set of thoughts, perceptions, and beliefs about oneself.

Description

Self-concept is a collection of beliefs about oneself formed in our interactions with the environment and significant others, and the value we place on others. It involves the perceptions, thoughts, and attitudes about oneself and is formed in childhood. Self-concept consists of an assessment of many individual characteristics, including personality, abilities, skills, talents, strengths, physical characteristics, and intelligence

Carl Rogers (1902–1987), listed as one of the 10 most eminent psychologists of the 20th century, was very important in the development of the theory of self-concept. He described self-concept as resulting from the totality of the experience of what is going on inside the individual. It is the perceptions one has of oneself, the perception of the self in relationship to others, and the values attached to those perceptions.

A person's self-concept consists of three components. The first component, self-image, is the view a person has of himself or herself. The second component, self-esteem (sometimes referred to as self-worth), consists of how much value a person feels he or she has. The third component, the ideal-self, is what a person wishes he or she were really like. Rogers believed that people feel and behave in ways consistent with

their self-image and reflect what we would like to be like. The closer our self-image is to our ideal-self, the higher our self-worth will be.

Roger's theory of self-concept teaches that a person's self-concept is the result of the conditional or unconditional positive regard of the parents. Individuals raised in a home in which they experienced unconditional positive regard would be fully self-actualized. A person who is self-actualized is able to reach his or her potential and be able to fully and confidently function in life. Those who were raised in homes where regard was conditional, meaning it had to be earned, only felt worthy when they met certain conditions.

Because people have the capacity for change and growth, a person's self-concept can be modified. Individuals who grew up in abusive, neglectful, or other adverse circumstances can develop a negative self-concept that can affect how they deal with life. For instance, a child who grew up in a home where she was never praised and was constantly told how stupid she was, or was never enjoyed by the parents, would develop a negative self-concept. She may believe and act as if she really is stupid and unworthy of recognition, or praise. Insight-oriented therapies, such as Adlerian therapy or cognitive behavior therapy, can provide assistance to individuals seeking to change negative and patterned ways of perceiving, thinking, feeling, and behaving.

Steven R. Vensel, PhD

See also: Rogers, Carl (1902–1987); Self-Actualization; Self-Esteem

Further Reading

Haggbloom, Steven, Renee Warnick, Jason E. Warnick, Vinessa K. Jones, Gary L. Yarbrough, Tenea M. Russell, Chris M. Borecky, Reagan McGahhey, John L. Powell III, Jamie Beavers, and Emmanuelle Monte. "The 100 Most Eminent Psychologists of the 20th Century." *Review of General Psychology* 6, no. 2 (2002): 139–152.

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Self-Efficacy

Self-efficacy is an individual's self-evaluation of his or her own ability to accomplish a particular task or engage in a particular process.

Definitions

- **Autonomy** is an independent and self-determining reliance on one's self and a resistance to social or peer pressures to think, act, or feel a certain way.
- **Behavioral psychology** is a form of psychology whose aim is to study behavioral adaptation to an environment and its stimuli.
- **Classical conditioning** is an involuntary process of neurological change in response to a stimulus that causes a reaction to occur automatically when the new stimulus is present.
- **Environmental mastery** is the ability to competently manage everyday affairs of living by making effective use of resources and opportunities while controlling external activities.
- **Evidence-based practice** is a form of practice that is based on integration of the best research evidence with clinical experience and client values.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Social learning theory** is the aspect of behavioral psychology that states knowledge is acquired through observation, modeling, and imitation. It is also known as social cognitive theory.

Description

Self-efficacy is an individual's belief as to whether or not he or she will be capable of performing a specific

practice or completing a specific task. It is not a behavior. Rather, self-efficacy is a self-perception or thought process. It actually serves to impede an individual's engagement in practices that he or she considers to be outside of his or her skills and abilities. Conversely, self-efficacy can promote behaviors that an individual has confidence in. Self-efficacy theory states that a person's self-evaluation affects his or her expectations of practice outcomes and motivation to attempt accomplishing a particular goal or objective. Decisions are affected by self-efficacy. In addition, when self-efficacy increases, motivation typically increases as well.

Self-efficacy has profound implications for mental health practitioners. They should utilize psychotherapeutic interventions that do not deviate too far from a client's perceived self-efficacy. A client's self-efficacy will predict what change behaviors he or she is willing to engage in. Due to the relationship between self-efficacy and motivation, motivational interviewing is one technique that can be used in psychotherapy to increase a client's self-efficacy. As a client's self-efficacy increases, his or her likelihood to engage in therapeutic behavior change is also likely to increase.

Self-efficacy is a self-evaluative thought that ranges from a semipermanent core belief to an immediate and reactionary assessment of one's own ability. An individual's self-efficacy can be influenced by traditional behaviorism, observations of others, social and cultural persuasions, or the individual's own level of psychological arousal. Psychotherapy related to self-efficacy is empirically supported and can assist a client achieve environmental mastery.

Development and Current Status

Behavioral psychology evolved in the 1970s to include social learning theory, which is also known as social cognitive theory. This evolution was largely due to the work of psychologist Albert Bandura (1925–) and the various cognitive theories of the time. Bandura helped integrate cognitive and behavioral theories. Social learning theory states knowledge is acquired through observation, modeling, and imitation. This is a departure from the classical conditioning and other forms of traditional behavioral psychology. In the 1980s, Bandura offered the addition of the theory of self-efficacy to social learning theory. Self-efficacy is important in the history of behavioral psychology because it provides a theoretical framework for self-determined behavior. Historically, behavioral psychologists believed that all behavior was conditioned. A client's evaluation of his or her own capabilities affects his or her choice of, and ultimately his or her success in, self-management, self-control, and self-determination.

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See also: Empirically Supported Treatment; Evidence-Based Practice; Positive Psychology

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Self-Esteem

Self-esteem is a psychological concept referring to an individual's internal sense of self-value or worth. Self-esteem is a component of a person's overall self-concept.

Description

Self-esteem is a psychological concept that refers to an individual's self-appraisal of himself or herself. It is a judgment of one's inherent self-worth. Self-esteem consists of attitudes and beliefs about self (e.g., I am smart vs. I am stupid) and emotions (e.g., feelings of pride vs. feelings of shame). Self-esteem is a component of a person's overall self-concept. At the most basic level, self-esteem is a combination of what we believe and how we feel about ourselves. Self-esteem tends to be either positive or negative and fluctuates throughout the life span in response to events. For instance, when a student received an excellent grade on a school project,

he or she might feel especially good about himself or herself. Although short-term variations occur, levels of self-esteem tend to be consistent and are generally viewed as part of a person's personality.

Current Status and Impact (Psychological Influence)

Carl Rogers, listed as one of the 10 most eminent psychologists of the 20th century, was very important in the early development of the theory of self-concept and self-esteem. The hypothesis of self-esteem continues to be widely researched. Initial research focused on how self-esteem is developed in childhood. This early research indicated that positive or negative levels of self-esteem were related to how an individual was raised and the experiences he or she had as a child. There are two dimensions of parenting that affect self-esteem. One dimension is how demanding and controlling a parent is in imposing rules, consequences, and punishments. The other dimension is how warm, supportive, loving, and responsive parents are to the emotional needs of their child. Individuals with high self-esteem usually have parents who were demanding, had clear expectations for school and behavior, had rules and consequences for their children's behavior, and were loving, warm, caring, and responsive to their children's emotional needs. Individuals with low self-esteem had parents who either were overly demanding, harsh, and controlling with little warmth, or were overly permissive with few rules and consequences.

Self-esteem research has also focused on the impact of academic and social experiences during childhood and adolescence in the development of self-esteem. Academic achievement in school has a significant influence on self-esteem as children become very aware of differences between themselves and their peer group. In elementary school comparison with peers regarding who did better or worse on quizzes, tests, exams, and projects can impact how children think and feel about themselves. As children move into adolescence, social standing and comparisons of looks, athletic ability, and popularity can have a significant influence on how they feel about themselves and what they believe about themselves. Studies indicate that individuals who are extroverted, emotionally stable, and conscientious have higher self-esteem.

A recent meta-analysis (an analysis of a group of research studies) of 50 self-esteem studies indicated that levels of self-esteem vary throughout a person's lifetime. The authors found that the self-esteem of children aged 6 to 11 years was fairly unstable. Self-esteem increased for young adults and reached its peak at about age 60 and then began to decrease. Young adult women had lower self-esteem than men, with differences decreasing as they aged. Caucasians and African Americans have similar self-esteem stability, with self-esteem sharply decreasing for African Americans after age 60. The more education a person has, the higher his or her self-esteem. Negative changes in socioeconomic status result in decreased self-esteem, as did declining physical health.

Self-esteem is an important psychological concept that has been highly researched. The fields of psychology, counseling, social work, and education are professions that engage in self-esteem research in order to more fully understand human development. Understanding how to increase the development of self-esteem in individuals of all ages is an important aspect to increasing individual well-being and improving our society.

Steven R. Vensel, PhD

See also: Rogers, Carl (1902–1987); Self-Actualization; Self-Concept

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Self-Fulfilling Prophecy

Self-fulfilling prophecy is a concept that describes how a person's beliefs and expectations elicit actions or behavior to occur, which confirms his or her initial assumptions.

Definitions

- **Confirmation bias** refers to the tendency people have to pay attention or favor information that supports their beliefs or hypotheses.
- **Placebo effect** is a phenomenon that has been evidenced in the medical community whereby patients experience perceived or actual improvement in their condition after being given a placebo, or simulated, treatment.
- **Pygmalion Effect,** or Rosenthal Effect, describes a phenomenon discovered in a Rosenthal–Jacobson study confirming that when teachers placed higher expectations on their students it resulted in better performance.
- **Social perception** is the process by which we gather information to form impressions of people and what they are like.

Description

"Self-fulfilling prophecy," also referred to as the Pygmalion or Rosenthal Effect, refers to the notion of how preconceptions, whether accurate or inaccurate, impact resulting behavior and reinforce initial beliefs. Essentially, self-fulfilling prophecies are beliefs that come true because an individual acts in ways, directly or indirectly, that result in their coming true. A self-fulfilling prophecy follows some basic steps. First, the perceiver holds expectations, or false beliefs, about the target. Next, the perceiver acts in a manner that is likely to elicit the target's expected behavior. In response, the target indeed behaves in the expected way, thus confirming the perceiver's original belief. Finally, the perceiver sees (objective experience) the target behave in this predicted way. Experiments have been conducted in a variety of areas (education, relationships, multicultural studies) to confirm this phenomenon.

Though prophecies have been in existence since the time of Ancient Greece, sociologist Robert King Merton was the first to coin the term "self-fulfilling prophecy." He used the term to describe how a false definition of a situation can evoke a new behavior that makes the original conception true. He used an illustration of "a run on a bank" in which a rumor began that a bank was going to run out of money. Fearing this was true bank customers immediately went to the bank and withdrew all of their money. Banks are unable to keep all of their customer's cash on hand, it would be too much cash to store, and it is very rare that a person would take all of his or her money out of a bank. Because banks cannot keep enough cash on hand, the people who heard the rumor later in the day got to the bank after all of the cash was given to those who heard the rumor earlier in the day. Thus, the prediction of the bank running out of money came true but only because of the prediction.

The term was popularizing it in his book *Social Theory and Social Structure* (1968). His concept was based on the Thomas Theorem from the late 1920s formulated by sociologist couple William Isaac Thomas and Dorothy Swaine Thomas, which states, "If men define situations as real, they are real in consequences," meaning that a person's interpretation of a situation causes the behaviors that result. Merton expounded on this principle by applying it to various human social experiences. He further suggested that in order to change outcomes, one must alter one's perceptions/beliefs. The distinction is also made between prophecies and predictions; prophecies are predetermined and destined to occur, while predictions are estimations on what may happen given predicted events.

In a notable 1968 study, experimenters Robert Rosenthal and Lenore Jacobson demonstrated the self-fulfilling prophecy phenomenon. Their research examined how teacher expectations were impacted by economic, cultural, and ethnic differences among students. Teachers were told that certain students in

their class could be expected to make significant academic gains during the school year when in actuality the students were selected at random and their potential success was no more probable than any other student in the class. However, results pointed to higher IQ scores, increased reading levels, and more favorable teacher reports for those identified students even a year later. These findings suggest that the preconceptions held by teachers may have caused them to behave more attentively, academically nurturing, and encouraging toward these students, thus contributing directly to students' improved performance. This study provided evidence of how social perceptions could influence outcomes.

Current Status and Impact (Psychological Influence)

Applications from the research on self-fulfilling have been noted in education, sports, medicine, economics, psychology, counseling, and law. It has been the subject of extensive social research in the fields of sociology, psychology, counseling, social work, and education. Self-fulfilling prophecy and its impact on student performance have been highly studied. Parenting and self-fulfilling prophecy have also been the focus of numerous studies. As a result of the extensive research findings indicating that self-fulfilling prophecies do indeed exert considerable effects on behaviors, the concept is generally regarded as a psychological truth.

Racial and ethnic stereotypes can become self-fulfilling prophecies if members of minority groups are underchallenged or underrepresented. Educators, administrators, and politicians have sought solutions to address the "achievement gap" with minority students, with findings suggesting that expectations can have a profound impact on future success. Efforts made to increase multicultural sensitivity and measures including affirmative action attempt to even the playing field for these groups. In the field of medicine a phenomenon known as the "placebo effect" has been well documented whereby patients who receive innocuous treatment but believe show improved health benefits. Research supports a strong connection between a patient's mind-set and his or her life span. Psychologists, counselors, and therapists employ the principle of self-fulfilling prophecy when using cognitive behavioral, rational emotive behavioral, and solution-focused approaches that stress the link between cognitions and one's resulting actions. The *law of attraction* provides an additional example of self-fulfilling prophecy, holding that "like attracts like," that the energy one puts out into the world, positive or negative, produces corresponding results.

Melissa A. Mariani, PhD, and Steven R. Vensel, PhD

See also: Placebo Effect

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Self-Help Groups

Self-help groups are peer-led, volunteer groups of people who share a common concern, need, bond, or desire related to a problem in living.

Description

Individuals, organizations, hospitals, schools, and just about any other person or group that has a concern can form self-help groups (SHGs) to address issues related to a multitude of problems such as parenting, physical illness, or a mental health illness. They may be led by professionals but are most often formed and led by nonprofessionals. The focus of SHGs can include management of a specific mental health disorder such as depression or anxiety; education and support for people impacted by diseases such as diabetes; grief support;

substance abuse; or for those dealing with other life issues such as divorce recovery groups. SHGs also focus on coping and stress management for physical illness such as support groups for cancer victims and paralytic conditions. According to the Substance Abuse and Mental Health Services Administration there are hundreds, if not thousands, of different kinds of SHGs.

Self-help groups are the oldest and most widespread type of peer support and generally fall into either lifestyle/behavior-oriented groups or coping/stress-related groups. Lifestyle groups, such as Alcoholics Anonymous, are usually focused on a debilitating addiction or compulsion. Behavioral SHGs focus on issues such as anger management. Coping/stress-oriented groups, such as cancer patient support or divorce recovery groups, focus on stress management, education, support resources, and member compassion. Basic principles of SHGs include reciprocity, which is receiving help through helping others, the absence of professionals, the empowering nature of peer interaction, and non-bureaucratic organizational practices.

Self-help groups offer many benefits to members. Developing a deeper understanding of one's problems, spending time with peers who are in the same situation or have a similar problem, developing a network of supportive social relationships and strengthened family relationships, receiving understanding and support, learning from other people's experiences, and an improved sense of being normal are just some of the recognized benefits of SHGs.

Traditionally self-helps groups have met almost exclusively in face-to-face meetings. With the expansion of Internet technology, online support groups have become widespread. Communication is conducted via e-mail, virtual chat rooms, or live forums. Although

Individuals, organizations, hospitals, schools, and just about any other person or group that has a concern can form self-help groups to address issues related to a multitude of problems such as parenting, physical illness, or mental health issues and illness. (AP Photo/Lefteris Pitarakis)

some Internet support groups (ISGs) are private and require some form of membership, most ISGs are public and open to anyone. ISGs offer greater anonymity where there is little chance of one's identity being discovered. Anonymity can be almost complete, allowing some members to "troll" in which an individual can read and benefit from all of the group interaction without ever revealing his or her presence.

Self-help groups addressing mental health and drug use are widely utilized in the United States. According to the National Survey on Drug Use and Health (NSDUH, 2009), approximately 2.4 million adults aged 18 or older receive support from mental health SHGs related to emotional or mental health difficulties. Of that group approximately 61% are females, 89% are over 25 years of age, and 47% were employed full-time. Approximately two-thirds of adults who participated in SHGs also received more traditional treatment consisting of inpatient treatment, outpatient treatment, or prescription medication. According to the Substance Abuse and Mental Health Services Administration, 5 million people attended an SHG for help with alcohol and illicit drug–related difficulties.

Self-help groups exist for virtually any diagnosable mental health disorder. There are multiple online sources for locating SHGs, including Mental Health America and the American Self-Help Group Clearinghouse.

Steven R. Vensel, PhD

See also: Peer Counseling; Support Groups

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Self-Medication Hypothesis

Self-medication hypothesis is a theory that explains drug use as an attempt to "solve" emotional and behavioral problems.

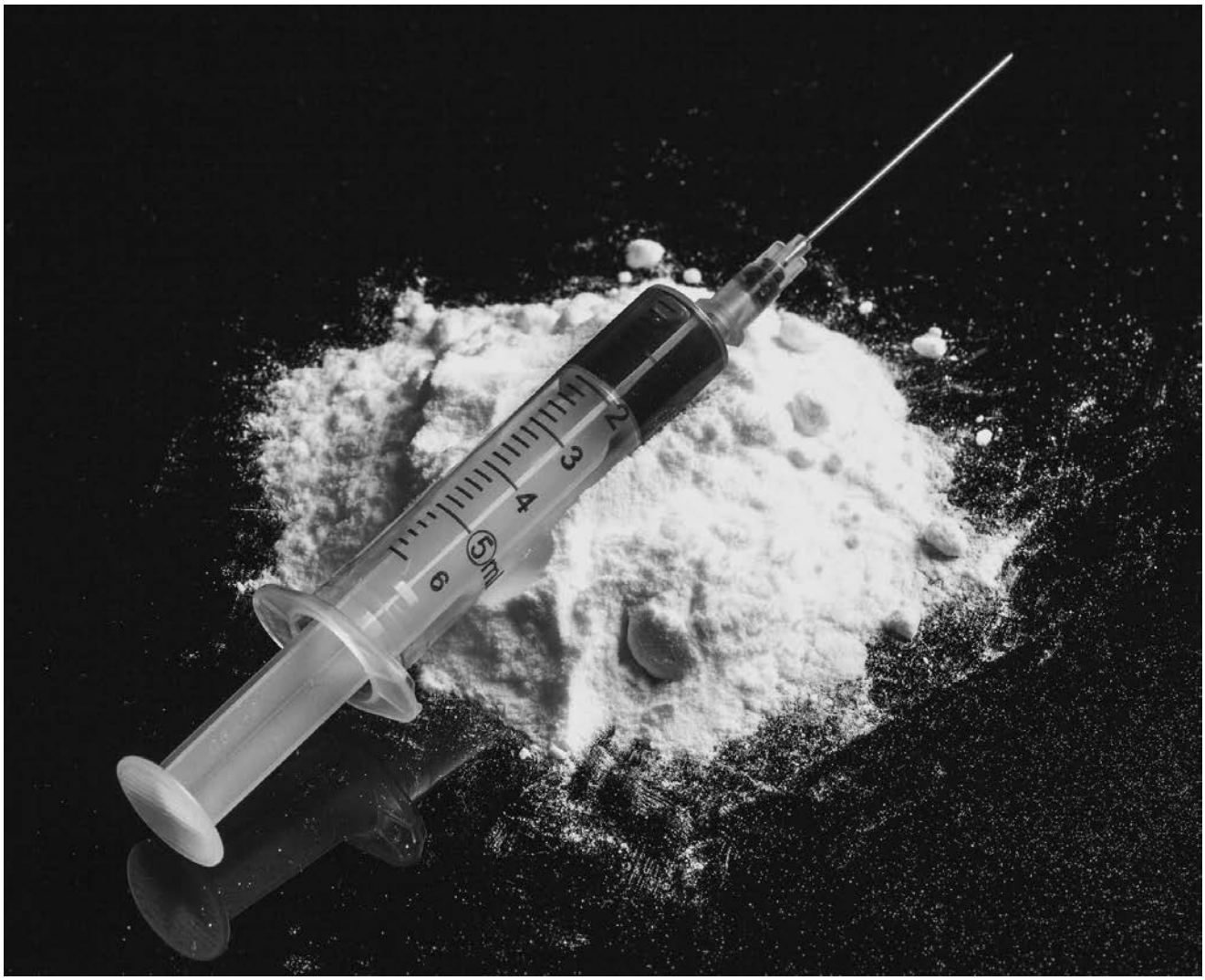
Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Addictive disorder** is a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Dependence** is the need for a drug to function normally. Dependence can be psychological and/or physical. Psychological dependence is dependence on a psychoactive substance for the reward it provides. Physical dependence refers to the unpleasant physiological symptoms if the drug is stopped.
- **Depressants** are a group of drugs that are prescribed to reduce the symptoms of anxiety. They are addictive and can be abused. Benzodiazepines, like Valium, are a very common depressant.
- **Opioids** are a group of drugs that reduce pain. They are highly addictive and include both prescription drugs like Percocet and illegal drugs like heroin.
- **Psychoactive** is a drug or substance that has a significant effect on mental processes. There are five groups of psychoactive drugs: opioids, stimulants, depressants, hallucinogens, and cannabis.
- **Psychopharmacology** is the study of drugs that affect thinking, feeling, and behavior.

- **Stimulant** is a drug that increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity, or suppresses appetite. Examples are cocaine, amphetamines, and Ritalin.

Description

Self-medication hypothesis is a theory used to explain why individuals use alcohol and drugs. Uncomfortable emotions, unresolved trauma, mental illness, and social problems are often improved through the use of different psychoactive substances. The theory holds that individuals prefer specific drugs because of their unique psychopharmacological properties. For example, an individual who suffers from feelings of anxiety and is uncomfortable in social situations may use a depressant like alcohol to feel calm and interact with others. In this case, a stimulant like cocaine would not improve these problems and may make them worse. However, stimulants may be attractive to those who have other problems like depression or low energy. Another example is opioids like heroin. This category of drugs reduces the perception of pain and produces feelings of euphoria. Those who experience feelings of aggression and rage often find comfort with this type of



Self-medication hypothesis is a theory that explains drug and alcohol abuse as an attempt to "solve" emotional and behavioral problems by altering the consciousness of the user. (Maxim Evdokimov/Dreamstime.com)

drug. The theory holds that individuals will experiment with many different substances until finally settling on the one that works. While the drug helps individuals feel better initially, continued use often develops into addiction and creates additional problems. These may include damaged social relationships, physical or psychological dependence, and legal troubles. Until the substance user finds some other way to meet his or her needs, the use will likely continue.

The self-medication hypothesis was separately proposed by Edward Khantzian, MD (1943–), and David Duncan, MD (1947–), in the 1970s. Khantzian focused on the psychological factors that explain self-medication, such as emotions and defense mechanisms. He believed that individuals use substances when they do not have the ability to manage feelings on their own. Duncan, however, considers self-medication as a behavioral issue. For him self-medication is a way of avoiding problems or responsibilities. When individuals are able to escape problems or responsibilities by using substances, their behavior is rewarded and they are likely to continue doing it.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Addiction; Addictive Disorder; Drug Dependence; Opioids; Psychoactive; Psychopharmacology; Stimulant Related Disorders

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Self-Mutilation/Self-Harm

"Self-mutilation" or "self-harm" refers to an intentional act of harm committed by mutilating one's own body but without the intent to commit suicide.

Definitions

- **Cutting** is a form of self-injury whereby one makes cuts on one's body, usually on the arms or legs, without the intent to kill oneself.
- **Deliberate self-harm,** or *self-inflicted injury*, refers to acts of harming oneself with non-suicidal intent.
- **Non-suicidal self-injury (NSSI) disorder** is the terminology used to describe the new diagnostic classification for self-damaging behaviors with the absence of suicidal intent.
- **Self-inflicted injury** is a term used to refer to a range of behaviors that encompass self-harm where one deliberately injures oneself but without suicidal intentions.
- **Self-injurious behavior (SIB),** often used interchangeably with *self-mutilation* or *self-harm*, refers to purposeful acts of self-harm that are free from suicidal intent.

Description

"Self-mutilation" is a term used in the literature to describe self-harm or self-injury (SI). These three terms are often used interchangeably. This behavior describes when a person causes deliberate or intentional damage to his or her body. Cuts, bites, burns, and picking are forms of self-mutilation. Self-mutilating behavior can be broken down into three different types: superficial or moderate, stereotypic, and major. Superficial self-mutilation is the most common form associated with people who cut, burn, or hit themselves. This type of self-inflicted harm is typically committed by those who are diagnosed with personality disorders. Superficial self-mutilation is often the result of experiences that happen early in life that impair normal development. Victims of sexual, emotional, verbal, or physical abuse or trauma may engage in this type of self-harm. Those characterized as stereotypic are more severe and engage in behaviors, including head banging, eye gouging, and biting, which are more typical of individuals who are diagnosed as mentally delayed. The most extreme and rare form of self-mutilation is

major self-mutilators, who attempt to amputate limbs or genitalia, seeking to permanently disfigure themselves. Self-injury is not just a human phenomenon; some animals that are kept in captivity also display these types of behaviors.

More recently, terms such as "self-cutting"/"cutting," "burning," "self-poisoning," "hair-pulling," and "skin-picking" have been used to refer to more specified forms of self-harm. Deliberate self-harm is most common in adolescents and young adults between the ages of 12 and 24, though people of any age can engage in these acts. The most common form of self-mutilation is cutting, or wounding, one's own bodily tissue with a sharp object such as a knife or razor blade. High incidence rates of self-poisoning, referring to the excessive use of dangerous or mind-altering substances, have also been noted in the literature.

It was previously believed that self-harm was done for attention-seeking purposes; however, research now indicates that the majority of sufferers attempt to hide evidence of these behaviors. For example, cutters may wear long sleeves or pants. Most sufferers who are properly diagnosed as self-injurers know exactly how far to go with their actions and do not want to commit suicide, though this group is at an increased risk. Those who are diagnosed incorrectly may use SI to explain away an unsuccessful attempt at suicide. Self-harmers may also unintentionally end up taking their own lives. This is most common in those who use substances to self-soothe (alcohol, illegal drugs).

Often those who self-harm are remorseful or ashamed of their actions. They may be unable to express their thoughts or feelings openly to others and turn rather to internalizing coping mechanisms like SIB. Self-harming is viewed as a form of depersonalization or dissociative behavior, meaning the person is unable to relate or connect directly to what he or she is experiencing or feeling in a healthy or appropriate manner. The individual may be either too numb or oversensitive; thus, self-harming provides a way to bring the person back to himself or herself, his or her physical body, and help him or her to feel connected or grounded again.

Self-injurious behavior is usually seen in conjunction with more complex problems or other forms of mental illness, including borderline personality disorder, depression, anxiety disorders, eating disorders, schizophrenia, or post-traumatic stress. Self-harm behaviors are also commonly associated with disabilities such as autism and mental retardation. Reduced levels of cognizance, self-control, or lack of awareness regarding possible consequences may be contributing factors. Those diagnosed with behavioral issues such as attention-deficit hyperactivity disorder, oppositional defiant disorder, low self-esteem, and poor social skills are also at higher risk for SI.

Impact (Psychological Influence)

Incidents of self-mutilation/harm have rapidly increased in terms of reported cases since the 1980s. Possible explanations for this include environmental factors, negative influence of media, increased social pressure, and earlier exposure to drugs/alcohol. Several therapeutic interventions have proven helpful in targeting SI; however, more research is needed in this area. Specifically, cognitive behavior therapy, solution-focused counseling, rational emotive behavior therapy, and the use of psychotropic/mood-altering medications have been evidenced as effective. As this issue most commonly plagues adolescents and young adults, school-based interventions, programs, and education should continue to be developed. In 2010, a formal proposal was offered to include Non-Suicidal Self-Injury as a stand along diagnosis in the most recent version of the *Diagnostic and Statistical Manual*, DSM-5. Prior to this, self-harm behavior was simply viewed as a symptom of other underlying disorders.

Melissa A. Mariani, PhD

See also: Cutting

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Seligman, Martin (1942–)

Martin Seligman is a psychologist, educator, and author who is best known as the founder of positive psychology, which is an approach to psychology that focuses on the best things in life, including positive emotions, traits, and institutions.

Description

Beginning in the late 1960s, Dr. Martin E. P. Seligman attracted attention within the psychological community with his theory of learned helplessness. This concept grew out of his experience with clients suffering from depression. Seligman observed that his clients had learned to act or behave in a helpless fashion even when they had the innate ability to improve. Seligman saw a clear link between their feeling that they had no control over their behavior or feelings and their clinical depression. From this initial theory Dr. Seligman developed positive psychology.

The psychological and psychiatric treatment of mental health after World War II was based on a disease model. In the disease model, practitioners were focused on their patients' lack of mental health, their problems, inappropriate behaviors, and deficits in personality. Seligman and his colleagues came to believe that this focus was too narrow. Rather than concentrate on problem behaviors and mental illness, positive psychology starts with a focus on trying to discover the things that make people happy, the things that bring them satisfaction in life. Working with Christopher Peterson, Seligman began to draw up a list of the strengths and character traits that enable individuals and groups of people to thrive.

Positive psychology focuses on tools and interventions that can help make people happy. It does this by asking questions like, which positive human strengths and virtues can be reinforced to help people achieve a better quality of life? Research shows that people who exhibit optimism and hope suffer less from adverse events and actually live longer with greater satisfaction than their pessimistic peers. One study of longevity in a community of nuns showed that the nuns who exhibited positive traits early in their lives lived longer than the nuns who did not.

Based on more mounting research, Seligman wondered whether it might be possible that people who did not seem to have a natural joyfulness or optimism could change their attitudes and behaviors. Seligman's conclusion is that optimism can be learned. Achieving optimism depends on the willingness of less optimistic people to become aware of their negative thinking and invest their efforts in how to counteract it.

In his most recent studies, Seligman concentrates on the idea of achieving psychological well-being, or the state of being happy, healthy, prosperous, or successful. This occurs through his identification of the five pillars of positive psychology. The five pillars of well-being are positive emotion, engagement, relationships, meaning, and accomplishment. Seligman believes that learning how to engage in these five areas of health is the foundation of a fulfilling and improved quality of life.

Impact (Psychological Influence)

Positive psychology helped supplement or counterbalance the disease model which had dominated the approach to and treatment of clients seeking counseling. This was accomplished in part by emphasizing the newly created classification of character strengths and virtues. Practitioners have been able to identify and develop psychological intervention tools that show significant increases in individual happiness measurements and a decrease in symptoms of depression. Interventions based on positive psychology utilize effective techniques and create a multifaceted treatment. Its results are the relief of suffering for those with mental disorders, especially depression, and the enhancement of their chances for living a happier life.

Dr. Seligman is presently director of the Positive Psychology Center at the University of Pennsylvania, where he continues to explore applications of positive psychology.

Seligman and his associates believe that complete mental health is not just the absence of mental illness. They emphasize that treatment needs to address the emotional, psychological, and social domains of clients in therapy. Mental health professionals have adopted Seligman's principles and developed other programs based on them, such as quality of life therapy.

The Dalai Lama and Martin Seligman on stage during a 2009 science of the mind conference in Sydney, Australia. Seligman, a psychologist, educator, and author, is best known as the founder of positive psychology. (Gaye Gerard/Getty Images)

Even though there are significant findings about the research and effectiveness of positive psychology, there are psychologists who remain critical of it. It has been criticized for what some consider a naïve concentration on the idea of happiness, and many are uncomfortable with its adoption of its own version of the law of attraction. The concern is that the reality and painful effects of mental illness may be ignored or underestimated. When it is applied in social or work settings, some fear that positive psychology may lead to a forced emphasis on being happy in the workplace which could actually be counterproductive.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Authentic Happiness (Book); Positive Psychology; Positive Psychotherapy; Well-Being

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Senior Mental Health

"Senior mental health" refers to the mental health status of older adults.

Description

Subjective overall well-being seems not to decline with age. Seniors, for example, report high perceptions of their health and of overall life satisfaction. However, older adults are more likely than younger members of the population to experience physiologically based comorbidities.

Mental decline like dementia and delirium are considered by many to be inevitable consequences of aging. However, normal aging does not inevitably include mental illness, such as depression and anxiety, and chronic mental illnesses like schizophrenia. While seniors experience the full spectrum of mental disorders, including anxiety, severe cognitive impairment, mood disorders, and schizophrenia, they often exhibit better mental health than younger adults.

Mental illness and decline are not inevitable consequences of aging. However, idiosyncratic aspects of mental illness add to the challenges of helping older adults manage these disorders. Although older adults tend to maintain their repertoires of coping skills as they age, the frequency of significant stressors associated with growing old increases. Thus, older adults need to manage the effects of multiple stressors simultaneously, so straining their capacity to successfully manage stress. The psychological strain of coping with these stresses, and with the consequences of physical illnesses, further stretches coping capacities and can affect mental health.

Some older adults experience subclinical depression and significant depressive symptoms. This can have devastating effects, including increasing the risk of mortality from physical illness, increasing the risk of suicide, and contributing to cognitive decline of the non-demented elderly. Although the prevalence of major depression appears to decline with age, there is some dispute as to whether or not there is undiagnosed depression among seniors. This makes depression particularly important among seniors because of the dangers of misdiagnosis, for example of dementia, when in fact the person is simply suffering from depression and is treatable.

Substance abuse, like heavy drinking, is known to occur in the senior population, although abuse of prescription and over-the-counter medications is considered more an issue of misuse rather than abuse. The use of illegal drugs is relatively low among this group; however, as the baby boomer generation floods into old age, it is believed that recreational drugs use/abuse will become more prevalent.

Older adults also experience chronic mental illnesses, like schizophrenia. Although typically associated with younger populations, schizophrenia can continue into older life. It can also emerge in older adulthood. Symptoms tend to be less severe in older adults. Delirium, also known as acute confusion, is a highly prevalent and serious mental health problem for older adults. In fact, it is considered a geriatric emergency.

Dementia is yet another mental illness prevalent in the older population. In fact, advancing age is a major risk factor for the development of dementia. The word is a broad term used to describe a cluster of symptoms that interfere with daily life by affecting intellectual function and cognitive skills. Dementia encompasses multiple cognitive deficits and impairments, including executive dysfunction, aphasia, apraxia, and agnosia. These changes significantly interfere with occupational and social functioning. The most common form of dementia is Alzheimer's disease, while vascular dementia has lower prevalence. While delirium and dementia are considered a common side effect of aging (i.e., physiologically based), depression and substance abuse are not.

Besides physiological impairments, the constellation of symptoms associated with a variety of physiological disorders tend to include physiological disturbances, such as sleep or appetite disturbances, and nonspecific complaints of pain. Unfortunately, older adults tend not to recognize that their symptoms can represent some underlying psychological issue, in part thanks to a long-held view that these symptoms are a normal consequence of aging. Also, historical stigma associated with mental illness is strongly ingrained in the older population, leading to a sense of shame and denial.

In considering mental health challenges in the senior population, Joan Erikson suggests there is a ninth stage to Erik Erikson's psychosocial development. The latter believed the eighth stage of psychosocial development to be one of ego integrity versus despair. The new ninth stage proposes to clarify the new demands, reevaluations, and daily difficulties that extreme old age brings.

Erik Erikson saw personality as a lifelong developmental process. Each of his eight stages of development resulted from the interplay of biological pressures within the individual and expectations from that person's social and cultural environment. At each stage, there is potential for crisis and conflict. The resolution of the eighth stage takes place when the individual can accept the past as inevitable and satisfying, and can also accept death without fear. The result is ego integrity. However, the negative outcomes of earlier stages would result in an adverse prognosis for the later ones, thus affecting mental health. Later in life, Erikson admitted that you couldn't find a person who has resolved all previous crises equally well.

Joan Erikson's theory suggests that living into old age and facing its challenges brings about a shift in meta-perspective from a materialistic and rational view to a more cosmic and transcendent one. This is reflected in the fact that senior adults continue to develop spiritually. It also highlights the need to better understand senior mental health and better manage it.

Current Status

Treatment approaches vary depending on the severity of symptoms. In cases of severe depression, pharmacotherapy in conjunction with psychotherapy is a treatment of choice. Selective serotonin reuptake inhibitors are recommended as the first-line pharmacological treatment. In cases where the severely depressed senior has not responded to other treatment, electroconvulsive therapy may be implemented. For milder symptoms of depression, non-pharmacological treatment approaches are preferred. These include interpersonal therapy, cognitive therapy, and reminiscence therapy. In treating substance abuse, the approach needs to be supportive and nonconfrontational. The focus should be on coping with depression, loneliness, and loss, and rebuilding a social support network.

Medication is particularly important in treating chronic mental illness, particularly schizophrenia. Because symptoms tend to be less severe in older adults, lower doses of traditional antipsychotic medications are often prescribed. However, older adults tend to be more susceptible to the development of side effects. Unfortunately, the mental health of seniors remains a neglected aspect of health-care services.

Mindy Parsons, PhD

See also: Gerontological Counseling; Retirement; Retirement, Psychological Factors

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Sensory Processing Disorder

Sensory processing disorder is a neurological disorder characterized by an abnormal experience of one or more of the five senses. It is also known as sensory integrating disorder.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Autism spectrum disorder** is a neurodevelopmental disorder characterized by difficulty learning, communicating, and repetitive bodily movements.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is considered a mental disorder only when it significantly disrupts one's daily functioning.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental

health professionals use to diagnose mental disorders.

- **Occupational therapy** is a type of therapy that focuses on helping individuals gain or regain abilities to engage in activities of daily living like dressing, eating, and walking.

Description

Sensory processing disorder is a neurological disorder whereby an individual's brain and nervous system do not receive and process sensory information correctly. The abnormal functioning that results is expressed as a hypersensitivity (higher than normal sensitivity) to one or more of the five senses (sight, smell, sound, taste, and touch). For example, an individual with this disorder may find his shirt to be very uncomfortable or that daylight is much too bright. In addition, sensory processing disorder may manifest as a lack of sensitivity. As a result individuals may excessively season their food or have to turn up the volume when listening to music. Currently, this disorder is not recognized as a diagnosis in DSM-5. Instead, it is considered to be the result of other disorders such as autism spectrum disorder. Although this point is debated, there are commonalities between symptoms of autism spectrum disorder and sensory processing disorder, specifically hypersensitivity to sensory information.

Sensory processing disorder is more common in children than in adults. The usual age of onset tends to be in early childhood. However, adults also can be diagnosed with this disorder. It is estimated that 1 in 20 children in the United States can be diagnosed with this disorder (Miller and Fuller, 2006).

The cause of this disorder is unknown. However, it has been suggested that genetics may play a significant role in the manifestation of symptoms. Individuals with this disorder often develop anxiety and depression as they age. They may also experience difficulty in learning, working, and interpersonal relationships.

Treatment

Treatment for this disorder is commonly provided by an occupational therapist. The goal of treatment is to help these children cope with and become accustomed to their hypersensitivity. Treatment may also include learning age-specific skills. These include earning an income or learning adaptive (healthy) ways to interact with others in uncomfortable circumstances. In addition, comorbid (occurring simultaneously) conditions such as anxiety or depression treatment may be treated. There is no known cure for this disorder.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Anxiety; Autism Spectrum Disorders; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM)

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Separation Anxiety Disorder

Separation anxiety disorder (SAD) is an anxiety disorder characterized by excessive anxiety resulting from separation from those to whom a child is attached.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorder.

Description

Separation anxiety disorder is defined by the American Psychology Association as the inappropriate and excessive display of fear and distress when faced with situations of separation from places, objects, or people to whom children are emotionally attached. Common examples include separation from home, blankets, teddy bears, or parents and other family members. Separation anxiety occurs often, especially with people to whom the individual has a strong emotional attachment. SAD may cause significant negative effects and emotions and hinder normal everyday life for the affected child.

SAD can present in many areas such as social and emotional contacts, family life, physical health, and school attendance and performance. The anxiety expressed needs to be more intense than the behavior expected for other people of the same age. The anxiety also must be present for about one month and occur in children before adulthood.

Causes and Symptoms

The causes of SAD are most often a combination of developmental and social factors. One important social factor influencing SAD is parenting style. Parent and child interactions that include confusing messages to the child about affection from their parent play a factor. So does the independence the parent gives and expects from the child. Parenting styles can range anywhere from neglect to smothering. The child's own temperament plays a role. If a child feels insecure in the world, he or she needs to find places, objects, or people who help him or her feel protected.

How children exhibit separation anxiety varies, but certain behaviors are common in SAD. Many children experience clear distress, worry, or even panic at the possibility of separation. This can be demonstrated by clinging to a person or object that represents security. It can also include crying, withdrawing, and screaming, which threatens physical distance from the object of security. Other common symptoms are sleep disturbance, including lack of sleep and night terrors. Physical sickness can also occur, including headaches, stomach aches, and nausea. Children may also exhibit a variety of resistant behaviors, such as avoidance and denial, when threatened with the loss of the person or object they are attached to.

Diagnosis and Prognosis

SAD is diagnosed when it happens frequently and consistently over time. There is some difference of opinion on the exact definitions of how much and for how long the behaviors need to occur to warrant a diagnosis. Usually children need to present with anxious behaviors during specific events. These events include actual separation or even the threat or worry of separation. A diagnosis also requires that a child refuse to do expected tasks, like sleep or go to school, or isolate himself or herself from others. It also requires that a child experience physical symptoms like nausea or headaches. Depending on the severity of symptoms and access to treatment, a child's prognosis will vary. A child's ability to tolerate separations should gradually increase over time when he or she is gradually exposed to the feared events.

Treatment

As children become more able to engage in self-reflection, it becomes important to help them identify the circumstances that make them anxious. This includes SAD. Exposure therapy and desensitization to separation are common behavioral therapy approaches on working with children with SAD. Encouraging a child with SAD to feel competent and empowered, as well as discussing feelings associated with anxiety-provoking events, helps promote recovery.

For the treatment of SAD several behavior therapies have proved very helpful. Among the most effective have been behavior therapy and cognitive behavior therapy. Behavior therapy can use a reward system to give children verbal or tangible reinforcement. When children show signs of independence, they are praised or given a reward. In working with younger children, behavior therapy, without a cognitive component, can be more effective.

Cognitive behavior therapy focuses on helping children reduce feelings of anxiety by exposing them to stressful situations and then helping them identify

different ways of thinking that can help them deal with their anxiety. It is more difficult to use cognitive behavior therapy with very young children. Cognitive behavior therapy requires some maturity because a child needs the communicative ability to express emotions or the self-control ability to cope with the separation anxiety on his or her own. The goals of the treatment are to help the child recognize the anxious feelings and behaviors and design a plan to help cope with them. Developing skills that will work for children and then applying them in an ongoing way and refining the techniques through evaluating their effectiveness are important parts of this treatment.

Alexandra Cunningham, PhD

See also: Adverse Childhood Experiences; Anxiety Disorders in Youth; Anxiety Reduction Techniques; Behavior Therapy with Children

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Serotonin

Serotonin is a chemical messenger in the brain that regulates learning, sleep, mood, and appetite. It is involved in disorders such as depression and anxiety.

Definitions

- **Selective serotonin reuptake inhibitors** are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.
- **Serotonin discontinuation syndrome** results from the abrupt discontinuation of antidepressant. It is characterized by withdrawal symptoms such as anxiety, agitation, insomnia, nausea, vomiting, diarrhea, fatigue, vivid or bizarre dream, dizziness, and other sensory disturbances.
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. Severe symptoms include high blood pressure, high fever, headache, delirium, shock, and coma. Milder symptoms include diarrhea, shivering, and goose bumps on the skin.

Description

Serotonin is a chemical messenger made from tryptophan, an amino acid, plentiful in a normal diet. About 80% of the body's total serotonin is in the gut where it regulates intestinal movements. Another 10% is synthesized by neurons in the brain, where it functions as a neurotransmitter. Serotonin acts by transmitting nerve impulses across synapses (gaps) between neurons (nerve cells). High levels of tryptophan in the blood signal the brain to make serotonin. One such signal is carbohydrate consumption, which explains why many individuals experience feelings of contentment after eating a cookie or other sugary or starchy snack. The beneficial consequences of increased serotonin include a sense of contentment and happiness, relaxation, and a good night's sleep.

Serotonin is called the "happiness hormone" because it can enhance an overall sense of well-being. Because of its importance in regulating moods and feelings of well-being, serotonin is targeted by medications that affect the mood, particularly antidepressants. Serotonin receptors and serotonin transporters play key roles in serotonin transmission or signaling. Serotonin receptors are found on the surface of neurons and other cells that receive and respond to serotonin. Research shows that women have more serotonin receptors than men, and lower levels of the protein that carries serotonin back into the nerve cells that secrete serotonin. This may explain why women experience more depression and chronic anxiety than men. Besides regulating serotonin, these receptors also regulate the release of other neurotransmitters like dopamine, acetylcholine, and gamma-aminobutyric acid. These

receptors are identified in groups numbered 5-HT1 to 5-HT7 and are the targets of antipsychotics, appetite suppressants, street drugs like ecstasy, and antidepressants. Serotonin transporters (SERT) regulate the amount of serotonin in synapses between neurons. They recycle serotonin by transporting (moving) serotonin from the synaptic space back into the presynaptic (originating) neuron. SERT is the target of many antidepressants, particularly the selective serotonin reuptake inhibitors (SSRIs).

Most antidepressants work by increasing serotonin in the brain. A class of antidepressant medications called monoamine oxidase inhibitors (MAOIs) prevent the breakdown of neurotransmitters, allowing them to increase in the brain and relieve depression. Commonly prescribed MAOIs are Parnate, Marplan, and Nardil. Unfortunately, these medications have some serious side effects and have problematic interactions with other types of medication.

SSRIs are also used to treat depression, yet they have fewer side effects, and they tend to react better than other medications. Commonly prescribed SSRIs are Prozac, Celexa, Zoloft, and Lexapro. There is a class of antidepressants that does not increase serotonin in the brain, however. Some, like tricyclic antidepressants, such as Elavil, actually block neurotransmitter reuptake.

Precautions and Side Effects

Despite its contributions to well-being, too much serotonin can be problematic. Extremely high levels can be toxic and even fatal. Serotonin syndrome is the name for this condition. Such high levels can result from an overdose of serotonin increasing antidepressant. In can also occur when an SSRI is used in combination with an MAOI medication. Serotonin syndrome is not always fatal; it can occur in milder forms. For example, the drug ecstasy can cause symptoms of the syndrome, yet the levels rarely reach toxicity. Other street drugs, including cocaine, methamphetamine, and LSD, can cause it. So can herbal remedies like St. John's wort and ginseng. The symptoms of serotonin syndrome typically appear within minutes to six hours after taking the medications. Serotonin discontinuation syndrome can also occur if an antidepressant is abruptly stopped rather than slowly tapered. Finally, all antidepressants can increase the risk of suicidal behavior. There appears to be a much higher risk of suicide among users of SSRIs as compared to other types of antidepressants.

Len Sperry, MD, PhD

See also: Antidepressants; Depression

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Seven Principles for Making Marriage Work, The (Book)

The Seven Principles for Making Marriage Work is a book written by clinical psychologist and marriage researcher John Gottman and Nan Silver and published in 1999.

Description

The book *The Seven Principles for Making Marriage Work* (SPMMW) is based on extensive research by John Gottman and others, and captures principles on what makes marriages work. The principles are as follows:

1. Enhance your love map. A love map is a person's knowledge of the inner world of his or her partner. How well a person knows his or her partner's history, worries, stresses, joys, and hopes denotes how detailed a love map is. Couples who make marriage work have a richly detailed love map of each other.
2. Nurture your fondness and admiration. According to Gottman happy couples have an admiration, fondness, and overall positive view of each other. Admiration and fondness are two of the most important dynamics in

successful marriages. If these are absent from a marriage, the marriage cannot be saved.

3. Turn toward each other instead of away. Gottman addresses the importance of real-life romance in marriages that work. Real-life romance is expressed in the everyday little things such as letting your partner know he or she is valued. Calling your partner and encouraging him or her, for example, or choosing to listen to your partner's difficulties can make the difference between a happy marriage and an unhappy one.
4. Let your partner influence you. This is the principle that happy couples work together and form a team based on consideration for each other's feelings and perspective. Allowing your partner to influence you is a sign of respect and shared control.
5. Solve your solvable problems. Some problems, according to Gottman, can't be solved but many can. Knowing the difference is crucial to good marriages. Some problems are solvable and some are perpetual. Solvable problems are less painful or intense than perpetual problems. Solvable problems are situational and are usually based in arguments about housecleaning, sex, or parenting. Perpetual problems are deeper and are often based on significant differences in personality, values, and lifestyle. Perpetual problems include feeling rejected by your partner; one or both partners being critical, harsh, belittling, and stubborn; feeling like nothing ever changes, and the couple finds themselves gridlocked.
6. Overcome gridlock. According to Gottman gridlock comes from unfulfilled dreams that are not being addressed or respected by each other. The goal is to begin discussing the issues underlying the unfulfilled dreams and helping the partner more toward making those dreams come true.
7. Create shared meaning. Gottman teaches that marriage is more than the tasks and goals of raising a family and living together. Couples in marriages that work create a shared inner life, develop a shared family culture, are open to each other's perspective, and share an appreciation for the roles and goals that link them together.

The Four Horsemen of the Apocalypse

One of the major contributions made by Gottman in *The Seven Principles for Making Marriage Work* is his articulation of the "Four Horsemen of the Apocalypse." The four horsemen are a reference to the New Testament Bible passages from the book of Revelations in which four angelic horsemen of conquest, war, hunger, and death usher in the end of days. Gottman uses the four horsemen as a metaphor for communication styles that predict the end of the relationship: Criticism, Contempt, Defensiveness, and Stonewalling. These horsemen come and go and can be expressed through verbal aggression or more subtly through nonverbal ques.

The first of the four horsemen is "Criticism," in which a partner's personality or character is attacked. A criticism is different from a complaint, which addresses a specific situation. Criticisms add blame and often contain generalizations such as "you always. . .," or "you never. . . ." For instance, a complaint might be, "We agreed that we would take turns cleaning the dishes." A criticism would include, "You never keep your word" or "you only think of yourself."

The second horseman is "Contempt," in which a partner is treated with disrespect, sarcasm, and ridicule, leaving him or her feeling despised and worthless. Contempt is fuel by long-held negative thoughts about the partner. Contempt is the single greatest predictor of divorce. A contemptuous response to the dish-washing conflict would be "whatever" as the partner rolls the eyes.

The third horseman is "Defensiveness." Defensiveness is very common in marriages that are heading toward divorce. When accused, the partner responds with excuses, so the attacking partner will back off. This rarely occurs though because defensiveness is essentially blaming the attacking partner. For instance, in the dish-washing conflict a defensive response to "you only think of yourself" would be "well you would only tell how bad a job I did anyway and redo the dishes." Defensiveness commonly escalates problems.

The final horseman is "Stonewalling." Once criticism, contempt, and defensiveness have become a

vicious repeating circle, one of the partners will tune out and withdraw from interacting. This unresponsive closing out of the partner allows him or her to be less exposed to criticism, contempt, and defensiveness.

The Seven Principles for Making Marriages Work by John Gottman is a significant contribution to strengthening marriages. One-day training is offered to clergy, educators, life coaches, community leaders, social workers, nurses, counselors, and others who may want to facilitate a couples group at a community center, church, home, and so on. Training is provided through the Gottman Institute, a for-profit training institute founded by Gottman and his wife, Julie Schwartz Gottman, PhD.

Steven R. Vensel, PhD

See also: Couples Therapy; Gottman, John (1942–)

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Sex and Gender

The terms "sex" and "gender" are often used interchangeably but are distinguishable in that sex refers to one's biological sex characteristics, while gender refers to how one personally identifies with being either male or female.

Definitions

- **Anisogamy** is what differentiates between the two sexes, male or female, referring specifically to size and form differences between sex cells, or gametes.
- **Gender identity** is the way in which one self-identifies one's gender, or personal sense of being male or female.
- **Gender/sex roles** describe stereotypical characteristics, preferences, aptitudes, and behaviors of being either masculine or feminine.
- **Intersex** is defined as when a person has a combination or mixture of male and female sex factors.
- **Sexual identity** refers to whether one identities oneself as predominantly homosexual, heterosexual, or bisexual.
- **Transgender** describes individuals who are experiencing gender dysphoria, who do not personally identify with the gender they were assigned at birth.

Description

Though the terms "sex" and "gender" are closely related, they are not synonymous as each describes different constructs. Sex defines the anatomical, physiological, or biological makeup that defines males or females at birth. Male or female sex is determined by chromosomal and hormonal differences, type of gonads, and the presence or absence of internal reproductive organs or external genitalia. There are two sex chromosomes in human beings, the X chromosome and the Y chromosome. The Y chromosome is responsible for determining one's sex. Females have two X chromosomes, while males have an X and Y chromosome. The Y chromosome is passed only from father to son. Male gonads are the testes and female gonads are the ovaries. Females have an internal reproductive sex organ, the uterus, while males have external genitalia, the penis. People can also be intersexed, or have a mixture of these sex factors.

Gender describes the traits, characteristics, and attributes associated with masculinity or femininity. Gender may be assumed or presumed by others, though this may not match what a person feels is his or her true identity (gender identity). Individuals who are trans- or cisgender may experience gender dysphoria. Often gender assumptions are based on societal norms for what is expected, deemed appropriate, or "normal" for males or females. Stereotypes such as these are referred to as gender roles. Gender roles can

influence an individual's thoughts, feelings, behaviors, and sense of self.

Current Status and Impact (Psychological Influence)

Historical views believed there to be only two distinct categories of sex and/or gender, male or female. However, additional categories are now recognized, including people who are intersexed and those who identify as transgender or transsexual. Research indicates that both sex and gender impact how an individual thinks, feels, acts, and perceives the world around him or her. Feminists in particular have argued against the traditional male/female dichotomy and have suggested that the emphasis society places on sex/gender results in inequity, bias, and undue pressure.

Melissa A. Mariani, PhD

See also: Gender Identity Development; Sexual Identity; Transgender

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Sexting

Sexting describes electronic communication sent through text messages, e-mails, or social networking that involves the use of sexually explicit or sexually suggestive language, photos, or videos.

Description

Sexting is defined as the sending or receiving of sexually explicit or suggestive messages, images, or videos via cell phone, e-mail, or social networking sites. This term is most commonly used to describe incidents where teenagers take seminude (for girls, topless) or nude pictures of themselves and proceed to send those to others using their cell phone or by posting the items on Internet sites like Facebook. Sexting also includes transmitting sexually suggestive message content. This type of communication is typically meant for someone the person has a romantic interest in or attraction to. However, a major concern about sexting behavior is that the content often ends up in the hands of those it was not intended for.

Sexting appears to occur along a continuum, ranging from typical teenage behavior to intentional victimization of others. Depending on the circumstances, some acts may be considered "experimental," while other, more serious instances may be categorized as "aggravated." Although adolescents are known to test boundaries and explore their sexual identity as they approach adulthood, red flags are raised when private, intimate communications become public. Of even greater concern is the emotional and psychological damage one can endure after being exposed to a broad audience electronically. Some sexting cases have resulted in tragic outcomes, including suicide.

Impact (Psychological Influence)

There has been growing concern about the rates at which adolescents participate in sexting. Reports indicate that both males and females engage in sexting behavior at nearly equal rates. Several factors contribute to high incidence rates among this population, including increased access to technology, impulsivity, hormone changes, and peer pressure. A Pew Research Center survey found that 77% of teens owned cell phones and two-thirds reported texting as their preferred method of communicating with friends (Lenhart, 2013). Girls send a median of 100 texts per day, while boys the same age send 50. However, evidence also suggests that many adults engage in sexting types of behaviors. Access to technology and the popularity of social networking sites, and online dating sites such as Match.com, may be factors impacting the adult subset.

In 2008, the Sex and Tech Survey, commissioned by The National Panel to Prevent Teen and Unplanned Pregnancy in conjunction with Cosmogirl.com,

indicated that 20% of teenagers (aged 13 to 19) had reported posting nude or seminude photos or videos of themselves online (Sex and Tech, 2008). These numbers increased to 33% as teens became young adults (Sex and Tech, 2008). Sending sexually explicit or suggestive messages via text, e-mail, or post was reported at even higher rates by teens, 39% (Sex and Tech, 2008). Peer pressure has been cited as a major contributing factor, particularly with the adolescent population.

Melissa A. Mariani, PhD

See also: Electronic Communication

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Sexual Abuse

Sexual abuse involves nonconsensual sexual contact of any kind in which individuals are forced to engage in sexual activity against their will.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about imagined danger.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing faulty behaviors, emotions, and thoughts.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Frotteurism** is a mental disorder characterized by deriving sexual pleasure or gratification from touching or rubbing against non-consenting individuals.
- **Grooming** refers to intentionally forming an emotional connection with someone in order to manipulate him or her psychologically in order to lower his or her resistance to sexual activity.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.
- **V codes** are codes listed in the DSM-5 that are used to identify conditions other than a disease or injury and are used to report significant factors that may impact the treatment.

Description and Diagnosis

Sexual abuse is one of the conditions presented as a V code in the DSM-5 "Other Conditions That May Be a Focus of Clinical Attention" section. Sexual abuse is listed under the categories of "Child Maltreatment and Neglect Problems and Adult Maltreatment and Neglect Problems." Sexual abuse is the coercion of unwanted sexual behavior by one individual on another. Sexual abuse does not necessarily involve direct physical contact. It can include exposing of one's genitals, sexual harassment, stalking, and exposing pornographic material to the victim. Child sexual abuse typically involves coercion, although it can include violence. Often young children are defenseless when they are sexually abused. Older children may become vulnerable to bribes, threats, and lies. Abusers typically manipulate a child through grooming for the purpose of gaining a child's trust. Sexual abuse can overwhelm a child with disbelief, fear, confusion, shame, and horror. It can leave a child emotionally devastated. Adults who have been sexually abused can lead to a host of symptoms that negatively impact their lives. Some symptoms include fear, anger, guilt, low self-esteem, anxiety, depression, and being afraid of or avoiding sex.

The occurrence of sexual abuse reports that one out of three girls and one out of five boys under the age of 18 in North America has been sexually abused (Centers for Disease Control and Prevention, 2011). Approximately, 4.8 million women and 2.8 million men report being sexually abused each year in the United States (Centers for Disease Control and Prevention, 2011).

According to the DSM-5, a child should be given the V-code of "Child Sexual Abuse" if the abuse includes any sexual act involving a child in order to provide sexual gratification to the abuser. The abuse may include incest, penetration, indecent exposure, and fondling a child's genitals. The abuse also may not involve sexual contact. For example, the abuser may pressure a child to become involved in acts for the gratification of others, without having direct physical contact between the abuser and the child. An adult (spouse) should be given the V-code of "Spouse or Partner Violence, Sexual" when he or she has been forced into sexual acts during the past year. Physical force may be used by the abuser to engage in sexual acts against the victims will. An adult (nonspouse) should be given the V-code of "Adult Abuse by Nonspouse or Nonpartner" when the victim has been abused by a stranger or non-intimate partner. The acts may involve sexual, physical, or emotional abuse (American Psychiatric Association, 2013).

There may be several causes of this disorder. Abusers may differ in their motivations why they sexually abuse other individuals. Some may have a past history of trauma (e.g., being sexually abused themselves). Some abusers may engage in this form of abuse due to their current physical and mental health status. In addition, some may have diseases or disorders (e.g., loss of self-control) and may act inappropriately with adults as well as children.

Treatment

Treatment for victims of sexual abuse typically involves psychotherapy. Cognitive behavior therapy has been shown to be effective in changing the victim's beliefs about the abuse that may be contributing to his or her depression of anxiety, among other symptoms. Some other forms of treatment that may be helpful include mindful meditation, massage therapy, yoga, and relaxation techniques.

Elizabeth Smith Kelsey, PhD, and
Len Sperry, MD, PhD

See also: Anxiety; Cognitive Behavior Therapy; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Frotteuristic Disorder; Psychotherapy

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Sexual Addiction

A sexual addiction is a mental disorder characterized by compulsive sexual acts and thoughts.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive behaviors, emotions, and thoughts.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life.
- **Exhibitionism** is the act of an individual exposing parts of his or her body that are normally not exposed in public.

- **Obsessive-compulsive disorder** is a mental disorder characterized by unwanted and unrepeated thoughts and feelings (obsessions), or behaviors that one feels driven to perform (compulsions).
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions and compulsions based on the Twelve Steps.
- **Voyeurism** is an individual who seeks sexual gratification from secretly observing naked bodies or sexual acts of others.

Description

A sexual addiction is described as a mental disorder characterized by an escalating, continuous, and compulsive pattern of sexual behavior despite negative consequences to self and others. For some individuals with a sexual addiction, their behavior does not develop beyond the use of pornography, uncontrollable masturbation, or computer sex services. For other individuals with a sexual addiction, they often engage in illegal activities, such as voyeurism, exhibition, molestation, rape, or obscene phone calls. The sexual addict often intensifies the addictive behavior to achieve the same results.

Some symptoms of sexual addiction include an individual frequently having more sex with more people than intended, having a preoccupation with or frequently craving sex, and frequently engaging in excessive sexual activity despite the desire to stop. An individual with a sexual addiction can negatively impact many areas of one's life (e.g., work, family, school). Often times, when a sexual addict is unable to engage in his or her desired behavior, he or she becomes very frustrated and irritable.

There is no known cause for an individual with a sexual addiction. However, biological, psychological, and social factors are thought to contribute to sexual addiction. For example, certain areas of the brain elicit chemicals that cause compulsion. Depression, anxiety, and obsessive-compulsive disorders are potential psychological risk factors for sexual addiction. Furthermore, individuals tend to be socially isolated from others, impulsive, and insecure, and have difficulty dealing with their emotions.

Treatment

Psychotherapy is one form of treatment for individuals with a sexual addiction. Cognitive behavior therapy has been shown to be an effective form of treatment by helping an individual learn what triggers his or her sexually destructive behaviors. This type of therapy also helps the individual to evaluate his or her distorted thoughts, which control his or her behavior. Individuals with a severe form of a sexual addiction may require an inpatient or outpatient treatment program. Twelve-Step meetings can also be helpful for an individual with a sexual addiction. In addition, some individuals are prescribed antidepressant medications if they are suffering from depression during their sexual addiction.

Elizabeth Smith Kelsey, PhD, and Len Sperry, MD, PhD

See also: Antidepressant Medications; Brain; Cognitive Behavior Therapy; Depression and Depressive Disorders; Exhibitionistic Disorder; Obsessive-Compulsive Disorders; Psychotherapy; Twelve-Step Programs; Voyeuristic Disorder

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Sexual Aversion Disorder

Sexual aversion disorder is a mental disorder characterized by strong dislike, fear, or disgust of genital contact with a sexual partner.

Definitions

- **Anxiety** is apprehension or worry about an imagined danger.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure** is a cognitive behavior therapy intervention (method) in which a client is exposed to a feared object or situation. It is also referred to as flooding.
- **Fear** is an emotional response to a known danger.
- **Genito-pelvic pain/penetration** disorder is a mental disorder in women characterized by persistent fear, pain, or difficulty with vaginal intercourse. Previously this disorder was referred to as dyspareunia and vaginismus.
- **Other specified sexual dysfunction** is one of the DSM-5 sexual dysfunctions disorders, which is used to diagnose presentations where symptoms cause significant distress but do not meet the full criteria for one of the listed sexual dysfunction disorders.
- **Sexual and gender identity disorders** were a group of mental disorders in DSM-IV-TR. They were characterized by disturbances in sexual desire or functioning, or discomfort with one's assigned gender.
- **Sexual dysfunctions disorders** are a group of mental disorders in DSM-5 characterized by significant difficulty in responding sexually or experiencing sexual pleasure. They include female orgasmic disorder and other specified sexual dysfunction.
- **Specific phobia** is a mental disorder characterized by a marked and enduring fear of specific situations or objects. Previously this disorder was referred to as simple phobia.
- **Systematic desensitization** is a form of cognitive behavior therapy that gradually exposes individuals to their phobia (fear) while remaining calm and relaxed.

Description and Diagnosis

Sexual aversion disorder was one of the DSM-IV-TR sexual and gender identity disorders. It was characterized by a strong aversion to genital contact. This aversion is usually experienced as disgust, fear, or anxiety that is focused on genitalia, bodily fluids related to sexual activity. The aversion can also be toward kissing or intimate touching. The symptoms of specific fear and anxiety are similar to that of a specific phobia. However, there are differences. The main difference is that feelings of disgust in sexual aversion disorder are not common in specific phobia. However, this disorder is not included as a separate disorder in DSM-5. Instead, it can be diagnosed as another specified sexual dysfunction. The prevalence of this disorder is unknown because it is not well researched and individuals with such disorders do not report their symptoms.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Addition, Text Revision*, an individual can be diagnosed with this disorder if he or she experiences distressing dislike and avoidance of genital contact with a sexual partner. For some, this disorder may have been present since they became sexually mature, while others may develop this disorder late (American Psychiatric Association, 2013). The cause of this disorder varies between individuals. It has been suggested that genito-pelvic pain disorder, adverse sexual experience and abuse, and the pairing of adverse stimuli with sexual activity may play a role in the manifestation of this disorder.

The cause of this disorder is not well understood. Several factors may contribute to it. These include partner factors, relationship factors, and individual factors such as history of sexual or emotional abuse, cultural and religious factors, and medical factors.

Treatment

Treatment for this disorder is very similar to that of specific phobia. Cognitive behavior therapy (CBT) is used

to reduce fear, anxiety, and pain. Specific CBT interventions (methods) include systematic desensitization and exposure techniques. If sexual abuse is a contributing factor, therapy may need to specifically address it.

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See also: Anxiety; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Exposure Therapy; Genito-Pelvic Pain/Penetration Disorder; Sexual Dysfunctions; Specific Phobia; Systematic Desensitization

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Sexual Dysfunctions

Sexual dysfunctions are a group of mental disorders characterized by a significant disturbance in an individual's ability to respond sexually or to experience sexual pleasure.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorder.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or the reduced ability to enjoy life.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Opioids** are a class of narcotic drugs used to treat moderate to severe pain.

Description and Diagnosis

Sexual dysfunctions are a group of DSM-5 mental disorders characterized by a significant disturbance in an individual's ability to respond to sexually or to experience sexual pleasure. An individual may have more than one sexual dysfunction at the same time. If this is the case, each dysfunction should be diagnosed separately. A number of circumstances must be taken into consideration when making the diagnosis of a sexual dysfunction. Some of these circumstances include partner factors (e.g., partner's sexual difficulties), relationship factors (e.g., lack of communication), individual vulnerability factors (history of abuse), the presence of two disorders (e.g., depression and erectile dysfunction), and stress (e.g., financial problems). Other circumstances to be considered include religious or cultural factors (e.g., attitudes toward sexuality). Medical factors relevant to the prognosis (prediction of outcome), course of action, or treatment options for sexual dysfunction must also be considered. Aging may also be related to a decrease in sexual response in individuals. In many situations, the cause of a sexual problem is unknown.

There are several separate disorders that fall under the DSM-5 classification of sexual dysfunctions. They include erectile disorder, delayed ejaculation, female sexual interest/arousal disorder, female orgasmic disorder, male hypoactive sexual desire disorder, genito-pelvic pain/penetration disorder, premature (early) ejaculation, substance-/medication-induced sexual dysfunction, other specified sexual dysfunction, and unspecified sexual dysfunction (American Psychiatric Association, 2013). Most of these disorders are more fully described in their own entries in this encyclopedia.

Erectile disorder. Erectile disorder is a sexual function disorder in males who repeatedly fail to obtain or maintain an erection during sexual activity with a partner. Symptoms may occur in specific situations

(e.g., a certain partner or type of stimulation) or may occur in all types of situations. Several men who experience this disorder have low self-confidence, low self-esteem, and a decreased level in their masculinity. Individuals with this disorder may avoid or have a fear of future sexual encounters. Many individuals with erectile disorder experience significant distress as a result of the symptoms. The symptoms of this disorder must occur for at least six months.

Delayed ejaculation. Delayed ejaculation is a sexual function disorder in which males have a significant delay in ejaculation or the inability to achieve ejaculation. These symptoms must occur on nearly all or all occasions of sexual activity with a partner. This disorder occurs despite the presence of adequate stimulation and having the desire to ejaculate. Individuals engaged in sexual activity may report an extended period of thrusting to reach orgasm to the point of extreme tiredness or genital soreness. If this occurs individuals generally end efforts to reach orgasm. The symptoms of this disorder must cause significant distress in the individual and occur for at least six months.

Female sexual interest/arousal disorder. Female sexual interest/arousal disorder is a sexual function disorder characterized by a lack of or significantly reduced sexual interest and arousal. It is often associated with difficulties in having an orgasm, pain during sexual activity, very little sexual activity, and differences in sexual desire between partners. Some symptoms of this disorder include feelings of disconnection, isolation, or boredom during sex. These symptoms can interfere with sexual interest and arousal if a woman does not feel close to her partner and does not find sexual activity pleasurable. A woman who has self-image problems (with her body) is another symptom of this disorder. Women with histories of emotional or sexual abuse, rape, incest, or other traumatic experiences may also contribute to a lack of interest or arousal in sexual activity. The symptoms associated with this disorder must occur for at least six months.

Female orgasmic disorder. Female orgasmic disorder is a sexual function disorder characterized by a woman having difficulty experiencing an orgasm. An individual diagnosed with this disorder may have a significant delay in achieving an orgasm or the absence of having an orgasm. She may also have a reduced intensity in the feeling of an orgasm. Although women with this disorder may not experience an orgasm during sexual activity, many women report high levels of sexual satisfaction whether they rarely or never have an orgasm (American Psychiatric Association, 2013). The symptoms of this disorder must cause significant distress in the individual and occur for at least six months.

Male hypoactive sexual desire disorder. Male hypoactive sexual desire disorder is a sexual function disorder characterized by a low or absent desire for sex and inadequate or absent sexual fantasies or thoughts. Men who experience erectile or ejaculation problems may be associated with this disorder. For example, if a man continually has difficulty obtaining and maintaining an erection, he may lose interest in sexual activity. Many men do not initiate sexual activity and often prefer the partner to do so. Several factors that affect sexual functioning are taken into account when making this diagnosis. They include age and general and cultural situations in the individuals' life. The symptoms of this disorder must cause significant distress in the individual and occur for at least six months.

Genito-pelvic pain/penetration disorder. Genito-pelvic pain/penetration disorder is a sexual function disorder characterized by recurrent difficulties with at least one of the following conditions. They include genito-pelvic pain, difficulty having intercourse, pressure in the pelvic muscles, and fear of vaginal penetration or pain. This disorder is frequently associated with other sexual function disorders (e.g., female sexual interest/arousal disorder). Individuals who do have sexual desire and interest will engage in sexual activity as long as penetration is not required. Women with this disorder often experience difficulties in their relationships (e.g., marriage). In addition, women tend to feel a decrease in their level of femininity. The symptoms of this disorder must cause significant distress in the individual and occur for at least six months.

Premature (early) ejaculation. Premature (early) ejaculation is a sexual function disorder characterized by ejaculation that occurs prior to or shortly after vaginal penetration. A heterosexual male with this disorder will usually ejaculate within 60 seconds of penetration. In severe forms of this disorder ejaculation may occur within 15 seconds of penetration. Many men with this

disorder claim that they have a lack of control over ejaculation. They also worry about their anticipated inability to delay ejaculation on future occasions involving sexual activity. The symptoms of this disorder must cause significant distress in the individual and occur for at least six months.

Substance-/medication-induced sexual dysfunction. Substance-/medication-induced sexual dysfunction is a sexual function disorder characterized by the use of a specific substance or medication that is causing sexual dysfunction. For example, an individual may be using substances such as opioids or antidepressant medications that may interfere with his or her sexual function. In particular, it is commonly reported that individuals who use antidepressant medication have difficulty achieving an orgasm or ejaculating (American Psychiatric Association, 2013). Illegal substance use (e.g., marijuana and cocaine) has also been found to decrease sexual desire, and cause problems obtaining an erection and difficulty achieving an orgasm. Sexual dysfunction can also occur when an individual is withdrawing (not using) such substances and medications. The symptoms of this disorder must occur for at least one month after the withdrawal period and cause clinically significant distress in the individual.

Other specified sexual dysfunction. Other specified sexual dysfunction is a category under sexual dysfunctions where an individual exhibits some symptoms of a sexual dysfunction that causes him or her clinically significant distress. However, the individual does not meet the full criteria for any of the other sexual function disorders necessary to make a diagnosis. A clinician will use this category in situations to share information of the specific reason the individual does not meet the criteria for another specific sexual dysfunction.

Unspecified sexual dysfunction. Unspecified sexual dysfunction is a category under sexual dysfunctions where an individual exhibits some symptoms of a sexual dysfunction that causes him or her clinically significant distress. However, the individual does not meet the full criteria for any of the other sexual function disorders necessary to make a diagnosis. In this category, a clinician chooses not to give a reason that the criteria are not met for a specific sexual dysfunction.

Treatment

Treatment for sexual dysfunctions will depend on the cause of a specific disorder. Some forms of treatment may include psychotherapy and medications. Cognitive behavior therapy in particular can be very helpful with many of the specific sexual disorders. There are several medications available for men who suffer from erectile dysfunction. For individuals who are taking antidepressant medications that are interfering with their sex life, they may want to seek medical consultation. There are several antidepressant medications on the market today, and some do not affect sexual activity or performance.

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See also: Antidepressant Medications; Delayed Ejaculation; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Erectile Disorder; Female Orgasmic Disorder; Female Sexual Interest/Arousal Disorder; Genito-Pelvic Pain/Penetration Disorder; Male Hypoactive Sexual Desire Disorder; Opioids; Premature Ejaculation

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Sexual Identity

A person's sexual identity describes how he or she thinks of himself or herself in terms of sexual behavior, attraction, or sexual orientation.

Definitions

- **Asexual** refers to the absence of a traditional sexual orientation, which may be considered a fourth category of sexual orientation.

- **Bisexual** describes the sexual orientation of an individual who is romantically, physically, or sexually interested in both females and males.
- **Heterosexual** describes the sexual orientation of an individual who experiences romantic, physical, emotional, or sexual attraction to a person of the opposite sex.
- **Homosexual** describes the sexual orientation of an individual who experiences romantic, physical, emotional, or sexual attraction to a person of the same sex.
- **Sexual orientation** describes an individual's ongoing pattern of sexual attraction toward persons of the same gender, opposite gender, or both genders.
- **Transgender** describes individuals who are experiencing gender dysphoria, who do not personally identify with the gender they were assigned at birth.

Description

Sexual identity can encompass both a person's sexual orientation and his or her sexual behavior. The term refers to a person's conception of himself or herself related to his or her sexual behavior, attraction, or orientation. Sexual orientation is defined as an enduring pattern of sexual attraction toward persons of the same sex, opposite sex, or both sexes. There are three commonly recognized classifications for sexual orientation: heterosexual, homosexual, or bisexual. Lesbian, gay, bisexual, and transgender are readily used to describe sexual orientation. A fourth category, asexual, has also been proposed, referring to individuals who do not identify with any of the three traditional orientations. "Sexual behavior" refers to actual sexual acts performed by the individual. These behaviors may or may not be aligned with one's sexual identity or orientation. Incongruence between these constructs can result in anxiety or stress for an individual and his or her loved ones.

Current Status and Impact (Psychological Influence)

Sexual identity can grow, change, and develop over the course of one's lifetime. Furthermore, most scientists agree that nature (biological and genetic factors) and nurture (environmental and social factors) both contribute to sexual identity. Though labels and categories exist, there is not one right way to define sexual identity. Professionals suggest that overall mental health and a positive self-concept are attained by finding alignment between one's sexual identity, defined sexual orientation, and performed sexual actions.

Melissa A. Mariani, PhD

See also: Gender Dysphoria in Adolescents and Adults; Homosexuality; Sex and Gender; Sexual Orientation; Transgender

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Sexual Masochism Disorder

Sexual masochism disorder is a mental disorder characterized by fantasizing about or engaging in being beaten, bound, or made to suffer, resulting in sexual satisfaction.

Definitions

- **Asphyxiophilia** is a form of sexual masochism that involves deprivation of oxygen to the brain and is controlled by suffocation or strangulation in order to enhance the pleasure of masturbation.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by

professionals to identify mental disorders with specific diagnostic criteria.

- **Hypoxyphilia** is a form of sexual masochism that involves deprivation of oxygen to the brain and is controlled by suffocation or strangulation in order to enhance the pleasure of masturbation. It is also referred to as asphyxiophilia.
- **Masochist** is an individual who obtains pleasure from having pain inflicted on him or her by others.
- **Pain and suffering** is a physical and emotional condition that leads to mental, emotional, and bodily stress.
- **Paraphilia** is a mental condition in which individuals can only become aroused by inappropriate object, actions, or fantasies.
- **Paraphilic disorders** are a group of DSM-5 mental disorders characterized by unusual sexual preferences and behaviors that are distressing or detrimental to one's self or others. They include exhibitionistic disorder, pedophilic disorder, and fetishistic disorder.
- **Sadist** is an individual who obtains pleasure from inflicting pain on others.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Sexual masochism disorder is one of the DSM-5 paraphilic disorders. It is characterized by the feeling of sexual arousal or excitement resulting from receiving pain, suffering, or humiliation. It may be self-inflicted or by the hands of another individual. The pain is real and can be physical or psychological in nature. In addition, those with this disorder experience significant distress or significant impairment due to their behaviors and fantasies (e.g., urges). Some masochistic acts include being restrained by ropes, handcuffs, chains, or cages. Other acts include spanking, burning, whipping, cutting, rape, and mutilation. Masochistic behavior can also occur in the context of fantasy role-playing. For example, a sadist can play the role of a prison guard and a masochist can play the role of a prisoner.

The occurrence of this disorder typically begins in childhood, and the onset of sexual masochism usually occurs during early adulthood (American Psychiatric Association, 2013). One particular form of sexual masochism is extremely dangerous and can result in death. This feature is known as hypoxyphilia and involves deprivation of oxygen to an individual during the act of being sexually aroused. This form of sexual masochism can be self-inflicted or by the hands of another individual. Sexual masochism is slightly more common in males (American Psychiatric Association, 2013). It has been estimated that in Australia 2.2% of males and 1.3% of females had been involved in this disorder within the last 12 months (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they engage in intense and recurrent sexual arousal for at least six months from the act of being beaten, bound, humiliated, and made to suffer, as indicated by urges, fantasies, or behaviors. The urges, fantasies, or behaviors must cause significant distress or impairment in social, occupational, or other important areas of the individual's functioning. If the individual engages in achieving sexual arousal by restricting his or her breathing, the diagnosis must include the specifier "with asphyxiophilia." If an individual is living in a controlled environment (e.g., institution) to restrict his or her masochistic behavior, the specifier "in a controlled environment" must be included in the diagnosis. If an individual has not had any distress or impairment for at least five years in social, occupational, or other areas of important functioning, the specifier "in full remission" must be included in the diagnosis. If an individual states he or she does not have any distress or hindrance due to paraphilic impulses, he or she should not be diagnosed with sexual masochism disorder (American Psychiatric Association, 2013).

The exact causes of this disorder are unknown. However, there are some theories that try to explain the presence of paraphilias in general. One theory is that

an individual becomes a paraphilia because of inappropriate sexual fantasies that are suppressed. Due to the suppression of acting out on these urges, when an individual eventually acts out on the fantasies, an individual exhibits considerable distress and/or arousal. There is also a belief that masochists want to engage in a dominating role. This belief can cause conflict and make them submissive to others. Another theory is that masochists use their behavior as a means to escape by acting out their fantasies and become new and different individuals.

Treatment

Treatment for this disorder typically varies depending on the individual and situation. Some medications may be useful in reducing fantasies and sexual impulses, particularly in individuals who prefer dangerous physical masochism. Psychotherapy is another option that has been found to be effective for this disorder. In particular, cognitive behavior therapy can help an individual to become aware of his or her patterns and help to reconstruct his or her feelings, thoughts, and behaviors, therefore preventing symptoms and initiating new and healthier options. Treatment may be complicated for individuals who have health problems as a result of their sexual behavior. For example, masochists may have sexually transmitted diseases and other medical problems. Individuals who engage in hypoxyphilia and other dangerous behaviors can suffer extreme pain that may result in death.

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See also: Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Pain and Suffering; Paraphilic Disorders

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Sexual Orientation

An individual's sexual orientation describes an ongoing pattern of sexual attraction toward persons of the same gender, opposite gender, or both genders.

Definitions

- **Asexual** may be considered a fourth category of sexual orientation referring to the absence of a traditional sexual orientation.
- **Bisexual** describes the sexual orientation of an individual who is romantically, physically, emotionally, or sexually attracted to both men and women.
- **Heterosexual** describes the sexual orientation of an individual who is romantically, physically, emotionally, or sexually attracted to members of the opposite sex.
- **Homosexual** describes the sexual orientation of an individual who is romantically, physically, emotionally, or sexually attracted to members of the same sex.
- **Sexual identity** refers to a person's conception of himself or herself as predominantly homosexual, heterosexual, bisexual, or asexual.
- **Transgender** describes individuals who do not self-identify with their assigned birth sex.

Description

Sexual orientation describes one's enduring pattern of sexual attraction toward members of the same gender, opposite gender, or both genders. A possible fourth category, asexual, has been proposed by researchers, describing those who do not identify with one of the three traditional sexual orientation categories. In the United States, common terminology used to describe sexual orientation includes "lesbian," "gay," "bisexual," and "transgender." Rather than viewing sexual orientation

as a characteristic, it is suggested that it be defined in terms of behavior, as it depends on relationships with other people. It has also been proposed that one's sexual orientation can change over time. The Kinsey Scale, also known as the Heterosexual-Homosexual Rating Scale, developed by Kinsey, Pomeroy, and Martin in the late 1940s early 1950s, has provided much evidence supporting the fluidity of sexual behavior. Subsequent assessment tools have followed supporting this same concept. Sexual orientation is thus seen on a continuum ranging from exclusive attraction to members of the opposite sex to exclusive attraction to members of the same sex.

One's sexual orientation differs from one's biological sex, gender identity, or prescribed gender roles. Biological sex is defined as an individual's biological, genetic makeup of being either male or female. "Gender identity" refers to one's personal sense of being either male or female. Gender roles are assumed characteristics, behaviors, or preferences that are typically associated with masculinity or femininity. Early views on sexual orientation believed it to be connected to and prescribed by one's assigned sex; males were sexually attracted to females and vice versa. However, this became highly debated around the latter part of the 20th century as the concept of *gender identity* began to take root. Writers, theorists, and researchers have since offered evidence that one's sexual orientation was a separate component to one's gender identity.

Current Status and Impact (Psychological Influence)

There is ongoing debate regarding whether or not sexual orientation is genetically predetermined or develops over time from parenting, socialization, and other life experiences. Most scientists and practitioners agree both nature and nurture play a role in sexual orientation. Sexual orientation has been a topic of critical debate for decades. Those who identify themselves as something other than heterosexual have been misunderstood, shamed, ridiculed, underrepresented, overlooked, and ostracized in mainstream society. Some have been physically attacked and killed. Many religions still regard any sexual relationship outside of heterosexuality as morally wrong. Prior to 1973, homosexuality was even referred to as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) by the American Psychiatric Association (APA). The prevailing view was that homosexuality was a chosen behavior or type of deviant lifestyle. Popular opinion further suggested that this sexual orientation was something that could be influenced with therapeutic and/or medical intervention. Since that time, APA has worked hard to change this social stigma and to foster more acceptance among people in terms of sexual orientation. In 2012, the Pan American Health Organization released a statement cautioning people against seeking out services or procedures that suggested they could change one's sexual orientation as they pose serious health and psychological risks.

Melissa A. Mariani, PhD

See also: Gay, Lesbian, Bisexual, Transgender (GLBT/LGBT); Gender Dysphoria; Homosexuality; Transgender

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Sexual Predator

A sexual predator is an individual who seeks sexual contact with another in a threatening manner. Sexual predators are also known as sexual offenders.

Definitions

- **Child abuse** is the physical, sexual, or emotional abuse of a child or minor, usually under the age of 18.

- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Sexual offender** is a label used for an individual who has been convicted of crimes involving rape, sex, molestation, pornography, and sexual harassment.

Description

A sexual predator is an individual who pursues or preys on other individuals for sex in a manner that is considered harmful or threatening. Individuals who commit sex crimes (e.g., child sexual abuse and rape) are considered sexual predators or sexual offenders. They prey on strangers, neighbors, friends, and even family members. Typically, sexual predators have an immature understanding of intimacy. For example, they may want to be close to others but lack the capability to feel trust and satisfaction. Often, they feel frustration that erupts into anger. When this occurs, a sexual predator can become dangerous.

Some common characteristics of a sexual predator include having deviant sexual behavior, a troubled childhood, a history of abuse, and a lack of empathy for other individuals. Often, sexual predators refuse to take responsibility for their actions and tend to blame others for their problems. Many sexual predators have a need for entitlement, power, and control. Many sexual predators are married and most are attracted to adults. They often offend when they think they will not get caught (e.g., misdirecting an individual's attention).

There is no known cause for what makes an individual become a sexual predator. One potential theory is that the individual was victimized sometime during his or her youth. The individual may have learned that it is better to have power than to be subjected by the power of others. Another potential theory is that a sexual predator acts out because he or she has low self-esteem. In order to make themselves feel better, sexual predators may use violent actions for control and power in order to boost their self-image and to dominate others.

Treatment

Psychotherapy is one form of treatment for individuals who are sexual predators. This can help assist a sexual predator to focus on learning new strategies for stopping his or her behaviors and actions, in addition to taking responsibility for harm done to others. There are also specialized treatment programs for sexual offenders. These programs help individuals become aware of and reduce their manipulative behavioral patterns, understand the impact of their harmful behaviors toward others, and develop healthy sexual behaviors and attitudes.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Child Abuse; Psychotherapy

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Sexual Sadism Disorder

Sexual sadism disorder is a mental disorder characterized by feelings of sexual excitement resulting from inflicting pain, humiliation, and suffering on another individual.

Definitions

- **Antidepressants** are prescription medications that are primarily used to treat depression and depressive disorders.
- **Antisocial personality disorder** is a mental disorder characterized by a pattern of disregarding and violating the rights of others.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive (faulty) behaviors.

- **Cognitive restructuring** is a psychotherapy technique for identifying maladaptive (unhealthy) thoughts and changing them to present a more accurate view of a situation.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Paraphilia** is a sexual disorder in which individuals can only become aroused by inappropriate object, actions, or fantasies.
- **Paraphilic disorders** are a group of DSM-5 mental disorders characterized by unusual sexual preferences and behaviors that are distressing or detrimental to one's self or others. They include exhibitionistic disorder, pedophilic disorder, and sexual sadism disorder.
- **Psychopath** is an individual who engages in antisocial behavior, has a lack of empathy and remorse, and has unrestrained and disrespectful behavior.
- **Sexual sadism** is an act of inflicting pain on others for the feeling of sexual excitement or pleasure.
- **Sexual masochism** is an act of engaging in or frequently fantasizing about being beaten, bound, or otherwise made to suffer, resulting in sexual satisfaction.
- **Social skills training** is a treatment method that assists individuals to learn specific skills that are missing or those that will compensate for missing ones.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Sexual sadism disorder is one of the DSM-5 paraphilic disorders. It is characterized by intense fantasies and/or performing acts of complete sexual, emotional, physical, or psychological domination over another individual. Individuals diagnosed with this disorder receive a feeling of sexual excitement from witnessing and causing suffering to another individual. An individual who engages in sexual sadism is referred to as a sadist. Those who experience sexual pleasure or excitement as a result of humiliation and of inflicting pain on another individual may experience significant distress and significant impairment in functioning resulting from sadistic behaviors and fantasies. Those who suffer at the hands of the sadist may or may not be a willing partner. Whether or not the partner is consenting, the suffering that occurs is real. When the sexual activity is consensual between both individuals, the consenting partner may be given the diagnosis of sexual masochism. The sadistic acts are often associated with dominating others. Some extreme acts performed by sadists may not be harmful, but they are humiliating to the other individual (e.g., being laughed at or urinated on). Other acts are criminal and can potentially result in death. In very serious cases, sexual sadism can lead to significant injuries or death. This is likely to occur when the sadism is diagnosed as very severe. Often in such cases there is an association with an individual who is a psychopath (e.g., antisocial personality disorder). Some examples of extreme sadism include cutting, rape, murder, mutilation, burning, whipping, and beating.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they engage in intense and recurrent sexual arousal from the psychological and physical suffering of another individual for at least six months, as indicated by urges, fantasies, or behaviors. In the absence of reported distress an individual can be given the diagnosis of sexual sadism as long as there is evidence that the individual has acted on sexual urges. An individual who has acted on sexual urges with a non-consenting individual or has significant distress and impairment in occupational, social, or other areas of important functioning can be given this diagnosis. For an individual who is living in an institutional-type setting where opportunities to engage in sadistic sexual behavior are restricted, the diagnosis must include the specifier "in a controlled environment." If an individual has not acted on the

urges with a non-consenting individual while living in an uncontrolled environment, and there has not been any significant distress or impairment in social, occupational, or other important areas of functioning for at least five years, then the diagnosis must include the specifier "in full remission" (American Psychiatric Association, 2013).

The exact causes of this disorder are unknown. Some researchers believe that paraphilias are related to schizophrenia, a brain injury, or other mental disorders. Some theories try to interpret the presence of paraphilias in general. One theory is that an individual becomes a paraphilia because of inappropriate sexual fantasies that are suppressed. Due to the suppression of acting out on these urges, when an individual eventually acts out on the fantasies, an individual exhibits considerable distress and/or arousal. Most individuals who are eventually diagnosed with sexual sadism usually begin with milder forms of sexual fantasies such as collecting pornographic material that portray sadistic acts or may draw ropes, chains, and handcuffs on models in magazines. These acts typically progress into hiring a prostitute or asking a partner to participate in their fantasy. The severity of sadistic acts tends to increase over time (American Psychological Association, 2013).

Treatment

Treatment for this disorder typically varies depending on the individual and situation. Some medications may be useful in reducing fantasies and sexual impulses, particularly in individuals who prefer dangerous physical sadism. Some of these medications include female hormones and antidepressants. Therapy is another option that has been found to be effective for this disorder. In particular, behavior therapy can help manage arousal patterns and reduce compulsive masturbation. Social skills training and cognitive restructuring can also be effective forms of treatment.

Elizabeth Smith Kelsey, PhD, and
Len Sperry, MD, PhD

See also: Antidepressants; Antisocial Personality Disorder; Behavior Therapy; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Pain and Suffering; Paraphilia; Sexual Masochism Disorder; Social Skills Training

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Shared Psychotic Disorder

Shared psychotic disorder is a mental disorder characterized by a shared belief in a common delusion that develops between individuals in a close relationship. It is also known as Folie à Deux and induced delusional disorder.

Definitions

- **Antipsychotic medications** are prescribed drugs that are intended to reduce psychotic symptoms. They are also known as neuroleptics.
- **Delusional disorder** is a mental disorder characterized by delusions. Previously this disorder was referred to as paranoia or paranoid disorder.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **ICD-10** stands for the International Statistical Classification and Related Health Problems,

10th edition. This is a publication of the World Health Organization that represents a comprehensive list of all known medical and psychological conditions affecting human beings worldwide.

- **Psychotic symptoms** are a group of severe symptoms that include hallucinations, delusions, disordered thinking, or disorganized movement.
- **Schizoaffective disorder** is a mental disorder characterized by severe disturbances in mood accompanied by psychotic symptoms such as hallucinations or delusions.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, and withdrawal from others.
- **Schizophrenia spectrum and other psychotic disorders** are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, delusional disorder, and brief psychotic disorder.

Description and Diagnosis

Shared psychotic disorder is a rare mental disorder in which two or more individuals share a common delusion. Because one individual induces the other into the delusion, it is called induced delusional disorder in ICD-10. This disorder was formerly recognized as a separate diagnosis in DSM-IV-TR. While it is not recognized as a separate diagnosis in DSM-5, it can be diagnosed as a form of delusional disorder. The occurrence of shared psychotic disorder is unknown. However, occurrence of delusional disorder is believed to be approximately 0.2% of the U.S. population (American Psychiatric Association, 2013).

Although shared psychotic disorder is not a formal diagnosis in DSM-5, it can be diagnosed as a delusional disorder involving two or more individuals with the same delusion. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, an individual may be diagnosed with delusional disorder if he or she experiences delusion(s) that last one month or more. The individual cannot be diagnosed with schizophrenia or schizoaffective disorder. If hallucinations are present, this diagnosis cannot be given. Also, the symptoms must not be attributable to other mental disorders or to substance use.

The cause of this disorder is not well understood but is believed to include genetic and relational factors. The genetic component is likely to be a vulnerability (predisposition) to a psychotic or a mood disorder (America Psychiatric Association, 2013). The relational component involves two or more delusional individuals who influence each other over time until they cocreate a common delusion. How the delusion is transmitted from one to another is unknown.

Treatment

Treatment for this disorder tends to be difficult and long term. Treatment usually includes both medications and psychotherapy. Antipsychotics are prescribed to reduce psychotic symptoms. In terms of psychotherapy, cognitive behavior therapy can be effective in the treatment of this disorder. Also, family therapy is often used to assist family members in adjusting to living with those experiencing delusions.

Len Sperry, MD, PhD, and
Jeremy Connelly, MEd

See also: Antipsychotic Medications; Delusional Disorder; Delusions; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Hallucinations; International Classification of Diseases; Psychotic Symptoms; Schizoaffective Disorder; Schizophrenia; Schizophrenia Spectrum and Other Psychotic Disorders

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Shyness

Shyness is a type of social withdrawal that results from fear and anxiety. It is described as wariness when confronted with novel social situations and/or self-conscious behavior in a social setting.

Description

Shyness is a multifaceted concept that describes an individual's hesitancy to act in social situations. Anxiety and social fear are key components of the condition. Psychologists distinguish between shy people as those with social phobias and those without. Those with social phobia suffer more symptomatology, functional impairment, and a lower quality of life. Many view shyness as a subclinical condition or normal personality trait that is not pathological. For shy people, no task may be more difficult than developing new relationships. Not only do shy individuals take longer to form friendships, they also form fewer of them; and they take longer to form romantic relationships and typically get married later in life.

There is a clear distinction between those who withdraw from social interaction due to anxiety and fear and those who withdraw for other reasons. The concept of shyness encompasses the former, while psychologists refer to the latter as asocial.

Psychologists also distinguish between shyness and social phobia. The former is a less well-defined lay term, while the latter is a well-defined clinical disorder. That said, the defining features of both are strikingly similar and include somatic symptoms like trembling, sweating, and blushing; cognitive symptoms like fear of negative evaluation; and behavioral symptoms like the avoidance of social situations. Shyness and clinical symptoms of anxiety are related, but they are not synonymous.

There are several hypotheses about the relationship between shyness and social phobia. One places both conditions on a continuum, where social phobia is conceptualized as extreme shyness. Another proposes that shyness and social phobia are partly overlapping conditions, with shyness being a broader construct than social phobia.

Some empirical investigations have begun to define the boundary between shyness and social phobia. One study found that the rate of social phobia was significantly higher among a highly shy sample, providing support for the continuum thesis. However, only half of the highly shy people in the study had generalized social phobia, which was lower than expected.

A shyness mind-set construct is based on the belief that shyness is fixed rather than malleable. The construction of this concept is an application of the implicit mind-set theory, which has been studied extensively in the domain of intelligence and academic achievement. Psychologist J. S. Beer was the first to propose the construct. She reports that the combination of high levels of shyness and low levels of shyness mind-set predicted a greater preference for learning social skills. Also, the combination of high levels of shyness and the shyness mind-set predicted especially high levels of social avoidance and negative perceptions by others.

Some studies have found that there are no significant gender differences in shyness through childhood and adolescence, while others show that gender differences gradually become apparent across childhood, with girls appearing more fearful and anxious than boys in preschool and becoming clearly more anxious during adolescence. Children rated as shy are four times more likely to have anxiety problems in adolescence. Shy adults experience the worst levels of adjustment, thus indicating that being shy may impede important developmental tasks of emerging adulthood, such as settling on one's religious beliefs, developing an identity, and developing quality relationships with others.

There are several different factors associated with the development of shyness. Children whose parents have an anxiety disorder are at an increased risk for developing internalizing behaviors themselves. Mothers who have difficulty with stress and anxiety are more likely to have shy or anxious children. Shyness is more likely caused by the uncertain environment created by an anxious parent.

Mindy Parsons, PhD

See also: Extraversion and Introversion and Personality Type; Social Anxiety Disorder

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Single-Parent Families

Single-parent families consist of one parent who is not living with a partner and who is the residential parent of one or more children.

Description

The structure of the American family has changed considerably over the past four decades. As many as 35% of all children born in the United States live in single-parent families (SPF). Single mothers head approximately 80% of all SPF. Researchers have recently defined a new subgroup of SPF as "fragile families" defined as unwed parents and their children. Researchers have investigated the impact of growing up in an SPF, including fragile families, and have found that SPF children have lower levels of health and lower cognitive, behavioral, social, and emotional well-being when compared to children growing up in traditional two-parent families.

Impact (Psychological Influence)

Researchers have identified several factors that impact children of SPF. These include parental resources, parental mental health, parental relationship quality, parenting quality, and father involvement. Single-mother households have significantly less money available to spend on their children, and single mothers tend to make less money and live in poorer school districts and neighborhoods. Even with enforced child support single mothers and their children are at an economic disadvantage compared to traditional families. Conflict between parents is higher in SPF than married families, and the negative consequences of divorce on children have been well documented. Single mothers shoulder all of the work, household and childcare duties, leaving them with less time to invest in their children. It is understandable that depression and other psychological problems are higher among single mothers than married mothers.

Given that single parents have less time, face more mental health challenges, and are economically disadvantaged, it is no wonder that the quality of their parenting suffers. Studies indicate that single parents are less emotionally available and supportive of their children, provide less supervision, have fewer rules but harsher inconsistent discipline, and have more frequent conflicts with their children. These parenting difficulties have been linked to children's poor academic achievement, emotional problems, low self-esteem, and difficulties in forming and maintaining social relationships. Higher positive father involvement is very beneficial to children of SPF and has been linked to fewer emotional and behavioral problems and higher academic achievement. Positive co-parenting that is cooperative, supportive, and consistent is especially beneficial to children of SPF.

In response to the significant challenges associated with SPF there are numerous support groups, school programs, web communities, and self-help books readily available to assist single parents. Both policy

makers and mental health professionals continue to explore ways to assist single parents and their children.

Steven R. Vensel, PhD

See also: Divorce

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Single-Photon Emission Computed Tomography (SPECT)

Single-photon emission computed tomography (SPECT) is a diagnostic imaging device that uses gamma rays to produce images of the body. It is also referred to as SPECT scan.

Definitions

- **Computed tomography** is a diagnostic imaging device that uses x-rays to produces cross-sectional images (tomographs) of the body
- **Gamma** is an extremely short-wavelength electromagnetic radiation released during the process of radioactive decay.
- **Gamma camera** is a device inside the SPECT scanner that generates images of gamma rays emitted by the radionuclides used in radioactive tracers.
- **Magnetic resonance imaging** is a diagnostic imaging device that uses electromagnetic radiation and a strong magnetic field to produce images of soft tissues.
- **Nuclear medicine** is the branch of medicine that uses radioisotopes to evaluate the rate of radioactive decay in diagnosing and treating various diseases.
- **Positron emission tomography** is a diagnostic imaging technique that uses radioactive substances to produce three-dimensional colored images within the body.
- **Prodromal** is the early stage or the start of a disease, before specific symptoms occur.
- **Radioactive tracer** is a substance containing a radioisotope that is injected and monitored as it progresses through the body.
- **Radionuclides** are atoms that emits gamma rays during the process of its radioactive decay. Also known as radioisotopes, they are used to make the tracers used in SPECT.

Description

Single-photon emission computed tomography is a diagnostic imaging method in nuclear medicine. SPECT uses radioactive materials injected through a vein that pass into the brain, or other organ, and generate high-resolution images. SPECT relies on two technologies: computed tomography (CT) and the use of a radioactive material (radionuclide) to label a compound known as a radioactive tracer. The SPECT scanner monitors the tracer's movement through body tissues. The rate of its radioactive decay allows the physician to obtain three-dimensional images of blood flow in the heart or electrical activity in different areas of the brain. It can also scan for tumors or bone disease.

The SPECT scanner contains a gamma camera, an imaging device that detects gamma rays emitted by the radioactive tracer. The scanner rotates around the individual, while the gamma camera records a series of two-dimensional images. A computer analyzes these images and produces three-dimensional images of the organs in question.

SPECT is used to diagnose head trauma, epilepsy, dementia, and cerebrovascular disease. Tracers like technetium-99 increase the resolution of brain images generated from SPECT that are very

accurate spatial with high-contrast resolutions. Other radioactive isotopes used in SPECT are iodine-123, xenon-133, thallium-201, and fluorine-18. The resulting sharp images permit the visualization of very small structures within the brain or other parts of the body.

Developments and Current Status

In 1971 the first computed tomography (CT) scan was administered. Shortly afterward, the positron emission tomography (PET) was introduced. In 1977 the first magnetic resonance imaging (MRI) scan was administered. At the end of the 1970s, SPECT was introduced. In 1999 the combined SPECT/CT was developed and introduced.

SPECT diagnostic indications are similar to other imaging techniques, particularly CT, MRI, and PET. SPECT imaging is a sensitive research tool for measuring blood flow through the brain (cerebral blood flow), in individuals with psychiatric (mental) disorder such as obsessive-compulsive disorder (higher blood flow) and alcoholism (lower blood flow). The accuracy of SPECT images makes it a useful clinical and research tool.

Len Sperry, MD, PhD

See also: Computed Tomography (CT); Magnetic Resonance Imaging (MRI); Positron Emission Tomography (PET)

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Sixteen Candles (Movie)

The film *Sixteen Candles* is director John Hughes's 1984 debut film. It was the first in a series of movies about the lives of teenagers who were called "the brat pack."

Description

The movie *Sixteen Candles* influenced other filmmakers, like Kevin Smith and Wes Anderson, who specialized in sympathetically representing the angst, preoccupations, and issues of youth. In this movie actress Molly Ringwald plays the central female character, named Sam, on the day of her 16th birthday. To her disappointment and sadness, all of her family and friends ignore or forget her special day. Eventually, Sam finds some comfort from identification with "the geek," a nerdy character who initially embarrasses her. Not being the most popular girl in school, Sam entertains his flirtations but her real affection lies with Jake, the best-looking and idolized guy in school. After many trials and tribulations throughout the day, Jake and Sam end up together in a birthday cake scene for which the film is well known.

Impact (Psychological Influence)

It is clear from the plot and approach to the characters that John Hughes, the writer and director of *Sixteen Candles*, understood and empathized with the traumas, challenges, and adventures of American teenagers in the 1980s. The movie accurately depicts some of the key factors that influenced life in a typical high school. It demonstrates the hierarchy of cliques among students and the constant pressure teenagers feel as a result of unwritten and often mysterious social codes. In addition, it addresses the natural separation and opposition that exists among teenagers, their parents, and teachers. The film highlights the terrors, heartbreak, and ecstasy of first love.

Several factors make *Sixteen Candles* important for teenagers watching it. Although it is a comedy, the subject matter is accurately portrayed. In addition the movie uses music and profanity in a realistic way that teenagers can identify with. One possible contributing factor is that the teenage actors were allowed to ad lib their lines. It is gender sensitive although the story is told from the teenage girl's perspective.

The movie had a huge impact at the time and for many years thereafter through a series of similar films.

In John Hughes's 1984 film, *Sixteen Candles*, actress Molly Ringwald plays the central character on the day of her 16th birthday. Hughes's movies about teenagers have been praised for respecting their problems and not condescending in dealing with their issues, although *Sixteen Candles* has also been criticized for its Cinderella aspects. (Universal/Photofest)

Several were written and produced by John Hughes himself, but other writers and directors came along and were also able to accurately depict and speak to an adolescent audience in a realistic and sympathetic way. There are two important psychological outcomes from this and similar movies. The first one is generally good and beneficial. Teenagers are treated realistically and with an appreciation for the important issues they are facing. These movies don't stereotype teenage problems nor condescend in dealing with their issues.

But the second effect, especially of *Sixteen Candles*, is that the central love story between the sophomore hero and her senior love interest is a fantasy that would tend to encourage the unrealistic dreams that often haunt teenage girls and some boys. The way both romance and young men are portrayed can feed delusion and false hopes. The special psychological challenges of adolescence are very hard for many teenagers and their parents and other responsible adults to handle. Bridging from threatened self-worth to self-confidence and independence often requires both role models and assistance.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Breakfast Club, The (Movie)

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Sixth Sense, The (Movie)

The Sixth Sense is a 1999 American film starring Bruce Willis and Haley Joel Osment.

Description

The Sixth Sense is a highly successful 1999 American psychological and supernatural thriller starring Bruce Willis and Haley Joel Osment. *The Sixth Sense* was written and directed by M. Night Shyamalan and is rated PG13. The movie is a story about a relationship between a troubled young boy who sees and speaks with dead people and child psychologist Dr. Malcolm Crowe. The film is known for the surprise ending, supernatural material, depth of acting talents of the principal actors, and the line "I see dead people." The film established Shyamalan as a highly talented writer and director and was nominated for six Academy Awards. Themes include the supernatural, relationships, loss, and personal redemption.

The story opens with child psychologist Dr. Malcolm Crowe (Bruce Willis) and his wife (Olivia Williams) returning home and celebrating a prestigious award for his work with troubled children. Although their relationship is an obviously loving one, his wife expresses a fear that she feels second to his work. As they enter into their bedroom they are confronted by

Still from *The Sixth Sense*.The movie is a story about a relationship between a troubled young boy who sees and speaks with dead people and child psychologist Dr. Malcolm Crowe. (Buena Vista/Photofest)

a man with a gun. The man, Vincent Grey, is a former child patient of Crowe's and he accuses Crowe of breaking his promise of helping him, that he is still a freak, and that he doesn't want to be afraid anymore. Vincent is deeply disturbed and yells that Crowe failed him. He shoots Crowe in the stomach before turning the gun on himself.

The next scene opens the following fall, with Crowe beginning to work with nine-year-old Cole Sear (Haley Joel Osment), a young boy with similar problems, and of about the same age, as Vincent Grey when he was in therapy with Dr. Crowe. Crowe struggles with self-doubt and a deep sense of personal failure after Grey's suicide. Cole, a soulful and sad boy, tells Crowe that he is a freak and sees dead people. At first Crowe believes the boy to be delusional. Eventually Crowe comes to suspect that not only is Cole telling the truth but also perhaps Vincent may have had the same ability that Crowe was unable to understand at the time Vincent was in therapy. Crowe encourages Cole to try and find out what the dead may want or need from him. In spite of his fears Cole begins to engage the dead in order to understand what they need from him. He learns how to help them and their living loved ones. As Cole assists the dead, they are able to let go and move on to the afterlife. Cole comes to accept the significance of his gift and begins to excel in school even getting the lead in the school play, which Dr. Crowe attends as a final therapeutic act.

During this time Crowe's wife is becoming more and more distant, and he discovers she has developed a friendship with another man. Cole encourages Dr. Crowe to speak to her while she is asleep. Soon after this Crowe comes home to find that his wife has fallen asleep on the couch while watching their wedding video. As he looks at her, his wedding band falls from her hand and rolls across the floor. Crowe is surprised he has not been wearing the wedding ring and is hit with a sudden realization. The twist is revealed that Crowe was in fact killed by Vincent the night of receiving the award and has unknowingly been dead the entire time he has been treating Cole. Cole was not only receiving help from Crowe but was helping Crowe resolve his shame and guilt over Vincent's torment and suicide. Crowe then speaks to his sleeping wife telling her she was never "second" and that he loves her. Now with no more unfinished business, Crowe is able to move on to the afterlife.

Reception and Criticism

The Sixth Sense was highly accepted by the critics and public alike, spending five weeks as the number one film at the U.S. box office. Worldwide it has grossed over $674 million. *The Sixth Sense* was nominated for six Academy awards.

Steven R. Vensel, PhD

See also: Hallucinations

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Skinner, B. F. (1904–1990)

Born Burrhus Frederic Skinner in 1904, "B. F." Skinner was an influential behavioral psychologist who explored the relationship between stimuli and behavior.

Description

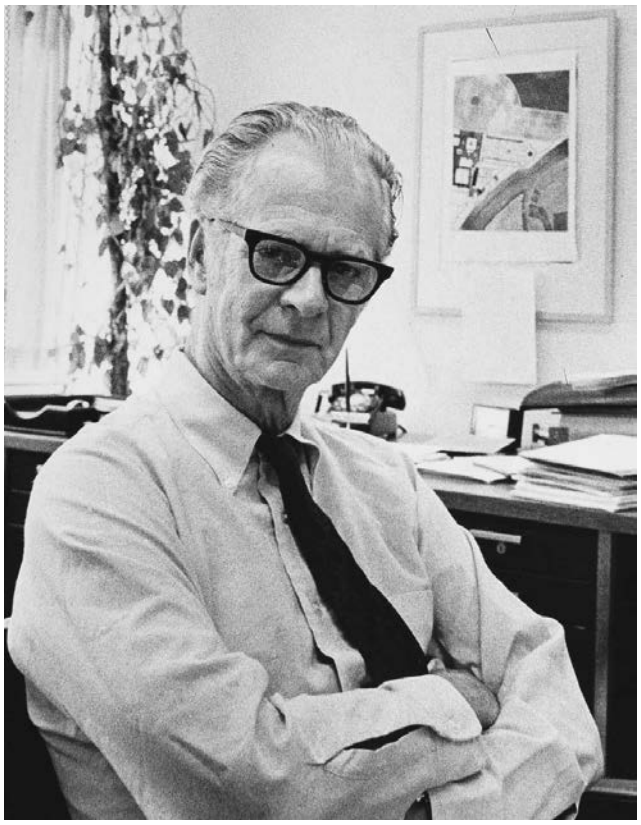
B. F. Skinner followed in the footsteps of John Watson and Ivan Pavlov in exploring human behavior. As a result of his experiments to find the roots of human behavior, he concluded that the notion of free will was a meaningless concept. His investigations seemed to show that in the stimulus-response-consequence model of behavior it was the consequences which were most determining of behavior. Skinner based many of his theories on his experimental work with rats and pigeons.

His research into behavior change showed that two things were important. First is that consequences,

rewards or punishments, tend to determine behavior. Second is that you can create behavior change more easily by breaking tasks into smaller parts and rewarding success on the parts not just the whole. He called this the principle of reinforcement, and it is influential in the fields of education, psychology, and more. Skinner was an advocate of behavioral engineering, which is also called operant conditioning. He thought that people could be controlled through the systematic allocation of external rewards, especially with the use of positive reinforcement.

Impact (Psychological Influence)

Skinner called his own philosophy of science radical behaviorism, and his investigation and experiments were presented in his work *Verbal Behavior*, as well as his philosophical manifesto *Walden Two*, both of which influenced not only scientists and educators but the whole culture. He extended his influence through a book called *Beyond Freedom and Dignity* where he advanced his idea that human beings are not truly free. Naturally this made him a target of controversy. Through his books and celebrity, his ideas became important in psychology, education, and training.



Born Burrhus Frederic Skinner in 1904, B.F. Skinner was an influential behavioral psychologist who explored the relationship between stimuli and behavior, building on the research of John B. Watson and Ivan Pavlov in studying human behavior. (AP Photo)

While Skinner's approach to behaviorism is no longer widely accepted today, his work remains influential, especially in the field of behavioral therapy where behavior modification and intervention of various kinds are used to change problem behaviors or reinforce positive new ones. His influence on fields as diverse as child rearing, management, education, and self-help continues; for example, the widely used concept of "time-out" with a child is based on Skinner's work. Mental health professionals often use operant techniques when working with clients; teachers frequently use reinforcement and punishment to shape behavior in the classroom; and animal trainers rely heavily on these techniques to train dogs and other animals.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Applied Behavior Analysis; Behavior Therapy; Behavior Therapy with Children

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Sleep

Sleep is the body's rest cycle, which is triggered by a group of hormones that respond to cues from the body itself and from the environment.

Definitions

- **Circadian rhythms** are variations in biological activities that repeat during 24-hour

intervals including the internal clock, which influences the amount and quality of sleep.

- **Non-REM sleep** is one of the two basic states of sleep consisting of stages 1, 2 (light sleep) and 3, 4 (deep sleep). It is also known as non-rapid eye movement and NREM sleep.
- **Polysomnography** is a medical test that records aspects of sleep (circadian rhythms, REM, NREM, number of arousals) as well as breathing patterns, heart rhythms, and limb movements.
- **REM sleep** is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain activity. It is also known as rapid eye movement and REM sleep.
- **Sleep deprivation** is a condition characterized by insufficient sleep, which, if it is chronic, can cause fatigue, daytime sleepiness, and loss of concentration and productivity.
- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.
- **Sleep stages** refer to five stages of sleep: 1, 2, 3, 4, and REM.

Description

Sleep is a basic necessity of life. It is as important for health and well-being as air, food, and water. When individuals sleep well, they wake up feeling refreshed, alert, and ready to face life's challenges. When they don't sleep well, every aspect of their lives can suffer. Jobs, productivity, health, and relationships are affected. Lack of sleep due to sleep deprivation or due to sleep disorders has taken its toll on Americans.

In 2002 the National Sleep Foundation (NSF) conducted a national survey called Sleep in America. It found that 80% believed they were not getting enough sleep. About 39% got less than seven hours of sleep each weeknight, and more than one-third were so tired during the day that it interfered with their daily activities. Also, 74% of adults reported that they experienced sleep problems. Over the years, data from NSF showed that Americans have increasingly reduced the amount of time they sleep. While society has changed, the human brain has not changed. Unfortunately, sleep deprivation has affected and continues to affect the health and well-being of Americans.

The amount and quality of sleep is regulated by two brain processes. The first is the restorative process when sleep occurs in response to how long an individual is awake. The longer one is awake, the stronger is the need for sleep. The second process controls the cycle of sleep and wakefulness. Timing is regulated by circadian rhythms, which act as an internal clock. This clock is influenced by exposure to light and darkness. The result is that individuals feel sleepy at night when it is dark and feel energetic during the day when it is light. Besides timing the sleep–wake cycle, the circadian clock regulates day–night cycles of other body functions. The result is that specific hormones that bring on sleep are secreted only at night, while other hormones that increase wakefulness are secreted only during the day. When this internal clock functions normally, individuals experience restorative sleep during the night and are refreshed and alert during the day (National Sleep Foundation, 2002).

This clock also influences sleep stages and cycles. There are five stages of sleep in a sleep cycle. These include stages 1, 2, 3, 4 of Non-REM, which are followed by REM sleep. Stage 1 is marked by drowsiness, stage 2 by light sleep, and stages 3 and 4 consist of deep sleep. Sleep begins with stage 1 and goes through each stage of the cycle until reaching REM sleep. The cycles are repeated, with each sleep cycle taking from 90 to 110 minutes. The brain acts differently in each stage of sleep. In some of the stages, there is movement of arms and legs, while in other stages there is no movement. These sleep stages and other biological patterns can be recorded with polysomnography.

Len Sperry, MD, PhD

See also: Insomnia and Insomnia Disorder; Sleep Disorders

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Organization

National Sleep Foundation. Sleep in America. 2002.
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E-mail: nsf@sleepfoundation.org
Website: http://www.sleepfoundation.org/article/how-sleep-works/let-sleep-work-you

Sleep Apnea

Sleep apnea is a temporary disruption or stoppage of breathing during sleep, which can result in daytime sleepiness.

Definitions

- **Central sleep apnea** is a type of sleep apnea in which the airway is not blocked, but the brain fails to signal the muscles to breathe.
- **Continuous positive airway pressure (CPAP)** is a device for treating sleep apnea that delivers air into airways through a specially designed face or nasal mask.
- **Non-REM sleep** is one of the two basic states of sleep consisting of stages 1, 2 (light sleep) and 3, 4 (deep sleep). It is also known as non-rapid eye movement and NREM sleep.
- **Obstructive sleep apnea** is a type of sleep apnea in which a blockage of the upper airway causes the body to snore and struggle for air.
- **Parasomnias** are a group of sleep disorders characterized by abnormal events that occur during sleep, such as sleepwalking, talking, or limb movement.
- **Polysomnography** is a medical test that records aspects of sleep (REM, NREM, and number of arousals) as well as breathing patterns, heart rhythms, and limb movements.
- **REM sleep** is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain activity. It is also known as rapid eye movement and REM sleep.
- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.

Description and Diagnosis

Sleep apnea is a sleep disorder in which breathing during asleep is interrupted by repeated pauses. This disorder can cause or worsen serious health conditions such as high blood pressure, stroke, obesity, diabetes, heart attack, and heart failure. It can also increase the risk for accidents since those with sleep apnea may fall asleep while working or driving.

There are three kinds of sleep apnea: obstructive sleep apnea (most common), central sleep apnea, and mixed sleep apnea. How does obstructive apnea differ from central apnea? Obstructive apnea results from an obstructed (blocked) airway. The result is the individual snores. Central apnea is caused by a problem in the brain sending proper signals to the muscles that control breathing. As a result, the individual gasps for air instead of snoring. Obstructive apnea is more common than central apnea. Both disorders are highly treatable, but obstructive apnea is curable. Obstructive sleep apnea affects 1%–2% of children, 2%–15% of adults in middle age, and over 20% of older adults. In contrast, central sleep apnea is relatively rare (American Psychiatric Association, 2013).

Obstructive sleep apnea. This disorder is characterized by shallow or complete disruptions of breathing during sleep. It is accompanied by snoring, gasping

for air, snorting, and pauses in breathing. Individuals with this disorder will often report daytime sleepiness, fatigue, and non-restorative sleep. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit excessive disruptions in normal breathing with excessive snoring, snorting, gasping, and prolonged pauses. It must result in daytime fatigues and sleepiness. It cannot be caused by another sleep disorder. The disorder must be demonstrated by polysomnography with 15 or more breathing disruptions per hour during sleep (American Psychiatric Association, 2013).

Central sleep apnea. This disorder is characterized by abnormally shallow breathing and complete cessation of breathing during sleep. Individuals with this disorder repeatedly engage in shallow breathing or simply stop breathing for short periods of time. Following the stoppage, they recover with a rapid deep breath. Those who also have heart failure, stroke, or kidney failure can have an atypical breathing pattern called Cheyne-Stokes breathing. This pattern consists of several deep breaths followed by a series of very shallow breaths or periods of several short, shallow breaths followed by a large, deep, recovery breath. This recovery breath usually results in an abrupt awakening. Those with this disorder are likely to be excessively sleepy and tired during the day. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit frequent episodes of abnormally shallow breathing or cessation of breathing during sleep. The episodes must last longer than 10 seconds and be followed by a sudden and rapid inhalation. Unlike obstructive sleep apnea there is no snoring, snorting, or gasping for air. This disorder cannot be caused by another sleep disorder and must be demonstrated by polysomnography with at least five episodes per hour of sleep (American Psychiatric Association, 2013).

Obstructive sleep apnea is caused by an obstructed airway. Several factors can lead to such obstruction. The most common factor is excess weight. Other factors include a narrowed airway (from enlarged tonsils or adenoids); gender (male to female ratios is 2:1); family history; smoking; and the use of alcohol, sedatives, or tranquilizers. The most common cause of central sleep apnea is heart failure. Less common causes are brain tumors and stroke.

Treatment

Effective treatment of sleep apnea begins with a professional sleep evaluation. The purpose of this evaluation, which includes polysomnography, is to determine the presence and type of the disorder. For those diagnosed with obstructive sleep apnea, several recommendations are made. The National Sleep Foundation recommends the avoidance of sleeping pills, alcohol, and nicotine. They also suggest losing weight and elevating the head when sleeping to reduce symptoms. If these measures fail to reduce symptoms or if the apnea is moderate to severe, surgery or the use of continuous positive airway pressure (CPAP) may be recommended. If the diagnosis is central sleep apnea, its cause, such as congestive heart failure, should be the focus of treatment. With obstructive apnea, CPAP may also be prescribed.

Len Sperry, MD, PhD

See also: Insomnia and Insomnia Disorder; Sleep; Sleep Disorders

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Sleep Disorders

Sleep disorders are a group of mental disorders characterized by disturbance in the amount and quality of

sleep and that cause significant emotional distress or interfere with daily functioning.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Sleep deprivation** is a condition characterized by insufficient sleep, which, if it is chronic, can cause fatigue, daytime sleepiness, and loss of concentration and productivity.
- **Sleep hygiene** refers to the habits, practices, and nonmedical treatments for insomnia and which improve the quality of sleep.

Description and Diagnosis

Sleep is vital for good health and well-being. Getting sufficient quality sleep is necessary for mental and physical health as well as quality of life. It is during restful sleep that restoration and rejuvenation of all body systems occur. In children and adolescents, adequate sleep is essential to support growth and development. Without sufficient sleep, an individual's ability to perform even simple tasks declines dramatically. Sleep deprivation has become a major public health concern. Chronically sleep-deprived individuals are likely to experience impaired performance, irritability, lack of concentration, daytime drowsiness, decreased immunity, and sleep disorders.

There are several sleep disorders. The most common ones are insomnia, sleep apnea, restless leg syndrome, and narcolepsy. Less common sleep disorders include hypersomnia, nightmare disorder, sleep terror disorder, and sleepwalking disorder. Following are brief descriptions of these disorders. Each is more fully described in its own entry in this encyclopedia.

Insomnia. Insomnia is a sleep disorder characterized by difficulty falling or staying asleep. In addition, individuals with insomnia typically wake up during the night and then have trouble falling back asleep. Or, they may wake up too early in the morning. In either case, they often feel tired on waking. Insomnia can be short term (acute) or can last a long time (chronic). It can also come and go, with periods of time when an individual experiences no sleep problems. Acute insomnia can last from one night to a few weeks. Chronic insomnia is longer, lasting at least three nights a week for a month or longer.

Sleep apnea. Sleep apnea is a sleep disorder in which individuals stop breathing while asleep. Their breathing is interrupted by repeated pauses known as apneic events. There are three kinds of sleep apnea: obstructive sleep apnea (most common), central sleep apnea, and mixed sleep apnea. This disorder can cause or worsen serious health conditions such as high blood pressure, stroke, obesity, diabetes, heart attack, and heart failure. It can also increase the risk for accidents since those with sleep apnea may fall asleep while working or driving.

Restless leg syndrome. Restless leg syndrome is a sleep disorder characterized by an irresistible urge to move because of uncomfortable or painful sensations in the legs when attempting to rest and causing a compelling urge to move the legs. The movement makes it difficult or impossible to sleep restfully. Symptoms usually begin within 15 minutes and usually result in significant sleep loss, fatigue, and problems with daily functioning. If the individual is asleep, these involuntary leg movements, called periodic limb movements in sleep, begin and interrupt sleep.

Narcolepsy. Narcolepsy is a sleep disorder that affects the control of sleep and wakefulness. Those with this disorder experience excessive daytime sleepiness and uncontrollable episodes of falling asleep during the day. These episodes may occur during any type of activity at any time of the day. The normal sleep cycle involves light sleep stages followed by deeper sleep stages and then rapid eye movement (REM) sleep after about 90 minutes. But, for those with narcolepsy, REM sleep occurs almost immediately in the sleep cycle. It then occurs periodically during the waking hours, which leads to the symptoms of narcolepsy. This disorder usually begins between the ages of 15 and 25.

Hypersomnia. Hypersomnia is a sleep disorder that is more commonly known as excessive sleepiness. It is a condition in which an individual has difficulty staying awake during the day. Individuals with this disorder can fall asleep at anytime and anywhere. For example, they may nod off at work or even when

they are driving. Typically, they experience other sleep-related problems such as low energy and difficulty with concentration. The National Sleep Foundation estimates that 40% of adults experience symptoms of hypersomnia on occasion.

Nightmare disorder. Nightmare disorder is a sleep disorder characterized by repeated awakening from sleep or naps with detailed recall of extended and extremely frightening dreams. These dreams involve threats to survival, security, or self-esteem. On awakening from the frightening dreams, the individual rapidly becomes oriented and alert. The awakenings generally occur during the second half of the sleep period.

Sleep terror disorder. Sleep terror disorder is a sleep disorder characterized by repeated temporary arousal from sleep, during which the individual appears and acts extremely frightened. It is commonly confused with nightmares and nightmare disorder. Unlike nightmares, children with this disorder do not recall a dream after a sleep terror episode, nor remember the episode the next morning. Sleep terror symptoms are frequent and recurrent episodes of intense crying and fear during sleep, with difficulty arousing the child. Unlike nightmare disorder in which the individual is oriented and alert on awakening, those experiencing sleep terror disorder are confused and disoriented if awakened.

Sleepwalking disorder. Sleepwalking disorder is a sleep disorder that causes individuals to get up and walk around while still sleeping. These episodes typically occur while the individual is in the deep stages of sleep. Usually, the eyes of sleepwalkers are open with a glassy, staring appearance as they walk. They may talk incoherently while walking, and on questioning, their responses are slow or absent. If they are returned to bed without awakening, they seldom remember the event.

Circadian rhythm sleep–wake disorder. Circadian rhythm sleep–wake disorder is a sleep disorder characterized by a sleep pattern that is out of sync with normal circadian rhythms. Individuals with this disorder have trouble sleeping during the times that others typically sleep. Those with this disorder may not follow the typical circadian rhythms of others, but if allowed to follow their particular patterns, they can experience sufficient and otherwise normal sleep. To be diagnosed with this disorder, they must have recurrent difficulty adjusting their circadian rhythms to life demands. It must also cause sleeplessness, sleepiness, or both.

Treatment

The clinical treatment of these disorders varies depending on the disorder. Generally, treatment involves some combination of behavior therapy, sleep hygiene, and/or medication.

Len Sperry, MD, PhD

See also: Behavior Therapy; Circadian Rhythm Sleep–Wake Disorder; Hypersomnia and Hypersomnolence Disorders; Insomnia and Insomnia Disorder; Narcolepsy; Nightmare and Nightmare disorder; Restless Leg Syndrome; Sleep Apnea; Sleep Deprivation; Sleep Terror Disorder; Sleepwalking

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Sleep Terror Disorder

Sleep terror disorder is a sleep disorder characterized by repeated temporary arousal from sleep, during which the individual appears extremely frightened. This disorder is also known as night terrors and is often confused with nightmares and nightmare disorder.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.

- **Nightmare disorder** is a sleep disorder that is characterized by recurrent occurrences of troubling dreams.
- **Non-REM sleep** is one of the two basic states of sleep consisting of stages 1, 2 (light sleep) and 3, 4 (deep sleep). It is also known as non-rapid eye movement and NREM sleep.
- **Parasomnias** are a group of sleep disorders characterized by abnormal events that occur during sleep, such as sleepwalking, talking, or limb movement.
- **REM sleep** is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain activity. It is also known as rapid eye movement and REM sleep.
- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.

Description and Diagnosis

Sleep terror disorder is a sleep disorder seen in children and rarely in adults. It is characterized by repeated temporary arousal from sleep, during which the individual appears and acts extremely frightened. This disorder is often mistaken for nightmares and nightmare disorder. Unlike nightmares, children with this disorder do not recall a dream after a night terror episode, nor are they likely to remember the episode the next morning. In contrast, the symptoms of sleep terror are recurrent episodes of intense crying and fear during sleep, with difficulty arousing the child. In nightmare disorder the individual is oriented and alert on awakening. However, those experiencing sleep terror disorder tend to be confused and disoriented if awakened. It is important to note that in children sleep terror tends to be temporary and often resolves on its own in a few weeks or a month.

Sleep terror disorder is a parasomnia, which are sleep disorders that occur during arousals from REM sleep or partial arousals from non-REM sleep. They include nightmare disorder, sleepwalking disorder, and restless leg syndrome in addition to sleep terror disorder.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit repeated episodes of abrupt arousal from sleep, typically with a panicky scream. They also exhibit extreme fear and autonomic arousal systems. These include rapid heartbeat, sweating, rapid breathing, and dilated pupils during the episodes. They are also likely to be unresponsive to efforts to comfort them during these times. They have no memory of the episode and little or no dream imagery is recalled. The episodes must also cause significant distress to the individual or result in significant level of impaired functioning. In addition, the disorder is not the result of a substance, medication, other medical condition, or another mental disorder (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. However, it appears that various factors can contribute to it. These include sleeping in unfamiliar surroundings, sleep loss, fatigue, lights or noise, and emotional stress. In children, a fever can trigger it. Certain medical conditions can trigger or exacerbate (worsen) it. These include sleep apnea, migraines, and head injuries In addition, alcohol and recreational drugs can trigger sleep terror episodes. Certain medications such as sleeping pills, sedatives, and antihistamines can also trigger the disorder.

Treatment

If the sleep terrors are associated with an underlying medical or mental condition or another sleep disorder, treatment is aimed at the underlying problem. If stress or anxiety seems to be contributing to the sleep terrors, psychotherapy may be useful. Cognitive behavior therapy and stress management may be useful. Medications are rarely used to treat sleep terrors, particularly for children. If necessary, an antidepressant like Prozac or Zoloft may help in reducing sleep terrors. For adults with severe sleep terrors, Klonopin may help.

If the disorder involves a child, the parents should be involved in therapy. Parents are helped to understand sleep terror disorders. They learn that during a

sleep terror episode, they should hold or rock the child or comfort the child in other ways, instead of trying to awaken the child. Parents are advised not to shake or yell at a child during a sleep terror as it can prolong the episode and further upset the child. Efforts to awaken the child will usually increase his or her disorientation. After a brief period of crying or screaming, the child will settle back into normal sleep mode and may not even remember the episode. Finally, parents can take comfort in knowing children generally outgrow night terrors within a matter of weeks or months.

Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Insomnia and Insomnia Disorder; Klonopin (Clonazepam); Nightmare and Nightmare Disorder; Prozac (Fluoxetine); Sleep; Sleepwalking; Zoloft (Sertraline)

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Sleepwalking

Sleepwalking is a condition in which individuals get up and walk around while still sleeping. In DSM-5 it is a diagnosable sleep disorder called a non-rapid eye movement (non-REM) sleep arousal disorder. Sleepwalking is also known as somnambulism.

Definitions

- **Continuous positive airway pressure (CPAP)** is a device for treating sleep apnea that delivers air into airways through a specially designed face or nasal mask.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Non-REM sleep** is one of the two basic states of sleep consisting of stages 1, 2 (light sleep) and 3, 4 (deep sleep). It is also known as non-rapid eye movement and NREM sleep.
- **Obstructive sleep apnea** is a type of sleep apnea in which a blockage of the upper airway causes the body to snore and struggle for air.
- **Parasomnia** is a group of sleep disorders characterized by abnormal events that occur during sleep, such as sleepwalking, talking, or limb movement.
- **REM sleep** is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain activity. It is also known as rapid eye movement and REM sleep.
- **Restless leg syndrome** is a sleep disorder characterized by an irresistible urge to move one's legs while attempting to rest.
- **Sleep disorders** are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.

Description and Diagnosis

Sleepwalking is a condition and diagnosable sleep disorder where individuals get up and walk around while still asleep. These episodes occur while these individuals are in the deep stages of sleep. Usually, their eyes are open with a glassy, staring appearance as they walk. They may talk incoherently while walking, and on questioning, their responses are slow or absent. If they are returned to bed without awakening, they seldom remember the event.

This is classified as a parasomnia, which is a class of sleep disorders that occur during arousals from REM

sleep or partial arousals from non-REM sleep. They include nightmare disorder, sleep terror disorder, and restless leg syndrome in addition to sleepwalking disorder.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, sleepwalking is listed as a non-rapid eye movement sleep arousal disorder. Individuals can be diagnosed with this disorder if they exhibit recurrent episodes of getting out of bed during sleep and walking around. During the episodes they stare blankly, are unresponsive when others attempt to communicate with them, and are only awakened with great difficulty. The episodes must cause significant distress to the individual or result in significant level of impaired functioning. In addition, the disorder is not the result of a substance, medication, other medical condition, or another mental disorder (American Psychiatric Association, 2013).

Various factors can cause this disorder. These can include genetic and environmental factors. Since sleepwalking runs in families, it may have a genetic basis. If one or both parents have a history of the disorder, it increases the likelihood of a child experiencing the disorder. Sleepwalking may occur when another medical condition that can affect sleep is present. These are obstructive sleep apnea, restless leg syndrome, migraines, or head injuries. In addition, alcohol, recreational drugs, and certain medications (antihistamines, sedatives, and sleep medications) can trigger sleepwalking.

Treatment

Treatment for sleepwalking may not be needed. A sleepwalker can often be gently lead back to bed. While it may not be dangerous to awaken the sleepwalker, it can be disorienting to them. If sleepwalking is caused by a medical or mental health condition, treatment is directed to that condition. For instance, if the sleepwalking is due to obstructive sleep apnea, the use of a continuous positive airway pressure device may be recommended. Should sleepwalking result in excessive daytime sleepiness, medication may be prescribed. Medications like Xanax or Prozac might be used with a continuous positive airway pressure device to stop episodes of sleepwalking.

Len Sperry, MD, PhD

See also: Restless Leg Syndrome; Sleep; Sleep Disorders

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Smoking Cessation

Smoking cessation is the process associated with discontinuing a nicotine-smoking habit.

Definition

- **Nicotine replacement therapy** is a type of treatment used to aid in smoking cessation that substitutes medications such as transdermal nicotine patches, lozenges, gum, inhalers, and other prescribed pharmaceuticals to help alleviate cravings, anxiety, and withdrawal symptoms associated with quitting.

Description

Smoking cessation describes the process one undergoes when trying to quit tobacco smoking. Tobacco contains an addictive carcinogen called nicotine that is a significant contributor in a multitude of health-related issues, including cancer, emphysema, and heart disease. Various interventions have been employed to assist those in quitting smoking, including nicotine replacement therapy, individual and small group counseling, and acupuncture. Many smokers though are reluctant to quit due to short-term side effects such as weight gain, headaches, stomachaches, and other withdrawal-related symptoms, including anxiety and irritability. However, research indicates that the benefits of discontinuing a nicotine habit greatly outweigh the costs. Studies have also found that it takes anywhere from 6 to 12 weeks

after one has quit smoking completely for the nicotine levels in the brain to return to levels of a nonsmoker. Health damage, though not entirely reversible, can be reduced if one quits smoking.

Cigarettes contain the chemical nicotine, which users can become addicted to. Nicotine acts on nicotine acetylcholine receptors in the brain causing them to release neurotransmitters such as dopamine, glutamine, and gamma-aminobutyric acid which causes cravings and withdrawal symptoms when ceased. Nicotine addiction is the most common form of addiction reported in the United States. Smokers generally increase the amount of cigarettes that they smoke per day over time, drastically increasing their risk of long-term health damage. The primary health concern for prolonged use is the development of certain types of cancer. Lung cancer is the leading cause of cancer deaths among both men and women, with approximately 90% of cases in men and 80% of cases in women being attributed to smoking. Nicotine use can also contribute to incidents of stroke, heart problems, and infertility.

Interventions to address nicotine addiction include both unassisted and assisted forms of treatment. Unassisted types refer to situations where users attempt to quit on their own volition, without the help of a health professional or the use of pharmaceuticals. Patients who attempt to quit "cold turkey" by eliminating all use or those who reduce their consumption on their own gradually over time would be classified as unassisted. The success rate for these individuals though is quite low, between 4% and 8%. Assisted types, on the other hand, include a range of treatments focused on emotional and psychological support and supplemental medication when necessary. Data further suggests that medical and dental providers who discuss health-care risks and encourage cessation readily with their patients are more likely to gain cooperation and yield higher success rates. Other beneficial forms of assisted treatment include nicotine replacement therapy, which makes use of medications, counseling, biofeedback, and even acupuncture. The American Cancer Society has projected a six-month success rate of around 30% for smokers who used other forms of assistance, referred to as nicotine replacement therapy, when trying to quit. Examples include transdermal nicotine patches, lozenges, gum, inhalers, and electronic cigarettes. Prescribed medications such as Bupropion, Varenicline, Moclobemide, Nortriptyline, and Clonidine, some of which are antidepressants, have also proven useful. Most smokers will attempt to quit several times throughout their lives, but most are unsuccessful, returning to the habit within six months.

Impact (Psychological Influence)

Cigarette smoking results in nearly 450,000 deaths each year, with approximately 49,000 of these due to exposure to second-hand smoke. Several forms of cancer, emphysema, coronary heart disease, stroke, and infertility have all been linked to smoking. Lawsuits have also been brought against Big Tobacco companies for their past failure in accurately informing and warning the public as to the dangers of cigarette smoking. Smoking cessation is a difficult process for many people and may require the assistance of health-care professionals or the use of medications. In the United States alone, it is estimated that some 60% of current smokers report that they would like to quit smoking. Studies are ongoing to determine not only the long-term health risks but also best forms of treatment for smoking addiction. Recent interventions have made use of web-based support groups and computer programs to assist addicts hoping to quit. Research indicates, however, that certain combinations of medications and nicotine replacement therapies have the highest rates of continued success. These include: (1) long-term nicotine patch and NRT gum/spray, (2) nicotine patch and nicotine inhaler, and (3) nicotine patch and Bupropion. A 2008 meta-analysis conducted by the U.S. Department of Health and Human Services on *Treating Tobacco Use and Dependence* also revealed that cigarette smokers were more likely to quit when they were informed about the risks and felt supported by their health-care provider, noting the importance of a positive relationship between doctor and patient.

Melissa A. Mariani, PhD

See also: Addiction; Tobacco Use Disorder

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Sobriety

Sobriety is the condition of complete abstinence from all mind-altering substances as well as increased mental, physical, and spiritual health.

Definitions

- **Abstinence** is the choice not to engage in certain behaviors or give in to desires such as alcohol or drug use.
- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholics Anonymous** is a mutual aid or self-help fellowship that was founded in 1935 to help individuals struggling with alcoholism.
- **Mind-altering substances** are drugs or alcohol that can significantly influence perceptions, thoughts, and behaviors.
- **Recovery** is a series of steps individuals takes to improve their wellness and health, while living a self-directed (responsible) life and striving to reach their highest potential.
- **Twelve-Step Programs** are self-help groups whose members attempt recovery from various addictions based on a plan called the Twelve Steps.

Description

Sobriety requires the complete abstinence from any mind-altering substances. It also involves an increased level of health and balance in life. In this sense, sobriety involves a transformation in an individual's mental, physical, and spiritual health. An individual who has abstained from mind-altering substances but desires to resume use or engages in behavior patterns when he or she was using is not considered to be sober. In other words, sobriety requires much more than abstinence. Sobriety also includes repairing (making amends) to old relationships, as well as building new ones. Accordingly, sobriety is part of the process of recovery.

Overcoming addiction requires a huge commitment, and discovering how to get sober is the first step. Since sobriety can take a lot of time and effort, it may be helpful for addicts to find reasons to stop using and state these reasons with clarity. Some of the reasons may include an addict rebuilding damaged relationships with family, friends, and coworkers. Many individuals who suffer addiction may also have jeopardized their professional life and have legal issues to face. Whether an individual has been addicted to a substance for a short or long period, achieving

sobriety is possible when an addict takes the following steps. These steps include a commitment to stop using all mind-altering substances, setting short-term and long-term goals, and developing a treatment plan. Finding a support network (e.g., Alcoholics Anonymous) and planning to live a life free of mind-altering substances are also important steps in sobriety.

Treatment

The first step of sobriety is complete abstinence from mind-altering substances. Participating in psychotherapy and Twelve-Step Programs has been shown to be effective forms of treatment for individuals seeking sobriety. In many cases individuals cannot get sober by attending Twelve-Step Programs and psychotherapy alone. An individual may need additional help, such as participating in an inpatient or outpatient treatment program. Once an individual completes an inpatient or outpatient treatment program, becoming involved in a Twelve-Step Program and participating in psychotherapy is generally the best form of treatment for individuals achieving sobriety.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Addiction; Alcoholics Anonymous (AA); Recovery; Twelve-Step Programs

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Social Anxiety Disorder

Social anxiety disorder is a mental disorder characterized by excessive and unreasonable fear of being judged or evaluated by others. Previously it was referred to as social phobia.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety, which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorder.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Cognitive therapy** is a type of cognitive behavior therapy that focuses on identifying and changing automatic thoughts and maladaptive beliefs.
- **Exposure therapy** is a behavior therapy intervention (method) in which a client is exposed to a feared object or situation.
- **Fear** is an emotional response to a known danger.
- **Phobia** is an intense fear of a person, place, or thing that significantly exceeds the actual danger posed.

Description and Diagnosis

Social anxiety disorder is one of the group of DSM-5 anxiety disorders in which an individual experiences distressing anxiety in social situations or in anticipation of social situations. More specifically, those with this disorder experience anxiety regarding the scrutiny of others that is abnormally severe. Often, their anxiety revolves around some sort of performance such as a presentation, dance, or speech. In more severe cases, simply attending a party or having a conversation with a stranger may be sufficient to induce significant anxiety. Social anxiety disorder can cause someone to become isolated or in severe cases unable to maintain relationships and/or become unemployed.

It is not uncommon for them to experience anxiety or fear regarding certain social circumstance. What characterizes this disorder from normal social functioning is that the anxiety almost always occurs as opposed to occasionally. The prevalence of this disorder in the United States is relatively common, affecting approximately 7% of the population. However, this disorder seems to occur far more frequently in the United States than it does in other countries. It is reported that it affects approximately 2% of European countries and less than 2% in the remainder of the world population. This disorder tends to affect roughly equal numbers of males and females. Also, it usually manifests during adolescence (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals must experience anxiety regarding social situations that is primarily focused on the critical scrutiny of others. They must fear that their own behavior will in some way be perceived as embarrassing. Also, they must experience anxiety in regard to almost all social situations. They must also actively avoid these situations as a direct consequence of their anxiety or experience intense anxiety while in the social situation. In addition, the anxiety experienced must be significantly disproportionate to the actual consequence posed by the situation. Also, the conditions and symptoms mentioned earlier must have been present for at least six months.

The exact cause of this disorder is unknown, but it is thought to result from the interaction of a number of factors. Like other anxiety disorders, it is believed that genetics, brain structure, and an individual's environment are factors. A family history of anxiety, depression, or neuroticism may predispose individuals to social anxiety disorder. Also, an overactive or sensitive amygdala, one of the brain structures involved in fear, may also influence the manifestation or experience of social anxiety. In addition, an individual's unique experience, especially adverse social experiences in childhood, may be a risk factor in the development of this disorder.

Treatment

This disorder is commonly treated with exposure therapy or cognitive therapy but may also be treated with medication. In exposure therapy of this disorder, individuals are slowly exposed to the specific social situation that causes them anxiety. The aim of exposure is to break the conditioned cycle of response. At first, the individual may be asked to perform a relaxation technique such rhythmic breathing. Once individuals have reached the relaxed state, they might be asked to imagine themselves entering a social situation that usually causes them a great deal of anxiety, but instead of avoiding the situation, they imagine themselves acting differently. Such exercises become progressively closer to the actual experience of the original social circumstances that were the focus of the individual anxiety. Eventually, such activities result in the extinction of the behaviors that were once associated with social anxiety.

Cognitive therapy is also used, often in conjunction with exposure therapy. The aim of this therapy is to help the individual uncover and understand his or her faulty beliefs about criticism of others and social situations. Self-help workbooks that incorporate both behavioral and cognitive techniques may also be used. In addition to these therapy techniques, medications are also employed in the treatment of this disorder. Both antidepressant medication and antianxiety medication may be utilized but serve different purposes. Antidepressants such as Prozac and Zoloft are used to reduce the severity and frequency of experienced anxiety, but do little to reduce acute symptoms once they manifest. This is in contrast to antianxiety medications such as Ativan or Klonopin, which are used to reduce acute symptoms.

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See also: Agoraphobia; Antianxiety Medications; Antidepressant Medications; Anxiety; Anxiety Disorders; Ativan (Lorazepam); Cognitive Therapies; Exposure Therapy; Fear; Klonopin (Clonazepam); Neurosis; Phobic Disorders; Prozac (Fluoxetine); Zoloft (Sertraline)

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Social Anxiety Disorder in Youth

Social anxiety disorder (SAD) in youth is a marked and persistent fear of social situations in which a person may feel shame or extreme psychological discomfort.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorder.

Description

Social anxiety disorder in children is one diagnosis within the category of anxiety disorders. The disorder is usually diagnosed in the period of a person's life between late childhood and young adulthood. Individuals who experience SAD are scared of performing in social situations. They often experience physical symptoms of discomfort when socializing with others. SAD is also known as social phobia. Social anxiety disorder is one of the most common of all anxiety disorders. Approximately 12% of the U.S. population is diagnosed with some kind of SAD (American Psychiatric Association, 2013). That rate of occurrence makes it the third most prevalent psychiatric disorder after depression and alcoholism.

SAD is characterized by intense internally generated fear in social situations. This fear causes considerable distress and can result in an impaired ability to interact with others in daily life. Often this can occur without any obvious signs or symptoms of anxiety. Individuals with SAD often think that others in social situations are passing unfavorable judgment on them. This makes the individual with SAD extremely self-conscious and fearful of being embarrassed by his or her own actions. These fears can be triggered by the misperception or the actual reality that the individual is being judged by other people.

Causes and Symptoms

As is true with many other mental health conditions, SAD probably arises from a complex interaction of genetics and environment. Some researchers have identified possible causes, which include a combination of genetically inherited traits that affect brain chemistry or structural problems with the amygdala that cause it to be overactive. Anxiety disorders in general often recur across generations of families. But it is not clear whether it is genetics alone, or the familial patterns of learned behaviors, or a combination of these things that influences this behavior more strongly.

Social anxiety disorder tends to develop early in life. About half of individuals who have this disorder have developed it by the age of 11 and almost all have developed it by age 20. It is understandable that children who are the victims of teasing, bullying, rejection, and humiliation are more likely to suffer from SAD. In addition to that, other negative events in life such as family conflict, death in the family, or abuse may be associated with SAD. Social anxiety disorder often occurs in combination with issues of low self-esteem and depression.

There are many physical symptoms that often accompany SAD. Some include excessive blushing of the face, sweating (hyperhidrosis), trembling, palpitations, and nausea. Panic attacks can also occur under intense fear and discomfort. Verbal stammering may also be present for those with social anxiety.

Diagnosis and Prognosis

In order to be diagnosed with SAD an individual must demonstrate several behavioral characteristics. These include persistent fear of one or more social situations, which may bind them to specific people and places. The person must recognize that his or her fear is excessive and that it negatively influences normal routines or daily activities. Lastly, in order to receive the diagnosis, the phobia cannot be caused by a substance or other medical condition.

An early diagnosis may allow those who are diagnosed with SAD to get both psychological and medication help. Both talk therapy and medication can minimize the symptoms of anxiety and the development of any other issues such as depression. Some people who suffer from SAD may use alcohol or other drugs to reduce their fears and inhibitions during social events. It is common for those who experience social phobias to self-medicate with alcohol or other drugs, especially when they are undiagnosed and untreated. While the fear of social interaction may be recognized by the person himself or herself and considered unreasonable, it can be difficult to overcome.

Treatment

A person with the disorder may be treated with psychotherapy, medication, or both. Psychotherapy or counseling can help people with SAD to recognize and change negative thoughts about themselves. Cognitive behavior therapy is the approach most favored for those with anxiety. This therapy helps deal with the role that your own thoughts, especially those about yourself, play in leading to your actions and behaviors. Group therapy, skills training, relaxation, and role-playing are also effective approaches for controlling stress in social situations.

If drugs are required, the patient will usually start with a low dose in order to reduce the risk of side effects. Remember in all cases, whether it is psychotherapy or drugs, that treatment is not a cure. Treatment can be brief or take some time for the symptoms to change and diminish. It is important to be patient when dealing with and treating anxiety disorders.

Alexandra Cunningham, PhD

See also: Antianxiety Medications; Anxiety Disorders in Youth; Social Anxiety Disorder

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Social Communication Disorder

Social communication disorder is a mental disorder characterized by difficulties with the social language and communication skills.

Definitions

- **Attention-deficit hyperactivity disorder** is a problem with the inability to focus and concentrate, being overactive, and the inability to control behavior.
- **Autism spectrum disorder** is a neurodevelopmental disorder that impairs an individual's ability to interact and communicate with others. It also includes repetitive interests, behaviors, and activities, and causes significant impairment in occupational, social, or other important areas of functioning.
- **Developmental disabilities** is a diverse group of serious chronic conditions due to mental and/or physical impairments. They may cause an individual difficulty with language, mobility, learning, and independent living.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.

- **Global developmental delay** is a significant delay in two or more developmental areas of an individual.
- **Intellectual disabilities** are characterized by significant limitations in both adaptive behavior and intellectual functioning.
- **Language impairment** is a disorder in one or more of the basic learning processes involved in understanding or in using spoken or written language.
- **Learning disabilities** are neurological disorders that make it difficult for an individual to acquire certain academic and social skills. They affect the brain's ability to receive, process, store, respond to, and communicate information.
- **Linguistics** is the scientific study of language, including phonetics, phonology, morphology, syntax, semantics, and pragmatics.
- **Neurodevelopmental disorders** are a group of DSM-5 disorders characterized by impairments of brain function that affect language, learning ability, self-control, and memory that develop as an individual grows. They include intellectual developmental disorder, autism spectrum disorder, and social communication disorder.
- **Speech therapy** is treatment of speech and communication disorders, which is usually performed by a speech-language therapist.

Description and Diagnosis

Social communication disorder is one of the DSM-5 neurodevelopmental disorders. It is characterized by impairment in how meaning is created and understood, and delayed language development. Symptoms include limited variety in the use of language, and difficulty understanding the main point of a question, understanding what is socially appropriate. It may be a specific diagnosis or may occur within the circumstances of other conditions, such as specific language impairment, autism spectrum disorder, intellectual disabilities, learning disabilities, attention-deficit hyperactivity disorder, developmental disabilities, and serious brain injuries. Emotional and psychological disorders and loss of hearing may also affect social communication skills. A child or teenager with this disorder will have problems in following normal social rules of communication whether nonverbal or verbal. These individuals often have difficulty following the rules for conversations, that is, taking turns in a conversation. Changing language depending on the situation and needs of the listener is another difficulty for these individuals. These social communication difficulties result in problems participating in a social manner with others, communicating effectively with others, and performing academically. This disorder is most commonly diagnosed by the age of five, since most children possess adequate speech and language abilities (American Psychiatric Association, 2013). However, there are milder forms of this disorder that may not become recognizable until early adolescence. This is the period of when language and social interactions become more complex.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they have persistent difficulties in the social use of nonverbal and verbal communication. This is demonstrated by deficits in communication for social purposes (e.g., sharing information with another individual that is appropriate for the social context). The individual must have impaired ability to change communication to match the situation of the listener (e.g., speaking differently in a classroom than when playing with friends). Individuals must have difficulties with following rules during storytelling and conversations. Individuals may have problems rephrasing a statement when misunderstood, and difficulty knowing how to use verbal and nonverbal gestures to manage interactions with others. These individuals must also have difficulties grasping what is not explicitly stated. These deficits must result in functional limitations in social participation, effective communication, academic achievement, social relationships, or occupational performance. These deficits may occur individually or in combination with each other. The onset of symptoms of this disorder occurs in the early developmental period, and the symptoms are not a result of another medical or neurological

condition. The symptoms must not be derived from low abilities in the area of grammar and word structure, and are not better explained by global developmental delay, an intellectual disability, autism spectrum disorder, or another medical disorder.

The exact causes of social communication disorder are unknown. A family history of communication disorders, autism spectrum disorder, or a specific learning disorder appears to increase the risk for social communication disorder (American Psychiatric Association, 2013).

Treatment

Treatment for social communication disorder is tailored to the individual's need. Speech therapy is one form of treatment in which the goal is to help the individual recognize and correctly interpret verbal and nonverbal cues and expressions. It also assists individuals in differentiating between a sincere voice and a sarcastic one, or between an angry or mean voice. Speech therapists also help individuals to use verb tenses correctly and distinguish between singular and plural nouns. Role-playing is also used to assist individuals to practice taking turns in a conversation. The speech-language therapist will confront and assist the individual with social communication disorder when the individual is speaking far too long. The therapist can also work with the child's parents and teachers and help coach them on ways to improve the child's communication skills. The prognosis for this disorder depends on support of the family, the child's intelligence level, and whether he or she has any other medical or mental disorder.

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See also: Attention-Deficit Hyperactivity Disorder; Autism Spectrum Disorders; Brain; Developmental Disabilities; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Intellectual Disability; Learning Disorders

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Social Justice Counseling

Social justice counseling (SJC) is a multifaceted approach to therapy that incorporates collaborative social advocacy and activism to promote growth and development of individuals, families, and communities.

Definitions

- **Activism** refers to the actions and behaviors taken to promote social or political change.
- **Advocacy** is the act of supporting, recommending, asking, or pleading for a particular cause, policy, or need of a group or individual.
- **Social Inequality** refers to the existence of unequal opportunities or distribution of resources because of social position or status with a social group.
- **Systemic abuse** refers to the existences and maintenance of social inequalities due to a larger system such as the laws, policies, and practices of the land.

Description

Social Justice counseling is based in the belief that all people have a right to equitable treatment and access to services and resources. SJC focuses on issues of oppression, privilege, and social inequities of individuals and group that have been systematically excluded on the basis of race, ethnicity, age, gender, education, sexual orientation, socioeconomic status, physical or mental disability, and other aspects of group membership. SJC incorporates social advocacy and activism as a means to address inequitable social, political,

and economic conditions that impede academic, career, personal, and social development of individuals, families, groups, and communities. Social justice counselors operate from the belief that client problems must take into account the oppressive social and environmental barriers that impede development, growth, change, and harmony.

SJC requires mental health professionals to expand how they conceptualize client problems to include the impact of oppression and inequality on client outcomes. Social justice counselors empower and join clients in the active confrontation of injustice and inequality. The goal of SJC is to ensure that every individual has the opportunity to reach his or her potential free from oppression and other unnecessary external barriers to a quality education, health-care services, and employment opportunities. The process for achieving social justice is through a collaborative therapeutic experience in which clients become aware and knowledgeable of all external barriers that debilitate their development. Clients participate in skill building to address, change, and overcome those barriers.

SJC requires counselors to include advocacy as a core helping competency. Recognizing the critical role counselors play in assisting clients overcome oppression, the American Counseling Association (ACA) adopted an advocacy competencies model. This model identifies the extent of involvement of the client in the advocacy process and the level of intervention on an individual, systemic, or societal level. Counselors may choose to advocate with the client or on behalf of the client.

At an individual level social justice counselors work with clients to empower them. Empowerment includes facilitating the process of identifying, naming, and developing strategies to overcome oppressive barriers. This may also include assisting clients develop self-advocacy skills and locate resources that can help address social, political, economic, and systemic change.

At a systems level, counselors engage in community collaboration in which they work with a larger group to address an oppression or barrier impacting the community. This is similar to individual empowerment but at a group level. Systems advocacy is used by counselors on behalf of a group or community in which the group may not be aware that a systemic barrier exists; may fear repercussions from the larger system; or may not have the power, credibility, or voice to address the issue.

For example, during consultation two counselors at a university become aware that a particular college department has behaved in a discriminatory fashion toward a particular ethnic group. The individual client/students were unaware of the pattern or that other students had attempted to address it without results and that others had left the college because of it. Recognizing that an oppressive barrier exists, the counselors could empower the students on an individual level by assisting them in recognizing and naming the inequality, organize and unite them at the community collaboration level, and engage in systems advocacy by informing the department of the problem and organizing a safe process of resolution.

Other social justice advocacy competencies include counselors engaging in public information to raise awareness about an issue. Social or political advocacy occurs when counselors work directly with policy makers and legislators to address issues impacting client groups.

Development and Current Status

SJC has its roots in the multicultural counseling movement developed in the 1990s. A multicultural perspective led to a deeper understanding of cultural variables and the need to view client problems in the context of the external environment, including sociopolitical factors that impact client functioning. The growth of SJC can be attributed to the growing diversity of the American population and the recognition by counselors that not all personal problems can be solved in a counseling office with an individual client. In 2003, the ACA, drawing from the multicultural literature, adopted the advocacy competencies and by the mid-2000s counseling from a social justice perspective was emerging as another force in the field. SJC continues to be further developed and is included in many graduate counseling programs.

Steven R. Vensel, PhD

See also: American Counseling Association (ACA); Ethnicity; Multicultural Counseling

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Social Learning Theory

Social learning theory is a way to understand how people behave and interact with others based on social contexts.

Description

Social learning theory was started and developed by psychologist Albert Bandura (1925–). The development of this theory moved beyond traditional behavioral theory. Instead the focus of social learning theory is to anchor the human learning process and new behaviors to human observation of other people's actions. Bandura, who is an emeritus professor at Stanford University, is recognized as one of the four great psychologists of the 20th century; he is included alongside Sigmund Freud, B. F. Skinner, and Jean Piaget.

Bandura showed that the social context of learning was key to thinking and behavior. This concept is most notably demonstrated in his Bobo doll experiments first conducted in 1961. The Bobo doll experiments used a five-foot-tall blow-up doll named Bobo. Bobo was weighted on the bottom so that when it was knocked over it would spring up again. Bandura set up experiments with nursery school children, aged three to six. He had half the children observe adults interacting aggressively with the Bobo doll. This included hitting it, knocking it over, and kicking it. The other half of the group were with an adult who simply played with other toys while ignoring the Bobo doll. Bandura exposed the children to these activities, one by one, so as to eliminate group pressure. There was also a control group who saw no modeling of behavior at all.

What Bandura discovered was that children who witnessed aggressive behaviors tended to demonstrate those same behaviors. This occurred more so than with the children who had not seen aggressive behavior. He also noted that boys who had seen an adult male act aggressive tended to be more aggressive themselves than boys who had seen the same behavior from an adult female. Although same-sex behavior modeling seemed to be more influential in terms of outcomes, girls in general tended to be almost 50% less aggressive than boys.

The Bobo doll experiments were criticized on many levels. Bandura conducted a revised version of the experiments in 1963. When adding a reward or punishment for the adult aggressive behaviors, things changed. He found that incorporating such consequences did impact whether or not the children themselves acted aggressively.

The main theme of social learning theory is that people learn by watching other people. This is true not only in terms of their motor behaviors, like hitting or kicking, but also in the way they may use language. But it seems clear that humans are not automatic copycats of behavior. Just because something has been observed or learned does not mean that behavior will change. As Bandura (1971) once wrote, "In the social learning view, man is neither driven by inner forces nor buffeted helplessly by environmental influences. Rather, psychological functioning is best understood in terms of a continuous reciprocal interaction between behavior and its controlling conditions."

Current Status and Impact (Psychological Influence)

Social learning theory moved beyond pure behavioral theories and practice, to see learning as part of a social process. It shows that learning can take place from observing behavior or the consequences of behavior. But learning is not passive observation; it requires gathering information and decision making. And while it is true that reinforcement plays a role in learning, it is not the only component necessary for learning. Social learning theory concludes that thinking, behavior, and environment all play an interactive role in the learning process.

Bandura's ideas have become a standard part of understanding human thinking and behavior. His theories helped people understand how anxiety could develop without having direct interactions with a triggering object itself. His work demonstrated that people can also learn from hearing about the experiences of other people.

The current empirical investigations of social learning strategies include a range of research from laboratory studies to observations in the natural environment. These studies consider factors big and small, from individual decision-making processes to observational work that seeks to explain population-level cultural and social issues. Such empirical studies build off the insight of social learning theory and the complexity of the human learning process.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Aggressive and Antisocial Behavior in Youth; Bandura, Albert (1925–); Behavior Therapy; Behavior Therapy with Children

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Social Media

"Social media" refers to different forms of electronic communication, such as websites, blogs, and chat rooms, that people use to interact with one another to share information, exchange ideas, and establish online communities.

Definition

- **User-generated content** defines various types of media content generated by and accessible for use by the general public; some examples are videos, blogs, podcasts, social networking sites, wikis, and forums. Since 2005, user-generated content has had various applications, including circulating news and gossip, generating research and problem solving, and gauging public interest and opinion.

Description

Social media applications offer ways for people to interact with one another in the online environment. There are six different types of social media: collaborative projects, blogs and microblogs, content communities, social networking sites, virtual gaming sites, and virtual social worlds. Some social media may combine two or more of these types. The content that is created in these virtual communities is referred to as "user-generated content." A difference between social media and traditional forms of media is that social media is much more far-reaching, accessible, and permanent. Social media users are able to network, collaborate, share ideas, and socialize right from the comfort of their own computer, cell phone, or tablet. The development of social media has substantially impacted how people communicate with one another in today's world.

One of the first social media sites was created in 1994, known as Geocities. Social media became widely used in the early 2000s. Since then, social media sites have continued to explode. Nowadays, people use social media sites for a range of functions such as to gather information, post their opinions, catch up with friends, search career opportunities, and even seek out romantic relationships. The business world has benefited and uses social media to conduct market research, promote products and discounts, and foster brand loyalty.

Users cite the quality, immediacy, and accessibility that social media provides as some of the top benefits. The increase in this type of communication has resulted in unlimited access to information provided on the Internet. Many sites are open platforms and do not require registration or membership fees. People are able to connect and form relationships, both personal and professional, with individuals around the world. Answers are only a keystroke or mouse click away.

There are some drawbacks to social media as well. Experts argue that the increase in social media usage

The logos of some social media, showing the numerous popular online social network sites that people use to express themselves, keep in touch, and establish online communities. Researchers worry that social media usage has greatly cut the amount of face-to-face interactions and tends to encourage impulsive and inappropriate postings, often later regretted. (Roberto Giovannini/Dreamstime.com)

has drastically decreased the amount of face-to-face interactions that people engage in. Some even suggest that social media usage can be addictive. Many debate further that communicating via social media reduces the quality and personal nature of interactions. Furthermore, users who are not able to establish boundaries between their personal and professional selves may be subject to risk. Another limitation, given the ease of use, is the concern over exposure, particularly for minors. Without even trying, one can be subject to graphic images, videos, and even sexual predators. Monitoring minors' use of social media and setting up parental controls and privacy settings is recommended. Research has also cited a positive correlation between the use of social networking sites and cyber-bullying. In addition, one must question the reliability and validity of the information one finds on the Internet. Ownership and copyright issues are also an issue with social media content.

Impact (Psychological Influence)

These types of sites are extremely popular and are accessed by Internet users more than any other type of site. By July 2012, the total time spent on social media in the United States increased 37% to 121 billion minutes from 88 billion minutes just the year before. Facebook is an example of a popular social networking

site. With over 1 billion active users, it is the primary method for communication among college students in the United States. In addition, 93% of businesses employ Facebook as a marketing tool. Users aged 65 and older are also on the rise; one out of every four people in that demographic is a member of a social networking site.

Melissa A. Mariani, PhD

See also: Electronic Communication; Facebooking

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Social Skills Training

Social skills training (SST) is a form of therapy used by teachers, therapists, and mental health professionals to help people with social challenges.

Definition

- **Social** means related to human society or its ways of being organized.

Description

Social skills training (SST) is a widely used treatment for different groups of people who struggle with interacting with others socially. Individual SST is effective when a trained therapist helps one child improve specific social behaviors. Examples of these include use of eye contact and taking turns during play. SST also includes group treatment, which has been effective because of the opportunity to practice with peers and learning from one another. Group SST has been overall proven more effective for clients and efficient for therapists and health-care systems.

The primary purpose of SST is to teach people how to overcome the problems they experience socially. In SST clients can be taught the interpersonal skills of how to start a conversation or have small talk, how to handle humor in groups, and what to do during a phone call. In most cases people who have trouble socially have not learned how to use and understand social cues. Social cues include verbal and nonverbal behavior. These cues let people know when someone else is bored or when to suggest changing an activity. SST helps teach specific social cues and rules for interaction based on social norms. These social norms can be complicated and require breaking down large concepts into smaller steps. If SST is effective, the people benefiting gain insight and successful experiences from socializing. This in turn positively affects their self-esteem and relationships overall.

There are various techniques and methods that are included in SST. These include teaching, modeling, rehearsal, and homework. People with social challenges often need to learn the rules or norms for socializing, which can be introduced and taught. Utilizing the method of Socratic questioning is a good way of engaging teens and adults in the learning process. After being taught it is important to provide a demonstration or real-life example of the skill. This can be done through live modeling or role-playing or through video. After learning and modeling are complete, a chance to practice or rehearse the skills and get feedback is important. During behavioral rehearsals, coaching from clinicians is critical for the delivery of corrective and positive feedback. Finally, having the opportunity to generalize the skills used in treatment outside of therapy is the last step to truly effective SST.

Understanding the effective methods of SST allows clinicians to provide a high standard of care with guidelines to help this population learn and grow therapeutically. It allows therapists to teach clients how to have friendships, manage emotions, become independent, and overall have a better quality of life. SST is an effective treatment for individuals with diagnosis such as autism, schizophrenia, and anxiety disorders.

Development

In the United States in the 1920s there was a major movement in the school system toward character education. During this movement, the introduction of teaching interpersonal and social skills happened in schools. A few decades later, psychologists became involved in SST through behavior therapy in children.

During the 1950s medication treatment for psychotic disorders became popular and psychologists were tasked with helping clients manage their bizarre behaviors. They were required to teach these patients how to interact successfully with others in the community. This is how SST became standard practice in treating individuals with chronic and acute social issues.

Current Status

In recent years the demand for SST has increased. Although SST has become popular, few of these have been formally researched and reviewed. Those that have been proven effective focus on changes in behavior and physiology. The advancements in functional magnetic resonance imaging measurements have allowed SST to be measured for changes in the brain after treatment. It is likely that the future direction of SST will continue to utilize physiological tests to identify effective social skills treatment.

SST can be used with other treatment to effective treat specific disorders. With disorders such as substance use or dependence, SST has been used with medication management and coping skills training. It is also commonly used alongside exposure therapy and behavior therapy to treat anxiety disorders. The incorporation of family education and therapy into SST has been extremely successful. Family education and therapy that works directly with the concepts being addressed in SST has the most effective, long-term outcomes. Current research suggests that if family treatment isn't involved, then follow-up support to SST is helpful.

There are many benefits of SST programs. One is that the treatment can be brief and structured, which allows clients to get maximum potential. Usually clients are placed in a group setting where they get support and resources from those whom they interact with. SST also focuses on new skills that are learned and built upon versus focusing on the history of struggles a client has experienced. This places a positive and concrete focus onto a psychological issue that can be more helpful to clients than analyzing its origins. More research needs to be done on SST, and SST is emerging as a standard best practice in treating those with social problems.

Alexandra Cunningham, PhD

See also: Attention-Deficit Hyperactive Disorder; Autism Spectrum Disorders; Behavior Therapy with Children; Disruptive, Impulse-Control, and Conduct Disorders; Nonverbal Communication; Oppositional Defiant Disorder (ODD)

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Social Workers

Social workers are professional individuals who work in human service settings assisting individuals, families, and communities.

Description

Social workers are highly trained individuals who most often work in human service settings to help people cope with challenges in their lives. The social work profession has a long and rich history of advocating and assisting underserved and minority populations. Social work core values include respect for the equality, worth, and dignity of human beings; civil rights; and social justice.

Social workers are represented by the National Association of Social Workers (NASW), the largest membership organization of social workers in

the world, representing over 140,000 members, in 56 states and local chapters. According to the NASW the social work mission is to "enhance the effective functioning and well-being of individuals, families, and communities through its work and through its advocacy" (NASW, 2013).

The profession of social work includes three levels of professional qualifications with distinct levels of service provision depending on education. Social workers may have a bachelor's degree in social work (BSW) or a master's degree in social work (MSW). Licensed clinical social workers (LCSWs) have an MSW and are licensed in the state where they work to provide mental health services. For those wishing to work in universities or colleges as social work educators, they must earn either a doctorate in social work or a PhD in social work. Over 650,000 individuals hold degrees in social work.

Social workers, those with either a BSW or an MSW degree who are not licensed, provide services in a wide range of social service settings. Service settings include family service agencies, childcare services, adoption and foster care settings, hospitals and community clinics, community mental health programs, disability support agencies, nursing homes and elder care, public health settings, criminal justice and correctional settings, community organizations, homeless organizations, programs for veterans, substance abuse treatment settings, and youth outreach programs. Master-level social workers also provide administrative leadership in social service settings.

Social workers are trained to assist individuals, families, and community organizations. On an individual/family level, social workers provide assessments of needs, identify beneficial resources such as community aid services and programs, develop plans to utilize resources, and provide assistance to individuals and families in need. On a community level social workers work with community and government service agencies in the development and provision of programs and policies to enhance individual and family well-being.

Licensed clinical social workers must have a master's degree in social work and hold state licensure to treat mental health disorders. Attaining state licensure is demanding and requires supervised clinical practice as a social work intern for a minimum of two years after graduating with an MSW. Although states vary somewhat in their requirements, licensure generally requires 1,500 hours of face-to-face psychotherapy experience while receiving clinical supervision from a state-qualified supervisor. LCSWs are qualified to diagnose and treat mental, behavioral, and emotional disorders such as depression, anxiety, trauma, and other mental disorders and conditions. They provide psychotherapeutic services to individuals, groups, couples, and families. LCSWs may also work in private practice, providing psychotherapeutic services for a fee.

The U.S. Bureau of Labor lists the following occupations as having job duties similar to social workers: health educators, mental health counselors, marriage and family therapists; probation officers and correctional treatment specialists; psychologists; rehabilitation counselors; school and career counselors; social and human service assistants, and substance abuse and behavioral disorder counselors. According to the U.S. Bureau of Labor as of 2010 the median annual wage of all social workers was $42,480, with half the workers earning more and half the workers earning less. The top 10% earned more than $70,000. Employment of social workers is expected to grow by 25% from 2010 to 2020, which is faster than the average for most occupations.

Social workers have a profound and far-reaching impact on our society. Social workers are found in every facet of community life and are employed throughout the mental health industry.

Steven R. Vensel, PhD

See also: Marriage and Family Therapist; Mental Health Counselor

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Socioeconomic Status

Socioeconomic status is a tool for identifying status based on individuals' income and occupation in relation to others.

Description

Socioeconomic status looks at how people relate to each other based on their income, background, and occupation. Socioeconomic status is often referred to as SES. In the fields of social sciences, it is one of the most widely studied constructs.

Socioeconomic status is measured by looking at family income, parental education, and parental occupation. This area is widely researched, as people want to know the impact and relation to physical health, mental health, and advantages or disadvantages for children based on the family's SES.

Socioeconomic status is generally broken down and referred to as high, middle or low. It is often used interchangeably with the term "social class." Families of low and high status tend to be focused on the most. Children born to low-status families tend to be considered behind those children of high status in relation to education and development. For instance, children of high-status families tend to learn words faster than those of low-status families, which is noticed in children as young as 18 months old.

Research dating back to the early 1900s highlights the connection between family life and SES. Those with low SES face more hardship, which impacts parent–child relationships and family life. Those who are considered to be in the ethnic minority are more often considered part of low SES in the United States.

In relation to child development, the focus on SES has surrounded the concern that those who come from low SES lack access to resources, education, and care, leading to developmental problems and limited better future prospects regarding education and occupation. Education is a large focus point in regard to exploring status, as many believe that education has a great influence on occupation and income later in life.

Studies have supported the idea that those coming from higher SES will have more opportunity for economic growth and occupation choices. Studies have also highlighted a connection that those of higher SES have decreased percentages of separation and divorce in their relationships as well as better parent–child relationships.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Poverty and Mental Illness

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Sociopathic Personality

Sociopathic personality is a mental disorder characterized by amoral and criminal behavior and a diminished sense of moral responsibility. It is also known as sociopathy and sociopath.

Definitions

- **Antisocial personality disorder** is a mental disorder characterized by a persistent pattern of disregarding and violating the rights of others.
- **DSM** stands for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.

- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behaviors, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **Psychopathic personality** is a mental disorder characterized by amoral behavior, inability to love and understand another's feelings (empathy), extreme self-centeredness, and failure to learn from experience. It is also known as psychopathy and psychopath.

Description

Individuals with sociopathic personality tend to spontaneously act out in inappropriate ways without thinking through the consequences. They may be nervous, easily agitated, and quick to display anger. They will lie, manipulate, and hurt others, but will often avoid doing so to the select few individuals they care about. Most often they are able to form attachments and loyalties to others. This means that they are likely to experience guilt and remorse when they hurt someone they care about. While they are capable of committing heinous crimes, they are unlikely to commit crimes against family or friends.

In the past, the term "sociopathic personality" has been used synonymously with psychopathic personality and antisocial personality disorder. More recently, clinicians and researchers favor distinguishing them. There appear to be differences among the three in both behavior and etiology (cause). While antisocial behavior is common in antisocial personality disorder and sociopathic personality, it is less common in psychopathic personality. Also, there are specific deficits in psychopaths that distinguish them from sociopaths. These include interpersonal deficits, such as grandiosity, arrogance, and deceitfulness, as well as affective deficits, such as a lack of guilt. In addition, psychopaths are characterized with global deficits of empathy. As for etiology, it appears that the psychopathic personality is more influenced by genetic inheritance than environment. In contrast, the sociopathic personality seems to be more influenced by environmental factors such as poverty, exposure to violence, and overly permissive or neglectful parenting. It should also be noted that the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* provided a description of the sociopathic personality. However, in subsequent editions, it has been replaced by a description and specific diagnostic criteria for the antisocial personality disorder.

Len Sperry, MD, PhD

See also: Antisocial Personality Disorder; Personality Disorder; Psychopathic Personality

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Solution-Focused Brief Therapy (SFBT)

Solution-focused brief therapy is a talking therapy that focuses on solutions rather than on problems.

Description

Solution-focused brief therapy (SFBT), also referred to as solution-focused therapy, is a talking therapy that focuses on the development of solutions rather than on past problems. SFBT is an evidence-based practice that minimizes emphasis on past failings and problems, and focuses on client's strengths and previous and future successes.

Development

The development of solution-focused brief therapy was led by husband and wife Steve de Shazer (1940–2005) and Insoo Kim Berg (1934–2007) at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. Finding that an excessive amount of time and energy was spent in thinking about, talking about, and analyzing problems, the team at BFTC developed a method to bring about

realistic change as quickly as possible. Since the conception of SFBT in the late 1970s, other therapists have added to its conceptual framework. Eve Lipchik, John Walter, and Jane Peller, have written extensively about solution-focused therapy. Michelle Weiner-Davis and Bill O'Hanlon, influenced by de Shazer and Berg's work, expanded their own work and created solution-oriented therapy, which shares many key concepts with SFBT. Both de Shazer and Kim Berg wrote extensively on SFBT. With the passing of de Shazer and Kim Berg, the BFTC was closed and all rights to their solution-focused training materials were bequeathed and transferred to the Solution-Focused Brief Therapy Association.

Solution-focused brief therapy is a collaborative process that works from the client's understanding of his or her concerns and what the client might want different. The therapeutic focus is on what the client desires for the future rather than on past problems or even current conflicts. One of the basic premises of SFBT is that there is no problem that happens all the time. SFBT uncovers "exceptions," which are times when the problem could have happened but didn't. The model assumes that exceptions are actually solution-oriented behaviors that already exist for the client. The nature of these exceptions is used by the client and therapist to co-construct future solutions. Clients are encouraged to increase the frequency of behaviors, which have led to solutions. Another key concept of SFBT is that small increments of change lead to large increments of change.

The therapist takes a positive, collaborative, and collegial position that assists the client in finding alternatives to current patterns of thinking, behaving, and interacting that are problematic. The focus of the therapist is on what is observable in the communication and social interactions between the client and the therapist. The mechanism of change is the dialogue between the therapist and client.

One of the main techniques utilized in SFBT is the "miracle question." When clients have difficulty articulating a goal, the miracle question can help the client what may occur if a solution was found. Although there are many variations to the miracle questions, the basic question is, "Imagine that sometime during the night a miracle takes place and while you are asleep the problem you are talking about is solved. But because you were asleep when it was solved when you wake up you don't know a miracle has taken place. So when you wake up how will you know the problem is no longer a problem?" The miracle question has been so effective in assisting clients in the change process that it has been adopted and used in many other models of psychotherapy.

Current Status

Solution-focused brief therapy has been found to be an effective form of psychotherapy and is included in Substance Abuse Mental Health Service Administration's National Registry of Evidence-Based Programs and Practices. It has been found to be helpful with both adult and adolescent populations and in both outpatient and inpatient treatment centers.

Steven R. Vensel, PhD

See also: de Shazer, Steve (1940–2005); Kim Berg, Insoo (1934–2007)

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Somatic Symptom Disorder

Somatic symptom disorder is a mental disorder characterized by bodily symptoms that are very distressing and result in disrupted functioning. In the past it was called somatization disorder.

Definitions

- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth*

Edition, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.

- **External locus of control** is the core belief that individuals' decisions and life are controlled by external factors over which they have little or no influence.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Somatic sensitivity** refers to the high level of sensitivity and attentiveness to bodily sensations in some individuals, leading them to overly focus on physical symptoms.
- **Somatic symptom and related disorders** are a group of DSM-5 mental disorders characterized by prominent somatic symptoms and significant distress and impairment. They include somatic symptom disorder, factitious disorder, and conversion disorder.
- **Somatization disorder** is a mental disorder characterized by multiple bodily symptoms that cannot be explained by a medical condition. This term is no longer used and has been replaced with somatic symptom disorder in DSM-5.
- **Stress management** is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Description and Diagnosis

Somatic symptom disorder is one of the groups of disorders known as somatic symptom and related disorders. Individuals with this disorder experience somatic (bodily) symptoms that are very distressing and that significantly disrupt daily functioning. The duration and severity of these symptoms and the pursuit of relief often become the focal point of their lives. Talking about their condition often becomes the primary focus and way in which they relate with others. Their suffering can also limit their ability to work or care for their children. Somatic symptom disorder is similar to but different from somatization disorder. Whereas somatization disorder required that symptoms could not be explained by a medical condition, somatic symptom disorder does not.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit one or more somatic (bodily) symptoms that disrupt their lives. The disruption and their response become problematic in that the person has excessive worry and anxiety regarding the seriousness of the symptoms regardless of the fact that medical evidence does not warrant it. These individuals may also expend considerable time and efforts focused on their symptoms. In addition, the symptoms must persist for more than six months (American Psychiatric Association, 2013).

The cause of somatic symptom disorder is not well understood. It may be that those with this disorder are more sensitive to their bodily sensations (somatic sensitivity) than others. They tend to amplify and interpret these sensations are indicators of physical illness. As a result, when they experience emotional stress, they are likely to interpret it as a physical symptom. They tend to view life as threatening and overwhelming. They are also likely to view themselves as unable to control and deal with overwhelming circumstances. These views reflect an external locus of control. This disorder not only confirms and perpetuates their suffering but also explains their reliance and overuse of medical treatment.

Treatment

Effective treatment of this disorder involves counseling or psychotherapy. Usually, these individuals are referred to psychotherapy by their physician. But, because they are likely to resist a psychological explanation and treatment for their condition, a team approach is essential if treatment is to be successful. Framing treatment as a team approach lets these individuals know that the therapist will work with their physician, as part of a team, to reduce their suffering. Psychological treatment should emphasize increasing functioning decreasing preoccupation with symptoms. Intervention strategies should target physical functioning by

teaching relaxation and other stress management skills. Such interventions can greatly help them feel better physically and increase their sense of self-efficacy. In addition, mindfulness practice can help in reducing their preoccupation with and acceptance of physical symptoms.

Len Sperry, MD, PhD

See also: Mindfulness; Somatic Symptom Disorder; Stress Management

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Somatizing Personality Disorder

Somatizing personality disorder (SPD) is a mental disorder characterized by a persistent and excessive preoccupation with bodily concerns.

Definitions

- **Alexithymia** is the inability to experience, express, identify, and describe emotional responses.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts.
- **Delusions** are fixed and false beliefs that persist despite contrary evidence.
- **Hypochondriasis** is a mental condition characterized by a preoccupation with having a serious medical condition based on a misinterpretation of bodily symptoms.
- **Personality disorder** is a long-standing pattern of maladaptive (problematic) behaviors, thoughts, and emotions that deviates from the accepted norms of an individual's culture.
- **PDM** stands for the *Psychodynamic Diagnostic Manual* and is a diagnostic framework that characterizes individuals in terms of their psychodynamics.

Description and Diagnosis

Somatizing personality disorder is a personality disorder characterized by an excessive preoccupation with bodily concerns that is ongoing and long-standing. Individuals with this disorder typically experience health concerns that doctors can't explain. As a result these individuals become frustrated and come to believe that others do not understand and accept their concerns. Being preoccupied with bodily concerns can lead individuals to experience a delusion. The delusion may involve a belief that a part of their body has been injured or altered in some way. Individuals with SPD often present a confusing combination of concerns. Other issues include having a diagnosable stress-related physical illness and bodily symptoms that express ideas and emotions that are too painful to put into words (PDM Task Force, 2006).

Individuals with SPD are also characterized by alexithymia. Children who cannot verbalize their feelings tend to either act out or complain they have body aches and pains. Individuals with this disorder have also been described as lacking the ability to fantasize and being incompetent in symbolic expression. They tend to invest more time in "things" than in the effects of the imagination (PDM Task Force, 2006). It is possible that early caregivers of individuals with this disorder did not encourage expressing feelings and emotions. Therefore, this left their bodies to communicate what their minds could not. Although they may at times receive some secondary gain from the sick role, the pain they suffer is real and debilitating. Individuals with this personality disorder often claim that they feel that nobody is listening to them. Others may tune out individuals with SPD as previous efforts to help them left them feeling frustrated due to a lack of resolving the problem. Individuals with this personality disorder may

also feel "unheard" because of the early experiences with caregivers who failed to respond to their communication. This personality disorder tends to significantly interfere with relationships, school, work, and social activities. It is important to distinguish SPD from hypochondriasis. Both involve a preoccupation with medical concerns. The lives of those with SPD are totally dominated by these concerns. However, it is less likely that hypochondriasis interferes with daily activities and relationships.

According to the *Psychodynamic Diagnostic Manual*, SPD is diagnosable by the following criteria. It is common for individuals with this disorder to have a developmental history that includes early sickliness. It might also include being physically fragile and early physical or sexual abuse. These individuals tend to be preoccupied with something being wrong with their bodies. They commonly exhibit distress and rage. Alexithymia prevents them from acknowledging their emotions. Their basic belief is they are vulnerable, fragile, and in danger of dying. Their view of others is that they are healthy, powerful, and indifferent. Furthermore, their main way of defending themselves is by regressing (returning to a previous or usually worse state) and continually expressing they have body aches and pains (PDM Task Force, 2006).

Treatment

Treatment of this disorder requires a supportive relationship with both a health-care provider (physician) and a mental health-care provider (therapist). Cognitive behavior therapy has been shown to be particularly effective for SPD. This approach can assist an individual in dealing with pain and helping him or her realize his or her health concern is not fatal. Effective therapy involves such individuals talking about their concerns and their therapists listening and acknowledging these concerns in a caring manner.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Alexithymia; Cognitive Behavior Therapy; Delusions; Hypochondriasis; Personality Disorder; *Psychodynamic Diagnostic Manual* (PDM)

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Somatopsychic

"Somatopsychic" refers to the influence of the body on the mind. It is the opposite of psychosomatic, which refers to the effect of the mind on the body.

Definitions

- **Depressive disorder due to another medical condition** is depression that occurs as the result of a physical illness. The depression causes substantial difficulty in social, occupational, and interpersonal areas.
- **DSM-5** is the *Diagnostic and Statistical Manual of Mental Disorders*. It is the handbook mental health professionals use to diagnose mental disorders.
- **Major depressive disorder** is a DSM-5 mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning. It is also referred to as clinical depression.
- **Psychosomatic** refers to the effects of mental processes on physical health.

Description

Somatopsychic is the relationship of the body and mind. It refers to the effect that physical bodily conditions have on mental processes, in other words, how physical health impacts mental health. Mental disorders such as depression and anxiety may be symptoms of physical illness or mental dysfunction. For example, the underlying cause of depression may be attributable

to a physical illness such as cancer. According to the DSM-5, the depression will be diagnosed as depressive disorder due to another medical condition and not as major depressive disorder. One of the criteria for major depressive disorder explicitly states that the depressive episode cannot be the result of a medical condition. The depression is the direct result of the physical illness and cannot be attributed to another mental disorder.

The interrelationship between body and mind makes it difficult for a physician or clinician to determine whether the presenting problem is somatopsychic or psychosomatic. It may be that both body-mind and mind-body play a role in symptom development. It is important for mental health clinicians, and especially physicians, to keep in mind that psychological symptoms could potentially be the result of physical illness. Conversely, it is important to remember that physical symptoms may be caused by psychological illness. Attentiveness to these possibilities can lead to more accurate diagnoses.

There are many physical conditions that are expressed through psychological symptoms. This is why it is crucial for mental health clinicians to rule out organic conditions as possible causes for psychological symptoms. A thorough history assessment is necessary to determine if an individual needs to be referred for a physical examination. It is important to ask when an individual was last seen by a physician, what type of exam was performed, what lab tests were performed, and what the results indicated. When a diagnosis is not clear, it is important to maintain awareness of the possibility that organic causes may be at the root of the problem.

The effects of the body on the mind were originally explored by early psychiatrists such as Christian Friedrich Nasse (1778–1851), Carl Friedrich Flemming (1799–1880), and Pavel Ivanovich Jacobi (1841–1913). These physicians were part of the somatic school and contended that psychological dysfunction was a symptom of biological diseases in the body. They believed that physical illness created an imbalance in the relationship between the body and mind.

Christina Ladd, PhD, and
Len Sperry, MD, PhD

See also: Mind-Body Medicine; Mind-Body Psychotherapies; Psychosomatic Disorder and Psychosomatic Medicine; Somatic Symptom Disorder

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South Park (Television Program)

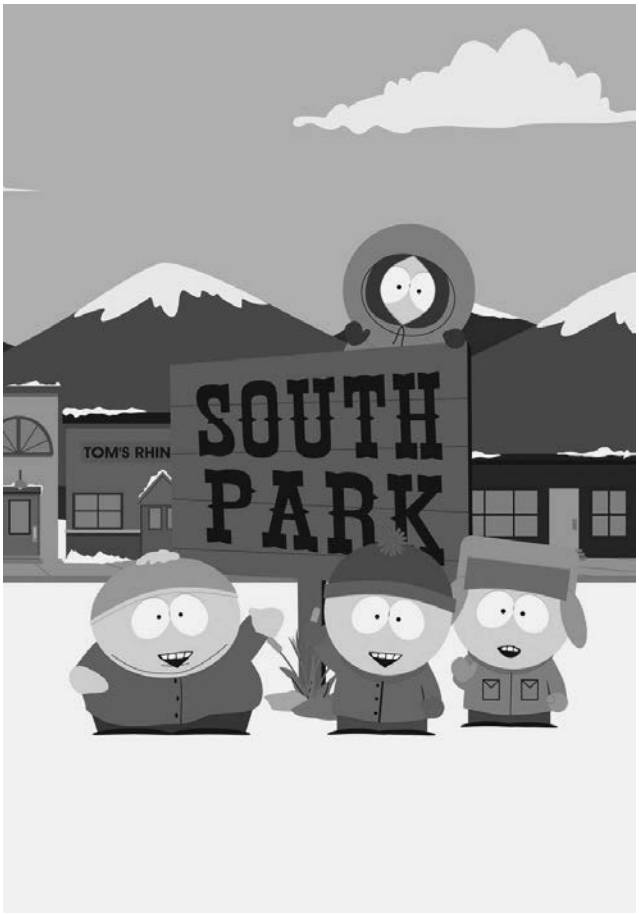
South Park is an American animated television program intended for mature audiences, televised on the Comedy Central cable network.

Description

South Park debuted in August 1997 and was created by Trey Parker and Matt Stone. Parker and Stone are the show's lead writers and producers and provide the voices of the main characters. Production took place at South Park Studios (SPS) in Culver City, California. *South Park* has received numerous awards and is known for its vulgarity, crude humor, strong profanity, dark satire, shock value, running gags, and pop-culture references. TV guide ranked *South Park* as the 10th greatest television cartoon of all time.

South Park is set in the fictionalized town of South Park Colorado and follows the strange adventures of four foul-mouthed boys in elementary school: Stan Marsh, Kyle Broflovski, Eric Cartman, and Kenny McCormick. Stan Marsh, described as the average fourth grader is modeled after Parker. Kyle, modeled after Stone, is described as the voice of reason, is Jewish, and is Stan's best friend. Eric Cartman is described as one of the worst human beings in the history of fiction and the most famous of the fourth graders. He is narcissist, self-centered, racist, and obese. Kenny is poor and, according to SPS, tends to frequently die and was killed in innumerable ways during the first five seasons.

South Park Studios has a staff of approximately 70 people. The use of cutout animation software allows for episodes to be produced the week of the airing. The production schedules allow for current events to be rapidly incorporated into episodes. Some episodes



South Park is an American animated television comedy about foul-mouthed elementary students. Its popularity, especially among teenagers, stems from its satirical representation of hypocrisy in religion, politics, parenting, and many other mainstream cultural topics. (Comedy Central/Photofest)

have featured events that had taken place just days prior to airing. For instance, the season 12 (2008) episode "About Last Night" included elements of President Obama's acceptance speech less than 24 hours after he won the election.

South Park has been an enormous ratings success and is credited with making Comedy Central a successful network. *South Park* has received numerous awards and has won the Emmy Award for Outstanding Animated Program four times as of the 2013 season.

South Park has been criticized for its crude humor and depiction of foul-mouthed elementary school-age children. It is known for its use of taboo subject matter and negative depiction of religion, politics, parenting, and most other main stream cultural topics. The show's portrayal of religion for comic effect is a frequent complaint, as is the use of profanity. Adding to the controversies, *South Park* frequently responds to criticism by producing shows containing more of whatever is being complained about. For instance, in response to complaints regarding the use of profanity, SPS released "It hits the fan" the first episode of season five (2005). During that episode the word "shit" is said 162 times uncensored.

Since its television debut in 1997 *South Park* has been the topic of countless college papers and has added many catchphrases to our cultural language. With its political incorrectness, satirizing of many of the world's most popular religions (Christianity, Mormonism, Islam, Scientology), and negative depictions of political leaders, *South Park* has generated worldwide controversy since its debut in 1997. *South Park* remains one of the most highly rated animated television programs of all time.

Steven R. Vensel, PhD

See also: Media Violence

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Special Education

Special education provides teaching instruction for students diagnosed with learning, behavioral, emotional, communicative, developmental, and physical disabilities, in specifically designed educational settings that meet their individual needs.

Definitions

- **Inclusion** is an educational approach that calls for students who are disabled to spend the majority of time in classrooms with nondisabled peers.
- **Learning disability,** or specific learning disability (SLD), is a neurological disorder that affects the brain and results in processing, reading, writing, reasoning, and recalling difficulties.
- **Mainstreaming** refers to the inclusion of students with special needs into regular, general education classrooms and activities.
- **Response to intervention**, also known as Multi-Tier System of Supports, is an approach used to provide students displaying academic and behavioral concerns with appropriate instruction and intervention.
- **Special needs** is a term used to describe persons who have been diagnosed with mental, emotional, and physical disabilities.

Description

Traditional classrooms, referred to as "general education" classrooms, provide education programs for typically developing students based on state standards as determined by state standardized achievement tests. Special education services are designed to supplement the regular curriculum and support the unique needs of students with qualified disabilities. Those disabilities include but are not limited to learning, emotional, behavioral, and communication disorders, physical impairments, and/or sensory needs. Students may become eligible for special education services after properly being diagnosed with one or more of these disorders. Those who receive special education support may be described as "special needs" or "learning disabled". The Individuals with Disabilities Education Act (IDEA), now the Individuals with Disabilities Education Improvement Act, mandates that children aged 3 to 21 with special needs receive a free and appropriate education in the least restrictive environment. Inclusion in general education classrooms with nondisabled peers should therefore be executed to the greatest extent possible. Evidence suggests that when disabled peers are mainstreamed, they experience positive outcomes. By providing proper support and services, educational systems seek to promote student well-being, self-sufficiency, and future success. Special education support can occur within traditional classrooms, resource rooms, self-contained classroom, or specialized schools. Reading and math instruction; speech-language, occupational, and physical therapies; small group counseling; and behavioral interventions may be offered.

Students who are born with noticeable disabilities or impairments (i.e., deafness, blindness, physical handicap) may be easily identified and thus begin their school careers with special support. However, other students, primarily those with specific learning disabilities (SLDs), require proper identification, evaluation, and diagnosis. The process for qualifying for special education support can be lengthy. Traditionally, a full psychoeducational evaluation by a licensed psychologist is required. Qualifying for an SLD is then determined based on the discrepancy model—whether or not there is significant difference, at least two standard deviations (30 points) between the individual's scores on an achievement test and his or her IQ. However, this model has been criticized as it does not provide a method for identifying children in primary grades, provides little information about the student's specific learning needs, and has resulted in disproportionate representation of minority groups. The recent introduction of an alternative approach, Response to Intervention, has placed heavy demands on educational

staff, primarily classroom teachers, to document and provide interventions aimed at meeting students' individualized needs. Each student with a documented disability is required to have an Individualized Education Plan/Program (IEP) on file outlining his or her specific needs, goals, and services received. IEPs are then tailored to each individual and describe both accommodations and modifications to the general curriculum. Accommodations are slight adjustments to the regular education that simply change the format in order to make it more palatable for the student, while modifications change or reduce the curriculum to bring it to a level that is obtainable for the student.

Development (Purpose and History)

Parents advocating for specialized schooling and support for their children can be traced back to the 1930s; however, over the next several decades slow progress was made toward advancing the rights of children with special needs. The 1950s and 1960s and the influence of the civil rights movement had a positive effect. Specifically, the landmark case of *Brown v. Board of Education* (1952) established precedence that segregating students based on race was unconstitutional, paving the way for other marginalized groups to follow. It was not until the 1970s that true educational reform benefiting disabled youth began. The federal Rehabilitation Act of 1973 was the first piece of legislation prohibiting discrimination on the basis of disability. In 1975, Congress enacted the Education for All Handicapped Children Act, mandating that specialized programs and services be made available to those who need them; that students who qualified for these services be guaranteed free, equal, and appropriate education; that specific monitoring procedures and policies for these programs be established; and that federal funds be allotted to support these efforts. This law has since became known as the Individuals with Disabilities Education Act after being signed into law by President George W. Bush on October 30, 1990. IDEA has been reauthorized several times, most recently in 2004. One of the key provisions calls for the creation of an IEP for every student who qualifies under the law for special services. Presently, increased emphasis has been placed on accountability standards, primarily in response to No Child Left Behind, and the required hiring of "highly qualified teachers" who are best able to meet the needs of those most vulnerable.

Current Status and Results

The Department of Education reports that over 6 million school-age children are receiving some type of special education support. This percentage has increased over the past several years mostly due to early intervention and proper identification. Debate continues over the disproportionate number of minority students who are targeted for services. Research suggests that the overrepresentation of certain ethnic groups may be attributed to lack of exposure to preschool foundational concepts, inadequate home support, and higher rates of reported behavior problems among these subgroups. In addition, reduced funding and a shortage of good teachers in underprivileged schools are also contributors.

Melissa A. Mariani, PhD

See also: Individualized Education Plan; Intelligence Testing

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Specific Learning Disorder

Specific learning disorder is a group of mental disorders characterized by specific deficits in the ability to understand and process information effectively and correctly.

Definitions

- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth*

Edition, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.

- **Learning disorders** are neurological disorders that can make it difficult for an individual to acquire certain academic and social skills.
- **Neurodevelopmental disorders** are a group of DSM-5 disorders characterized by early life deficits that produce impaired personal, social, academic, or job functioning. These include autism, attention-deficit hyperactivity disorder, and specific learning disorder.
- **Specifiers** are extensions to a diagnosis that further clarifies the course, severity, or type of features of a disorder or illness.

Description and Diagnosis

Specific learning disorder is one of the DSM-5 neurodevelopmental disorders. It is characterized by continuous and impairing problems with learning fundamental skills in writing, reading, or math. This results in academic performance that is well below average for their age. The disorder occurs when the learning demands or evaluation procedures (e.g., timed tests) create obstacles that cannot be overcome by their natural intelligence and compensatory strategies. Specific learning disorder results in lifelong impairments (e.g., job performance) for individuals affected by this disorder.

The occurrence of this disorder across the academic areas of writing, reading, and mathematics is 5%–15% among school-age children. This includes children who speak different languages and are from different cultural backgrounds. The occurrences of this disorder in adults are not exactly known, but estimates indicate being approximately 4% (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience problems with learning and academic skills with at least one of the following symptoms. These symptoms include inaccurate or slow word reading, problems understanding what the meaning of what is read, and problems with spelling and written expression. Additional symptoms include problems mastering sense of numbers, calculation, and number facts, and problems with mathematical reasoning. Symptoms of this disorder must occur for at least six months. In addition, academic skills must be significantly below what is expected for an individual's chronological age. Individuals with this disorder experience significant interference with academic and occupational performance. The learning problems must have begun during school-age years. The learning problems are not better accounted for by other neurological or mental disorders or a lack of skill in the language of academic or educational instruction. Specifiers must be included in this diagnosis if an individual has impairment with reading, written expression, or mathematics. The current level of severity of this disorder must also be specified in making this diagnosis. The levels include mild, moderate, and severe (American Psychiatric Association, 2013).

The exact cause of this disorder may be due to environmental and genetic factors. For example, individuals born prematurely have an increased risk for having this disorder. Individuals are more likely to have this disorder if their first-degree relatives have been diagnosed with this disorder. In addition, individuals who had a delay in speech or language during preschool years are likely to be diagnosed with this disorder.

Treatment

Children diagnosed with this learning disorder can qualify for special education services. Experts can help a child learn skills by building on the child's strengths and develop ways to make up for his or her weaknesses. Specific treatment techniques may vary depending on whether the individual is struggling with reading, writing, or mathematics. The earlier an individual receives help, the more likely he or she will be successful in school and later in life.

Len Sperry, MD, PhD, and
Elizabeth Smith Kelsey, PhD

See also: Diagnostic and Statistical Manual of Mental Disorders (DSM); Learning Disorders

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Specific Phobia

Specific phobia is a mental disorder characterized by a marked and enduring fear of specific situations or objects. Previously this disorder was referred to as simple phobia.

Definitions

- **Anxiety disorders** are a group of mental disorder characterized by anxiety as a central or core symptom. The group includes specific phobias, social anxiety disorder, and generalized anxiety disorder.
- **Behavior therapy** is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavioral therapy.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure therapy** is a type of behavior therapy that involves repeated actual, simulated, or visualized exposure to a feared object, situation, or traumatic event that reduces fear and anxiety.
- **Social anxiety disorder** is an anxiety disorder characterized by excessive and unreasonable fear in social situations of being judged or evaluated by others. Previously it was referred to as social phobia.

Description and Diagnosis

Specific phobia is an anxiety disorder characterized by a persistent and unreasonable fear of presence or thought of a specific object or situation. However, it must be noted that the object or situation poses little or no actual danger. Yet exposure to the object or situation leads to an immediate reaction in which an individual experiences intense anxiety or avoids the object or situation entirely. This distress, or the need to avoid the object or situation, significantly interferes with the individual's ability to function. Adults with this disorder recognize that their fear is unreasonable but are unable to overcome it. Others may view those with this disorder as introverts or self-absorbed because of the amount of attention they put on the fear of either avoiding or having to engage in a situation that is causing the fear. A related disorder is social anxiety disorder in which the fear is of being judged or evaluated by other individuals.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit excessive anxiety or fear about an object or situation. Children with these disorders may express their fear in a multitude of flight or fight behaviors, including tantrums, crying, or clinging. The fear is avoided at multiple costs, is persistent, lasts at least six months, and is out of proportion to the actual risk or danger. Specific phobias are coded according to the feared stimulus (animal, natural environment, blood injection injury, situations, etc.) (American Psychiatric Association, 2013).

DSM-5 describes the following types of specific phobias.

- Animal phobias. These phobias involve a fear of dogs, snakes, insects, or mice. Animal phobias are the most common specific phobias.
- Natural environment phobias. These phobias involve a fear of storms, water, bridges, or heights.

- Blood-injection-injury phobias. These phobias involve a fear of medical procedures, such as blood tests or injections, of seeing blood, or of being injured.
- Situation-specific phobias. These phobias involve a fear of specific situations, such as flying, driving a car, riding in a car or on public transportation, going over bridges or in tunnels, or being in a closed-in place such as an elevator.
- Other phobias. These phobias involve a fear of choking or vomiting. Among children the fears are of loud sounds, of falling down, and of costumed characters, such as clowns.

The likelihood of experiencing this disorder in one's lifetime is about 8%. It is twice as common (16%) among those between the ages of 13 and 17, but much less common (4%) in the elderly. Women are twice as likely as men to report phobic experiences. Of the various phobias, women are more likely to experience animal, situation-specific, and natural environment phobias (American Psychiatric Association, 2013).

The cause of this disorder is not well understood. Often, there is no explanation for the development of a specific phobia. However, the cause may be traced to a traumatic experience or may develop from a general tendency to be anxious. It usually begins in childhood when exposure to a feared object or situation results in an immediate anxiety response. Experiencing a traumatic event, such as being bitten by a dog, could trigger the development of a phobia. Also, a child may learn phobias by observing a family member's phobic reaction to an object or a situation, such as a fear of dogs.

Treatment

The clinical treatment of this disorder usually involves exposure therapy. Gradual, repeated exposure to the feared object or situation helps individuals to conquer their fear and reduce their anxiety. Cognitive behavior therapy is also used to learn to view and cope with the feared object or situation differently. It focuses on developing a sense of mastery and control over one's thoughts and feelings.

Len Sperry, MD, PhD

See also: Anxiety Disorders; Behavior Therapy; Cognitive Behavior Therapy; Exposure Therapy; Social Anxiety Disorder

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Speech-Language Pathology

Speech-language pathology is a branch of medical treatment to assess, diagnose, treat, and help people who cannot produce speech sounds correctly or clearly.

Description

Speech-language pathologists (SLPs), sometimes called speech therapists, help people with a variety of communication or speech disorders. This includes those who suffer from speech delays and deficits or an inability to speak well because of physical speech limitations. Therapy will include a variety of strategies to improve speech, promote communication through alternative methods, and help with the motor movements of the mouth overall.

Speech-language pathology can be observed in both communication disorders and swallowing disorders. These difficulties are often medically linked to swallowing deficits, which also have their origin or effects in the throat region. When speech is the issue, the focus is on the elements of speech production, which include vocalizing or producing sound, tone, and pitch. When swallowing is the issue, the focus is on the physical components of respiration or breathing.

Speech-language pathologists are trained to screen and diagnose different types of speech-language disorders. They work with individuals and their families (especially those on the autism spectrum) to thoroughly understand the issues before helping choose appropriate intervention strategies and delivery models.

Development (History and Application)

As a distinct endeavor speech-language therapy has existed since the days of Annie Sullivan, who worked with Helen Keller, and Lionel Logue, who worked with King George V. Outside of education and general rehabilitation it became a specialty in the American medical field after George L. Larsen began to do important diagnostic work at the VA hospital in Seattle in the 1960s. He was especially skillful at relating swallowing problems to nervous system impairments, and he pioneered a team approach to speech and swallowing-related issues.

The original focus of speech-language pathology was on those with severe physical vocal restrictions and other language-related issues. The need for this occurred when war veterans after both World War I and World War II returned and required help. It has broadened to include individuals who suffer from the inability to use language with proper meaning as well as those who suffer from problems with the social aspects of communication. This latter group includes many individuals with a variety of developmental and learning disorders. The field of speech-language pathology became increasingly specialized, including formal certification. Today, certified speech therapist professionals work in both medical and educational settings.

Current Status

Today the field of speech-language pathology is well established. There are over 120,000 SLPs in the United States about equally divided between those who work in schools and those who work directly in clinical settings. SLPs who have been trained in the reliable and valid use of diagnostic and assessment tools are qualified to identify a variety of language and speech disorders. They are used frequently as independent or private practitioners who help plan a course of treatment to improve a variety of speech, language, and swallowing disorders.

Alexandra Cunningham, PhD

See also: Speech Sound Disorder

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Speech Sound Disorder

Speech sound disorder (SSD) is described as a difficulty with or delay in the development of speech.

Description

Speech sound disorder is a general category that includes many disorders such as articulation disorder, phonological disorder, and childhood apraxia of speech. They are also referred to as speech impairments or speech difficulties. Specifically, SSD affects children's ability to develop easily understood speech by the time they are about four years old.

In 2008, the American Speech Language Association created separate definitions for different SSDs. It described articulation disorders versus phonological disorders. Articulation disorder includes problems with developing speech sounds. This includes motor speech control issues so that the child will say "yeth" for "yes" where he or she does not yet have the muscle motor control to make the "s" sound. Phonological disorder is comprised of errors that develop into a pattern of speech problems. This disorder has an emphasis on the inability to grasp and apply differences in sound. One example is using "tat" for "cat." In the case of phonological disorder, it is not only articulation that is the problem; it is also the ability to understand and use words well. Other people usually have a difficult time understanding a child with phonological disorder.

If children have poor speech when they start school at about five or six years old, it is likely that their peers and teachers will have difficulty understanding them. It can also negatively impact their ability to learn reading and spelling. About 5% of preschool children are diagnosed with SSD. It is more common in boys than in girls.

Causes

Problems or changes in the structure or shape of the muscles and bones in the head and neck may cause SSD. These are the muscles and bones that are used to make speech sounds. These changes may include cleft palate and problems with the teeth. Another cause can be damage to parts of the brain or the nerves that control how the muscles and other structures work to create speech.

In some cases the cause of phonological disorder in children is unknown. Close relatives may have had speech and language problems. Multiple languages and poor pronunciation at home can complicate the issue.

Symptoms

Children with SSD will substitute, leave off, or change sounds. These errors may make it hard for other people to understand them. Only family members may be able to understand a child who has a very severe phonological speech disorder.

Commonly, children with this disorder have problems with words that begin with two consonants. "Friend" becomes "fiend" and "spoon" becomes "soon." There may also be problems with words that have a certain sound, such as words with "k," "g," or "r." They may either leave them out or not pronounce them clearly, or replace them with a different sound.

It is common for children to have problems pronouncing words while their speech is developing. However, by age three, it is thought that at least half of what a child says should be understandable by a stranger. By the beginning of school, age five or six, a child's speech should be mostly intelligible to everyone.

Treatment

Speech sound disorder should be diagnosed and treated by certified speech-language pathologists. The approach to treatment of SSD is based on principles that emphasize several things. It is important to look into the nature of the SSD with a focus on the person's language skills in combination with his or her motor abilities. It also includes the building of activities that support the child in developing a way to organize his or her speech. This aims to help the child generalize and apply what he or she has learned to other situations. To do this many other therapies may apply, which are core vocabulary therapy, cycles therapy, and imagery therapy.

Before any course of treatment is chosen, children should be examined for other problems. These problems include intellectual disabilities, hearing impairment, neurological problems, and physical conditions such as a cleft palate. In examining each case it is important to evaluate whether relatives have similar problems, and whether more than one language is spoken in the home. In all cases a comprehensive evaluation will help refine the treatment decisions and increase the likelihood of a child's success.

Alexandra Cunningham, PhD, and
William M. Cunningham, MA

See also: Speech-Language Pathology

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Spiritual Awakening

Spiritual awakening is a life-changing experience in the way an addicted individual thinks and acts. This experience often includes improved mood and increased spirituality.

Definitions

- **Abstinence** is the restraint of indulging oneself in bodily activities that typically gives an individual pleasure (e.g., alcohol and drugs).

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Addiction recovery** is the state of abstinence from addictive behaviors, usually achieved through self-reflection and spiritual exploration.
- **Alcoholics Anonymous** is a self-help fellowship that was founded by Bill Wilson and Dr. Bob Smith in 1935 to help people struggling with alcoholism.
- **Drug abstinence** is when an individual completely discontinues drug or alcohol use for a given period of time.
- **Higher power** is a term used in Alcoholics Anonymous to refer to a "power greater than ourselves." It can include a god, deity, nature, or anything beyond the individual.
- **Narcotics Anonymous** is a self-help and support group for those addicted to drugs to help them learn how to live without the use of mind- and mood-altering chemicals. It is a Twelve-Step Program.
- **Spirituality** is the sum of an individual's unique worldview and self-view, religious beliefs, attitudes, and behaviors.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions based on a plan called the Twelve Steps.
- **Twelve Steps** refer to the 12 guiding principles on which Alcoholics Anonymous is based.

Description

Spiritual awakening is a major shift in the way an individual struggling with addiction thinks and acts. This change can include abstinence from drugs and alcohol, improved mood and physical health, heightened spirituality, and increased service to others. The term is used synonymously with spiritual experience. The experience is often triggered by a major conflict or "hitting bottom." As a result, individuals who have this experience often report reduced drug or alcohol cravings, abstinence, increased voluntary service, and increased positive mood states. In some cases, the experience can lead to an individual achieving complete recovery from addiction. This experience is clearly spiritual in nature and may or may not involve religion.

The term "spiritual awakening" was originally used in 1939 in the first edition of the Twelve-Step text called "the big book" of Alcoholics Anonymous, which is titled *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*. The book was written primarily by Bill W., also known as William Griffith Wilson (1895–1971), who is one of the founding members of Alcoholics Anonymous. The book is for individuals who are working a Twelve-Step Program to manage their addiction to drugs or alcohol. Millions of individuals have sought help for their drug or alcohol addiction by entering Alcoholics Anonymous or Narcotics Anonymous to seek support. Participation in Twelve-Step support groups includes engaging in the Twelve-Step protocol, attending frequent meetings, volunteering for services, and believing in a "higher power." The term "spiritual awakening" is the 12th step of the Twelve Steps. The step is identified as "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs."

Research has studied the experience of spiritual awakening and examined traits that characterize the triggering event context and the common reactions of the experience of individuals who are in recovery from drugs or alcohol (Galanter et al., 2014). This concept is a significant component among the field of addiction, Twelve Steps, and spirituality.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Addiction; Alcoholics Anonymous (AA); Alcoholism; Spirituality and Practices; Twelve-Step Programs

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Spiritual Bypass

Spiritual bypass is the process of avoiding uncomfortable psychological issues by focusing on spiritual matters.

Definitions

- **Addiction recovery** is the state of abstinence from addictive behaviors, usually achieved through self-reflection and spiritual exploration.
- **Defense mechanisms** are strategies for self-protection against anxiety and other negative emotions that accompany stress.
- **New Age spirituality** is a spiritual movement whose purpose is for individuals to reach their highest potential. It rejects religious doctrine and promotes individual ways of attaining truth.
- **Religion** is a spiritual belief system shared by many individuals that may include specific rules, practices, and institutions.
- **Spirituality** is the sum of an individual's unique worldview and self-view, religious beliefs, attitudes, and behaviors.

Description

Spiritual bypass is a way to avoid dealing with emotional, developmental, and relationship problems. The term "spiritual bypassing" was first used in 1984 by psychologist John Welwood (1943–) and has since been explored by others. Those who use spiritual bypass tend to focus on spiritual issues and practices rather than on the psychological or emotional problems that they experience as threatening. Spiritual issues include abstract ideas like "faith," while specific practices include prayer and meditation. Psychological issues that are avoided may include feelings of anger and sadness, relationship problems, or lack of direction.

Those who use spiritual bypass may appear to be psychologically healthy because of their focus on spirituality. In reality, spiritual bypass leads to underdeveloped coping skills with the result that individuals are less effective in dealing with everyday problems. An example of spiritual bypass is a wife praying about forgiveness in response to her husband's repeated verbal abuse. Rather than address her hurt feelings or the abuse directly, she "bypasses" them using spirituality. As a result, she misses the opportunity to develop new skills that may lead to a better relationship with him. Spiritual bypassing is like taking a shortcut to avoid traffic only to arrive right back where one started.

Interestingly, those using spiritual bypass are likely to have a simplistic and shallow sense of spirituality. In addition, they tend to have an exaggerated sense of detachment from "worldly" problems and blindly follow spiritual rules or practices without question. They may overemphasize positive feelings like happiness and well-being while fearing negative feelings. They are also likely to have relationship problems. These include isolation, people pleasing, and "holier-than-thou" behavior. Spiritual bypass has become increasingly common since the rise of New Age spirituality in the 1960s. It is also common in addiction recovery, which emphasizes spirituality.

This avoidance strategy can be difficult to recognize because spiritual development is generally seen as a healthy and desirable pursuit. What may appear as a positive behavior, such as volunteering at a homeless shelter, can be used to avoid negative feelings like inadequacy or guilt. The way to change spiritual bypass, once it is recognized, is to face difficult or unpleasant emotions and experiences. Counseling can be helpful in this process.

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Len Sperry, MD, PhD

See also: Substance-Related and Addictive Disorders; Religious Coping; Twelve-Step Programs

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Spiritual Identity

"Spiritual identity" refers to how one relates to, experiences, and incorporates spirituality into their personal sense of self.

Definitions

- **Divine** refers to objects, practices, and experiences associated with God, gods, or a supreme being.
- **Deity** means a god or a supreme being.
- **Religion** refers to the beliefs, doctrines, and practices associated with membership in a specific religious institution.
- **Sacred** refers to revered objects, practices, or experiences that are considered holy or divine by religious individuals.
- **Transcendence** refers to the perception that there are extraordinary dimensions to life that go beyond the limits of our physical reality.

Description

The human experience consists of moral, social, physical, psychological, and spiritual dimensions. All individuals experience some form of spiritual hunger and a desire for self-transcendence that manifest in a search for meaning and purpose. This search results in the development of a spiritual identity that impacts all of the dimensions of life. An individual's spiritual identity will impact how events, experiences, and challenges are responded to. A person's spiritual identity may be expressed through an organized religion but may also be expressed in many other ways. Researchers have noted that in the last quarter of the 20th century Americans have been moving away from traditional religious expressions and seeking a spiritual direction outside of religious traditions to find meaning, purpose, and a sense of inner fulfillment to their lives.

There are multiple conceptions of just how a person's spiritual identity is formed. Douglas MacDonald, a psychologist and researcher of spirituality, conducted a large-scale analysis using data from 1,400 participants and identified five clear factors, or dimensions, related to spiritual development and identity. The first factor is a person's cognitive orientation, or beliefs about spiritual matters, the transcendent, and how personally relevant these beliefs are. The second factor is what kind of spiritual experiences the person has had. The third factor is a person's sense of existential well-being, or his or her sense of purpose and meaning, and how he or she copes with uncertainty such as the meaning of death. The fourth factor is belief in the paranormal. The fifth factor is religiousness and his or her belief in the existence of a higher power/intelligence and how sincere these beliefs are.

Other conceptions of spiritual identity view the process as a spiritual journey that shares common themes. Hope provides a sense that difficult or painful experiences have meaning and are not in vain. Hope allows individuals to endure hardship and look toward a better future. Virtue and character is the power to live a genuine life as a unique individual with a sense of social-minded obligation toward others. The search for the sacred or holy in an attitude of receptivity to what the future may bring and of how the divine within would emerge in wholeness of self is part of the spiritual journey. Spiritual identity involves reconciling polarities and ambiguity such as good and evil, happiness and sorrow, life and death. It also calls for balance of activity and patience, contemplation and action, self and others. Facing oneself by confronting the difference between the real self and the ideal self is an important part of one's spiritual identity. Compassion,

love, and forgiveness are vital spiritual themes that assist a person in being tolerant, empathic, helpful, and caring. The process of developing spiritual meaning in life is central to a sense of spiritual peace and well-being. Transcendence and going beyond ordinary or personal limits, feeling a sense of spiritual union and self-forgetfulness, is another characteristic of spiritual development and identity.

Spirituality is highly related to psychological well-being, and one's spiritual identity impacts how one interprets events and responds to stress. Spirituality and spiritual identity is related to a one's sense of meaning and purpose, hope and optimism, and social connectedness.

Steven R. Vensel, PhD

See also: Pastoral Counseling and Psychotherapy; Religious Coping; Spirituality and Practices

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Spirituality and Practices

"Spirituality" refers to one's sense of awareness and connection with the divine, sacred, transcendent, Supreme Being, or higher power.

Definitions

- **Deity** means a god or a supreme being.
- **Divine** refers to objects, practices, and experiences associated with God, gods, or a supreme being.
- **Religion** refers to the beliefs, doctrines, and practices associated with membership in a specific religious institution.
- **Rituals** are a series or sequence of actions and behaviors performed in a specific order.
- **Sacred** is defined as those things that are holy, "set apart," and include objects, rites, and rituals.
- **Transcendence** refers to the perception that there are extraordinary dimensions to life that go beyond the limits of our physical reality.

Description

An individual's search for meaning, fulfillment, purpose, and ways of coping with problems often involves a spiritual journey. Interest in spirituality within the professional mental health communities has grown steadily over the past three decades. The role a person's spirituality plays in an individual's sense of self, well-being, and healthy functionality has been the focus of attention by both clinicians and researchers. Spiritual issues most often surface as a result of loss, conflicts, or health problems; because of events that cause a crisis in faith such as victimization, betrayal, or the sudden death of a loved one; or as a desire to increase well-being.

There are many perspectives on spirituality, and definitions continue to evolve over time. A person's spirituality should not be confused with being religious. The word "religion" is more frequently being associated with specific faith institutions and the beliefs, doctrines, and practices that express that religion. Religious practices include attending worship services, praying, reading holy text, singing, and other acts of devotion. A person's religious orientation, or religiousness, may be "intrinsic" or "extrinsic." A person with an intrinsic religious orientation participates in religious activities as a sincere form of worship in order to express his or her faith and devotion. The person's religion is a positive motivating force resulting in personal growth and increased well-being. A person with an extrinsic religious orientation may participate in religious practices but only because he or she gets something out of it, such as feeling good about

himself or herself, social gain such as meeting potential business clients, or the approval of others such as parents or teachers. Their religion is not a motivating or growth-promoting force. An example of this would be the politician who attends church in order to get the votes of religious people.

Spirituality is a complex concept, and although there is no consensus definition, it is possible to identify common components to most conceptualizations. Spirituality is universal and innate, spontaneous and developmental, private and highly personal. It is both an emotional and intellectual pursuit. Spirituality involves the capacity to seek out and transcend one's physical reality in order to experience the sacred in a search for meaning, purpose, and connectedness. Spirituality positively impacts a person's sense of well-being, as well as his or her mental, emotional, and physical health. Researchers have found that spirituality and intrinsic religiosity are linked to greater longevity, positive health outcomes, better coping skills, less depression, less anxiety, and higher quality of life even when coping with severe illness.

Spiritual wellness and a clear sense of spiritual identity can provide a consistent theme for one's life; a sense of connection to others as well as to the transcendent; and a sense of purpose, motivation, and vitality. Spiritual practices include prayer in order to express thoughts, needs, and attitudes toward the divine or sacred; meditation in order to reduce stress, find peace, or connect to the transcendent; use of ritual such as communion or purification ceremony; spiritual journaling providing a way to express, ponder, and develop spiritual insights; and bibliotherapy or reading spiritual texts. Practicing spiritual disciplines include forgiveness of self and others; confession in which one acknowledges one's wrongdoings or transgressions; and surrender that involves relinquishing the need to control others and acceptance of the direction of one's life.

Spirituality is an important aspect of an individual's search for meaning, fulfillment, and purpose. Developing a clear sense of spirituality can increase well-being, enhance abilities to cope, and provide a sense of connectedness to others and to the greater whole.

Steven R. Vensel, PhD

See also: Pastoral Counseling and Psychotherapy; Religious Coping; Spiritual Identity

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Spiritually Oriented Psychotherapy

Spiritually oriented psychotherapy is a form of psychotherapy that is sensitive to spiritual, religious, and life meaning considerations.

Definitions

- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior.
- **Religion** refers to the search for significance through the sacred. It typically involves dogma (belief system) and rituals, which often are communal.
- **Spirituality** refers to the search that reflects one's deepest desires and the ways in which individuals think, feel, act, and relate in their efforts to find, conserve, and transform the sacred in their lives.

Description

Believing that spirituality is vital for growth and essential for dealing with life's problems, many individuals are pursuing a journey of spiritual growth. Pursuing this

journey typically involves a commitment to engaging in spiritual practices such as prayer and meditation. As a result of this pursuit, some are finding their lives are more centered and fulfilling, whereas others are finding themselves trapped in old feelings, attitudes, and habits that appear to undo their progress. Even those who have made progress on the journey often encounter spiritual and psychological roadblocks to growth. For a number of reasons, many individuals are turning to psychotherapy rather than to ministers, rabbis, and other spiritual guides for spiritual advice. In addition, those who are already in conventional psychotherapy expect that therapy will focus on their spiritual concerns.

Spiritually oriented psychotherapy is psychotherapy that is sensitive to spiritual, religious, and life meaning considerations whether it is formally designed as spiritually oriented psychotherapy or not. Spiritual considerations include the individual's relationship with God or higher power, prayer life, and spiritual practices as well as involvement in a faith community. Religious considerations include one's beliefs about God, faith, doctrine, salvation, denominational affiliation, and the afterlife. Unlike psychotherapy, personality change is not usually a goal of pastoral counseling. Life meaning considerations include one's purpose or calling in life and one's sense of belonging and connection with others.

There are three clinical contexts in psychotherapy in which religious, spiritual, and life meaning considerations are likely to surface. The first context is a spiritual resource for coping with a serious health problem, personal or professional loss, or interpersonal conflict, for example, situations involving betrayal and death of a child. The second context is a sense of loss resulting in symptoms that reflect a crisis of faith or of meaning in life. The third context is the quest for increased well-being and spiritual growth. While a focus on spiritual growth may seem more consistent with traditional spiritual direction, clients today are increasing seeking out psychotherapists rather than ministers and other spiritual guides to foster their spiritual growth and development.

Developments and Current Status

Spiritually oriented psychotherapy is similar but different from pastoral counseling and spiritual direction. Basically, the primary goal of pastoral counseling is spiritual change, while psychological change is a secondary goal. As such, pastoral counseling can also address symptom relief, problem resolution, and the restoration of psychological health. The primary goal of spiritual direction is spiritual change and growth with a focus on prayer. It may also address crisis issues that impact the directee's spiritual life. Yet its primary emphasis is on developing the directee's relationship with God. Because prayer is critical to this relationship, the directee's prayer life is a major consideration. In contrast, the primary goal of spiritually oriented psychotherapy is psychological change and secondary goal is spiritual change or growth. Often, the focus is on the development and maintenance of psychological health and well-being and subsequent spiritual health and well-being.

Spiritually oriented psychotherapy is a broad characterization for a variety of psychotherapeutic approaches that are sensitive to the spiritual dimension. These approaches range from non-Christian approaches, transpersonal psychotherapies, and various Christian approaches. Despite considerable variability among these approaches, some general observations about typical clientele, goals and purposes, the nature of the relationship with the professional, and the type of interventions utilized in spiritually oriented psychotherapy are possible. Individuals seeking spiritually oriented psychotherapy range from relatively healthy spiritual seekers to disordered clients presenting with symptomatic distress and/or impairment in one or more areas of life functioning. The goals of treatment vary according to client presentation and need. They may include help with spiritual emergencies, the process of spiritual growth, increased psychological well-being, self-fulfillment or individuation, or the reduction of symptomatic distress and the restoration of baseline functioning. The therapeutic relationship typically involves mutual collaboration. Not surprisingly, those practicing spiritually oriented psychotherapy presumably will demonstrate respect for the client's spiritual values and concerns. Various psychotherapeutic and psychospiritual interventions are utilized depending on client need and indication. If indicated, referral for a psychiatric evaluation for medication or hospitalization may occur. Spiritual interventions may also

be involved. These include spiritual practices, such as prayer and meditation, and, when indicated, collaboration or referral to clergy or chaplain.

Len Sperry, MD, PhD

See also: Pastoral Counseling and Psychotherapy; Psychotherapy; Religion and Religiosity; Spirituality and Practices

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Split Brain

"Split brain" refers to the experiments that were conducted by Roger Sperry to learn about the left and right hemispheres of the brain.

Description

The split brain experiments began in an attempt to learn more about the brain as well as to gain a better understanding of epilepsy. In completing this study Dr. Roger Sperry (1913–1994) and his colleagues were able to learn about the differences between the right and left hemispheres of the brain and what happens when they don't or cannot communicate with each other. Sperry was an American neuropsychologist who earned a Nobel Prize in physiology or medicine in 1981 for his discoveries.

This study led to the realization that the two hemispheres of the brain control different parts of thought as well as action. This meant that the right and left parts of the brain had an area of specialization. The left brain for language and speech and the right for visual-motor tasks. This idea has translated into modern culture where people will casually refer to themselves as being right or left brained based on the areas of interest and skills. For instance, a writer may refer to himself or herself as being left brained as the basis of what he or she does is controlled by the left part of the brain.

The original study provided information about how the halves of the brain communicate to each other and how they do so if separation occurs. This revelation has been helpful in preparing doctors to better understand patients who come in with medical issues such as epilepsy or traumatic brain injury. The study provided information on language, attention, the organization of the brain and consciousness.

The study consisted of 11 participants whose hemispheres had been separated and all had a history of epilepsy. This case study provided in-depth investigations of each of the individuals. Participants were asked to complete tasks and with different tasks part of their vision blocked or covered.

The split brain experiment looked at patients whose hemispheres were already separated. The experiment provided evidence that when the brain had a disconnect it impacted the person on multiple levels. Conflicting demands from each of the hemispheres can have an impact on task completion and communication. However, these separated hemispheres allowed for Sperry and his colleagues to gain an understanding that had not existed previously to how each functioned and what tasks each controlled.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Brain; Neuropsychiatry

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Sports Psychology

Sport psychology is a multidisciplinary field that focuses on psychological factors affecting the performance and well-being of athletes; systemic issues associated with sports settings and organizations; and developmental and social aspects of sports participation.

Definitions

- **Kinesiology** is the study of anatomy, physiology, and the mechanics of body movements.
- **Sport sciences** include fields such as kinesiology, biomechanics, sport management, sport physiology, sport nutrition, and athletic training.

Description

Sports psychology is a multidisciplinary field of study that focuses on health and exercise psychology, athletic performance psychology, and social psychology. The term "psychology" as applied to sports includes counseling, developmental, clinical, and social psychology. Sports psychology professionals include psychologists, social workers, mental health counselors, and industrial-organizational psychologists.

Health and exercise psychology focuses on psychological factors in sports and exercise related to athletic performance, disease development, and remediation; injury impact and recovery; health promotion; and sports related anxiety and stress. Areas addressed included exercise adherence, impact of exercise on mood and quality of life, and promotion and maintenance of health-enhancing behaviors over the life span. Use of sports and exercise in stress reduction and management as well as cognitive behavioral change strategies in treating performance and physique anxiety, disordered eating, exercise addiction, and movement disorders are also a focus of intervention by sports psychology professionals. Performance psychology focuses on the improvement of athletic performance in competition. Enhancing performance through mental strategies that target overcoming the pressure of competition and managing performance stress related to other's expectations such as coaches, teammates, and parents are frequently provided services. Social psychology focuses on individual and group dynamics in sport and exercise participation and settings.

Development

Coleman R. Griffith (1893–1966) is credited as the founder of sports psychology in North America. Griffith made numerous contributions to the field and in 1923 taught the first university course in sports psychology. The field expanded due to Griffith's pioneering work as other researchers began to contribute to the investigation of psychological processes at work in athletic performance. In 1979 the *Journal of Sports Psychology* became the first published professional journal. In 1986 a group of sports psychologists led by John Silva formed the Association for the Advancement of Applied Sports Psychology, later dropping the word "Advancement" and becoming the Association of Applied Sports Psychology (AASP). The AASP was formed in recognition of the need to emphasize the application of research knowledge to athletes and athletic groups. Also in 1986, members of the American Psychological Association (APA) formed Division 47: Exercise and Sport Psychology.

Current Status

AASP is an international, multidisciplinary, professional organization with over 1,600 members in 39 countries. It is the largest certification body designating qualified sports psychology professionals as "AASP Certified Consultants." Only Certified Consultants may use the letters CC-AASP after their names. Certification as a CC-AASP requires membership in AASP, a master's or doctorate degree with specific course work in sport and exercise psychology, 400 hours of mentored and applied experience, and an extensive evaluation process conducted by the AASP Certification Review Committee. Graduate degrees applicable to CC-AASP status include clinical psychology, educational and mental health counseling, clinical social work, industrial-organizational psychology, and sport and exercise psychology from a sport science field. CC-AASP is the only certification recognized by the United States Olympic Committee. It is important to note that CC-AASP is a credentialing

process and does not bar individuals without CC-AASP from practicing sports psychology.

Sports psychology is emerging as a distinct profession and has made steady progress over the past two decades. A growing number of professional athletes seek out and acknowledge working with sports psychology professionals, and both amateur and professional trainers are making increasing referrals to sports psychology professionals. In addition, university and high school coaches are increasingly drawing from the growing body of literature and research, which focuses on game preparation, teamwork, and psychological performance enhancement techniques.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy; Well-Being

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St. John's Wort

St. John's wort is an herbal remedy used to treat symptoms of depression and various medical conditions.

Definitions

- **Immunosuppressants** are medications that lower the body's immune system. They are primarily used to help the body accept a transplanted organ.
- **Monoamine oxidase inhibitors** are a group of antidepressant drugs that decrease the activity of monoamine oxidase, a neurotransmitter found in the brain that affects mood.
- **Selective serotonin reuptake inhibitors** are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. It occurs when medications that increase serotonin are taken together. Symptoms

St. John's wort is an herbal remedy sometimes used to treat symptoms of depression and various medical conditions. (iStockPhoto)

include high blood pressure, high fever, headache, delirium, shock, and coma.

Description

St. John's wort is a perennial, yellow-flowering plant and is so named because it blooms about June 24, the birthday of John the Baptist. "Wort" is an old English word for plant. For centuries it has been used as treatment for depression, anxiety, inflammation, injuries, burns, muscle pain, high blood pressure, stomach problems, fluid retention, insomnia, hemorrhoids, and cancer. Research has proven the clinical effectiveness of St. John's wort in treating mild-to-moderate depression. It also shows promise in treating somatoform disorders, but the research on its treatment of anxiety is conflicting and inconclusive.

Hypericin and hyperforin are two chemicals in St. John's wort that play a role in relieving depressive symptoms. Both act on chemical messengers in the nervous system that regulate mood. St. John's wort is believed to work by balancing neurotransmitters (chemical messengers) in the brain in much the same way as SSRIs like Paxil and Celexa, and MAOIs like Marplan and Parnate

Precautions and Side Effects

There are a number of precautions to observe in using St. John's wort. Depression can be a serious, even life-threatening, condition. For that reason depressed individuals using St. John's wort must be carefully monitored. It can bring on mania in those with bipolar disorder and can increase cycling between depression and mania. St. John's wort could worsen symptoms of attention-deficit hyperactivity disorder, especially in those taking Ritalin. It might trigger psychotic symptoms in some with schizophrenia. St. John's wort can contribute to dementia in people with Alzheimer's disease. Pregnant or lactating women should never use it. Nursing infants of mothers who take St. John's wort can experience colic, drowsiness, and listlessness.

St. John's wort is generally safe when taken for the short term (three to four months). It can cause some side effects such as anxiety, diarrhea, dizziness, dry mouth, fatigue, headache, irritability, restlessness, trouble sleeping, vivid dreams, stomach upset, skin rash due to sun sensitivity, and tingling. It appears to be safe when used in children under 12 years of age for less than six weeks.

Dangerous interactions can occur when using St. John's wort with other antidepressant medicines. Of particular concern is serotonin syndrome. Several cases of serotonin syndrome have been reported in those taking St. John's wort in combination with MAOIs, SSRIs, Pondimin, or Serzone. John's wort may interfere with the effectiveness of birth control pills, increasing the risk of pregnancy. Also, women taking both birth control pills and St. John's wort may notice bleeding between menstrual periods. Other medications with reported interactions include amphetamines, asthma inhalants, decongestants, diet pills, narcotics, and the amino acids tryptophan and tyrosine. St. John's wort increases bleeding time in those under general anesthesia. Accordingly, its use should be discontinued at least two weeks prior to major surgery.

Len Sperry, MD, PhD

See also: Depression

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Stages of Change

Stages of change are sequential periods of time that describe clients' varying motivation, readiness, and process of engagement in change behaviors.

Definitions

- **Assimilative integration** occurs when one theoretical orientation primarily informs the psychotherapeutic process and techniques of other theories are deliberately adjunctive.

- **Common factors** are the similarities among theories of psychotherapy and the belief that these common factors are the real therapeutic factors.
- **Evidence-based practice** is a form of practice that is based on integration of the best research evidence with clinical experience and client values.
- **Motivational interviewing** is a form of psychotherapy that aims to enable, engage, and improve on a client's motivation to change.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Self-efficacy** is the belief in one's own abilities.
- **Technical eclecticism** is the psychotherapeutic use of intervention techniques from various theories without endorsing the theories themselves.
- **Theoretical integration** is the assimilation of two or more theories of psychotherapy.
- **Transtheoretical therapy** is an integrative approach to psychotherapy that identifies processes of change, stages of change, and levels of change to tailor treatment to the client.

Description

The stages of change are often conceptualized as a process that occurs over a period of time. Traditionally there are five stages of change: precontemplation, contemplation, preparation, action, and maintenance. The first stage of change, precontemplation, is marked by the client's absence of thought about change. After passing through precontemplation a client will enter the contemplation stage of change. In the contemplation stage a client will begin to think about his or her problems and imagine what he or she can do to change. After thinking about change sufficiently in the contemplation stage, a client will progress on to the preparation stage of change. The preparation stage of change is marked by the first attempts to actually change; however, the client still lacks a full commitment to the change process. Next is the action stage of change where clients are serious and committed to their change efforts. Finally, after a client has successfully made the change, he or she will enter the maintenance stage of change. In the maintenance stage of change, a client will strive to preserve therapeutic gains and prevent relapse.

It is important to note that the stages of change model is unique in that it allows psychotherapy to be personalized to the specific stage of change a client is operating from. Further, motivational interviewing is a commonly utilized technique to foster a client's movement through the stages of change.

Development and Current Status

The stages of change theory is the most well-developed approach to come out of the eclectic and integrative psychotherapeutic movement that began in the 1930s. The early years of the movement is famously discussed in a paper published by psychologist Saul Rosenzweig (1907–2004) in 1936. It examined the common factors among the diverse theories of psychotherapy. Over the years three other distinct approaches to eclecticism and integrationism were identified and named technical eclecticism, theoretical integration, and assimilative integration. The stages of change model is part of the theoretical integration approach to psychotherapy. It is also part of a larger psychotherapeutic theory called the transtheoretical model introduced by psychologists James Prochaska (1943–) and Carlo DiClemente (1940–) in 1983. In 2007, the stages of change model was expanded to include two additional stages of change, which are recycling and termination. Recycling alters the linear process of change to incorporate the common occurrence of relapse. When clients do not maintain change, they recycle to an earlier stage of change. "Termination" refers to a stage of client change that is stable enough to remove the threat of relapse. In the stages of change model, termination is the successful resolution of a problem through sufficient change.

Layven Reguero, MEd, and
Len Sperry, MD, PhD

See also: Evidence-Based Practice; Motivational Interviewing; Self-Efficacy

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Stanford Prison Experiment

The Stanford Prison Experiment, conducted by psychologists at Stanford University in 1971, demonstrated the influence of situational forces on changing the attitudes, values, and behavior of normal, healthy individuals.

Definitions

- The **"Lucifer Effect,"** a phrase coined by Stanford psychologist Philip Zimbardo, refers to the point in time when an ordinary, good person transforms into an evil one as a result of situational influences.
- **Obedience studies** ("Milgram's Experiments"), led by psychologist Stanley Milgram during the early 1960s, articulated the salience of real or perceived authority at influencing a human being's thoughts, values, and actions.

Description

In 1971, psychologists at Stanford University conducted an extreme study, now known as the Stanford Prison Experiment, with a volunteer group of college students using a mock prison setting to test the power of social and institutional influence on individual attitudes, values, and behavior. Lead researcher Dr. Philip Zimbardo, a former high school classmate of Stanley Milgram, sought to expand on Milgram's obedience studies, looking specifically at the impact of institutional factors. The primary question at hand is whether or not normal, healthy, well-functioning individuals would change under stressful, dehumanizing, and hostile circumstances. The results were alarming, causing the experiment to be called off early. Zimbardo summarized the findings in what he called the "Lucifer Effect," whereby ordinary, good people behave in evil ways if the situation perpetuates it. He wrote about the experiment and his subsequent impressions in the *New York Times* best seller *The Lucifer Effect* in 2007.

Development

The Stanford Experiment's research team included Dr. Zimbardo, Craig Haney, Curtis Banks, David Jaffe, and Carlo Prescott. Some more than 70 college students from the United States and Canada responded to an ad in the newspaper requesting participation in a study on prison life in exchange for $15 a day. Each potential participant was interviewed, subjected to a background check, administered a personality assessment, and examined for physical and mental health. Twenty-four males were selected and randomly assigned to be either guards or prisoners; 9 guards and 9 prisoners (18 total) were actively involved in the study, while the others remained on call if needed. The experiment was planned to last for a one- to two-week period. Researchers attempted to simulate a real incarceration setting in the basement of Stanford's psychology building. This mock prison consisted of three, six-by-nine-foot cells with three cots in each, a room for the guards, an office for the warden (Jaffe), a small room designated as "solitary confinement," and another small room deemed the prison yard. Prisoners were subjected to commonly experienced circumstances of incarceration: cell confinement, limited privileges, regulated meals, and verbal and physical degradation. They were not permitted to leave the prison at any time. The guards were assigned to three-man teams and required to work eight-hour shifts, but could return home when their shift was over. On day 6 the experiment had to be shut down after a graduate student, Christina Maslauch, raised concerns

about the behaviors she witnessed among the guards and prisoners. The guards were abusing their power, treating the prisoners in aggressive and dehumanizing ways. The prisoners were affected as well, and either rebelled or retreated, but actively displayed signs of stress, anxiety, and depression. Even the researchers themselves, Zimbardo and Jaffe included, who were videotaping the daily happenings became caught up in the simulation and neglected to stop the injustices. The Stanford Prison Experiment is a poignant example of how situational influences can alter a person's thoughts, feelings, and actions.

Current Status and Results

Critics of the study refer to concerns pertaining to generalizability, validity, and researcher bias. Though it would now be in violation of many ethical codes, the Stanford Prison Experiment has added valuable insight into the psychological and sociological study of obedience to authority and to the critical role that power plays in determining one's sense of control, freedom, and choice. The lessons of this experiment extend to the areas of education, social sciences, human rights, and national defense, and the study's findings have been applied to situations ranging from bullying among school children to abuse in the military to acts of terrorism. The incidences that occurred at Abu Ghraib Prison during 2003–2004 where Iraqi prisoners were subject to abuses by U.S. Army reservists articulate a recent example of the existence of this phenomenon. Instances such as these have created a national dialogue and spawned research into preventing these types of evils in the future.

Melissa A. Mariani, PhD

See also: Evil; Milgram, Stanley (1933–1984); Obedience Studies; Zimbardo, Philip (1933–)

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STEP Parenting Program

STEP parenting program teaches basic skills to help parents relate more effectively with their children. It is also called systematic training for effective parenting program.

Definitions

- **Adlerian psychology** is an approach to psychology that understands individuals within their social context, particularly their families. Accordingly, parenting is emphasized.
- **Assumed inadequacy** is when a child gives up to be left alone so that others will expect little from him or her.
- **Attention seeking** is when a child keeps others busy through various behaviors to seek attention.
- **Parenting** is a process of educating and coaching parents to support children's development and change their problem behaviors.
- **Power** is when a child seeks power to feel in control and a sense of belonging.
- **Psychoeducation** is done by educating clients who are receiving counseling services through informative materials or verbally sharing information that has a psychological basis.
- **Revenge** is when a child seeks to get even or to retaliate for a previously perceived wrong doing of another person.

Description

The STEP parenting program teaches basic parenting skills such as communication, positive discipline, and boundaries setting. It is a seven-session course that teaches parents about dealing with conflict in the family and also enhancing communication. STEP is based on Adlerian psychology. The program is facilitated by

a designated facilitator and also includes reading materials and a parent survey. The seven sessions cover the following topics:

1. Understanding Yourself and Your Child
2. Understanding Beliefs and Feelings
3. Encouraging Your Child and Yourself
4. Listening and Talking to Your Child
5. Helping Children Learn to Cooperate
6. Discipline That Makes Sense
7. Choosing Your Approach

The program includes the following methods of instruction and learning: role plays, group discussions, analyzing videos, analysis of challenging situations, and homework. Some of the skills and content that are covered include reflective listening, using I-messages, utilizing family meeting, exploring alternatives for solving problems, using natural and creating logical consequences of an action, showing respect, and identifying the four goals of misbehavior. The four goals of misbehavior include power, revenge, assumed inadequacy, and attention seeking. There are four versions of the STEP program available: Early Childhood STEP for parents of children up to age 6; STEP for parents of children ages 6 to 12; STEP/Teen for parents of teens; and Spanish STEP, which is a complete translation of the STEP program for parents of children ages 6 to 12.

Developments and Current Status

This program was created by Adlerian psychology practitioners and authors: Don Dinkmeyer, Sr. (1924–2001), Gary D. McKay, and Don Dinkmeyer, Jr. STEP has been taught to over 4 million parents and has been translated into Japanese, French, Korean, Chinese, German, and Spanish. The STEP program is still utilized today throughout the world and is considered an evidenced-based program.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Adlerian Therapy; Parenting Skills Training

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Stereotypic Movement Disorder

Stereotypic movement disorder is a mental disorder characterized by repeated and purposeless physical movements that cause distress or impairment.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Autism spectrum disorder** is a mental disorder characterized by impaired social and communication skills, repetitive behaviors, and a restricted range of emotions and interests.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neurodevelopmental disorders** are neurological disorders characterized by impairments of the growth and development of the brain or central nervous system.
- **Obsessive-compulsive disorder** is a mental disorder characterized by unwanted and repeated thoughts and feelings (obsessions), or

behaviors that one feel driven to perform (compulsions). It is commonly referred to as OCD.

- **Tourette's syndrome** is a neurological disorder characterized by recurrent involuntary movements and vocal tics such as grunts, barks, or words, including obscenities.

Description and Diagnosis

Stereotypic movement disorder is one of the DSM-5 neurodevelopmental disorders. It is characterized by repeated, rhythmic, and purposeless movements of the body. These may be harmless or cause harm (self-injury) to the individual. Examples of harmless behaviors include body rocking, hand waving, and head nodding. Harmful behaviors include head banging, face slapping, eye poking, and biting. Individuals typically develop a specific pattern of these movements. Movements may occur multiple times per day or there may be weeks in between episodes. They may occur generally or in specific situations, such as when individuals are under stress, bored, or excited. There are simple and complex stereotypic movements. Simple stereotypic movements are common during childhood development. These movements begin in the first year of life and generally disappear by age three. For example, infants often make repetitive sucking motions. This serves the purpose of getting food and developing motor skills. These types of movements are not considered harmful or purposeless and are not evidence of stereotypic movement disorder.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit repetitive and purposeless movements. The movements must cause harm or interfere with individuals' daily lives, such as in school, work, and social interactions. There must not be any other direct cause for the movements, such as the effects of substances like stimulants. Symptoms must also appear during early childhood development (American Psychiatric Association, 2013). Stereotypic movement disorder is different from other mental disorders that involve repetitive movement, like obsessive-compulsive disorder and Tourette's syndrome. These disorders occur later in development.

The exact causes of this disorder are unknown. It is believed that inadequate caregiving or social isolation during childhood can lead to these movements. This may be because movement relieves anxiety or produces self-soothing (activities that comfort and nurture). Stereotypic movement disorder is common in individuals who are institutionalized. Another possible explanation is the presence of other neurodevelopmental disorders like autism spectrum disorder. Movements may indicate underlying medical conditions such as infection and seizures.

Treatment

There is no cure for stereotypic movement disorder. Treatment usually focuses on decreasing harmful behaviors. This may involve behavior therapy and antipsychotic medications. In extreme cases, individuals are physically restrained to keep them from harming themselves. Occasionally, movements may disappear naturally as individuals age. Others may experience them throughout life. Currently, there is no way to prevent the development of this disorder.

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See also: Antipsychotic Medications; Autism Spectrum Disorders; Behavior Therapy; Diagnostic and Statistical Manual of Mental Disorders (DSM); Neurodevelopmental Disorders; Obsessive-Compulsive Disorder (OCD); Tourette's Syndrome

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Stigma

Stigma is a negative judgment made by an individual or group, which results in isolation or rejection of the persons being judged.

Description

Being excluded from a desirable social group is something that almost everyone experiences during the course of his or her life. From a therapeutic or psychological point of view, social stigma is of interest because of the extreme or lasting negative impact that rejection, exclusion, and marginalization can have on individuals. Stigma occurs among a variety of individuals and groups whose beliefs or lifestyles do not fit the norm. This can be based on ethnicity, religion, race, or other demographic factors. Stigma is often associated with those who suffer from mental illness. Stigma is usually applied because those with mental disorders may exhibit behaviors or characteristics that are found morally or socially unacceptable by the majority.

In the 1890s social scientists began to deal with the negative effect that the reactions of others can have on the excluded person's sense of identity. It was Canadian sociologist Erving Goffman's book *Stigma: Notes on the Management of Spoiled Identity* that brought this issue to international public awareness. Since that time many psychologists have explored the effects of social stigmatization on individual identity, subgroups, and those with mental health issues.

Stigma and shame are very closely connected because being judged negatively results in feelings of rejection, unworthiness, and embarrassment. This in turn leads some stigmatized people to try to hide their identity, known as concealment. Their values and feelings are often hidden from others. Concealment can be applied to someone's background, experience, or culture. It is damaging when people are forced to disguise themselves because they fear rejection or even physical and psychological personal threats. Stigmatization has demonstrated negative effects on one's self-esteem, academic achievement, and general health.

For many societies and cultures, mental illness is a stigma that means automatic rejection from others. This includes placing people into categories such as crazy or deranged. Society has a tendency to label those who suffer from more severe conditions as potentially dangerous. This kind of stereotyping can place added pressure on individuals with mental disorders who are already suffering from identity and inclusion issues. In some cases, the results of stigmatization can cause additional life stressors that challenge their already poor coping skills.

Current Status and Impact (Psychological Influence)

Although social norms and standards are constantly changing, counselors need to be aware that clients may not immediately be able to identify the effects of stigma in their life. Such diverse factors as ethnicity, sexual orientation, and socioeconomic status may lead to stigmas that affect clients psychologically. Clients may present with depression or other issues related to their self-identity. It is important for counselors to consider the issue of stigmatization for each client. The very event of seeking help or getting counseling can be a stigmatizing process itself. Most therapists can be trained on the different ways that the effects of stigma are expressed.

It is important for health-care professionals to be able to recognize the impact of stigma and its causative role in mental health and psychological problems. This is key to developing successful strategies for intervention. These interventions may take various forms from identifying and targeting stigma or stress-related health problems to helping the client decrease his or her vulnerability to being stereotyped. A focus on strengthening resilience for individuals so that they can overcome issues surrounding stigma is one effective tool. Not all the issues connected with stigmatization can be handled in clinical therapeutic settings. Many stigmatized issues require social action and political change.

The concept of stigma has been criticized for being too vague and overly focused on the individual. Nevertheless, the fact that individuals and groups are rejected and isolated socially or politically is a reality. This is especially true for those who have been diagnosed with and treated for mental health issues. Being diagnosed with a mental disorder can have negative effects on a person's life, including lower salaries, less access to housing, the potential for criminal involvement, and vulnerabilities to physical health problems. Many argue that the stigma associated with mental disorders puts people at a clear disadvantage and can negatively impact their prognosis and quality of life.

Alexandra Cunningham, PhD, and
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See also: Coping; Multicultural Counseling; Peer Groups; Resilience

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Stimulant Use Disorder

Stimulant use disorder is a mental disorder that is characterized by the use of stimulants leading to significant problems for the user. It includes stimulants such as amphetamine and cocaine, but not caffeine or nicotine.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Benzodiazepines** are a class of medications that slow the nervous system and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms. They can be highly addictive.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Detoxification** is a medical treatment for drug addiction that removes the physiological effects of the addictive substance and withdrawal from it.
- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **Stimulant** is a drug that increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity, or suppresses appetite. Examples are cocaine, amphetamines, and Ritalin.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

Description and Diagnosis

Stimulant use disorder is one of the substance-related and addictive disorders. It is characterized by a pattern of stimulant use that results in significant distress or disrupted functioning within a period of 12 months. This disorder includes amphetamine, cocaine, MDMA, ecstasy, and other stimulants but not caffeine or nicotine. Stimulants cause a buildup of dopamine in the brain, which leads to its many effects including intense pleasure and increased energy. The most often abused stimulants are of two types: amphetamine-like stimulants and cocaine. It is estimated that approximately 0.2% of the adult population are addicted to amphetamine-type stimulants and 0.3% are addicted to cocaine (American Psychiatric Association, 2013).

Amphetamines produce feelings of euphoria, provide relief from fatigue, increase mental alertness, and enhance mood. Negative short-term side effects include anxiety, confusion, paranoia, and aggression. Chronic use can result in side effects such as depression, psychotic behavior, and hallucinations. It can also lead to respiratory problems, cardiovascular problems, and extreme weight loss. Other dangers include infectious disease (due to shared needle use), intense cravings, and extremely poor oral hygiene. Cocaine produces feelings of profound well-being, enhanced alertness, and increased energy and strength. It also increases self-confidence, sexual drive, and a sense of mastery and power, while decreasing anxiety. Dangers include severe cardiovascular problems, irritability, nervousness, and agitation. Its long-term use leads to fewer dopamine (brain

chemical) receptors. That results in decreased ability to experience pleasure as well as nasal cavity irritation, problems swallowing, and lung damage.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit a problematic pattern of cannabis use, leading to significant impairment or distress. This must occur within a 12-month period. This includes taking the substance in larger amounts or for longer than intended. It means wanting to cut down or stop using the substance but not achieving this goal. It involves spending much time getting, using, or recovering from use of the substance. This disorder also involves cravings and urges to use the substance, and continuing to use, even when it causes problems in relationships. It involves failure to meet obligations at home, work, or school because of substance use. It also means reducing or stopping important social, work, or recreational activities because of substance use. This disorder involves repeated substance use even when it is physically dangerous. Despite knowing the risks of the physical and psychological problem that are caused or made worse by the substance, use of it continues. It means develop tolerance (needing more of it to get the desired effect). Finally, it involves withdrawal symptoms, which can be relieved by taking more of the substance (American Psychiatric Association, 2013).

Adolescents and adults use and abuse stimulants for various reasons. These include feeling good, getting high, relaxing, or relieving tension. Other reasons include reducing appetite and increasing alertness, and preventing withdrawal symptoms. These drugs are also used to be accepted by peers (amid peer pressure) or to be more social. Finally, they are used to improve concentration and work or academic performance. These drugs are also used by those with bipolar disorder. From a psychological perspective, stimulant use can also serve specific purposes. For instance, cocaine can be used to feel strong and empowered, while cocaine provides relief from discouragement.

Treatment

Treatment of this disorder usually requires detoxification and counseling or psychotherapy. Because withdrawal can be dangerous, detoxification should be done under medical supervision. This treatment involves tapering off the medication and relieving withdrawal symptoms, which typically includes sleep, appetite, and mood disturbances. Cognitive behavior therapy may be used to identify the beliefs, behaviors, and situations that trigger stimulant use and cravings. Therapy then focuses on developing a plan to reduce the likelihood of relapse. This may include a Twelve-Step Program. Other treatments may also be needed, particularly if depressant drugs (alcohol or barbiturates) were used to reduce anxiety and promote sleep. Detoxification will be needed for these substances. Treatment for stimulant addiction is often longer in duration when it causes depression or another mental disorder. Accordingly, these other disorders must be treated simultaneously. Finally, unlike marijuana and opiate drugs, the craving for stimulant drugs is much more intense and extended.

Len Sperry, MD, PhD

See also: Addiction; Cognitive Behavior Therapy; Dopamine; Drug dependence

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Stimulant-Related Disorders

Stimulant-related disorders are a group of mental disorders characterized by significant distress and disruption of daily life caused by the use of stimulants.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled

pursuit of reward or relief with substance use and other compulsive disorders.

- **Amphetamines** are a class of stimulant medications that increase activity in the nerves and brain by increasing the amount of chemicals in the body.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about imagined danger.
- **Attention-deficit hyperactivity disorder** is a disorder characterized by significant problems with attention, hyperactivity, or acting impulsively that are not appropriate for an individual's age.
- **Depression** is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than external stimuli.
- **Narcolepsy** is a sleep disorder involving daytime sleepiness and uncontrollable episodes of falling asleep during the day.
- **Paranoia** is an unfounded or exaggerated distrust or suspiciousness of others.
- **Psychoactive** is a drug or substance that has a significant effect on mental processes. They include opioids, stimulants, depressants, hallucinogens, and cannabis.
- **Psychosis** is a severe mental condition in which an individual loses touch with reality.
- **Seizure** is an episode of abnormal electrical activity in the brain that results in changes in the brain and in behavior.
- **Stimulants** are drugs that increase brain activity and produce a sense of alertness, euphoria, and productivity, or that suppress appetite. Examples are cocaine, amphetamines, and Ritalin.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders characterized by the continued use of addictive substances or behaviors despite significant impairment or distress. They include alcohol use disorder, opioid withdrawal disorder, and stimulant-related disorders.
- **Twelve-Step Programs** are self-help groups whose members attempt recovery from various addictions based on a plan called the Twelve Steps.

Description and Diagnosis

Stimulant-related disorders are a group of DSM-5 mental disorders characterized by significant psychological and physical distress and impaired daily functioning caused by the use of stimulants. This group of disorders is one of the 10 classes of disorders known as the substance-related and addictive disorders in DSM-5. Because stimulants are energizing, they may be prescribed to reduce sleepiness, decrease appetite, and reduce restlessness. They are also used to treat conditions such as narcolepsy, depression, and attention-deficit hyperactivity disorder. Some examples of legal stimulants include caffeine, nicotine, and prescription medications (e.g., amphetamines). Individuals also use stimulants for recreational use and abuse. They are often abused for the intense excitement that accompanies them. Some examples of illegal stimulants include ecstasy, cocaine, and methamphetamine. Illegal stimulants are extremely addictive. They cause mind racing and rapid heartbeat, and have the potential for overdose and death. Whether or not a stimulant is legal or illegal, they all may eventually lead to addiction.

There are five separate classifications of mental health diagnoses that fall under the category of stimulant-related disorders. They include stimulant use disorder, stimulant intoxication, stimulant

withdrawal, other stimulant-induced disorders, and unspecified stimulant-related disorder. Following are brief descriptions of each of these disorders. Stimulant use disorder is more fully described in its own entry in this encyclopedia.

Stimulant use disorder. Stimulant use disorder is a mental health disorder characterized by problems associated with the use of amphetamine-type substances, cocaine, or other stimulant drugs. Individuals with this disorder often lead to having significant distress or impairment as a result of taking larger amounts of a stimulant or over a longer period than intended. Individuals have a strong urge to use a stimulant and spend a great deal of time trying to acquire, use, and recover from the stimulant. Those with this disorder fail to fulfill obligations at home, work, or school. Stimulant use disorders lead to persistent or recurrent interpersonal and social problems, and important activities in one's life are reduced or given up as a result of continued use. Individuals continually use stimulants despite physical and psychological problems. Individuals who use amphetamine-type stimulants or cocaine can develop this disorder within one week. Tolerance of this disorder will occur with repeated use regardless of how the stimulant is administered (e.g., orally, injection, smoking, or snorting). One who has developed tolerance to a stimulant will need an increased amount of the drug in order to achieve the desired effect. Withdrawal symptoms can occur after an individual stops using or reduces the amount of a stimulant. They include excessive daytime sleepiness, increased appetite, depression, suicidal thoughts, irritability, and difficulty concentrating. Aggressive and violent behavior is common when large doses of a stimulant are smoked, ingested, or administered intravenously. Furthermore, those who use high doses of stimulants may experience extreme anxiety, paranoia, hallucinations, and psychosis.

Stimulant intoxication. Stimulant intoxication is a mental health disorder characterized by the presence of significant behavioral or psychological changes that begin during or shortly after the use of cocaine, an amphetamine-type substance, or other stimulant. Some of the behavioral and psychological changes include excitability, impaired judgment, anxiety, and anger. Hallucinations and paranoia may also be present. Stimulant intoxication usually begins with a high feeling and includes some of the following symptoms. They include hyperactivity, restlessness, talkativeness, alertness, grandiosity, and poor judgment. Signs and symptoms accompany these behavioral and psychological symptoms shortly after stimulant use. They include rapid heartbeat, pupil dilation, chills or perspiration, nausea, vomiting, difficulty breathing, chest pain, seizures, or coma. Stimulant intoxication can either be acute or chronic and is associated with impaired social or occupational functioning. Severe stimulant intoxication can result in death.

Stimulant withdrawal. Stimulant withdrawal is a mental health disorder characterized by withdrawal symptoms that usually develop within a few hours to several days after complete discontinuation or reduction of prolonged amphetamine-type substance, cocaine, or other stimulant use. The development of a distressed mood is an element of withdrawal, along with several other symptoms, which includes lack of energy, lack of sleep or excessive daytime sleepiness, increased appetite, unpleasant dreams, and agitation. A slower than normal heart rate is often present with the withdrawal of stimulants. Individuals experience significant impairment and distress in occupational, social, and other important areas of one's life. The signs and symptoms of stimulant withdrawal cannot be attributed to another medical condition and are not better explained by another mental disorder.

Other stimulant-induced disorders. Other stimulant-induced disorders, which include amphetamine, cocaine, and other stimulant disorders, are described in other chapters of the DSM-5 with disorders with which they share occurrences. Some examples of shared occurrences include stimulant-induced psychotic disorder, stimulant-induced anxiety disorder, and stimulant-induced obsessive-compulsive disorder. These stimulant-induced disorders are diagnosed instead of stimulate intoxication or stimulant withdrawal only when the symptoms are severe enough to justify independent clinical attention.

Unspecified stimulant-related disorder. Unspecified stimulant-related disorder is a category that is applied to the presentation of symptoms that are characteristic of a stimulant-related disorder. The one symptom that clearly occurs in this disorder is the

significant impairment and distress in an individual's occupational, social, or other areas of important functioning. The full criteria needed to make the diagnosis of a specific stimulant-related disorder are not met. Therefore, this is the diagnosis given.

Treatment

The clinical treatment of these disorders varies depending on the disorder. Generally, treatment involves a combination of participating in an inpatient treatment program, complete abstinence from any mind-altering substances, psychotherapy, attending Twelve-Step Programs, obtaining a sponsor, working the Twelve Steps of recovery, and medication management.

Elizabeth Smith Kelsey, PhD, and Len Sperry, MD, PhD

See also: Addiction; Amphetamines; Anxiety; Attention-Deficit Hyperactivity Disorder; Depression; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Hallucinations; Narcolepsy; Paranoia; Psychosis; Psychotherapy; Seizures; Twelve-Step Programs

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Stockholm Syndrome

Stockholm syndrome is a mental disorder characterized by an individual having positive feelings or sympathy toward his or her captor or abuser.

Definitions

- **Defense mechanisms** are strategies for self-protection against anxiety and other negative emotions that accompany stress.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.

Description

Stockholm syndrome is an uncommon mental disorder whereby an individual who has been exposed to severe stress by an abusive individual who feels positively or sympathetically toward that individual. The most common activities associated with the manifestation of this disorder are kidnapping, hostage situations, domestic or other abuse, prisoners of war, and cults. The occurrence rate of this disorder is not known because such situations occur rarely. Although this disorder is recognized, it is not induced in DSM-5 because it lacks sufficient research support.

The explanation given for the behavior of those exhibiting this disorder is the false sense of gratitude felt by those whose lives are acutely threatened but then spared. Another explanation is that it occurs as a defense mechanism or survival strategy. In the case of defense mechanism, the disorder may occur in response to the unbearable stress created by the life-threatening circumstance of the victim. Similarly, if the disorder is a strategy for survival, individuals are believed to act and feel positively toward their captor in the hopes that they will be sparred. The bonding that occurs between victim and captor occurs in a very short period of time.

This disorder was named after an extended bank robbery that took place in Stockholm, Sweden, in 1973. Hostages were taken and held captive for several days but began to support their captors and even defended them after the hostages were released. A similar situation occurred when Patricia Hearst, then a 19-year-old heiress of the Hearst publishing fortune, was kidnapped and held hostage in 1974 by a revolutionary group called the Symbionese Liberation Army. She participated in a bank robbery with them. Even months after her release, Ms. Hearst actively supported her captors, although she later condemned them for their treatment of her. This syndrome was also noted among some hostages in the 1985 hijacking of TWA

Patricia Hearst, an heiress to the Hearst publishing fortune, was kidnapped and held hostage in 1974 by a revolutionary group called the Symbionese Liberation Army, and participated in a bank robbery with them. Even months after her release, Ms. Hearst actively supported her captors, but she later condemned them. Hearst was thought to exhibit Stockholm syndrome behavior. (Bettmann/Corbis)

flight 847 by Lebanese Shia extremists, even though one of the hostages was killed.

Len Sperry, MD, PhD, and Jeremy Connelly, MEd

See also: Defense Mechanisms; *Diagnostic and Statistical Manual of Mental Disorders* (DSM)

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Strategic Family Therapy

Strategic family therapy involves the whole family unit in a brief therapeutic intervention designed to bring about rapid change. The therapist plays the leading role, with the family members completing various tasks to shift their systems of interaction toward the contracted outcome.

Description

Strategic family therapy is a form of brief therapy that involves the entire family unit. It was developed in California in the 1950s, rising to therapeutic prominence over the next several decades through the work of Gregory Bateson, Don Jackson, Jay Haley, Salvador Minuchin, Cloe Madanes, and Milton Erickson, among others. Though its popularity has waxed and waned in the subsequent years, strategic family therapy has been found to be a scientifically effective model appropriate for use with families from all cultures and ethnicities.

During strategic family therapy, the therapist takes a leading role. The goal of therapy is to address a specific issue or change a specific behavior pattern. It is not introspective, and the examination of the reasons behind an issue is given less emphasis than action to change the issue. Toward that end, the therapist may assign tasks to family members in session or give homework to the group to complete between sessions. The therapy is deemed successful when the targeted behavior or issue has been addressed or improved to the satisfaction of the family group.

Strategic family therapy aims to change family patterns of interaction in order to achieve a specific outcome. This might mean improved marital relations, a cessation of domestic violence, better school performance, or even a drug habit intervention. The overarching goal is the change in exhibited behaviors, and as such, introspection and understanding the roots of the problem are given less of a role in therapy sessions. It is not that the past is wholly irrelevant; it is simply that here, present and future outcomes have the leading role.

Designed as a brief therapy, strategic family therapy enrollment is typically triggered by a social services referral or specific event tipping point, such as an arrest, school suspension, or "last straw" moment from within the family. It begins with an evaluative assessment where group members meet with the therapist (individually or jointly, depending on the case) to discuss desired outcomes prior to beginning therapy.

While there may be multiple issues at place, the subsequent strategic therapy sessions will focus only on the contracted issue or change goals and not move beyond the immediate problem unless the family specifically requests this expansion.

The family attends sessions as a group, though the therapist may meet with individual family members separately in addition to the group sessions as needed. During the therapy sessions, the therapist takes a leading role and plays the part of interventionist. Role-playing, tests/ordeals, directives, and take-home assignments may all be used to try and shift family behavior patterns. Thus, the therapist must balance both a role as a trusted helper and a role as an antagonist challenging the existing system when leading the family through the sessions. Therapy ends when the contracted outcomes are reached, though some clients may transition to other forms of ongoing individual or family therapy.

Development and Current Status

Strategic family therapy grew from Bateson's cybernetics model. The first major institute championing its research and use was the Palo Alto Mental Research Institute, founded in 1958 by Jackson. Erickson, Haley, Madanes, and Minuchin, along with Virginia Satir, Richard Fisch, R. D. Laing, and Irvin Yalom, spent significant time there over the next decade developing aspects of the therapy and enshrining it as a key part of the marriage and family therapy canon.

However, the active, interventionist role played by the therapist in strategic family therapy became a source of tension as the different researchers theorized about different sources for family imbalance. Erickson, Bateson, and Jackson focused on systems and feedback loops, while Haley and Madanes focused more on power imbalances, believing shifts in hierarchical structures could both cause and repair family dysfunction. Difference in practice approaches led Haley to leave the institute, though he continued to be a major influencer in the strategic family therapy movement.

The interventionist model attracted additional negative attention in late 1970s and 1980s. At that time, shifting views on the appropriate roles for therapists in patient behavior change led some strategic family therapy practices—such as assigned tests or intentional deceptions to bring about change—to be accused of being manipulative by the broader psychological community. This led to a sharp decline in research and study in the strategic family therapy space, though it was still widely practiced.

Since 2000, there has been a resurgence in research and study, especially as long-term studies and field teams have continued to report on the effectiveness of strategic family therapy "in the trenches," particularly for treating complex cases. Emerging data in the dynamic systems field has justified many of the more controversial and "manipulative" practices of strategic family therapists, proving that these hands-on directives are in fact grounded in sound science within the context of treating complex systems, including families. Cross-cultural studies from the late 1990s and early 2000s have also shown that the short, action-oriented sessions can be extremely effective in treating families from diverse ethnic and racial backgrounds, especially as they seek to adapt to new environments.

Currently, the Mental Research Institute has regained its status as an active trainer and leader in the field of strategic family therapy. The therapy is increasingly popular in complex social services settings, particularly for dealing with adolescents. In that context, the therapy has proven to be effective both at changing behaviors in families with troubled adolescents and in containing costs of treatment where multiple agencies (schools, social welfare groups, and the legal system) are involved. As a result, strategic family therapy is likely to maintain a steady presence in the marriage and family therapy world for the foreseeable future.

Mindy Parsons, PhD

See also: Family Therapy and Family Counseling; Minuchin, Salvador (1921–); Satir, Virginia (1916–1988)

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Strattera (Atomoxetine)

Strattera is a prescription medication used to treat attention-deficit hyperactivity disorder. Its generic name is atomoxetine.

Definitions

- **Attention-deficit hyperactivity disorder** is a mental condition characterized by a lack of concentration, impulsive or inappropriate behavior, and hyperactivity.
- **Dopamine** is a chemical messenger in the brain that transmits nerve impulses that regulate attention, concentration, emotion, movement, impulse control, and judgment.
- **Neurotransmitters** are a group of chemical messengers in the brain that message to other nerve cells. Common neurotransmitters include acetylcholine, dopamine, norepinephrine, and serotonin.
- **Norepinephrine** is a chemical messenger in the brain that serves to transmit nerve impulses that regulate attention and power the "fight or flight" stress response. As such, it causes constriction of blood vessels. It is also called noradrenaline.
- **Selective serotonin norepinephrine reuptake inhibitors (SNRI**) are antidepressant medications that act on and increase the levels of serotonin and norepinephrine in the brain that influences mood. They differ from selective serotonin reuptake inhibitors, which act only on serotonin.

Description

Strattera belongs to a class of non-stimulating medications known as a selective norepinephrine reuptake inhibitors (SNRIs). It is used to treat children and adults with attention-deficit hyperactivity disorder (ADHD). Unlike ADHD medications like Ritalin, Strattera is not likely to be abused. Also, because it is not a controlled substance, the rules for prescribing it are much less strict. Strattera was the first non-stimulant medication approved for the treatment of ADHD. It is commonly used for those who develop multiple side effects from stimulants or who cannot tolerate stimulants because of coexisting anxiety or substance abuse. Since stimulants can worsen tics in those with Tourette's syndrome and ADHD, Strattera is particularly useful because it can treat ADHD without worsening coexisting tics. For those with ADHD and coexisting depression, Strattera is useful since it also has antidepressant properties. It is believed that a decrease in norepinephrine in the brain contributes to disorders such as ADHD and depression. As an SNRI, Strattera is thought to work by increasing levels of norepinephrine, while also regulating dopamine in certain brain areas.

Precautions and Side Effects

Strattera must be used with caution in those with uncontrolled hypertension, liver or kidney function impairment, glaucoma, heart conditions, and seizure disorder. Strattera must be used with care in those with bipolar disorder since it can trigger mania. Care should be taken to weigh the risks and benefits of Strattera in women who are or wish to become pregnant, as well as in breast-feeding mothers.

Common side effects include dry mouth, abdominal pain, nausea and vomiting, constipation, insomnia, vivid dreams, decreased appetite, erectile dysfunction, drowsiness, numbness and tingling in the extremities, dizziness, fatigue, hot flashes, increased blood pressure and heart rate, sweating, and palpitations. Rare but serious reactions include very high blood pressure, glaucoma, loss of consciousness, heart arrhythmias, heart attack, stroke, seizures, liver toxicity, and sudden death. Some develop increased aggressiveness, psychosis, mania, or suicidality in the first weeks of use. Children are especially at risk for these behavioral side effects. When starting treatment or after dose changes, those taking Strattera need to be monitored closely for behavioral changes.

Medications that may cause toxicity with Strattera include antidepressants such as Wellbutrin and Cymbalta; the antiulcer medication cimetidine; caffeine; and antipsychotics like Haldol and Mellaril. It is unknown which herbal supplements interact with Strattera. Since monoamine oxidase inhibitors (MAOIs) increase norepinephrine and dopamine, they cannot be used concurrently with Strattera. Switching treatment from an MAOI to Strattera may require a waiting period of up to two weeks. Ludiomil (an antidepressant) may also have additive effects with Strattera that cause toxicity.

Len Sperry, MD, PhD

See also: Attention-Deficit Hyperactivity Disorder; Dopamine

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Stress

Stress is the psychological, emotional, and physical state of strain resulting from negative appraisals of events, situations, and circumstances.

Definitions

- **Cognitive appraisals** are what a person thinks, believes, and concludes about events, situations, and circumstances.
- **Insomnia** is an inability to get to sleep or remain asleep during normal sleep times.

Description

Stress is the physical, emotional, and behavioral reactions to adverse events, situations, and circumstances. Stress can be acute or chronic. Acute stress is the most common and is short term in nature. Acute stress can result in emotional upset with some temporary physical manifestations such as headache or upset stomach. Not all acute stress is negative, such as the stress associated with riding a roller-coaster. Acute stress also has some positive effects as when it motivates people toward positive action. For instance, when an exam or deadline is in the near future, stress contributes to motivating a person to study or prepare. In extreme circumstances an automatic response to acute stress is a "fight or flight" reaction that serves to protect or defend an individual.

Physical symptoms of acute stress can include an increase in heart rate and blood pressure, sweating, dry mouth, stomach upset, and muscle tightening. Emotional reactions can include feelings of anxiety, anger, panic, and fear. Stress-related behaviors can include disturbed sleep patterns, overeating or undereating, social isolation, irritability, increased use of alcohol and drugs, or developing nervous habits such as nail biting or pacing back and forth.

Stress has been highly studied. Perhaps the best-known research on stress and coping was led by American psychologist Richard Lazarus (1922–2002). Lazarus and colleagues proposed that stress is an interaction between how individuals appraise, or assess, situations and its impact on their well-being. Individuals assess and categorize stressful events through primary and secondary cognitive appraisals. Primary appraisals evaluate the impact of an event or situation on one's life and well-being. Secondary appraisals evaluate what can be done to manage or cope with the event or circumstances. Secondary appraisals of coping options and primary appraisals of what is at stake interact with each other in shaping the degree of stress and the nature of the emotional reaction. For instance, a college student is assigned to a group project that will be worth half of her overall grade for the class. Her primary appraisal is that she could fail the class if her teammates perform poorly on the assignment. Her secondary appraisal is that she has no control over the assignment. This primary appraisal "I could fail" and the secondary appraisal "I have no control" result in a high level of stress and she becomes anxious and unable to sleep. Substitute

her secondary appraisal with the thought "I am pretty good at motivating people and working with a team" and the level of stress would be much less. Cognitive appraisals are very powerful in the formation and management of stress.

Prolonged or chronic stress has been shown to have many adverse physical effects on the body. Because stress can raise blood pressure, chronic stress can lead to heart attack and stroke. Chronic stress can manifest in specific areas of the body such as the head or stomach resulting in migraine headaches, irritable bowel syndrome, or ulcers, to name a few. Chronic stress can also lead to emotional debilitation through depression or anxiety disorders. Both acute and chronic stress can impact the immune system making people more vulnerable to illness.

Individual levels of hardiness and resiliency have a direct impact on perceived stress. Hardiness is the ability to withstand or tolerate stress, and resiliency is the ability to recover from stressful events. People who are hardy and resilient are able to cope with stressful events more effectively and with less emotional upset than are those who are less hardy and resilient. There are some events so stressful that they overwhelm a person's ability to recover. People who have experienced or witnessed life-threatening and horrific situations sometimes develop post-traumatic stress disorder and need the help of a mental health professional in order to recover.

Treatment for people who suffer from chronic stress, or are vulnerable to stress, is generally referred to as stress management. Stress management refers to a wide spectrum of treatments and includes exercise programs, self-relaxations techniques, biofeedback, guided imagery, meditation, and psychotherapy. The most common stressors are work, marital, and family related. Because stress is so common, there are a multitude of books, techniques, and seminars aimed at teaching people how to reduce and cope with stress. Most stress-related psychotherapies are cognitively oriented. The most common psychotherapy for addressing stress-related difficulties is cognitive behavior therapy (CBT). CBT focuses on changing and modifying an individual's primary and secondary cognitive appraisals in order to strengthen coping skills.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy; Post-Traumatic Stress Disorder (PTSD); Stress Management

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Stress Management

"Stress management" refers to a wide variety of techniques and methods used to reduce and manage acute and chronic stress.

Definitions

- **Acute stress** is the most common form of stress, is short term, and results in minor and temporary emotional and physical upset.
- **Chronic stress** is long-term stress that is emotionally and physically harmful to the health and well-being of the individual.
- **Cognitive appraisals** are what a person thinks, believes, and concludes about events, situations, and circumstances.
- **Stress** is the psychological, emotional, and physical state of strain resulting from negative appraisals of events, situations, and circumstances.

Description

Stress management refers to a wide variety of techniques used to assist individuals in reducing and managing stress. Stress occurs when situations are perceived as more demanding than a person's ability or resources to cope with the demands. Stress is the interaction between how individuals appraise, or assess, situations

and its impact on their well-being. Chronic stress has been found to have extremely negative health consequences, including hypertension and developing cardiovascular disease, obesity through emotional eating, and increased risk for heart attack and stroke, as well as developing chronic fatigue syndrome, depression, anxiety, and other mental health difficulties.

Because of the severity of stress impact on individual well-being, a multitude of preventative and stress management interventions have been developed. Stress management techniques are not only therapeutic but can also prevent the development of stress-related disorders. Evidence-based stress management methods include relaxation and breathing techniques, imaginal processing and mindfulness techniques, and cognitive-based techniques.

Muscle relaxation and breathing techniques are strategies that help clients attend to physical sensations in order to achieve periods of physical and mental relaxation. Muscle relaxation includes both a physical and a mental component. The physical component includes the sequential tightening and relaxing of muscles in the legs, abdomen, chest, arms, and face. Therapists instruct clients to tense muscle groups for 10 seconds and then relax the muscle group for 20 seconds before moving to the next group of muscles. Clients are instructed to practice the technique multiple times a day for short periods of time in order to produce a relaxed and peaceful physical and mental state. While tensing and relaxing the client concentrates on the difference between the tension and relaxation and learns to more quickly dissipate the physical symptoms of stress. Concentrating on muscles assists clients to block the cognitive processes associated with stress production. Outcome studies indicate that relaxation techniques help decrease blood pressure and heart rate, decrease headaches, and decrease levels of anxiety. Concentrating on deep breathing has long been used to produce states of relaxation. Diaphragmatic slow breathing in which individuals breathe from the diaphragm in the abdomen has been successfully used to decrease fatigue, reduce anxiety, manage aggressive behaviors, and reduce signs and symptoms of various health difficulties such as asthma.

Biofeedback is a technique in which individuals learn to control certain body functions by using electrical sensors and instruments to measure brainwaves, heart function, breathing, muscle activity, and skin temperature. The sensors provide instant feedback of body responses to changes in a person's thinking, emotions, and behaviors during biofeedback sessions. Trained therapists provide biofeedback training, and in three to six months an individual can learn to control functions such as heart rate and blood pressure. Biofeedback has been successfully used to reduce anxiety, blood pressure, headache, and other medical difficulties.

Stress management techniques include the use of guided imagery, meditation, and mindfulness techniques. Guided imagery is a method that focuses and directs the imagination in ways that are symbolic of a client's health and life issues. Therapists facilitate the development of personalized images and have clients create a script to follow that promotes relaxation and stress reduction. Engaging daily in these guided imaginal scripts have been found to reduce stress and promote health. Meditation in various forms has been found to be effective in reducing stress. Meditation has been practiced for thousands of years and involves focusing one's attention on a single activity such as a mantra. A mantra, as used in transcendental meditation, is a series of meaningless sequence of sounds and provides an activity that requires a person to disregard all other distractions such as thoughts and memories of stressful daily events. Other foci of attention may be body sensations, ambient sounds, images, and so on. Mindfulness is a type of meditation that focuses attention on moment-to-moment body awareness, and bringing one's complete attention to the present experience, thought, emotion, and sensation, but from a nonjudgmental distance. The goal is to assist clients learn to regulate emotions by awareness and reflection in a meditative state.

Cognitive behavior therapy (CBT) is a highly researched evidence-based psychotherapy that promotes changes in emotions, thinking, and behaving by helping clients modify their cognitive appraisals. CBT is based on the premise that thinking, feeling, and behaving are interconnected and a change in one will promote change in another. Clients are assisted in understanding and recognizing patterns of irrational or distorted thinking and restructuring the thoughts to promote

beneficial emotional states leading to increased health and well-being. CBT has been shown to be effective in stress reduction, management of cardiovascular disorders, chronic fatigue syndrome, diabetes, headaches, depression, anxiety, and many other health issues.

Chronic stress has many adverse effects on health and well-being. Stress management consists of a wide array of techniques and methods utilized in the reduction of stress-related emotional and physical difficulties.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy; Cognitive Restructuring; Guided Imagery; Post-Traumatic Stress Disorder (PTSD)

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Stroke

A stroke is damage or death of brain cells due to insufficient blood flow.

Definitions

- **Brain** is the organ at the center of the nervous system. It is responsible for a wide range of functions including learning, movement, and regulation of the body.
- **Computed tomography** is a medical diagnostic test in which computer-processed x-rays produce tomographs (cross-sectional images) of body areas. It is also referred to CAT scans.
- **Electroencephalography** is a medical diagnostic test that records electrical activity on the scalp to evaluate various brain functions and psychological disorders. It is also known as the brain wave test.
- **Magnetic resonance imaging** is a medical diagnostic test, which uses electromagnetic radiation and a strong magnetic field to produce detailed images of the brain and internal organs.
- **Physical therapy** is a method of treating of physical disability, malfunction, or pain by exercise, massage, and other nonmedication approaches.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Speech therapy** is a method of treating speech conditions with exercises and audiovisual aids that develop new speech habits.

Description

A stroke occurs when blood flow to the brain is blocked. This can happen when an artery bursts or closes due to a blood clot. Arteries carry blood from the heart to the brain. The area of the brain that was supplied by that artery does not receive blood, which contains oxygen and nutrients. Because of this, it becomes damaged or dies altogether. A stroke can result in paralysis, loss of vision, speech problems, impairment in memory and reasoning, coma, or death. This depends on the area of the brain that is affected and how much damage occurs. Individuals with other conditions like diabetes, heart disease, obesity, and high blood pressure have higher risk of stroke. Certain racial groups (African Americans, Asians, and Hispanics) have increased risk of stroke. Behaviors such as cigarette smoking, intravenous drug use, and lack of exercise also increase risk. Stroke is one of the leading causes of death in the United States. It is more common in men and in those over age 55.

There are four main types of stroke. *Cerebral thrombosis* is the most common. It occurs when a thrombus (blood clot) forms in the brain and blocks

incoming blood flow. This is generally the result of atherosclerosis (hardening) of the brain arteries. Atherosclerosis in the brain is caused by buildup of fatty deposits inside blood vessels. This type of stroke usually develops gradually. *Cerebral embolism* is another type of stroke. It occurs when a blood clot from somewhere else in the body breaks free and becomes lodged in an artery that supplies the brain. This also results in loss of blood flow to the brain. Cerebral embolism accounts for about 15% of all strokes. This type usually comes on quickly with severe symptoms. Both cerebral thrombosis and cerebral embolism are considered *ischemic* strokes because they result from restricted blood flow. Symptoms of ischemic strokes include dizziness; numbness of the face, arm, or leg; and blurred vision. The other two types of strokes are *hemorrhagic* strokes. These occur when a blood vessel bursts in or around the brain due to trauma or pressure. In a *subarachnoid hemorrhage*, blood spills into the space between the brain and cranium (skull). This is usually caused by hypertension (high blood pressure) or defective blood vessels such as an aneurism. Subarachnoid hemorrhages account for about 7% of all strokes. The final type of stroke is called *intracerebral* (inside the brain) *hemorrhage*. It occurs when there is bleeding in the brain itself. This deprives the tissue of blood and creates pressure on the brain. About 10% of all strokes are intracerebral hemorrhages. Symptoms of hemorrhagic strokes are loss of consciousness, severe headache, vomiting, and sensitivity to light (Levine, 2012).

A stroke is a medical emergency that requires immediate treatment. If individuals receive treatment quickly, then survival rates are high. Once a stroke is suspected, imaging technology is used to identify the type of stroke. Computed tomography scans and magnetic resonance imaging are two methods. Blood and urine tests and electroencephalogram are also used. Treatment varies depending on the type of stroke. For ischemic strokes, treatment involves trying to dissolve the blood clot with medications. Hemorrhagic strokes are treated with surgery to relieve pressure and repair ruptured blood vessels. Damage caused by a stroke usually requires rehabilitation therapy. Physical therapy is used to strengthen affected limbs and improve range of motion. Speech therapy is sometimes needed to help individuals improve communication ability. Psychological treatment involves psychotherapy to address emotions related to the stroke, such as depression. It may also be used to help caregivers manage stress and provide support. Strokes can be fatal, though improved medical treatments have reduced the number of deaths due to stroke. Measures to prevent stroke include quitting smoking, exercising, controlling blood pressure, and regular medical checkups.

Len Sperry, MD, PhD, and George Stoupas, MS

See also: Brain; Computed Tomography (CT); Electroencephalography (EEG); Magnetic Resonance Imaging (MRI); Psychotherapy

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Structural Family Therapy

Structural family therapy is a treatment approach developed by Salvador Minuchin (1921–) that focuses on restructuring the family organization to improve function and health.

Definition

- **Eco structural model** is a way of understanding the basic organization of the family, which includes the social impacts on the individual or family member.

Description

Structural family therapy uses a system-based treatment focus, which means that the whole family is considered as part of the therapeutic intervention. The focus of therapy starts with how the family system interacts, how it balances, any dysfunctional patterns, and their impact. The basic idea of structural family

therapy is exploring family rules, roles, boundaries, and organization.

The primary goal of this therapy is to restructure the family so that health and wellness can be attained. To achieve this, the therapist must first join the family as a leader. The therapist then can study the way in which the family interacts and the patterns that have a negative impact on the family. The therapist pays close attention to who says what to whom and how it is said. They also look at the impact of that and how the family members connect or disconnect. The therapist can then challenge the patterns that have made growth difficult.

Structural family therapy seeks to understand a family within the context of the presenting concerns. It looks at the family subsystems and the boundaries. It looks at how supportive, functional, and accepted the members are within the family unit. However, therapists using this treatment do not just look at the family unit alone but also the role that the community has in connection to the family.

The therapist has three functions: to join with the family in a leadership position, map the structure, and intervene allowing for a change to the ineffective structure. The assumption is that changing the organization and how it interacts will lead to symptom decrease and an increase in healthy functioning.

Structural family therapists use three key techniques. The first is family mapping where a diagram is drawn of the family connections and their boundaries. The mapping also looks at how engaged they are with each other. Enactments allow the family members to act out a common conflict that they experience at home. This allows an inside look to the family structure and communication patterns. Finally, reframing is used to allow for a different or new interpretation so that the family can understand the problems from different points of view.

Developments and Current Status

Structural family therapy was developed by Salvador Minuchin in the 1960s. At the time, Minuchin was working with juvenile delinquent boys in New York and found that the individual therapy was ineffective. Minuchin decided to include the family members to help gain a better understanding of the patterns and relationships and their impacts. Minuchin felt that studying the interaction patterns could allow the clinician to understand the symptoms the client was experiencing.

Including the families allowed Minuchin to see how the family members would interrupt each other and speak over one another. It was often unclear who the leader of the family was and each member's role lacked clarity. This allowed Minuchin the opportunity to redefine these roles, or the organization, to lead to appropriate boundaries and healthy communication.

Minuchin's work has been continued by Harry Aponte, who is considered to be a distinguished scholar. Aponte created an ecostructural model, which was designed to challenge oppression that is based on race, poverty, and culture.

Ashley J. Luedke, PhD, and
Mindy Parsons, PhD

See also: Family Therapy and Family Counseling; Minuchin, Salvador (1921–)

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Organization

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Subjective Units of Distress Scale (SUDS)

The Subjective Units of Distress Scale (SUDS) is a short psychological measure for assessing levels of anxiety. It is also called the Subjective Units of Disturbance Scale and the SUDS scale.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Behavior therapy** is a form of psychotherapy that uses basic learning techniques to modify maladaptive behavior patterns.
- **Eye movement desensitization reprocessing** is a psychological treatment for removing painful memories by providing a moving object for the eye to track in the therapy process.

Description

The Subjective Units of Distress Scale is a scale of 0 to 100 for measuring the subjective intensity of disturbance or distress currently experienced by an individual. Individuals can self-assess their level on the scale. The SUDS may be used as a benchmark for a therapist to evaluate the progress of treatment. It is a commonly used measure of anxiety in behavior therapy. It is a quick means of quantifying an individual's experience of anxiety and provides a way to monitor or assess an individual's responses and make comparisons with others.

The individual is asked to think of the worst anxiety and call it the maximum anxiety, or a rating of 100. Being absolutely calm is given a rating of 0. All other fears are ranked in between. The same scale is used later on during therapy to determine the strengths of the person's reactions during desensitization and after treatment. In clinical practice, asking the client or patient to rate his or her SUDS levels provides a quantitative index of progress. It also fosters a sense of accomplishment and empowerment in clients. In addition, it helps clinicians evaluate blocks and facilitators of the therapy process.

Developments and Current Status

This scale was published by South African psychologist Joseph Wolpe (1915–1997) in 1969. He developed it because there was no available quick measure for rating emotional distress or for monitoring change and evaluating progress in therapy. He called it the Subjective Units of Disturbance Scale. Originally, it was defined as a self-rated measure of current anxiety, with 0 being a state of absolute calmness and 100 as the worst anxiety ever experienced. It quickly became a standard measuring anxiety in exposure-based therapies. Later, it would be adapted for describing subjective alcohol urge and subjective level of sexual arousal. It has become a standard technique in eye movement desensitization reprogramming as a measure of distress before and after target memory processing. In 1990, Wolpe proposed the use of a more compact SUDS scale ranging from 0 to 10. SUDS has been criticized as lacking reliability and validity. However, recently published research has confirmed that SUDS does in fact have adequate psychometric properties. Overall, SUDS is a clinically useful and powerful assessment measure in psychotherapy.

Len Sperry, MD, PhD

See also: Behavior Therapy; Eye Movement Desensitization and Reprocessing (EMDR)

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Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency created by the U.S. government to centralize efforts to help people struggling with drug abuse and mental disorders.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.

- **Substance abuse** involves the use of substances (drugs or alcohol) in amounts or with methods that are harmful.
- **Substance-related and addictive disorders** are a group of DSM-5 mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.

Description

SAMHSA was created by an act of the U.S. Congress in 1992. As an agency of the government it is part of the Department of Health and Human Services. Its mission is to reduce the impact of substance abuse and mental illness on America's communities.

There are four beliefs that are the basis for the creation of SAMHSA. First is that behavioral health is essential to a healthy society. Second and third beliefs are that prevention efforts are worthwhile and that treatment is effective. The fourth belief is that people can recover from substance abuse and mental health problems. SAMHSA attempts to put these beliefs into effect through initiatives carried out by regional offices in collaboration with other state and local social service agencies.

The impact of substance abuse and mental illness on society was the reason for creating SAMHSA. Its continued funding and existence is justified by research and statistics produced by the agency. The agency estimates that in 2010 the total economic cost of substance abuse in the United States was over $510 billion annually. In the same period, over 23 million Americans aged 12 and older needed treatment for substance abuse. In addition, at least 10 million adults experience serious mental illness of some kind.

Impact (Psychological Influence)

Recently SAMHSA has devoted its efforts in multiple areas. These include people affected by trauma and the military. It is also aiming to improve access to culturally competent and high-quality services as well as to developing community, peer, and family support.

As with other government programs, SAMHSA collects and reports data, which shows the challenges and positive results from the programs it funds. One example of a statistic it tracks reveals the challenges faced by youth dealing with substance abuse. The problem society faces is the overall rate of treatment admissions for substance misuse among people. The age range group of 12 years and older in the United States was stable from 1999 to 2009. Yet during this same time period there was a 430% increase in the rate of treatment admissions for the misuse of prescription opioid drugs.

Not unlike other government agencies, SAMHSA struggles with budget cuts and an increasing need for social and government action. The agency often receives criticism for being ineffective and for the fact that some of its many programs may both be flawed and have conflicts of interest. The role of SAMHSA will continue to be important as long as the government needs to play a role in creating effective treatment for substance abuse and for people with other mental health and social issues.

Alexandra Cunningham, PhD

See also: Addiction; Substance Abuse and Related Disorders; Substance Abuse Treatment

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Substance Abuse Treatment

Substance abuse treatment is the medical or psychotherapeutic method used to decrease or stop the abuse of psychoactive substances.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **Disulfiram** is a man-made substance used to treat alcohol addiction. It is designed to create

very unpleasant side effects after alcohol consumption.

- **Methadone** is a man-made substance that is used to treat opiate addiction. It acts as a pain inhibitor and lessens the effect of withdrawal symptoms.
- **Psychoactive substances** are drugs or other substances that produce mood changes and distorted perceptions.
- **Psychotherapeutic** refers to a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also referred to as therapy and therapeutic counseling.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions based on a plan called the Twelve Steps.

Description

Substance abuse treatment is the process of assisting individuals addicted to drugs and/or alcohol to decrease or cease substance abuse. Substance abuse is usually a chronic condition that requires more than one treatment or continuing treatment over a long period of time. The type of treatment used depends on the individual's characteristics and the types of substances used. Typically, medical and psychological therapies are used to treat drug addiction. A very effective type of psychotherapy is cognitive behavior therapy. Cognitive behavior therapy helps an individual to identify, modify, and replace maladaptive thoughts and behaviors. Medical treatment may consist of medication. Certain medications are used to treat specific addictions. For example, methadone can be used to treat opiate addiction and disulfiram can be used to treat alcohol addiction. Other types of treatment include group therapy, and Twelve-Step Programs. Groups can offer social support to individuals. Substance abuse treatment may involve therapy alone or therapy in conjunction with medication.

There are several goals of substance abuse treatment. First, it engages individuals in the treatment process. It also teaches coping skills, relapse prevention, and effective response strategies if and when relapse occurs. Treatment also helps individuals develop or enhance communication and interpersonal skills. If necessary, it also addresses co-occurring disorders such as anxiety or depression. If appropriate, it will also include medication. Finally, substance abuse treatment provides individuals assistance with legal, occupational, medical, and family issues. These problems may be addressed during treatment, or the individual may be referred to an outside source. Substance abuse treatment can consist of a combination of different therapy modalities (i.e., individual, group, family) and medications. Treatment success requires tailoring treatment interventions and services to each individual's unique needs. It is also important to consider cultural factors and the role they play in an individual's life.

Len Sperry, MD, PhD, and
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See also: Addiction; Cognitive Behavior Therapy; Group Counseling; Group Therapy; Twelve-Step Programs

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Substance-Induced Psychotic Disorders

Substance-induced psychotic disorder is a mental disorder characterized by hallucinations or delusions caused by the use of or withdrawal from substances like alcohol or cocaine. It is referred to as substance/medication-induced psychotic disorder in DSM-5.

Definitions

- **Antipsychotics** are prescription medications used to treat psychotic disorders, including schizophrenia, schizoaffective disorder, and psychotic depression.
- **Brief psychotic disorder** is a type of psychotic disorders characterized by a sudden onset, short duration, and the full return of functioning.
- **Delusions** are fixed false beliefs that persist despite contrary evidence.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations, delusions, and disordered thinking.
- **Schizophrenia** is a chronic psychotic disorder characterized by hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Description and Diagnosis

Substance-induced psychotic disorder is a psychotic disorder that results from the use of medications or substances. These substances include alcohol and various recreational drugs like cannabis, cocaine, amphetamines, inhalants, sedatives, or hallucinogens. Hallucinations and delusions are the result of intoxication with the substance or, less often, in withdrawal from it. Experienced clinicians consider this diagnosis when evaluating adolescents and young adults who abruptly present with psychotic symptoms, particularly when visual hallucinations are involved. Laboratory testing, particularly drug screens, are invaluable in making this diagnosis. This disorder shares some common features, namely hallucinations and delusions, with brief psychotic disorder, schizophrenia, and other psychotic disorders.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit prominent delusions and/or hallucinations that are the physiological effects of a medication, drug of abuse, or toxic substance. This disorder is differentiated from other psychotic disorders by considering its onset and course. When the history, physical examination, or laboratory findings suggest that the cause of hallucinations or delusions is substance related, this diagnosis is highly likely. These symptoms must develop during or soon after intoxication by or withdrawal from the substance, and the substance must be capable of producing these symptoms. It must be determined that the disorder is not better accounted for by a non-substance-induced psychotic disorder. Finally, this diagnosis cannot be given if symptoms occurred primarily during the course of a delirium. This disorder can be further specified. The designation "with onset during intoxication" is given when symptoms occur during the period of intoxication. Likewise, the designation "with onset during withdrawal" is used with the substance and the withdrawal symptoms occur during the period of withdrawal. Finally, severity can be rated on a five-point scale ranging from 0 (no present) to 5 (present and severe) (American Psychiatric Association, 2013).

Treatment

The goal of treatment is the reduction and elimination of psychotic symptoms (hallucinations). If the disorder resulted from the effects of alcohol or a recreational drug, the focus of treatment is on relieving the intoxicated condition under careful medical supervision to control withdrawal symptoms. If the disorder resulted from the effects of a medication, the focus of treatment is reduction of the dose and withdrawal of the medication under close medical supervision. Antipsychotic medication may be used to quickly control psychotic symptoms. Usually, treatment takes place in an

inpatient medical or psychiatric setting to ensure the individual's safety and to provide life supportive measures. If the treatment is not successful, it may indicate that the diagnosis is actually brief psychotic disorder.

Len Sperry, MD, PhD

See also: Brief Psychotic Disorder; Psychosis

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Substance/Medication-Induced Anxiety Disorder

Substance/medication-induced anxiety disorder is a mental disorder characterized by panic or anxiety as the result of a substance, medication, or toxin.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Anxiety disorders** are a group of mental disorders characterized by anxiety which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, generalized anxiety disorder, and substance/medication-induced anxiety disorder.
- **Delirium** is a thought disturbance caused by a substance or medical condition.
- **Detoxification** is a process of purging the body of the toxic effects of a drug or substance. During this process the symptoms of withdrawal are also treated. Also called detox, it is the first step in a drug treatment program.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Intoxication** is a response to taking a substance. It involves changes in mental and physical functioning.
- **Panic attack** is an episode of sudden, intense, and debilitating sense of fear that is short lived.
- **Pharmacokinetics** is the body's reaction to a drug or substance.
- **Psychoactive** is a drug or substance that has a significant effect on mental processes. There are five groups of psychoactive drugs: opioids, stimulants, depressants, hallucinogens, and cannabis.
- **Withdrawal** is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of certain drugs after prolonged regular use.

Description and Diagnosis

Substance/medication-induced anxiety disorder is one of the DSM-5 anxiety disorders. It is characterized by panic attacks or anxiety as the result of using a psychoactive substance or being exposed to a toxin. Individuals develop symptoms soon after use or exposure to the substance (intoxication) or as it begins to leave the body (withdrawal and detoxification). Examples of substances that can produce these symptoms include stimulants like cocaine and caffeine. Individuals withdrawing from substances such as alcohol or opiates may also experience panic or anxiety. Some medications can also produce these symptoms. These include bronchodilators used to treat asthma and antihistamines used to treat allergies. Toxins such as insecticide and gasoline may also produce panic or anxiety symptoms.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder only if they have significant feelings of panic or anxiety. These feelings must arise during or soon after intoxication or withdrawal from the

substance or exposure to a toxin. The substance must also be capable of producing such symptoms based on its pharmacokinetics (the body's reaction to a drug). Individuals who have some other anxiety disorder, such as generalized anxiety disorder, do not qualify for this diagnosis. Symptoms must not be related to delirium, which is another response to a substance. In addition, the disorder must cause significant distress or disrupt daily life (American Psychiatric Association, 2013).

The cause of this disorder is the substance, medication, or toxin itself. Once individuals are no longer in contact with and detoxified of the substance, then symptoms decrease and eventually stop. There are no reliable statistics regarding how often substance/medication-induced anxiety disorder occurs in the population. It is believed to be rare and is more common in individuals who have other mental disorders (American Psychiatric Association, 2013).

Treatment

Treatment for this disorder depends on the specific types of substances used and symptoms experienced. It involves discontinuing use of or exposure to the substance responsible for the symptoms. Treatment may include antianxiety medications or behavior therapy, which are commonly used in treating other anxiety disorders. Since substances can remain in the body for extended periods of time, symptoms may continue even after use of the substance has stopped. This may last hours, days, or weeks. Substance/medication-induced anxiety disorder may be prevented by using substances in moderation or abstaining from them altogether.

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See also: Antianxiety Medications; Anxiety; Anxiety Disorders; Delirium; Detoxification; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Intoxication; Panic Attack; Psychoactive; Psychopharmacology; Withdrawal

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Substance/Medication-Induced Depressive Disorder

Substance/medication-induced depressive disorder is a mental illness characterized by a depressed mood that results from the use of a substance or medication.

Definitions

- **Antidepressants** are prescription medications that are primarily used to treat depression and depressive disorders. They are also known as antidepressant medications.
- **Depressive disorders** are a category of mental illness that is characterized by depressed or lowered mood.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Mood** is an individual's subjective emotional experience and expression.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Substance** refers to chemical compounds that influence bodily processes. Typically this refers to alcohol and other drugs.
- **Substance-related and addictive disorders** is a group of DSM-5 mental disorders that are characterized by the problematic use of substances.
- **Twelve-Step Programs** are support groups that follow specific steps to help alcoholic and addicts stay sober. Such groups include Alcoholics Anonymous and Narcotics Anonymous.

Description and Diagnosis

Substance/medication-induced depressive disorder is one of the groups of DSM-5 depressive disorders. It is characterized by a depressed mood or decreased pleasure as a result of the use of a substance or a medication. It can also include symptoms similar to the other depressive disorders, such as a sense of hopelessness, fatigue, or listlessness. This disorder is relatively rare, occurring in less than 0.26% of the U.S. population (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they must experience a depressed mood or decreased pleasure as a result of substance or medication use. In addition, the individual must experience a significant distress related to the professional life, social relationships, or other important aspect of his or her life as a direct result of his or her symptoms. A key differentiator of this disorder and one of the substance-related and addictive disorders is that the depressed or lowered mood is the most significant symptom. The diagnosis cannot be given if the individual is only mildly depressed but has other symptoms that are more severe. Moreover, the individual is not considered to have this disorder if he or she is depressed independent of substance or medication use. As with the other depressive disorders, it is critical that a clinician assess the individual for suicide risk (American Psychiatric Association, 2013).

Unlike many mental disorders, the cause of substance/medication-induced depressive disorder is known. It is either a substance (alcohol or an illicit drug) or a prescription medication. Some of the medications known to cause this disorder include medication for smoking cessation, cancer, and oral contraceptives and antidepressants.

Treatment

Because this disorder is caused by a substance or medication, the initial goal of treatment is to remove the substance or medication—if present—and to reduce its effects. Usually treatment initially takes place in a hospital or clinic. This disorder is often treated similar to a substance-related and addictive disorders. This typically includes psychotherapy, group therapy, Twelve-Step Programs, and the use of drugs that reduce withdrawal symptoms. The symptoms of this disorder typically resolve as the effects of the medication or substance wear off. In the event that the depressive symptoms do not subside, an alternative diagnosis should be considered.

Jeremy Connelly, MEd, and
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See also: Antidepressants; Depressive Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Major Depressive Disorder; Mood; Psychotherapy

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Substance-Related and Addictive Disorders

Substance-related and addictive disorders are a group of mental disorders characterized by the problematic use of substances or addictive behaviors.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.
- **American Society of Addiction Medicine** is an organization of physicians whose purpose is to improve the care and treatment of individuals with addictions and to advance

the practice of addiction medicine. It is also referred to as ASAM.

- **Brain reward system** refers to brain circuits (pathways) that cause feelings of pleasure when activated (turned on) by something enjoyable (drugs, food, etc.). It reinforces addictive behaviors and explains the attraction of addictions over normal activities.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **DSM-5** is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is the handbook mental health professionals use to diagnose mental disorders.
- **Motivational interviewing** is a counseling strategy for helping individuals to discover and resolve their ambivalence (uncertainty) to change. It is also referred to as MI.
- **Process addiction** is a term to describe non-substance-related disorders that are compulsive behaviors that have similar consequences to substance use disorders such as sex addiction, spending addiction, and gambling.
- **Psychological dependence** refers to reliance on an addictive substance for the effect it provides. It eventually leads to physiological (physical) dependence on the substance.
- **Tolerance** is the phenomenon in which the body requires increased amounts of the substance to achieve the desired effect.
- **Withdrawal** is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of certain drugs after prolonged regular use.

Description

Substance-related and addictive disorders are a group of DSM-5 mental disorders that activate the brain reward system. They are characterized by psychological dependence, drug seeking, tolerance, and withdrawal. This group includes alcohol use disorder; cannabis use disorder; opioid use disorder; sedative, hypnotic, or anxiolytic use disorder; stimulant use disorder; and gambling disorder. Non-substance-related disorders, such as gambling and Internet addiction, are called process addictions. The occurrence of these disorders differs greatly. For example, alcohol use disorder occurs in 4.6% of adolescents and 8.5% of adults. On the other hand, cannabis use disorder occurs in 3.4% of adolescents and 1.5% in adults (American Psychiatric Association, 2013).

These disorders have various conceptualizations regarding the cause and treatment of each substance use disorder. The biological perspective holds that addictions are a "brain disease" that has a genetic influence, while the psychological perspective views the cause of addiction to be a form of self-medicating other psychological conditions such as anxiety. Personality traits and issues such as self-esteem and self-worth are also psychological factors that predispose an individual to addiction. Social factors include easy availability of substances, stress, and hopelessness.

Treatment

Treatment methods vary among these disorders. However, generally, motivational interviewing and cognitive behavior therapy are commonly used in many of the substance-related and addictive disorders.

Len Sperry, MD, PhD, and Jon Sperry, PhD

See also: Addiction; Alcohol Use Disorder; Cannabis Use Disorder; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Stimulant Use Disorder

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Suicide

Suicide is defined as the intentional or unintentional act of taking one's own life, of killing oneself.

Definitions

- **Euthanasia,** also known as "assisted suicide," refers to the practice of aiding another person in intentionally ending his or her own life in order to end pain and suffering.
- **Intentional suicide** occurs when an individual purposefully commits the act of killing himself or herself through the use of deadly weapons or behaviors.
- **Involuntary hospitalization** may be necessary for persons at imminent risk of harming themselves or others, referring to the reprimanding of persons into a hospital for psychiatric care without their consent.
- **Suicidal ideation** is the clinical term used to describe when an individual has preoccupied or persistent thoughts about suicide.
- **Suicide risk assessment** is an in-depth, thorough review of history, present situation, and future probability, which is conducted by a trained clinician to determine an individual's potential risk, plan, intent, and means for suicide.
- **Unintentional suicide** occurs when an individual feigns suicide but ends up killing himself or herself unintentionally.
- **Voluntary hospitalization** occurs when a person willingly agrees to enter a hospital for psychiatric care in order to ensure his or her own safety and the safety of others.

Description

"Suicide" refers to when an individual ends his or her own life, either intentionally or unintentionally. The term derives from the Latin word *suicidium*, from *sui caedere*, meaning "to kill oneself." Intentional suicide results when one uses deadly weapons (guns, knives, ropes, substances) or engages in lethal behaviors (jumping off a building/bridge, walking into oncoming traffic, drowning) in order to kill oneself. Unintentional suicide results when a person accidentally takes his or her own life but didn't intend to. Though the final decision to commit suicide lies with the individual alone, those surrounding victims can assist by noticing warning signs. Several risk factors are frequently cited as common characteristics of those who end up killing themselves, including having a mental health disorder(s), making previous suicide attempts, having a family history or of attempted or completed suicide, and suffering with a serious medical condition and/or chronic pain. If an individual experiences one or more of these at the same time, his or her suicide risk is even higher. Major depression has been closely linked with tendency toward suicidal behaviors. Suffering from schizophrenia, bipolar, anxiety, and substance abuse disorders also places a person at greater risk. However, simply being diagnosed with one or more of these disorders does not mean one will engage in suicide, particularly if one is seeking proper medical treatment and under the close supervision of a doctor. In addition to these commonly cited risk factors, additional forces at play in the environment may place an individual at greater risk for suicide. For example, stressful life events including job loss, financial pressures, the death of a loved one, trouble with the law, serious relationship conflict, bullying/harassment, and exposure to someone else who has taken his or her own life can increase one's susceptibility. These external factors may lead to anxiety, stress, extreme sadness, loneliness, hopelessness, and depression, which can contribute to suicidal ideation.

In addition to being under the care of an effective mental health professional, there are other protective factors, which assist in deterring suicide. Social and emotional support from loved ones is a key force in resiliency. Having a spiritual or religious connection

serves as another protective factor. Those with the ability to problem-solve and effectively navigate through life's pitfalls are also more likely to resist suicidal thoughts and behaviors.

Suicide statistics indicate that about 20% of people who die by suicide have a history of suicide attempts. Gender also plays a role in successful completions. While females are more likely to attempt suicide, they typically engage in less lethal means than males who are more likely to use deadly weapons and more drastic approaches. Persons at acute risk for suicide often display a host of behaviors that serve as warning signs. Talking about wanting to kill oneself or wishing one was dead should be taken seriously. Statistics indicate that the majority of people who attempt or commit suicide tell someone about their intentions. Having a suicide plan and means to carry out that plan is a glaring sign. Struggling with intense feelings of anxiety, sadness, anger, embarrassment, or hopelessness should be addressed. If an individual begins to pull away from others and social situations, or isolates himself or herself, this is a warning sign. Loss of interest in regularly engaged activities is also a warning sign. These signals should be noticed and addressed at once in order to prevent tragedy. Training professionals, educators, and laypeople in noticing warning signs and seeking out help for the struggling person is critical in reducing incidents.

Development

Beliefs about suicide have evolved throughout history. In ancient times, suicide was viewed as permissible and justified in cases where an individual was ordered by the state to commit the act for an indiscretion or crime, was suffering from a painful or incurable illness, or was compelled to because he or she was experiencing some intolerable misfortune in life. Greek philosopher Socrates was one of the first to publicly oppose suicide, stating that human beings had no right to take their own lives, as they were property of the gods. The Jewish and Christian religions contain examples of martyrs who were highly regarded for taking their own lives rather than being persecuted for their religious beliefs. It was not until the fourth century AD that the Church, persuaded by arguments made by St. Augustine, denounced suicide. Thomas Aquinas went onto support this position in the 13th century, concluding that it was an act against God. Those who committed suicide in the Middle Ages were subject to shaming, ridicule, and punishment. The Renaissance and Reformation periods evidenced more understanding views, particularly in situations where individuals were experiencing overwhelming pain or suffering. This trend continued into the next several centuries as the fields of sociology and psychology grew. French sociologist David Émile Durkheim's work did much to improve society's sensitivity toward suicide. In the 1897 book *Le Suicide*, he wrote about how societal and environmental stressors can contribute significantly to the problem. Psychologists Sigmund Freud, Alfred Adler, and Carl Jung approached the issue from a different lens, each offering views on the internal and external contributors to mental health and wellness. In 1938, American psychologist Karl Menninger published *Man against Himself*, tackling the delicate topic of suicide from a mental health perspective. As the shift regarding interest and compassion toward suicide victims and their families increased, laws and policies began to change as well. Suicide was no longer regarded a criminal act, though assisted suicide has remained under much debate. The establishment of task forces, online resource networks, nonprofit agencies, and support groups has continued.

Current Status and Results

Research on suicide has compared the brains of suicide victims to those of "normal" people. Findings indicate that there are key differences in specific cells called astrocytes contained within the brain's white matter. As suicide has been strongly linked to depression, scientists have noted that those with a history of depression have larger and more branched networks of astrocytes than those with no history of mental illness. Further studies have linked suicidal behavior with abnormalities in serotonin receptor subtypes located in the prefrontal cortex, hippocampus, and choroid plexus. Twin studies have also confirmed these neurological distinctions. Additional studies have associated suicidal behavior with traumatic life events, including sexual abuse and bullying.

Each year approximately 39,000 people commit suicide in the United States alone and about 1 million adults report making a suicide attempt. A recent report from the World Health Organization indicates that suicide is a global health problem. It is the 10th leading cause of death for Americans overall and the second leading cause of death among adolescents and young adults aged 15 to 29. Prevention efforts have focused on increasing understanding and education surrounding the causes and consequences of suicide and also on promoting support and intervention to those demonstrating warning signs, suicidal thoughts, or attempts. Evidence-based prevention programs that work to enhance protective factors and resilience have proven successful.

Melissa A. Mariani, PhD

See also: Depression and Depressive Disorders; Depression in Youth; Suicide Assessment; Suicide in Youth

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Suicide Assessment

Suicide assessment involves the process in which a qualified professional evaluates and determines a patient's level of risk for suicide through the use of screening tools, questionnaires, observation forms, checklists, and review health and medical history.

Definitions

- **Suicidal ideation** is the clinical term used to describe when an individual has preoccupied or persistent thoughts about suicide.
- **Suicide** is the intentional or unintentional act of taking one's own life.
- **Suicide contract,** also called a *suicide prevention contract* or *no-suicide contract*, is a written agreement initiated by a practitioner or health-care provider caring for a patient at risk of suicide that states that he or she will not commit suicide.
- **Suicide risk assessment** is an in-depth, thorough review of history, present situation, and future probability, which is conducted by a trained clinician to determine an individual's potential risk, plan, intent, and means for suicide.

Description

Assessing an individual's risk and taking the proper steps to provide intervention, treatment, and support is critical in reducing suicide incidence rates. Suicide assessment, also referred to as suicide risk assessment, is a complex process that involves the use of screening tools, observation forms, checklists, and questionnaires designed to gauge an individual's likelihood of suicidal behavior in the near future. Assessments such as these are conducted by properly qualified practitioners, usually mental health-care providers. Research has identified certain predictors strongly associated with suicide risk: demographics, existence of psychiatric and/or medical illness, and significant life stressors. In addition to these key areas, a comprehensive suicide assessment also examines prior suicide attempts, plan and means, presenting symptomatology, and protective factors. Acute (recent changes in circumstances and mental state) and chronic (diagnosed mental illness, social and demographic factors) patient risk are assessed on a continuum ranging from nonexistent to extreme. Several warning signs of suicidality exist: threatening to hurt/kill oneself, seeking out means to kill oneself, and talking, writing about death, dying, or suicide; displaying feelings of anger, despair, revenge, and/or hopelessness; engaging in risky behaviors; withdrawing from friends and family; excessive sleeping; and drastic mood swings. The more detailed and specified an individual's suicide

plan, the more likely he or she is to carry it out. The existence of a suicide note also increases one's probability. After assessing patients in threat of suicide, practitioners may recommend voluntary/involuntary hospitalization or outpatient treatment consisting of medication, behavioral intervention, and/or counseling support.

Development (Purpose and History)

Though informal means for gauging suicidality have existed for centuries, more formal tools were developed in the later part of the 20th century. Psychiatrist Aaron T. Beck released the Suicide Intent Scale in 1974, a questionnaire designed to measure aspects related to suicidal attempts and intent. In 1979, Beck went on to create the Scale for Suicide Ideation (SSI) with colleagues Maria Kovacs and Arlene Weissman, to assist practitioners in determining the intensity of suicidal thoughts in patients. A popular self-report measure, the Suicidal Behaviors Questionnaire (SBQ), was then published in 1981 by psychologist Marsha M. Linehan. The SSI and SBQ are often used in conjunction. Subsequent instruments were later developed, including the Reasons for Living Inventory (RFL) in 1983, also developed by Linehan and the Life Orientation Inventory by Kowalchuk and King in 1992. Other valid and reliable instruments recommended by researchers to determine suicidal risk are the Manchester Self-Harm Rule, the Re-ACT Self-Harm Rule, the Risk Assessment Matrix, and the Violence and Suicide Assessment Form. Brief assessments are also available through the American Counseling Association, the Substance Abuse and Mental Health Services Administration, the American School Counselor Association, and the National Institute of Mental Health.

Current Status and Results

Research on suicide assessment indicates that some practitioners refrain from using formal suicide-specific risk assessments, but rather rely on the information obtained during clinical interviews. Graduate programs should incorporate coursework, training, and practice in administering these assessments in order to increase practitioner exposure and confidence. Suicidality, though, is not definitive and can be prevented if addressed effectively. Therefore, suicide risk should be reevaluated and monitored on a continual basis until potential self-harm is no longer imminent.

Melissa A. Mariani, PhD

See also: Suicide; Suicide in Youth

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Suicide in Youth

Suicide in youth, or youth suicide, is described as when a young person, between the ages of 10 and 24, engages in dangerous, lethal behaviors with the intent to end his or her own life.

Definitions

- **Suicide contagion,** also known as copycat suicide, refers to the phenomenon that occurs when, in the absence of protective factors, an individual chooses to kill himself or herself after being influenced by a prior person's suicide.
- **Youth suicide** is a term used to define adolescents or young adults, aged 10 to 24, who commit suicide.

Description

Suicide in youth is a serious public health concern, particularly in Western cultures. The term "youth suicide" focuses on the impact of this problem in young people aged 10 to 24. The Centers for Disease Control and the National Mental Health Association report that youth suicide rates have increased markedly over the past decade, resulting in thousands of deaths per year. Suicide

is the third leading cause of death for adolescents and the second leading cause of death for college students. Results from a national study of high school students from both public and private settings found that nearly 20% of youth have seriously considered suicide. Suicide contagion, or copycat suicide, is described as when a person kills himself or herself after experiencing the suicide of prior person. Unfortunately, this phenomenon is evident among youth suicide cases. As with adult suicide, youth suicide has been significantly associated with the presence of certain mental illnesses or psychological disorders; depression, substance abuse, and aggressive or disruptive disorders are the most prevalent. In addition to these risk factors, certain external events can contribute to youth suicide, including the loss of a loved one, trauma, bullying, poor grades, a breakup, arguing with parents, familial discord, separation, or divorce.

Demographic indicators suggest that while young females are more likely to attempt suicide, young males are more likely to succeed in their attempts, as they employ more lethal means. Youth who commit suicide most often do so through the use of firearms (approximately 45%), suffocation (approximately 40%), or poisoning (approximately 8%). Studies report that suicide rates are high among LGBTQ youth. Cultural differences also exist, with statistics indicating that Native American/Alaskan Native youth have the highest rates of suicide-related fatalities. Rates among Hispanic/Latino youngsters are also higher than their non-Hispanic peers.

Impact (Psychological Influence)

Though suicide among young people is prevalent, it is preventable. Research suggests that certain factors can serve as protective barriers to suicidal behavior in youth. Those with social support networks (family and friends), cultural/spiritual/religious/school connections, and access to effective medical and mental health resources fare better. In addition, youth who possess good communication skills, adaptive coping and problem-solving skills, positive self-esteem, and a general sense of life satisfaction are more resilient. Intervention should begin at an early age and consist of both prevention and postvention efforts. Creating school communities that are positive, caring, supportive, and safe is critical as is proper training for faculty and staff. Most districts now mandate that youth suicide be addressed in schools, requiring that educators become knowledgeable as to the risk factors, warning signs, and procedures to follow. Having a crisis response team/plan in place can alleviate stress and anxiety if and when a suicide occurs. Students and their parents should also receive information and be provided with resources to access if they or a loved one needs help. Seeking proper medical and mental health care in a timely manner is key. A trained professional can then conduct a thorough suicide risk assessment and outlay a treatment plan for the family. Ongoing services may consist of medication, individual counseling, support groups, family intervention, and school adjustments.

Melissa A. Mariani, PhD

See also: Cutting; Suicide; Suicide Assessment

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Support Groups

Support groups are a type of therapy group that provides emotional support and self-help to those willing to confront, discuss, and learn how to better cope with similar issues.

Definition

- **Support** means to help bear the weight of something such as the burden of disease or loss.

Description

Support groups are diverse. Some are self-help groups run by nonprofessionals, which are aimed at supporting behavioral change. One famous and highly attended example of this is Alcoholics Anonymous. In other support groups there is a gathering of people who come together for the purpose of giving emotional support and helping people cope in the face of common problems. One example of this is bereavement support groups, who help people deal with the loss of a loved one. A designated leader or professional therapist may facilitate these groups, but a licensed professional is not required. Psychotherapy support groups are the most intense since they usually focus on more complex interventions to help people learn about and cope with ongoing mental and physical health challenges. This last class of support group is almost always facilitated by a professional counselor and linked to a social service agency of some kind. One example of this kind of group is victims of domestic violence or people dealing with depression.

The great advantage of support groups is that the diversity of experience and background of the people involved provide the chance for a broad application of experiential knowledge to whatever problem the group is formed around. In other words, it is not just providing a shared chance to complain; it can help in real problem solving based on the accumulated wisdom of the group. Since they are so focused, membership in support groups is almost always restricted to those affected by a specific situation or problem.

Development

There are scattered examples of support groups historically. Jacob Moreno is considered the founder of group counseling. He discovered its importance when he facilitated a group of former prostitutes who were trying to reform themselves in Vienna before World War I. But the most famous self-help support group in history is Alcoholics Anonymous (AA), which started in the 1930s as a way for those struggling with alcohol dependency to get and stay sober. There has been a proliferation of groups modeled on AA, which have expanded to include groups for people with addictions to gambling, overeating, or other process addictions.

Within the field of psychology, the German American psychologist Kurt Lewin is responsible for much of the interest in and development of group work. He specifically had a concentration on group dynamics out of which grew training groups or sensitivity training groups. Lewin believed that groups were much more powerful than individual counseling due to the insight and support provided by others in the group. By the 1960s group work in therapy had become very popular throughout the United States.

During the 1960s and by the 1970s support groups were sometimes called encounter groups. In these groups psychological and personal issues could be discussed within a safe environment. The support group world has continued to grow exponentially with many reports that participation has led to good health outcomes for members, both in terms of physical and mental health.

Current Status

Support groups are common in the United States. Today there are many hospital and social service agency-based support groups for a wide variety of issues, topics, problems, diseases, and interests. Support groups for the mentally ill and for their family members have proven to be very helpful in providing education, information, and coping mechanisms.

In recommending support groups as a therapeutic tool, it is important that health-care professionals should encourage clients to seek out a support group where they can comfortably participate. Respect for personal boundaries, a skilled and experienced leader, and acceptance of differences between individuals' beliefs are some of the hallmarks of successful support groups. Online support groups have also become popular in recent years. Great caution should be taken in assessing the trustworthiness and seriousness of those participating in such groups before sharing private information.

Alexandra Cunningham, PhD

See also: Group Counseling; Group Therapy; Self-Help Groups

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Sybil (Book and Movie)

Sybil is a book and television movie that is best known for its controversial depiction of a patient suffering from multiple personality disorder, which is now known as dissociative identity disorder.

Description

Sybil is a 1973 best-selling book written by Flora Rheta Schreiber about the psychiatric treatment of Sybil Dorsett by her psychiatrist Cornelia Wilbur. The book was publicized as a true story about a woman suffering from multiple personalities. *Sybil* is also known for the 1976 television movie starring Joanne Woodward as the psychiatrist, and Sally Field who won an Emmy award for her portrayal of *Sybil*.

Sybil is the story of Sybil Dorsett, a young woman who seeks medical treatment for blackouts, disturbing memory image fragments, and memory lapses. She begins treatment with Dr. Cornelia Wilbur, who discovers that Sybil has suffered from her symptoms for many years. Dr. Wilbur tells Sybil she suffers from hysteria and begins treating her. After Sybil loses her job she becomes suicidal and calls Dr. Wilbur as "Vicky." Dr. Wilbur soon discovers that Vicky is just 1 of 16 personalities that will eventually be revealed during treatment. Both the book and movie chronicle Sybil's psychiatric treatment, the unveiling of Sybil's many personalities, and the traumatic and horrific childhood abuse she experienced that led to the splitting of Sybil's personality. The story closes as Sybil is able to merge and integrate the many personalities into a single whole individual.

Impact (Psychological Influence)

The book and movie led to a worldwide psychological phenomenon and fascination with multiple personality disorder (MPD). Prior to the book's release there was no official diagnosis of MPD. At the time, reported cases of MPD were quite rare, with less than a few hundred cases reported worldwide. Within a few years of the release of the book and movie, thousands of cases a year were being diagnosed. *Sybil* reportedly played a role in the diagnosis of MPD being included in the *Diagnostic and Statistical Manual of Mental Disorders III* in 1980.

Sybil also affected the psychotherapy profession. Use of hypnosis and regression therapy to reveal repressed and blocked memories became the psychological fad of the day. This eventually led to the phenomenon of false memories in which patients "recover" lost memories of terrible events in their lives but

Sybil is a 1973 book and 1976 television movie shown here with Joanne Woodward, left, as a therapist, and Sally Field, right, as Sybil, who is a patient suffering from multiple personality disorder, now known as dissociative identity disorder. In 2011, a biography of Shirley Mason (the real Sybil) suggested that Mason did not have "multiple personalities," and that the doctor was using unethical treatments on the patient. (NBC/Photofest)

in actuality are false memories rooted in the method of therapy used by the treating psychotherapist.

Shirley Mason is the name of the woman portrayed as Sybil Dorsett in the book and movie. Mason did receive treatment from Dr. Cornelia Wilbur, but considerable controversy surrounds Wilbur's diagnosis, methods, and motivations. The truth of Mason's condition and appropriateness of her treatment by Wilbur are also controversial. In 2011, journalist and writer Debbie Nathan published *Sybil Exposed*, detailing evidence of lies, fabrications, and significantly unethical treatment of Mason by Wilbur. According to Nathan, Wilbur was providing as much as 18 hours of therapy a week to Mason, was using shock therapy, and injecting Mason with Pentothal, a barbiturate commonly referred to as "truth serum."

Steven R. Vensel, PhD

See also: Dissociative Identity Disorder; *Three Faces of Eve, The* (Movie)

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Systematic Desensitization

Systematic desensitization is a form of behavior therapy and exposure therapy that gradually exposes a client to his or her phobia while teaching him or her to stay relaxed in the increasing presence of his or her phobia. It is also known as graduated exposure therapy.

Definitions

- **Behavioral psychology** is a form of psychology whose aim is to study behavioral adaptation to an environment and its stimuli.
- **Classical conditioning** is an involuntary process of neurological change in response to a stimulus that causes a reaction. Classical conditioning occurs when the involuntary reaction is associated (paired) to a new unrelated stimulus causing the reaction to occur automatically when the new stimulus is present. It is also known as Pavlovian conditioning.
- **Environmental mastery** is the ability to competently manage everyday affairs of living by making effective use of resources and opportunities while controlling external activities.
- **Evidence-based practice** is a form of practice that is based on integration of the best research evidence with clinical experience and client values.
- **Exposure therapy** is a therapeutic technique that encourages a client to confront a fear and refrain from reacting in his or her typical manner. It is also known as flooding.
- **In vivo** is a Latin term that means "in the living" and signifies therapeutically that an intervention is occurring in real life, as opposed to in an imagination or in a theory.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Practice** is a method or process used to accomplish a goal or objective.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Reciprocal inhibition** is a therapeutic technique that obstructs the presence of one response through the introduction of an opposite response.
- **Relaxation training** is a progressive tensing and relaxing of specific muscle groups to teach acceptance and letting go of anxious symptoms.

Description

Systematic desensitization is a form of behavioral psychology that aims to create behavioral modification in clients suffering from phobic avoidance or other unwanted behaviors. Systematic desensitization aims to alter the involuntary response to a classically conditioned stimulus. It attempts to replace the fear response to a particular stimulus with a relaxation response to the same stimulus.

Systematic desensitization is similar to but different from exposure therapy. Both Exposure therapy and systematic desensitization are therapeutic techniques that focus on the extinction (removal) of a conditioned response. Exposure therapy (flooding) usually occurs in vivo. Sometimes it is impossible or impractical to expose a client to his or her feared stimulus in vivo, and in such cases imaginal exposure therapy is prescribed. Imaginal flooding requires the client to envision his or her phobia and refrain from becoming distressed. There is no subtlety to flooding. It is an all or nothing exposure to a phobia that teaches a client to tolerate the exposure. Therapists must be trained to assist the client through the distress that may result from exposure to a phobic stimulus. In contrast, systematic desensitization trains a client to tolerate progressive exposure to a phobia. In systematic desensitization a client is taught to stay relaxed when exposed to his or her phobia in increasing amounts. The gradual nature of systematic desensitization makes it a unique behavioral intervention.

Development and Current Status

Systematic desensitization was introduced by psychologist Joseph Wolpe (1915–1997) in the 1950s. It was a very common form of therapeutic intervention in the 1960s and 1970s. Wolpe coined the term "reciprocal inhibition" to describe the process of classically conditioning an opposite response to replace an automatic reaction to a stimulus. It was believed that a reaction and its opposite reaction could not exist simultaneously in a client. Systematic desensitization is fundamentally associated with reciprocal inhibition.

In systematic desensitization a client is instructed to rank all of his or her related fears on a scale of 1 to 100. Typically, the therapist ensures that there is no more than 10-point increments between identified fears. The fears are arranged in order of the amount of fear that the client experiences. After the fear hierarchy is created the client is trained in relaxation. Relaxation training, typically in the form of progressive muscle relaxation, is taught to clients so that they might utilize it in the presence of a feared stimulus. When the client has become proficient in relaxation training, the client is gradually exposed to his or her fears. This exposure can be imaginary or in vivo. During this exposure it is necessary for the client to remain as relaxed as possible. As distress returns, the stimulus is removed. This procedure is repeated until relaxation can be maintained for a sufficient amount of time prior to exposure to a more feared stimulus. Progressively a client learns to maintain relaxation in the presence of increasingly feared stimulus. Gradual repetition is essential to effective systematic desensitization.

The clinician works closely with the client to ensure that the client experiences no more than minimal fear during the entire systematic desensitization process. This is a critical aspect of the intervention as the conditioned response of fear must be replaced with relaxation. Research indicates that the process of successful systematic desensitization occurs within 10 to 30 therapeutic sessions.

Layven Reguero, MEd, and Len Sperry, MD, PhD

See also: Positive Psychology; Exposure Therapy; Evidence-Based Practice; Empirically Supported Treatments

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Systems Biology

Systems biology is a new approach to the study of biology that seeks to understand how biological systems function.

Definitions

- **Biological system** is a group of cells, genes, and processes that work together to perform a specific task or function.
- **Genomic research** is the scientific study of the genes of an organism or a cell.
- **Metabolomics** is the scientific study of the chemical molecules of a cell, organ, tissue, or whole organism.
- **Proteome analysis** is the research of every protein found in a cell, organ, tissue, or whole organism at a particular point in time.
- **Proteomics** is the scientific study of proteomes. A proteome is every protein found in an organism.
- **Transcriptomics** is the scientific study of all the RNA molecules in a particular cell or group of cells.

Description

Systems biology is the integrative (putting together) approach to the study of biology. This is in contrast to the reductionistic (taking apart) approach of traditional biology. Systems biology facilitates the understanding of the larger system that biological subsystems are a part of. In systems biology the "sum of the parts is greater than the whole." Scientists strive to understand how the various subsystems combine to create the entire system, more specifically, how the different parts of a biological system interact and behave. Researchers collect data, process, and analyze it. Research analysis includes mathematical models, statistical tools, simulations, flow charts, and information processing. These computational techniques assist researchers in understanding complicated cellular and molecular processes.

Systems biology has been used to better understand the biochemical processes of the immune system and how it responds to infection and vaccination. Other uses include proteome analysis, genomic research, and cancer research. Systems biology utilizes different techniques such as transcriptomics, metabolomics, and proteomics to gather measurable data. The data is then used to construct and confirm mathematical models. Systems biology incorporates the use of computer science, statistics, and informatics. Specifically, it involves new ways to compute models, mine and combins data from empirical research literature, creates online databases for sharing information, and develops systematic methods for genomic data analysis.

The term "systems biology" was originally used by Mihajlo Mesarovic (1928–) in 1966 during an international conference entitled "Systems Theory and Biology." Mesarovic, a scientist and professor, is the forerunner of systems theory. Ludwig von Bertalanffy (1901–1972), a general systems theorist, made significant contributions toward systems biology before it was considered a field of its own. Alan Lloyd Hodgkin (1914–1998) and Andrew Fielding Huxley (1917–2012), both biologists, also made key contributions that set the stage for systems biology.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Quantitative Research

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Tarasoff Decision

Informally, the *Tarasoff* decision refers to the result of the 1974 (reheard in 1976) landmark case of *Tarasoff v. The Regents of the University of California*, in which the Court ruled that it was a therapist's duty to warn potential victims of foreseeable danger arising from his or her patient's mental state.

Definitions

- **Confidentiality** defines the keeping private of information that is disclosed by a patient, client, or other protected party within the context of a safe, trusting relationship.
- **Duty to protect** refers to the responsibility of mental health professionals to protect their patients and other potential victims from foreseeable harm, established from the Tarasoff II decision of 1976.
- **Duty to warn** refers to the obligation of mental health professionals to warn third parties of potential harm if their client is deemed a threat to himself or herself or others that was established in the Tarasoff I decision of 1974.
- **Privileged communication** is the legal protection of any written or verbal correspondence that occurs within a confidential relationship.

Description

The Tarasoff decision refers to the landmark case of *Tarasoff v. The Regents of the University of California* that set the legal precedent of duty to warn and duty to protect for mental health professionals. In 1968, Tatiana Tarasoff and Prosenjit Poddar met at a dance and briefly dated while students at the University of California at Berkeley. Tarasoff was an undergraduate student and Poddar, who grew up in an elite caste in Bengal, India, was a graduate student in Naval Architecture. Poddar, unaccustomed to American dating customs, believed the relationship to be much more serious than Tatiana did. When Poddar discovered that Tatiana was romantically involved with other men, he became jealous and enraged, began stalking Tatiana, and telling friends and coworkers of his desire to kill her. He was urged to seek counseling and in 1969 became a patient of Dr. Lawrence Moore, a psychologist at UC Berkeley's Cowell Memorial Hospital, to whom he again relayed wanting to kill Tatiana, though he did not use her name as she was easily identifiable. Moore, believing Poddar was suffering from paranoid schizophrenia, notified police and recommended that his patient be civilly committed as he was a danger to others. Poddar was detained for a short period but then released. Dr. Harvey Powelson, Moore's supervisor, soon after ordered that Poddar not be subject to any further detainments. Neither Tatiana nor her parents ever received warning of the threat. While Tatiana traveled to visit an aunt in Brazil, Poddar befriended and moved in with her brother, though he also knew nothing of his intent. When she returned to school, Poddar carried out his plan, stabbing and killing Tarasoff on October 27, 1969, then calling the police himself. The Tarasoffs proceeded to sue Dr. Moore and several other university employees for negligence. The case went to trial but was dismissed, citing no cause of action and supporting prior precedence that a doctor's duty was to his

or her patient and not a third party. An Appeal's Court also dismissed the case and the case was then taken to the California Supreme Court. In 1974, the Supreme Court reversed the appellate decision, establishing it was a mental health professional's responsibility to provide reasonable care to patients but that this could not come at the expense of the welfare of others, who had the right to be warned of any foreseeable harm. This is commonly referred to as the Tarasoff I decision. In 1976, the case was reheard whereby the precedent of duty to protect was established, or Tarasoff II. Tatiana's family was awarded monetary damages and Poddar was sentenced to five years for manslaughter, of which he served four before his conviction was overturned due to faulty jury instructions and he was ordered to return to India.

Current Status and Impact (Psychological Influence)

Since 1976, Tarasoff has been the subject of much debate and has received increasing attention over the past few decades due to cases of school and mass shootings. The Tarasoff decision is now upheld in nearly every U.S. state where there are laws that require or permit mental health professionals to break confidentiality if they are concerned about the safety of the patient or others. Though a special, confidential relationship exists between a patient and his doctor/therapist, this cannot outweigh the safety of others. A regularly cited statement by Justice Matthew Tobriner, "*The protective privilege ends where the public peril begins*," summarizes this precedent.

Melissa A. Mariani, PhD

See also: Privilege and Privileged Communication

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Tardive Dyskinesia

Tardive dyskinesia is a neurological disorder characterized by abnormal and involuntary bodily movements. It sometimes occurs after taking antipsychotic medications.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **Neurotransmitters** are chemicals in the brain that send messages between brain cells. There are many different types of neurotransmitters that regulate a variety of functions such as emotions and movement.
- **Psychosis** is a severe mental condition in which an individual loses touch with reality.
- **Psychotic disorder** is a severe mental condition in which an individual loses touch with reality. Symptoms can include hallucinations, delusions, and disordered thinking.
- **Schizophrenia** is a chronic mental disorder that affects behavior, thinking, and emotion, which make distinguishing between real and unreal experiences difficult.

Description

"Tardive dyskinesia" refers to abnormal bodily movements that result from taking antipsychotic medications

for a long period of time. Tardive means "late" and dyskinesia means "abnormal movements." It is not a mental disorder listed in the DSM-5 but rather a side effect of medication. Symptoms of tardive dyskinesia include involuntary movements of the face, such as frowning, blinking, mouth puckering, and clenching the jaw. Individuals may have involuntary twitching or tapping of the arms, legs, hands, or feet. Whole body movements like rocking or twisting can also occur. Some individuals may make grunting sounds or have difficulty speaking. This is due to involuntary movements of the diaphragm, the muscle that controls breathing and speech. Tardive dyskinesia progresses through stages and symptoms may be subtle at first. Subtypes of this disorder include tardive dystonia, which causes abnormal contractions of the neck and shoulders. Tardive akathisia is a general feeling of restlessness all of the time. A defining feature of tardive dyskinesia is the inability to stop these abnormal movements. This disorder is more common in the elderly. It affects between 16% and 43% of individuals taking antipsychotic medications.

Tardive dyskinesia is associated with long-term use of antipsychotic medications used to treat disorders such as schizophrenia. These medications block proteins in the brain that transmit signals from the neurotransmitter dopamine. One of dopamine's functions is coordinating movement of voluntary muscle groups. It is believed that nerves become overly sensitive to dopamine after a long period without it. This results in the abnormal and uncontrollable movements seen in tardive dyskinesia. There is no specific treatment for this disorder.

Because symptoms are caused by antipsychotic medications, discontinuing use of these medications leads to improvement. However, individuals with psychotic disorders have a high risk of psychosis returning if they do not take their medications. Tardive dyskinesia was very common in individuals taking "first-generation" antipsychotic medications. These are also known as neuroleptics. There are newer "second-generation" antipsychotic medications, which are known as "atypical" antipsychotics. These newer medications are believed to have a lower risk of tardive dyskinesia, though symptoms are still possible. Some individuals use "drug holidays" to control or prevent tardive dyskinesia. These are planned periods of time in which they do not take their medications before resuming use again. It is presently unclear whether or not drug holidays are effective. There is a better chance of eliminating symptoms of tardive dyskinesia the earlier they are identified. In most cases, they are not permanent and can be reversed.

George Stoupas, MS, and
Len Sperry, MD, PhD

See also: Antipsychotic Medications; Dopamine; Psychosis; Psychotic Disorder; Neurotransmitters; Schizophrenia

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Tattoo

Tattooing is a form of body modification in which permanent marks or designs are applied by inserting indelible pigments into the skin with a needle.

Description

The custom of permanently marking the body with pigments has been practiced across cultures for centuries as a normal and socially sanctioned custom. American attitudes have evolved over time, with tattoos, piercings, and other body modifications increasingly accepted as a way to mark a life experience, express identity, or collect as "body art." The number of Americans with a tattoo or body piercing is increasing, especially among college-age students, with genders equally represented. Recent studies indicate that 15%–25% of 15- to 25-year-olds have tattoos and 13% of the general population has a body piercing.

Formerly tattoos were associated with criminals, gang members, or members of the military who had gotten tattoos while on leave. Now, tattoos have become generally accepted. (Litwinphotography/Dreamstime.com)

American attitudes toward tattoos have vacillated between being regarded as fashionable and associated with deviance. In the 18th century tattooing was in vogue with the upper classes, but by the end of the 19th century criminologists began associating tattooing with criminal pathology and social attitudes began to change. With the invention of the electric tattoo machine, tattooing became more accessible, affordable, and popular among the less wealthy, and tattooing began to be associated with the lower-working classes and subcultures. By the beginning of the 20th century tattooing was closely associated with deviance, criminality, and socially undesirable behaviors. Having a tattoo was an indicator of low self-esteem, aggressiveness, impulsivity, sexual deviance, and psychopathology. Tattooing has also been closely associated with marginalized and stereotyped subculture groups, such as sailors, "savages," bikers, and motorcycle gang members, the incarcerated, and circus performers.

In response to the negative social connotations of tattooing, a vibrant subculture developed that provided support to the tattooed and began to redefine and change the negative social and intrapersonal connotations. In the 1960s public interest grew as the tattoo industry made advancements in technique, design, style, and sanitation standards. By the 1980s tattooist were redefining themselves as artist and more professionals and females were purchasing custom tattoos. By the 1990s tattooing was no longer singularly associated with social outcasts and was practiced by individuals from a wider range of socioeconomics, education, and occupations.

More recently, nationally representative research studies have been conducted, examining the social characteristics of those who are tattooed compared to non-tattooed, and the association to deviance. The research results have been mixed, with one study finding that having a tattoo was not associated with recreational

drug and alcohol use and another study finding a strong association. Younger respondents were more likely to have multiple tattoos than older respondents, and those with tattoos compared to non-tattooed individuals were more likely to have a body piercing and have a family member who was tattooed. People with tattoos, as a group, tend to be less educated and less religious than the non-tattooed. The research found that having a tattoo on the face, neck, hands, or fingers was associated with having spent three or more days incarcerated. This suggests that the area of the body which is tattooed can be stigmatizing and associated with deviance and criminality.

In spite of the positive change in attitudes toward tattoos, research suggests that the practice of tattooing continues to carry a stigma. Studies have indicated that in spite of evidence to the contrary teenagers with tattoos are often perceived as dropouts, drug users, and trouble makers, and medical professionals tend to attribute tattoos to gang affiliation. Ethnic and racial minorities are likely to be perceived as gang members and criminals by the non-tattooed. Others may easily misinterpret symbols that have a positive meaning for the tattooed, and tattooed individuals are frequently required to cover their body art by employers.

Tattooing is a form of body modification and is increasing in frequency especially among teenagers and college students, but also among adults of all ages. American attitudes are changing about the tattooed but continue to be stigmatizing. Tattooing and other body modifications are an increasingly popular form of self-expression, community, and social commentary.

Steven R. Vensel, PhD

See also: Body Piercing

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Teen Pop Stars

Teen pop stars are a select group of young celebrities who become famous for their participation in music, movies, television, the Internet, and more.

Description

Music is a kind of universal language that speaks to people's emotions. As a genre, pop music has an especially

Singer Britney Spears, a child performer on the Mickey Mouse Club, and later a teen pop star in the late 1990s and early 2000s, was criticized for overly sexualized dress and performances. She also went through a period of erratic behavior and stayed in various treatment centers. Because she and other pop stars exert an enormous influence on impressionable young fans through their language, style, attitudes, and habits, there is always concern about fans imitating the less desirable traits of celebrities. (S. Bukley/ Dreamstime.com)

strong connection with teenagers and preteens. The musicians who create and play pop music often become the focus of young people's interest, admiration, and even obsession. Many of these musicians cross entertainment genres to play roles in movies and television.

Teen pop music is defined by the age and interests of its fans. The term "pop" comes from the more traditional or popular music and first came about in the 1950s and 1960s when representing the new music of the baby boomers. It especially came to public notice with the worldwide success of the Beatles and other bands in the early 1960s.

The music itself can be of many genres, from rhythm and blues, to hip-hop, country and rock and roll. The content of the music focuses on subjects and issues of interest to teenagers. This includes first loves, sexual relationships, finding yourself, friendships, independence, and the role of authority figures. The approach to these subjects ranges from serious introspection and self-pity to comedic and light-hearted awareness of the irony and humor in life. This musical form often includes a catchy beat and a repeated soaring chorus.

The stars and musicians who perform these songs often begin as teenagers themselves like Elvis Presley, the Beatles, and Michael Jackson. Every year there seems to be a new pop sensation, like Beyoncé, Taylor Swift, Justin Bieber, or Miley Cyrus, who attracts the passions and the pocketbooks of a new generation of fans. The best of these go on to long careers, and what begins in adolescent adoration can become a lifelong devotion and fandom that makes these teen pop stars enduring cultural icons. Teen pop stars today ride on a wave of reality television, auto-tuned vocals, dance, and special effects.

Impact (Psychological Influence)

If popular culture taste, styles, and the identification of its stars were once under the control of adults, this changed after World War II. When the baby boomer generation was growing up, they had unparalleled access to education, electronic media, and money. These three enabled them to exert an influence on the kinds of music that were produced and on the stars who would be successful.

Teen pop stars can often represent a world of freedom, success, and perfection to the young people who idolize them. They can inspire their fans to levels of fantasy involvement and style imitation that have an enormous influence not only on their attitudes but also on the way they spend their time and their money. Sadly some teen pop stars rise to success at a young age where their power combined with poor decisions means that in adulthood they are plagued with mental health and substance abuse issues.

Many teen pop stars exert an enormous influence on their fans through their language, style, attitudes, and habits. When these are problematic, as they were with Madonna in the 1990s and Britney Spears in the early 2000s, imitation can be dangerous to the life and health of the fans. Use of drugs, negative body image, and unhealthy sex habits are all areas where teens can be vulnerable because of observing and imitating the teen pop stars they follow.

When the influence of teen pop stars is more positive, they can reinforce good habits and attitudes in their fan base. In the future teen pop stars will continue to be imitated and influential. The symbiotic relationship between stars and fans will continue to change personal attitudes and set trends that will have a great effect not only during their own brief period of success but for many years afterward.

Alexandra Cunningham, PhD, and
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See also: Cobain, Kurt (1967–1994); Reality Television (TV)

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Tegretol (Carbamazepine)

Tegretol is a prescribed medication for the treatment of seizures and mania. Its generic name is carbamazepine.

Definitions

- **Anticonvulsants** are medications used to treat and to prevent seizures.

- **Mania** is the euphoric or irritable mood of bipolar disorder. It is characterized by mental and physical hyperactivity, disorganized behavior, and inappropriate elevation of mood.
- **Seizure** is a sudden convulsion or uncontrolled discharge of nerve cells that may spread to other cells throughout the brain.

Description

Tegretol belongs to a class of medications known as anticonvulsants. Tegretol is effective in the treatment of psychomotor and grand mal seizures and a type of facial pain called trigeminal neuralgia and, in combination with other drugs, for mental disorders such as mania and extreme aggression. Tegretol is also occasionally used to control pain in persons with cancer.

It is structurally related to tricyclic antidepressants such as Elavil and Tofranil. Tegretol is believed to work by increasing the levels gamma-aminobutyric acid (GABA), which is an inhibitory neurotransmitter. That means that as GABA levels increase in the brain, neurons (nerve cells) become less excitable. The result is a lessening of seizure activity, manic behavior, and aggression.

Precautions and Side Effects

Because Tegretol causes aplastic anemia, blood counts should be monitored in those using this medication. Tegretol should be used with caution in those other types of seizure disorders such as atypical absence seizures. Among such individuals, Tegretol usage has been associated with an increased risk of initiating, rather than controlling, generalized convulsions. This medication should not be discontinued abruptly since it may result in seizures. Tegretol use can increase the risk of birth defects when taken during pregnancy. Women who take Tegretol should not breast-feed, since it can pass into the breast milk. It also can decrease the effectiveness of oral contraceptives. Tegretol causes drowsiness and impairs alertness in some individuals, so care must be taken in driving and using machinery until they determine how the drug affects them. The sedative effects are increased in the presence of alcohol, so it should be avoided when taking Tegretol.

The most commonly reported adverse reactions to Tegretol are dizziness, drowsiness, unsteadiness, nausea, and vomiting. It may also cause a skin rash or sensitivity to the sun as well as blurred vision. Using Tegretol along with E-M erythromycin, Tagamet, Darvon, Laniazid, Prozac, and heart medications like as Procardia and Calan may increase the blood level of Tegretol to a toxic range. Using Tegretol and oral contraceptives may increase the possibility that they will not be effective in preventing pregnancy. Those taking Tegretol should not drink grapefruit juice as it can increase the concentration of Tegretol in the bloodstream.

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See also: Bipolar Disorder; Seizures

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Temper Tantrum

A "temper tantrum," or tantrum, refers to a bout of uncontrolled, angry, violent, or disruptive physical and/or verbal behavior.

Definitions

- **Attention-deficit hyperactivity disorder (ADHD)** is a behavioral diagnosis characterized by a combination difficulty sustaining attention, hyperactivity, and impulsivity.

- **Bipolar disorder** is a diagnosed disorder characterized by marked fluctuations in mood and emotional state, both manic and depressive.
- **Disruptive mood dysregulation disorder (DMDD)** is a mood disorder marked by disruptive outbursts indicative of severe impairment in one's ability to regulate temperament.
- **Oppositional defiant disorder (ODD)** is a mood disorder categorized by an ongoing pattern of defiant, uncooperative, hostile behavior.

Description

The term "temper tantrum" is used to refer to out-of-control behavior displayed by an individual, typically a child. Tantrums can be short lived, lasting only a few seconds, or continue for longer periods of time, perhaps up to several hours. Temper tantrum behavior is characterized by verbal outbursts, loss of bodily control, and/or physical aggressiveness. When one is in the midst of a tantrum, one may cry, scream, curse, hit, kick, punch, throw, and/or destroy things. Tantrums occur most commonly in small children between the ages of two and four, though older children, adolescents, and even adults can display tantrums. This type of behavior is often associated with the "terrible twos." When tantrum behavior continues into school age (past five years old), or outbursts become increasingly intense or excessive, then this may be indicative of other problems. Oftentimes temper tantrums result from feelings of anger or frustration with a situation, person, or thing. The individual displaying tantrum behavior may have been denied access to something he or she wants; may have been asked to do something he or she doesn't want to do; may be overtired, hungry, or ill; may be unable to express his or her feelings appropriately; may have been rewarded in the past for the tantrum, or may simply want attention.

Use of the term "temper tantrum" increased during the 1950s as mothers began expressing concerns over noticeable patterns of disruptive outbursts from their young children. Pressure to fit the perfect family mold lessened as psychologists, psychiatrists, therapists, counselors, and educators began to acknowledge the developmental prevalence of tantrum behavior. The term "terrible twos" followed noting the highest incidence rates between the ages of two and three years. Scientists later determined a neurological connection between this type of behavioral impairment and activity in the amygdala, part of the limbic system responsible for the flight or fight response.

Impact (Psychological Influence)

Multiple research studies, workshops, manuals, and parenting guides have been conducted to address the temper tantrum issue. An association has been made between children who are easily frustrated, emotionally oversensitive, impulsive, stubborn, or strong-willed and higher incidences of temper tantrums. Older children who exhibit a history of being unable to control their anger, regulate emotions, or manage their own behavior may be diagnosed with ADHD, bipolar disorder, ODD, or DMDD. DMDD is a new diagnostic term that may be used to categorize an excessive history of temper tantrums. There is an ongoing need to investigate and incorporate childhood behavior and mood-related disorders into diagnostic criteria and treatment protocol to further educate people on the difference between normal childhood stages and excessive incidences of tantrum behavior.

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See also: Attention-Deficit Hyperactivity Disorder; Bipolar Disorder; Disruptive Mood Dysregulation Disorder; Oppositional Defiant Disorder (ODD)

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Terminal Illness, Psychological Factors

When a person is medically diagnosed with a terminal illness, this means that his or her condition will not respond adequately to treatment and will eventually result in death.

Definitions

- **Advance directives** are instructions outlined in a legal document that provide details for care that a person wants carried out on his or her behalf should his or her health, either medical or mental, become compromised; examples include living wills and do-not-resuscitate orders.
- **Anticipatory grief** is the type of grief associated with situations where the loss of a loved one is impending as with a terminal illness.
- **End-of-life care** refers to health care that is provided by nurses, hospice care professionals, or other medical practitioners to patients in the final days or hours of their life, commonly those who have been diagnosed with a terminal illness.
- **Euthanasia,** also known as "assisted suicide," refers to the practice of aiding another person in intentionally ending his or her own life in order to end pain and suffering.

Description

When a condition is deemed "terminal," medical professionals in charge of care have determined that the patient is not likely to benefit from further treatment interventions and that death is inevitable. A patient may be categorized as *terminally ill* or *terminal* when his or her life expectancy is approximately less than six months, though this is just an estimate and can vary depending on the progression of the disease. Common diseases for which there is no cure include some kinds of cancer, advanced heart disease, HIV/AIDS, and Alzheimer's disease. Being diagnosed with a life-threatening or terminal illness can result in psychological and emotional trauma for both patients and their loved ones.

A patient who has been diagnosed as terminal may experience a wide range of feelings, behaviors, and psychological reactions that can vary depending on his or her coping style, prognosis, support system in place, personality, and/or additional compounding factors. If a patient's prognosis is grim and he or she does not have long to live, then this can significantly impact his or her thoughts, feelings, and behaviors. Initially, the person may seek answers as to why this has happened to him or her. The person may also investigate the disease further in hopes of understanding how best to cure it. Some patients may pursue radical treatment options (strict nutrition regimens, supplements, acupuncture), while others may choose to stop treatments altogether. As time passes and the disease progresses, however, the patient may become more anxious and feel an impetus to get in as many experiences as possible while he or she is still able to do so. Spending time with loved ones and attempting to put one's affairs in order are behaviors that are also more likely to occur as death nears.

The ways in which one copes with a terminal diagnosis (anticipatory grief) is important. Negative coping behaviors include those in which the patient closes himself or herself off to others, emotionally and/or physically, becoming reclusive and increasingly depressed. In addition, someone who remains angry, hostile, and resentful may also be characterized as having a negative coping style. Those who remain in denial about their prognosis are not effectively coping with the terminal diagnosis either. On the other hand, positive coping behaviors may include seeking counseling from a mental health professional or support group, discussing the prognosis openly and honestly with loved ones, enjoying the remainder of life's experiences, and putting one's affairs in order.

Emotionally, those dealing with terminal illness may react in a variety of ways. In her 1969 book *On Death and Dying*, psychiatrist Elisabeth Kübler-Ross introduced five stages of grief that are commonly experienced by terminally ill patients: *denial, anger, bargaining, depression*, and *acceptance*. These stages have been applied to the emotional, psychological, and behavioral reactions of patients and their loved ones as well as those who are experiencing other forms of loss

including divorce, infertility, incarceration, and addiction. The five stages are not intended to be all encompassing or describe every possible emotional reaction of those who are grieving. Neither are they meant to be sequential; one can progress through each in a linear fashion or jump back and forth through different stages at any point in the grieving process. During the first stage, *denial*, patients are often in shock or disbelief and are not ready to accept the information as reality. They may seek alternative opinions that contradict the diagnosis in order to maintain hope. In stage two, *anger*, the patient may lash out, be hurtful to others, or react with envy or resentment toward those who are healthy. This can be an extremely difficult stage for loved ones of the patient to endure. Stage three, *bargaining*, is characterized by negotiating. The patient does what he or she can to sustain hope by trying to avoid or postpone the inevitable. The patient may bargain with a higher power for a miracle cure, more time with their loved ones, or a resolution to a problem. *Depression*, stage four, is one in which the patient experiences extreme sadness, fear, and regret about the impending death. At this point, the patient realizes that there is nothing he or she can do to change his or her situation and he or she begins to accept his or her fate. In stage five, *acceptance*, which is the goal of the grieving process, a patient may act more calm, retrospective, and peaceful as he or she has accepted death as an inevitable fate.

Current Status and Impact (Psychological Influence)

The majority of professionals in the medical and mental health fields support being up front, honest, and realistic with patients regarding their diagnosis. Research indicates that patients who are hopeful and optimistic experience lower rates of depression, anger, and anxiety. Longer survival rates are also noted in these types of patients.

There has been much controversy surrounding matters related to end-of-life care, euthanasia, and advance directives. Some regard the final stages of life as a natural progression that should remain free from medical imposition, while others argue that medical advancements exist to offer patients reduced pain and suffering during these times. Euthanasia, intentionally intervening to promote an individual's death, is outlawed in the majority of states nationwide. In addition to legal considerations, religious and moral implications exist for these acts. Another issue for debate is the creation of advance directives that allow for individuals to indicate their medical intentions legally in the event that they become incapacitated. *Do not resuscitate* orders in particular have been questioned in cases where brain activity remains. All of these issues pose difficult legal, moral, and ethical dilemmas for the majority of people.

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See also: Advance Directives; Death, Denial of; Grief; Grief Counseling

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Texting

"Texting" is a verb used to describe the action of sending a text message typically via a cellular phone application. It describes a process of communicating through typed word messages from one cell phone to another. Text messaging has become a preferred method of communication and has replaced phone calls and e-mail and is particularly popular with adolescents and young adults.

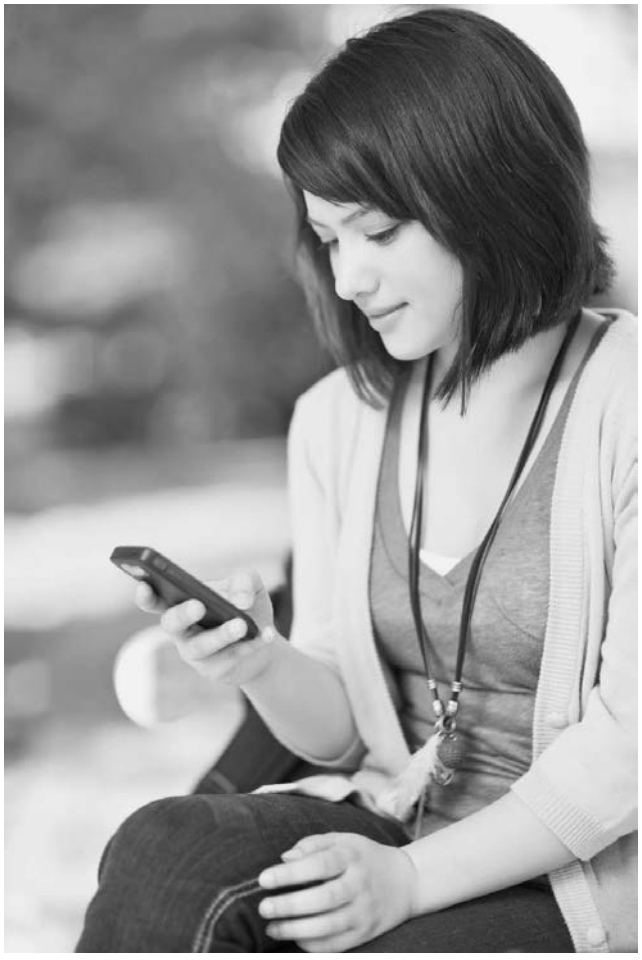
Definition

- **Short message service (SMS)** is another name for texting, sending a text message, or text messaging. This service describes the

process of sending brief texted script from one cell phone to another or from an Internet source to a cell phone. SMS has now grown to include images, video, and sound content (known as MMS messages).

Description

"Texting," or "text messaging," refers to a type of communication whereby a person (the texter) sends a message in typed text to another person (the receiver) via a mobile phone or portable device through a network. In the United States, or other locations where English is the predominant language, texts can be made up using all 26 letters of the alphabet, 10 numeric numerals, and any combination of the two.



Especially for young people, text messaging has essentially replaced phone calls or face-to-face communication. Texting or reading texts while driving has become a major safety issue for all ages and is considered as dangerous as driving while under the influence of alcohol or drugs. (Suprijono Suharjoto/Dreamstime.com)

Back in 1920, a New York company, RCA Communications (now Verizon Wireless), introduced the first "telex" service to transmit messages between New York and London. In the early 1970s, radiotelegraphy, the transmittal of alphanumerical messages sent by radio, was developed using a service known as ALOHA.net. Several contributions followed, including key ideas about function, operation, and technology from Matti Makkonen (regarded as the "father of text messaging"), Hillebrand and Ghillebaert, Finn Trosby, and Holley and Harris. All of these added to the eventual creation of SMS. The first SMS message, "Merry Christmas," was sent on December 3, 1992, by Neil Papworth, a young test engineer for the Sema Group. Finland was the first nation to offer SMS on a commercial basis. Omnipoint Communications was the first to provide text messaging services in the United States.

Today, texting is a common communication method used by people to interact with friends, family, and even coworkers. It is used all over the world but is particularly popular in Europe, Asia, the United States, Australia, New Zealand, and Africa. A study conducted by The Pew Research Center in May 2010 indicated that 72% of adult cell phone users in the United States send and receive text messages. These numbers are even higher for U.S. teens. Numbers indicate that American teens use text messaging over all other forms of communication, and reports cite that they send between 50 and 100 texts per day.

Communicating via text message can be quick and effective; however, content can also be misconstrued if it is read or interpreted incorrectly by the receiver. Largely, text messaging has replaced face-to-face contact or even voice contact over the phone. This has raised concerns about the value and authenticity of texting as a sole source of communication.

Impact (Psychological Influence)

Issues have been raised over the prevalence of text messaging and how it has essentially replaced verbal or face-to-face communication nowadays, particularly with the adolescent and young adult populations.

Of recent concern is the problem of texting while driving. Texting while driving has been proven to be more dangerous and even fatal than drinking and driving.

Proponents of texting argue that it is easier, faster, and more convenient to send a text than it is to pick up the phone; however, consideration must be given to how this can impact relationships and communication styles. When people do not readily engage in face-to-face or other forums of direct communication, much can be lost in translation. Voice tone, quality, inflection, sarcasm, and feelings are likely to be misconstrued if texting is the sole form of communication taking place between two people.

Regardless of the drawbacks, texting remains the most widely used mobile data service. Given this fact, it has been used across several areas: marketing, sales, research, and even politics. Companies and organizations have developed ways to use texting to gather information from the masses and drive sales, gauge product popularity, and predict voter trends.

Melissa A. Mariani, PhD

See also: Electronic Communication; Sexting

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Thematic Apperception Test (TAT)

The Thematic Apperception Test (TAT) is a projective test consisting of picture cards used to assess a person's major personality traits, underlying motives or concerns, and overall psychological well-being.

Definitions

- **Apperception** is the process of understanding something through associating it with a previous experience.
- **Projective test** is a type of psychological assessment that seeks to assess a person's true feelings, thoughts, and attitudes based on responses to ambiguous stimuli.

Description

The Thematic Apperception Test is a projective personality test that uses picture interpretation to gain insight regarding one's personality dynamics, hidden desires, and overall psychological wellness. Projective assessments, used commonly by Sigmund Freud, encourage one to freely express one's thoughts, feelings, and experiences. Practitioners make general impressions and insights based on the answers the person gives after being exposed to a series of ambiguous picture cards. The TAT was created for use with individuals 10 years of age and older.

The complete version of the TAT is comprised of a series of 32 picture cards. Pictures depict human figures, adults and/or children, in common social and relational situations; other pictures have no human figures at all. One picture card is completely blank, allowing for the client to develop his or her own original story. Respondents are asked to develop their own stories and share them aloud based on the scenes in the cards. Stories should contain the following four elements: (1) current situation, (2) thoughts and feelings of the characters, (3) preceding events, and (4) outcome. Answers are believed to reveal underlying themes, emotions, and conflicts about the person's inner world and interpersonal relationships. The test was designed for use with ages 10 and older, and any picture card can be used with these subjects though Murray proposed that scenes showing characters of similar age and gender may elicit more information from subjects. In order to gather the most information it is recommended that practitioners employ a variety of 20 cards, though generally most select 8 to 12 cards. Administration of the TAT takes approximately one and a half to two hours. However, there is no set time limit. There are no right or wrong answers, and no numerical scores are given on the TAT.

Development (Purpose and History)

The TAT was developed by American psychologist Henry A. Murray and psychoanalyst Christiana D.

Morgan at the Harvard Psychological Clinic at Harvard University during the 1930s and early 1940s. Murray and Morgan spent the latter part of the 1930s selecting pictures from illustrated magazines for the TAT. Three separate picture series (Series A, Series B, and Series C) were proposed before they decided on a final set, Series D. This version of the test was published in 1943 and is still in use today. Though Morgan was credited on the first publication citing the TAT in 1935, she was not listed as an author on the published version of the assessment tool itself. Psychoanalysts, clinicians, and therapists began readily using the TAT after World War II to assess the emotional stability of returning veterans. Increased use of the TAT came again later during the 1970s, and the Human Potential Movement as mental health practitioners used it as a vehicle to get to know more about its clients and promote their personal growth.

Current Status and Results

Administration of the TAT should be conducted only by a trained professional (psychiatrist, psychologist, licensed counselor, social worker, or teacher with specific training in this type of assessment). The results of this assessment alone should never be used to diagnose but should be included as part of a larger battery of tests. Thorough medical, familial, and behavioral histories should also be obtained. This way the assessor has a comprehensive picture of the examinee's overall psychological functioning.

Concerns have been raised as to the reliability and validity of the TAT as it lacks a standardized administration protocol, scoring system, and established norms. In addition, both inter-rater reliability and test–retest reliability are highly variable, indicating that there is no clear evidence to support that this test measures what it seeks to or that it measures constructs consistently from person to person. Finally, due to the subjective nature of the TAT, findings are likely to endure examiner bias and error.

Melissa A. Mariani, PhD

See also: Children's Apperception Test (CAT)

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Therapeutic Alliance

"Therapeutic alliance" refers to the relationship between a therapist and client that is a necessary component of effective psychotherapy.

Definitions

- **Bond** is the relational and emotional dynamic between the client and counselor.
- **Clinician credibility** is the client's perception that the therapist is effective and trustworthy.
- **Common factors** is the viewpoint that psychotherapy has common components or factors and that these effect change more than specific factors or techniques.
- **Goals** are objective and measurable outcomes that a client can achieve while in therapy.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Tasks** are the objectives or steps that support achieving a treatment goal.

Description

The therapeutic alliance is a crucial part of the change process in psychotherapy. It is also an important variable in psychotherapy research. The therapeutic alliance can have a significant effect on the process of therapy and the overall outcome. Research on common factors in therapy suggested that the therapeutic alliance accounts for 30% of the variance in client change and improvements (Sperry, 2010). Lambert identified

the following "common factors" that influence change and improvements among clients in therapy: the therapeutic alliance, the placebo or hope effect, therapeutic strategies, and client factors. The research on common factors contends that regardless of theoretical orientation, the therapeutic alliance and other factors effect change in the therapy process.

Psychologist Edward S. Bordin (1913–1992) is credited with proposing the commonly accepted understanding of the therapeutic alliance. Based on research, Bordin found that there were three components to a therapeutic alliance. The therapeutic alliance incorporates a bond between the client and counselor, and mutually agreed-upon goals and tasks to assist the client in achieving therapy goals. Both the therapist and client are responsible for setting an agenda for each session, while many of the tasks that occur in counseling are collaboratively determined by both individuals. The therapeutic alliance is an ongoing relational process that occurs throughout the duration of therapy. The initial contacts are typically facilitated by the therapist's rapport-building skills, while each encounter between the therapist and client influences the development of the alliance. The bond between the client and a therapist includes an emotional component, which could be called a "meeting of the hearts," and also a cognitive element called "a meeting of the minds" (Sperry, 2010). This process includes the client and therapist collaborating on what needs to occur in session for the client to attain treatment goals. The "meeting of the hearts" occurs when the client feels that the therapist cares about the client and wants to see him or her succeed. Therapists who incorporate active listening and responding, encouragement, and warmth will facilitate an effective therapeutic alliance. In such a relationship, clients will feel valued, supported, and accepted, and will believe that their therapist wants to see them succeed.

Psychologist Carl R. Rogers (1902–1987) identified three core conditions that he believed were the necessary and sufficient conditions for change in counseling. The core conditions include unconditional positive regard toward the client, genuineness of the therapist toward the client, and empathy. The majority of counseling theories articulate that the therapeutic alliance facilitates change, while some theories such as Carl Roger's person-centered theory articulate that the relationship is a primary mechanism of change in counseling. Many of the psychodynamic counseling theories also endorse the therapeutic alliance as a primary mechanism for change in counseling. Besides the importance of therapeutic alliance, the client's perception that the therapist is effective and trustworthy is called clinician credibility.

The client's perception of the therapist's effectiveness and trustworthiness influences the therapeutic alliance. The therapist will be seen as trustworthy if he or she is supportive; is sensitive to the client's needs; is accepting and caring; and instills confidence, hope, and faith that the client will improve. The therapist will establish effectiveness and interpersonal influence by showing evidence of multicultural competence, by displaying a sense of focus and direction in the treatment, by structuring sessions, and by fostering change among the client in sessions and between sessions.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Psychotherapy

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Thorazine (Chlorpromazine)

Thorazine is a prescribed antipsychotic medication used to treat schizophrenia and the manic phase of bipolar disorder. Its generic name is chlorpromazine.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They

are sometimes referred to as antipsychotics or neuroleptics.

- **Bipolar disorder** is a mental disorder characterized by alternating episodes of extremely low mood (depression) and exuberant highs (mania). It is also known as manic-depressive disorder.
- **Deinstitutionalization** is the process of replacing long-stay psychiatric hospitalization with less isolated community mental health services for those diagnosed with a severe mental disorder or a developmental disability.
- **Extrapyramidal symptoms** are a group of side effects associated with antipsychotic medication use that are characterized by involuntary muscle movements, including rigidity, contraction, and tremor.
- **Neuroleptic malignant syndrome** is a potentially fatal condition resulting from antipsychotic use characterized by severe muscle rigidity (stiffening), fever, sweating, high blood pressure, delirium, and sometimes coma.
- **Psychosis** is a severe mental condition in which an individual loses touch with reality. Symptoms include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.
- **Schizophrenia** is a mental disorder in which it is difficult to distinguish real from unreal experiences. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others. Tardive dyskinesia are involuntary movements caused by certain antipsychotic medications. They include tongue thrusting, repetitive chewing, jaw swinging, and facial grimacing.

Description

Thorazine is one of a class of antipsychotic medications known as "typical" or first-generation antipsychotics. It is in the subclass of phenothiazines along with Prolixin, Stelazine, and Navane. Thorazine was the first medication developed (1950) with specific antipsychotic action. It has been described as the single greatest advance in improving the prognosis of patients in psychiatric hospitals worldwide. Its use was a major impetus in achieving deinstitutionalization. Therapeutically, Thorazine is effective in treating "positive" symptoms of schizophrenia (abnormal thoughts and perceptions, such as delusions, hallucinations, or disordered thinking) and the manic phase of bipolar disorder. It is also used to manage behavioral symptoms such as aggression, combativeness, and excessive excitability. Thorazine is sometimes used as a sedative and to relieve nausea, vomiting, and persistent hiccups. It is thought to work by blocking dopamine receptors in the brain and interfering with dopamine transmission.

Precautions and Side Effects

The most common side effects of Thorazine include drowsiness, low blood pressure, constipation, decreased sweating, muscle spasms, dry mouth, and nasal congestion. Children may be especially susceptible to muscle spasms, while the elderly may be particularly sensitive to sedation and low blood pressure. Thorazine has the potential to cause extrapyramidal symptoms, tardive dyskinesia, and neuroleptic malignant syndrome. Other risks of Thorazine include liver damage, seizures, visual impairment, and tardive dyskinesia. Overdose symptoms include significant drowsiness, severe dizziness, significant breathing difficulties, severe weakness, trembling muscles, and severe uncontrolled movements. Thorazine should not be used by women who are pregnant, trying to become pregnant, or breast-feeding. Infants born to mothers who had taken Thorazine during pregnancy may develop extrapyramidal symptoms and withdrawal symptoms, including agitation, trouble breathing, and difficulty feeding.

Thorazine interacts with a number of other medications. Individuals who are starting this drug should review the other medications they are taking with their doctor for possible interactions. Thorazine should not be combined with other substances that depress the central nervous system, such as antihistamines,

alcohol, tranquilizers, sleeping medications, and seizure medications. Thorazine should not be combined with anticholinergic drugs because of the potential of decreased antipsychotic effects. Thorazine may enhance the effects of medications that lower the seizure threshold, such as steroid medications, asthma medications, and other psychiatric medications. Patients with epilepsy may require dosage adjustments of their antiseizure medications. The effectiveness of medications for Parkinson's disease may be reduced by Thorazine and other antipsychotics. The likelihood of changes in heart rhythm may be increased when the drug is taken with other medications that have the same effect, including other antipsychotic drugs, antidepressants, certain heart medicines, and erythromycin.

Len Sperry, MD, PhD

See also: Antipsychotic Medications; Schizophrenia

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Three Faces of Eve, The (Movie)

The Three Faces of Eve is both a best-selling book and a major motion picture that is based on the biography of a woman diagnosed with multiple personality disorder, now called dissociative identity disorder.

Description

The Three Faces of Eve was both a best-selling book and a major motion picture. The movie, starring Joanne Woodward, first appeared in theaters in 1957 but remains a classic to this day. Based on the biography of a woman diagnosed with multiple personality disorder, the movie is chronicled in a book of the same name written by two psychiatrists, Corbett H. Thigpen and Hervey M. Cleckley. Woodward won a Best Actress Oscar and Golden Globe award for her role as Eve, a young, unassuming Georgia housewife suffering from multiple personalities, a term currently known in the DSM-5 as dissociative identity disorder. Nunnally Johnson was the producer and director of the movie, and also wrote the screenplay.

At the time, *The Three Faces of Eve* was considered a landmark film delving into the depths of what was once considered a mythical psychiatric illness. After displaying strange behavior, Eve White (played by Joanne Woodward) is taken to a psychiatrist (played by Lee J. Cobb) by her violent and abusive husband (played by David Wayne). Her husband reports she has been singing and dancing in bars and has purchased seductive clothing that is out of character for her. Her psychiatrist soon meets Eve Black, which is one of Eve's other personalities, or "alters." The psychiatrist realizes he is witnessing a rare case of multiple personality disorder and begins intensive psychotherapy with her to reclaim her missing memories. Through the course of her treatment, she leaves her unhealthy marriage and begins to uncover repressed memories of childhood trauma and abuse. Ultimately, in addition to Eve White (the good girl) and Eve Black (the bad girl), a third personality emerges—Jane (the mature intellectual). Jane slowly replaces the other two personalities and finds a new life with a loving husband.

Impact (Psychological Influence)

By today's standards, the book and movie seem old-fashioned and tame, but in 1957 it was considered groundbreaking. Never before had Hollywood tackled the true story of a patient with multiple personalities. The reason it resonated with the American public has much to do with the social climate at the time. At the end of World War II (1945), soldiers were coming home with post-traumatic stress disorder and other types of psychological distress. This, in turn, created a groundswell of curiosity among the general public in psychology and psychiatry.

Until the release of *The Three Faces of Eve* in book form, such well-documented (and well-distributed)

The Three Faces of Eve was both a best-selling book and a popular movie of 1957 starring Joanne Woodward, who won an Oscar for her performance. Based on the life of a woman diagnosed with multiple personality disorder, now called dissociative identity disorder, it also focused on her psychiatric treatment. (Twentieth Century Fox Film Corp./Photofest)

information by clinicians didn't exist on the topic. In 1951, Eve White (a pseudonym for the patient later revealed to be Chris Costner) was referred by her physician to the two psychiatrists. Three years later, Thigpen and Cleckley submitted a 17-page article that was published in the *Journal of Abnormal and Social Psychology*. The article was believed to be the first documented observation of documented multiple personality disorder that had been recorded in the 20th century. The response was so overwhelming by their colleagues that the two later expanded the article into a book, which soon afterward became a major motion picture.

Mindy Parsons, PhD

See also: Dissociative Identity Disorder; *Sybil* (Book and Movie)

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Tic Disorders

Tic disorders are mental disorders characterized by rapid and recurrent body movements and vocalizations.

Definitions

- **Antipsychotic medications** are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Cognitive behavior therapy** is a form of psychotherapy that focuses on changing maladaptive (faulty) behaviors, emotions, and thoughts. It is also known as CBT.
- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neurodevelopmental disorders** are neurological disorders characterized by impairments of the growth and development of the brain or central nervous system.
- **Serotonin** is a chemical messenger in the brain that regulates learning, sleep, mood, and appetite. It is involved in disorders such as depression and anxiety.
- **SSRI** stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain resulting in symptom reduction.
- **Stereotypic movement disorder** is a mental disorder characterized by repeated and purposeless physical movements that cause distress or impairment.
- **Tics** are involuntary, compulsive, repetitive, and stereotyped movements or vocalizations. While they are experienced as irresistible, they can be temporarily suppressed.
- **Tourette's disorder syndrome** is a neurological disorder characterized by recurrent involuntary movements and vocal tics such as grunts, barks, or words, including obscenities.

Description and Diagnosis

Tic disorders are listed in the DSM-5 as neurodevelopmental disorders. They are characterized by involuntary, sudden, rapid, recurrent, and nonrhythmic body movements or vocalizations. Examples of movement-related tics include blinking, shoulder shrugging, and facial gestures. Vocal (or phonic) tics include coughing, barking, or repeated statements such as "Stop it!" Tics may be either simple or complex. Simple tics are only one movement or sound and last about one second. Complex tics involve longer and purposeful movements and sounds, such as *copropraxia* (obscene gestures), *echopraxia* (imitating another individual's movements), and *coprolalia* (obscene words, phrases, or slurs). These last many seconds and are usually a combination of multiple simple tics. Tics come and go over time, and may fluctuate in severity and type. They may also become more frequent or severe during times of increased stress or emotion. Many individuals with mild or moderate tics do not experience problems functioning in daily life. While temporary tics are common in children, only a small percentage develops a tic disorder. Tic disorders are separate from stereotypic movement disorder, which is a separate neurodevelopmental disorder that typically occurs before age three (American Psychiatric Association, 2013).Tic disorders usually develop between ages 4 and 6, with peak severity between ages 10 and 12. These disorders are more common in males.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, there are four categories of tic disorders. These are Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, and other specified or unspecified tic disorder. An individual's diagnosis depends on the severity and duration of symptoms. Tourette's disorder is the most severe form of tic disorder. Individuals must have both motor and vocal tics for more than one year. In persistent (chronic) motor or vocal tic disorder, only motor or vocal tics are present but not both.

A diagnosis of provisional tic disorder is given to individuals who have had symptoms for less than one year. The category of other specified or unspecified tic disorder refers to the presence of minimal symptoms that do not meet the criteria for the other tic disorders. For all of the categories, symptoms must be present prior to age 18 (American Psychiatric Association, 2013).

The exact causes of this disorder are unknown. It is believed that tic disorders are due to abnormalities in the brain. These include problems with the neurotransmitters serotonin and dopamine. There is some evidence that genetics influence tic severity. Environmental stress can also contribute to worsening symptoms. Problems in development such as low birth weight, maternal smoking during pregnancy, and birth complications similarly result in increased severity.

Treatment

Treatment for tic disorders involves a combination of cognitive behavior therapy and antipsychotic medications or SSRIs. There is no cure for tic disorders and no way to prevent their development. However, tics often disappear or diminish as individuals age.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Antipsychotic Medications; Cognitive Behavior Therapy; Dopamine; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Neurodevelopmental Disorders; Serotonin; SSRI; Stereotypic Movement Disorder; Tourette's Syndrome

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Tobacco Use Disorder

Tobacco use disorder is a mental disorder involving a pattern of tobacco use, which leads to significant problems for the user.

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Stimulant** is a drug that increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity, or suppresses appetite. Examples are cocaine, amphetamines, and Ritalin.
- **Substance-related and addictive disorders** are a group of mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. This group also includes the non-substance disorder of gambling.
- **Withdrawal** is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of certain drugs after prolonged regular use.

Description and Diagnosis

Tobacco use disorder is one of the DSM-5 substance-related and addictive disorders. It is characterized by the use of tobacco, which results in significant distress or disrupts daily functioning. Tobacco can be smoked in cigarettes or used in smokeless form as in chewing tobacco. A primary ingredient in tobacco is nicotine, which is a stimulant. While some individuals use tobacco on occasion, those with this disorder use it to excess. For example, individuals with this disorder may "chain smoke" cigarettes, smoking one right after the other. They may also engage in risky activities, such

as smoking in bed. In the past, this disorder was represented by the disorders of nicotine abuse and dependence. However, nicotine is only one aspect of tobacco use. Tobacco use disorder is a common disorder affecting approximately 13% of the adult population (American Psychiatric Association, 2013).

Tobacco use has both short- and long-term effects. Short-term effects include increased heart rate, alertness, and feelings of satisfaction. The sense of relaxation produced by tobacco use is associated with the elimination of withdrawal symptoms. Withdrawal occurs when tobacco's primary ingredient—nicotine—begins to decrease in the body of an individual who is physically dependent. This commonly leads to irritability, difficulty concentrating, insomnia, and restlessness. Individuals continue to use tobacco in an attempt to avoid these uncomfortable withdrawal symptoms. This is the basis for tobacco addiction. Long-term effects of tobacco use include medical problems like cancer, birth defects, and emphysema. Tobacco use also leads to cardiovascular illnesses such as stroke. Most medical conditions caused by long-term tobacco use are due to carbon monoxide, tars, and non-nicotine chemicals.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they use tobacco in larger amounts than intended and have a persistent desire to cut back or control tobacco use. Craving (a strong desire or urge to use tobacco) is another criteria, as is tolerance (increasing amounts needed to achieve desired effect) and withdrawal symptoms. These must occur within a 12-month period and lead to significant problems in functioning. The severity of this disorder can be diagnosed or specified on a continuum of severity. Those presenting with two to three symptoms are classified as "mild"; those with four to five symptoms are "moderate"; and those with six or more are "severe" (American Psychiatric Association, 2013).

The cause of this disorder involves biological, psychological, and sociocultural factors. While a majority of adolescents in the United States experiment with tobacco, only some go on to develop tobacco use disorder. Genetic factors and heredity contribute to tobacco use and other substance use disorders. In addition, individuals with certain personality traits such as impulsiveness and low self-esteem are at increased risk. This includes those with depression, anxiety, and other substance use disorders. Tobacco use is more common among individuals with low incomes and education levels. Cultural acceptability and peer approval are also factors.

Treatment

The goal of treatment for this disorder is abstinence (no longer using tobacco). Individuals may attempt to quit multiple times before finally remaining abstinent. Treatment may include nicotine replacements such as gum and transdermal patches. Individuals gradually decrease the strengths (doses) of these to wean themselves off nicotine without experiencing withdrawal symptoms. Prescription medications are also used in the treatment of this disorder. These include antidepressants to reduce withdrawal symptoms and medications that block nicotine receptors in the brain. Behavior therapy is also common in the treatment of tobacco use disorder. This may include support groups, counseling, or aversion therapy in which individuals intentionally make themselves nauseous.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Addiction; Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Smoking Cessation; Stimulant Related Disorders; Withdrawal

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Tofranil (Imipramine)

Tofranil is a prescription medication used to relieve symptoms of depression. Its generic name is imipramine.

Definitions

- **Selective serotonin reuptake inhibitors** are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain.
- **Tricyclic antidepressants** are an older class of antidepressant medications called tricyclic because of their three-ring chemical structure.

Description

Tofranil is the first of the class of medications known as tricyclic antidepressants. Like other tricyclic antidepressants it has long been used to treat depressive disorders but have largely been replaced by selective serotonin reuptake inhibitors. Tofranil is also used in the treatment of enuresis (bed-wetting). Tricyclic antidepressants are thought to work by changing the balance of neurotransmitters (chemical messengers) in the brain that regulate the transmission of nerve impulses between cells. Tofranil works primarily by increasing the levels of the neurotransmitters norepinephrine and serotonin in the brain. It also blocks the action of acetylcholine, another neurotransmitter. Tofranil shares most of the properties of other tricyclic antidepressants, such as Elavil, Sinequan, Anafranil, Nortriptyline, and Asendin.

Precautions and Side Effects

Those taking Tofranil should be closely monitored for signs of worsening depression or other risk factors such as difficulty falling asleep, irritability, planning to engage in self-harm, or abnormal excitement. Manic episodes and the reemergence of psychotic symptoms have been reported when Tofranil is started. The risk of suicide may also be increased when Tofranil is taken in overdose or combined with alcohol. Children and adults up to age 24 are at an increased risk of developing suicidal thoughts or behaviors when they first begin taking Tofranil or other antidepressants. Like all tricyclic antidepressants, Tofranil should be used cautiously and with close medical supervision in those with enlarged prostates, urinary retention, glaucoma, seizures, or heart disease. Those taking the monoamine oxidase inhibitors (MAOIs) like Parnate or Nardil should not combine it with Tofranil. Since fetal deformities have been reported with taking this drug during pregnancy, women should discuss the risks and benefits of Tofranil with their doctors. Breast-feeding should be avoided while using Tofranil.

Tofranil shares side effects common to all tricyclic antidepressants. The most frequent of these are dry mouth, constipation, urinary retention, increased heart rate, irritability, dizziness, decreased coordination, and sedation (drowsiness). The sedative effect is increased when Tofranil is taken with alcohol, sleeping medications, other sedatives, or antihistamines. Less common side effects include confusion, disorientation, delusions, insomnia, anxiety, seizures, ringing in the ears, nausea, vomiting, loss of appetite, diarrhea, and abdominal cramping.

Tofranil may decrease the effect of some medications used to treat high blood pressure. It should not be taken with other antidepressants, particularly MAOIs, or with Ritalin. It is important to check with one's doctor before taking Tofranil with Tagamet or Neo-Synephrine or other over-the-counter medications. Those taking Elavil should avoid the natural remedies like St. John's wort. Because it can increase the depressant action of alcohol, it should not be used by those taking Tofranil. The anticholinergic (drying out) effects of Tofranil are additive with other anticholinergic drugs such as Cogentin, Akineton, Artane, and antihistamines.

Len Sperry, MD, PhD

See also: Antidepressants; Depression

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Tourette's Syndrome

Tourette's syndrome is a neurological disorder characterized by recurrent involuntary movements and vocal tics such as grunts, barks, or words, including obscenities. It is also known as Tourette's.

Definitions

- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (faulty) behaviors, emotions, and thoughts. It is also called CBT.
- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Exposure and response prevention therapy** is the cognitive behavior therapy method that involves exposure to the anxiety that is provoked by the obsession and then preventing the use of compulsive behaviors to reduce the anxiety. This cycle of exposure and response prevention is repeated until the obsessions are less distressing and compulsions are reduced.
- **Habit reversal** is a CBT intervention for treating repetitive behavior disorders such as tics. It works by increasing tic awareness and developing a competing response to the tic.
- **Neurodevelopmental disorders** are neurological disorders characterized by impairments of the growth and development of the brain or central nervous system.
- **Tics** are involuntary, compulsive, repetitive, and stereotyped movements or vocalizations. While they are experienced as irresistible, they can be temporarily suppressed.

Description and Diagnosis

Tourette's syndrome is a neurodevelopmental disorder characterized by repetitive motor and vocal tics. Its symptoms include involuntary movements of the arms, legs, shoulders, and face. Along with these movements are often involuntary sounds or words. When the words are obscene or offensive, it is called "coprolalia." Tourette's syndrome is not a progressive nor a degenerative disorder. Instead, the symptoms tend to be variable and wax and wane throughout an otherwise normal life. These symptoms tend to vary greatly from individual to individual. For example, only some individuals exhibit coprolalia. Furthermore, an individual's can change even though the disorder itself persists. The combination of motor and vocal tics, while they may not occur simultaneously, is the hallmark symptom of this disorder (American Psychiatric Association, 2013). In DSM-5 this disease is listed as a neurodevelopmental disorder. Tourette's also commonly occurs with other disorders like obsessive-compulsive disorder, attention-deficit hyperactivity disorder, and anxiety disorder.

The onset of this disorder may not be obvious very early in life. The reason is that early tics, like repetitive eye blinking, may not be highly noticeable or may be covered up for some time. The DSM-5 indicates that tic onset usually begins between ages 4 and 6 years, but the peak severity of Tourette's symptoms may not manifest until ages 10 to 12. Also, tics may change over time and increase or decrease in severity over time due to factors such as fatigue, anxiety, or excitement (American Psychiatric Association, 2013). It should be noted that unlike other mental or neurological disorders, its symptoms may initially be interpreted as willful misbehavior or intentional disruptions. As a result, it is not uncommon for those with Tourette's, and who have not yet been diagnosed, to be mislabeled as defiant, rebellious, and impulsive in school setting.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they exhibit both motor and vocal tics at some time before the age of 18. Tic symptoms must be present for more than a year since the initial onset. Also, the tics are not due to another cause or condition. Individuals who have only

ever had motor tics or vocal tics, but not both in the course of the condition, would likely meet criteria for persistent motor or vocal tic disorder, rather than Tourette's syndrome.

The exact cause of Tourette's is currently unknown. However, it is an inherited disorder, meaning that it runs in families. The cause might involve abnormalities in certain brain regions, or it defects in specific brain circuits. It could also involve deficits in neurotransmitters such as dopamine.

Treatment

Tourette's syndrome is usually treated with a combination of medication and cognitive behavior therapy. The basic treatment goal for Tourette's is the reduction or extinction of tics. Commonly prescribed medications to reduce tics include clonidine, Haldol, and Risperdal. CBT interventions for Tourette's syndrome to reduce tics include exposure and response prevention, and habit reversal. Other CBT interventions are directed at increasing social skills and strengthening self-esteem.

Len Sperry, MD, PhD

See also: Anxiety Disorder; Attention-Deficit Hyperactivity Disorder; Cognitive Behavior Therapy; Haldol (Haloperidol); Obsessive-Compulsive Disorder (OCD); Risperdal (Risperidone); Tic Disorders

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Transgender

"Transgender," or "across gender," is a descriptive term that refers to individuals who do not identify with their assigned birth sex.

Description

Transgender individuals self-identify their gender (male, female, both, or neither) as different from the assigned sex they were at birth, or as determined by their genitals. The term "transgender" should be used as an adjective rather than a noun ("a transgender man" vs. "he is a transgender"). It describes the self-identification of a person's sex (gender), not his or her sexual orientation (heterosexual, homosexual, bisexual, pansexual, polysexual, or asexual). A transgender person identifies with the sex opposite from his or her birth sex, and thus, most would like others to perceive and address them accordingly. When speaking to a transgender person, it is appropriate and respectful to refer to he or she using the gender and pronouns to which they identify rather than by what appears on their birth certificate or other forms of identification.. "Transgender" is an umbrella term that encompasses various gender identities, including transgender women/men, transitioning women/men, transsexuals, transvestites, drag queens/kings, and gender queers.

A transgender person struggles with gender identity. This term, also commonly referred to as "gender variant," is descriptive rather than diagnostic. Certain procedures and surgeries for those persons seeking gender reassignment are available, from male-to-female (or trans-female) or female-to-male (or trans-man). This can be a lengthy, costly, and complicated process and may not resolve the psychological, emotional, and social difficulties experienced. Seeking psychological evaluation and counseling support is therefore recommended. People who are transgender can encounter significant mental health issues from feelings of distress, discomfort, sadness, and loneliness as they struggle to resolve their gender identities. Transgender persons who do not wish to pursue these more permanent means may choose to express themselves through their behavior or dress, while others keep feelings and thoughts private or suppressed.

Self-awareness regarding one's gender develops at a young age. Transgender individuals report feelings of discomfort and ambiguity about their assigned sex early on. Gender identity is often reinforced and supported by traditional gender roles. However, stereotypes further complicate the process for those who are transgender. This can have damaging effects on

one's emotional and psychological well-being as one's sexual identity plays a large part in overall development. Puberty can be an exceptionally difficult period for those who are transgender. As the body grows, matures, develops, and changes, male or female sex characteristics become more prominent (hair, breasts, Adam's apple, voice changes, etc.), making assigned sexual identities more obvious. This can lead to negative emotions, thoughts, and behaviors if a person does not feel he or she is what the world perceives him or her to be or treats him or her as.

Those who are transgender have been included in the LGBT (lesbian, gay, bisexual, transsexual) community for decades, having been rejected by the larger community. Misunderstanding about the transgender lifestyle caused paranoia, discrimination, and rejection. However, transgender individuals are deserving of the same inalienable rights as all people and should be treated accordingly.

The word "transgender" was first used during the 1950s by an American, Christine Jorgenson, a trans-woman, who was born George William Jorgenson, Jr. Jorgenson was the first woman in the United States to undergo sex reassignment surgery in Copenhagen, Denmark, after gaining special permission. Her struggles were highly publicized and she is revered for bringing attention, sensitivity, and understanding to the transgender community. The 1970s brought about further clarity to the distinctions between sex and gender identity. In 2000, Monica Helms, unveiled the transgender pride flag at a parade in Phoenix, Arizona. Consisting of five horizontal stripes, two light blue (traditional boy color), two pink (traditional girl color), and a white stripe in the middle (representative of those transitioning), the flag remains a symbol of the transgender community. Other symbols including the butterfly and light blue and pink yin and yang symbol have also been used as representations. At present, though transgender persons are still considered protected members of the LGBT community, they continue to work toward respect and acceptance.

Current Status and Impact (Psychological Influence)

Those experiencing psychological impairment resulting from conflicts over one's gender identity that results in distress or discomfort may be diagnosed by a mental health professional as having gender dysphoria, formerly termed gender identity disorder, by the DSM classification. Those experiencing the disorder experience significant emotional, psychological, and social consequences resulting from either living in secrecy or pursuing gender transition. In addition, persons who are transgender are subject to further discrimination if they are restricted access to certain health care and/or denied rights pertaining to religious freedom, marital unions, and adoption.

Melissa A. Mariani, PhD

See also: Gay, Lesbian, Bisexual, Transgendersexual (GLBT/LGBT); Gender Dysphoria; Sex and Gender; Sexual Identity

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Transpersonal Psychotherapy

Transpersonal psychotherapy integrates psychological concepts and methods with spiritually transcendent personal experiences in order to assist individuals reach their highest potential.

Definitions

- **Mindfulness** is the practice of maintaining a present awareness and focus of one's thoughts, feelings, and sensations without judgment as to whether they are right or wrong, good or bad.

- **Trans** is a prefix that means to go beyond conventional or individual limits of experience.
- **Transcendent** means going beyond the physical realm and exceeding conventional limits of ordinary consciousness and personal identity.

Description

Transpersonal psychotherapy is grounded in transpersonal psychology (TP), which combines spiritual and transcendent human experiences in an understanding of human potential, wholeness, and transformation. The word "transpersonal" means to go beyond the physical realm of self. Transpersonal psychotherapy integrates psychological concepts with a variety of transpersonal and spiritual experiences such as mediation, mindfulness, and other spiritual disciplines. TP recognizes that individuals are spiritual beings and not just a self or psychological ego. A core principle of TP is that optimal individual well-being must address the spiritual dimension of life and focus on ways to enlighten, strengthen, and heal through spiritual pathways.

Transpersonal themes include nonduality, holism, beyond-person experiences, highest potential, and transformation. Nonduality is the recognition that each individual person is a fundamental part of the whole (sometimes simply referred to as the cosmos or universe), which extends far beyond physical reality. Holism is the belief that the parts of the whole are interdependent and cannot exist or be fully understood independent from the whole. Beyond person or beyond-ego experiences focus on personal connections to the whole made through mystical states of consciousness. As individuals are able to experience and identify with the deeper unified whole, they become less aware of self and more self-transcendent resulting in a deepening sense of connection, peace, and service to all parts of the whole. This is transformational not only on an individual level but also on a potentially global level as all parts of the whole (including individuals) experience unity, peace, and service.

TP is spiritual but it is also psychological. Transpersonal psychotherapy integrates the spiritual dimensions and practices with psychological insights, theory, and methods to help people overcome problems in living, behavioral health disorders, and suffering, while gaining enlightenment, peace, and well-being. Transpersonal practices include the use of meditation and mindfulness for self-exploration, emotional regulation, relaxation, stress reduction, finding peace, and connecting to the greater whole.

Development

TP was first developed in California beginning in 1969 and continues to be an emerging perspective. Carl Jung, Abraham Maslow, and William James, all of whom integrated some form of spiritual, humanistic, mystic, and/or religious thought into their theories of human functioning, influenced early proponents of the perspective. *The Journal of Transpersonal Psychology* was first published in 1969, and in 1972 the Association for Transpersonal Psychology was established to investigate and promote ultimate and mystical states of consciousness and how these experiences could be encouraged to change both personal and cultural perspectives. Various researchers and proponents of the field have worked to identify central themes and define TP but have yet to agree on a clear consensus definition.

Current Status

TP is continuing to develop. TP is receiving an ever-increasing level of investigation and research into its themes and assumptions and is being applied to many fields, including health care, education, business development, alternative medicine fields, counseling, and clinical psychology.

Steven R. Vensel, PhD

See also: Spiritually Oriented Psychotherapy

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Transvestic Disorder

Transvestic disorder is a mental disorder characterized by transvestic behavior that causes distress or impairment.

Definitions

- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- **Behavioral addiction** is a form of addiction caused by the compulsion to repeatedly engage in a behavior that causes harmful consequences. It is also referred to as process addiction or non-substance-related addiction.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Fetishism** is the sexual arousal an individual receives from a physical object or from a specific situation.
- **Paraphilia** is a mental condition in which an individual can only become sexually aroused by inappropriate objects, actions, or fantasies.
- **Paraphilic disorders** are a group of mental disorders characterized by paraphilias that cause distress or impairment or whose satisfaction involves personal harm. Included in this group are exhibitionistic disorder, fetishistic disorder, pedophilic disorder, and voyeuristic disorder.
- **Transvestic behavior** is wearing or fantasizing about wearing clothes associated with the opposite gender. This leads to intense sexual arousal. It is also called cross-dressing.

Description and Diagnosis

Transvestic disorder is one of the DSM-5 paraphilic disorders. It is characterized by transvestic behavior that causes distress or impairment. Those engaging in this behavior are sexually aroused by wearing or fantasizing about wearing clothes associated with the opposite gender. This may involve only one article of clothing or an entire outfit. For example, a man may wear women's underwear only. Others may wear a dress, makeup, and wig. Sexual excitement is achieved as the result of this behavior. Some individuals may masturbate to achieve orgasm. Others may avoid masturbation to prolong the cross-dressing session. Men with transvestic disorder sometimes exhibit autogynephilia (sexual arousal by imagining being female). Some also have fetishism and become aroused by certain fabrics, garments, or materials. The majority of males with transvestic disorder are heterosexual. Individuals may cross-dress in isolated episodes, or they may engage in this behavior continuously. Transvestic behavior is considered transvestic disorder according to DSM-5 only when specific criteria are met.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience intense sexual arousal from cross-dressing. This includes behavior as well as fantasies and urges. This behavior or fantasies must cause significant distress or disrupt daily life. Distress may be indicated by "purging and acquisition" behavior. This is when an individual discards cross-dressing items in an attempt to stop, only to purchase new ones later. The individual must be at least 18 years old and the behaviors must also last for at least six months (American Psychiatric Association, 2013).

The causes of this disorder are unknown. It may be that paraphilias are behavioral addictions, or they could reflect a problem with brain functioning. It is almost exclusively seen in men, although it occasionally occurs in women. Transvestic behavior usually begins in childhood with fascination regarding opposite-sex

clothing. This continues in adolescence and becomes associated with sexual arousal.

Treatment

There are no drugs to treat this disorder. Treatment for this disorder typically involves behavior therapy. The goal is to teach the individual to control the impulse and learn acceptable ways to achieve sexual gratification. The effectiveness of this treatment is unknown. This disorder is a chronic condition and there is little hope for change. The main reason is that individuals receive pleasure from this behavior and have little incentive to change. Since transvestic behavior is viewed as harmless to others, those with this disorder do not commonly seek treatment. However, relationship problems and demands for change from an individual's spouse may prompt treatment. Currently, there is no way to predict who will develop this disorder; however, it may be prevented through education about appropriate sexual behavior.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Paraphilic Disorders; Substance-Related and Addictive Disorders

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Trauma

"Trauma" refers to the deep emotional and psychological effects of a variety of extreme and negative experiences.

Description

The word "trauma" means wound, injury, or shock. The causes of trauma are many and include physical mistreatment and abuse such as a physical assault or domestic violence; terrifying disaster experiences such as being in a building fire or a tornado victim; emotional experiences and mistreatment such as being relentlessly ridiculed and bullied; or being a witness to traumatic events. Trauma can include physical neglect such as a young child being left alone all day; interpersonal violence such as being robbed or being physically abused; sexual assault such as molestation or rape; large-scale acts of violence such as terrorist attacks; small-scale acts of violence such as being held at gunpoint; man-made disasters such as car accidents and plane crashes; natural disasters such as tornadoes, earthquakes, and hurricanes; and war.

Trauma affects people in many ways depending on the context of the traumatic event, a person's age, development, his or her personality, and who was involved in the event either as victim or as perpetrator. Trauma can cause both emotional and psychological wounds but can also cause deep spiritual and existential wounds. A traumatic event is something that inflicts severe harm to a person's psyche.

Trauma is profoundly personal, and how traumatic an event is depends on many variables. For instance, a trauma that is personal in nature is different from a trauma that occurred due to a natural disaster. Someone who witnessed a loved one dying in an accident is different from witnessing a loved one being murdered. Another aspect of trauma that impacts its victims is whether the perpetrator of the traumatic event was someone personally known to the victim and the nature of the abuse. Being abused by a parent, a sibling, a relative, a member of clergy, or a teacher is an example of abuses that are traumatic partly due to the relationship between the victim and perpetrator.

Trauma refers to events that are extreme, often violent, emotionally overwhelming, and inherently difficult to cope with. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) lists diagnostic features, criteria, and symptoms that are commonly experienced by trauma survivors. Symptoms include distressing and intrusive memories, which means a person cannot get the memories of the event out of his or her mind; the person is always thinking about them even when he or she doesn't want to. Feelings of stress, fear, and/or anxiety when exposed to, or

reminded of, the traumatic event are another cluster of symptoms. These feelings may be intense and distressful, with physiological (body) reactions occurring such as a racing heartbeat and sweating profusely. Nightmares and dreams about the event are common. Going out of their way to avoid people or places that victims associate with the trauma such as not driving on a road where an accident occurred is another symptom. Flashbacks occur when a trauma victim feels or acts like the event is actually taking place in the here and now even though it may have occurred months or even years earlier. Symptoms can also include increase in "startle response," sometimes referred to as "jumpiness," self-destructive behavior, sleep disturbances, and other mood symptoms. Symptoms also include changes in a person's memory, personal relationships, and beliefs about oneself and the world around oneself.

The DSM-5 lists several disorders that are associated with trauma. Perhaps the best-known trauma diagnosis is post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2013). In order to be diagnosed with PTSD an individual must have been exposed, in some way, to an event that involved actual or threatened death, serious injury, or sexual violence. The traumatic event may have been directly experienced, or witnessed in person as it occurred to someone else. PTSD can also apply to individuals who learn of the accidental or violent death of a close family member or loved one. People who are exposed to repeated and extreme details of traumatic events, such as first responders to catastrophic accident scenes, medical personnel, firefighters, and child abuse authorities,, can experience and be diagnosed with PTSD. Very similar to PTSD is acute stress disorder (ASD), with the main difference being how long symptoms have been present. If symptoms occur more than one month, the diagnosis would be PTSD; between three days and one month, the diagnosis would be ASD. According to the International Society for the Study of Trauma and Dissociation, approximately 10%–25% of adults who are exposed to an extreme event may develop ASD or PTSD.

Treatment of trauma is a multidimensional task that requires assessment, psychotherapy, and sometimes medication. The main goal of treatment is to assist clients in developing coping skills, increase self-awareness to assess intensity of symptoms, develop and maintain the ability to manage daily life responsibilities, manage symptom triggers rather than avoiding them, and increase a client's overall personal control. Common treatment approaches include exposure therapy, dialectical behavior therapy, cognitive behavior therapy, psychodynamic therapy, and eye movement desensitization and reprocessing.

Steven R. Vensel, PhD

See also: Compassion Fatigue; Post-Traumatic Stress Disorder (PTSD); Trauma Counseling

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Trauma Counseling

Trauma counseling includes a variety of psychotherapies provided to individuals suffering from traumatic experiences.

Description

Mental health professionals have been providing psychotherapeutic services to people suffering from the impact of traumatic experiences for over a century. "Trauma" refers to the deep emotional and psychological effects of extreme, often violent, and terrifying experiences. A person who is traumatized is debilitated, and his or her quality of life is diminished as compared to how he or she was prior to the traumatic event.

"Trauma disorders" is a general term describing a group of several specific disorders in which exposure to a traumatic event is listed as the cause of the person's difficulties. Perhaps the most well-known and researched trauma disorder is post-traumatic stress disorder (PTSD). PTSD is most often associated with war combat veterans, but war-related PTSD is only one of the causes of PTSD. There are many causes of trauma, including domestic violence, child neglect and abuse, natural disasters, catastrophic and deadly accidents, rape, and other acts of violence.

People who suffer from trauma reexperience the traumatic event in intrusive and debilitating ways. Common experiences include intrusive and horrifying memories, flashbacks, and nightmares. Emotional and physiological reactions are triggered by reminders of the trauma and can be severe and debilitating. For instance, someone who was held at gunpoint and robbed in a parking lot may experience extreme anxiety or panic attacks whenever he or she enters any parking lot. People who suffer from trauma disorders often go to great lengths to avoid anything that may trigger trauma reactions. This can become quite debilitating. Imagine how difficult life would be if a person was unable to go anyplace there was a parking lot. The person would be extremely limited to where he or she could go, whom he or she could go with, and what he or she could experience. The person would live a lonely and fearful life.

Development and Current Status

Since the 1980s trauma counseling has been the focus of considerable research and development. This has resulted in evidence-based practice guidelines and treatment methods known to be effective in the treatment of trauma disorders. These practices include exposure-based treatments, cognitive behavior therapy (CBT), and eye movement desensitization reprocessing (EMDR).

Exposure-based treatments include exposure therapy (ET) and prolong exposure therapy (PE), both of which have been the focus of significant research. Both ET and PE have been found to be effective in providing relief from trauma symptoms. The U.S. Department of Veteran Affairs considers PE to be one of the most effective treatments of PTSD and has initiated a national PE training program in order to provided needed services to combat veterans.

Prolonged exposure therapy is a type of counseling that decreases trauma-related distress by helping clients face the thoughts, feelings, and circumstances that have been avoided so as not to evoke memories of the traumatic event. Repeated exposure to these thoughts, feelings, and circumstances increases a person's ability to cope and decreases the debilitating effects of the trauma. Therapy involves educating the client about trauma and the therapy process. Relaxation and breathing techniques are taught in order to ground the person in the here and now as he or she talks about what happened to him or her in the past. Talking through the trauma and repeatedly telling and retelling his or her story and sharing the memories is called "imaginal exposure" and helps the client make sense of what happened to him or her. Imaginal exposure helps the client gain emotional control over the memories and learn to not be afraid of the memory. In vivo experiences are practiced in which clients are gradually exposed to real-world situations that evoke the trauma memories. In vivo experiences decrease trauma-related distress over time.

The goal of the therapy is to help the client process the experience, reduce stress and avoidance, and engage in enjoyable activities. For instance, treatment for the victim of the parking lot armed robbery would begin with educating him about trauma and PE. He would be informed that treatment would include him feeling anxious and distressed but that this is a reaction to the memories. He would be taught breathing and relaxation techniques and would be interrupted if he becomes too distressed to practice the breathing exercises. He would then be asked to tell his story. This

process of story, breathing, story, relaxing, would be repeated over and over. This may take several counseling sessions. As the client's distress decreases as he tells his story, the therapist helps him process situational triggers. The therapist may suggest that he drive by a parking lot that has evoked a strong emotional reaction and practice breathing. As the client is able to drive by the parking lot, the therapist may suggest entering the parking lot, parking for a moment without getting out of the car, and leave once the emotions are too negative, even if that means just a second or two. The in vivo experiences and the memories the experience evoked are discussed in therapy sessions. This process continues until the client is no longer debilitated by the feelings, thoughts, and situations associated with the traumatic event.

Cognitive behavior therapy and EMDR are two other therapies that have been found to be effective in decreasing trauma-related symptoms. CBT focuses on the distorted thoughts and beliefs associated with traumatic events and how to manage the residual emotions of the experience. EMDR is a relatively recent addition to trauma therapy and involves eye movements and body focus as clients talk about and recall traumatic experiences.

Trauma is highly treatable, and most victims are able to make a full recovery. Trauma counseling includes a variety of psychotherapies that are helpful to victims of traumatic experience.

Steven R. Vensel, PhD

See also: Cognitive Behavior Therapy; Compassion Fatigue; Post-Traumatic Stress Disorder (PTSD); Trauma Counseling

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Traumatic Brain Injury

Traumatic brain injury (TBI) is an insult or injury to the brain from an external force. In DSM-5, this disorder is known as neurocognitive disorder due to traumatic brain injury.

Definitions

- **Concussion** is a mild form of brain injury and is the most common type of traumatic brain injury. It involves a brief loss of brain function due to head trauma that resolves spontaneously without a loss of consciousness.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neurocognitive disorders** is a group of disorders in DSM-5 that are characterized by a decline from a previous level of neurocognitive function. In DSM-IV this group was called delirium, dementia, and amnestic and other cognitive disorders.
- **Neurodegenerative disease** is a medical condition in which the nervous system progressively and irreversibly deteriorates.
- **Post-concussion syndrome** is a collection of symptoms that some develop as a complication of concussion, such as headache, disorientation, amnesia (inability to remember the injury), and memory and concentration problems, which usually clear within three months after the head injury.

Description and Diagnosis

Traumatic brain injury (TBI) is an injury to the brain from an external force. It is neither congenital nor degenerative. It can lead to temporary or permanent impairment of cognitive, physical, and psychological functions, and may involve a diminished state of consciousness.

TBI can range from mild (concussion) to severe and can last for hours, days, weeks, or longer. It results from a blow to the head, a fall, or anything that shakes the brain and leads to bruising, swelling, or tearing of brain tissue. Most individuals will fully recover from a mild brain injury. But severe or repeated injury to the brain can have long-term problems with learning, movement, or speech. Symptoms may include headaches, vision problems, dizziness, or trouble remembering new information. Occasionally, they include feelings of sadness, anxiety, anger, or disturbed sleep.

Traumatic brain injury is one of the groups of neurocognitive disorders in DSM-5. As the name suggests, this disorder requires clear evidence of TBI. Usually, this involves a head injury that has led to a change in cognitive functioning. The most common variation would be post-concussion syndrome.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if there is evidence of a TBI. This injury must involve disorientation and confusion, neurological signs, post-traumatic amnesia, or the loss of consciousness. This diagnosis also requires that these symptoms and signs occur immediately after the brain injury occurs or right after recovery of consciousness. Criteria must also be met for either major or mild neurocognitive disorder. This disorder can be coded with or without behavioral disturbance (American Psychiatric Association, 2013).

As noted earlier, TBI is caused by a blow or other traumatic injury to the head. The degree of damage depends on several factors, including the type and the force of the impact. Common causes are falls, vehicle-related collisions, violence, explosive blasts and combat injuries, and sports injuries. For example, individuals who are hard driving and/or thrill seekers and are engaged in sports and related activities are prone to TBIs. This includes football players, race car drivers, and extreme sports enthusiasts, like skateboarders, who commonly experience TBIs.

Treatment

Most individuals with mild TBI require no treatment beyond rest and over-the-counter pain relievers for their headache. However, these individuals need to be observed and monitored closely at home for any worsening or new symptoms. Moderate to severe TBI may require treatment in an emergency room and/or hospitalization. The goal of such treatment is to ensure that the individual has an adequate oxygen and blood supply, to maintain blood pressure, and to prevent further injury to the head or neck. Those with significant brain injury will require rehabilitation. This may include relearning basic skills like talking and walking. The goal is to restore the individual's ability to perform daily activities. Other treatment interventions may include counseling, medication, psychiatric consultation, and family therapy.

Len Sperry, MD, PhD

See also: Neurocognitive Disorders

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Trichotillomania

Trichotillomania is a mental disorder characterized by the repeated pulling out of one's hair that leads to hair loss and significant distress or disruption in various areas of life.

Definitions

- **Obsessive-compulsive and related disorders** are a group of DSM-5 mental disorders marked

by preoccupations and repetitive behaviors that lead to personal distress or problems with daily functioning (e.g., obsessive-compulsive disorder). Other related disorders are characterized by repetitive behaviors that are fixated on the body. These disorders also result in personal, occupational, and/or social difficulties.

- **Obsessive-compulsive disorder** is a mental disorder that is distressful to the individual and is characterized by unreasonable obsessions or compulsions that are inappropriately time consuming or cause marked distress or impairment. It is commonly referred to as OCD.
- **Preoccupations** are thoughts, urges, or images that are undesirable and bothersome.
- **Selective serotonin reuptake inhibitors (SSRIs)** are antidepressants that boost serotonin levels in the brain. They are mainly used to treat depression, anxiety, and particular personality disorders. They are also used to treat trichotillomania.
- **Tricyclic antidepressants** are antidepressants that increase serotonin and norepinephrine levels in the brain. They have also been used to treat trichotillomania.

Description and Diagnosis

Trichotillomania is one of the DSM-5 obsessive-compulsive and related disorders. Individuals with this disorder experience the recurrent urge to pull out hair primarily from their scalp, eyebrows, and eyelashes. Other less likely places include hair from the face, pubic, and peri-rectal areas. The preferred location for hair pulling may change periodically. The duration and frequency of hair pulling also vary. An individual may engage in hair pulling intermittently but often during daily activity. Or the individual may pull out hair only for a concentrated period of time, such as one or two hours, during the day. Typically, hair pulling leads to hair loss, which is noticeable by others. However, in some cases the hair pulling is performed evenly over a particular region so it is less obvious. In other cases, an individual may try to hide hair loss by wearing a head scarf, hat, or wig; coloring in eyebrows; or wearing false eyelashes.

The occurrence of this disorder is low among the general population. Approximately 1%–2% of individuals meet the criteria for trichotillomania. Adult and adolescent females are 10 times more likely than males to develop the disorder. In childhood the occurrence is relatively equal in males and females (American Psychiatric Association, 2013). Trichotillomania typically begins in childhood or adolescence.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they pull out their hair frequently enough that it results in hair loss. This behavior results in negative emotions (e.g., shame and embarrassment) and problems in significant life domains. Any efforts to control or stop the behavior have been unsuccessful. There is no evidence of a medical condition or other mental disorder that may be the cause of the hair pulling or hair loss (American Psychiatric Association, 2013).

The cause of this disorder is considered to stem from difficulty with impulse control. It is also thought to have a genetic component. It occurs more often in individuals with obsessive-compulsive disorder. These individuals also are likely to have family members with obsessive-compulsive disorder. Other factors may include stress, trauma, anxiety, or boredom.

Treatment

Treatment may include psychotherapy and medication. Cognitive behavior therapy is instrumental in helping an individual develop awareness of hair pulling, identify and reframe negative thoughts and beliefs, and change maladaptive behaviors. Medication therapy may include SSRIs or tricyclic antidepressants, particularly clomipramine.

Christina Ladd, PhD, and Len Sperry, MD, PhD

See also: Cognitive Behavior Therapy; Obsessive-Compulsive Disorder (OCD); Serotonin

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Truancy

Truancy is defined as any intentional, unexcused absence on the part of a student from his or her compulsory education.

Definitions

- **Compulsory education** is described as the required period of schooling for every person under law; in the United States this varies by state but typically begins at age 5 till approximately age 17.
- **Delinquency** is a general term used to describe the unlawful activity, wrongdoing, or misbehavior of young people.
- **Dropout** is a term that refers to a person who stops attending or withdraws from school prior to completing his or her degree (high school, college) or the equivalent to a degree.
- **Homeschool,** also termed home-based learning or home education, refers to the teaching or instruction of a student at home by a parent, guardian, or tutor, rather than at a traditional public or private school environment.
- **School refusal,** an umbrella term now used in lieu of the term "school phobia," describes child-motivated noncompliance in attending school, remaining in class for the entire school day, or both.

Description

Truancy is the unexcused absence of a student from his or her required attendance at school. Other terms or phrases commonly used to describe truancy are "skipping school," "cutting class," "ditching," and "playing hooky." Students who are truant do not miss class for acceptable (excused) reasons such as an illness, a medical condition, or a family emergency; rather, they choose to not attend at their own free will. Truancy is often identified and then reported by teachers or professional school counselors to administrators or school resource officers who may impose consequences, including detentions, in school suspensions, fines, or additional/remedial coursework (i.e., summer school). In the United States, truancy is considered a status offense, like alcohol consumption and curfew violations, because the perpetrator of the act is a minor. Furthermore, parents or guardians are charged with the responsibility to ensure that their child attends school. Laws, regulations, and policies regarding truancy can vary from state to state and even school districts.

Absentee rates are monitored on a daily basis and remain a part of the student's permanent educational record. Notification systems via phone call, e-mail, or text have been incorporated in recent times to help address truancy. Parents receive messages from their child's school that their child either has not arrived or has been marked absent from a class period or multiple class periods. Truancy officers have also been designated at school sites to assist in combating this problem. Some are authorized to ticket students directly or remand them into their parents' custody or directly back to their school site.

Current Status and Impact (Psychological Influence)

Truancy is a social concern as students who are truant are more likely to drop out of school, engage in delinquent behavior, and have a negative effect on their peers. Research indicates that truancy rates are highest in inner-city public schools where poverty rates are also high. Additional findings suggest that truancy peaks around 15 years of age and that males are slightly more likely than females to engage in this behavior. Truancy has also been linked to several factors, including poor academic performance (specifically in reading and math), specific learning disabilities (dyslexia, ADHD), friction with teachers and/or administrators, inability to make and keep friends, lack of family stability and parent involvement, and low

teacher expectations. Furthermore, studies suggest that there is a high correlation between students who were habitually truant during their youth and later criminal behavior. School personnel, in particular teachers and school counselors, can work together to improve truancy issues. Students who feel connected, safe, and supported during difficult times are more likely to remain in school. Likewise, parents who closely monitor their children's behavior, value education, and remain actively involved in the schooling process can also have a positive effect.

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See also: Gangs; Juvenile Offenders; Social Anxiety Disorder in Youth

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Twelve Traditions of Alcoholics Anonymous, The

The Twelve Traditions of Alcoholics Anonymous are principles and guidelines for relationships between Twelve-Step groups, members, other groups, the global fellowship, and society at large.

Definitions

- **AA Grapevine** is the international journal of Alcoholics Anonymous. It is written, edited, illustrated, and read by AA members and other individuals interested in recovery from alcoholism.
- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use and other compulsive behaviors.
- **Alcoholics Anonymous** is a mutual aid or self-help fellowship that was founded by Bill Wilson and Dr. Bob Smith in 1935 to help individuals struggling with alcoholism. It is also referred to as AA.
- **Sobriety** is the continued abstinence from any mood-altering substance (e.g., alcohol, marijuana, opiates, and tobacco).
- **Spiritual principles** are the concepts that correspond to each of the Twelve Steps of Alcoholics Anonymous.
- **Twelve Steps** refers to the 12 guiding principles on which Alcoholics Anonymous is based.
- **Twelve-Step Programs** are self-help groups whose members attempt recovery from various addictions based on a plan called the Twelve Steps.

Description

The Twelve traditions grew out of the Alcoholics Anonymous (AA) movement and outlined the means by which AA relates itself to the world and maintains AA unity. Questions regarding finance, authority, public relations, eligibility, anonymity, donations, outside opinions, and purpose are all addressed in the twelve traditions. The Twelve traditions contain the spiritual principles that keep Twelve-Step Groups focused on AA's primary purpose. The primary purpose of AA is to stay sober and to help others to achieve sobriety. Without such guidelines, it would be nearly impossible to maintain a worldwide fellowship and keep the AA message strong. The three legacies of AA include recovery, unity, and service. Each of these legacies is grounded on the foundation of spiritual principles. Each step, tradition, and concept is a principle (e.g., a rule of personal conduct).

Often, an individual in AA will extract a word or two from the Twelve traditions and formulate his or her own interpretation of the principle(s) rather than to

be positively informed by AA literature. Much can be gained from the Twelve traditions both in understanding and in results, when viewed as a whole instructive sentence. Each whole constructive sentence (tradition) can be viewed as a "principle." The Twelve traditions provide rules of personal conduct that are practiced in all of the affairs of those with addiction problems and as a way of developing a spiritual state that offers a daily reprieve from alcohol. The result is a gift called sobriety (e.g., freedom from alcohol). The gift of the traditions is "unity" (e.g., to keep the fellowship from destroying itself).

In 1939, several of the principles of what would become AA's Twelve traditions were first written in the beginning of the first edition of the *Big Book of Alcoholics Anonymous*. By 1944, several AA groups had some concerns of how to handle disputes caused by issues such as religion, publicity, and finances. They forwarded these concerns to AA headquarters. In 1946, Bill Wilson (1895–1971), the cofounder of AA, clearly developed the basic concepts for the Twelve traditions by collaborating with several AA groups. During this time, guidelines were set on how groups and members should interact with the public, each other, and AA in its entirety. The Twelve traditions were first published in April 1946 in the AA Grapevine under the title *Twelve Points to Assure Our Future*. In July 1949, during the first International AA Convention in Cleveland, Ohio, an estimated 3,000 attendees adopted the Twelve traditions unanimously by a standing vote. Bill Wilson's book *Twelve Steps and Twelve Traditions* was later published in April 1953. The Twelve traditions are not specifically mandatory in any AA group or groups. However, the overwhelming majority of its members have adopted the Twelve traditions as the foundation for AA's expanding internal and public relationships.

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See also: Addiction; Alcoholics Anonymous (AA); Spirituality and Practices; Twelve-Step Programs

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Twelve-Step Programs

Twelve-Step Programs are self-help groups whose members attempt recovery from various addictions based on a plan called the "Twelve Steps."

Definitions

- **Addiction** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Addiction recovery** is the state of abstinence from addictive behaviors, usually achieved through self-reflection and spiritual exploration.
- **Addictive disorder** is a chronic disease of the brain, which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.
- **Alcoholics Anonymous** is a mutual aid or self-help fellowship that was founded by Bill Wilson and Dr. Bob Smith in 1935 to help people struggling with alcoholism.
- **Compulsions** are habitual behaviors, practices, or rituals that are impulsively engaged in to defend against perceived threats, to reduce fears, or otherwise to minimize distress.
- **Mutual aid fellowship** is a community in which individuals struggling with the same problem (e.g., alcoholism) help one another.
- **Spirituality** is the sum total of an individual's unique worldview and self-view, religious beliefs, attitudes, and behaviors.
- **Twelve Steps** refers to the 12 guiding principles on which Alcoholics Anonymous is based.

Description

All Twelve-Step Programs share the same model as Alcoholics Anonymous, which was established in 1935. The foundation for this model is the Twelve Steps, which focuses on the addiction recovery process. These steps include tasks such as admitting powerlessness, completing a moral inventory, making amends to those who were harmed, and helping other members of the Twelve-Step Group. While there is some variation depending on the specific focus of the Twelve-Step Group, most of the steps are the same. For example, Step 1 in Alcoholics Anonymous is "We admitted we were powerless over alcohol—that our lives had become unmanageable." In Narcotics Anonymous, "alcohol" is replaced with the words "our addiction." Other examples are Step 2: "We came to believe that a power greater than ourselves could restore us to sanity" and Step 5: "We admitted to God, to ourselves, and to another human being the exact nature of our wrongs." The ultimate goal of the Twelve Steps is to achieve a spiritual awakening that will help the individual continue to stay away from the problem substance or behavior. Twelve-Step Programs are based on the belief that addiction and compulsions are diseases for which spiritual development is the only cure.

Twelve-Step Programs are mutual aid fellowships intended for individuals who share the same problem to help one another. As with other self-help programs, lay members run meetings and activities rather than professionals such as physicians and counselors. Members participate in regular group meetings to discuss various topics. Other activities may include providing guidance through sponsorship, performing service work, and studying program literature. There are many different types of Twelve-Step Programs that address addictions to both different substances and compulsive behaviors. Narcotics Anonymous is the second-most popular program for substance abuse behind Alcoholics Anonymous. Other programs include Sex and Love Addicts Anonymous, Overeaters Anonymous, and Gamblers Anonymous. There are also Twelve-Step Programs that focus on relationships. These include Al-Anon and Adult Children of Alcoholics, and address family issues. Regardless of the specific focus, members of all Twelve-Step Groups are expected to maintain confidentiality, follow program guidelines, and support each other through the process of recovery.

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See also: Addiction; Alcoholics Anonymous (AA); Compulsions

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U

Understanding Human Nature (Book)

Understanding Human Nature is a book written by Alfred Adler that explains the principles of Individual Psychology.

Definitions

- **Alfred Adler (1870–1937)** was an Austrian psychiatrist who developed the psychological system called Individual Psychology.
- **Family constellation** includes information about individuals' relationships with other family members, family values, and the way they found a sense of belonging in their family.
- **Individual Psychology** is an approach to psychology that understands individuals as social beings with a need to belong and to strive for significance. It is also known as Adlerian Psychology.
- **Inferiority feelings** are feelings that occur when an individual believes they are incompetent or inadequate.
- **Lifestyle and lifestyle convictions** are conclusions an individual makes about their inner world based on their interpretations of previous experiences.
- **Psychological birth order** is the perceived position or role that an individual takes or is given in a family system.
- **Rudolf Dreikurs** is an American psychiatrist and educator known for advancing Adlerian psychology through his writings and professional publications.

Description

Understanding Human Nature is a book written in 1927 by Alfred Adler (1870–1937). The book was Adler's effort to explain human behavior through a discussion of the principles of Individual Psychology. The book is written in a style that can be understood by lay citizens and mental health professionals. Content in the book is based on a year's worth of lecture material delivered by Adler at the People's Institute of Vienna.

Understanding Human Nature discusses various philosophical and psychological concepts from the theory of Individual Psychology. Adler believed that individuals seek to have a sense of power, belonging, and significance in the world. Individuals experience inferiority feelings and they compensate for those perceived inferiorities by having the courage to take risks, or by declaring bankruptcy through displaying weakness as an adult to seek help or attention. The book also explained that behavior is goal-oriented, and that individuals are always striving toward a conscious or unconscious goal. Additionally, psychological birth order, family constellation, and early memories influence our lifestyle convictions or personality.

Alfred Adler created Individual Psychology and was born in Austria. In 1911, Adler left the Vienna Psychoanalytic Society as a colleague of Sigmund Freud (1856–1939) due to differences in their explanations of human behavior. Freud believed that individuals experience psychological issues due to repressed

sexual feelings, while Adler believed that people's perceptions of their shortcomings and their difficulties with social belonging influenced human suffering. Rudolf Dreikurs (1897–1972) was an American psychiatrist and educator who also advanced the theory and practice of Individual Psychology. Dreikurs was a student and eventually became a close colleague of Alfred Adler. After Adler's death in 1937, Dreikurs went on to promote the use of Individual Psychology around the world. Individual Psychology is considered one of the most influential theories among the contemporary counseling theories. While the approach is criticized for having limited empirical research, it has thousands of active members in Adlerian societies around the world.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Adler, Alfred (1870–1937); Dreikurs, Rudolf (1897–1972); Early recollections; Lifestyle and Lifestyle Convictions

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V

Vaginismus

Vaginismus is the inability to allow vaginal penetration in sexual intercourse because of anxiety and fear of pain that results in vaginal spasm.

Definitions

- **Anxiety** is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.
- **Cognitive behavior therapy** is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Dyspareunia** is the experience of genital pain during sexual intercourse.
- **Exposure** is a cognitive behavior therapy intervention (method) in which a client is exposed to a feared object or situation. It is also referred to as flooding.
- **Fear** is an emotional response to a known danger. It is similar but different from anxiety.
- **Genito-pelvic pain/penetration disorder** is a mental disorder in women characterized by persistent fear, pain, or difficulty with vaginal intercourse. Previously this disorder was referred to as dyspareunia and vaginismus.
- **Pelvic floor muscle training** involves a series of exercises designed to strengthen the muscles of the pelvic floor. These exercises are used to treat problems with urine leakage, bowel control, and pelvic pain.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Sexual dysfunction disorders** are a group of mental disorders characterized by significant difficulty in responding sexually or experiencing sexual pleasure. They include female organismic disorder, and genito-pelvic pain/penetration disorder.
- **Specific phobia** is a mental disorder characterized by a marked and enduring fear of specific situations or objects. Previously this disorder was referred to as simple phobia.
- **Systematic desensitization** is form of cognitive behavior therapy that gradually exposes individuals to their phobia (fear) while remaining calm and relaxed.

Description and Diagnosis

Vaginismus is a sexual disorder in DSM-IV-TR but is not listed as such in DSM-5. It is characterized by vaginal spasm during or before vaginal penetration. This vaginal spasm is associated with anxiety and fear

related to penetration as opposed to a medical cause. This spasm, or the anxiety and fear of experiencing the spasm, tends to inhibit normal intercourse. For some individuals, these spasms may be associated with any form of vaginal penetration, including penetration by a finger or other objects. This disorder has been combined with dyspareunia in the DSM-5 diagnosis of genito-pelvic pain/penetration disorder. These two disorder were combined in DSM-5 because it was difficult for clinicians to distinguish between these two disorders and because they commonly occurred together.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, an individual may be diagnosed with this disorder if they experience recurring vaginal spasms that inhibit intercourse. This spasm must cause the individual distress. These symptoms cannot be better explained by a medical condition or an alternative psychological diagnosis. This disorder may be present in an individual's entire life or it may begin after a period of normal sexual functioning. Symptoms may occur in a particular circumstance or in all situations involving intercourse. Also, some individual with symptoms of this disorder may also be diagnosable with a specific phobia related to sex.

The cause of this disorder is unclear. It is believed that sexual abuse, body-image issues, relationship issues, religious beliefs, and a history of vaginal infection may contribute to the manifestation of this disorder. However, for the majority of individuals, a combination of psychological, physiological, and social factors are likely to be present. For this reason, it is important for a clinician to be diligent in their assessment of this disorder.

Treatment

Treatment includes a comprehensive medical evaluation to identify any medical condition that might cause vaginismus. If one is found, than medical treatment is appropriate. If no such cause is identified, it is usually treated with a combination of physical therapy and psychotherapy. Physical therapy is necessary to help the individual learn how to train and control their pelvic floor muscles. The most common form of psychotherapy for this disorder is cognitive behavior therapy (CBT). CBT is used to reduce fear, anxiety, and pain. It emphasizes systematic desensitization and exposure techniques. If trauma issues are involved, it would also address them or refer for specialized treatment.

Len Sperry, MD, PhD and Jeremy Connelly, MEd

See also: Anxiety; Cognitive Behavior Therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Dyspareunia; Exposure; Fear; Genito-Pelvic Pain/Penetration Disorder; Psychotherapy; Sexual Dysfunction Disorders; Specific phobia

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Valerian

Valerian is an herbal remedy used primarily for sleep problems.

Definitions

- **Flavonoids** are plant compounds that have anti-inflammatory, anticancer, or antioxidant effects.
- **GABA** (gamma-aminobutyric acid) is a chemical messenger in the brain that leads to relaxation, calmness, and sleep by reducing nerve cell excitement.

Description

Valerian (*Valeriana officinalis*) is a medicinal herb that promotes calmness and relaxation. It has long been used as a tranquilizer that acts without narcotic

effects. Because of its flavonoid properties, it has also been used as a pain reliever, antispasmodic, and sedative. Other uses include digestive problems, headaches, and arthritis. Valerian is thought to work by increasing gamma-aminobutyric acid (GABA), a neurotransmitter (chemical messenger) in the brain. To date there is limited research on the effectiveness of valerian. Based on a few small clinical trials valerian has been shown to have mild sedative and tranquilizing properties, but less than prescription sleep medication. There is not yet sufficient research evidence to support the use of valerian in the treatment of anxiety disorders. However, anecdotal reports indicate that regular use of the supplement promotes feelings of calmness and reduces stress.

Precautions and Side Effects

Unlike prescription sleep medications, valerian root is not believed to carry a risk of dependency. However, the supplement should only be used under the supervision of a qualified health-care professional. Caution should be exercised if taking the supplement over an extended period of time. Similarly, exercise caution in driving and in operating machinery particularly when using this supplement for the first time. Valerian should not be used in large doses or for an extended period. Individuals should not take valerian continuously for more than two to three weeks as they may become tolerant to its effects. Some research suggests that prolonged use could result in liver damage and central nervous system impairment. Increasing the dose of the herb to achieve desired effects may result in adverse (negative) effects. Women who are pregnant or breast-feeding should not use valerian, as its effects on the fetus or infant have yet to be tested. Those planning to undergo surgery should stop taking valerian at least two weeks before their procedure.

Side effects of valerian root are rare. They may include headache, upset stomach, daytime drowsiness, and dizziness. Large doses of valerian may occasionally cause headache, muscle spasm, heart palpitations, dizziness, gastric distress, sleeplessness, and confusion. Continuous, uninterrupted use of valerian may cause depression.

While valerian has been regarded as a relatively safe herb, it can interact with medications and other natural remedies. It can interfere with the effectiveness of medications broken down in the liver, such as allergy medications, cholesterol medications, antifungal medications, and cancer medications. Valerian root may also cause drowsiness if taken with prescription medications such as selective serotonin reuptake inhibitors, benzodiazepines like Valium, Xanax, or Klonopin. Drowsiness is also likely if used with narcotics such as codeine; barbiturates such as phenobarbital, over-the-counter cold and sleep remedies, or antihistamines; and alcohol. Long-term studies of valerian use are still needed to determine its safety.

Len Sperry, MD, PhD

See also: Sleep Disorders

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Valium (Diazepam)

Valium is an antianxiety medication belonging to a class of drug known as benzodiazepines. Its generic name is diazepam.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Anxiety** is a psychological state of strong feeling of apprehension, distress, worry, or agitation, which is accompanied by physical symptoms of sweating, tension, and increased heart rate.
- **Benzodiazepines** are a group of central nervous system depressants that are used to relieve anxiety or to induce sleep.

- **Epilepsy** is a medical condition involving episodes of irregular electrical discharge within the brain that causes impairment or loss of consciousness, followed by convulsions.
- **Anterograde amnesia** is a type of amnesia in which new memories cannot be formed while existing memories remain intact.
- **Seizure** is a sudden convulsion or uncontrolled discharge of nerve cells that may spread to other cells throughout the brain.

Description

Valium is one of the class of antianxiety medications called benzodiazepines. Benzodiazepines help to relieve nervousness, tension, and other anxiety symptoms by slowing the central nervous system. They accomplish this by blocking the effects of chemical messenger that decrease the excitability of nerve cells in the brain. All benzodiazepines, including Valium, cause sedation, drowsiness, and reduced mental and physical alertness. Its primary use is in the short-term treatment of mild to moderate anxiety. Valium is also used to treat epilepsy, muscle spasms, nervous tension, and symptoms relating to alcohol withdrawal. Unlike Xanax and Ativan, which are short-acting benzodiazepines, Valium is a longer-acting benzodiazepines which makes it ideal for certain applications such as the treatment of epilepsy.

Precautions and Side Effects

Children, the elderly, and those with significant health problems should be carefully evaluated before been prescribed Valium. Children under the age of six months should not take Valium. In addition, those with a history of liver disease, kidney disease, or those with low levels of a protein in the blood called albumin need to be carefully assessed before starting this drug.

The sedative effects of Valium are cumulative and long-lasting. Because Valium can cause drowsiness, care should be taken while driving, operating machinery, or engaging in other activities that require mental alertness. Alcohol and other medications used in the treatment of mental illness should not be taken concurrently with Valium. Those who have had adverse reaction to any other benzodiazepines should not take Valium, neither should those with acute narrow-angle glaucoma. Valium, like other longer-acting benzodiazepines carries the risk of anterograde amnesia. As with other benzodiazepines, long-term use of Valium can be habit-forming. Because of its abuse potential, it should be used with caution in those with a history of substance abuse. Valium should not be discontinued abruptly as this can lead to withdrawal effects such as nervousness, confusion, depression, sensitivity to light, nausea, irritability, shaking, and abdominal cramps.

Common side effects of Valium include drowsiness, clumsiness, slurred speech, and dizziness.

More rarely reported are the following side effects: behavior changes, low blood pressure, muscle weakness, hallucinations, and jaundice or yellowing of the eyes or skin. Valium interacts with several medications, particularly other central nervous system depressant drugs such as alcohol, other tranquilizers, and sleeping pills. Therefore, in making the decision to use Valium, one's physician (and pharmacist) should review the other medications being taken for possible interactions.

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See also: Anxiety; Ativan (Lorazepam); Benzodiazepines; Epilepsy; Xanax (Alprazolam)

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Vascular Neurocognitive Disorder

Vascular neurocognitive disorder is a mental disorder characterized by loss of mental functioning that is caused by brain damage from impaired (blocked) blood flow. It is also known as vascular dementia.

Definitions

- **Alzheimer's disease** is a medical and mental disorder that causes a slow, progressive dementia usually late in life.
- **Dementia** is a group of symptoms including loss of memory, judgment, language, and other intellectual (mental) functions caused by the death of neurons (nerve cells) in the brain.
- **DSM-5** stands for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, which is a diagnostic system used by professionals to identify mental disorders with specific diagnostic criteria.
- **Neurocognitive disorders** are a group of disorders in DSM-5 that are characterized by a decline from a previous level of neurocognitive (mental) functions.
- **Vascular** refers to blood vessels. When blood flow through a vessel is impaired, (blocked) damage to the heart, kidneys, or brain can result.

Description and Diagnosis

Vascular neurocognitive disorder is one of the neurocognitive disorders listed in the DSM-5. It is characterized by a decline in mental processes caused by brain damage from impaired blood flow to the brain. Such damage results in significant distress or disrupted daily functioning. Those with vascular neurocognitive disorder have problems with memory and are unable to recall names or events. They also tend to have difficulty communicating, both verbally and in writing. Motor skills are also impaired in this disorder. Individuals may be unable to perform tasks that require hand-eye coordination, such as tying shoes. Some individuals experience physical symptoms like weakness of the arms and legs or abnormal reflexes.

Vascular neurocognitive disorder can also cause behavioral disturbances. Individuals may become aggressive or act impulsively. While the symptoms of vascular neurocognitive disorder resemble those of Alzheimer's disease, the two are different disorders. Vascular neurocognitive disorder occurs quickly with clear physiological causes. Alzheimer's disease generally begins slowly. Approximately 10%–20% of those who are diagnosed with neurocognitive disorders have the vascular form. It is the second most common after Alzheimer's disease. It is also more prevalent in men than in women. Vascular neurocognitive disorder typically occurs after age 60, and has a younger age of onset than Alzheimer's disease (American Psychiatric Association, 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, memory impairment must be present in individuals in order to diagnose this disorder. This may refer to problems learning new information or recalling previously learned information. An individual must also have one or more cognitive impairments. These may include aphasia (language disturbance), apraxia (motor skills disturbance), agnosia (inability to recognize objects), or problems in executive functioning (planning, organizing, etc.). They must also represent a decline from the individual's previous level of functioning. Neurological symptoms, such as weakness in limbs, or laboratory tests must point to cerebrovascular disease for this diagnosis. None of these symptoms can be caused by delirium, which is a separate diagnostic category (American Psychiatric Association, 2013).

Vascular neurocognitive disorder is caused by brain damage from impaired blood flow to the brain. A stroke or cerebrovascular disease ("cerebro"—brain; "vascular"—blood vessel) can block a major book vessel and cause this disorder. It is believed to be the result of small strokes that interfere with blood flow to the brain. Lack of blood flow depletes the brain's oxygen supply, leading to the symptoms described. Typically, this occurs after many small strokes over time rather than one large stroke. Strokes are the most common, but not the only cause of this disorder.

Treatment

There is no cure for vascular neurocognitive disorder and its effects cannot be reversed. Treatment is intended to slow or stop the progression of the disorder and improve symptoms. The most basic way to accomplish this is to prevent future strokes. This may be

done through changes in diet and drug treatments for high blood pressure. Lifestyle changes such as quitting smoking, avoiding heavy alcohol use, and reducing stress are usually prescribed.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Alzheimer's Disease; Dementia; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Neurocognitive Disorders

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Video Games

Video games (VGs) are a form of electronic interactive entertainment played by controlling images on a computer, console, or mobile-based video screen, including smart phones.

Description

Video games provide players with increasingly realistic and socially interactive experiences that deliver immersive emotional, social, and cognitive challenges. Players may play alone or with thousands; cooperatively or competitively; with other players physically present or located anywhere on the planet; and with people they know or with complete strangers. As many as 97% of children between the ages of 2 and 17 play VGs.

Impact (Psychological Influence)

VGs have been highly scrutinized with most of the research focused on the negative effects of VGs. Increased aggression, addictive gaming behaviors, negative mood states, and a decrease in empathy and prosocial behaviors (behaviors that benefit others) have all been linked to VG play. Findings however are disputed. While there is agreement that VG play has negative effects, some researchers argue that the actual magnitude of the effect is quite small and does not have any real predictive power. VGs are frequently cited as being connected to violence, mass killings, and school rampages but no research actually links these events to VG play.

Studies have identified many cognitive, emotional, and social benefits associated with playing VGs. VGs promote a wide range of cognitive benefits including the development of spatial skills. Spatial skills have been linked to achievement in science, technology, engineering, and mathematics, which in turn have been linked to long-term career success. VG play has also been associated with improved mood and increased positive emotions. Game play also evokes negative emotions but learning to control and regulate emotions for the sake of goal attainment is another emotional benefit to players.

Gaming is a social activity. Over 70% of gamers play with friends and some of the most popular games take place in virtual communities that contain millions of players. Acquiring social skills, engaging in prosocial behaviors, and learning to work cooperatively, even in violent VGs, carry over into positive offline behaviors. Emerging research indicates that playing violent VGs cooperatively in social groups verses competitively and alone increases prosocial behaviors while actually reducing hostility and aggressive thoughts. VG researchers acknowledge that more sophisticated and rigorous research models are needed in order to more fully understand both the positive and negative consequences of game play. There has been concern recently about sexism among gamers, including offensive criticism and cyberbullying of female VG developers. There is also concern about the addictive power of video and online games, which for some may create problems with school, work, or personal relationships.

Researchers agree that VGs are complex and sophisticated forms of entertainment that have tremendous potential in the fields of education and health care. Emerging data indicates that VGs can enhance both learning and health outcomes. VGs also represent a largely untapped potential for the promotion of well-being and the prevention and treatment of mental health problems. The future use of VGs in these fields has great promise.

Steven R. Vensel, PhD

While many researchers agree that video games are complex and sophisticated forms of entertainment with tremendous potential in the fields of education and health care, there are also concerns about video games leading to increased aggression, addictive gaming behaviors, and a decrease in empathy and in pro-social behaviors. Researchers are especially concerned about their impact on children and teenagers. (Gemenacom/Dreamstime.com)

See also: Flow, Psychological

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Vocational Counseling

Vocational counseling is therapy for people looking to obtain or maintain work.

Definition

- **Vocation** is a person's employment, trade, or main occupation.

Description

Vocational counseling is also known as career counseling. This is because of its focus on helping people find jobs and be successful in those jobs. Vocational counseling is usually provided by mental health or rehabilitation counseling professionals. These services can be provided through schools, government agencies, and private practice.

Many centers that offer vocational counseling serve people with diverse backgrounds. Usually clients

are referred to the service when they are unable to find work independently or because they need special arrangements due to a disability. Vocational counselors will meet with clients to evaluate, improve, and develop skills. This includes teaching how to conduct a job search, build a resume, and practice interview skills.

The types of clients who seek out career or vocational counseling vary. A person who has difficulty keeping a job or who has skills that are no longer useful for work might need help getting a new job and could benefit from career counseling. Additionally, clients with disabilities or who are older might need these services in order to be employed. Before someone can qualify to receive government benefits, such as social security or unemployment, they often require an assessment from a vocational counselor.

One of the first steps of vocational counseling is to help identify the client's interests. This can be accomplished through tests and questionnaires that help produce lists of possible career options based on interests and strengths. These tests should be administered and interpreted by the career counselor as they help their client work through understanding the results. If a client does not have the skills required to seek out a career they have chosen during counseling, the counselor can provide recommendations for additional training and education.

Career counseling can be short in duration. Some clients simply need referrals or resources which could be obtained in one or two sessions. Others could require more visits as the counselor works through evaluations and coaching a client to improve their skills. A vocational counselor could help a client look at reasons why they have had difficulty getting or maintaining employment. When this is the case, the challenges that arise for some clients might indicate that they require help from other professionals who can support the client's particular needs. These clients' needs can range from housing issues to psychiatric or physical medical problems that need to be addressed in order for a client to be successful in work. For more complex cases that require more attention, the duration of vocational counseling can be longer. Rehabilitation counseling for people with disabilities can be longer in duration and includes vocational counseling.

Vocational counseling occurs in different places and phases throughout a person's lifespan. In middle and high school, school counselors and teachers will likely introduce career issues. At colleges and universities, vocational counseling also exists to help students identify their transition to employment after completing their degrees. Outside of these educational settings, government services that provide vocational counseling are usually provided at no cost. Lastly, vocational counseling can be provided through not-for-profit agencies and private services that are specifically geared to certain populations.

Development

In the early 1900s, the father of vocational counseling, Frank Parsons, published a book on this important topic. *Choosing a Vocation* is the first major work that discussed the need for children and adults to have professional guidance in their career choices. He stressed the importance of career guidance as early as possible.

As interest in the field of career guidance and vocational counseling grew, more developments were made. In the 1970s, Donald Super identified a lifespan approach to career counseling to help identify career characteristics at different ages. There were others who focused on matching values or traits to specific careers as well. From these concepts many theories of career counseling have been identified and are widely used today. Many of these models focus on investigating the individual person and their needs as they evolve throughout their lifespan and identify careers of interest that are the best match to their characteristics.

Over the years several pieces of federal legislation have supported the use of vocational counseling in educational and government-run agencies. These laws and regulations have helped to establish the national vocational rehabilitation programs that were initially targeted for veterans. Eventually these acts have evolved to include different populations including people with disabilities, young people, and generally people in need of or interested in career assistance.

Current Status

Vocational counseling continues to be a funded service of national and local governments. The professions of rehabilitation and career counseling are growing and anticipated to continue being a necessary service. The need can be attributed to economic challenges and an increased population of those being diagnosed with disabilities and mental health issues.

One of the major challenges associated with career counseling is encouraging participants to engage in the process. When career counseling is mandated or forced, it is often difficult for clients to engage. Likewise, when a client is receiving government assistance, there may be incentives not to take advantage of vocational counseling services. Career placement counseling depends on resources in the community and is faced with a serious challenge when there are no options for employment.

It is important to note that career advice is provided through a range of formal and informal roles. Some prefer to rely on family members or people in the community for more informal career guidance. Others seek out more formal support through teachers, therapists, managers, and other professionals who are officially trained. Many people rely on themselves and independently search for Internet-based resources for career advice. The resources available online include help with resume writing, virtual interview practice, and searching and applying for available jobs. Vocational counseling is still considered a formal process of seeking therapeutic services from a trained professional.

Alexandra Cunningham, PhD

See also: Career Counseling; Rehabilitation Counseling

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Voyeuristic Disorder

Voyeuristic disorder is a mental disorder characterized by voyeuristic behavior that causes distress or impairment.

Definitions

- **Behavioral addiction** is a form of addiction caused by the compulsion to repeatedly engage in a behavior that causes harmful consequences. It is also referred to as process addiction or non-substance-related addiction.
- **Behavior therapy** is a form of psychotherapy that focuses on identifying and changing maladaptive behaviors.
- ***Diagnostic and Statistical Manual of Mental Disorders*** is the handbook mental health professionals use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.
- **Paraphilia** is a mental condition in which an individual can only become sexually aroused by inappropriate objects, actions, or fantasies.
- **Paraphilic disorders** are a group of mental disorder characterized by paraphilia that causes distress or impairment or whose satisfaction involves personal harm. Included in this group are exhibitionistic disorder, fetishistic disorder, pedophilic disorder, and voyeuristic disorder.
- **Voyeuristic behaviors** are behaviors that result in intense sexual arousal. These include watching others undress or engage in sexual activities, or secretly filming them. It is also called voyeurism.

Description and Diagnosis

Voyeuristic disorder is one of the DSM-5 paraphilic disorders. It is characterized by voyeuristic behavior that causes distress or impairment. Those engaging in this behavior are sexual aroused by spying on others engaged in intimate behavior. The term "voyeurism"

comes from the French word *voyeur* which means "one who looks." Common to voyeuristic disorder is that the individual observes but does not directly interact with those being observed. The term "peeping Tom" is associated with such behavior. Besides being sexually aroused by watching others, voyeurs may engage in masturbation. Many states consider voyeurism a crime. Voyeuristic behavior is considered voyeuristic disorder according to DSM-5 only when specific criteria are met.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, individuals can be diagnosed with this disorder if they experience intense sexual arousal on a recurrent basis from observing a non-consenting, naked individual who is undressing or engaging in sexual activity. This behavior or fantasies must cause significant distress or disrupt daily life. The individual must be at least 18 years old and the behaviors must also last for at least 6 months (American Psychiatric Association, 2013).

The causes of this disorder are unknown. Voyeuristic behavior usually starts before age 15. There are no reliable statistics regarding how often voyeurism occurs in the population. It seems it is more common in men, although it occasionally occurs in women. It may be that paraphilias are behavioral addictions or it could reflect a problem with brain functioning.

Treatment

There are no drugs to treat this disorder. Treatment for this disorder typically involves behavior therapy. The goal is to teach the voyeur to control the impulse and learn acceptable ways to achieve sexual gratification. The effectiveness of this treatment is unknown. This disorder is a chronic condition and there is little hope for change. The main reason is that they receive pleasure from this behavior and most individuals have little incentive to change. However, legal problems such as arrests and court orders are the main reasons individuals seek treatment. Currently, there is no way to predict who will develop this disorder; however, it may be prevented through education about appropriate sexual behavior.

Len Sperry, MD, PhD and George Stoupas, MS

See also: Behavioral Addiction; Behavior therapy; *Diagnostic and Statistical Manual of Mental Disorders* (DSM); Paraphilic Disorders; Substance-Related and Addictive Disorders

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Vygotsky, Lev (1896–1934)

Lev Vygotsky was a Jewish Russian psychologist who applied Marxist thinking to the study of human development.

Description

Vygotsky is considered one of the most significant and influential educational psychologists of the late 20th and early 21st centuries. He has been credited as the key figure in developing a social constructivist understanding of psychological development. Vygotsky's goal was to solve the psychophysical problem and thereby the problem of the crisis in psychology. He also wanted to provide solutions to problems in education. His two main ideas are the notion of cultural "tools" and the "zone of proximal development." He argued that children's intellectual growth is not an autonomous, self-guided affair. Rather, it depends greatly on the tools that the culture provides for them. These tools include language (written and oral); mathematical procedures; and, today, computers.

Vygotsky also believed that whenever children undergo some significant developmental change, they must go through a period of time—or "zone"—when they make sense of what they've learned. At the beginning of this period, the child can usually copy only with the help of someone more skilled than him or her. By the end, he or she can manage by himself or herself. What goes on during that zone of proximal

Lev Vygotsky was an influential Russian psychologist whose two main concepts are the notion of cultural "tools" and the "zone of proximal development." He argued that children's intellectual growth depends greatly on the tools that the culture provides for them, which include language (written and oral), mathematical procedures, and, today, computers. (Heritage Images/Corbis)

development is the essence of human development, Vygotsky believes.

During his university years in Moscow (1913–1917), Vygotsky studied medicine before switching to law. Because he was Jewish, he was allowed into the university only through a lottery, because there was a quota. At the same time, he read for a master's degree in history and philosophy at a different university. His philosophy was influenced by the likes of Karl Marx, Friedrich Engels, and Vladimir Lenin. Benedictus de Spinoza also had an influence on his views, as did Ludwig Feuerbach and the linguist, Aleksandr Potebnya. He drew empirical data from the anthropology of Lucien Levy-Bruhl, and the psychology of Pierre Janet and Jean Piaget.

Vygotsky often held research meetings, called internal conferences, where his closest associates would discuss completed work and plan for the future. A deep interest and passion for the arts, especially literature, filled Vygotsky's personal and intellectual life. He turned to plays, poems, fables, and novels in his search for examples to illustrate and support his complex arguments. Vygotsky died of tuberculosis on June 11, 1934, at the age of 37. Much of his work and plans survived only in rough drafts and notes to himself. In 2006, a large quantity of his handwritten notes (unpublished) were found in the family archive.

Impact (Psychological Influence)

His influence had a deep impact on his colleagues. However, his approach seemed to suffer an eclipse during Stalin's time, apparently for political reasons. It was only after one of his main works, *Thought and Language*, was published and translated into English in 1962—after Stalin's death—that Vygotsky's contribution to psychology became widely known. A collection of his papers on child development and learning was later published under the title, *Mind in Society*.

Since then, enthusiasm for Vygotsky's ideas, and interest in his work, has steadily increased, but not uniformly around the world. There is a tendency for those in the United States and continental European countries to show more interest in Vygotsky's work than those in Britain.

There is some disagreement among Vygotsky's supporters about the interpretation of his work. For example, there is some debate about the use of "tools-and-results" versus "tools-for-results." Vygotsky uncompromisingly took the "tools-and-results" view, in which the tool is inseparable from the development in question. However, many Vygotsky followers misrepresent his view by simply arguing in "tools-for-results" terms, which means acquiring a tool to be able to do something (like using a calculator to do mathematical operations quickly).

Vygotsky's system was originally compared to that of Gestalt psychologists, Piaget and Pavlov. Now it is discussed in context of the school of literary Formalists, Bakhtin's theory of inner dialogue, and Habermas's

notion of communicative action. He is credited with making contributions to the fields of aesthetics, special education, history, linguistics, neuropathology, neuropsychology, and pedagogy. Still, his concepts and theories have been criticized for being unnecessarily obscure and cryptic. His psychological theory of aesthetics has largely been ignored or undervalued. His paper, *The Psychology of Art*, was only published in English in 1971.

Mindy Parsons, PhD

See also: Zone of Proximal Development

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W

WAIS

See Wechsler Adult Intelligence Scale (WAIS)

Watson, John B. (1878–1958)

John B. Watson was an American psychologist who is considered to be the founder of behaviorism.

Description

John B. Watson, PhD, was born in South Carolina to a devout religious mother and an emotionally distant father. Watson's life and career is intriguing in that he began life immersed in poverty in South Carolina and as a student who struggled academically. He would go on to found behaviorism and by the time he was 36 years old he was the president of the American Psychological Association, as well as the head of the psychology department at John Hopkins.

In the 1920s, Watson left academia abruptly and turned to the world of advertising. He used his knowledge of psychology and behaviorism to influence marketing strategies. To this day, Watson remains a controversial figure in the field of psychology with some crediting him as a major contributor while others remarking that he is as an embarrassment to the field.

Watson believed that behaviorism was a branch of natural science. He identified the goal of behaviorism as being able to predict as well as control behavior. Watson felt that children could be raised with specific behavioral guidance to become the person he wanted or would choose for them to be. Watson also believed that the actual behavior of a person was the only way to understand the internal feelings and views of a person.

Watson believed that the environmental influence on behavior began prenatally. He felt strongly that there needed to be emphasis on understanding how learning and experience function. One of Watson's most famous experiments is now known as the "little Albert" experiment. Watson believed that emotional responses could be classically conditioned in humans. He also felt that there were three basic emotions present from birth—rage, love, and fear. To prove this theory, Watson and his colleague Rosalie Raynor used a child they called "Albert B." The child was exposed to various stimuli including white rats and loud noises. Albert had positive response to the white rat and would reach for it without fear. The rat was then paired with a loud noise, which would startle Albert. Eventually, after several pairings, when just presented with the rat, Albert still withdrew in fear. This study raised numerous ethical concerns in the care of the child used in the experiment both during and after the test.

Impact (Psychological Influence)

Watson's work had a great impact on the debate of nature versus nurture, especially in exploring what has a greater influence on people—the genetics or the environment that surrounds them. His work paved the way for other behaviorists such as the well-known psychologist B.F. Skinner (1904–1990).

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Behavior Therapy; Nature versus Nurture; Skinner, B.F. (1904–1990)

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Wechsler Adult Intelligence Scale (WAIS)

The Wechsler Adult Intelligence Scale (WAIS) is a test used for measuring intelligence (cognitive abilities) in adults and older adolescents

Definitions

- **Intelligence quotient,** or IQ, is a score derived from one of several standardized tests designed to assess intelligence.
- **Intelligence test** is a standardized method of assessing an individual's ability to form concepts, solve problems, acquire information, reason, and perform other intellectual operations.
- **Standard deviation** is a statistical measure of the difference to an arithmetical mean or average. The wider the spread of scores from the mean, the larger the standard deviation.

Description

The Wechsler Adult Intelligence Scale is a widely used standardized test for measuring intelligence. It is currently in its fourth edition (WAIS-IV) which has been available since 2008. It is one of a series of intelligence tests used to assess cognitive abilities n in children and/or adults. Included in this series are the Wechsler Preschool and Primary Scale of Intelligence for children from three to seven years of age, the Wechsler Intelligence Scale for Children for children from 6 to 16 years of age, and the WAIS for adults 16 years and older. All of these scales test cognitive abilities (intelligence) in children and adults by providing various index scores that indicate different verbal and nonverbal (performance) abilities. Distinguishing verbal from performance intelligence is the distinctive feature of the Wechsler scales.

The Verbal Scales measure general knowledge, reasoning, language, and memory skills, and the Performance Scales assess problem solving, spatial, and sequencing abilities. Verbal intelligence is most identified with academic achievement, while performance intelligence implies the ability to perceive relationships and integrate individual parts together logically into a whole. Scores on the performance section are particularly helpful in assessing the cognitive ability of non-native individuals and those with speech and language disorders. The specific subtests of performance section are used by psychologists in screening for specific learning disabilities.

The WAIS is administered by trained professionals, usually a psychologist. The current version of this test, WAIS-IV, consists of 10 core subtests and 5 supplemental subtests. It takes approximately 60 to 90 minutes to administer the core subtests, and about 10 to 15 minutes for each supplemental test that might

be given. Raw scores are generated and converted to standard scores with a mean and standard deviations from that average. Scores in on the verbal subtests are calculated and converted to a Verbal IQ score as are performance scores and converted to a Performance IQ score. The Verbal and Performance IQ scores are added together and are then converted to an overall Full Scale IQ score. A Full Scale IQ score higher than 130 indicates the highest intelligence category. Scores in the 120s are considered very high, those in the 110s considered above normal, while scores from 90 to 109 are considered normal average. Scores in the high 80s are considered low-average, while scores below 85 are considered low in mental functioning.

Developments and Current Status

The WAIS was developed by David Wechsler (1896–1981) an American psychologist. In 1939, Dr. Wechsler developed the Wechsler-Bellevue Intelligence Scale at the Bellevue Hospital Center in New York City. In 1949, he developed the Wechsler Intelligence Scale for Children; in 1955, the WAIS (Form I); and in 1967, the Wechsler Preschool and Primary Scale of Intelligence was published. These tests were originally developed by Wechsler as a way to learn more about his patients at Bellevue because of the shortcomings of existing intelligence tests such as the Stanford–Binet Intelligence Scales.

Wechsler's basic premise was that intelligence should measure performance instead of capacity, and that intelligence was the ability to solve problems. Accordingly, he defined intelligence as the global capacity to act purposefully, to think rationally, and to deal effectively with one's environment. He believed that general intelligence is composed of various specific and interrelated functions that can be individually measured. This belief guided his development of the WAIS with a specific subscale reflecting each of these functions. He assigned an arbitrary value of 100 to the mean intelligence, to stand for the average or expected value of intelligence. Wechsler then added or subtracted 15 points from 100 for each standard deviation above or below the mean, respectively.

Len Sperry, MD, PhD

See also: Intelligence

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Wechsler Intelligence Scale for Children (WISC)

The Wechsler Intelligence Scale for Children (WISC) is a test that was developed for use with children to provide a score that would describe their intelligence level.

Definitions

- **Intelligence** is the capacity a person has to learn and understand information and solve problems.
- **Intelligence quotient** is a measure of intellect to determine a person's level of cognitive ability.

Description

David Wechsler (1896–1981) was an American psychologist who developed WISC. The instrument is an individually administered intelligence test for children between the ages of 6 and 16. It can be completed without reading or writing. The WISC usually takes about an hour and ten minutes to administer and yields an intelligence quotient (IQ) score which represents a child's general cognitive ability.

Development (Purpose and History)

Intelligence has been shown to be predictive of a wide variety of important life outcomes. Therefore attempts to measure it have been occurring since the 1800s. One

of the first successful attempts that achieved great recognition in the world was the Stanford–Binet Intelligence Quotient test.

David Wechsler first became involved in intelligence testing while helping induct troops during World War I. This gave him an intimate knowledge of a range of previous intelligence testing. After 1932, when he became chief psychologist at Bellevue Psychiatric Hospital in New York City, he began to use and adapt some of the existing intelligence tests which he found lacking. David Wechsler developed his original tests (Wechsler–Bellevue) during the 1930s.

Wechsler's dissatisfaction with existing intelligence tests was based on his wartime experience. During this time he met recruits who had been successful and smart but who, according to the army group examinations, exhibited low mental-age scores. He was convinced that the discrepancy between their abilities and the test results was a factor of the excessive emphasis on verbal skills necessary to get high IQ scores on the Stanford–Binet scale.

Wechsler published his first widely used intelligence scale, the Wechsler Adult Intelligence Scale (WAIS) in 1939. WISC followed in 1949 after at least five years of development. This development included being thoroughly tested with school-age students who had been rated with average intelligence.

In his tests, Wechsler incorporated two very important innovations. The first was technical and involved replacing the ratio IQ result with a deviation score which yielded more reliable results. The second reflected his insight that task performance, not only verbal expression, should be a part of intelligence evaluation. The scales in his tests focused on a child's ability to do things rather than a concentration on their ability to speak about them.

Current Status and Results

The basic structure of the WISC has remained almost unchanged through the later revisions made over the years. Many studies have been conducted to test the scale's reliability and validity. Psychologists have embraced it because of its ability to measure intelligence without solely relying on verbal skills but by including performance skills, and it is one of the most widely used IQ tests.

Each successive version is thorough in its scientific rigor. This is accomplished through norming each version of the test to ensure that the norms do not become outdated. Also its revisions are designed to ensure that they are representative of the current population. The WISC distinguishes between a child's intelligence and their performance. This helps to identify differences and develop a plan of action when there are learning difficulties.

The WISC, like all tests, should be used and interpreted by experienced psychologists. Those interpreting the WISC results should apply contextual factors including elements from a child's background which can influence learning and the expression of intelligent behavior. Results of the WISC for individual children may produce the similar test scores as other children but each should be interpreted in different ways depending on the child's unique background.

There are two criticisms about the WISC and its popularity. The first is that it is based on tests originally designed for adults but applied to children. This is compared to the Stanford–Binet which was designed originally for children and later changed to include adults. The second criticism is that when educators rely on this test to make decisions, they are using a test with scales that do not reflect the many advances in the understanding of cognitive functioning that have been made over the years.

Alexandra Cunningham, PhD

See also: Intelligence Testing; Kaufman Assessment Battery for Children (K-ABC); Wechsler Adult Intelligence Scale (WAIS)

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Well-Being

Well-being is the state of being happy, healthy, prosperous, or successful.

Description

Well-being is described as how individuals think about and experience their lives. Well-being is an indicator of how well individuals perceive their lives to be going. It reflects several health, job, family, and social outcomes. For example, higher levels of well-being are associated with decreased risk of disease, illness, and injury. It is associated with faster recovery, better immune functioning, increased longevity, and better physical and mental health. In addition, those with high levels of well-being are more productive at work, get along better with others, and contribute more to their communities. Accordingly, well-being is a key consideration for the Centers for Disease Control and Prevention (CDC) in tracking American's health.

The CDC indicates that while there is no consensus on the definition of well-being, there is general agreement that it includes the presence of positive emotions and moods, the absence of negative emotions, satisfaction with life, a sense of personal fulfillment, and positive functioning. In short, they describe well-being as judging life positively and feeling good. The CDC specifies various kinds of well-being. These include physical well-being, economic well-being, social well-being, emotional well-being, and psychological well-being. Finally, they state that while well-being can be attributed to heritable factors, environmental factors play an equally if not more important role. Proponents of positive psychology have made significant contributions to the theory and research on well-being.

Recently, researchers from Gallup, Inc. and Healthways have begun reporting results on the largest database on well-being in the world. Data was collected on two survey instruments: the Wellbeing Finder and the Gallup-Healthways Well-Being 5. Some 1.9 million individuals from 150 countries have reported on how they experience their days and evaluate their lives overall. Five distinct statistical factors emerged from this research. These factors are named the core elements of well-being.

Here is a brief summary of each of the five elements of well-being.

- **Purpose:** Liking what one does each day and being motivated to achieve one's goals.
- **Social:** Having supportive relationships and love in one's life.
- **Financial:** Managing one's economic life to reduce stress and increase security.
- **Community:** Liking where one live, feeling safe, and having pride in one's community.
- **Physical:** Having good health and enough energy to get things done daily.

Findings show that these elements are interconnected and that they can identify individuals on a continuum from thriving to struggling to suffering. For example, 66% of those surveyed were thriving in one of the five elements. However, only 7% were found to be thriving in all five elements. This ongoing research tracks and reports on the well-being of individuals and organizations. Much of this data is reported in the book *Wellbeing: The Five Essential Elements* and the Gallup website.

Len Sperry, MD, PhD

See also: Chronic Illness; Positive Psychology

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Well-Being Therapy

Well-being therapy (WBT) is a form of psychotherapy that focuses on developing greater autonomy, growth,

environmental mastery, self-acceptance, and positive relationships to improve one's personal well-being.

Definitions

- **Autonomy** is an independent and self-determining reliance on one's self and a resistance to social or peer pressures to think, act, or feel a certain way.
- **Environmental mastery** is the ability to competently manage everyday affairs of living by making effective use of resources and opportunities while controlling external activities.
- **Evidence-based practice** is a form of practice that is based upon integration of the best research evidence with clinical experience and client values.
- **Pathology** is an experience of suffering or aspect of a disease incorporating cause, development, structure, and consequences.
- **Positive psychology** is the sub-field of psychology whose aim is to understand the positive aspects of human thought, emotion, and behavior instead of focusing on pathology.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapeutic counseling.
- **Third-order change** is change that results from an individual's own efforts rather than change that is mediated by a therapist or personal coach.
- **Well-being** is the presence of positive emotions and moods, the absence of negative emotions, satisfaction with life, fulfillment, and positive functioning.

Description

Well-being therapy is psychotherapy whose primary focus is to improve upon clients' subjective experience of psychological well-being and quality of life. It assists in the achievement of, or growth toward, clients' optimal human functioning (potential). WBT is commonly used to treat the anxiety disorders and mood disorders. Instead of focusing interventions on the reduction of the negative symptoms, WBT focuses intervention on increasing positive feelings and well-being. Heightening positive emotions is believed to interact with the negative symptoms of the anxiety disorders and mood disorders to promote balance within a client. A balanced lifestyle is considered to be a healthy lifestyle and an aspect of optimal human functioning.

WBT is a form of short-term psychotherapy. Typically, WBT involves between 8 and 12 sessions. In the initial stages of WBT, a structured diary is utilized. A structured diary helps a client learn skills related to self-observation. A client learns how to identify and document patterns of thoughts and ways of believing that may be inhibiting their access to well-being. Clients are also educated in ways to recognize and rank brief episodes of well-being. The structured diary develops clients' insight into their patterns of thinking and believing, as well as displaying clients' growth over time.

WBT typically begins with a focus on increasing self-determination and autonomy. For example, as individuals become increasingly autonomous and self-sufficient, they become increasingly able to analyze their own structured diary. Clients learn to think and act like a psychotherapist and discover ways to access well-being on their own. In time, they are able to function as their own therapists. This is called third-order change. Increasing self-determination and autonomy are significant aspects of WBT. Other essential aspects of well-being are personal growth, environmental mastery, self-acceptance, and positive relations with others.

Development and Current Status

In his 1998 presidential address to the American Psychological Association, psychologist Martin Seligman called on psychology to emphasize the positive: people's strengths and virtues. Seligman lamented that psychology had been overly preoccupied with

dysfunction (problems) and pathology. Instead of focusing on relieving mental distress, psychology should focus on nurturing well-being. Seligman's call resulted in sub-field of positive psychology. One of the most promising developments of positive psychology has been WBT.

Research evidence indicates that the remediation of pathology does not inherently produce well-being. Further, research has shown that well-being reduces the probability of relapse into symptomatic distress. WBT was originally developed as a relapse-prevention strategy for individuals rehabilitating from affective disorders, such as the anxiety or mood disorders. While it is still in its infancy, the value of WBT is becoming increasingly recognized by health and mental health-care professionals. Research interest in positive emotions and well-being has also increased. This research is imperative in establishing WBT as an evidence-based practice. WBT also appears to be effective with children and the elderly.

As the promised psychotropic "miracle pills" are failing to deliver a cure from anxiety and depression, more people are turning to interventions that foster well-being. Well-being does not only impact the lives of individuals, but it can also promote social advancement through the actualization of its individuals.

Len Sperry, MD, PhD, and Layven Reguero, MEd

See also: Empirically Supported Treatment; Evidence-Based Practice; Positive Psychology

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Wellbutrin (Bupropion)

Wellbutrin is a prescribed antidepressant medication used to treat depressive disorders and aid in smoking cessation (marketed as Zyban). Its generic name is bupropion.

Definitions

- **Antidepressant medications** are prescription drugs that are primarily used to treat depression and depressive disorders. These are known as antidepressants.
- **Dopamine** is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.
- **Seasonal affective disorder** is a mental disorder characterized by depression weight gain and excessive sleep during the winter months.
- **Seizure** is a convulsion or uncontrolled discharge of nerve cells that may spread to other cells throughout the brain.

Description

Wellbutrin is in its own class of antidepressant medication because it is the one that increases dopamine. It is primarily used to treat depression and seasonal affective disorder. In addition, it useful in helping individuals quit smoking. It is also used in treating panic disorder and attention deficit hyperactivity disorder. Wellbutrin was developed as an alternative to the tricyclic antidepressants with their problematic side effects of sedation (sleepiness), dizziness, and weight gain. Wellbutrin is thought to work by balancing two neurotransmitters (chemical messengers) in the brain, norepinephrine and dopamine.

Precautions and Side Effects

While Wellbutrin is less likely to cause weight gain and lower blood pressure compared to other antidepressants,

it is more likely to trigger seizures. Those taking Wellbutrin should minimize alcohol use since consumption of it increases the chance of seizures. Increases in blood pressure have occurred in those taking Wellbutrin. When taken for smoking cessation, some patients have developed severe symptoms, including aggression, depression, mania, panic attacks, and suicidal thoughts and actions. As with other antidepressants, children and adults up to 24 years of age are at increased risk for developing suicidal thoughts and actions. It has not been determined whether Wellbutrin is safe to take during pregnancy. Pregnant women should take Wellbutrin only if the benefits outweigh its risks. Since it is secreted in breast milk, women taking Wellbutrin should consult their doctors about breast-feeding.

Some common side effects reported with Wellbutrin include insomnia, agitation, confusion, restlessness, anxiety, headache, dizziness, and tremor. Weight loss is more common than weight gain, but both have been reported. Less common side effects include blurred vision, constipation, decreased appetite, dry mouth, excessive sweating, nausea, rapid heart rate, sedation, sore throat, and vomiting.

Wellbutrin should not be taken with other medications that lower the seizure threshold. These include steroids, asthma medications like Theo-Dur, and monoamine oxidase inhibitors like Parnate and Nardil. Adverse effects may increase in those taking Wellbutrin and Parkinson's disease like L-dopa. Nicotine patches may be used concurrently with Zyban in smoking cessation treatment. However, blood pressure must be monitored since it can increase. Wellbutrin may delay the elimination of antidepressants, antipsychotic drugs, and heart medications, resulting in higher blood levels and potentially increased side effects.

Len Sperry, MD, PhD

See also: Depression and Depressive Disorders; Seasonal Affective Disorder (SAD)

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Wellness Counseling

Wellness counseling focuses on the connection between physical and mental health and focuses on how they can be integrated to give a better quality of life to clients.

Definition

- **Wellness** is the state or condition of being in good physical and mental health and steps to promote it.

Description

A healthy lifestyle is an important aspect of mental health that is infrequently targeted, especially in outpatient mental health settings. Although the relationship of psychological and physical factors has often been acknowledged, interventions and treatment in the past frequently focused solely on mental functioning. When physical health was included as a factor at all, it was usually in the context of side effects from antipsychotics or other drugs.

Patients with psychiatric disorders have been shown to be at greater risk for comorbid drug, alcohol, or other substance abuse. Patients who are severely mentally ill are often on a regular regimen of antipsychotic drugs with the side effect of causing substantial weight gain which can endanger their physical health. This reality of multiple layers of problems is a challenge both for patients and for caregivers.

For wellness counseling, awareness of the interrelationship between the mental challenges patients face and its effect on their physical health is vital. Wellness counseling will differ depending on the patient's needs. Overall it aims to help people cope with their mental disorders in a different way. It focuses on enhancing the healthy aspects of clients' lives and improving those instead of simply focusing on reducing

problems. It seems clear that treatment and exercises that improve both psychosocial and physical functioning make a positive difference even for those who suffer from more severe mental issues. In one study, for example, war veterans who suffer from comorbidity between psychosis and alcohol/drug use were greatly helped by positively oriented group process activities and wellness counseling.

Development

Wellness programs are generally recognized to have begun in the 1960s based on an increasing awareness of human beings as integrated in mind and body. The start of this work was in Rogerian therapy with its emphasis on the wisdom of the client and concern for the whole person. Later, with the development of positive psychology, there was an emphasis on achieving happiness and the responsibility to work toward achieving a healthy life both physically and emotionally.

One of the results of the emphasis on wellness counseling is integrated health-care treatment versus fragmented treatment plans for the mentally ill. Interventions aimed at improving mental functioning must be conducted in the context of a healthy body and lifestyle. This means that both thinking and behavior need to be addressed. In addition, it is necessary to include the wider psychosocial environment. This includes working with the friends and family of someone who suffers from mental illness, so that they not only learn how best to cope with the mentally ill person but also can reinforce positive activities and be on the alert for signs of illness.

Current Status

There are several wellness models from which mental health professionals can learn how best to address the physical and social issues involved in treatment of mental illness. One example of the need for awareness is that when medications interfere with clients' ability to participate in physical activities that they value, there is a greater chance that they will change or stop following their drug protocol. This means clinical professionals should carefully regulate and track the effects of any prescribed drugs so that they do not interfere with the client's pursuit of physical activities which can aid in the coping or recovery processes.

In all of this it is important to have an integrative approach. Selecting and sequencing the appropriate interventions requires a careful assessment of the client's current functional levels. This includes both mental and physical aspects of a client's life and an awareness of the way the specific disorder is manifested or acted out, as well as the specific circumstances of the client's life. Above all, it is vital to involve the clients in making choices around their own treatment and activities because this will reinforce their sense of worth and their commitment to treatment. The range of treatments for issues that they are experiencing then becomes something they own, rather than something that is done to them.

Alexandra Cunningham, PhD

See also: Mindfulness; Mindfulness-Based Psychotherapies; Well-Being; Well-Being Therapy

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Wernicke-Korsakoff Syndrome

Wernicke–Korsakoff is an alcohol-related medical condition characterized by severe problems with sight, memory, confusion, hallucinations, and loss of coordination.

Definitions

- **Alcoholism** is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing. It is also called alcohol abuse.
- **Alcohol withdrawal** is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of alcohol after prolonged regular use.

- **Antipsychotics** are prescription medications used to treat psychotic disorders including schizophrenia, schizoaffective disorder, and psychotic depression.
- **Delirium** is a mental disorder characterized by rapid onset of extreme disorientation and confusion and is usually caused by illegal drugs, medications, or medical conditions.
- **Dementia** is a group of symptoms including loss of memory, judgment, language, and other intellectual (mental) function caused by the death of neurons (nerve cells) in the brain.
- **Family therapy** is a type of psychotherapy for families that focuses on improving relationships and understanding between family members.
- **Hallucinations** are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.
- **Psychotherapy** is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.
- **Twelve-Step Program** is a self-help group whose members attempt recovery from various addictions and compulsions based on a plan called the Twelve Steps.

Description and Diagnosis

Wernicke–Korsakoff syndrome is a severe medical condition that results from long-term alcohol abuse. It is named after the German physician, Carl Wernicke (1848–1905). This syndrome is actually the combination of Wernicke encephalopathy and Korsakoff syndrome. Wernicke encephalopathy is characterized by delirium, inability or poor control of motor functions, severe vision impairments, and other symptoms associated with alcohol withdrawal. Alcohol withdrawal alone can be very difficult to bear as well as fatal. Korsakoff syndrome is a disorder causing memory problems and hallucinations. Individuals may become unable to form new memories or recall existing memories. They may also experience hallucinations. It is important to note that symptoms of Korsakoff syndrome mimic dementia and it is sometimes referred to alcohol-related dementia.

These two syndromes are combined because they often occur together. It is uncertain whether they are distinct but related disorders or if they are different evolutions of the same syndrome. Specifically, Wernicke–Korsakoff syndrome is caused by a severe deficiency of thiamine (vitamin B-1). However, this deficiency is most often the consequence of alcoholism. Wernicke–Korsakoff syndrome is also known to result from a failure to absorb nutrients (minerals and vitamins) from food. Regardless of specific cause, the symptoms of this syndrome are the consequence of brain damage. Consequently, the damage is not likely to be repaired and some symptoms may become permanent. Also, symptoms will continue to worsen if these individuals continue to drink and will ultimately result in death. Abstaining from alcohol use is the only way to stop the worsening of symptoms.

Treatment

Treatment for this condition usually begins with correction of the thiamine deficiency. This is accomplished by injecting this vitamin directly into the blood stream. Following the correction of this deficiency, both the harmful behavior of the individual and the symptoms will be treated. Treatments of alcoholism often includes 12-step programs, psychotherapy, group therapy (psychotherapy in small groups), and family therapy. Alcoholism can be a difficult disease to treat and individuals, even those with the severe symptoms of Wernicke–Korsakoff syndrome, may relapse. When severe, this syndrome can be treated with antipsychotic medication to control delirium or hallucinations. Other medical treatments to reduce other symptoms may also be used.

Jeremy Connelly, MEd, and Len Sperry, MD, PhD

See also: Alcoholism; Antipsychotic Medications; Delirium; Dementia; Family Therapy; Hallucinations; Psychotherapy; Twelve-Step Programs

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Whitaker, Carl (1912–1995)

Carl Whitaker was a physician, psychiatrist, professor, and family therapist best known for his pioneering family therapy work and controversial style of therapy.

Description

Carl Whitaker was born in Raymondville, New York, in 1912. He received his medical degree in gynecology and obstetrics before studying psychology at Syracuse University. Whitaker worked at the Syracuse Psychopathic Hospital in 1938 and began exploring family dynamics after observing that many of his psychiatric patient's symptoms would reappear after they were sent home. At the time, therapy was provided almost exclusively to individuals in private sessions. Whitaker created an approach that included all available family members and is considered a pioneer in experiential family therapy.

Whitaker was influenced by existential models of therapy and stressed freedom, choice, self-determination, self-actualization, and growth. He stressed the importance of the relationship between the family and therapist and believed that both would be changed by the encounter. Whitaker did not propose specific methods of therapy but encouraged therapist to use their intuition and spontaneous reactions to promote family interaction. He believed that through personal involvement a therapist could promote change and growth.

Whitaker was also known for being irreverent and outrageous in his methods and as a freewheeling, shoot from the hip therapist. Many stories are told of his humor and wit in both his approach to teaching and to therapy, sometimes bordering on the inappropriate. He believed the family should operate as an integrated whole not as a group of discrete individuals. He also believed that lack of emotional closeness and sharing led to interpersonal problems and family dysfunction. He used humor and spontaneity to creatively expose and confront emotions held by family members who were unable or unwilling to express them. Characterized as being confrontational his goal was to creatively promote realness in family relationships by developing autonomy for individuals and connectedness with family members.

Impact (Psychological Influence)

Whitaker was one of the first therapists to acknowledge the role of the family in the development and maintenance of an individual family member's difficulties. He believed that dysfunctional family members were symbolically expressing family dysfunction. Whitaker developed a unique approach to family therapy referred to as symbolic-experiential family therapy and is considered a founder of experiential family therapy. He also pioneered the use of co-therapists in which a pair of therapist would work with families. Whitaker served as chairman of the Department of Psychiatry at Emory University and then as professor of Psychiatry at the University of Wisconsin-Madison until his retirement in 1982.

Steven R. Vensel, PhD

See also: Family Therapy and Family Counseling; Multisystemic Therapy (MST)

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White, Michael (1948–2008)

Michael White was an Australian social worker and family therapist who developed narrative therapy, which is an approach that connects identity as shaped by the individual's story and perception of those stories.

Description

Michael White was born and raised in Australia. He grew up in a working-class family. White has written about how he had limited access to information on how others lived and found himself fascinated by those worlds that were different from his own. On his 10th birthday he received a bicycle, which was his first opportunity to explore other worlds. He found himself intrigued with maps and the adventures that they held.

White felt his appreciation for maps and exploration directed him on his professional path. He viewed the journey as an opportunity to learn about what is possible for people to know about their own lives. White felt that the maps he loved provided an excellent metaphor for working with clients. He wrote of how sitting down with a client was the beginning of a journey with an unknown destination with routes that could not be predetermined. White felt it was important to not speak on behalf of others but instead to create opportunities where they would be able to speak for themselves. He felt it important to not make assumptions about other people's lives.

White first presented his idea of narrative therapy in 1990 in his book with David Epston, entitled *Narrative Means to Therapeutic Ends*. White gave credit to the clients he saw throughout his lifetime as providing the assistance and inspiration to the evolution of narrative therapy. He felt that the collaborative process with his clients was a learning opportunity and a motivation for new ways of therapeutic practice. White refused to engage in defining clients by their mental illness or even identifying what was normal for any individual. He felt it was important to maintain an open mind and work from a place of complete equal partnership with his clients. Michael White died from a heart attack at the age of 59 in 2008.

Impact (Psychological Influence)

White published numerous books and articles. He was the founding editor of the *Australian Journal of Family Therapy*, which would later be renamed the *Australian and New Zealand Journal of Family Therapy*. He is considered to be an innovator in the field of family therapy in Australia. He embraced each project with great enthusiasm, curiosity, and great humility.

Ashley J. Luedke, PhD, and Mindy Parsons, PhD

See also: Narrative Therapy

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Organization

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Wide Range Achievement Test (WRAT)

The Wide Range Achievement Test (WRAT) is a measure of academic skills in the areas of reading, spelling, and math.

Definitions

- **Intellectual** refers to the ability to think and understand ideas.

- **Intelligence** is the capacity a person has to learn and understand information and solve problems.
- **Intelligence quotient** is a measure of intellect to determine a person's level of cognitive ability.

Description

The Wide Range Achievement Test is a short assessment tool that measures a person's ability to read words, comprehend sentences, spell, and solve math problems. The present version, the WRAT4, has two levels. The first level is designed for and provides consistent results for children between the ages of 5 and 11. The second level is normed for and covers a broader population from children 12 years old up to older adults in their 80s and 90s. It is important to note that the WRAT4 is not intended to identify cognitive disorders or learning disabilities. It is most useful for a simple, quick assessment of basic academic skills.

Development (Purpose and History)

In the 1930s, psychologist Joseph F. Jastak developed the first version of the WRAT. Jastak wanted to improve on Wechsler's cognitive performance tests by getting a more complete view of an individual's academic abilities. Later Jastak worked with pioneer child behavioral psychologist Sidney W. Bijou to refine the WRAT, which was officially published in 1946. Sara R. Jastak also contributed to the editing and development of revised versions of the WRAT. Since the 1940s several versions have been developed and the latest version, the WRAT4, was published in 2006.

Reliability ratings for the WRAT4 are strong. For the later teenage years through middle-adult years, the WRAT subtests are not as precise at the higher score levels. Nevertheless, clinical studies have shown that the WRAT4 can help distinguish between people with low and high cognitive ability. The WRAT's ease of application has continued to make it a popular choice for the assessment of reading comprehension and math skills.

Current Status and Results

As its title indicate, the WRAT4 currently is in its fourth revision and contains the four traditional subtests in the areas of word reading, sentence comprehension, spelling, and mathematical computation. For validity the first two tests need to be administered individually while the second two have the option of being administered in a group setting.

There are two different versions of the WRAT4 which gives administrators the advantage of being able to give the test a second time shortly after the first without impacting the results. The tests are also valued because they are relatively easy to score and take only between 15 and 45 minutes to complete. For these reasons, it remains a popular way of getting a lot of information about a person's cognitive abilities in a relatively simple and brief way.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Intelligence Testing

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Willpower

Willpower is the ability to resist a short-term temptation in order to achieve a long-term goal.

Definitions

- **Ego depletion** is the term used to describe the temporary exhaustion of self-control. It is also known as willpower depletion.
- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.

- **Self-control** is the capacity for self-discipline. Some use this term interchangeably with willpower.

Description

Willpower is the ability to delay gratification and resist short-term temptations in order to achieve long-term goals. It is also commonly referred to as self-control. Willpower is the conscious and effortful regulation of the self to override unwanted thoughts, feelings, and impulses. It is also a limited resource capable of being depleted. Lack of willpower is the main reason most give for not achieving their goals whether it be eating right, exercising regularly, or saving for retirement. Actually, there are three necessary conditions for achieving goals. The first is a clear goal and the motivation for change. The second is monitoring one's efforts to achieve the goal, and the third is willpower. Of the three conditions, willpower is the most problematic for many.

Roy Baumeister (1953–) is the American psychologist credited with promoting scientific research on willpower. This research shows that willpower is correlated with various positive markers of health and well-being. It shows that those with a high self-control tend to have high grade-point averages, higher self-esteem, lower alcohol and substance abuse rates, better overall physical and mental health, and better relationship skills. Willpower is more important than intelligence quotient in predicting academic success. Even more remarkable is that one's capacity for self-control appears to persist throughout life. Children with a high capacity to delay gratification (an indicator of willpower) are found to have fewer criminal convictions, fewer cavities and other dental problems, better health and well-being, fewer traffic tickets, fewer divorces, and more savings and financial security as adults than those with less capacity to delay gratification.

Baumeister compares willpower to a muscle and likens ego depletion to energy depletion in a muscle. Just as a muscle's energy may be depleted slowly over many small actions or quickly in fewer large actions, so too can an individual's ability to exert willpower decrease with use. That is because individuals have only a limited amount of mental energy that they may utilize in a given amount of time. As the individual uses this energy for self-control, they deplete this energy and have less available for the next action. Furthermore, the more difficult a given decision is, the more mental energy is required to act on the decision.

Notions of limited willpower date back to Sigmund Freud's model of the psyche (mental) energy that became the basis of psychoanalytical theory. Freud suggested that drives associated with the pleasure-seeking id (unconscious and primitive instincts) conflicted with the superego (moral part of self) that represented societal rules and ideas of fairness. This conflict was resolved by the ego (decision-making part of self), but not always consistently. Freud used the analogy of a horse and rider whereby the rider is the ego and the horse is the remainder psyche; the rider controls the horse but at times, the horse acts without direction from the rider. As it pertains to ego depletion and Freud's structural model, this term indicates that the ego is able to control the action of the self as long as it has sufficient energy in reserve. If this energy is low or completely exhausted, it follows that the ego has far ability to dictate the actions of the self.

Baumeister's research shows that ego depletion has a physical basis and those with low self-control show differing brain patterns when presented with temptation (Baumeister and Vohs, 2004). Individuals whose willpower has been depleted have decreased activity in a brain region involved in thinking and planning, and have lower blood-glucose (sugar) levels than do individuals whose willpower has not been diminished. Fortunately, the effects of ego depletion can be lessened in various ways. These include eating a healthy diet; getting regular exercise and sleep; and maintaining positive moods, beliefs, and attitudes.

Len Sperry, MD, PhD

See also: Addiction; Ego Depletion; Psychoanalytic Theory

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Wilson, Bill

See Alcoholics Anonymous

WISC

See Wechsler Intelligence Scale for Children (WISC)

Wolpe, Joseph (1915–1997)

Joseph Wolpe was a South African Psychiatrist who is best known for his contributions to development of behavior therapy.

Description

Joseph Wolpe, MD, was born in Johannesburg, South Africa, in 1915. He was the son of Michael Salmon Wolpe and Sarah Millner. Wolpe received his medical degree from the University of the Witwatersrand in Johannesburg. During World War II, he was assigned to a military psychiatric hospital in South Africa. There he worked with soldiers diagnosed with what was then called "war neurosis." Today, this diagnosis is called post-traumatic stress disorder, a mental disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. Wolpe created psychological treatments to treat the soldiers who experienced significant symptoms due to their traumatic experiences.

Impact (Psychological Influence)

Joseph Wolpe's practice, research, and publications have had significant influence in the field of behavioral psychology and behavior therapy, which espouses that maladaptive behaviors are learned and can be unlearned. He was most known for developing and researching reciprocal inhibition and systematic desensitization. Wolpe's work laid the foundation for the treatment of individuals living with significant anxiety by teaching them to relax by using a gradual exposure to an anxiety-producing object or situation. His other behavior therapy technique reciprocal inhibition involves an individual practicing a desired behavioral response in the presence of a stimulus that triggers an undesired response.

Wolpe was a professor of Psychiatry at Temple University's Medical School in Philadelphia from 1965 to 1988. He was also the director of the behavior therapy unit at the Eastern Pennsylvania Psychiatric Institute. He was a prolific author and received many awards in the fields of psychology and behavioral sciences. He received the American Psychological Association's Distinguished Scientific Award for the Applications of Psychology and a lifetime achievement award from the Association for the Advancement of Behavior Therapy. Wolpe's involvement in the field of psychology was a lifelong endeavor; even a month before his death he was attending conferences and giving lectures. Additionally, his theories and research have lasted beyond his death at the age of 82.

Jon Sperry, PhD, and Len Sperry, MD, PhD

See also: Acceptance and Commitment Therapy (ACT); Cognitive Behavior Therapy; Exposure Therapy; Generalized Anxiety Disorder; Psychotherapy

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Women's Mental Health Issues

Women are at higher risk of experiencing certain mental health disorders such as depression, anxiety, self-inflicted injury, and eating disorders.

Definitions

- **Eating disorders** are mental health conditions that involve extremes in eating patterns that lead to serious physical and mental health complications; two of the most common eating disorders are *anorexia nervosa* and *bulimia nervosa*.
- **Generalized anxiety disorder** is a mental health condition characterized by uncontrollable, exaggerated, and chronic bouts of worry and tension.
- **Major Depression** is a clinical psychological diagnosis that persists over time and is characterized by overwhelming feelings of sadness, hopelessness, and difficulty engaging in normal everyday activity.
- **Self-inflicted injury** is a term used to refer to a range of behaviors that encompass self-harm where individuals deliberately injure themselves but without suicidal intentions.
- **Suicide** is the intentional or unintentional act of taking one's own life.

Description

Mental health disorders are a public health concern with estimates suggesting that nearly 500 million people are affected worldwide. Deaths resulting from mental health conditions are second only to cardiovascular disease. Though psychological disorders affect both men and women, women are at a greater risk of experiencing certain types of conditions including major depression, generalized anxiety disorders, post-traumatic stress disorder, self-injurious behaviors, attempted suicide, and eating disorders.

High depression rates have been linked to hormonal changes in women. Reports suggest that these rates are double that of men from the time a female reaches puberty onward. Statistics also indicate that these numbers are highest in white/Caucasian and Hispanic females as opposed to other ethnic groups. Major depression coincides with additional disorders including self-injurious behavior and suicide. Furthermore, women are at greater risk of experiencing anxiety-related disorders, which also have a biological connection, though societal and social factors contribute as well. Additionally, the prevalence of eating disorders in women has been evidenced. Oftentimes, women cite anxiety, stress, and lack of control as reasons for engaging in these extreme behaviors. Comorbidity further complicates matters as several mental health illnesses have been linked with substance abuse issues. Women who use illicit drugs, drink alcohol in excess, and who smoke cigarettes are at greater risk of experiencing mental health problems.

Biological, environmental, and psychosocial factors contribute to higher incidence rates of mental illness in women. All can impact women's mental health risks, rates of the disorders, and their progression. Biological contributors include hormone differences and variations in brain structure. Female hormones, estrogen and progesterone, drastically increase during premenstrual, postpartum, and perimenopausal periods, experiences distinct to women. These hormonal shifts result in physical symptoms (bloating, weight gain, cramping, nausea, headaches) and accompanying mood fluctuations in women. Estrogen and progesterone levels effect how the female brain reacts and subsequently responds to stress-related situations. Male and female brains also differ structurally. While male brains are larger, female brains are more complex. Specifically, female brain comprises a larger frontal lobe, the part of the brain that is responsible for regulating judgment, language, problem solving, and socialization. Environmental and psychosocial factors impact women's mental health as well. The majority of people who seek medical and therapeutic treatment for psychological distress are women. In particular, individual counseling and small group counseling are interventions that are primarily sought out by women. Psychosocial factors include the influence of gender roles, sexism, lower socioeconomic status, and differences in coping styles. Feminine social expectations and prejudices toward women can add to stress and anxiety levels. Women are not financially compensated equally to men and most bear the majority of the burden of caretaking tasks. Media also places added pressure on women to look and act in certain ways. Additionally, varying coping styles between men and

women can contribute to the onset of mental disorders. While most men tend to externalize problems, most women internalize them, which may result in self-blame, doubt, and negative thought patterns.

Current Status and Impact (Psychological Influence)

Much of the research over the past decade has focused on gender-based differences and success rates for various treatment interventions. Critical importance has focused on overall mental health and wellness over the lifespan. With early and proper diagnosis, most mental health disorders are highly treatable. However, certain protective or resiliency factors can prevent the onset of mental health illnesses. These include proper self-care and adequate social support. The literature has noted the effectiveness of comprehensive, holistic, and family-based interventions with female clients. Women also respond positively to culturally sensitive, strength-based approaches. Identifying cultural pressures that may be contributing to the deterioration of a woman's mental health is advised. Medical and mental health professional are also advised to properly educate and routinely screen for any evidence of trauma, violence, and/or abuse as these problems are also much more commonly experienced by women. Recovery is possible with proper and effective intervention.

Melissa A. Mariani, PhD

See also: Depression and Depressive Disorders; Eating Disorders; Feminist Counseling; Generalized Anxiety Disorder; Self-Mutilation and Self-Harm; Suicide

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Work Orientation

Work orientation is an individual's overall attitude toward work.

Definitions

- **Higher power** refers to a greater being or some form of God.
- **Intrinsic motivation** is the internal desire to engage in an action or activity.

Description

Work orientation is the view and attitudes individuals have toward work and their drive to work. It is influenced by personal values, beliefs, and work experiences. It also involves how individuals get along with co-workers, subordinates, and supervisors. Three work orientations that have been extensively researched in the United States are job, career, and calling orientations. Each orientation is associated with job satisfaction, attitude toward work, and motivation to work.

Job orientation means that an individual views work as the means to obtain material goods and services. He or she is motivated by outside interests and activities. Activities outside of work have greater personal value and provide greater satisfaction than work.

Career orientation means that an individual's primary focus is work and career advancement. Personal satisfaction is derived from career status, promotions, and pay raises. Individuals with career orientation are motivated to work and strive to improve their professional standing. In calling orientation, individuals find their work meaningful because it serves to provide services for others and the greater community. Promotions and pay raises are not as important as contributing to the well-being of others.

Vocation orientation is sometimes used synonymously for calling orientation but, technically, it is not the same. Individuals with a vocation orientation deem their work important for the well-being of others but do so for personal reasons. In comparison, individuals with a calling orientation consider their work meaningful and are motivated to work for the good of

others and the community. Both vocation and calling orientation involve working to serve others. However, with vocation orientation the motivation to work stems from internal reasons. Finding personal life meaning is the usual reason. With calling orientation individuals work for external reasons such as the greater good of humanity or for a higher power.

The term "work orientation" was originally used by Mihaly Csikszentmihalyi (1934–) a psychologist who teaches, researches, and writes about happiness, flow, and intrinsic motivation. According to Csikszentmihalyi, individuals with a desire to improve work performance, through continuous practice, will become intrinsically motivated. Work then becomes a way for the individual to express himself or herself. Even though the individual may receive monetary compensation and job benefits, what matters most is the sense of identity and purpose derived from work. Work becomes intrinsically motivating and develops into the individual's calling in life.

Len Sperry, MD, PhD, and Christina Ladd, PhD

See also: Motivation; Positive Psychology

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Working with Emotional Intelligence (Book)

Working with Emotional Intelligence, published in 1998, is an influential book by Daniel Goleman that investigated and expanded the concepts of social and emotional intelligence (EI).

Definition

- **Emotional intelligence** is the ability to accurately identify and respond to emotions in oneself and others.

Description

Daniel Goleman (1946–) began his career as a psychologist and science writer for *The New York Times* but is best known for this book and others on EI all of which became bestsellers. In the book *Working with Emotional Intelligence* (1998), Goleman highlights the research which challenges the effectiveness of using classical intelligence measures to predict a person's abilities and success.

The idea of EI and social intelligence was first noted by Edward Thorndike in the 1930s. In the work of others such as David Wechsler, Abraham Maslow, and Howard Gardner, they also recognized the important role that the emotions play in the concept of intelligence.

Goleman researched dozens of successful business people and exceptional individuals in society to conclude that they achieved their prominence not simply because of their measurable intelligence quotient but also because of the key factor of EI. EI comprises a set of skills that help people manage how they deal with feelings, interactions, and communication. Based on the research, he identifies two areas of vital skills: self-mastery and relationship skills. Self-mastery is based on 12 personal competencies such as accurate self-assessment, self-control, initiative, and optimism. Relationship skills involve 13 aptitudes such as service orientation, developing others, conflict management, and building bonds.

Many of Goleman's findings in the book came from research others conducted. These include the works of Peter Salovey and John Mayer published in their influential article *Emotional Intelligence*. In this scholarly work, the authors define EI as the ability to use the emotions one experiences with discrimination to help determine the most healthy thoughts and actions.

Impact (Psychological Influence)

The book brought the concept of EI to the forefront of public attention and pop culture. Several other books and articles preceded and followed this book to help educate

people about the concept of EI. This helped to create more interest in the topic and the development of ways to measure the concept. Over the years different tools have been developed to try to provide an objective measurement of EI. Among them are the Emotional Quotient Inventory, the Multifactor Emotional Intelligence Scale, the Seligman Attributional Style Questionnaire, and the Emotional Competence Inventory. These instruments are qualitative and descriptive in nature. They are used primarily to help identify and improve ways of expressing oneself and working with other people.

In working with clients, mental health professionals would do well to know and utilize the five elements that Goleman found to be crucial to EI. The first is encouraging self-awareness or knowing oneself including strengths and weaknesses. Second is self-regulation or the ability to control impulses and emotional responses. The third is motivation in order to embrace the challenge of ignoring short-term gains for long-term results. The fourth is empathy or the ability to identify and understand the needs and feelings of others. The last is social skills or the ability to engage with others on teams, communicate clearly and build lasting relationships.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Emotional Intelligence

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Worldview

Worldview describes the individualized experience of how one perceives the world around him or her.

Definitions

- **Collectivism** is a psychological construct that stresses that survival and betterment of people in any given society depend upon their interrelated dependence and mutual effort.
- **Emic** describes a type of worldview that is specific to an individual person or culture, one that does not pertain to the collective group.
- **Etic** describes a type of worldview that is commonly shared or widely accepted by members of all cultures.
- **Individualism**, the opposite of collectivism, is a psychological construct that stresses that the overall good and/or survival of members in any given society depend upon their individual freedom and self-reliance.

Description

A person's worldview describes the way in which they perceive the world around them based on their values, beliefs, opinions, and life experiences. Worldview can also refer to the collective assumptions of a particular group, subgroup, or culture. An *etic* worldview describes one that is universally accepted by all cultures while an *emic* view pertains to a worldview that is held by an individual or by members of a specific cultural group. Several factors can influence worldview including family of origin, parenting style, socialization, education, culture, ethnicity, gender, time, and location. Understanding a person's worldview is important as this provides the basis for how one interprets reality. Mutual understanding can also help to promote a collaborative working relationship. Being knowledgeable and respectful of others' worldviews is critical in counseling relationships. Maintaining a level of openness and inquiry regarding cultural differences is an integral part of a counselor's ethical practice.

Current Status and Impact (Psychological Influence)

Derald Wing Sue was the first to introduce the concept of worldview in late 1970s. He wrote about the importance of maintaining culture competence within the counseling relationship and stressed how a client's worldview should be incorporated into the client's therapeutic goals. Sue suggested that the

manner in which individuals view the world is critical to how they think, feel, and subsequently behave. For example, a person who maintains a collectivist view of the world will operate quite differently than a person who holds and individualistic view. In the 1990s, Ibrahim referred to four specific worldview types: optimistic, traditional, pessimistic, and here and now, and offered that every person has both a primary and secondary worldview type that determines how they navigate the world around them. Assessing for one's worldview type and responding with an appropriate counseling style at the onset of therapy is advised.

Melissa A. Mariani, PhD

See also: Cultural Competence; Culture; Multicultural Counseling

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Wundt, Wilhelm (1832–1920)

Many consider Wilhelm Wundt to be the father of experimental psychology.

Description

Wundt began his professional career at the University of Leipzig in Germany where, in 1879, he opened the Institute for Experimental Psychology. There, he attracted students from Germany, the United States, and Britain to what was the first institute that focused exclusively on psychology. His institute became the model for many other psychological laboratories that opened afterward.

Wilhelm Wundt, a German psychologist, was a pioneer in experimental psychology; much of today's research and experimental methods in cognitive psychology can be traced back to Wundt's work. (Corbis)

Perhaps Wundt's most notable achievement was to demonstrate that psychology can be a valid experimental science. His research was highly structured using carefully controlled experimental methodology. His focus was focused on three main parts of cognitive functions, namely thoughts, images, and feelings. Wundt founded voluntarism, which is a school of thought that looks at the process of organizing the mind.

Development and Impact (Psychological Influence)

In 1874, Wundt published an influential work entitled *Principles of Physiological Psychology*,— the first psychology textbook and one that many place among the most influential in the history of the field. He also is credited with establishing the first psychology journal, *Philosophical Studies* in 1881.

Today's research in cognitive psychology can be traced back to Wundt's work. In addition, his work

set the stage for researchers in behaviorism, many of which still use his experimental methods today.

Wundt was a prolific writer, authoring numerous articles and books. However, one of his greatest contributions came from mentoring more than 100 graduates students in psychology—many of whom went on to become well-known, influential psychologists in their own right.

Mindy Parsons, PhD

See also: Cognitive Therapies

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X

Xanax (Alprazolam)

Xanax is a prescription medication used to treat anxiety symptoms and anxiety associated with depression. Its generic name is alprazolam.

Definitions

- **Antianxiety medications** are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.
- **Benzodiazepines** are a group of central nervous system depressants used to relieve anxiety and to induce sleep.
- **Epilepsy** is a medical condition involving episodes of irregular electrical discharge within the brain that causes impairment or loss of consciousness, followed by convulsions.
- **Seizure** is a sudden convulsion or uncontrolled discharge of nerve cells that may spread to other cells throughout the brain.

Description

Xanax is one of the group of antianxiety medications called benzodiazepines. Xanax is primarily used to induce sleep and to treat anxiety, panic disorder, and anxiety associated with depression. It works by slowing the central nervous system and blocking the transmission of nerve impulses in the brain. This decreases the excitability of nerve cells and results in decreased anxiety. While all benzodiazepines cause sedation, such as drowsiness and reduced mental alertness, Xanax causes less drowsiness than other benzodiazepine drugs.

Precautions and Side Effects

Because Xanax is a nervous system depressant, it should not be taken with other depressants, such as alcohol, other sedatives, sleeping pills, or tranquilizers. Xanax should not be taken by those who are pregnant, have glaucoma, or liver or kidney disease. Nor should it be taken with other medications used for treating other mental disorders. Because its use can be habit-forming, Xanax should be carefully monitored by a physician.

The most common side effects of Xanax include sedation, dizziness, drowsiness, insomnia, and nervousness. The intensity of these side effects gradually declines over eight weeks or so. A drop in blood pressure and an increase in heart rate may also occur in those taking Xanax. Decreased sex drive, menstrual disorders, and weight gain or weight loss have also been reported. Less common side effects include diarrhea and constipation, as well as tremor, muscle cramps, vision disturbances, rash, and amnesia or memory loss. Those who experience stomach upset, nausea, vomiting, and dry mouth should eat frequent, small meals or chew sugarless gum.

Len Sperry, MD, PhD

See also: Antianxiety Medications; Benzodiazepines; Valium (Diazepam)

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Y

Yoga

Yoga is a physical and mental practice of mindfulness that involves a sequence of body postures, breathing, and visualizations.

Definitions

- **Mindfulness** is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.
- **Mindfulness practices** are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.
- **Well-being** is the state of being happy, healthy, prosperous, or successful.

Description

Yoga started as a physical and spiritual discipline centuries ago in India. It is aimed at training the consciousness in order to achieve a state of perfect spiritual insight and tranquility. In order to achieve this, yoga uses a complex system of physical and mental exercises. The exercises promote balance in body and mind through removing ego and unconscious desires. Research has shown that yogic techniques can facilitate physical balance, psychological equanimity, and good health even apart from any spiritual aims. Yoga is used as a technique in achieving mindfulness and in some practices it is a common therapeutic recommendation for clients who are in therapy.

It has been said that yoga is a process of physical and mental exercises that enable us to become more aware of who we are and to be peaceful about that. Most yogic practices include postures and controlled breathing as essentials. Related practices include exercise for control of subtle forces, cleansing of the body-mind, visualizations, chanting of mantras, and many forms of meditation.

Yoga was first introduced in the United States in 1893 through the teachings of Swami Vivekananda. Vivekananda was an Indian monk who electrified American audiences through the simplicity of his teaching based on Indian sacred literature and traditions. He stressed the spiritual aspects of his Hindu traditions but inevitably the other physically based practices of the yogic tradition also gained attention and became popular.

Current Status and Impact

Yogic awareness of the dark side of human nature had a great influence on the psychiatrist Carl Jung and through him on Western psychotherapy. Part of the continuing fascination with yoga is that it offers a different, nonreligious, way of encountering the unconscious. Today about 20 million people in the United States report that they are regular practitioners of the many different kinds of yoga; breathing and exercise being among the most popular. There has been a major increase in the number of those certified as yoga teachers. It is clear that the influence of yogic ideas and practices have physical and mental health benefits that have contributed to its popularity and growth.

Yoga focuses on aligning the inner being and obtaining spiritual peace. Its practices align very well

Yoga, a physical and mental practice of mindfulness involving a sequence of body postures, breathing, and visualizations, aligns well with newer psychological theories that move away from a medical model and toward focus on building health and well-being. (Antonio Guillem/Dreamstime.com)

with newer psychological theories that move away from a medical model and focus on building health and well-being. Wellness counseling focuses on a holistic approach to both physical and mental health that is consistent with yogic ideas as well. Within the psychological community yoga has become an accepted recommendation based on research that demonstrates its therapeutic effectiveness in achieving mindfulness. The ultimate goal of mindfulness therapy and yoga is to provide an integral view of human nature that will support healing, growth, and individual transformation.

Alexandra Cunningham, PhD

See also: Mindfulness; Mindfulness-Based Psychotherapies; Well-Being; Well-Being Therapy, Wellness Counseling

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Yohimbine

Yohimbine is a prescription medication that increases blood flow and is used to treat sexual dysfunction. Its brand name is Yocon.

Definitions

- **Alkaloids** are plant compounds composed of carbon, hydrogen, and nitrogen which are pharmacologically active. Examples are caffeine, morphine, nicotine, and Yohimbine.
- **Erectile dysfunction** is the inability to achieve or maintain an erection long enough to engage in sexual intercourse. It is also known as impotence.
- **Selective serotonin reuptake inhibitors (SSRI**) are medications that act on and increase the levels of serotonin in the brain that influences mood.

Description

Yohimbine is an alkaloid with stimulant and aphrodisiac (sexual arousal) effects, found naturally in the bark of the Yohimbine tree. Yohimbine is used to arouse sexual excitement, for erectile dysfunction, for sexual problems caused by selective-serotonin reuptake inhibitor (SSRI) medications, and for other sexual problems in both men and women. It is also used for athletic performance, weight loss, exhaustion, chest pain, high blood pressure, low blood pressure that occurs when standing up, diabetic nerve pain, and for depression. Yohimbine is a prescription medicine in a pure form for the treatment of sexual dysfunction. It is also available as an over-the-counter medicine in an herbal extract form. This form is much weaker than the prescription form, which means it has limited therapeutic effect and fewer side effects. What follows pertains only to the prescription form. Yohimbine is believed to work by increasing peripheral blood flow and nerve impulses to the penis or vagina. An erection occurs because blood flow into the penis is increased and then prevented from flowing out. It also helps counteract the sexual side effects of SSRIs used for depression.

Precautions and Side Effects

Yohimbine should not be used in those with kidney disease or prostate problems. It can worsen the symptoms of benign prostatic hyperplasia and slow or stop the flow of urine. Neither should Yohimbine be used in those with liver disease. Since it can interfere with insulin and cause low blood sugar, Yohimbine should not be used in diabetic patients. Yohimbine can significantly affect blood pressure. While small doses of it can increase blood pressure, large doses can cause dangerously low pressure. Since Yohimbine can damage the heart, it should not be used in those with chest pain or heart disease. Yohimbine should not be used in those who are, or plan to be, pregnant as it can affect the uterus and endanger the pregnancy. It should not be used in those breast-feeding. Yohimbine should be used with caution in those with schizophrenia since it can trigger psychotic symptoms. It can also worsen the symptoms of anxiety and post-traumatic stress disorder. Yohimbine use can trigger manic-like symptoms in those with bipolar disorder, and suicidal tendencies in those with depression.

When taken orally in typical doses, Yohimbine can cause stomach upset, excitation, tremor, sleep problems, anxiety or agitation, high blood pressure, a racing heartbeat, dizziness, stomach problems, drooling, sinus pain, irritability, headache, frequent urination, bloating, rash, nausea, and vomiting.

Taking high doses can also cause other severe problems, including difficulty breathing, paralysis, very low blood pressure, heart problems, and death. Yohimbine has been reported to negatively interact with a number of medications. These include Abilify, Advil, Adderall, Klonopin, Paxil, Wellbutrin, and Zoloft.

Len Sperry, MD, PhD

See also: Sexual Dysfunctions

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Young Man Luther: A Study in Psychoanalysis and History (Book)

Young Man Luther: A Study in Psychoanalysis and History is a book about Martin Luther. It uses psychological concepts to analyze Luther's life. It was written by Erik Erikson.

Definitions

- **Psychoanalytic theory** is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.
- **Indulgence** is the belief that those who say certain prayers, do good deeds, or pay a fee will have some or all of their punishment for their sins reduced.
- **Psychobiography** is a biography written from a psychoanalytic point of view.
- **Psychosocial** refers to the impact of social environment and relationships on psychological development.

Description

Erik Erikson (1902–1994) was a psychoanalyst who developed a system of eight psychosocial stages to understand how individuals change throughout life. These stages are related to age. In each stage, there is a specific "crisis" that must be resolved. If individuals are successful, they move on to the next stage with no problem. However, if they do not respond to the crisis effectively, then problems will carry over into the future. Erikson coined the term "identity crisis" to describe the choices that individuals face at each stage of development. The complete order of Erikson's psychosocial stages and their ages are as follows: Trust versus Mistrust (0–2), Autonomy versus Shame (2–4), Initiative versus Guilt (4–5), Industry versus Inferiority (5–12), Identity versus Role Confusion (13–19), Intimacy versus Isolation (20–39), Generativity versus Stagnation (40–64), Integrity versus Despair (65–death). For example, Erikson believed that children between the ages of two to four experience a crisis of "Autonomy versus Shame." This occurs in their relationship with parents and through experiences such as toilet training. Those who have a supportive environment will develop a sense of autonomy (independence) and will feel good about themselves. Those who do not will feel ashamed and doubt their abilities. During adolescent years (around 13 to 19), the crisis is "Identity versus Role Confusion." Teenagers seek an identity and look to peers for approval. They are between childhood and adulthood, and must begin coming to terms with who they will be as adults. Those who successfully resolve this crisis will have a strong sense of self and a clearly defined purpose in life. Those who do not will lack direction as adults. They may have difficulty making important decisions, such as what type of job to pursue. These individuals will look to others to create an identity for them. Erikson believed that individuals define themselves throughout life. The adolescent identity crisis is one of the most important points in this process. He writes that societies should let young people take time out to "find themselves" before going into adulthood. When individuals are forced into roles, then they are unable to reach their full potential and experience problems.

In *Young Man Luther: A Study in Psychoanalysis and History*, Erikson applies his psychosocial stages to the life of Martin Luther (1483–1546), the leader of the Protestant Reformation. This book is considered a "psychobiography" because psychological concepts are used to examine an individual's life. Luther was born in a humble family in Germany. His father wanted him to become a lawyer and improve the family's standing. After graduating from university, Luther enrolled in law school. However, he was not committed to this path and instead decided to become a Catholic monk. This greatly upset his father. While Luther enjoyed life in the monastery, sexual temptation led him to doubt his vows. In his interpretation, Erikson writes that this was a classic identity crisis. Luther was caught between two different paths and did not feel comfortable in either one. Despite his doubt, Luther remained in the Catholic Church and studied theology. However, his studies led him to question the power of the Church and some of its practices. In 1517, Luther

publicly proclaimed his disagreement by posting his "95 Theses" on the door of the Castle Church in Wittenberg. These theses (arguments) spoke against practices such as selling forgiveness for sin in the form of "indulgences." Luther's writing inspired others to rebel against the Church and formed the beginning of the Protestant Reformation.

Erikson interprets Luther's behavior using psychoanalytic theory. He writes that Luther's disobedience to the Church represented his own conflict with his father. Luther rebelled against one authority figure and then another in his search to find an identity. However, he still questioned his choices throughout his life. Even after many years, Luther tried to defend his decisions to his father. This final crisis was one of Integrity versus Despair. Erikson called this the mature adult crisis in which individuals ask themselves if their lives were meaningful.

George Stoupas, MS, and Len Sperry, MD, PhD

See also: Erikson, Erik (1902–1994); Psychoanalysis; Psychosocial

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YouTube

YouTube is a website that provides access to videos online in a user-friendly format. It is one of the most popular video web portals on the Internet.

Description

Although registered as a corporation in 2005, YouTube, which is owned by Google, only began business in 2006. It became an Internet phenomenon because it allows users to easily upload, share, and view videos. The revolutionary aspect of YouTube is the fact that it allows anyone who visits the site to view the videos for free, without being a registered user.

There are several key features of YouTube which have made it so popular. One is that the visitor can browse videos based on content and popularity. Another is that videos play as soon as the webpage opens and files do not have to be downloaded. Third, all kinds of videos can be posted from the tacky and tasteless to the inspiring and educational, and from the professionally created to the homemade. Music videos are extremely popular. Upon viewing videos, visitors can rate the videos they have watched. Users who are registered have more features such as uploading their own videos and commenting on other users' videos.

Impact (Psychological Influence)

YouTube has had phenomenal success. In 2006, about 20 million visitors used the site each month. By 2013, that had grown to 1 billion visitors per month. The impact is also global as 70% of YouTube usage takes place with users who live outside of the United States. YouTube's auto-speech recognition technology makes it available in more than 50 languages.

YouTube's audience is broad-based. Most users are in the 18- to 54-year age range and have the equivalent of a high school education. There are few controls over the videos posted on YouTube. This has created some political problems in societies with more authoritarian governments, such as China. In countries with even more authoritarian governments, such as Cuba and North Korea, YouTube is banned entirely.

In addition to its success, YouTube has been the subject of criticism because of its impact on society. Due to its open platform, YouTube videos have both positive influences, through educational content, and negative influences through dissemination of violent content. A number of legal, ethical and social issues have surfaced. It has been the cause of lawsuits, primarily over copyright problems with illegal pirating of movie, television, and music content. YouTube has faced legal trouble with pharmaceutical companies and in high-profile divorce cases. Parents and educators have raised questions about its content, especially the violence, due to its open access to users of all ages including children.

Video content websites where users can upload free material have become popular on the internet

With more than 1 billion users on the Internet, and millions of videos submitted from around the world, YouTube, owned by Google, has enormous influence, especially on young people. (Sebastian Czapnik/Dreamstime.com)

and social media. Following the creation of YouTube, other video content sites have followed like Vimeo, Vevo, and Flickr. YouTube, like other popular internet video websites, will continue the momentum toward a shared global information base for entertainment and education.

Alexandra Cunningham, PhD, and William M. Cunningham, MA

See also: Electronic Communication; Social Media; Teen Pop Stars

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Z

Zimbardo, Philip (1933–)

Philip Zimbardo is an American psychologist who is considered one the most influential psychologists of the 20th century, particularly for his Stanford Prison Experiment (SPE).

Description and History

Philip Zimbardo has a long and prolific body of work, including publishing more than 50 books and 400 articles, serving as president of the American Psychological Association (APA), and creating, in 1990, a 26-part PBS series entitled *Discovering Psychology*. After receiving his PhD in psychology from Yale University, Zimbardo spent more than 50 years teaching psychology and is professor emeritus at Stanford University. In fact, in 2012, he received the APA's prestigious Gold Medal for Lifetime Achievement in the Science of Psychology.

According to an interview with Zimbardo, he credits much of his dedication as a reaction to degrading experiences he had as an impoverished immigrant child. Zimbardo is well known for published works on topics such as shyness, terrorism, madness, evil, and post-traumatic stress disorder and is currently researching heroism.

He is probably best known, however, for the controversial SPE, a social experiment that gained national attention following a 1973 article on the results in *The New York Times Magazine* and a documentary aired on *Chronolog*—an NBC documentary television program. The SPE was initially intended to be a follow up to his deindividuation experiment he performed at New York University based on the Nobel Prize-winning novel *The Lord of the Flies*. The premise of the deindividuation experiment was that by changing a person's external appearance it would lead to a change in morality. This, in turn, was a follow up to Stanley Milgram's experiments.

The SPE involved testing the reactions of roles of two dozen male volunteers recruited for the roles of either guard or prisoner in a simulated prison environment. With the flip of a coin, the young men were divided into two groups—prisoners and guards. Zimbardo's aim was to offer an explanation for dehumanizing conditions of the penal system.

Originally planned to last two weeks, Zimbardo stopped the experiment after six days as a result of emotional breakdowns of four of the prisoners in reaction to guards' increasing sadistic treatment of the prisoners that included humiliation and degradation. The prisoners experience depression, crying, rage, and acute anxiety. The experiment itself became well known; Zimbardo even notes its status as "virtually an urban legend" (Drury et al., 2011, 161) and has been the inspiration for two feature films, including the German thriller *Das Experiment* (2001) and an American version, *The Stanford Prison Experiment*, first shown at the Sundance Film Festival in January 2015 and to be commercially released later.

Impact (Psychological Influence)

The experiment is considered one of the most famous psychological experiments of all time. More than 40 years after the experiment took place, controversy still clings to the SPE. Most articles that criticized the SPE were in top tier peer-reviewed journals, whereas the articles on the experiment were relegated to publishing in lesser respected venues. Notably, only a

Philip Zimbardo, shown in 1971, is a prominent American psychologist perhaps best known for the Stanford Prison Experiment in 1971, which showed that in certain situations normal, healthy people could become sadistic in their treatment of others. Zimbardo is also known for his work on shyness, PTSD, terrorism, evil, and, currently, heroism. (Duke Downey/San Francisco Chronicle/Corbis)

portion of the findings of the SPE were published and, as stated in his best-selling book *The Lucifer Effect: Understanding How Good People Turn Evil* (2008), which explores how group dynamics and situations can elicit harmful behavior in individuals, the full story has never been told.

Mindy Parsons, PhD

See also: Evil

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Zinc

Zinc is a mineral that is essential for a healthy immune system and normal physical, mental, and emotional functioning.

Description

Zinc is an "essential trace element" because very small amounts of zinc are necessary for human health. It is found in nearly every cell of the body and is the key to the proper functioning of more than 300 enzymes. Normal growth and development cannot occur without zinc, and it is vital for healthy mental and emotional functioning. It has been shown to sustain intellectual (cognitive) function and mood control. Zinc is also important in promoting mental health and has increasingly been found to reduce symptoms of certain mental disorders. Research has found that symptoms of schizophrenia, autism, attention deficit hyperactivity disorder, Down's syndrome, Wilson's disease, and other mental health problems may be reduced with zinc supplementation.

Zinc is also vital for healthy physical functioning. It has been shown to sustain healthy skin, strong vision, blood-clotting ability, cell division, wound repair, and proper taste and smell.

Zinc is used for treatment and prevention of zinc deficiency and its consequences, including stunted growth and acute diarrhea in children, and slow wound healing. It is also used for boosting the immune system, treating the common cold and recurrent ear infections, and preventing lower respiratory infections. Some use zinc for an eye disease called macular degeneration, for night blindness, and for cataracts. It is also used for asthma; diabetes; high blood pressure; acquired immunodeficiency syndrome (AIDS); and skin conditions such as psoriasis, eczema, and acne. Other uses include treating attention deficit hyperactivity disorder, blunted sense of taste, ringing in the ears (tinnitus), severe head injuries, Crohn's disease, Alzheimer's disease, Down's syndrome, ulcerative colitis, peptic ulcers, and promoting weight gain in people with eating disorders such as anorexia nervosa. Some use zinc for benign prostatic hyperplasia, male infertility, erectile dysfunction, weak bones (osteoporosis), rheumatoid arthritis, and muscle cramps associated with liver disease.

Precautions and Side Effects

General symptoms of zinc deficiency include depression, impotence in men, low fertility in men and women, poor growth in infants and children, along with delayed sexual maturation in adolescents, night blindness, pale skin, acne, eye sores, lowered alertness levels, hair loss, lack of menstrual period, reduced ability to taste or smell, and poor wound healing. Symptoms of too much zinc in the body include nausea, vomiting, loss of appetite, abdominal cramping, diarrhea, headaches, and low levels of high-density lipoprotein cholesterol—the so-called good cholesterol.

The absorption of vitamin A is improved by zinc supplements, but these supplements may interfere with the absorption of other minerals taken at the same time, including calcium, magnesium, iron, and copper. Supplements of calcium, magnesium, and copper should not be taken as along with zinc supplements. Iron should only be taken if a known deficiency exists. Drinking coffee at the same time as taking zinc can reduce the absorption by as much as half. Some diseases increase the risk of zinc deficiency. Sickle cell anemia, diabetes, and kidney disease can all affect zinc

metabolism. People with Crohn's disease, sprue (celiac disease), chronic diarrhea, or babies with acrodermatitis enteropathica (a metabolic disorder affecting the absorption of zinc) also have an increased need for zinc. Those who are anorexic also are at increased risk of having insufficient amounts of zinc within the body, as are people with hookworm, cirrhosis, chronic renal disease, and severe trauma.

Len Sperry, MD, PhD

See also: Nutrition and Mental Health

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Zoloft (Sertraline)

Zoloft is a prescribed medication used for treating depression and various anxiety disorders. Its generic name is sertraline.

Definitions

- **Antidepressant Medications** are prescription drugs that are primarily used for treating depression and depressive disorders. They are known as antidepressants.
- **Selective Serotonin Reuptake Inhibitors (SSRIs)** are antidepressant medications that act on and increase the level of serotonin in the brain that influences mood.
- **Serotonin discontinuation syndrome** results from the abrupt discontinuation of SSRIs. It is characterized by withdrawal symptoms such as anxiety, agitation, insomnia, nausea, vomiting, diarrhea, fatigue, vivid or bizarre dream, dizziness, and other sensory disturbances
- **Serotonin syndrome** is a serious medication reaction resulting from an excess of serotonin in the brain. It occurs when a number of medications that increase serotonin are taken together. Symptoms include high blood pressure, high fever, headache, delirium, shock, and coma.

Description

Zoloft is an antidepressant medication that belongs to the class of medications known as SSRIs. It is used for treating major depression, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, premenstrual dysphoric disorder, and social anxiety disorder. Depression and some other mental disorders are thought to be caused by low levels of serotonin, a chemical messenger (neurotransmitter) that is released and transmitted in the brain. Like other SSRI medications such as Celexa, Luvox, and Paxil, Zoloft is believed to work by increasing the level of serotonin in the brain. Increased levels can benefits those with major depression, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, mood swings, premenstrual tension, alcoholism, and certain kinds of headaches. While Zoloft is not any more or less effective than the other SSRIs, fewer medication interactions have been reported with it than with other SSRIs.

Precautions and Side Effects

Those taking Zoloft should be monitored closely for insomnia, anxiety, mania, significant weight loss, and seizures. Its use should also be monitored in children and adults up to age 24 because they are at an increased risk of developing suicidal thoughts. Caution should also be exercised when prescribing Zoloft to those with impaired liver or kidney function, those over age 60, children, individuals with known bipolar disorder or a history of seizures, and those with diabetes. The risks and benefits of Zoloft should be considered by women who are or might become pregnant, and those who are

breast-feeding. Those with diabetes should monitor their blood or urine sugar carefully, since Zoloft can affect blood sugar. Alcohol should not be used while taking Zoloft. Care must be taken in driving, operating machinery, or participating in hazardous activities when taking this medication. Zoloft use should not be stopped abruptly since it can cause withdrawal symptoms (serotonin discontinuation syndrome).

There are some reported side effects with the use of Zoloft. These include insomnia, dizziness, and headache, delayed ejaculation, and decreased sex drive, nausea and diarrhea, agitation, anxiety, rash, constipation, vomiting, tremors, or visual difficulty. As already noted, Zoloft interacts with fewer medications than the other SSRIs.. Those considering taking this medication should review the other medications they are taking with their physician for possible interactions. Also, those who are taking Prozac should inform all their health providers including dentists.

As already above, Zoloft has fewer medication interactions than other SDSRIs. The risk of seizures is increased in patients using Ultram (narcotic-like pain reliever) and Zoloft. Taking Zoloft with monoamine oxidase inhibitors like Nardil or Parnate may result in the serotonin syndrome. Erythromycin (antibiotic) may inhibit the breakdown of Zoloft in the liver and cause increased central nervous system effects, such as drowsiness, and decreased mental alertness. Other antidepressants should not be taken by those using Zoloft except in rare cases where prescribed by a physician. Zoloft interacts with an herbal remedy St. John's wort. Finally, Zoloft should not be taken with grapefruit juice as the combination may increase Zoloft levels in the body.

Len Sperry, MD, PhD

See also: Antidepressant Medications; Depression and Depressive Disorders

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Zone of Proximal Development

The zone of proximal development is a period of time that children must take to make sense of something they've learned as they undergo a significant development change.

Description

The zone of proximal development is the brainchild of the Jewish Russian psychologist Lev Vygotsky (1896–1934). As defined by Vygotsky himself, the zone of proximal development is the distance between the actual developmental level as defined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers. The premise is that whenever children undergo a significant developmental change, they must go through a period of time—or zone—when they strive to make sense of what they've learned.

A key concept in Vygotsky's work is the social situation of development. In his view, the social situation in which a child finds himself or herself constitutes a predicament from which the child can only emancipate himself or herself developing. When this development takes place, the child must then move through the zone of proximal development. At the beginning of the zone of proximal development, a child can usually copy only with the help of someone more skilled than him or her. By the end, he or she can manage by himself or herself. According to Vygotsky, what goes on during that zone of proximal development is the essence of human development.

In the development of his theory of the zone of proximal development, Vygotsky, who grew up, studied, and practiced in a revolutionary Russia, draw on the insights of Marx, Goethe, and Hegel. Like Marx, he conceived of the Gestalt not just as a brain structure or scheme of perception but as a system of social relationships and activities that include the person in the social situation through which his or her needs are

met. Accordingly, the child is the child of the existing social formation. The relation between the whole social formation and the child is mediated through the family and other institutions.

The social situation of development, which precedes the zone of proximal development, is made up of the child's adult caregivers and all the material conditions surrounding them. This situation is the microcosm of the whole society. Of course, every child is in a different situation and no two are just alike. It is through this concept that a researcher or psychologist can grasp the dynamics of a child's development. By grasping the situation as a predicament rather than simply as an inventory of attributes, the therapist can gain insight into exactly how a social situation drives the child's development.

Development means transforming the mode of psychological functioning and transcending the social situation of development. Overcoming the barriers and developing the new formation allows the child to escape from a social situation of development. According to Vygotsky, the fact of development of infants into adult citizens can be made intelligible only by the fact that, beginning with the birth itself, individuals strive to emancipate themselves from barrier that bar them from achieving their own expectations. The zone of proximal development is significant to Vygotsky exclusively in terms of development. In his view, all other learning is secondary to development. Also, the intervention of the adults in the child's social situation is indispensable to create for the child a social space receptive to the transformation of his or her behavior and interactions.

Transformation of the child's mode of behavior entails the adults acting in relation to the child in a way that the child is not yet fully capable of responding to. It entails acting as if the child has already completed the passage to a new, stable phase of development.

Current Status

The British radical social developmentalists of the 1970s seized upon Vygotsky's zone of proximal development as a powerful theoretical addition to their methodology. However, according to mainstream psychology, which has embraced more enthusiastically the concept of psychoanalysis, Vygotsky's work does not address the likes of intersections, contradictions, and fragmentations wrought by gender, ethnicity, and class upon the developing child.

There is a controversy about the application of Vygotsky's ideas into modern-day psychology. Some argue that the Russian psychologist's views would have a more receptive home in a hybrid psychological-sociological field, or from a more interdisciplinary perspective. Today, Vygotsky's writings are considered more research than theory.

Mindy Parsons, PhD

See also: Vygotsky, Lev (1896–1934)

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Zyprexa (Olanzapine)

Zyprexa is a prescription medication used for treating schizophrenia and manic episodes of bipolar disorder. Its generic name is olanzapine.

Definitions

- **Antipsychotic medications** are prescription drugs used for treating psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.
- **Atypical antipsychotic** is a class of newer (second) generation antipsychotic medications that are useful in treating schizophrenia and other psychotic disorders.
- **Extrapyramidal symptoms** are a group of side effects associated with antipsychotic medication use that are characterized by involuntary muscle movements, including rigidity, contraction, and tremor.

- **Mania** is an elevated or irritable mood as well as mental and physical hyperactivity, and disorganized behavior. It is characteristic of the manic phase of bipolar disorder.
- **Neuroleptic malignant syndrome** is a potentially fatal condition resulting from antipsychotic use characterized by severe muscle rigidity (stiffening), fever, sweating, high blood pressure, delirium, and sometimes coma.
- **Schizophrenia** is a mental disorder in which there is difficulty distinguishing real from unreal experiences. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.
- **Tardive dyskinesia** are involuntary movements caused by certain antipsychotic medications. They include tongue thrusting, repetitive chewing, jaw swinging and facial grimacing.

Description

Zyprexa is in the class of antipsychotic medications known as "atypical" or second-generation antipsychotics. Its primary use is to treat schizophrenia and to control manic episodes of bipolar disorder. Although it is sometimes used in Alzheimer's diseases, Zyprexa is not approved by the Food and Drug Administration for the treatment of behavior problems in older adults with dementia. Zyprexa is thought to work by binding to dopamine receptors while preventing dopamine from fully activating them. This differs from first-generation antipsychotics which completely block dopamine receptors.

Precautions and Side Effects

Zyprexa should be used with caution in those with heart disease because it may cause blood pressure to fall too low, resulting in dizziness, rapid heartbeats, or fainting. Zyprexa should be used carefully in those diagnosed with epilepsy since it can increase the likelihood of seizures. Those with liver disease should have their liver function monitored regularly while taking Zyprexa. Women who are pregnant or breast-feeding should not take Zyprexa. Infants born to mothers who took Zyprexa during pregnancy may develop extrapyramidal symptoms and withdrawal symptoms, including agitation, trouble breathing, and difficulty feeding. Zyprexa has also been associated with the risk of developing a blood disorder.

Common side effects with Zyprexa use include involuntary movements, weakness, dizziness, drowsiness, constipation, weight gain, dry mouth, low blood pressure, stomach upset, increased appetite, cold-like symptoms, and fever. Less common ones include body aches and pains, elevated liver enzymes, vision abnormalities, chest pain, rash, and rapid heartbeats. Although rare, Zyprexa can cause tardive dyskinesia and neuroleptic malignant syndrome.

Any drug that causes drowsiness may lead to decreased mental alertness and impaired motor skills when taken with Zyprexa. Some examples include alcohol, antidepressants such as Tofranil or Paxil, antipsychotics such as Mellaril, and some antihistamines. Because Zyprexa may lower blood pressure, it may reduce blood pressure to dangerously low levels if taken with drugs that are used to treat high blood pressure. Tegretol, an antiseizure medication, may decrease the effectiveness of Zyprexa.

Len Sperry, MD, PhD

See also: Antipsychotic Medication; Schizophrenia

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Glossary

Abandonment is a psychological concept that defines a set of emotional reactions and behavioral responses to perceptions of rejection or loss in personal relationships.

Abuse is the intentional physical, psychological, or sexual maltreatment of an individual.

Abusive personality is a term used to describe the personality of those who criticize, dominate, undermine, and physically harm their intimate partners (spouses).

Acculturation is the process of blending a person's native culture with another culture.

Acculturative stress defines the psychological, somatic, and social challenges that members of a racial or ethnic minority group experience as they adapt to the culture of the majority group.

Achievement refers to anything done successfully, typically by effort, courage, or skill.

Activism refers to the actions and behaviors taken to promote social or political changes.

Acupressure is an ancient art of healing that uses tactile manipulation of pressure points on the body to relieve pain and promote wellness.

Acute disease is medical condition with a single cause, a specific onset, and identifiable symptoms which is often treatable with medication or surgery and is usually curable.

Acute stress is the most common form of stress, is short term, and results in minor and temporary emotional and physical upset.

Addiction is a chronic disease of the brain which involves compulsive, continued, out of control use of substances, or behaviors, despite physical harm or negative consequences.

Addiction recovery is the state of abstinence from addictive behaviors, usually achieved through self-reflection and spiritual exploration.

Addictive personality is the concept that addiction is the result of preexisting personality traits or defects.

Adjustment disorder is a mental disorder characterized by emotional or behavioral symptoms in response to an identifiable stressor that is significantly distressing or causes impairment.

Adler, Alfred (1870–1937) was the Austrian psychiatrist who parted ways with Sigmund Freud and formulated Individual Psychology, which is also known as Adlerian Psychology.

Adlerian therapy is a psychotherapy approach developed by Alfred Adler, which emphasizes the individual's lifestyle, belonging, and social interest.

Adoption is the legal process of establishing the parental rights of a child by an individual or couple who is not the child's biological parent(s) and raise the child as his or her own.

Adrenaline is a neurotransmitter involved in the fight-or-flight response that increases heart rate, pulse rate, and blood pressure.

Advance directives are instructions outlined in a legal document that provide details for care that individuals want carried out on their behalf should their health, either medical or mental, become compromised; examples include living wills and do-not-resuscitate orders.

Adverse childhood experience is a traumatic experience in an individual's life that occurs before the age of 18. For the purposes of an ongoing Centers for Disease Control study to

determine the effects of these experiences on physical health in later adult years, the three main types are abuse (e.g., sexual); neglect (e.g., emotional); and household dysfunction (e.g., divorce).

Advocacy is a process in which an individual or group aims to influence decisions in political, economic, or social policies.

Alcohol use disorder is a mental disorder involving a pattern of alcohol use which leads to significant problems for the user.

Alcohol withdrawal is the unpleasant and potentially life-threatening physiological changes that occur due to the discontinuation of alcohol after prolonged regular use.

Alcoholics are individuals addicted to alcohol.

Alcoholics Anonymous (AA) is a self-help fellowship that was founded by Bill Wilson and Dr. Bob Smith in 1935 to help people struggling with alcoholism.

Alcoholism is a general term for the compulsive and uncontrolled consumption of alcohol to the detriment of the drinker's health, relationships, and social standing.

Alzheimer's disease is a medical and mental disorder that causes dementia particularly late in life. It is also referred to as Neurocognitive Disorder Due to Alzheimer's disease.

American Academy of Child and Adolescent Psychiatry is a nonprofit group of psychiatrists and other related medical professionals created in 1953. It is a national organization with 7,500 members dedicated to helping children who have been diagnosed with psychiatric disorders.

American Society of Addiction Medicine (ASAM) is an organization of physicians whose purpose is to improve the care and treatment of individuals with the disease of addiction and to advance the practice of Addiction Medicine.

Americans with Disabilities Act (ADA) is a civil rights law intended to protect against discrimination based on disability. It was originally signed in 1990 and amended in 2008.

Amnesia is the inability to recall past events or retain new information. It usually occurs as a result of physical or psychological trauma.

Amygdala is an almond-shaped mass of gray matter inside each cerebral hemisphere of the brain that is involved with the experiencing of emotions.

Androgyny is the combination of personality traits that are both feminine and masculine. Androgynous individuals are sometimes hard to identify as either distinctly male or female—whether it is in their appearance, in how they dress, or how they behave.

Anger management is a method of increasing temper control and the skill of remaining calm.

Anima is the female image that is part of the male psyche.

Animus is the male image that is part of the female psyche.

Anisogamy is what differentiates between the two sexes, male or female, referring specifically to size and form differences between sex cells, or gametes.

Anomalies are something that is different from what is considered normal or expected.

Anorexia nervosa is a mental disorder characterized by refusal to maintain minimal normal body weight along with a fear of weight gain and a distorted body image.

Antecedent is something that occurs before a behavior and includes places, people, and things involved in the environment.

Antianxiety medications are prescribed drugs that relieve anxiety symptoms. They are also called anxiolytics or tranquilizers.

Anticipatory grief is the type of grief associated with situations where the loss of a loved one is impending as with a terminal illness.

Antidepressant medications are prescription drugs that are primarily used to treat depression and depressive disorders. They are known as antidepressants.

Antimanic medications are prescription drugs that are primarily used to treat bipolar disorder (manic depression). They are also called antimanics and mood stabilizers.

Antipsychotic medications are prescription drugs used to treat psychotic disorders. They are sometimes referred to as antipsychotics or neuroleptics.

Antiretroviral therapy is regarded as the main type of treatment for HIV or AIDS consisting of drug combinations taken on a daily basis to counteract and prolong the spread of the disease.

Antiseizure medications are prescription drugs used to treat epilepsy (seizures) as well as burning, stabbing, and shooting pain. These are also called anticonvulsant medications.

Antisocial personality disorder is a mental disorder characterized by a pattern of disregarding and violating social norms (rights of others).

Anxiety is a negative emotional state characterized by feelings of nervousness, worry, and apprehension about an imagined danger.

Anxiety disorders are a group of mental disorders characterized by anxiety which tends to be intermittent instead of persistent. The group includes panic disorder, phobias, and generalized anxiety disorder.

Anxiolytics are medications that relieve anxiety symptoms. They are also called antianxiety medications or tranquilizers.

Anxious personality disorder is a personality disorder characterized by a persistent, continuous pattern of anxiety.

Apperception is the process of understanding something through associating it with a previous experience.

Applied describes something put into practical purpose or use; it also describes conclusions derived from or involved with actual phenomena.

Applied behavior analysis is a science that aims to understand and improve human behavior.

Apraxia is a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked, even though the request or command is understood; the term is often used in regard to "apraxia of speech."

Archetype is a pattern of behavior used to organize, understand, and interpret how we experience life. Archetypes can be fluid, meaning they can change over time.

The Archetypes and the Collective Unconscious is a book written by Swiss psychiatrist Carl Gustav Jung and originally published in 1959. This book is Jung's explanation of a universal unconsciousness of mankind, which he believed was impersonal in nature and expressed as instinct. In the book, Jung states that the universal unconsciousness is not anything that has been blocked from our consciousness, but instead is a preconscious experience that has always existed.

Arousal means to stir to an action or response, especially a sexual one.

Art therapy is a mental health specialty used by specially trained therapists working with clients using a variety of art media. The process of creating art is a form of therapy that helps clients to explore their feelings, improve personal insight, resolve emotional conflicts and address a variety of challenges, including addictions, social skills, anxiety, depression, and more.

Asexual refers to the absence of a traditional sexual orientation, which may be considered a fourth category of sexual orientation.

Asperger's disorder is a mental disorder characterized by severely impaired social skills, repetitive behaviors, and narrow interests. In DSM-5, it is known as autism spectrum disorder without language or intellectual impairment.

Assertiveness is the quality of being self-assured and confident without being aggressive.

Assertiveness training is behavior change methods for increasing self-esteem and self-expression in intimidating interpersonal situations.

Assimilation refers to the gradual adaptation of a minority group member's customs, attitudes, and practices to those of the majority culture.

Ataxia is the loss of full control of bodily movements.

Atheoretical refers to untested treatments that are not based on theory.

Attachment is the emotional bond between children and caregivers that provides a secure (healthy) base from which children are able to safely explore their environment and relate to others.

Attachment style refers to the way in which an individual cognitively and emotionally interacts with others. Attachment styles are important since human relationships are central and impact all areas of a person's life.

Attention-Deficit Hyperactivity Disorder (ADHD) is a mental disorder characterized by significant problems with attention, hyperactivity, or acting impulsively that are not appropriate for an individual's age.

Autism spectrum disorders are developmental disabilities that affect a person's ability to communicate, socialize, and behave like most others.

Authoritarian parenting describes a disciplinary style that is highly structured, rule-oriented, rigid, and demanding with a low level of responsiveness.

Authoritative parenting, also known as democratic parenting, characterizes parenting that is both demanding and responsive; authoritative parents provide the proper balance of expectations, limits, and support.

Aversion is a feeling of strong dislike or repugnance toward something with a desire to avoid or turn away from it.

Aversion therapy is a treatment in which the patient is discouraged from a behavior by being subjected to a punishing stimulus when they engage in that behavior.

Avoidant personality disorder is a mental disorder characterized by a pattern of social withdrawal, feelings of inadequacy, and over-sensitivity to negative evaluation.

Banality of evil is a phrase used by political theorist Hannah Arendt to describe the mindless actions of high-ranking Nazi figures such as Adolf Eichmann, an unremarkable figure who engaged in atrocious crimes against countless numbers of Jews for senseless reasons.

Barbiturates are a class of prescribed drugs that slow the nervous system and are prescribed primarily for sedation, general anesthesia, and for treating some types of epilepsy.

Bariatric surgery is a surgical procedure on the stomach and/or intestines to help those who are extremely obese lose weight. It is also called weight loss surgery.

Beattie, Melody (1948–) rose to become a widely acclaimed self-help author, particularly among the addiction and recovery circles following the release of her international best-seller, *Codependent No More*.

Behavior is an observable action demonstrated by a human or animal caused by either internal or external occurrences.

Behavioral activation is a brief, structured treatment approach which activates those who are depressed so they can again experience pleasure and satisfaction.

Behavioral addiction is a form of addiction caused by the compulsion to repeatedly engage in a behavior that causes harmful consequences. It is also referred to as process addiction or non-substance-related addiction.

Behavioral analysis is a type of assessment which focuses on the observable and quantifiable aspects of behavior and excludes subjective phenomena such as emotions and motives.

Behavioral Health is an inclusive term referring to both mental health and substance use disorders.

Behavioral therapy is a psychotherapy approach that focuses on identifying and changing maladaptive behaviors. It is also referred to as behavior therapy.

Behaviorism is a theory of human behavior that limits the study of psychology to measurable or observable behavior rather than inner processes such as thoughts and feelings.

Benzodiazepines are a class of drugs that slow the nervous system and are prescribed to relieve nervousness and tension, to induce sleep, and to treat other symptoms. They are highly addictive.

Bereavement is the feeling of deprivation and grief following the loss of a loved one.

Biculturalism refers to the coexistence of two separate, distinct cultures.

Bilateral eye movement is to look with the eyes to the right and then to the left without moving the head.

Binge eating is a pattern of out-of-control eating consisting of episodes of uncontrolled intake of food.

Binge eating disorder is an eating disorder characterized by binge eating without subsequent purging episodes.

Biofeedback is both the process and device used to train individuals to regulate their own physiologic functions. By giving the individual constant, moment-to-moment updates on specific physiologic functions like heart rate, breathing, and so forth, this therapy allows an individual to master control over what would otherwise be unconscious bodily reactions.

Bipolar disorder is a mental disorder characterized by a history of manic episodes (bipolar I disorder), mixed, or hypomanic episodes (bipolar II disorder), usually with one or more major depressive episodes.

Bipolar and related disorders are a group of mental disorders characterized by changes in mood and in energy (e.g., being highly irritable and impulsive while not needing sleep). These disorders include bipolar I disorder, bipolar II disorder, and cyclothymic disorder.

Bisexual describes the sexual orientation of an individual who is romantically, physically, or sexually interested in both females and males.

Blended families are families in which one or both parents have children from a previous relationship and have merged to form a new family.

Body dysmorphic disorder is a mental disorder characterized by an excessive preoccupation with an imaginary or minor defect in a part of the body.

Body image is a complex psychological concept that includes a subjective picture of one's own physical appearance that comes from both self-observation and from the reactions of others.

Body work therapy is a general term that refers to all physical and physiotherapeutic treatments involving movement or touch to heal the body. These body-based therapies are often designed to unite the body and the mind or heal other injuries in the body.

Borderline personality disorder is a mental disorder characterized by a pattern of instability in interpersonal relationships, self-image, affects, self-harm, and a high degree of impulsivity.

Bowen family systems theory was developed in the 1950s by Dr. Murray Bowen (1913–1990), a psychiatrist and professor, considered a pioneer in family therapy. The foundation of his theory is the belief that a family is best understood as an interconnected emotional unit and thus any therapeutic intervention needs to address the complex interactions among various family members in context of the entire family system.

Brain is the organ at the center of the nervous system. It is responsible for a wide range of functions including learning, movement, and regulation of the body.

Brief psychotic episode is a period in which an individual experiences psychotic symptoms such as hearing voices (hallucinations), paranoid thoughts, depersonalization (feeling unreal), or disorganized speech. The episode is usually triggered by substances, medications, or extreme stress.

Brief psychotic disorder is a type of psychotic disorder characterized by a sudden onset, short duration, and the full return of functioning.

Bulimia nervosa is a mental disorder characterized by recurrent binge eating with loss of control over one's eating and compensation for eating.

Bully, the aggressor, victimizer, or perpetrator of bullying; a person who uses his or her power to intimidate, harass, or harm another person.

Bullycide refers to a suicide where the victim's death has been attributed to victim having been bullied either in person or online.

Bullying is an act of repeated aggressive behavior in order to intentionally harm another individual.

Bystander is a person who is present at, observes, or witnesses a particular event or circumstance (such as bullying), but who does not have direct involvement.

CACREP is the Council for Accreditation of Counseling and Related Educational Programs, which is the primary accrediting organization for hundreds of counseling programs at colleges and universities throughout the United States.

Cannabis use disorder is a mental disorder characterized by cannabis (marijuana) use which leads to significant problems for the user.

Career assessment is the process of using tools such as surveys, inventories, and questionnaires to gather information about a person's aptitudes, interests, and abilities to assist in determining their potential success in a certain career.

Career counseling, also referred to as career coaching or career guidance, involves working with a professional counselor or trained coach who assists clients in exploring their job interests and potential matches.

Career counselor, or vocational counselor, is a counseling professional who has received specialized coursework, training, and certification in career-related guidance in order to provide advice to persons seeking assistance in this area.

Career development defines the lifelong process of how individuals manage and navigate along their vocational paths.

Caregiver is the term applied to family members or paid helpers who regularly look after a child or a sick, elderly, or disabled person.

Case conceptualization is a method and strategy for obtaining and organizing information, understanding and explaining maladaptive patterns, focusing treatment, anticipating challenges, and preparing for termination.

Cataplexy is a medical condition characterized by loss of muscle tone resulting in slurred speech and complete weakness of most muscles. It can last for up to a few minutes.

Central sleep apnea is a type of sleep apnea in which the airway is not blocked, but the brain fails to signal the muscles to breathe.

Cerebral palsy is a condition marked by impaired muscle coordination (spastic paralysis) and/or other disabilities, typically caused by damage to the brain before or at birth.

Certification is a formal procedure by which an accredited or authorized person or agency assesses and verifies (and attests in writing by issuing a document) that a person has the knowledge and skills to perform certain activities.

Characterological anxiety is a persistent pattern or trait of anxiety which reflects an individual's general level of distress. It contrasts with state (situational) anxiety which reflects an individual's distress in a given situation.

Child abuse is the physical, sexual, or emotional maltreatment or neglect of a child or minor, usually under the age of 18, and includes any act or series of acts of commission or omission by a parent of caregiver that results in harm, potential for harm or threat of harm to a child.

A child and adolescent psychiatrist is a medical doctor with specialized training who assesses, diagnoses, and treats mental, behavioral or developmental disorders in children and adolescents, usually by prescribing medication.

Child psychoanalysis is a subfield of psychoanalysis that uses both talk and play therapy to understand psychological processes and emotional disorders in children and adolescents.

Childhood is the early stage in the existence or development of human beings before the advent of sexual maturity or pubescence, also called youth, infancy, babyhood, boyhood, girlhood, pre-pubescence.

Choice theory, first termed "Control Theory," a theory developed by William Glasser to explain human behavior which states that all humans choose to behave in ways that satisfy five basic needs, the most important being love and belonging.

Chronemics describes the study of how one communicates nonverbally using time.

Chronic disease is a disease entity which usually does not have a single cause, a specific onset, or a stable set of symptoms. While cure may be possible, it is unlikely for advanced levels of the disease process. It is also referred to as chronic medical conditions.

Chronic fatigue syndrome is a prevailing state of exhaustion that lasts longer and is more profound than normal, day-to-day weariness and can result in diminished physical, mental, and emotional capacity often requiring one to seek medical or psychological intervention.

Chronic illness is the subjective experience of a chronic disease.
Chronic stress is long-term stress that is emotionally and physically harmful to the health and well-being of the individual.
Circadian rhythms are variations in biological activities that repeat during 24-hour intervals, which influences the amount and quality of sleep. It is also called a biological or internal clock.
Circadian rhythm sleep–wake disorder is a mental disorder that is characterized by irregular patterns of sleep.
Cliques are small groups of people (typically the term refers to groups of adolescents) who have similar characteristics, common interests, and who generally socialize exclusively with one another.
Codependence is an unhealthy level of emotional or psychological dependence on a loved one whereby one or both individuals in the relationship need the other to feel fulfilled.
Cognitive describes acts or processes about learning, knowing, and perceiving.
Cognitive appraisals are what a person thinks, believes, and concludes about events, situations, and circumstances.
Cognitive behavior therapy is a type of psychotherapy that focuses on maladaptive (problematic) behaviors, emotions, and thoughts. It is also called CBT.
Cognitive behavioral modification is a psychotherapy approach that focuses on identifying dysfunctional self-talk in order to change unwanted behaviors.
Cognitive processing therapy is a form of CBT specifically designed for treating post-traumatic stress disorder (PTSD) which teaches skills for recovery from traumatic events by changings one's view of self, world, and others.
Cognitive restructuring is a psychotherapy technique for identifying maladaptive (unhealthy) thoughts and changing them to present a more accurate view of a situation.
Cognitive therapy is a type of cognitive behavior therapy that focuses on identifying and changing automatic thoughts and maladaptive beliefs.
Cognitive-behavior modification is a therapeutic technique which focuses on identifying and challenging negative self-talk patterns in order to counteract maladaptive behavior.
Cohabitation is to live together with someone in a marriage, or marriage-like, sexual relationship.
Collectivism is a psychological construct that stresses that survival and betterment of people in any given society depends upon their interrelated dependence and mutual effort.
College advising is the process of providing students with the information they need to decide upon what post-secondary options are right for them including application, admittance requirements, coursework progression, and financial aid options.
College readiness counseling is a type of counseling provided individually, in small groups, or in classroom settings to students prior to post-secondary entrance in an effort to boost preparedness and eventual completion.
Commercial sex is a sexual act in which something of value is given to or received by any of the involved parties.
Comorbid means to have more than one simultaneous medical condition.
Comorbidity is the existence of one or more mental disorders or physical illnesses that occur with a primary psychiatric illness. It is also referred to as dual diagnosis.
Compensatory behaviors include self-induced vomiting, use of laxative or diuretics, fasting, and excessive exercise.
Competence is a legal term designating that a person is capable of entering into legally binding contracts, transfer assets, and participating in legal proceedings.
Competency defines one's ability to demonstrate skill in an efficient and successful manner.
Complicated grief describes when individuals do not cope well with a loss and it begins to impact their lives in physically, emotionally, socially, psychologically unhealthy ways, or at a level that is not considered normal in that culture and/or society.

Compromise defines when opposing parties move toward one another, finding common ground in order to come to some resolution, understanding, or agreed upon solution.

Compulsions are habitual behaviors, practices, or rituals that are impulsively engaged in to defend against perceived threats, to reduce fears, or otherwise minimize distress.

Compulsory education describes the required period of schooling for every person under law; in the United States this varies by state but typically begins at age 5 till approximately age 17.

Computer-based testing is a form of automated psychological assessment that uses computer software programs to interpret, analyze, and even administer testing procedures. A broader definition of computer-based testing can also include Internet-based assessments, whereby subjects respond through an online medium.

Computer-Mediated Communication (CMC) describes the electronic means of communicating via the Internet including emailing, text messaging, social networking, and videoconferencing.

Concussion is a mild form of brain injury and is the most common type of traumatic brain injury. It involves a brief loss of brain function due to head trauma that resolves spontaneously without a lose consciousness.

Conditioning is a form of learning which involves the formation, strengthening, or weakening of an association between a stimulus and a response.

Conduct disorder is a mental disorder characterized by pervasive patterns of behavior that infringe on the rights of others or that violate social norms. These include aggressive, rule-breaking, rebellion, and other destructive behaviors.

Confidentiality is defined as keeping private the information that is disclosed by a patient, client, or other protected party within the context of a safe, trusting relationship.

Confirmation bias refers to the tendency that people have to pay attention or favor information that supports their beliefs or hypotheses.

Conflict management describes an ongoing process of mediating disputes between two parties where a resolution, though sought after, may not be reached.

Confrontational indicates tending to deal with situations in an aggressive, hostile, or argumentative way.

Congruence model is a way of characterizing organizations that thrive based on the degree of compatibility among four elements: task, people, structure, and culture.

Conjoint means consisting of, or involving two or more persons in a psychological therapy setting, for example, both partners in a marriage or relationship get therapy in the same session.

Conjoint family therapy is a form of psychotherapy which addresses the issues and problems raised by the family members as a system rather than addressing the problems being experienced by individual members of the family.

Conjoint therapy takes place when both relationship partners are present in a therapy session.

Consent is an act of voluntary willingness.

Consequence is the result or outcome that occurs after a behavior is demonstrated.

Constructivism is a philosophy that posits that meaning is continually and actively constructed based on the experiences one encounters and the value they attribute to their experiences.

Continuous Positive Airway Pressure (CPAP) is a device used for treating sleep apnea that delivers air into airways through a specially designed face or nasal mask.

Controlled Substance Act is the federal drug policy that increases research, prevention, treatment, and rehabilitation of drug abusers and strengthen existing laws and regulations against illegal drug trade in the United States.

Conversion disorder is a mental health condition characterized by conditions such as paralysis, seizures, or other neurologic symptoms that cannot be explained by medical evaluation. It is also known as functional neurological symptom disorder and hysteria.

Coping means to handle a situation or an adversity with success.

Coping strategies describe means or techniques, both positive and negative, that individuals use to help them deal with life's stressors.

Counseling means providing assistance and guidance in resolving personal, social, or psychological problems and difficulties, especially by a professional.

Counselor is a person trained to give guidance to others on personal, social, or psychological problems.

Couples refer to two people in an established married or unmarried partnership and may include, lesbian, gay, bisexual, transgender, and heterosexual couples.

Covert means something hidden, concealed, disguised, not openly acknowledged or displayed.

Craving is a strong desire for more of a substance or behavior (sex, shopping, and Internet use) in order to experience a euphoric effect, or to avoid withdrawal symptoms.

Crisis is an event, or series of events, in a person's life marked by danger, instability, and chaos that negatively impacts the person's life.

Culture refers to the knowledge and values; patterns of though, speech, and actions; and customary beliefs, social forms, and speech shared by a society.

Custody explores the rights of the parent or guardian over children. The primary purpose of a custody evaluation is to assess the best psychological interest of the child. In separation or divorce, custody evaluations review who has residential or primary care of the child or children as well as identify visitation rights and expectations. Custody evaluations are conducted to help determine which parent or caregiver best meets the child's needs and is generally conducted by a child psychologist appointed by the court or *guardian ad litem*.

Cutting is a form of self-injury whereby one makes cuts on his or her body, usually on the arms or legs, without the intent to kill oneself.

Cyberbullying refers to using technology (texting, emailing, chat rooms, social media sites, pictures, etc.) to repeatedly and intentionally degrade, threaten, or humiliate another person.

Cyclothymic disorder is a mental disorder characterized by alternating cycles of hypomanic and depressive periods with symptoms like those of some depressive disorders but of lesser severity.

Dance therapy is the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual.

Darkness Visible: A Memoir of Madness is a book written by William Styron (1925–2006) and published in 1990. This first-person account of his near-fatal descent into depression is considered one of the most vivid and insightful even after more than 25 years since it was first published.

Dating is a stage in the human mating process when two people meet socially for companionship, beyond the level of friendship, or with the aim of each assessing the other's suitability as a partner in an intimate relationship or marriage.

Debriefing is a careful review of a situation or activity once it has been completed in order to learn how to handle it better in the future.

Defense mechanisms are unconscious, maladaptive coping strategies that individuals use to prevent unpleasant feelings and experiences.

Defiant is an adjective used to describe resistance or objection.

Deinstitutionalization is the release of a person with mental or physical disabilities from a hospital, asylum, or other medical institution, usually with the intention of providing treatment, support, or rehabilitation through outpatient community resources.

Deity means a god or a supreme being.

Deliberate self-harm, or self-inflicted injury, refers to acts of harming oneself with non-suicidal intent.

Delinquency is a general term used to describe the unlawful activity, wrongdoing, or misbehavior of young people.

Delusional disorder is a mental disorder characterized by delusions. Previously this disorder was referred to as paranoia or paranoid disorder.

Delusions are fixed, false beliefs that persist despite contrary evidence.

Delusions of reference are strongly held beliefs that events, the behaviors, or remarks of others have a particular and unusual significance to oneself, when, in fact, they do not. Unlike ideas of reference, delusions of reference must disrupt daily functioning.

Dementia is a group of symptoms including loss of memory, judgment, language, and other intellectual (mental) functions caused by the death of neurons (nerve cells) in the brain.

Denial of death is when someone refuses to accept the concept of mortality for either themselves or someone else.

Dependence, related to drug use, is the need for a drug to function normally. It can be psychological and/or physical. Psychological dependence is dependence on a psychoactive substance for the reward it provides. Physical dependence refers to the unpleasant physiological symptoms if the drug is stopped.

Dependency with drugs refers to the body's physical need for continued or increasing use of a substance in order to maintain the effect or to ward off withdrawal symptoms.

Dependent personality disorder is a mental disorder characterized by pervasive pattern of submissiveness, a lack of self-confidence, and an excessive need to be taken care of by others.

Depersonalization is a mental state of detachment or a sense of being "outside" oneself and observing one's actions or thoughts.

Depressants are a groups of drugs that are prescribed to reduce the symptoms of anxiety. These are addictive and can be abused. Benzodiazepines, like Valium, are a very common depressant.

Depression is an emotional state characterized by feelings of sadness, low self-esteem, guilt, or reduced ability to enjoy life. It is not considered a mental disorder unless it significantly disrupts one's daily functioning.

Depressive disorders are a group of mental disorders characterized by a sad or irritable mood, and cognitive and physical changes that significantly disrupt the individual's daily functioning. These include major depressive disorder and persistent depressive disorder.

Depressive personality disorder is a mental disorder characterized by a persistent and pervasive pattern of unhappiness, low self-esteem, pessimism, guilt, and an inability to relax and experience pleasure.

Depressive phase is a mental state characterized by sad mood, reduced ability to enjoy life, and decreased energy or activity seen during the course of a bipolar disorder.

Desensitization refers to diminished emotional responsiveness to a negative or aversive stimulus after repeated exposure to it.

Desensitization techniques are behavior change methods for reducing over sensitivity to fearful situations by intentionally and gradually exposing an individual to various emotionally distressing events.

Determinism is a philosophical belief that every event that exists is inevitable, predetermined, and established by preceding events.

Detoxification is the process of ridding the body of toxic substances, such as drugs and alcohol, until laboratory tests and physical examination show that the individual is free of toxins.

Developmental relates to growth and the ability to learn new things, especially in regard to the gradual learning and maturing process in children.

Diagnosis means the identification of the nature of an illness or other problem by examination of the symptoms.

Diagnostic and Statistical Manual of Mental Disorders is the handbook for mental health professionals' use to diagnose mental disorders. The current edition (fifth) is known as DSM-5.

Dialectical Behavior Therapy (DBT) is a psychotherapy approach which focuses on coping with stress, regulating emotions, and improving relationships.

Dichotomy, or dichotomous, refers to the division of two opposing or contradictory, constructs, ideas, or forces in which being high in one is to be low in the other.

***Dictionary of Occupational Titles* (DOT)** is the former print publication published during the late 1930s to 1990s by the U.S. Department of Labor that sought to match job seekers to jobs; it was replaced by an online computer system, the Occupational Information Network, or O*NET.

Diffusion of responsibility suggests that bystanders rationalize their hesitance, reluctance, or lack of intervening on a victim's behalf due to a belief that others present will take responsibility.

Disability is a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

Disability evaluation is a formal determination of the degree of a physical, mental, or emotional disability.

Discrimination is the unjust treatment of others based on racist beliefs.

Disease is an objective medical condition that can be acute or chronic.

Disinhibited social engagement disorder is a mental disorder in children characterized by an overly familiar and culturally inappropriate behavior with strangers.

Disintegrative is an adjective that describes separation into parts, a break up, or deterioration, especially in regard to the self-concept or personality of a person.

Disorder is a term applied to an abnormal physical or mental condition.

Disruptive mood dysregulation disorder is a mental disorder in children characterized by a severe and frequent temper tantrums that interfere with daily functioning.

Dissociation is a psychological process in which an individual experience being disconnected from his or her sensory experience, sense of self (identity), or personal history. Daydreaming is a non-pathological form of it, while depersonalization (a sense that the self is unreal) is a pathological form of dissociation.

Dissociative amnesia is a dissociative disorder characterized by the inability to remember important personal information beyond what could be explained by normal forgetfulness. It is also known as psychogenic amnesia.

Dissociative disorders are a group of mental disorders characterized by a disturbance of self, memory, awareness, or consciousness, which cause disrupted life functioning.

Dissociative fugue is a dissociative disorder characterized by a temporary loss of personal identity, moving to a new location, and assuming a new identity.

Dissociative identity disorder is a dissociative disorder characterized by having more than one distinct identity. Previously it was referred as multiple personality disorder.

Diuretics are substances that elevate the rate of urination and water loss.

Divine refers to objects, practices, and experiences associated with God, gods, or a supreme being.

Dodo bird verdict is the claim that all psychotherapies are equally effective regardless of their components.

Domestic abuse is the abuse by one partner against the other in an intimate relationship. It can involve physical, sexual, and/or psychological abuse.

Domestic violence is a form of abuse between intimate partners (spouses). It is also called domestic abuse.

Dopamine is the chemical messenger in the brain responsible for coordinating the movement of voluntary muscle groups. It also regulates attention, pleasure, and coping with stress.

Dream interpretation is a method of deciphering and understanding the unconscious meaning of dreams.

Drug Enforcement Administration (DEA) is the federal law enforcement agency that enforces controlled substance laws and regulations.

Drugs refer to medications or other substance which have a physiological or psychological effect when ingested or introduced into the body.

DSM is the abbreviation for the *Diagnostic and Statistical Manual of Mental Disorders*, which is the handbook mental health professionals use to diagnose mental disorders. The current edition is the fifth, and is known as DSM-5.

Dyscalculia refers to difficulty in performing simple mathematical functions. It is another name for Mathematics Disorder.

Dysfunction means an abnormality or impairment in the operation of a specified or expected system or organization, physical or mental.

Dyslexia is a learning disorder that impairs a person's ability to read.

Dyspareunia is the experience of pain during sexual intercourse.

Dyspraxia is a learning disorder characterized by the inability to perform tasks or movements when asked, even though the request or command is understood. It is also called apraxia of speech.

Dysregulation is a problem with the control of physical or emotional functions.

Early recollections is a personality assessment method developed by Alfred Adler that analyzes single incident memories from childhood.

Eating disorder is a class of mental disorders that are characterized by difficulties with too much, too little, or unhealthy food intake, and may include distorted body image.

Economic and financial stress is often a response to trying unsuccessfully to balance outgoing money for bills and earning enough income, which numerous studies have found is strongly linked to an increased rate of mental health issues. Among the most significant factors in the onset of mental health issues are job loss and underemployment, both of which have been connected to depression and substance abuse.

Ego depletion is the term used to describe the temporary exhaustion of self-control. It is also known as willpower depletion.

Elder abuse is the physical, sexual, or emotional abuse of individuals, usually one who is disabled or frail.

Ellis, Albert (1913–2007) was an influential American psychologist and author. He began his career as a sexologist before pioneering the development of Rational Emotive Behavior Therapy (REBT). Designed to help people actively overcome challenges and live more fulfilled lives, REBT grew from a fringe school of thought to become a major philosophy and practice.

Emotion is the individual experience of psychological and physical activity which may be positive or negative.

Emotional abuse is a form of abuse characterized by one individual subjecting or exposing another to behavior that may result in anxiety, chronic depression, or post-traumatic stress disorder.

Emotional intelligence is the ability to accurately identify and respond to emotions in oneself and others.

Empathy is the capacity to recognize and respond to another's expression of emotion.

Empathy training is a method of increasing skills of recognizing and responding to another's expression of emotion.

Empty nest is a phrase that describes the family after all of the children have permanently left the home.

Envy and Gratitude is a now famous monograph written by the well-known psychoanalyst Melanie Klein (1882–1960). In this controversial work, Klein theorized that even infants are torn between the struggle for goodness or destructiveness, which she defined as gratitude and envy.

Envy and jealousy are generally considered negative emotions associated with a person's desire to have something or someone that someone else already has, and not having it feels like a threat to the person's sense of self. Envy can sometimes be connected to depression and low self-esteem and, when left unchecked, may escalate to destructive or even violent behavior.

Epistemology is the study of knowledge and understanding and is grounded in philosophy.

Ethnicity refers to a shared distinctive culture based on region of the world, language, religion, and lifestyle.

Evidence-based practice is a form of practice that is based upon integration of the best research evidence with clinical experience and client values.

Evolution is a theory first proposed by Charles Darwin that states all species and organisms develop and change through the natural selection of small, inherited variations that increase the ability of the species or organism to compete, survive, and reproduce.

Evolutionary time refers to an unspecified amount of time usually in the hundreds of thousands to millions of years.

Executive functions are high-level cognitive abilities such as planning, organizing, reasoning, decision-making, and problem-solving that influence more basic abilities such as attention, memory, and motor skills.

Existential psychotherapy is an experiential and relationship-oriented approach to psychotherapy that focuses on meaning and the nature of the human experience.

Exploitation involves illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder.

Exposure therapy is a behavior therapy intervention (method) in which an individual is exposed to a feared object or situation. It is also referred to as flooding.

Expressive means effectively conveying thoughts or feelings.

Expressive arts therapy is the practice of using storytelling, imagery, dance, drama, poetry, movement, music, dream work and visual arts to help promote and encourage personal growth and healing.

Expressive language is the ability to communicate with others through words and speech; when children begin to talk, their receptive language skills are usually much more advanced than their expressive language skills.

Extended families consist of the parents and their children and other biologically related family members such as grandparents, aunts, uncles, and cousins. They may or may not live in the same household.

External locus of control is the belief that one's decisions and life is controlled by forces outside the individual's control.

Externalization is the process of separating an idea from oneself and looking at it from a different view.

Extrapyramidal symptoms are side effects of certain antipsychotic drugs. They include repetitive, involuntary muscle movements, such as lip smacking, and the urge to move constantly.

Eye Movement Desensitization and Reprocessing is a treatment method to reduce trauma-based symptoms by visualization of the traumatic event while concentrating on the rapid lateral movements of the therapist's finger. It is also known as EMDR.

Factitious disorders are a group of mental disorders in which individuals intentionally act as if they are physically or mentally ill, but who have created their own symptoms. One such disorder is Munchausen syndrome.

False memory syndrome is a condition in which a person believes they were the victims of abuse that in reality never actually occurred.

Family assessment is the evaluation of family characteristics, relationship patterns, and family dysfunction (disturbing behavior) and their influence on individual family members.

Family constellation refers to the relationship characteristics with a family unit.

Family counseling and family therapy are synonymous terms used to describe a form of therapy that focuses on at least two or more members of a couple or family unit that works to improve relationships and communication. Instead of focusing on a single individual, family counseling involves the family being treated as a whole unit using one of the various psychotherapy approaches to improve communication and family relationships.

Family of origin refers to the family an individual grew up in and is recognized by mental health experts as having a significant influence on patterns of thinking, feeling, and behaving.

Fear is an emotional response to a known danger.

Feeling Good, The New Mood Therapy is a self-help book by David D. Burns, MD, to offer practical advice, insight and hope to those struggling with depression who want an alternative to medication. It advocates the use of simple cognitive behavioral therapy techniques.

Fetal alcohol syndrome is a medical condition characterized by birth defects, learning, and behavioral problems in children resulting from the mother's alcohol use during pregnancy.

Figure drawing is a projective test used to gain insights on intelligence, trauma, emotional state, and relational interactions. Often used with young children, trauma survivors, and non-native speakers, figure drawing offers a chance to access what may not be able to be expressed in words.

Filial Therapy is a form of therapy geared toward helping children aged 3 to 13 in their mental and emotional development by strengthening the bonds between the child and his or her parent or caregiver.

Flirting is acting as if one is sexually attracted to another person, usually in a playful manner.

Fluency is the ability to speak or do anything correctly and seemingly easily.

Foster care is the temporary placement of a child or infant with surrogate caregivers. It was designed as a proactive attempt by society to address the needs of children in at-risk situations.

Fragile X syndrome is an inherited condition characterized by an X chromosome that is abnormally susceptible to damage, especially by folic acid deficiency. Affected individuals tend to be mentally handicapped.

Frankl, Viktor (1905–1997) was the Austrian psychiatrist who developed logotherapy and was the author of the popular book, *Man's Search for Meaning,* which details his experience as a Holocaust survivor.

Freud, Anna (1895–1982) was a psychiatrist and daughter of Sigmund Freud who is best known for founding the field of child psychoanalysis.

Freud, Sigmund (1856–1939) was the Austrian neurologist who founded psychoanalysis and considered one of the most influential thinkers of the 20th century.

Fundamentalism refers to strict, narrow, and demanding beliefs and practices, usually in reference to religion.

Gambling is the term for playing games of chance for money or betting.

Ganser's syndrome is a mental disorder in which individuals give silly or absurd answers to simple questions.

General intelligence is traditionally understood to be a measurable single capacity that every human being possesses.

Generalized anxiety disorder is a disorder characterized by chronic anxiety and multiple exaggerated worries even when there is little or nothing to provoke it.

Genito-pelvic pain/penetration disorder is a mental disorder in women characterized by persistent fear, pain, or difficulty with vaginal intercourse. Previously this disorder was referred to as dyspareunia and vaginismus.

Genocide is the large-scale murder of people belonging to a particular racial, political, or social group.

Genogram is a detailed graphic that represents an individual's family tree. It is used by family therapists to succinctly portray information about the individual's relationships, family, medical, social, and even developmental history.

Gerontological counseling is a psychological method for working with older clients who face the emotional and mental health challenges associated with aging.

Gestalt psychotherapy is an existential, experiential, and insight-oriented form of psychotherapy and counseling.

Gifted is an adjective that indicates the persons described have talent or natural ability greater than the expected norm or average.

Glasser, William (1925–2013) was the American psychiatrist who developed Reality Therapy.

Going postal is a slang term referring to the sudden and uncontrollable expression of anger to the point of violence. The term originated from a series of shootings involving U.S. postal employees.

Group counseling is two or more people gathering for a face-to-face meeting for the purpose of working toward mutually agreed upon goals.

Group home is a residence for persons requiring care or supervision, such as troubled youth, the developmentally disabled, the elderly or those suffering from addiction. Group homes were a response to the closing of institutions, asylums, and orphanages in the 1960s and 1970s.

Group therapy involves one or more therapists meeting with several clients at one time and it is widely used for a variety of psychiatric problems. Group therapy can be an important part of a client's treatment, depending on his or her diagnosis. Some patients may require a combination of group and individual therapy to improve.

A Guide to Rational Living is a book written by psychologists Albert Ellis and Robert A. Harper. It describes how irrational beliefs lead to suffering and shows how to change them to rational beliefs that result in rational living and increased well-being. First published in 1961, it continues to be near the top of the self-help bestseller lists.

Habit reversal is a behavior therapy intervention for treating repetitive behavior disorders such as tics. It works by increasing tic awareness and developing a competing response to the tic.

Haley, Jay (1923–2007) was a pioneer who changed the approach to family therapy. He believed that therapists were problem solvers who should guide their clients toward a solution. He was one of the developers of strategic therapy which promotes the belief that therapists should acknowledge their ability to influence the behavior of their clients.

Hallucinations are false or distorted sensory perceptions that appear to be real perceptions that are generated by the mind rather than by an external stimuli.

Harlow, Harry (1905–1981) is the psychologist best known for his discoveries of the infant–mother relationship which he uncovered through experimental studies with rhesus monkeys.

Hate crimes are hostile criminal acts such as assault or vandalism motivated by racial, sexual, or other group prejudices.

Heritage refers to the practices, traditions, or characteristics that are passed down from one generation to the next.

Histrionic refers to behavior that is very dramatic or excessive.

Histrionic personality disorder is a personality disorder in which individuals first appear to be charming, likable, energetic, and seductive. But as time passes, others find them to be emotionally unstable, immature, and egocentric.

Hoarding disorder is a mental disorder characterized by persistent difficulty discarding or letting go of possessions regardless of their actual value.

Homeless individuals are those who lack permanent housing and often face mental health issues as a result of being homeless.

Horney, Karen (1885–1952) is the psychologist and psychoanalyst best known for character and character development, feminine psychology, the conception of the self, and her theories on neurosis.

Hospitalization is the act of placing a person as a patient in a formal medical facility.

Household dysfunction is a category of adverse childhood experience that includes household substance abuse, household mental illness, and parental separation or divorce.

House-Tree-Person Test is a projective drawing technique used originally as a measure of intelligence and later as a tool to investigate potential exposure to abuse. The House-Tree-

Person Test is often used to gain insight for the presence of abuse and child's perception of safety and security and has grown to include an assessment of personality dynamics and more.

Humanistic Psychology is based on the idea that people are inherently good. This theory focuses on the exploration of human potential, while emphasizing wholeness and creativity.

Hyperactivity means more active than is usual or desirable.

Hypersomnia refers to difficulty staying awake during the day. Hypersomnolence disorder is a sleep disorder characterized by a recurrent pattern of excessive daytime sleepiness.

Hypnagogic hallucinations are false perceptions that occur when individuals fall asleep.

Hypnopompic hallucinations are false perceptions that occur when individuals are awakening.

Hypnosis is a psychological technique used to induce a trance state.

Hypnotics are substances that induce or cause sleep.

Hypochondriasis is a mental disorder characterized by a preoccupation with having a serious medical condition based on a misinterpretation of bodily symptoms. In DSM-5, this disorder is replaced by illness anxiety disorder.

Hypocretin is a brain chemical that regulate wakefulness and REM sleep and is associated with some symptoms of narcolepsy.

Hypomania is a mental state similar to mania but less intense.

Hypomanic personality disorder is a mental disorder characterized by an enduring pattern of hypomania that shapes cognition, attitudes, and identity. This pattern predictably shapes an individual's behavior and relationships with others.

Hysterical personality comes from the word hysteria which referred to a medical condition caused by the uterus (in Greek: "hysteria" means uterus). The belief was that various symptoms were caused by the movement of a uterus throughout various locations within a woman's body.

Idealizing is the exaggeration of positive qualities and the minimization of negative qualities.

Ideas of reference are the beliefs that events, the behaviors, or remarks of others have a particular significance to oneself when, in fact, they do not.

Illness is the subjective experience of a disease.

Illness anxiety disorder is a mental disorder characterized by severe anxiety and a preoccupation of having a serious medical condition. Previously, this disorder was called hypochondriasis.

Illusions are a misperception or false interpretation of an actual sensory image or impression.

Immigration occurs when people move and settle in a country in which they were not born.

Incomplete grief is grief that persists and is chronic with no resolution, which may include a lack of satisfaction regarding the end of relationship with a deceased parent or other loved ones.

Inferiority complex is a behavioral manifestation of a subjective feeling of inferiority.

Inferiority feeling is the emotional reaction to a self-appraisal of deficiency that is subjective, global, and judgmental.

Infidelity is the act of having a romantic or sexual relationship with someone other than a wife, husband, or committed partner; also referred to as cheating, adultery, or having an affair.

Informed consent means to voluntarily consent in writing, by a competent person, to inpatient or outpatient treatment

Insecure attachment is a lack of trust or consistency in the relationship between a caregiver and child. The caregiver may fail to respond to the infant's needs where the child may become distressed or anxious.

Insomnia refers to difficulty falling asleep or remaining asleep during normal sleep times.

Insomnia disorder is a sleep disorder characteristic by persistent difficulty in falling asleep and staying asleep.

Intellectual refers to the ability to think and understand ideas.

Intelligence is the capacity a person has to learn and understand information and solve problems.

Intelligence quotient is a measure of intellect to determine a person's level of cognitive ability.

Intermittent explosive disorder is mental disorder characterized by impulsive, aggressive, violent behavior or angry verbal outbursts.

Intervention is the act or method of interfering with the outcome or present course of a condition or process so as to prevent harm or improve functioning.

Intrinsic refers to the inherent and essential nature of a thing.

Involuntary commitment is a legal process in which someone suffering from a severe mental disorder can be involuntarily admitted to for psychiatric hospitalization or treatment.

Involuntary hospitalization is the legal process whereby individuals are placed in inpatient mental health treatment against their will.

IQ stands for "Intelligence Quotient," which is a numerical score obtained on standardized tests of human intelligence.

James, William (1842–1910) was one of America's first psychologists. He was a major influence on the modern views of cognitive neuroscience, and wrote extensively on attention, motivation, emotion, and perception. He is also known as an influential philosopher.

Jung, Carl Gustav (1875–1961) was the Swiss psychoanalyst and psychotherapist recognized as the founder of Analytical Psychology. Based on archetypal and symbolic theory, he suggested that the unconscious, especially the collective unconscious, is the starting point and purpose of pursuing ultimate spirit or psychological reality.

Jungian therapy is a specialized form of psychotherapy in which the analyst and patient work together to increase the patient's consciousness in order to move toward psychological balance and wholeness, and to bring relief and meaning to psychological suffering. Its fundamental goal is to build a vital relationship between the conscious and unconscious parts of the mind so that psychic development can be ongoing. Jungian therapy was developed by Carl Jung (1875–1961).

Kernicterus is a brain dysfunction due to severe jaundice.

Kinesiology is the study of anatomy, physiology, and the mechanics of body movements.

Klein, Melanie (1882–1960) was an influential pioneer in the psychoanalysis of children. Many list Klein as second only to Freud in her influence on modern psychoanalysis. She took analyzing young children to a level that had never before been seen. As a result of her work, more is understood about the nonverbal communication of children and patients at all ages.

The Language and Thought of the Child was written by Jean Piaget in 1923. Piaget was the first to apply the insights of social psychology and psychoanalysis to the observation of children, uncovering ways in which children actively constructs their understanding of the world through language.

Law is the collection of rules that govern the behavior of individuals in a community, state, or country.

Laxatives are drugs, medications, or substances that stimulate the evacuation of the bowels.

Lazarus, Arnold (1932–2013) was a psychologist who was one of the pioneers in behavior therapy, particularly the version known as multimodal therapy. He is also known for emphasizing the value of technical eclecticism and stressing the dangers of theoretical integration, and developing the multimodal BASIC I.D. model.

Learning is the acquisition of knowledge or skills through experience, study, or by being taught.

LGBT is an abbreviation for lesbian, gay, bisexual, and transgender people.

Light therapy is a medical treatment in which doses of bright light are administered to normalize the body's internal clock and treat depression. It is also called phototherapy.

Linehan, Marsha M. (1943–) is the driving force behind the development of dialectical behavior therapy, which *Time* magazine noted as one of the top 100 most important discoveries. Her writings on the treatment is the most cited work in the field of mental health in the past 25 years. DBT began as a treatment primarily for suicidal and self-injurious behavior. It has expanded to include many other areas, including addictive and eating disorders, depression, and family conflict.

Logotherapy is a form of therapy that is based on the meaning-focused, existential philosophy of Viennese psychiatrist Viktor E. Frankl (1905–1997). At its essence, logotherapy involves healing and the enhancement of one's well-being through changing one's attitude and beliefs.

Magnetic resonance imaging is a medical diagnostic test which uses magnetic field to produce detailed images of the brain and internal organs. It is also referred to as nuclear magnetic resonance imaging.

Major depressive disorder is a mental disorder characterized by a depressed mood and other symptoms that interfere significantly with an individual's daily functioning. It is also referred to as clinical depression.

Male privilege is the belief in some societies that men have power which exempts them from certain responsibility which women are expected to perform because of their subordinate status.

Malingering is the practice of intentionally exaggerating or faking physical or psychological symptoms for personal gain. It is also known as fictitious illness.

The Man Who Mistook His Wife for a Hat and Other Clinical Tales is a best-selling book written by neurologist Oliver Sacks and published in 1985. The book is a collection of several of the Dr. Sacks's case studies that explores the worlds of his patients, and offers an interesting look at a series of neurological anomalies.

Mania is a mental state of expansive, elevated, or irritable mood with increased energy or activity.

Manic phase is a mental state characterized by expansive, elevated, or irritable mood with increased energy or activity seen in during the course of a bipolar disorder.

Man's Search for Meaning is a book that emphasizes the importance of meaning, faith, hope, humor, and many other adaptive constructs. Meaning-focused existential psychologist and psychiatrist, Viktor E. Frankl (1905–1997) wrote this book over a nine-day period in 1945, shortly after his concentration-camp liberation during World War II.

Marriage Counseling is another term for couples therapy or counseling.

Marriage and Family Therapist is a protected professional title that designates an individual as meeting the educational standards set forth by the Commission on Accreditation for Marriage and Family therapy Education.

Mathematics is the study of numbers, equations, functions, and geometric shapes and their relationships, as in arithmetic, algebra, geometry, and calculus.

Melatonin is a chemical messenger in the brain which regulates the sleep–wake cycle and promotes restorative sleep.

Memory recovery techniques include an array of methods including recovered memory therapy, hypnosis and age regression, guided imagery, dream interpretation, body memory, free association, past life regression, and the use of sodium amytal (the so-called truth serum). Some memory recovery techniques have been associated with false memory syndrome.

Mental disorder is a mental or behavioral pattern or anomaly that causes either distress or an impaired ability to function in daily life. It is also known as a mental illness or psychiatric disorder.

Mental imagery includes visual and bodily sensation images that take place within one's mind and imagination.

Mental retardation is a disorder that describes people with well below average level of intelligence, an IQ of 70 or below, and who have major limitations in the skills needed for daily living.

Methadone is a drug that reduces symptoms of withdrawal for people addicted to other drugs.

Mild cognitive impairment is a mental condition characterized by memory problems that do not significantly impact daily functioning. Commonly, the condition is hardly noticeable or troublesome to the individual. It is also known as MCI.

Mindfulness is the moment-by-moment awareness of one's thoughts, feelings, sensations, and environment without evaluating or judging them.

Mindfulness practices are intentional activities that foster living in the present moment and awareness that is nonjudgmental and accepting.

Mindfulness-based psychotherapies are forms of therapy whose primary intention is to increase a client's capacity for an awareness or attention that is nonjudgmental, accepting, and engaged in experiencing the present moment.

Minnesota Multiphasic Personality Inventory is a psychological test used to assess personality and psychopathology. It is also known as MMPI.

Minuchin, Salvador (1921–) is an Argentinian psychiatrist best known for his work in creating Structural Family Therapy.

Mobbing is harassment of a coworker by a group of others in a workplace to force the targeted individual out of the workplace.

Modeling is a form of teaching where individuals learn how to act or perform by observing other individuals.

Morality is the perception of correct and proper behavior, often based on culture or religion.

Motivational Interviewing is a counseling strategy for helping individuals to discover and resolve their ambivalence to change. It is also referred to as MI.

Movement describes an individual's style of interactions with others, which may be toward, against, or away.

Multicultural counseling refers to the integration of multicultural and culture-specific awareness, knowledge, and skills into counselor interactions, training, and practices.

Multimodal Therapy is a form of psychotherapy which attends to seven modalities of human functioning: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs or biological processes.

Munchausen Syndrome is a mental disorder characterized by fabricated and convincing physical symptoms and a false medical history. It was named after Baron von Munchausen who is known for telling exaggerated stories. It is also known as factitious disorder.

Munchausen syndrome by proxy is a mental disorder in which caregivers fabricate or cause symptoms, falsify medical history, or tamper with laboratory tests in order to make a child appear sick.

Muscle dysmorphia is the obsessive belief that one is not muscular enough.

Muscular dystrophy is a hereditary condition marked by progressive weakening and wasting of the muscles.

Mutual Aid Fellowship is a community in which individuals struggling with the same problem (e.g., alcoholism) help one another.

Narcissistic rage is a reaction to narcissistic injury and can range from aloofness, to mild irritation or annoyance, to serious outbursts, including violent attacks.

Narcissistic injury is the perceived threat to a narcissist's self-esteem or self-worth. It occurs after experiencing a defeat or criticism and results in feelings of emptiness, degradation, or humiliation.

Narcissistic personality disorder is a mental disorder characterized by a pattern of grandiosity, lack of empathy, and a need to be admired by others.

Narcolepsy is a sleep disorder involving daytime sleepiness and uncontrollable episodes of falling asleep during the day.

Narcotics Anonymous is a self-help and support group for those addicted to drugs to help them learn how to live without the use of mind- and mood-altering chemicals. It is a Twelve-Step Program.

Narrative Therapy is an approach that connects identity as shaped by the individual's story and perception of those stories.

National Institute of Mental Health (NIMH) is one of 27 components of the National Institutes of Health based in Bethesda, Maryland. The goal of the NIMH is a world in which mental illnesses are prevented and cured. Its mission is to transform the understanding and treatment of mental illness through basic and clinical research and in so doing aims to pave the way for the prevention, recovery, and cure of the mental illness. The NIMH is a governmental agency. As such, it holds a great deal of authority and credibility on mental health issues.

Natural selection is a process by which an organism or species best adapted to an environment is able to survive longer and reproduce in greater numbers with the adaptive traits being passed down to the next generation. As the number of adapted offspring increases, there is an ever-decreasing chance for the less-adapted organism to reproduce eventually resulting in the extinction of the less-adaptive traits.

Neglect involves refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable child or elder.

Neurocognitive disorders are a group of disorders in DSM-5 that are characterized by a decline from a previous level of neurocognitive (mental) function.

Neurodegenerative disease is a medical condition in which the nervous system progressively and irreversibly deteriorates.

Neurodevelopmental disorders are neurological disorders characterized by impairments of the growth and development of the brain or central nervous system.

Neuroscience is the scientific study of the nervous system and the brain.

Neurosis is an outdated but still used term for various mental disorders characterized by considerable anxiety, irrational fears, depression, or obsessive thoughts. It is also called psychoneurosis.

Nightmare is a dream that results in feelings of terror, fear, or extreme anxiety.

Nightmare disorder is a sleep disorder that is characterized by recurrent troubling dreams.

Noncompliance is the failure, in whole or part, to follow a prescribed treatment regimen.

Nondirective refers to a clinical approach to treatment where the therapist allows the client to set the pace and content of therapeutic counseling sessions.

Non-REM sleep is one of the two basic states of sleep consisting of stages 1, 2 (light sleep) and 3, 4 (deep sleep). It is also known as non-rapid eye movement and NREM sleep.

Nuclear families are traditional families that comprise a cohabiting and committed couple and their biological children.

Obesity is an excessive accumulation of body fat, usually 20% or more over an individual's ideal body weight.

Object Relations Theory is a form of psychoanalytic psychology which explains the essential need for close relationship. The attempted fulfillment of this need through mental representations of self and others is believed to determine one's motivations and behaviors.

Obsessions are persistent, intrusive, inappropriate, and unwanted thoughts, impulses, or images that result in anxiety or distress.

Obsessive-compulsive disorder is a mental disorder that is distressful to the individual and is characterized by unreasonable obsessions or compulsions that are inappropriately time-consuming or cause marked distress or impairment. It is commonly referred to as OCD.

Obsessive-compulsive personality disorder is a mental disorder characterized by a pattern of preoccupation with perfectionism, orderliness, and control.

Obstructive sleep apnea is a type of sleep apnea in which a blockage of the upper airway causes the body to snore and struggle for air.

Oedipus complex is the desire for sexual involvement with the parent of the opposite sex with a concurrent sense of rivalry with the parent of the same sex. Freud considered the complex a critical stage in normal development.

One Flew over the Cuckoo's Nest was a bestselling novel by Ken Kesey (1935–2001) that portrayed life in a mental hospital. It was published in 1962 and later made into a movie in 1975, winning five Academy Awards, including for best picture.

Opioids are a group of drugs that reduce pain. They are highly addictive and include both prescription drugs like Percocet and illegal drugs like heroin.

Oppositional is the act of displaying anger or hostility toward a person or group of people.

Oppression is the unjust exercise of authority or power.

Panic is an intense sense of fear.

Panic attack is an episode of a sudden, intense, and debilitating sense of fear that is short lived.

Panic disorder is a mental disorder characterized by severe panic attacks that occurs frequently and produces significant distress and/or impaired functioning.

Paranoia is an unfounded or exaggerated distrust or suspiciousness of others.

Paranoid personality disorder is a mental disorder characterized by a pattern of a high level of distrust and suspiciousness of the motives of others.

Paraphilia is a sexual disorder in which an individual can only become aroused by inappropriate objects, actions, or fantasies.

Paraphilic disorders are a group of sexual disorders in which an individual can only become sexually aroused by inappropriate objects, actions, or fantasies.

Parasomnias are a group of sleep disorders characterized by abnormal events that occur during sleep such as sleepwalking, talking, or limb movement.

Parkinson's Disease is a disease of the nervous system that causes tremor, rigidity, slowness of movement, and unstable posture. When cognitive impairment is also present, this disease can is known as neurocognitive disorder due to Parkinson's disease in DSM-5.

Passive-aggressive behavior is the indirect expression of hostility characterized by procrastination, stubbornness, forgetfulness, sarcasm, inconsistency, stubbornness, resentment, and repeated failure to accomplish requested tasks for which an individual is responsible.

Passive-aggressive personality disorder is a mental disorder characterized by an enduring pattern of negative attitudes and passive aggressive behaviors. It is also known as the negativistic personality disorders.

Pathology is the study of the essential nature of diseases and especially of their cause, development, structure, and consequences.

PDM stands for the *Psychodynamic Diagnostic Manual*, a diagnostic framework and handbook that characterize individuals in terms of their psychodynamics.

Pedophile is the term given to those who engage in pedophilia, sexual activity with children.

Pedophilic disorder is a sexual disorder in which sexual arousal is achieved with fantasies, urges, or behaviors that involve sexual activity with prepubescent children (13 years of age or younger). It is also referred to as pedophilia.

Perfectionism is the belief that striving for perfection is important because one's self-worth is measured by one's productivity and accomplishments.

Periodic limb movement in sleep is a medical condition characterized by involuntary, jerking movements of the legs or arms.

Persistent depressive disorder is a depressive disorder characterized by a chronic, depressed mood lasting for more than two years. It was previously called dysthymic disorder.

Personality is the enduring pattern of perceiving, feeling, relating, and thinking about one's environment and oneself.

Personality disorder is a long-standing pattern of maladaptive (problematic) behavior, thoughts, and emotions that deviates from the accepted norms of an individual's culture.

Personality type refers to a collection of personality traits and preferences that produce a consistent and predictable pattern of thinking, feeling, and behaving.

Pervasive means present or noticeable in every part of something or in every stage of life.

Phantom limbs is the sensation of feeling that a part of the body that is physically missing or has been removed is still present. The feelings are generally painful.

Phobias are extreme or irrational fears of objects or situations.

Phonological pertains to the distribution and patterning of speech sounds in a language and/or the tacit rules governing pronunciation.

Physical abuse involves inflicting, or threatening to inflict, physical pain or injury on individuals, or depriving them of a basic need.

Pica is the persistent craving and compulsive eating of nonfood substances, like dirt, paint chips, or ice. It is considered an eating disorder in DSM-5.

Play therapy is a therapeutic modality used by a trained play therapist who provides carefully selected play materials in a safe setting for the child to express his or her feelings, emotions, fears, and beliefs. There are many different theoretical approaches to play therapy, including filial therapy, client-centered play therapy, Adlerian play therapy and nondirective play therapy to name a few.

Polysomnography is a medical test that records aspects of sleep (circadian rhythms, REM, NREM, and number of arousals) as well as breathing patterns, heart rhythms, and limb movements.

Positive Psychology is the science about the best things in life with a focus on positive emotions, traits, and institutions.

Post-concussion syndrome is a collection of symptoms that some develop as a complication of concussion such as headache, disorientation, amnesia (inability to remember the injury), and memory and concentration problems which usually clear within three months after the head injury.

Post-traumatic stress disorder is a mental disorder characterized by nightmares, irritability, anxiety, emotional numbing, and recurrent flashbacks of a traumatic event that an individual experienced or witnessed. It is also referred to as PTSD.

Practice is a method or process used to accomplish a goal or objective.

Prejudice is a preconceived opinion about a group or class of people, based on limited, inaccurate, or assumed information.

Premenstrual dysphoric disorder is a mental disorder characterized by a severe form of premenstrual syndrome in which depression, mood swings, irritability, and anxiety disrupt daily functioning.

Premenstrual syndrome is a medical condition in which cramps, breast tenderness, bloating, irritability, and depression occurs prior to a woman's menstrual period and subsides after it.

Primary Care is health care that is provided by nonspecialist physicians like family doctors and pediatricians.

Process is a series of actions or steps taken in order to achieve a particular end result.

Process addiction is a compulsive behavior pattern, not involving substances or chemicals, which interferes with daily living.

Proprioception is the sense of how our bodies are positioned in relation to our environment.

Psychedelic is a term applied to drugs (especially lysergic acid diethylamide, mescaline, or psilocybin) that produce hallucinations and apparent changes in consciousness.

Psychoactive refers to a drug or substance that has a significant effect on mental processes. There are five groups of psychoactive drugs: opioids, stimulants, depressants, hallucinogens, and cannabis.

Psychoanalysis is a theory of human behavior and a form of therapy based on psychoanalytic theory. It focuses on conflicts and compromises between the unconscious (internal) and the conscious mind. Clients are encouraged to talk freely about personal experiences, particularly their early childhood and dreams. It was initially developed by Sigmund Freud.

Psychoanalytic theory is a psychological theory that explains behaviors and perceptions as the result of unconscious, sexual, and biological instincts. It was originally developed by Sigmund Freud.

Psychoanalytic Therapy is a form of psychotherapy that emphasizes unconscious (outside awareness) conflicts and focuses on an individual's early childhood and dreams.

Psychodrama is a form of psychotherapy in which patients act out events from their past.

***Psychodynamic Diagnostic Manual* (PDM)** is a diagnostic system based on psychoanalytic theory that is used by professionals to identify mental disorders with specific diagnostic criteria.

Psychoeducation is a psychological treatment method that provides individuals with knowledge about the condition as well as advice and skills for reducing their symptoms and improving their functioning.

Psychological abuse involves inflicting mental pain, anguish, or distress on individuals through verbal or nonverbal acts. It is also called emotional abuse.

Psychological factors affecting medical conditions is a mental disorder characterized by emotional factors that worsen a medical condition.

Psychopathic personality is a mental disorder characterized as amoral behavior, inability to love and understand another's feelings (empathy), extreme self-centeredness, and failure to learn from experience. It is also known as psychopathy and psychopath.

Psychopharmacology is the study of drugs that affect thinking, feeling, and behavior. It includes antipsychotic, antianxiety, antidepressant, and antimanic medications.

Psychosis is a severe mental condition in which an individual loses touch with reality.

Psychotherapists offer a form of treatment known as talk therapy with individuals, couples, and families, in order to help clients overcome a wide range of psychological and emotional challenges. Employing a variety of theoretical approaches, psychotherapists work to build rapport and trust with clients in an effort to help them address maladaptive thought processes, feelings, and behavior.

Psychotherapy is a psychological method for achieving desired changes in thinking, feeling, and behavior. It is also called therapy and therapeutic counseling.

Psychotherapy integration is a psychotherapeutic process that involves a combination of psychotherapy techniques. It is based on the belief that there are common factors in nearly every treatment approach. The combining and integration of such techniques can create a synergistic effect that leads to more effective treatment.

Psychotic disorder is a severe mental disorder in which an individual loses touch with reality. Symptoms can include hallucinations (hearing or seeing things that are not there), delusions (fixed false beliefs that persist despite contrary evidence), and disordered thinking.

Psychotic features are characteristics of psychotic disorders: delusions, hallucinations, disorganized thinking and speech, grossly disorganized or abnormal motor behavior, and negative symptoms, for example, lack of initiative and diminished emotional expression.

Psychotropic medications are prescribed drugs that affect thinking, feeling, and behavior. These include antipsychotic, antianxiety, antidepressant, and antimanic medications.

Purging, in eating disorders, is a means of clearing the stomach and/or the intestines of material by the use of laxatives, diuretics, or self-induced vomiting.

Race refers to a socially constructed system of classifying individuals according to observable characteristics such as physical attributes (skin tone, height, eye shape, etc.) or language.

Racism is a socially shared belief that all members of a particular race possess characteristics that are inferior to another race, resulting in oppression.

Rational Emotive Behavioral Therapy (REBT), developed by Albert Ellis, is a form of psychotherapy based on the idea that problems are caused by irrational thoughts, beliefs, and expectations.

Reactive attachment disorder is a mental disorder characterized by disturbed and developmentally inappropriate social relatedness.

Receptive means able or willing to receive something, especially (new) signals or stimuli.

Recidivism, within criminal justice terms, refers to the behavior of individuals who relapse back into criminal behavior after having served jail time or some other form of criminal penalty.

Recovered memories are the apparent recollection of childhood abuse of which the person had no previous knowledge of prior to therapy.

Reduction is the action or fact of making something smaller or less in amount, degree, or size.

Reflex indicates an action that is performed as a response to a stimulus and without conscious thought.

Reggae is a musical style built on an irregular, offbeat rhythm accompanied by spoken-song lyrics. It is built on jazz and Rhythm & Blues traditions, breaking through to worldwide popularity in the late 1960s. Early reggae stars came primarily from Jamaica, but reggae is now performed worldwide. Songs often focus on social issues with a view toward illuminating injustices and inspiring marginalized peoples (particularly of African heritage) to take action and make changes.

Rehabilitation is the process of restoring to good health or improved quality of life through therapy or education.

Rehabilitation counseling is a type of counseling that focuses on helping individuals who have disabilities in order to achieve their career, personal, and independent living goals.

Rehabilitation counselors are certified counseling professionals who help people with emotional and physical disabilities live independently.

Reinforcement is a result of a behavior that will strengthen the likelihood of the behavior happening again in the future.

Relapse is the recurrence of symptoms after a period of improvement or recovery.

Relapse prevention is the effort to maintain health and prevent the recurrence of relapse.

Relaxation is the state of being free from tension and anxiety or the restoration of equilibrium following emotional disturbance.

Religion refers to the beliefs, doctrines, and practices associated with membership in a specific group or system that believes in a god or gods.

REM sleep is a stage in the normal sleep cycle characterized by rapid eye movement, dreaming, loss of reflexes, and increased brain activity. It is also known as rapid eye movement and REM sleep.

Repression is a Freudian defense mechanism in which memories of traumatic experiences are hidden from or "repressed" out of conscious awareness.

Reprocessing means to rethink, reorganize, and reconsider the meaning and significance of painful events.

Restless leg syndrome is a sleep disorder characterized by an irresistible urge to move one's legs while attempting to rest.

Retardation means the act, process, or condition of being delayed or impaired from an expected course of development.

Retirement, psychological factors, are the mental and emotional factors that impact individuals who are considering retirement or have retired from their occupation. They include well-being, self-worth, social supports and networking, goals and financial stability. An individual's perception of retirement can largely impact his or her ability to participate or enjoy in separating from the work environment.

Rituals are a series or sequence of actions and behaviors performed in a specific order.

Role-playing is a therapeutic technique which is designed to reduce the fear or discomfort that people experience in various social situations.

Sacred refers to those things that are holy, "set apart," and include objects, rites, and rituals.

Sand tray therapy is a nonverbal form of communicating thoughts, feelings, emotions, and worldviews through the use of specific materials, such as sand; a sand tray; and collection of miniatures, symbols, and figurines all guided by a trained therapist.

Satir, Virginia (1916–1988) was a pioneer in the family therapy movement. She was one of the first therapists to work with the entire family, instead of just individuals, and many

of her methods are still in use today. She is also remembered for her theories on family systems and how they affect individuals.

Schizoid personality disorder is a mental disorder characterized by a pattern of detachment from social relationships and a limited range of emotional expression.

Schizophrenia is a chronic mental disorder that affects behavior, thinking, and emotion and which makes distinguishing between real and unreal experiences difficult. Symptoms include hallucinations, delusions, thought and communication disturbances, and withdrawal from others.

Schizophrenia spectrum and other psychotic disorders are a group of mental disorders characterized by psychotic features. These disorders include schizophrenia, schizophreniform disorder, schizoaffective disorder, and schizotypal personality disorder, and delusional disorder.

Schizophreniform disorder is a psychotic disorder with the signs and symptoms of schizophrenia but with a total duration of less than six months.

Schizotypal personality disorder is a mental disorder characterized by a pattern of acute discomfort in close relationships, eccentric behaviors, and distorted thinking and feeling. It is also referred to as schizotypal and schizotypal personality.

Scope of practice includes the procedures, processes, and acts which professionals can legally use in their jobs.

Seasonal affective disorder is a mental disorder in which depression comes on during the late fall and winter and begin to lift during spring and summer. It is also called SAD, winter depression, and winter blues.

Secure attachment is an emotional bond between children and caregivers. Children with secure attachments trust their caregivers to meet their needs.

Sedatives are substances that have a soothing, calming, or tranquilizing effect.

Selective mutism is a mental disorder in which children or adolescents fail to speak in some social situations although they have the ability to talk normally at other times. Previously it was called elective mutism.

Selective serotonin norepinephrine reuptake inhibitors (SNRI) are medications that act on and increase the levels of serotonin and norepinephrine in the brain that influences mood. These differ from selective serotonin reuptake inhibitors which only act on serotonin.

Selective serotonin reuptake inhibitors (SSRI) They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain resulting in symptom reduction.

Self-actualization is the highest level need at the top of Maslow's pyramid of needs and is based on the human desire for self-fulfillment once other, more basic needs have been met.

Self-control is the capacity for self-discipline. Some use this term interchangeably with willpower.

Self-help groups are a group of individuals, sometimes led by a therapist, who provide each other emotional support, information, and advice on problems relating to some shared concern such as an addiction. Alcoholics Anonymous is such a group.

Self-instruction, a strategy used in cognitive behavior modification, teaches an individual to actively engage in verbal self-prompting and then follow up with a related behavior or action.

Self-transcendence is the sense of going or being beyond oneself, of overcoming the limits of the physical self.

Separation anxiety disorder is an anxiety disorder characterized by excessive anxiety resulting from separation from those to whom a child is attached.

Serotonin is a chemical messenger in the brain that regulates learning, sleep, mood, and appetite. It is involved in disorders such as depression and anxiety.

Serotonin discontinuation syndrome results from the abrupt discontinuation of a SSRI medication. It is characterized by withdrawal symptoms such as anxiety, agitation, in-

somnia, nausea, vomiting, diarrhea, fatigue, vivid or bizarre dream, dizziness, and other sensory disturbances.

Sexual abuse involves non-consensual sexual contact of any kind, coercing an elder to witness sexual behaviors.

Sexual dysfunction disorders are a group of mental disorders characterized by significant difficulty in the ability to respond sexually or to experience sexual pleasure. Disorders include delayed ejaculation, female orgasmic disorder, and genito-pelvic pain/penetration disorder.

Shyness is a type of social withdrawal that results from fear and anxiety. It is described as wariness when confronted with novel social situations and/or self-conscious behavior in a social setting. Many view shyness as a subclinical condition or normal personality trait that is not pathological.

Sick role is the protective role given an individual with a medical or mental condition which accords them special treatment and excuses them from specific expectations or responsibilities.

Sleep is the body's rest cycle which is triggered by a group of hormones that respond to cues from the body itself and from the environment.

Sleep apnea is a temporary disruption or stoppage of breathing during sleep which can result in daytime sleepiness.

Sleep deprivation is a condition characterized by insufficient sleep, which if it is chronic, can cause fatigue, daytime sleepiness, and loss of concentration and productivity.

Sleep disorders are a group of mental disorders characterized by disturbance in the amount and quality of sleep and that cause significant emotional distress or interfere with daily functioning.

Sleep hygiene refers to the habits, practices, and nonmedical treatments for insomnia and which improve the quality of sleep.

Sleep paralysis is a condition in which individuals are aware of the surroundings but are unable to move when they awaken from sleep.

Sleep stages refers to five stages of sleep: 1, 2, 3, 4, and REM.

Sleep terror disorder is a sleep disorder characterized by repeated temporary arousal from sleep, during which the individual appears extremely frightened. This disorder is also known as night terrors and is often confused with nightmares and nightmare disorder.

Sleep–wake disorders are a group of mental disorders that are characterized by various sleeping disturbances including circadian rhythm sleep-wake disorder.

Sleepwalking is a condition in which individuals get up and walk around while still sleeping. In DSM-5 it is a diagnosable sleep disorder called a non-rapid eye movement (non-REM) sleep arousal disorder. Sleepwalking is also known as somnambulism.

Sober, in relation to alcohol and drug addiction, means not consuming alcohol, drugs, or engaging in other related addictive activities.

Sobriety refers to the state of being sober and of not having any mood altering substances such as drugs or alcohol in one's system.

Social means related to human society or its ways of being organized.

Social anxiety disorder is an anxiety disorder characterized by excessive and unreasonable fear in social situations of being judged or evaluated by others. It was previously referred to as social phobia.

Social inequality refers to the existence of unequal opportunities or distribution of resources because of social position or status with a social group.

Social Interest is one of Alfred Adler's key concepts that describes a feeling of community, when a person acts in the best interests of others as opposed to being consumed by their own personal needs and concerns.

Social skills training is treatment method that assists individuals to learn specific skills that are missing or those that will compensate for the missing ones.

Sociopathic personality is a mental disorder characterized by amoral and criminal behavior and a diminished sense of moral responsibility. It is also known as sociopathy and sociopath.

Somatic sensitivity refers to the high level of sensitivity and attentiveness to bodily sensations in some individuals leading them to overly focus on physical symptoms.

Somatic symptom and related disorders are a group of DSM-5 mental disorders characterized by prominent somatic symptoms and significant distress and impairment. They include somatic symptom disorder and factitious disorder. Previously they were known as somatoform disorders.

Somatic symptom disorder is a mental disorder characterized by bodily symptoms that are very distressing or result in disrupted functioning,

Somatization disorder is a mental disorder characterized by multiple bodily symptoms that cannot be explained by medical condition. This term is no longer used and has been replaced with somatic symptom disorder in DSM-5.

Somatoform disorders are a group of mental disorders characterized by physical symptoms that cannot be explained by a medical condition. DSM-5 calls them somatic symptom and related disorders.

Specific phobia is a mental disorder characterized by a marked and enduring fear of specific situations or objects. Previously this disorder was referred to as simple phobia.

Spectrum is the entire range over which some measurable property or observed phenomenon can vary.

Speech-language refers to verbal means of communicating.

Spirituality is the sum total of an individual's unique world- and self-view, religious beliefs, attitudes, and behaviors.

Splitting is the inability to synthesize (put together) contradictory qualities, such that the individual views others as either all good or all bad.

Spousal battering is a type of domestic violence which involves a systematic pattern of intimidation, control, terror and physical violence for the purpose of gaining total control over the partner.

SSRI stands for selective serotonin reuptake inhibitors. They are a class of antidepressant medications that work by blocking the reabsorption of serotonin in nerve cells and raising its level in the brain resulting in symptom reduction.

Standardized means something has been brought into conformity with a norm or standard.

Stereotype means to categorize, characterized, or group people into oversimplified and inaccurate classifications.

Stereotyping is an activity where people or events are classified according to conventional, formulaic, and oversimplified conceptions, opinions, or images.

Stigma is an identifying mark or characteristic especially of shame or discredit; often applied to the symptoms of psychological or mental health issues.

Stimulant use disorder is a mental disorder that is characterized by the use of stimulants that leads to significant problems for the user. It includes stimulants such as amphetamine and cocaine, but not caffeine or nicotine.

Stimulants are a class of drugs which increases brain activity and produces a sense of alertness, euphoria, endurance, and productivity, or suppress appetite. Examples are: cocaine, amphetamines, and Ritalin.

Strategic Family Therapy is a form of therapy that involves the whole family unit in a brief therapeutic intervention designed to bring about rapid change. The therapist plays the leading role, with the family members completing various tasks to shift their systems of interaction toward the contracted outcome.

Stress is the psychological, emotional, and physical state of strain resulting from negative appraisals of events, situations, and circumstances.

Stress management is a set of psychological techniques for increasing the capacity to better cope with psychological stress. It usually includes relaxation methods.

Structural Family therapy looks at the organization of a family.

Stuttering is talking with continued involuntary repetition of sounds, especially initial consonants.

Subconscious is that part of the conscious mind which consists of information that is not in awareness unless attention is directed to it. It is also called the preconscious.

Substance abuse involves the use of substances (drugs or alcohol) in amounts or with methods that are harmful.

Substance-induced psychotic disorder is a mental disorder characterized by hallucinations or delusions caused by the use of or withdrawal from substance like alcohol or cocaine. It is referred to as substance/medication-induced psychotic disorder in DSM-5.

Substance-related and addictive disorders are a group of DSM-5 mental disorders that include substance disorders characterized by physiological dependence, drug-seeking behavior, tolerance, and social withdrawal. It also includes the non-substance disorder of gambling.

Substance use disorders are a category of conditions associated with the continued use of substances, such as alcohol or drugs, despite causing significant cognitive, social, behavioral, and psychological consequences.

Support means to help bear the weight of something, psychologically especially applied to bearing the burden of diseases or losses.

Symptoms are physical or mental features that are regarded as indicating a condition of disease, or of an undesirable situation.

Syndrome is a group of symptoms that consistently occur together or a condition characterized by a set of associated symptoms.

Systematic desensitization is form of cognitive behavior therapy that gradually exposes individuals to their phobia (fear) while remaining calm and relaxed.

Systemic abuse refers to the existence and maintenance of social inequalities due to a larger system such as the laws, policies, and practices of the land.

Target is the individual who is the recipient or victim of bullying or mobbing.

Temper tantrums are disruptive behaviors or emotional outbursts displayed in response to unmet needs or desires.

Theology refers to the study of and concepts about the nature of God.

Theoretical integration is the assimilation of two or more theories of psychotherapy.

Theory refers to a body of knowledge, or set of principles, that explains the phenomenon in question.

Therapeutic is of or relating to the healing of disease

Therapy means treatment intended to relieve or heal mental or psychological disorders.

The Three Faces of Eve was both a bestselling book and a major motion picture. The movie, starring Joanne Woodward, first appeared in theaters in 1957 but remains a classic to this day. Woodward won a Best Actress Oscar and Golden Globe award for her role as Eve, a young, unassuming Georgia housewife suffering from "multiple personalities," a term currently known in the DSM-5 as dissociative identity disorder.

Tics are involuntary, compulsive, repetitive and stereotyped movements or vocalizations. While they are experienced as irresistible, they can be temporarily suppressed.

Tolerance refers to the need for higher doses of a substance or more frequent engagement in an behavior to achieve the same effect.

Tourette's Syndrome is a neurological disorder characterized by recurrent involuntary movements and vocal tics such as grunts, barks, or words, including obscenities.

Trance is an altered mental state of consciousness in which a person experiences heightened concentration with a greater ability to block out distractions.

Transcendence refers to the perception that there are extraordinary dimension to life that go beyond the limits of our physical reality.

Transcendent means going beyond the physical realm and exceeding conventional limits of ordinary consciousness and personal identity.

Trauma is a singular or recurrent event that is both extraordinary and severely distressing. It is also called traumatic event. This can include abuse, domestic violence, medical trauma, accidents, acts of terror, war experiences, natural and man-made disasters.

Trauma symptoms are any symptoms (anxiety, angry outburst, depression, etc.) that occurs as a result of a severely distressing event.

Trauma and stressor-related disorders are a group of mental disorders characterized by exposure to a traumatic or stressful event. These include post-traumatic stress disorder, reactive attachment disorder, and disinhibited social engagement disorder.

Traumatic brain injury is an insult or injury to the brain from an external force. In DSM-5, this disorder is known as neurocognitive disorder due to traumatic brain injury.

Treatment noncompliance is the phrase used when individuals fail to follow treatment instructions, regimens, or advice. It is also known as non-adherence.

Triggers are situations that activate memories and emotional states associated with a past traumatic event.

Twelve-Step Program is a self-help group whose members attempt recovery from various addictions based on a plan called the 12 Steps.

Twelve Steps refers to the 12 guiding principles on which Alcoholics Anonymous is based.

Twelve Traditions are the rules that govern how Twelve-Step Program groups operate.

Unconscious is the part of the conscious mind which consists of the primitive, instinctual wishes and information that operates without awareness and over which one does not have active control.

Vaginismus is the inability to allow vaginal penetration because of anxiety and fear of pain.

Values are principles that govern virtuous behavior. When values are lived or put in action they are known as virtues.

Vocation is a person's employment, trade, or main occupation.

Vocational counseling is therapy for people looking to obtain or maintain work.

Vygotsky, Lev (1896–1934) is considered one of the most significant and influential educational psychologists of the late 20th and early 21st centuries. He has been credited as the key figure in developing a social constructivist understanding of psychological development.

Well-being is the state of being happy, healthy, or successful.

Wellness is the state or condition of being in good physical and mental health and steps to promote it.

Willpower is the ability to resist a short-term temptation in order to achieve a long-term goal. It also involves the ability to delay gratification.

Withdrawal is the unpleasant and potentially life-threatening physiological changes reaction (e.g., cravings, depression, pain, trembling, and hallucinations) that occur due to the discontinuation of certain drugs after prolonged regular use.

Wundt, Wilhelm (1832–1920) is often referred to as the father of experimental psychology. His most notable achievement was to demonstrate that psychology can be a valid experimental science as described in his influential book, *Principles of Physiological Psychology*.

Yoga is a spiritual and ascetic discipline founded in India, a part of which, including breath control, simple meditation, and the adoption of specific bodily postures, is widely practiced for health and relaxation.

Zimbardo, Philip (1933–) is the psychologist best known for the controversial Stanford Prison Experiment which involved testing the reactions of male volunteers recruited for the roles of either guard or prisoner in a simulated prison environment. With the flip of a coin, the young men were divided into two groups—prisoners and guards. This study has offered an incisive explanation for dehumanizing conditions of the penal system.

Zone of proximal development is the brainchild of the Jewish Russian psychologist Lev Vygotsky (1896–1934). The premise is that whenever children undergo a significant developmental change, they must go through a period of time—or zone—when they strive to make sense of what they've learned.

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Organizations

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Alcoholics Anonymous World Services, Inc.
475 Riverside Drive at West 120th Street, 11th Floor
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Website: http://www.aa.org

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Website: http://www.arttherapy.org/

American Association for Marriage and Family Therapy (AAMFT)
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Website: www.aamft.org

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American Foundation for Suicide Prevention
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Website: http://www.afsp.org

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American Institute of Stress
124 Park Avenue
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Website: http://www.stress.org

American Medical Association
330 N. Wabash Avenue
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Website: https://apps.ama-assn.org

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Website: www.musictherapy.org

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Website: http://www.apa.org

American Psychotherapy Association
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American Retirement Counselors
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Website: www.asha.org

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Clovis, CA 93612
Telephone: (559) 294-2128
Fax: (559) 294-2129
E-mail: info@a4pt.org
Website: www.a4pt.org

Association for Specialists in Group Work
A Division of the American Counseling Association

6101 Stevenson Avenue
Alexandria, VA 22304
Telephone: (800) 347-6647
Fax: (800) 473-2329
E-mail: webmaster@counseling.org
Website: http://www.counseling.org

Association for the Study of Dreams
1672 University Avenue
Berkeley, CA 94703
Telephone: (209) 724-0889
Fax: (209) 724-0889
E-mail office@asdreams.org
Website: www.asdreams.org

Association for Transpersonal Psychology
P.O. Box 50187
Palo Alto, CA 94303
Telephone: (650) 424-8764
E-mail: info@atpweb.org
Website: http://www.atpweb.org/

Attention Deficit Disorder Association (ADDA)
PO Box 7557
Wilmington, DE 19803-9997
Toll free: (800) 939-1019
E-mail: infor@add.org
Website: http://www.add.org

Autism Society
4340 East-West Highway, Suite 350
Bethesda, MD 20814
Telephone: (301) 657-0881
E-mail: info@autism-society.org
Website: www.autism-society.org

Beck Institute for Cognitive Therapy and Research
One Belmont Avenue, Suite 700
Bala Cynwyd, PA 19004-1610
Telephone: (610) 664-3020
Fax: (610) 664-4437
E-mail: beckinst@gim.net
Website: http://www.beckinstitute.org

Biofeedback Certification International Alliance
5310 Ward Road, Suite 201
Arvada, CO 80002
Telephone: (720) 502-5829
E-mail: info@bcia.org
Website: www.bcia.org

The Bowen Center
4400 MacArthur Blvd. NW #103
Washington, DC 20007
Telephone: (202) 965-4400
Fax: (202) 965-1765
E-mail: info@thebowencenter.org
Website: www.thebowencenter.org

Brain and Behavior Research Foundation
60 Cutter Mill Road, Suite 404
Great Neck, NY 11021
Telephone: (516) 829-0091
Fax: (516) 487-6930
E-mail: info@bbfoundation.org
Website: http://www.bbrfoundation.org

Brain Trauma Foundation (BTF)
7 World Trade Center, 34th Floor, 250 Greenwich Street
New York, NY 10007
Telephone: (212) 772-0608
Website: http://www.braintrauma.org

Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027
Telephone: (800) 232-4636
E-mail: http://wwwn.cdc.gov/dcs/RequestForm.aspx
Website: http://www.cdc.gov/

Center for Mind-Body Medicine
5225 Connecticut Avenue NW, Suite 415
Washington, DC 20015
Telephone: (202) 966-7338
Fax: (202) 966-2589
Website: http://www.cmbm.org

Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Rm. 5-1015
Rockville, MD 20857
Fax: (240) 276-2130
Telephone: (240) 276-1660
E-mail: webmaster@samhsa.hhs.gov
Website: http://www.samhsa.gov/csat

Children and Adults with Attention Deficit/ Hyperactivity Disorder (CHADD)
8181 Professional Pl., Suite 150
Landover, MD 20785
Telephone: (301) 306-7070
Fax: (301) 306-7090
Website: http://www.chadd.org

Co-Dependents Anonymous (CoDA)
CoDA, Fellowship Services Office
P.O. Box 33577
Phoenix, AZ 85067-3577
Telephone: (602) 277-7991
E-mail: info@coda.org
Website: www.coda.org

Council for Accreditation of Counseling and Related Educational Programs (CACREP)
1001 North Fairfax Street, Suite 510
Alexandria, VA 22314
Telephone: (703)535-5990
Fax: (703)739-6209
E-mail: http://www.cacrep.org/contact/
Website: www.cacrep.org

Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201
Telephone: (202) 619-7800
Toll free: (877) 696-6775
Website: http://www.hhs.gov

Drug Enforcement Administration
Mailstop AES
8701 Morrissette Drive
Springfield, VA 22152
Toll free: (800) 882-9539
Website: http://www.justice.gov/dea

The Dulwich Centre
The Gateway to Narrative Therapy and Community Work
14 St. John Street
Adelaide, South Australia 5000
Telephone: (61-8) 8223 3966
Fax: (61-8) 8232 4441
E-mail: dulwich@dulwichcentre.com.au
Website: http://www.dulwichcentre.com.au/

Eunice Kennedy Shriver National Institute of Child Health and Human Development
Public Information and Communications Branch
31 Center Drive
Building 31, Room 2A32, MSC 2425
Bethesda, MD 20892-2425
E-mail: NICHDInformationResourceCenter@mail.nih.gov
Website: www.nichd.nih.gov

False Memory Syndrome Foundation
P.O. Box 30044
Philadelphia, PA 19103
Telephone: (215) 940-1040
E-mail: mail@fmsfonline.org
Website: http://www.falsememorysyndromefoundationonline.org/index.php

Food and Drug Administration (FDA)
10903 New Hampshire Avenue
Silver Spring, MD 20993
Toll free: (888) 463-6332
Website: http://www.fda.gov

Gamblers Anonymous
International Service Office
P.O. Box 17173
Los Angeles, CA 90017
Telephone: (626) 960-3500
Fax: (626) 960-3501

E-mail: ISOMAIN@GAMBLERS ANONYMOUS.ORG
Website: www.gamblersanonymous.org

Gay, Lesbian, Bisexual, and Transgender National Help Center
2261 Market Street, PMB #296
San Francisco, CA 94114
Telephone: (415) 355-0003
Fax: (415) 552-5498
E-mail: info@GLBTNationalHelpCenter.org
Website: http://www.blgnationalhelpcenter.org

The Gottman Institute
1410 E. Jefferson Street, Suite 501
Seattle, WA 98122
Telephone: (888) 523-9042
Fax: (206) 523-7306
E-mail: couples@gottman.com
Website: http://www.gottman.com/

Hazelden Foundation
P.O. Box 11
Center City, MN 55012-0011
Telephone: (651) 213-4200
Fax: (651) 213-4200
E-mail: info@hazelden.org
Website: http://www.hazelden.org

International Association of Marriage and Family Counselors (IAMFC)
A Division of the American Counseling Association
6101 Stevenson Avenue
Alexandria, VA 22304
Telephone: (800) 347-6647
Fax: (800) 473-2329
E-mail: webmaster@counseling.org
Website: http://www.iamfconline.org/

International Dyslexia Association (IDA)
40 York Road, 4th Floor
Baltimore, MD 21204
Telephone: (410) 296-0232
Fax: (410) 321-5069
E-mail:interdys.org/ContactUs.htm
Website: http://www. interdys.org

International Expressive Arts Therapy Association
P.O. Box 320399
San Francisco, CA 94132
Telephone: (415) 522-8959
E-mail: info@ieata.org
Website: www.ieata.org

International Society for Interpersonal Psychotherapy
c/o ISIPT Executive Officer
Scott Stuart, MD
University of Iowa
Department of Psychiatry
1-293 Medical Education Building
Iowa City, Iowa 52242
Telephone: (319) 353-4230
Fax: (319) 353-3003
E-mail scott-stuart@uiowa.edu
Website: http://interpersonalpsychotherapy.org/

International Society for the Study of Personality Disorders
University of Michigan Health System, Psychiatry MCHC-6, Box 5295
1500 E Michigan Center Dr.
Ann Arbor, MI 48109-5295
Telephone: (734) 936-8316
Fax: (734) 936-9761
Website: http://www.isspd.com

International Society for the Study of Trauma and Dissociation
8400 Westpark Dr., 2nd Floor
McLean, VA 22102
Telephone: (703) 610-9037
Fax: (703) 610-0234
Website: http://www.isst-d.org

Leadership Council on Child Abuse and International Violence
c/o Joyanna Silberg, PhD, 6501 N Charles Street, PO Box 6815
Baltimore, MD 21285-6815
E-mail: desk1@leadershipcouncil.org
Website: http://www. leadershipcouncil.org

Learning Disabilities Association of America (LDA)
4156 Library Road
Pittsburg, PA 15234-1349
Telephone: (412) 341-1515
Fax: (412) 344-0224
E-mail: http://www Idanatl.org/contact/contact.cfm
Website: http://www.Idanatl.org

Mental Health America
2000 N. Beauregard Street, 6th Floor
Alexandria, VA 22311
Telephone: (703) 684-7722
Toll free: (800) 969-6642
Fax: (703) 684-5968
E-mail: infoctr@mentalhealthamerica.net
Website: http://www.mentalhealthamerica.net/

Minuchin Center for the Family
P.O. Box 258
Oaklyn, NJ 08107
Telephone: (212) 481-3144
E-mail: contact@minuchincenter.org
Website: www.minuchincenter.org

Narcotics Anonymous
PO Box 9999
Van Nuys, CA 91409
Telephone: (818) 773-9999
Fax: (818) 700-0700
E-mail: fsmail@na.org
Website: http://www.na.org

National Alliance on Mental Illness (NAMI)
3803 N. Fairfax Dr., Suite 100
Arlington, VA 22203
Telephone: (703) 524-7600
Fax: (703) 524-9094
E-mail: info@nami.org
Website: www.nami.org

National Association of School Psychologists
4340 East-West Highway, Suite 402
Bethesda, MD 20002
Telephone: (301) 657-0270
Fax: (301) 657-0270
Website: http://www.nasponline.org

National Association of Social Workers
750 First Street NE, Suite 700
Washington, DC 20002-4241
Telephone: (202) 408-8600
Website: http://www.naswdc.org

National Autism Association
One Park Avenue, Suite 1
Portsmouth, RI 02871
Telephone: (877) 622-2884
Fax: (401) 293-5342
Website: http://nationalautismassociation.org

National Career Development Association (NCDA)
305 N. Beech Cr.
Broken Arrow, OK 74012
Fax: (918) 663-7058
Telephone: (918) 663-7060
Website: http://associationdatabase.com/aws/NCDA/pt/sp/home_page

National Center on Elder Abuse (NCEA)
University of California—Irvine, Program in Geriatric Medicine
101 The City Dr. S
200 Building
Orange, CA 92868
Fax: (714) 456-7933
Toll free: (855) 500-3537
E-mail: ncea-info@aoa.hhs.gov
Website: http://www.ncea.aoa.gov

National Center for Learning Disabilities (NCLD)
381 Park Avenue S, Suite 1401
New York, NY 10016
Telephone: (212) 545-7510
Fax: (212) 545-9665
Toll free: (888) 575-7373
E-mail: ncld@ncld.org
Website: http://www.ncld.org

National Clearinghouse on Alcohol and Drug Information
PO Box 2345
Rockville, MD 20847

Fax: (240) 221-4292
Toll free: (877) SAMHSA-7
Website: http://www.ncadi.samhsa.gov

National Coalition Against Domestic Violence
One Broadway, Suite B210
Denver, CO 80203
Telephone: (303) 839-1852
Fax: (303) 831-9251
E-mail: mainoffice@ncadv.org
Website: http://www.ncadv.org/

National Council for Adoption
225 N. Washington Street
Alexandria, VA 22314
Telephone: (703) 299-6633
E-mail: ncfa@adoptioncouncil.org
Website: https://www.adoptioncouncil.org/

National Council on Alcoholism and Drug Dependence, Inc. (NCADD)
244 E 58th Street, 4th Floor
New York, NY 10022
Telephone: (212) 269-7797
Fax: (212) 269-7510
Toll free: (800) 622-2255
E-mail: national@ncadd.org
Website: http://www.ncadd.org

National Council for Behavioral Health
1400 K Street NW, Suite 400
Washington DC, 20005
Telephone: (202) 684-7457
E-mail: Communications@thenationalcouncil.org
Website: http://www.thenationalcouncil.org/

National Eating Disorders Association
165 W 46th Street
New York, NY 10036
Telephone: (212) 575-6200
Fax: (212) 575-1650
E-mail: infor@NationalEatingDisorder.org
Website: http://www.nationaleatingdisorder.com

National Human Genome Research Institute
National Institutes of Health
Building 31, Room 4B09
31 Center Drive, MSC 2152
9000 Rockville Pike
Bethesda, MD 20892-2152
Telephone: (301) 402-0911
Fax: (301) 402-2218
E-mail: info@mail.nih.gov
Website: http://www.genome.gov

National Institute on Aging (NIA)
Bld. 31, Rm. 5C27, 31 Center Dr., MSC 2292
Bethesda, MD 20892
Telephone: (301) 496-1752
Fax: (301) 496-1072
Toll free: (800) 222-2225
Website: http://www.nia.nih.gov

National Institute on Alcohol Abuse and Alcoholism (NIAA)
5636 Fishers Ln., MSC 9304
Bethesda, MD 20892-9304
Telephone: (301) 443-3860
Website: http://www.niaaa.nih.gov

National Institute on Drug Abuse (NIDA)
6001 Executive Blvd., m 5213
Bethesda, MD 20892
Telephone: (301) 442-1124
E-mail: information@nida.nih.gov
Website: http://www.nida.nih.gov

National Institute of Neurological Disorders and Stroke (NINDS)
P.O. Box 5801
Bethesda, MD 20824
Telephone: (800) 352-9424
E-mail: info@ninds.nih.gov
Website: ninds.nih.gov

National Institute of Relationship Enhancement and Center for Couples, Families and Children
4400 East-West Highway, Suite 24
Bethesda, MD 20814
Telephone: (301) 680-8977
Fax: (502) 226-7088
E-mail: niremd@nire.org
Website: www.Nire.org

National Institutes of Health
9000 Rockville Pike
Building 45, Lobby Room 1AS-13
Bethesda, MD 20814
Telephone: (301) 496-1776
E-mail: info@mail.nih.gov
Website: www.nih.gov

National Registry of Evidence-based Programs and Practices
Telephone: (866) 436-7377
E-mail: nrepp@samhsa.hhs.gov
Website: http://www.nrepp.samhsa.gov/

National Sleep Foundation
1010 N. Glebe Road, Suite 310
Arlington, VA 22201
Telephone: (703) 243-1697
E-mail: nsf@sleepfoundation.org
Website: http://www. sleepfoundation.org

North American Drama Therapy Association
1450 Western Avenue, Suite 101
Albany, New York 12203
Telephone: (888) 416-7167
Fax: (518) 463-8656
E-mail: office@nadta.org
Website: www.nadta.org

Obsessive Compulsive Foundation
PO Box 961029
Boston, MA 02196
Telephone: (617) 973-5801
Website: http://www.ocfoundation.org

Office of Juvenile Justice and Delinquency Prevention
810 Seventh Street NW
Washington, DC 20531
Fax: (301) 240-5830
Telephone: (202) 307-5911
E-mail: james.antal@usdoj.gov
Website: http://www.ojjdp.gov/

Olweus Bullying Prevention Program
Toll free: (800)328-9000
E-mail: olweusinfo@hazelden.org
Website: http://www.olweus.org/oublic/index.page

Parents Anonymous, Inc.
675 W Foothill Blvd., Suite 220
Claremont, CA 91711-3475
Telephone: (909) 621-6184
Fax: (909) 625-6304
E-mail: Parentsanonymous@parentsanonymous.org
Website: http://www.parentsanonymous.org

Positive Psychology Center
University of Pennsylvania
3720 Walnut Street, Solomon Labs
Philadelphia, PA 19104-6241
Telephone: (215) 898-7173
E-Mail: SeligmanInfo@psych.upenn.edu
Website: http://www.positivepsychology.org

Rape, Abuse & Incest National Network (RAINN)
2000 L Street NW, Suite 406
Washington, DC 20036
Telephone: (202) 544-1034
Toll free: (800) 656-HOPE
E-mail: info@rainn.org
Website: http://www. rainn.org

The Sandplay Therapists of America (STA)
P.O. Box 4847
Walnut Creek, CA 94596
Telephone: (925) 820-2109
Fax: (925) 820-2109
E-mail: sta@sandplay.org
Website: www.sandplay.org

Sex Addicts Anonymous
PO Box 70949
Houston, TX 77270
Toll free: (800) 477-8191
E-mail: info@saa-recovery.org
Website: http://www.sexaa.org

Sexuality Information and Education Council of the United States
1706 R Street, NW
Washington, DC 20009
Telephone: (202) 265-2405
Fax: (202) 462-2340
Website: http://www.aasect.org

Society for the Exploration of Psychotherapy Integration
E-mail: geosticker@gmail.com
Website: http://sepiweb.org

The Society for Family Psychology
American Psychological Association, Division 43
750 First Street NE
Washington, DC 20002-4242
Telephone: (202) 336-6013
E-mail: division@apa.org
Website: http://www.apa.org/about/division/div43.aspx

Substance Abuse and Mental Health Services Administration (SAMHSA)
1 Choke Cherry Road
Rockville, MD 20857
Telephone: (877) 726-4727
Fax: (240) 221-4292
E-mail: info@samhsa.hhs.gov
Website: www.samhsa.hhs.gov

United States Bureau of Justice
Bureau of Justice Assistance
Office of Justice Programs
810 Seventh Street NW
Washington, DC 20531
Telephone: (202) 616-6500
Fax: (202) 305-1367
Website: https://www.bja.gov/About/contact.html

United States Department of Education
400 Maryland Avenue SW
Washington, D.C. 20202
Telephone: (800) 872-5327
Website: http://www.ed.gov/

United States Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201
Telephone: (877) 696-6775
Website: http://www.hhs.gov/about/

United States Department of Labor
Frances Perkins Building
200 Constitution Avenue NW
Washington, DC 20210
Telephone: (866) 487-2365
Website: www.dol.gov

United States Department of Labor Bureau of Labor Statistics
Postal Square Building,
2 Massachusetts Avenue NE
Washington, DC 20212-0001
Telephone: 202-691-5200
E-mail: blsdata_staff@bls.gov
Website: www.bls.gov

United States Department of Veterans Affairs
810 Vermont Avenue NW
Washington DC 20420
Telephone: (800) 488-8244
Website: http://www.va.gov/

United States Drug Enforcement Administration
8701 Morrissette Dr.
Springfield, VA 22152
Telephone: (202) 307-1000
Website: http://www.dea.gov/index.shtml

United States Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
Telephone: (888) 463-6332
Website: www.fda.gov

Workplace Bullying Institute (WBI)
PO Box 29915
Bellingham, WA 38228
E-mail: http://www.workplacebullying.org/aboutwbi/contact/
Website: http://www.workplacebullying.org

World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland
Fax: + 41 22 791 31 11
Telephone: + 41 22 791 21 11
Website: http://www.who.int/en/

Recommended Resources

The following references are offered as important resources for further exploring topics in mental health and mental disorders.

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