

**HUMAN BEHAVIOR COURSE**  
**BLOCK III SYLLABUS**  
**MAJOR DISORDERS**

**Academic Year 2004**

# HUMAN BEHAVIOR COURSE 2004

## CONTENTS

Course Topic	Page Number
1. Dates .....	2
Objectives .....	3
Attendance .....	4
Text & Required Readings .....	5
Schedule .....	6
Grading .....	10
PAR .....	12
Web .....	14
Small Groups .....	16
Lecturers .....	19
<b>PART IV: THE MAJOR PSYCHIATRIC DISORDERS (Continued)</b> .....	
<b>405</b>	
25. Somatoform & Related Disorders .....	406
26. Reactions to Stress & Trauma .....	428
27. <i>DIAGNOSIS &amp; FORMULATION III</i> . Vignette 3:1 – “Postpartum Piety” .....	432
<i>DIAGNOSIS &amp; FORMULATION III</i> . Vignette 3:1 – Discussion Questions .....	433
<i>DIAGNOSIS &amp; FORMULATION III</i> . Vignette 3:2 – “Crimes Against The State” .....	434
<i>DIAGNOSIS &amp; FORMULATION III</i> . Vignette 3:2 – Discussion Questions .....	435
28. Eating Disorders .....	436
29. Developmental Disorders & Mental Retardation .....	446
30. Childhood Disorders .....	449
31. Personality Disorders One .....	492

## HUMAN BEHAVIOR COURSE 2004 DATES

JANUARY 8 (THURSDAY).....COURSE STARTS

FEBRUARY 19 (THURSDAY).....**MANDATORY:** FIRST SMALL GROUP

MARCH 4 (THURSDAY).....BLOCK ONE EXAM

APRIL 2 (FRIDAY).....LAST DAY TO DECLARE INTENT & TOPIC FOR PAR PROJECT

APRIL 2 (FRIDAY).....**MANDATORY:** SECOND SMALL GROUP

APRIL 7 (WEDNESDAY).....BLOCK TWO EXAM

APRIL 9 (FRIDAY).....**MANDATORY:** THIRD SMALL GROUP

APRIL 19 (WEDNESDAY).....**MANDATORY:** TORREY & FRESE LECTURE ON SCHIZOPHRENIA

APRIL 26 (MONDAY).....PAR PROJECT DUE (BONUS POINTS)

APRIL 26 (MONDAY).....BLOCK THREE EXAM

APRIL 26 (MONDAY).....**MANDATORY:** FOURTH SMALL GROUP

APRIL 28 (WEDNESDAY).....**MANDATORY:** JAMISON LECTURE ON SUICIDE & MOOD DISORDERS

MAY 5 (WEDNESDAY).....BLOCK FOUR & FINAL EXAM

MAY 15 (FRIDAY).....FINAL COURSE GRADES POSTED

# HUMAN BEHAVIOR COURSE 2004

## OBJECTIVES

**MAIN OBJECTIVE.** Introduce second-year medical students to the theory and practice of psychiatry and biopsychosocial patient care.

**LEARNING OBJECTIVES.**

Students should achieve the following objectives during the Human Behavior Course:

1. Learn the phenomenology and range of normal and disordered behavior, emotions, and relationships over the human life span.
2. Grasp the concept and application of the biopsychosocial model to general medical and psychiatric care.
3. Learn and practice how to create biopsychosocial formulations and management plans for patients.
4. Understand and discuss the impact of various predisposing, protective, precipitating, perpetuating, and therapeutic factors on the natural history of psychiatric disorders.
5. Rehearse prioritized differential diagnoses based on appropriate nomenclature, diagnostic categories, and criteria using patient vignettes or actual patient histories.
6. Develop a foundation of knowledge and experience in psychiatry that is applicable to medical practice and a framework for new knowledge obtained using various life-long learning strategies.

## HUMAN BEHAVIOR COURSE 2004

### ATTENDANCE

**ABSENCES.** To be excused from any mandatory activity (e.g., small groups, examinations) you must notify Dr. Engel in writing **AT LEAST 24 HOURS** prior to your absence, emergencies excepted.

**ALL SMALL GROUPS ARE MANDATORY.** They will meet in rooms and labs as assigned. Please see "Small Group Assignments" section of the syllabus for details. The small group sessions may be found in the main class schedule (course hours 15, 22, 27, and 36).

**SOME LECTURES ARE MANDATORY.** Some of the course lectures are mandatory because guest lecturers, patients, or family members of patients are volunteering their time (and in some cases traveling great distances) to speak to the class. **Mandatory lectures are bolded in the main class schedule.** To learn more about the lecturers, see the "Lecturers" section of this syllabus.

**CONSEQUENCES OF MISSING MANDATORY ACTIVITIES.** Role is taken at all mandatory lectures and small groups. More than one unexcused absence from the mandatory course activities (lectures plus small groups) will drop the responsible student's course grade one letter grade (e.g., drop from B to C or from C to D). A more protracted pattern of unexcused absences (i.e., more than 3) may result in a failing course grade.

## HUMAN BEHAVIOR COURSE 2004 TEXT & REQUIRED READINGS

### **REQUIRED COURSE READINGS ARE FROM:**

Cohen BJ. *Theory and Practice of Psychiatry*. Oxford University Press, New York, NY; 2003. Students should review the assigned readings prior to attending lectures. This book is lent to each student for the duration of the course. Please don't mark in these books because they will be reused.

### **THE REFERENCE TEXT FOR THE COURSE IS:**

Hales RE, Yudofsky SC, Editors. *Textbook of Clinical Psychiatry*, 4th Edition. American Psychiatric Press, Washington, DC; 2002. This book has been issued to students and comes with a CD-ROM version of the complete *Diagnostic & Statistical Manual, Fourth Edition (Text Revision)* (DSM-IV-TR). DSM-IV-TR is the principal diagnostic manual used in clinical psychiatry. Neither these two books are required reading for the Human Behavior Course. However they are useful reference texts that provide broader and more comprehensive coverage of psychiatry than the Cohen book.

**NOTE: The Hales & Yudofsky chapter on normal development (chapter 2) is *required* reading for the normal development lectures in the course that are delivered by Dr. Gemelli. This is the only exception to the rule that Hales & Yudofsky is not required reading for the course.**

## HUMAN BEHAVIOR COURSE 2004 SCHEDULE (V2)

Lectures are in Lecture Room D unless otherwise noted.

PART I.			FUNDAMENTALS.	LECTURER
1.	8 Jan THU	0730- 0745	Course Introduction READ: Introductory Parts of the Syllabus	Engel
2.	8 Jan THU	0745- 0820	Global Burden of Psychiatric Disorders READ: Syllabus	Engel
3.	8 Jan THU	0830- 0920	Neurobiology of Psychiatric Disorders One READ: Syllabus & Cohen Ch 4	Lacy
4.	15 Jan THU	0730- 0820	Neurobiology of Psychiatric Disorders Two READ: Syllabus & Cohen Ch 4	Lacy

PART II.			DEVELOPMENT.	LECTURER
5.	15 Jan THU	0830- 0920	Suicide READ: Cohen Ch 16	Engel
6.	22 Jan THU	0730- 0820	Infancy & Toddlerhood READ: Hales & Yudofsky Ch 2:67-105	Gemelli
7.	22 Jan THU	0830- 0920	Infancy & Toddlerhood READ: Hales & Yudofsky Ch 2:67-105	Gemelli
8.	29 Jan THU	0730- 0820	Childhood READ: Hales & Yudofsky Ch 2:67-105	Gemelli
9.	29 Jan THU	0830- 0920	Childhood READ: Hales & Yudofsky Ch 2:67-105	Gemelli
10.	5 Feb THU	0730- 0820	Adolescence READ: Hales & Yudofsky Ch 2:67-105	Gemelli
11.	5 Feb THU	0830- 0920	Adolescence READ: Hales & Yudofsky Ch 2:67-105	Gemelli

<b>PART III.</b>			<b>ASSESSMENT</b>	<b>LECTURER</b>
<b>12.</b>	12 Feb THU	0730-0820	Psychiatric Evaluation, Diagnosis, & Formulation READ: Cohen Ch 1, 2, 3	Engel
<b>13.</b>	12 Feb THU	0830-0920	Violence READ: Cohen Ch 17	Engel
<b>14.</b>	17 Feb TUE	0730-0820	Adult Development READ: Syllabus only	Privitera
<b>15.</b>	19 Feb THU	0730-0920	DIAGNOSIS & FORMULATION ONE TOPIC: Introduction to Diagnosis & Formulation READ: Syllabus only	Faculty

<b>PART IV.</b>			<b>MAJOR DISORDERS.</b>	<b>LECTURER</b>
<b>16.</b>	26 Feb THU	0730-0820	Delirium READ: Cohen Ch 5	Engel
<b>17.</b>	26 Feb THU	0830-0920	Dementia READ: Cohen Ch 6	Engel

<b>BLOCK 1 EXAM</b>		<b>THURSDAY MARCH 4 0830-0920 [COVERS LECTURE HOURS 2-15]</b>
---------------------	--	---

<b>PART IV.</b>			<b>MAJOR DISORDERS.</b>	<b>LECTURER</b>
<b>18.</b>	29 Mar MON	0730-0820	Psychotherapies One READ: Cohen Ch 18	Ursano
<b>19.</b>	29 Mar MON	0830-0920	Psychotherapies Two READ: Cohen Ch 18	Ursano
<b>20.</b>	31 Mar WED	0730-0820	Mood Disorders One Read: Cohen Ch 7	Engel
<b>21.</b>	31 Mar WED	0830-0920	Anxiety Disorders One READ: Cohen Ch 9	Engel
<b>22.</b>	2 Apr FRI	0730-0920	DIAGNOSIS & FORMULATION II TOPIC: Gender-Related Issues READ: Syllabus only	Faculty
<b>23.</b>	5 Apr MON	0930-1020	Anxiety Disorders Two READ: Cohen Ch 9	Engel

24.	5 Apr MON	1030- 1120	Substance Use Disorders READ: Cohen Ch. 12	Holloway
-----	--------------	---------------	---	----------

<b>BLOCK 2 EXAM</b>	<b>WEDNESDAY 7 APRIL 0730-0820 [COVERS LECTURE HOURS 16-24]</b>
-------------------------	---

<b>PART IV.</b>		<b>MAJOR DISORDERS (Continued).</b>		<b>LECTURER</b>
25.	7 Apr WED	0830- 0920	Somatoform & Related Disorders READ: Cohen Ch 13	Engel
26.	7 Apr WED	0930- 1020	Reactions to Stress & Trauma READ: Cohen Ch 9:273-280; Ch 7:Table 7-6; & Ch 14	Osuch
27.	9 Apr FRI	0730- 0920	DIAGNOSIS & FORMULATION III TOPIC: Social & Cultural Aspects of Psychiatry READ: Cohen Ch 7	Faculty
28.	12 Apr MON	0730- 0820	Eating Disorders READ: Cohen Ch 11	Hall
29.	12 Apr MON	0830- 0920	Developmental Disorders & Mental Retardation READ: Cohen Ch 19	Randall Hanson
30.	14 Apr WED	0930- 1020	Childhood Disorders READ: Cohen Ch 19	Waldrep
31.	14 Apr WED	1030- 1120	Personality Disorders: Introduction & Cluster A Disorders READ: Cohen Ch 10	Engel
32.	19 Apr MON	0930- 1020	Schizophrenia & Psychosis One READ: Cohen Ch 8	Torrey Frese
33.	19 Apr MON	1030- 1120	Schizophrenia & Psychosis Two READ: Cohen Ch 8	Torrey Frese

<b>PART V.</b>		<b>THERAPEUTICS.</b>		<b>LECTURER</b>
34.	21 Apr WED	0930- 1020	Forensic Psychiatry READ: Cohen Ch 20	Benedek
35.	21 Apr WED	1030- 1120	Schizophrenia & Psychosis Three READ: Cohen Ch 8	Engel

<b>BLOCK 3 EXAM</b>	<b>MONDAY 26 APR 0730-0820 [COVERS LECTURE HOURS 25-31]</b>
-------------------------	---

<b>PART V.</b>		<b>THERAPEUTICS (Continued).</b>		<b>LECTURER</b>
<b>36.</b>	26 Apr MON	0830- 1020	DIAGNOSIS & FORMULATION IV TOPIC: The Geriatric Patient READ: Syllabus	Faculty
<b>37.</b>	28 Apr WED	0930- 1020	<b>Mood Disorders One</b> READ: Cohen Ch 7	<b>Jamison</b>
<b>38.</b>	28 Apr WED	1030- 1120	<b>Mood Disorders Two</b> READ: Cohen Ch 7	<b>Jamison</b>
<b>39.</b>	3 May MON	0930- 1020	Sexual & Gender Identity Disorders READ: Cohen Ch 15	Engel

<b>PART VI.</b>		<b>SPECIAL TOPICS.</b>		<b>LECTURER</b>
<b>40.</b>	3 May MON	1030- 1120	Personality Disorders: Cluster B and Cluster C Disorders READ: Cohen Ch 10	Engel
<b>41.</b>	4 May TUE	0930- 1020	Military Psychiatry READ: Syllabus	Holloway
<b>42.</b>	4 May TUE	1030- 1120	Comprehensive Review Session	Engel

<b>FINAL EXAM</b>		<b>WEDNESDAY 5 MAY 0730-1030</b> <b>[COMPREHENSIVE BUT EMPHASIZES LECTURE HOURS 32-42]</b>
-------------------	--	---

# HUMAN BEHAVIOR COURSE 2004

## GRADING

**POSTING OF GRADES.** During the course, exam grades will be posted outside Dr. Engel's office, B3066.

**EXAM EMPHASIS.** Not all topics will receive equal emphasis on examinations. Generally, lecture topics are weighted on the exams in proportion to the amount of class time spent on them. Topics that receive a little more emphasis on exams than one might expect from the amount of course time spent on them include neuropsychiatry, mood disorders, schizophrenia, substance use disorders, disorders resulting from situational stressors, anxiety disorders, suicide and violence.

**CHALLENGES TO EXAM QUESTIONS.** Students will have five working days after exam grades are posted to challenge exam questions. Challenges are to be submitted electronically to the class representative, who collates them without editing into a single submission to Dr. Engel ([cengel@usuhs.mil](mailto:cengel@usuhs.mil)).

To successfully challenge an answer to any Human Behavior Course exam question, students must make their case based upon statements from the book, the lectures, and/or the way the question is worded. All course director decisions regarding exam question challenges are final.

### **EXAMINATIONS.**

#### **Block Exams: 120 points (three exams worth 40 points each)**

All examinations will be administered in Lecture Room D. The format for all examinations is the same and consists of single-best-answer multiple choice and extended-matching questions.

#### **Final Exam: 72 points**

32 points on this examination will address cumulative course content. 40 points will cover the last course block only.

#### **Small Groups (ATTENDANCE MANDATORY): 8 points (four groups worth up to 2 points each)**

There are four small group sessions during the course. Any readings assigned for the small groups are testable for exam purposes. Students earn a grade from 0-2 points per small group session. Small group leaders evaluate and grade student participation (absent & unexcused=0; present=1; active in discussions=2). Student concerns or complaints regarding any small group may be addressed by email to Dr. Engel. Except for determinations regarding excused versus unexcused absences, however, small group leader grades are final. Small group evaluations of student performance can be decisive for students on the border between grades.

#### **Bonus Points: 10 points possible**

Up to 10 bonus points will be added to your final grade point average **after** letter grade cutoffs have been determined from examination and small group performance. These points can make a major difference in your overall grade. BONUS POINT ACTIVITIES ARE VOLUNTARY and amount to 'extra credit' work. Bonus points can have a significant impact on your final course grade. Bonus points are earned by successfully completing a **Psychiatry Academic Report (PAR)**, as described the corresponding section of the syllabus. Note that the PAR must be completed on time to be eligible for full credit.

### **FINAL COURSE GRADES.**

Final grades will be disseminated to students at the end of the course. The final grade will reflect each exam score, each small group grade, and any bonus points received during the course. If you wish to have us email your final grade to you, please notify Dr. Engel or Jennifer Stecklein at or before the Final Exam.

#### **FINAL COURSE POINT TOTAL (up to 210 points)**

**Block Exams (up to 120 pts) + Final Exam (up to 72 pts) + Small Group (8 pts) + Bonus Points**

Dr. Engel will assign all students a preliminary course letter grade based on your course point total before bonus points are added. The ranges listed below are based on the class grades from previous years and serve as a guideline.

CLASS STANDING RELATIVE THE MEAN IN SD	GRADE
Greater than +1.1 SD from Class Mean	A
Class Mean to + 1.1 SD From Class Mean	B
-1.5 SD to Class Mean	C
-2.0 SD to -1.5 SD from Class Mean	D
Less than -2.0 SD from Class Mean	F

Once the class curve and individual grade cut points have been established, bonus points are added, and the final course point total and grade are determined. Academic Awards will be based on your final course point total that includes your bonus points. A letter grade of "I" (incomplete) will be given for failure to complete required assignments, tests, or the final course evaluation.

Some years, students score very well as a group, leading to an unfairly difficult class curve. To prevent this from occurring, any student with a final course point total of 90% or greater is insured an "A", 80% or greater at least a "B", 70% or greater at least a "C", and 65% or greater at least a "D."

### ACADEMIC DIFFICULTIES.

#### What the department will do:

- **After the Block 2 Exam.** Any student with a cumulative point total of less than -2.0 SD who is scoring less than 65% on the first two examinations must meet with Dr. Engel to discuss the situation.
- **After the Block 3 Exam.** Any student with a cumulative point total of less than -2.0 SD who is scoring less than 65% on the first two examinations will be offered a plan of remedial action. The student and the Associate Dean for Student Affairs will be notified of the potential for academic deficiency.

#### What you can do:

- *Don't* wait for the last minute.
- *Don't* be afraid to ask for assistance.
- *Don't* take the course lightly. We do everything we can to get students successfully 'past the finish line'. However, every year four or five people struggle to get a 'C' final grade, and one or two students struggle to get a 'D' final grade. A small percent of students have failed the course (perhaps one student in every 200 or so that take the course) and must either take it again, complete a PAR after the course is over (getting in the way of spring USMLE exams), and/or have to take an extra clinical psychiatry rotation in the fourth year. *Don't* be one of these students!
- *Do* anticipate emerging academic or scheduling problems. Meet with Dr. Engel to prevent them. Dr. Engel maintains an open door policy for students, but 'drop-in' visits may sometimes be impossible, so please request an appointment via email ahead of time ([cengel@usuhs.mil](mailto:cengel@usuhs.mil)). Please suggest two or three possible meeting times and wait for Dr. Engel's reply.
- *Do* Contact Jennifer Stecklein B3066 (295-9799 or 9796 or [jstecklein@usuhs.mil](mailto:jstecklein@usuhs.mil)) if you have any trouble contacting Dr. Engel.

### DISCIPLINARY ACTIONS.

***Any student who does not display consistent seriousness of purpose and effort may be denied a letter grade above a C.*** Small group facilitator evaluations of student performance during small group sessions can be a decisive factor for students who are on the border between the A/B, B/C, or C/D grades. Dr. Engel reserves the right to change a student's letter grade if there is sufficient evidence of inappropriate, disruptive, or unethical behavior. This includes actions disruptive to other students or to faculty.

# HUMAN BEHAVIOR COURSE 2004

## PAR

**CONCEPT.** The Psychiatry Academic Report (PAR) is an optional project that allows you to obtain bonus points toward your final course grade (see 'Grading' section in this syllabus). The objective of the project is to cultivate independent learning skills that will be critical to your continued success as a clinician and to give you a chance to pursue a topic of interest in psychiatry.

**WHY DO A PAR?** The biggest and most immediate benefit is on the course grade. In past years, 80% of individuals completing a PAR raised their final point total enough to come up one full letter grade for the course. A PAR can also bring departmental visibility to the students producing it. Each year, the student completing the best PAR (determined by department faculty consensus) is invited to present his or her work to the entire National Capital Area Department of Psychiatry Grand Rounds at Walter Reed Army Medical Center. There may be the opportunity for other students to similarly present their work too. This kind of visibility may be a big benefit if a student is considering psychiatry as a career. Lastly, a good PAR can support write-ups required in the third year USUHS psychiatry clerkship.

**APPROACH.** The PAR is an optional project that students complete individually to receive course bonus points (essentially extra credit points). **Student collaboration on PAR projects is not allowed.** In other words, the PAR is an independent project, not a group project. Any student with an innovative idea for a PAR, i.e., one that deviates from the formats described below, is encouraged to discuss his or her idea with Dr. Engel. **All topics and ideas must receive his approval in advance to be accepted for bonus points.**

**SUGGESTED FORMATS. Please double-space all PARs.**

**Format One (Good for up to 10 bonus points): Conventional Report**

This type of PAR is essentially a substantial and relatively conventional report on any topic pertaining to Psychiatry. The standards for Format One PARs are as follows:

1. Title page. Include title, author, date of completion.
2. Abstract. Summarize the paper in 250-400 words.
3. The body of the PAR should contain some appropriate visuals such as pictures, tables, or figures.
4. Length of the overall report excluding references should be 4,500-6,000 words (15-25 double-spaced pages of 12-point text with one inch margins).
5. Clinical case examples are often useful to illustrate points but they are not required.
6. PAR literature citations should emphasize primary articles from the medical or social science literature. Citing textbooks is discouraged, but published review articles are acceptable, and often textbooks can help the student to identify relevant primary literature.
  - A. A minimum of 10 and maximum of 30 literature citations is required.
  - B. Citations must be formatted in a consistent manner. The recommended format for citations may be found in the "information for authors" posted in the journal *JAMA* (see <http://jama.ama-assn.org/info/auinst.html>).

**Format Two (Good for up to 10 bonus points): Book Report/Review.**

Novel or biographical account that focuses on an individual with an apparent psychiatric disorder. Books may address an individual with a major axis I psychiatric disorder such as schizophrenia (many great books of this sort, for example, *Shine* or *A Beautiful Mind*) or an individual with an axis II disorder such as mental retardation or an apparent personality disorder. The resulting book report would be 3,000-4,000 words (10-15 double-spaced pages of 12-point text with one inch margins) and should focus on a specific issue relevant to psychiatry. The student should clearly state the issue they want to develop after reading the book and use 5-10 references from the medical or social sciences literature to support the discussion. Issues of relevance, for example, might include stigma, patient versus clinician perspective of psychiatric disorders, the range of disability associated with psychiatric disorders, or differential diagnosis of a particular psychiatric symptom or sign. **Students should seek course director approval or advice regarding an appropriate book before reading it for the course.** To receive bonus points, the student must read the book during the period of time

encompassing the Human Behavior Course. Students are not allowed to report on a book they have previously read.

**Format Three (Good for up to 5 bonus points each, but students can do up to two for a maximum of 10 total bonus points). Movie Review.**

Movies reviews should address a movie that focuses on an individual with an apparent psychiatric disorder. Movies may address an individual with a major axis I psychiatric disorder such as schizophrenia or an individual with an axis II disorder such as mental retardation or an apparent personality disorder. The resulting movie review should be 2,000-3,000 words (7-10 double-spaced pages of 12-point text with one inch margins) and should focus on a specific issue relevant to psychiatry. The student should clearly state the issue they want to develop after reading the book and use up to 5 references from the medical or social sciences literature to support the discussion. Issues of relevance, for example, might include stigma, patient versus clinician perspective of psychiatric disorders, the range of disability associated with psychiatric disorders, or differential diagnosis of a particular psychiatric symptom or sign. **Students should seek course director approval or advice regarding an appropriate movie to review before watching it for the course.** To receive bonus points, the student must watch the movie during the period of time encompassing the Human Behavior Course. Students are not allowed to report on a movie they have previously viewed.

**GRADING.** Dr. Engel will coordinate Department of Psychiatry faculty reviews of and grades for the completed PARs.

**DUE DATES.** To receive bonus points, you must submit your topic(s) to Dr. Engel on email ([cengel@usuhs.mil](mailto:cengel@usuhs.mil)) by **COB Friday April 2**. Any student missing this deadline cannot receive bonus points (exceptions to this rule may be made for students who discover late that they are struggling to pass the course – note that this exception will not be extended to people are otherwise passing and decide late that they want to raise their grade). A completed electronic version of the PAR must be submitted to Dr. Engel by **COB Monday April 26** (please note that this is also the date of the block 3 examination, so students are warned not to wait until the last minute to complete the PAR). PARs submitted late but before May 3 will be accepted but cannot receive more than half credit. PARs submitted after COB April 28 will not receive bonus points unless by previous arrangement with Dr. Engel (usually reserved for students struggling to pass the course or students with extenuating personal circumstances that prevent them from meeting the regular deadline).

**PLAGIARISM:** It is increasingly easy to plagiarize previously written reviews or reports by cutting and pasting material from the World Wide Web and other source material. All PARs are submitted to a web-based service that reviews them for evidence of plagiarism. Any student who has plagiarized all or part of their PAR will be punished to the maximum extent allowed by University policy.

# HUMAN BEHAVIOR COURSE 2004

## WEB

THE HUMAN BEHAVIOR COURSE WEBSITE IS AT <http://cim.usuhs.mil/ps02001/>

**WEBSITE PURPOSE.** The course website is a centralized repository for course materials. Content includes:

1. A homepage with recent course announcements and reminders.
2. A bulletin board for asking questions pertinent to other students.
3. Syllabus materials – for example, notices regarding modifications may be found on the site.
4. Study materials – for example, old exams.
5. Downloadable lecture slides.
6. Class curves, answers to the exams, and responses to student exam challenges.

**ACCESSING THE SITE.** It is recommended that you access the course website once each week. This will insure you don't miss important course announcements and other developments. Having said that, all course announcements will be sent via email at the same time it is placed on the website. Emails to the students will routinely contain a link to the course website reminding students to log in to the site. If you have any trouble linking to the site, please contact Jennifer Stecklein or Dr. Engel for assistance.

### **SOME OTHER INTERNET PSYCHIATRY RESOURCES.**

These Internet resources may prove useful during the course or in the future. For students planning to complete the Psychiatry Academic Report (PAR) for up to five bonus points at the end of the course, these links may provide useful leads when planning for web-links to sites related to your report. There is also a website for obtaining software compatible with the Palm OS. There are many programs relevant to psychiatry that are designed to run on the students' issued palm devices.

### **USEFUL SITES FOR RESEARCHING THE PAR BONUS PROJECT.**

#### **PubMed.**

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>

Particularly user-friendly.

#### **Free Medical Journals.com.**

<http://www.freemedicaljournals.com/>

Good for finding full text journal articles and/or abstracts of key articles from the peer-reviewed medical literature.

#### **Evidence-Based Mental Health.**

<http://www.ebmentalhealth.com>

This site covers the quarterly journal, "Evidence-Based Mental Health". The journal summarizes clinically relevant evidence of clinical utility for psychiatrists and other clinicians.

#### **Palm, Inc. Software Site.**

<http://www.handango.com/>

Go to the 'search for software' box, and enter terms like 'psychiatry', 'psychiatrist', 'mental', 'psychology', and 'psychologist' and see what comes up. Lots of inexpensive and often useful software for PDAs. Be sure to check out a shareware program called, "Eliza Pilot Psychologist".

### **USEFUL SITES FOR MEDICAL STUDENTS LEARNING PSYCHIATRY.**

**CAUTION!** The accuracy of the information found on the web varies from site to site and sometimes from topic to topic within a given site. In short, the sites below are variably quality controlled, so while we endorse their general use, Dr. Engel, Dr. Privitera, and the Department of Psychiatry at USUHS do not "stand behind" the information found on them.

**Emergency Psychiatry Service Handbook.**

<http://www.vh.org/Providers/Lectures/EmergencyMed/Psychiatry/TOC.html>

A Virtual Hospital and a University of Iowa Hospitals and Clinics sponsored tool.

**US Naval Flight Surgeon's Manual – Psychiatry.**

<http://www.vnh.org/FSManual/06/SectionTop.html>

A Virtual Naval Hospital product is available for 330 page adobe file download called “Aviation Psychiatry Handbook”.

**Iowa Family Practice Handbook – Psychiatry.**

[http://www.vh.org/navigation/vh/topics/adult\\_provider\\_psychiatry.html](http://www.vh.org/navigation/vh/topics/adult_provider_psychiatry.html)

**Internet Mental Health – Psychiatry.**

<http://www.mentalhealth.com/>

**Merck Manual – Psychiatry.**

<http://www.merck.com/pubs/mmanual/section15/sec15.htm>

## HUMAN BEHAVIOR COURSE 2004

### SMALL GROUPS

Small groups are central to the structure of the Human Behavior Course. Small groups meet for four small group sessions (see the "Schedule" or "Dates" sections of this syllabus). All of these small group meetings will take place in the rooms designated below. **SMALL GROUP SESSIONS ARE MANDATORY.**

GROUP	STUDENT NAMES	ROOM NUMBER & STUDENT NAMES
<b>Group A</b>		<b>Room A2015</b>
	Adams, Michael Burkhardt, Gabriel Callis, William Damasco, Leo Egloff, Brian George, Jennifer Gray, Jon	Haggerty, Paul Kaesberg, Julie Matthews, Tokunbo Rabens, Clayton Schwalier, Erik Talley, William
<b>Group B</b>		<b>Room A2052A</b>
	Adams, Thomas Barker, Patrick Dansie, Chad Faircloth, Ruth Kent, Zachary Lefringhouse, Jason Lynch, Michelle	McArthur, Conshombia Nasir, Javed Odone, James Porsi, Luke Rao, Luigi Ugochukwu, Obinna
<b>Group C</b>		<b>Room A2052B</b>
	Afiesimama, Boma Campos, Napoleon Daschbach, Emily Harper, Stephen Ignacio, Patrick Jacobs, Justin Mack, Takman	Moore, Matthew Neiner, James Padlan, Claire Rappe, Jodie Seigh, Mark Tan, Erico
<b>Group D</b>		<b>Room A2053A</b>
	Ajao, Michael Barna, Michael Capra, Gregory Gim, Sylvia Harris, Jason Kho, Ellie Lackey, Jeffrey	Maddox, John Martinez-Ross, Juan Palmer, Eldon Quan, Sara Redding, Shawn Shaffer, Brett

GROUP	STUDENT NAMES	ROOM NUMBER & STUDENT NAMES
<b>Group E</b>		<b>Room A2053B</b>
	Aldrich, Shelly Barstow, Craig Fasoldt, Jerry Gratrix, Max Jones, Ronald Lanzi, Joseph McArthur, Samuel	Neuffer, Marcus Patel, Shimul Reha, Jeffery Shayegan, Shahrooz Sundell, Zoe Royster, Don
<b>Group F</b>		<b>Room A2069</b>
	Allan, Nicholas Baldwin, Allister Capra, Jason Dimmer, Brian Ferguson, Katrina Gray, Kelly Hilton, William	Kitley, Charles Lee, Mary Nijjar, Upneet Paul, Michael Rice, Jason Simpson, Michael
<b>Group G</b>		<b>Room A2039</b>
	Angelidis, Matthew Bernzott, Stephanie Carbone, Peter Dirks, Michael Fernelius, Colby Lesperance, Richard Levy, Gary	McGill, Robert McPherson, John Payne, Kathryn Robinson, David Smith, Ryan Wright, Heath
<b>Group H</b>		<b>Room A2041</b>
	Arner, David Bode, David Cho, Timothy Downs, John Gregory, Leslie Hobernicht, Susan Lewis, Aaron	Mei, Jian Pederson, Aasta Rodgers, Blake Soto, Adam Tou, Kevin Wells, Nicholas
<b>Group I</b>		<b>Room A2045</b>
	Arnett, Gavin Brown, Jamey Cleaves, John Fick, Daryl Gudeman, Suzanne Hunsaker, John Kraus, Gregory	Lewis, Troy Messmer, Caroline Penska, Keith Rodgers, Matthew Stringer, Sarah Treffer, Christine

GROUP	STUDENT NAMES	ROOM NUMBER & STUDENT NAMES
<b>Group J</b>		<b>Room A2049</b>
	Arnold, Michael Bryant, Summer Covey, Carlton Flaherty, Kathleen Gregory, Todd Liebig, Jonathan Liu, Scott	Mielcarek, Emily Phinney, Samuel Rogers, Derek Rose, David Summers, Noelle Vojta, Christopher
<b>Group K</b>		<b>Room A2057</b>
	Cragin, Douglas Fowler, Elizabeth Gwinn, Barbara Knudson, Todd Loveridge, Benjamin Longwell, Jason Lotridge, Jessica	Montenegro, Karla Moore, Jacqueline Pieroni, Kevin Rose, Matthew Summers, Thomas Wherry, Sean
<b>Group L</b>		<b>Room A2061</b>
	Bernhard, Jason Fox, David Hamele, Mitchell Luger, Richard Macian Allen, Diana Miletich, Derek Musikasinthorn, Chayanin Musser, John	Nelson, Austin Nelson, Austin Palmer, Bruce Rice, Robert Wright, Heath Vachon, Tyler
<b>Group M</b>		<b>Room A2065</b>
	Freeman, Benjamin Hicks, Brandi Loughlin, Carrie Lai, Tristan McDivitt, Jonathan Mosteller, David Poulin, John	Ryan, Jenny Sunkin, Jonathan Tintle, Scott White, Dennis Segura, Christopher Wilde, Matthew Weatherwax, Robert

## HUMAN BEHAVIOR COURSE 2004 LECTURERS

### COURSE CONTACT INFORMATION.

LTC Charles Engel, Course Co-Director

Tel: 202.782.8064

Fax: 202.782.3539

Eml: [cengel@usuhs.mil](mailto:cengel@usuhs.mil)

Dr. Charles Privitera, Course Co-Director

Tel: 301.295.9851

Eml: [crivitera@usuhs.mil](mailto:crivitera@usuhs.mil)

Ms. Jennifer Stecklein, Course Coordinator

Tel: 301.295.9796 or 301.295.9799

Fax: 301.295.1536

Eml: [jstecklein@usuhs.mil](mailto:jstecklein@usuhs.mil)

Ms. Alice Fladung, Administrative Officer, Department of Psychiatry

Tel: 301.295.9797

Fax: 301.295.1536

Eml: [afladung@usuhs.mil](mailto:afladung@usuhs.mil)

### HUMAN BEHAVIOR COURSE LECTURERS.

**David Benedek, MD MAJ, MC, USA**

[david.benedek@na.amedd.army.mil](mailto:david.benedek@na.amedd.army.mil)

Dr. Benedek is a member of the Walter Reed Army Medical Center staff and the National Capital Area Forensic Psychiatry Fellowship Director. He is a USU medical school graduate and completed general psychiatry and forensic psychiatry training in National Capital Area programs. Dr. Benedek was one of the first psychiatrists deployed to Bosnia and has presented his experiences there at an American Psychiatric Association annual meeting. Dr. Benedek comes from a rich family tradition in psychiatry: his mother is a past president of the American Psychiatric Association.

**Charles Engel, MD, MPH LTC, MC, USA**

[cengel@usuhs.mil](mailto:cengel@usuhs.mil)

Dr. Engel is co-director of the Human Behavior Course with Dr. Privitera. He is a full-time member of the USU military faculty and the chief of the Deployment Health Center (formerly the Gulf War Health Center) at Walter Reed Army Medical Center, a center specializing in treatment and research related to redeployment health issues, especially unexplained illnesses such as the infamous "Gulf War Syndrome". Dr. Engel is a consultation-liaison psychiatrist and epidemiologist and served as the First Cavalry Division psychiatrist during the Gulf War. His interests include medically unexplained physical symptoms, clinical hazard communication, psychiatric practice in primary care, psychiatric research design, health services research, and teaching psychiatrists how to interpret and use research evidence.

### **Frederick J. Frese, III, PhD**

For 15 years until his retirement in 1995, Fred Frese he served as Director of Psychology at Western Reserve Psychiatric Hospital, a state-operated facility in the Cleveland-Akron area. A member of the National Alliance for the Mentally Ill (NAMI) since 1989, Dr. Frese is currently the First Vice President of its National Board. He currently serves on the Board of the Summit County Alliance for the Mentally Ill.

Dr. Frese has given more than 300 presentations on topics related to serious mental illness in 30 states, Canada, Puerto Rico, and Washington, D.C. He has published extensively, and has been on the advisory reviewing boards of five professional journals, including Schizophrenia Bulletin. Along with his wife, Penny, he has also co-produced a widely distributed training video about coping with schizophrenia.

Dr. Frese has been a faculty member at Case Western Reserve University, Kent State, Ohio University, and Ashland Theological Seminary. He has also served as Chairperson of the Akron Area Mental Health Board. Dr. Frese was the founder and first president of Community and State Hospital Psychologists, the American Psychological Association's division for psychologists serving persons with serious mental illness. He also was on the Board of Trustees of the Ohio Psychological Association, where he served as Chair of the committee for the Mentally Ill Homeless. Additionally, he served as president of the National Mental Health Consumers' Association.

Dr. Frese served as a consultant to the Department of Veterans Affairs on a project to improve clinical practice. He has testified before congressional committees on priorities for public mental health services and is a part of the American Psychological Association Task Force for the Seriously Mentally Ill/Seriously Emotionally Disturbed.

### **Ralph Gemelli, MD CAPT(RET), MC, USN**

[gemelli@tidalwave.net](mailto:gemelli@tidalwave.net)

Dr. Gemelli is the founder of the USU Human Behavior Course, is a past psychiatric residency training director at National Naval Medical Center, and has been teaching the normal development portion of the course for many years. He is a psychoanalyst and is currently on the teaching faculty at the prestigious Washington Psychoanalytic Institute. He has recently published an excellent book on normal childhood development (10 copies are available for students in the library). Students consistently rate Dr. Gemelli's lectures as among the very best in the second year, and he is the recipient of numerous teaching awards. Dr. Gemelli is a Naval Academy graduate; the first Academy graduate to go directly into medical school upon completion of his Annapolis education.

### **Molly Hall, MD Col, MC, USAF**

[mhall@usuhs.mil](mailto:mhall@usuhs.mil)

Dr. Hall is assigned to the Department of Psychiatry, USUHS as an associate professor. She has served in several capacities in the National Capital Area including Chief, Clinical Quality Management Division, Air Force Medical Operations Agency, Bolling AFB (1998-2000); Flight Commander, Mental Health Flight 89<sup>th</sup> Medical Group, Andrews AFB (1995-1998) and Consultant for Psychiatry to the USAF Surgeon General (1995-1999). Dr. Hall attended Yale College as a member of the first class of women and graduated magna cum laude in 1973 with Departmental Honors in Combined Sciences, Biology and Psychology. Col Hall attended Cornell University Medical College where she was elected to Alpha Omega Alpha in 1976. She joined the Air Force in 1985 and was assigned to Wright-Patterson AFB where she was the Psychiatry Residency program director until 1995. Col Hall received numerous Wright State University faculty awards, including the Career Achievement award in 1995 and was the recipient of the first annual Excellence in Medical Education award conferred by the American Psychiatric Association (APA) in 1991. She has served as a psychiatric consultant to the Astronaut Selection Board at NASA since graduating from the Aerospace Primary Course at Brooks AFB in 1990. Col Hall is a distinguished graduate of the Aerospace Medicine Course and a distinguished graduate of the Air War College Seminar. Col Hall has four children: Kate, Aaron, Hannah and Sarah and three dogs: Elsa, Bou and Merlin.

**Jan Hanson, PhD**[jhanson@usuhs.mil](mailto:jhanson@usuhs.mil)

Dr. Hanson is a special educator and Research Assistant Professor of Pediatrics. She and Dr. Randall co-direct a project that involves parents of children with special needs and adults with chronic health conditions as advisors to the medical education program at USUHS. They have presented abstracts about family-centered care, involving patients and families as advisors, and the patient/physician relationship at many professional meetings. Before coming to USUHS, Dr. Hanson was Director for Research and Evaluation at the Institute for Family-Centered Care from 1992-1999. She has worked in a wide variety of educational and research settings, including special education programs for children of all ages, the DoD system of services for children with special needs, and pre-service and in-service education programs for educators and physicians. Dr. Hanson and Dr. Randall along with several parents will teach the lecture on developmental and learning disorders.

**Harry Holloway, MD COL(RET), MC, USA**[hhollowa@impop.bellatlantic.net](mailto:hhollowa@impop.bellatlantic.net)

Dr. Holloway is internationally respected as the dean of modern military psychiatry. He served thirty years in the US Army Medical Corps including tours in the Vietnam War, Thailand, and Walter Reed Army Institute of Research. He has around 50 publications and many scholarly works to his credit. He finished his active duty career as the first Chairman of Psychiatry at USU and later held positions as Deputy Dean and Acting Dean of the medical school and the director of life sciences at NASA. Arguably, Dr. Holloway knows more about substance abuse in the military than any other physician does. Currently, he is a co-principal investigator on a project aiming at assembling a scholarly history of substance use in the military through the year 1985. Dr. Holloway will speak to us on alcohol and other substance abuse, disorders due to traumatic events, and on military psychiatry.

**Kay Redfield Jamison, PhD**

Dr. Jamison is the daughter of an Air Force officer and was brought up in the Washington, D.C. area. She attended UCLA as an undergraduate and as a graduate student in psychology, and she joined the medical school faculty there in 1974. She later founded the UCLA Affective Disorders Clinic, which has treated thousands of patients for depression and manic-depression.

Dr. Jamison is now Professor of Psychiatry at the Johns Hopkins University School of Medicine. The textbook on manic-depressive illness that she wrote in association with Dr. Frederick Goodwin was chosen in 1990 as the Most Outstanding Book in Biomedical Sciences by the Association of American Publishers. She is also the author of, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (1993), and has produced three public television specials on the subject: one on manic-depressive composers, one on Vincent van Gogh, and one on Lord Byron. In recent years she has written and spoken extensively on her own battle with bipolar disorder, publishing two award winning books, one on bipolar disorder (*An Unquiet Mind*, 1997), and one on suicide (*Night Falls Fast: Understanding Suicide*, 2000)

The recipient of numerous national and international scientific awards, Dr. Jamison was a member of the first National Advisory Council for Human Genome Research, and is currently the clinical director for the Dana Consortium on the Genetic Basis of Manic-Depressive Illness.

**Timothy Lacy, MD Maj, MC, USAF**[tlacy@usuhs.mil](mailto:tlacy@usuhs.mil)

Dr. Lacy is the Malcolm Grow Medical Center site director for the National Capital Area Psychiatry Residency Program and the director of Family Practice - Psychiatry Combined Residency Program. Dr. Lacy is a graduate of Wilford Hall Air Force Psychiatry Residency Program. He is an expert on neuropsychiatry.

**Charles Privitera, MD COL(RET), MC, USA**

[crivitera@usuhs.mil](mailto:crivitera@usuhs.mil)

Dr. Privitera is co-director of the Human Behavior Course with Dr. Engel. USU students know him best as the psychiatrist at the USU Student Health Center. He is a noted teacher and practitioner of family therapy who is a past USU Dean for Student Affairs. Dr. Privitera has many years of experience in academic medicine and medical student education. His parallel and complimentary roles as student counselor, mentor, and colleague make him ideally suited to teach the course lectures on adult development, the military family, and medical marriages. Dr. Privitera retired from Army medicine after a long and decorated military career.

**Ginny Randall, MD COL, MC, USA**

[vrandall@usuhs.mil](mailto:vrandall@usuhs.mil)

Dr. Randall is a developmental pediatrician interested in children under three years of age with developmental disabilities such as cerebral palsy, mental retardation, and autism. She has been an Army pediatrician for 27 years, first as a general pediatrician in Alaska for 6 years, then specializing in developmental pediatrics, then doing a 9 year stretch at the Army Surgeon General's Office working on the policy and budget associated with the care of children with special needs in overseas locations. Currently, Dr. Randall is teaching pediatrics at USU and collaborating with Dr. Hanson in research involving parents of children with special needs as participants and facilitators of medical education.

**E. Fuller Torrey, MD**

Dr. Torrey is an internationally respected expert, clinician, and scientist specializing in schizophrenia and bipolar disorder. He is the Executive Director of the Stanley Foundation Research Programs, which supports research on schizophrenia and bipolar disorder. From 1976 to 1985, Dr. Torrey was on the clinical staff at St. Elizabeths Hospital, specializing in the treatment of severe psychiatric disorders. From 1988 to 1992, he directed a study of identical twins with schizophrenia and bipolar disorder. His research has explored viruses as a possible cause of these disorders, and he has carried out research in Ireland and Papua New Guinea. Dr. Torrey was educated at Princeton University (BA, Magna Cum Laude), McGill University (MD), and Stanford University (MA in Anthropology). He trained in psychiatry at Stanford University School of Medicine. He practiced general medicine in Ethiopia for two years as a Peace Corps physician, in the South Bronx in an OEO health center, and in Alaska in the Indian Health Service. From 1970 to 1975, he was a special assistant to the Director of the National Institute of Mental Health.

Dr. Torrey is the author of 16 books and more than 200 lay and professional papers. Some of his books have been translated into Japanese, Russian, Italian, and Polish. Dr. Torrey has appeared on national television (e.g., Donahue, Oprah, 20/20, 60 Minutes, and Dateline) and has written for many newspapers. He received two Commendation Medals from the US Public Health Service, a 1984 Special Families Award from the National Alliance for the Mentally Ill (NAMI), a 1991 National Caring Award, and in 1999 received research awards from the International Congress of Schizophrenia and from NARSAD.

**Robert J. Ursano, MD Col(Ret), USAF, MC**

[rursano@usuhs.mil](mailto:rursano@usuhs.mil)

Dr. Ursano is a rabid Notre Dame football fan. When he is not rooting for the Fighting Irish, he serves as Professor and Chair, USU Department of Psychiatry. Dr. Ursano is an internationally respected expert on psychiatric responses to trauma who has co-authored more than 100 publications and written or edited several books. He is a psychoanalyst who has written and lectured extensively on psychotherapy, including psychotherapy for the medically ill, and he is on the editorial board of the Journal of Psychotherapy Research & Practice and Military Medicine. He completed his undergraduate education at Notre Dame. He went to medical school at Yale, but he doesn't seem to follow the Yale football team very closely.

**Douglas A. Waldrep, MD LTC, MC, USA**

[Douglas.Waldrep@NA.AMEDD.ARMY.MIL](mailto:Douglas.Waldrep@NA.AMEDD.ARMY.MIL)

LTC Douglas A. Waldrep, MD, is presently assigned to the Department of Psychiatry Walter Reed Army Medical Center, Washington DC. After finishing his undergraduate education at West Point, NY and completing five years as a Field Artillery Officer in the United States Army he attended medical school on an Army scholarship at the Medical University of South Carolina, Charleston SC. He completed his General Psychiatry and Child and Adolescent Psychiatry training at Tripler Army Medical Center, Honolulu, HI. He has had the opportunity to practice in Heidelberg, Germany, Dwight D. Eisenhower Army Medical Center, Ft Gordon GA and presently at Walter Reed Army Medical Center. He has held multiple leadership positions in Army Psychiatry and is presently the Chief, Continuity Services, Assistant Psychiatry Training Director for the National Capital Area, Director of Curriculum, the site-training director for the Walter Reed Psychiatry Program as well as a member of the Center for the Study of Traumatic Stress, Uniformed Services University Bethesda, MD. He has spoken and published in the areas of adult, child and adolescent psychiatry. He is extremely happy to be married to Heda for 22 years and adores his two daughters Megan 21, 3<sup>rd</sup> year at the University of Georgia, and Caraline 14, a freshman at Sherwood High School, Sandy Spring, MD. His favorite past time is spoiling the women in his life.

**Human Behavior Course  
2004**

**PART IV**

**MAJOR DISORDERS  
(CONTINUED)**

# **Human Behavior Course 2004**

## **Somatoform & Related Disorders**

**Charles C. Engel, MD, MPH  
LTC, MC, USA**

**Associate Professor of Psychiatry  
Uniformed Services University**

**HUMAN BEHAVIOR COURSE 2004**  
**SOMATOFORM DISORDERS - SLIDES**

**LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.**

1. Know the meaning of the terms and concepts listed in slide one below.
2. Describe the distinction between illness and disease.
3. What is somatization? Is somatization a central feature of malingering? Of factitious disorder? Why or why not?
4. Name the different somatoform disorders and whether they are very common (point prevalence > 5%), common (1-5%) or uncommon (<1%) in the general population. What about malingering and factitious disorder?
5. Know whether each somatoform is more common in men, more common in women, or occurs in a similar proportion of men and women. What about malingering and factitious disorder?
6. What are the diagnostic features of somatization disorder?
7. What are the diagnostic features of conversion disorder?
8. What are the diagnostic features of pain disorder? How does this disorder relate to conversion disorder?
9. What are the diagnostic features of hypochondriasis? What is the central difference between hypochondriasis and the above three somatoform disorders?
10. What are the diagnostic features of body dysmorphic disorder? Is this disorder more like hypochondriasis or more like somatization, conversion, and pain disorders? How so?
11. What are the diagnostic features of malingering?
12. What are the diagnostic features of factitious disorder? What differentiates malingering from factitious disorder?
13. What is "illness behavior"? How is it different from the "sick role"? How are these two things different from somatization?
14. Does somatization result only from somatoform disorders? If not, what other disorders is somatization a secondary phenomenon?
15. Describe what is known about the psychosocial pathogenesis of somatization and the various somatoform disorders plus malingering and factitious disorder.
16. Describe what is known about the neurobiological mechanisms of somatization and the various somatoform disorders plus malingering and factitious disorder.
17. What psychotherapies work best for somatoform disorders? Factitious disorder? Malingering? Name some of the techniques used and give an example of how each might be used to treat somatization.
18. What medications work best for somatoform disorders? Factitious disorder? Malingering?

## Somatoform Disorders – Terms & Concepts

- ★ illness vs. disease
- ★ complaints vs. pathology
- ★ symptom vs. sign
- ★ conscious
- ★ unconscious
- ★ feigning
- ★ somatization disorder
- ★ hysteria
- ★ conversion disorder
- ★ pain disorder
- ★ hypochondriasis
- ★ body dysmorphic disorder
- ★ somatization
- ★ subsyndromal somatization
- ★ factitious disorder
- ★ malingering
- ★ illness behavior
- ★ Munchausen's syndrome
- ★ Munchausen's syndrome by proxy
- ★ sick role
- ★ abnormal illness behavior
- ★ alexithymia
- ★ somatic or somatosensory amplification
- ★ amplifier or augments
- ★ minimizer or reducer
- ★ neuroticism
- ★ harm avoidance
- ★ selective attention or attention bias
- ★ pseudoseizures
- ★ "masked depression"
- ★ primary gain
- ★ secondary gain
- ★ disability neurosis
- ★ "psychological overlay"
- ★ enabling (or enabler)
- ★ illness belief
- ★ illness model
- ★ conversion symptom



*Uniformed Services University*

## Idiopathic Physical Symptoms Medicine's "Dirty Little Secret"

<u>Specialty</u>	<u>Clinical Syndrome</u>	<u>Specialty</u>	<u>Clinical Syndrome</u>
Orthopedics	Low Back Pain Patellofemoral Syndrome	Endocrinology	Hypoglycemia
Gynecology	Chronic Pelvic Pain Premenstrual Syndrome	Dentistry	Temporomandibular Disorder
ENT	Idiopathic Tinnitus	Rheumatology	Fibromyalgia Myofascial Syndrome Scleroderma
Neurology	Idiopathic Dizziness Chronic Headache	Internal Medicine	Chronic Fatigue Syndrome
Urology	Chronic Prostatitis Interstitial Cystitis Urethral Syndrome	Infect Disease	Chronic Lyme Chronic Epstein-Barr Virus Chronic Brucellosis Chronic Candidiasis
Anesthesiology	Chronic Pain Syndromes	Gastroenterology	Irritable Bowel Syndrome Gastroesophageal Reflux
Cardiology	Atypical Chest Pain Idiopathic Syncope Mitral Valve Prolapse	Physical Medicine	Mild Closed Head Injury
Pulmonary	Hyperventilation Syndrome	Occ Medicine	Multiple Chemical Sensitivity Sick Building Syndrome
		Military Medicine	Gulf War Syndrome
		Psychiatry	Somatoform Disorders



*Uniformed Services University*

# Somatization

- ★ Idiopathic symptoms common
- ★ Vexing to primary care clinicians
- ★ “Idiom of Distress” – The use of somatic language to communicate emotional distress
- ★ Stress & anxiety –
  - Butterflies in the stomach
  - Headaches before & after exams
  - “Chicken soup” (placebo) phenomenon
- ★ Associated with most mental disorders
- ★ Central in somatoform disorders



*Uniformed Services University*

# Etiologies of Somatization

- ★ Physiologic concomitants of emotional arousal or withdrawal
- ★ Stigma of mental illness
- ★ Behavioral reinforcement
- ★ Insurance reimburses physical more than emotional disorders
- ★ Sick role
- ★ Desire for nurturance or cry for help



*Uniformed Services University*

## Idiopathic Physical Symptoms Populations & Primary Care

- ★ About **one-third** of symptoms that primary care patients report are ultimately idiopathic (Kroenke et al, 1994; Kroenke & Price, 1993)
- ★ Only **16%** of patients ever receive an explanatory 'organic' diagnosis given no diagnosis following the initial medical visit (Kroenke & Mangelsdorff, 1989)



Uniformed Services University

## Idiopathic (Somatoform) Symptoms in Primary Care

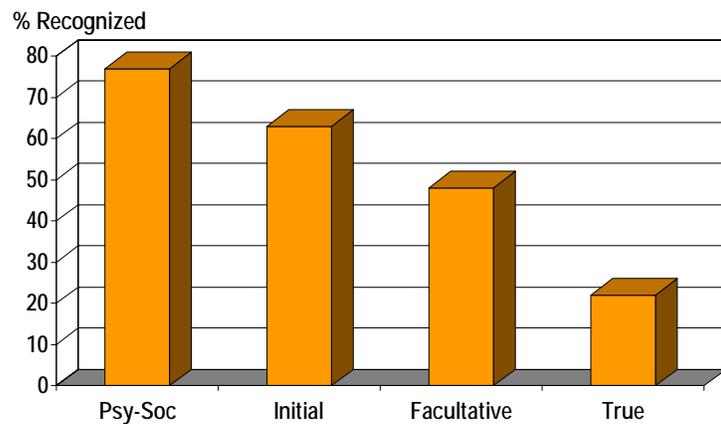
Number of Symptoms	Number of Patients	Psychiatric Disorder N (%)		
		Anxiety	Mood	Any
<i>Physical (N=1000)</i>				
0-1	215	2 ( 1)	5 ( 2)	16 ( 7)
2-3	225	17 ( 7)	27 (12)	50 (22)
4-5	191	25 (13)	44 (23)	67 (35)
6-8	230	68 (30)	100 (44)	140 (61)
9+	130	68 (48)	84 (80)	113 (81)
<i>Somatoform (N=900)</i>				
0	654	68 (10)	107 (16)	102 (25)
1-2	143	42 (29)	60 (42)	74 (52)
3-5	87	35 (40)	40 (46)	77 (89)
6+	49	40 (55)	34 (68)	45 (94)



Uniformed Services University

Kroenke et al. Arch Fam Med 1994; 3:774

## Somatization & Recognition of Depression in Primary Care



Uniformed Services University

## From Symptom to Disability Illness as Behavior

Perception → Belief → Response

- ★ Perception: result of physiologic process
- ★ Belief: determined largely by past experience
- ★ Response:
  - behavior
  - emotion
  - physiology



Uniformed Services University

## Somatization The Building Blocks

- ★ Symptom perception
- ★ Symptom-related beliefs or cognitions
- ★ Symptom-related health care seeking
- ★ Absence of a full medical explanation



## Somatoform Disorders

- ★ When somatization is the central characteristic of the disorder
- ★ Mimics medical conditions
- ★ Shared characteristics with –
  - Factitious Disorder
  - Malingering



## Component Prototypes

Perceptual problem

Somatization disorder

Cognitive problem

Hypochondriasis

Health care seeking

Factitious disorder



*Uniformed Services University*

## Disease

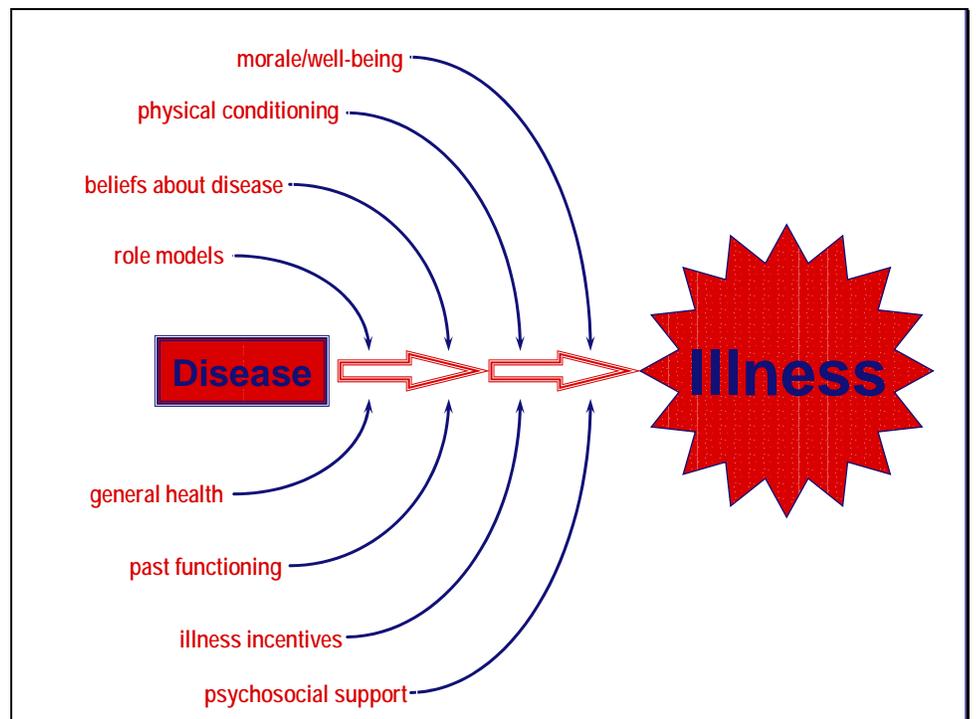
- ★ an objective and measurable physiological disturbance
- ★ diagnosis corroborated with laboratory, objective physical, or radiographic findings



*Uniformed Services University*

# Illness

- ★ Manifestations of suffering
- ★ Usually only inferred via patients' behavior
  - symptom reports
  - medication requests
  - impairments
- ★ Can think of illness as a behavior



## Abnormal Illness Behavior Some Examples

- ★ Maladaptive perceptions or actions in relation to one's health status
- ★ Noncompliance
- ★ Denial of illness
- ★ Chest pain believed to be indigestion
- ★ Allergy patients who smoke
- ★ Diagnoses popularized by the media



**Table 13-2. Pilowsky's Model of Abnormal Illness Behavior\***

		Patient	
		<i>Ill</i>	<i>Not ill</i>
Doctor	Ill	A	B
	Not ill	C	D

\*Patient A demonstrates illness-affirming, normal illness behavior; patient B demonstrates illness-denying, abnormal illness behavior; patient C demonstrates illness-affirming, abnormal illness behavior; patient D demonstrates illness-denying, normal illness behavior.

Source: Adapted from a theoretical model presented in Pilowsky I: "A General Classification of Abnormal Illness Behaviors." *Br J Med Psychol* 51:131-137, 1978.

## Somatization Disorder Symptom Criteria

- A. A history of many physical complaints:
  - (1) Beginning before age 30 years;
  - (2) Occurring over a period of several years; and
  - (3) That result in treatment seeking or functional impairment.
- B. The following symptoms have occurred during the course:
  - (1) four pain symptoms affecting at least four sites/functions.
  - (2) two nonpain gastrointestinal symptoms.
  - (3) one nonpain sexual or reproductive symptom.
  - (4) one nonpain pseudoneurological symptom or deficit.



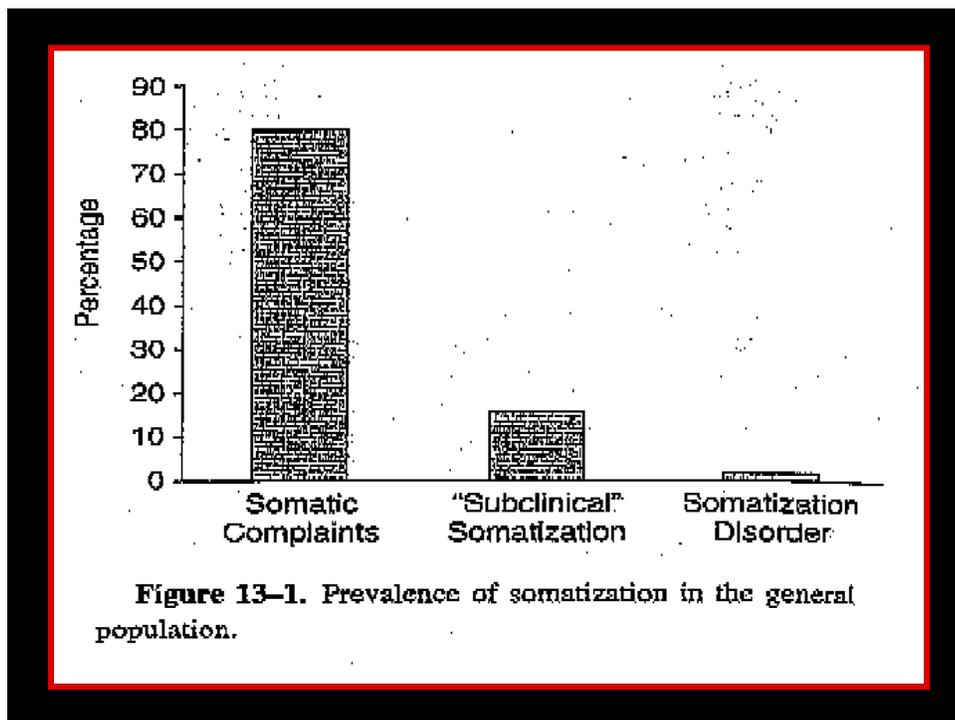
Uniformed Services University

## Somatization Disorder Medical Explanation Criteria

- ★ After appropriate investigation, none of the symptoms above can be fully explained by known medical or substance-induced conditions;
- OR*
- ★ When there is a related condition, the physical complaints or resulting impairments are in excess of that expected from the available data.

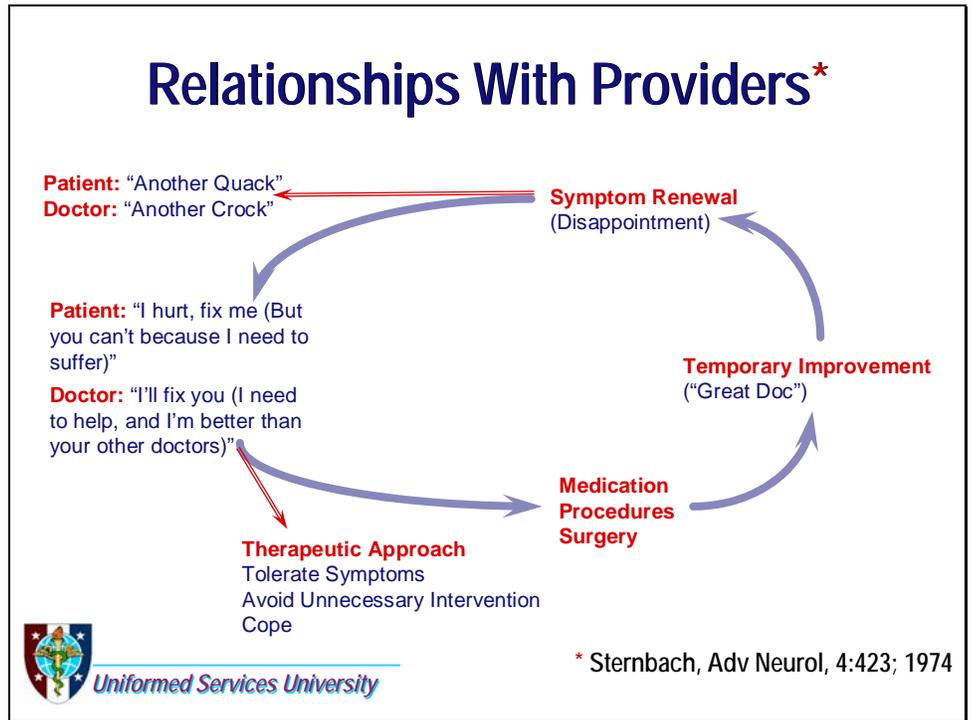


Uniformed Services University



**Table 13-3. Initiating and Sustaining Factors in Somatic Disorders**

<i>Initiating Factors</i>	<i>Additional Sustaining Factors</i>
Genetic factors	Unconscious gain
Neuropsychological and physiologic factors	Primary gain
Personality factors	Secondary gain
Alexythymia	Family and friends
Somatic amplification	The physician
Neuroticism	
Personality disorder	
Learned responses	
Comorbid depressive disorders	
Comorbid anxiety disorders	



- ## Undifferentiated Somatoform Disorder
- A. One or more physical complaints.
  - B. Either:
    - (1) After appropriate investigation, symptoms cannot be fully explained by known medical conditions or substances; OR
    - (2) When there is a related condition, physical complaints or impairments are in excess of that expected from the data.
  - A. The duration of the disturbance is at least 6 months.
  - B. The symptom is not feigned or intentional.
-  *Uniformed Services University*

## latrogenesis

**"UK 'Skull-drillers'" *BBC News, April 11 2000***

"Two men who helped carry out a bizarre procedure in which a hole was drilled in a British woman's head have been spared jail. Trepanning is thought by some proponents of alternative medicine to improve mental capacity by relieving pressure on the brain and improving blood flow.

"Heather Perry, from Gloucester, traveled to Utah last February to undergo the procedure, aided by Peter Halvorson, 54, and William Lyons, 56. Both men pleaded guilty to practicing medicine without a license, and were fined and put on probation. Both were also ordered to undergo a mental health evaluation.

"Ms Perry, a chronic fatigue sufferer who has since returned to the UK, said she had experienced a "definite improvement" in her health since the procedure. However, court papers suggested she had suffered some side effects, such as the leakage of brain fluid.



*Uniformed Services University*

## latrogenesis

**"UK 'Skull-drillers'" *BBC News, April 11 2000***

### Shown on television

"The 'operation' was filmed and broadcast on national US news. According to court documents, Ms Perry injected herself with local anesthetic, then used a scalpel, with Halvorsen holding a mirror, to make a cut. Halvorsen is then said to have used an instrument to spread the skin away from the skull, and Lyons drilled a hole.

"The British woman learned about trepanning after exchanging emails with Halvorsen, who has himself undergone the operation. She said at the time: 'I know what I've done sounds totally ridiculous and I can understand the reaction I've provoked... but I felt something radical needed to be done. I can't say the effects have been dramatic but they are there. I definitely feel better and there's definitely more mental clarity.'

"Halvorsen told the Salt Lake Tribune newspaper that the case had helped promote the cause of the surgery. He said: 'It's personally been helpful to me. It provided an impulse to me to find a way to do this legally. But I'm not glad I was charged.'"



*Uniformed Services University*

## Conversion Disorder

- A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
- B. Psychological factors are judged to be associated because the initiation/exacerbation of the symptom/deficit is preceded by conflicts/stressors.
- C. Not intentionally produced or feigned.
- D. Cannot be fully explained by a GMC or direct effect of a substance, or as a culturally sanctioned behavior or experience.
- F. The symptom or deficit is not limited to pain/sexual dysfunction/Somatization Disorder.



*Uniformed Services University*

## Pain Disorder

- A. Predominant clinical focus is pain in one or more sites severe enough to warrant clinical attention.
- B. Psychological factors judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- C. Not intentionally produced or feigned.
- D. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.



*Uniformed Services University*

## Pain Disorder, Subtypes

- ★ **Pain disorder with psychological factors:**  
psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. Acute (< 6 mo) versus Chronic (> 6 mo)
- ★ **Pain disorder with psychological factors & GMC:**
  - both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain.
  - The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.



Uniformed Services University

## Hypochondriasis

- A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
- B. The preoccupation persists despite appropriate medical evaluation and reassurance.
- C. The belief in Criterion A is not of delusional intensity and is not restricted to a circumscribed concern about appearance.
- D. The duration of the disturbance is at least 6 months.



Uniformed Services University

## Body Dysmorphic Disorder

- A. Preoccupation with an imagined defect in appearance.
- B. If a slight physical anomaly is present, the person's concern is markedly excessive.



## Malingering

- ★ Intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives.
- ★ Malingering should be strongly suspected if any combination of the following is noted:
  - 1) Medicolegal context
  - 2) Marked discrepancy between the person's claimed stress or disability and the objective findings.
  - 3) Lack of cooperation/compliance with diagnosis or treatment
  - 4) Presence of antisocial personality disorder



## Factitious Disorder, Criteria

- A. Intentional production or feigning of physical or psychological signs or symptoms.
- B. The motivation for the behavior is to assume the sick role.
- C. External incentives for the behavior are absent.



*Uniformed Services University*

## Factitious Disorder, Subtypes

- ★ With Predominantly Psychological Signs and Symptoms
- ★ With Predominantly Physical Signs and Symptoms
- ★ With Combined Psychological and Physical Signs and Symptoms



*Uniformed Services University*

## Methods Used by Factitious Disorder Patients

- ★ Inject self with insulin
- ★ Inject self with feces to induce fever and infection
- ★ Take steroids to become Cushingoid
- ★ Take laxatives to induce severe diarrhea
- ★ Traumatize the urinary tract to induce hematuria
- ★ Traumatize the rectum to induce GI bleeding
- ★ Take thyroid medication
- ★ Swallow shards of glass to require surgery
- ★ Inject air to create subcutaneous emphysema



Uniformed Services University

## Factitious Disorder NOS

- ★ Disorders with factitious symptoms that do not meet the criteria for Factitious Disorder.
- ★ An example is **factitious disorder by proxy**: the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role.



Uniformed Services University

## Variants of Factitious Disorder

- ★ Chronic Factitious Disorder -- Munchausen's Syndrome
- ★ Factitious Disorder by Proxy -- Acts to another person, e.g., a child
- ★ Factitious Disorder by Adult Proxy -- So that the caretaker receives sympathy and support



Uniformed Services University

**Table 13-4. Distinctions between Illness-Affirming Abnormal Illness Behaviors**

<i>Disorder</i>	<i>Behavior</i>	<i>Motivation</i>
Somatiform disorders	Unconscious	Unconscious
Malingering	Conscious	Conscious
Factitious disorder	Conscious	Unconscious

## Somatoform Disorder NOS

- ★ Disorders with somatoform symptoms that do not meet the criteria for any specific somatoform disorder.
- ★ Examples include . . .
  1. Pseudocyesis: a false belief of being pregnant that is associated with objective signs of pregnancy. The syndrome cannot be explained by a general medical condition that causes endocrine changes.
  2. Nonpsychotic hypochondriacal symptoms of less than 6 months duration.
  3. Unexplained physical complaints of less than 6 months in duration that are not due to another mental disorder.
  4. Mass sociogenic or psychogenic illness



Uniformed Services University

## Summary Somatoform & Related Disorders

- ★ Somatization Disorder ==> 8 symptoms, > 6 mos.
- ★ Undifferentiated Somatoform Disorder ==> 1+ symptom, > 6 mos.
- ★ Conversion Disorder ==> one unconscious symptom
- ★ Pain Disorder ==> pain is the 'conversion' symptom
- ★ Hypochondriasis ==> preoccupation with illness
- ★ Body Dysmorphic Disorder ==> preoccupation with appearance
- ★ Factitious Disorder ==> conscious acts, primary gain
- ★ Malingering ==> conscious acts, secondary gain



Uniformed Services University

## General Management of Somatization & Somatoform Disorders

- ★ curative emphasis is a formula for disappointment, mutual rejection, & iatrogenic complications
- ★ visits scheduled on time-contingent (not 'as needed or PRN) basis every 4-6 weeks
- ★ single primary care physician coordinating continuity of care
- ★ validate symptoms -- don't try to talk patients out of them or push psychogenicity



Uniformed Services University

## General Management of Somatization & Somatoform Disorders 2

- ★ avoid CNS depressants & opioid agents
- ★ somatoform disorders typically require multidisciplinary approach
- ★ conservative use of invasive diagnostics or therapeutics
- ★ acute somatization – look for precipitating stressors
- ★ chronic somatization – cognitive & behavioral approaches are better than insight oriented approaches (patients reject the latter)



Uniformed Services University

# **Human Behavior Course 2004**

## **Reactions to Stress & Trauma**

**Elizabeth Osuch, MD  
Assistant Professor of Psychiatry  
Uniformed Services University**

**HUMAN BEHAVIOR COURSE 2004**  
**REACTIONS TO STRESS & TRAUMA - SLIDES**

**LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.**

1. Know the meaning of the terms and concepts listed in slide one and two below.
2. What is the difference between dissociation and psychosis?
3. Is it true that PTSD is a “normal response to an abnormal event?” Why or why not?
4. Some have suggested PTSD and ASD are dissociative disorders rather than anxiety disorders. How are these disorders like an dissociative disorder? How are they like an anxiety disorder?
5. Name the different trauma/stress disorders and list whether they are very common (point prevalence > 5%), common (1-5%) or uncommon (<1%) in the general population.
6. Know whether each trauma/stress disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.
7. What are the diagnostic features of post-traumatic stress disorder (PTSD)?
8. What are the diagnostic features of acute stress disorder (ASD)?
9. What are the diagnostic features of dissociative amnesia?
10. What are the diagnostic features of dissociative fugue? Contrast dissociative fugue with dissociative amnesia.
11. What are the diagnostic features of depersonalization disorder?
12. What are the diagnostic features of dissociative identity disorder?
13. What are the diagnostic features of adjustment disorder? How is the stressor in this disorder different or the same as the one in PTSD and ASD?
14. Describe what is known about the psychosocial pathogenesis of dissociation and the various dissociative disorders.
15. Describe what is known about the neurobiological mechanisms of dissociation and the various dissociative disorders.
16. What general type of psychotherapy works best for ASD? For PTSD? For dissociative disorders? Name some of the techniques used and give an example of how each might be used to treat ASD, PTSD, and the different dissociative disorders.
17. What medications may be used to treat PTSD? ASD? The different dissociative disorders?

**Slides To Be Distributed**

Slide 1

## Reactions to Stress & Trauma – Terms & Concepts

- ★ adjustment disorder
- ★ post-traumatic stress disorder
- ★ acute stress disorder
- ★ dissociative disorder
- ★ dissociative identity disorder
- ★ dissociative fugue
- ★ dissociative amnesia
- ★ depersonalization disorder
- ★ dissociation
- ★ dissociation as defense
- ★ dissociation as conversion
- ★ integration
- ★ “alter”
- ★ isolation
- ★ countersuggestion
- ★ depersonalization
- ★ amnesia
- ★ hypnosis
- ★ hypnotic state
- ★ absorption
- ★ suggestibility
- ★ hypnotizability
- ★ narrative truth
- ★ historical truth
- ★ declarative (explicit) memory
- ★ nondeclarative (implicit) memory
- ★ semantic memory
- ★ episodic memory
- ★ medial temporal lobe circuit
- ★ basal ganglia-frontal lobe circuit
- ★ amnesic syndrome
- ★ Ganser syndrome
- ★ personality state
- ★ multiple personality disorder
- ★ true dissociative identity disorder
- ★ iatrogenic dissociative identity disorder
- ★ malingered dissociative identity disorder



Uniformed Services University

Slide 2

## Reactions to Stress & Trauma – Terms & Concepts

- ★ irritable heart
- ★ soldier's heart
- ★ Da Costa's syndrome
- ★ shell shock
- ★ disordered action of the heart
- ★ concentration camp syndrome
- ★ flashback
- ★ traumatic event criterion (“criterion A stressor”)
- ★ reexperiencing criteria
- ★ emotional numbing & avoidance criteria
- ★ autonomic hyperactivity & arousal criteria
- ★ delayed PTSD
- ★ compensation & reactivation
- ★ limbic kindling
- ★ hippocampus
- ★ endorphin release
- ★ learned helplessness
- ★ intrusive memories
- ★ nightmares
- ★ eye movement desensitization & reprocessing (EMDR)
- ★ selective serotonin reuptake inhibitors
- ★ tricyclic antidepressants
- ★ lithium
- ★ carbamazepine
- ★ benzodiazepines



Uniformed Services University

**Human Behavior Course  
2004**

***DIAGNOSIS & FORMULATION III***  
**Cultural Aspects of Psychiatry**

**SMALL GROUP DISCUSSION THREE**

*HUMAN BEHAVIOR COURSE 2004*  
**VIGNETTE 3:1 - "POSTPARTUM PIETY"**

Ms. Z is a 30-year-old high-school teacher living in Lagos, Nigeria. She is married and has five children. The birth of her last child was complicated by hemorrhage and sepsis, and she was still hospitalized in the gynecology ward 3 weeks after delivery when her gynecologist requested a psychiatric consultation. Ms. Z was agitated and seemed to be in a daze. She said to the psychiatrist, "I am a sinner. I have to die. My time is past. I cannot be a good Christian again. I need to be reborn. Jesus Christ should help me. He is not helping me." A diagnosis of Postpartum Psychosis was made. An antipsychotic drug, chlorpromazine, was prescribed, and Ms. Z was soon well enough to go home.

Three weeks later, she was readmitted, this time to the psychiatric ward, claiming that she had had a "vision of the spirits" and was wrestling with the spirits. Her relatives reported that at home she had been fasting and "keeping vigil" through the nights and was not sleeping. She had complained to the neighbors that there was a witch in her house. The "witch" turned out to be her mother. Ms. Z's husband, who was studying engineering in Europe, hurriedly returned and took over the running of the household, sending his mother-in-law away and supervising Ms. Z's treatment himself. She improved rapidly on an antidepressant medication, and was discharged in 2 weeks. Her improvement, however, was short-lived. She threw away her medications and began to attend mass whenever one was given, pursuing the priests to ask questions about scriptures. Within a week she was readmitted.

On the ward she accused the psychiatrist of shining powerful torchlight's on her and taking pictures of her, opening her chest, using her as a guinea pig, poisoning her food, and planning to bury her alive. She claimed to receive messages from Mars and Jupiter and announced that there was a riot in town. She clutched her Bible to her breast and accused all the doctors of being "idol worshipers," calling down the wrath of her God on all of them.

After considerable resistance, Ms. Z was finally convinced to accept electroconvulsive treatment, and she became symptom free after six treatments. At this point, she attributed her illness to a difficult childbirth, the absence of her husband, and her unreasonable mother. She saw no further role for the doctors, called for her priest, and began to speak of her illness as a religious experience that was similar to the experiences of religious leaders throughout history. However, her symptoms did not return, and she was discharged after 6 weeks of hospitalization.

*HUMAN BEHAVIOR COURSE 2004*  
**VIGNETTE 3:1 - DISCUSSION QUESTIONS**

1. Now that you have the history, review it for any:
  - A. Biological, psychological, and social predisposing factors?
  
  - B. Biological, psychological, and social precipitating factors?
  
  - C. Biological, psychological, and social perpetuating factors?
  
2. What is the patient's DSM-IV multiaxial diagnosis/diagnoses? Why?
  
3. Speculate regarding how cultural factors may be at work in this vignette.
  
4. What do you think the prognosis is for Ms. Z?

**VIGNETTE 3:2 - "CRIMES AGAINST THE STATE"**

The following vignette takes place in another country:

**Background:** Dr. G, a 40-year-old economist, is brought from a prison for people suspected of crimes against the national interest to a maximum-security ward at the government's forensic psychiatry institute. During his arrest and detention Dr. G was uncooperative and government police referred him for a forensic psychiatric evaluation on the possibility that his behavior might be caused by chronic mental illness.

Four months before referral, government agents found that Dr. G was publishing materials subversive of the government. Dr. G denies the criminal nature of his activities, and he claims that his publications were only in pursuit of his interests as an economist. Government investigators provided summaries of treatment from a local health center and a district mental health clinic. These summaries note that Dr. G had a "stormy adolescence" during which he was described by his teachers as "stubborn, oppositional, and obsessed with ideas." A school principal noted he had a promising intellect but was, "too sensitive and intense for his age...and his tastes in art and music are bizarre." Local draft board records revealed that Dr. G was relieved from compulsory military duty because of "psychoneurosis" established by a district mental health clinic psychiatrist who described him as "moody, preoccupied...precise and compulsive in his habits, with excessive concern about his health." He was seen at the mental health clinic three times with no further treatment or follow-up.

**Mental Status Examination:** The forensic psychiatrist notes his "burning and penetrating eyes, and a Christ-like beard." During the interview Dr. G was noted to be suspicious, insisting on taking notes, and writing down all questions asked of him, and then refusing to participate in the interview when told that he could not take notes. On the ward, he was observed to become isolative and "withdrawn, with long staring spells, and persistent refusal to discuss his thoughts and feelings." The staff notes he is suspicious and paranoid about the food he is served; he is preoccupied with the concern that someone has put medication into it. He is generally mistrustful of the medical staff, and fails to recognize his symptoms as pathological or acknowledge his need for psychiatric treatment.

**Hospital Course:** By the end of the first week, Dr. G is increasingly preoccupied with the belief that he is somehow "special" and entitled to special treatment. For example, he repeatedly demands to see the hospital medical director (who has never met Dr. G). When the medical director obliges, Dr. G accuses him of "collaborating in crimes against humanity" and reminds the director of the fate of the Nazi doctors during the Nuremberg Trials."

By the end of the third week, the Dr. G is given small doses of a neuroleptic medication. He refuses the medication and actively resists taking them so they it is administered involuntarily. Dr. G becomes weak and apathetic, complaining of dry mouth, increased appetite, daytime grogginess, and an increasing troublesome tremor, so the neuroleptic medication is discontinued.

By week four, Dr. G looks more cheerful, and he finally agrees to cooperate with the three forensic psychiatrists managing him. During the interview, he is noted to be guarded with "hypervigilance" and manifesting of "obvious ideas of reference." The forensic psychiatrists diagnose him as having a mild variant of schizophrenia that carries a relatively favorable prognosis compared to others with schizophrenia. Involuntary treatment is recommended for Dr. G because of lack of insight into his condition and his history of poor adherence to appropriate treatment. "

*HUMAN BEHAVIOR COURSE 2004*  
**VIGNETTE 3:2 - DISCUSSION QUESTIONS**

The differences between psychopathology and normality are often indistinct and subject to potential misuse.

1. What "red flags" exist that perhaps the issues in this vignette may be neither cross-cultural nor psychiatric in nature?
  
2. If you were one of the forensic psychiatrists seeing Dr. G, what other historical or documentary information would you like to have to determine the nature of Dr. G's problems?
  
3. Context is critically important when determining whether behavior is normal or pathological. What instances can you cite from the vignette where you suspect that observed behaviors may have been "reasonable" under the circumstances?
  
4. Could analogous circumstances as those in this vignette arise in the military? What factors exist in the military that lend itself to the potential for misuse of military psychiatry? How can the potential for the misuse of psychiatry be avoided in the military setting?

# **Human Behavior Course 2004**

## **Eating Disorders**

**Molly Hall, MD  
Colonel, USAF, MC**

**Associate Professor of Psychiatry  
Department of Psychiatry  
Uniformed Services University**

# HUMAN BEHAVIOR COURSE 2004

## EATING DISORDERS - HANDOUT

### LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slide one below.
2. What are the differences between normal eating and pathological eating that characterize the eating disorders?
3. Name the different eating disorders and whether they are very common (point prevalence > 5%), common (1-5%) or uncommon (<1%) in the general population.
4. Know whether each eating disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.
5. What are the diagnostic features of anorexia nervosa?
6. What are the diagnostic features of bulimia nervosa?
7. What is the difference between bulimia nervosa and anorexia nervosa?
8. What are the stages of bingeing and purging that occur in bulimia nervosa?
9. Does bingeing and purging ever occur in anorexia nervosa?
10. Describe the key behavioral consequences of anorexia nervosa? Of bulimia nervosa?
11. Describe current understanding of the psychosocial pathogenesis of anorexia nervosa? Of bulimia nervosa?
12. Describe what is known about the neurobiological mechanisms of anorexia nervosa? Of bulimia nervosa?
13. Describe what is known about the potential medical complications of anorexia nervosa? Of bulimia nervosa?
14. What general type of psychotherapy works best for eating disorders? Name key techniques used and give an example of how each might be used to treat a patient with anorexia nervosa and one with bulimia nervosa.
15. What role do psychodynamic therapies play in the treatment of eating disorders?
16. What medications may be used to treat anorexia nervosa? Bulimia nervosa?

## Eating Disorders – Terms & Concepts

- ★ anorexia nervosa
- ★ bulimia nervosa
- ★ culture-bound syndrome
- ★ binge
- ★ purge
- ★ restrict
- ★ appetitive phase
- ★ consummation phase
- ★ compensatory behavior
- ★ Russell's sign
- ★ autonomous dieting
- ★ self-injury
- ★ impulse control
- ★ craving
- ★ positive reinforcement
- ★ negative reinforcement
- ★ serotonin
- ★ selective serotonin reuptake inhibitors
- ★ fenfluramine (Pondimin®)
- ★ cyproheptadine (Periactin®)
- ★ norepinephrine
- ★ endorphins
- ★ exogenous opioids
- ★ naloxone (Narcan®)
- ★ naltrexone
- ★ cholecystokinin (CCK)
- ★ neuropeptide Y (NPY)
- ★ peptide YY (PYY)
- ★ leptin
- ★ cortisol
- ★ rebound hypoglycemia
- ★ ideal body weight
- ★ tricyclic antidepressants
- ★ bupropion
- ★ monoamine oxidase inhibitors



*Uniformed Services University*

## **EATING DISORDERS**

### **What is an Eating Disorder?**

Eating disorders are complicated psychiatric illnesses in which food is used to deal with unsettling emotions and difficult life issues. Patients with anorexia or bulimia are surprised to learn that food has very little to do with the underlying conflicts and family issues that lie at the heart of these disorders. The cause of eating disorders is unknown but is likely a combination of societal influences, psychological predisposition and biological vulnerability.

### **What is Anorexia?**

Anorexia is an obsessive quest for thinness- an intense preoccupation with body weight and shape prompting very disturbed eating behaviors.

It is diagnosed when weight loss leads to a body weight of less than 85% of a healthy norm. There is an intense fear of gaining weight, becoming fat, and a disturbed comprehension of the meaning of weight and self worth along with the denial of the seriousness of the low weight. Menses cease for at least three consecutive cycles

There are two types: restricting and binge-eating purging type.

Personality changes include increased irritability, isolative behavior

Depression and anxiety are common as are obsessive-compulsive personality traits—

85% of cases begin during adolescent years. Somewhere between 0.5-5% of female adolescents will develop anorexia, a higher number Bulimia.

Anorexia has peaks around age 14 and age 18; bulimia—age 18

95% of the time anorexia begins with dieting but in anorexia behavior becomes autonomous —ultimately anorexia becomes one's identity

Estimates from high school and college-age populations place the prevalence among women at 1%. The frequency in men is one tenth that. Women outnumber men ten to one.

**ANOREXIA NERVOSA**  
from the  
*Diagnostic and Statistical Manual of  
Mental Disorders*

Diagnostic criteria for 307.51 Anorexia Nervosa

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

## What is bulimia nervosa?

First named in 1979—considered a variant of anorexia

Binge-purge—twice a week over 3 months—similarly preoccupied with body size shape and weight—but within 5-10 pounds of normal weight—food has calming effect initially on anxiety and painful feelings—followed by guilt, shame, fear---

Defining feature is binge eating- sense of loss of control-eat until physically unable to continue or run out of food—followed by compensatory behavior—usually self-induced vomiting (80-90%) or fasting or exercise (10-20%) The bulimic patient is aware that relationship w/food and behavior is abnormal/out of control

Depression, anxiety common, Greater difficulty with impulse control—risky sexual behavior, alcohol and substance use---cycle of low self-esteem, depression, more self destructive behavior

The bulimic tends to be more anxious and then relieved when” discovered”, more highly motivated in psychotherapy.

*Diagnostic and Statistical Manual of  
Mental Disorders*

Diagnostic criteria for 307.51 Bulimia Nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
- (1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
  - (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
- B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

## **What is Binge Eating Disorder?**

Binge eating disorder—recurrent episodes of binge eating without compensatory weight loss behaviors of Bulimia or anorexia. 1.5%-2% of the general population

Associated with obesity. Common among obese individuals seeking weight management — 70% of individuals in Overeaters Anonymous.

## **Why does someone develop an eating disorder?**

### **Societal influences**

Children as young as five have body image concerns and up to 80% of teenage girls worry about being overweight.

The years between puberty and young adulthood- ages 11 to 22- are the most vulnerable for the onset of anorexia. 7% of children between the ages of 8 and 11 score in the “anorexic range” of eating attitudes

Young women are supposed to do everything: be thin and beautiful, have husbands and children, have professions, power and money. Sexual freedom for girls and women in our culture has added to the anxiety of growing up. Physical obsession with their bodies and dieting may develop in young girls by eight or nine. Confusion, anxiety and concern about these multiple roles are believed to contribute to some girls focus on their appearance as a way to feel in control. Food and weight are entities that can be controlled.

Eating disorders are more common in industrialized nations.

### **Genetic Factors:**

Family studies of anorexia—increased risk of mood disorders in first-degree relatives as well as eating disorders

Bulimia-similar increased rates of mood disorders and eating disorders

Twin studies of both disorders show genetic effects—MZ versus DZ

### **Biological correlates**

Disturbance in the central nervous serotonergic system—serotonin modulates eating behavior by producing feelings of fullness and satiety

Serotonin pathways also involve regulation of mood, impulses and obsessionality—both compulsive behaviors and impulsive behaviors are associated with lower serotonergic activity

Starvation is associated with cerebral atrophy in 82% of patients with anorexia—associated cognitive impairment characteristic of subcortical dementia

### **Individual personality characteristics, emotional features, cognitive style**

Low self-esteem and perfectionism as well as the need for achievement, control and approval—perfectionistic, rigid, dependent and socially insecure.

Anorexics tend to be anxious-strive to please everyone and avoid conflict. Compliant, model children-rarely display teenage rebellion. Prevents recognition and expression of their own feelings—‘fear of sexuality’, avoid growing up

Bulimics may have any combination of these features but tend to be more emotional—impulsive and rejection sensitive--intense emotions that are confusing—more self-destructive behaviors—alcohol, drug abuse, sexual promiscuity or shoplifting

Both anorexics and bulimics have difficulty with a sense of developing their own beliefs, values and opinions—uncertain sense of self- identity

Turn to their bodies as an imagined means of coping with problems in their lives and to feel in control

Perfectionism in childhood is one of the risk factors for both anorexia and bulimia.

### **Family Characteristics**

Family may play a prominent role in some patients but very little in others

Role of family is assumed as it is the backdrop—holding environment for the child-- but degree of impact uncertain—eating disorders are complex disorders

Difficulty with individuation and separation from family of origin noted

Individuation is person's ability to establish a separate identity—opinions, tastes, values and goals-distinct sense of self in spite of overlap with family's values

Family therapists describe these families as enmeshed (emotionally overinvolved with one another—'fused' identities)

### **Eating Disorders in Males**

Largest discrepancy between males and females in diagnosis of psychiatric illnesses occurs among eating disorders: one male for nine-ten females.

Appearance does not define men in quite same way as women in our culture—attributes such as power, money and success are held in more esteem. Males entering puberty see

Appearance as important to sexual appeal—more concerned with shape versus weight—"buff"—males are depicted as more muscular over last 25 years—and body dissatisfaction is growing in a younger group of boys.

Associated depression and anxiety reported, greater unhappiness with their bodies, more confusion about their emotions; obsessive compulsive traits –preoccupied with orderliness, rules, details, perfectionistic. These traits cause anxiety as well as standards are impossible to meet.

An eating disorder in males as in females can bring relief or divert attention from difficult adolescent issues by focusing concerns on weight/ calories/food

### **Treatment**

Course: Full recovery to death-rates 6-7% for anorexia—up to 20% over 20 years; bulimia much higher recovery rates 50-75%

25-40% have a good outcome; the rest have symptoms- such as a distorted body image or abnormal eating behaviors—20% chronically ill

Poor outcome associated with older age at onset, longer duration, severity (hospitalizations), comorbid personality disorder and poor premorbid adjustment

#### **Treatment**

- 1- Restore nutritional status
- 2- Modify distorted eating behaviors
- 3- Change distorted, erroneous beliefs about weight

SSRIs decrease binge-purge (Prozac only one FDA approved for bulimia)

No effect on anorexia—unless comorbid mood disorder or OCD

Bupropion contraindicated (lowers seizure threshold)

Periactin or cyproheptadine a serotonin receptor antagonist may act on hypothalamic feeding center and prevent satiety

Medical consultation

Nutritional counselor—so psychotherapy does not focus on food and avoid underlying issues—  
educational/supportive focus

Individual, family therapy

Practical and goal oriented---insight focus later

**Human Behavior Course  
2004**

**Developmental & Learning Disorders**

**Ginny Randall, MD  
Colonel, USAF, Medical Corps  
Developmental Pediatrician  
Department of Pediatrics  
Uniformed Services University**

**Jan Hanson, PhD  
Research Assistant Professor  
Department of Pediatrics  
Uniformed Services University**

# HUMAN BEHAVIOR COURSE 2004

## DEVELOPMENTAL DISORDERS - SLIDES

### LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slide one below.
2. What characterizes the pervasive developmental disorders?
3. Name each of the pervasive developmental disorders, and categorize each as 'very common' (point prevalence > 5%), 'common' (1-5%) or 'uncommon' (<1%) in the general population.
4. Briefly describe each of the different pervasive developmental disorders. What key features delineate one from another?
5. Know whether each pervasive developmental disorder is more common in boys, more common in girls, or occurs in a similar proportion of boys and girls.
6. What are the diagnostic features of autistic disorder? What differentiates it from normal childhood eccentricity?
7. What are the diagnostic features of childhood disintegrative disorder?
8. What are the diagnostic features of Rett's disorder?
9. What are the diagnostic features of Asperger's disorder?
10. What is the main difference in diagnostic features between Asperger's disorder and autistic disorder?
11. Describe what is known about the psychosocial pathogenesis of the pervasive development disorders.
12. Describe what is known about the medical and neurobiological mechanisms of pervasive developmental disorder.
13. What medical testing is of importance for evaluating pervasive developmental disorder?
14. What role do psychodynamic therapies play in the treatment of pervasive developmental disorder?
15. What medications may be used to treat pervasive developmental disorders?
16. What is the relationship of autism to mental retardation? How are these two problems the same? How are they different?
17. Define mental retardation.
18. What is IQ, what does it predict, and how is it used to differentiate mental retardation subtypes?
19. Categorize each subtype of mental retardation as 'very common' (point prevalence > 5%), 'common' (1-5%) or 'uncommon' (<1%) in the general population. How common is each subtype compared to the other subtypes?
20. Know whether each mental retardation subtype is more common in boys, more common in girls, or occurs in a similar proportion of boys and girls.
21. Describe what is known about the psychosocial pathogenesis of mental retardation.
22. Describe what is known about the medical and neurobiological mechanisms of mental retardation.
23. What medical testing is of importance for evaluating mental retardation?
24. What role do psychodynamic therapies play in the treatment of mental retardation?
25. What medications may be used to treat mental retardation?
26. What is a learning disorder? How is it different from a pervasive developmental disorder and from mental retardation?
27. What are the subtypes of learning disorders?

## Developmental Disorders – Terms & Concepts

- ★ pervasive developmental disorders
- ★ autistic disorder
- ★ childhood disintegrative disorder
- ★ Rett's disorder
- ★ Asperger's disorder
- ★ mental retardation
- ★ learning disorders
- ★ motor skills disorder
- ★ communication disorders
- ★ reciprocal social interaction
- ★ autistic spectrum conditions
- ★ semantics
- ★ echolalia
- ★ prosody
- ★ stereotyped (noncreative) play
- ★ rituals and routines
- ★ stereotyped body movements
- ★ postural abnormalities
- ★ savant
- ★ know table 3-1
- ★ mental subnormality
- ★ mild mental retardation
- ★ moderate mental retardation
- ★ severe mental retardation
- ★ profound mental retardation
- ★ intelligence
- ★ intelligence quotient (IQ)



*Uniformed Services University*

# **Human Behavior Course 2004**

## **Childhood Disorders**

**Doug Waldrep, MD  
Colonel, Medical Corps, US Army  
Department of Psychiatry  
Walter Reed Army Medical Center**

# HUMAN BEHAVIOR COURSE 2004

## CHILDHOOD DISORDERS - SLIDES

### LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slides one and two below.
2. How does clinical depression differ in children versus the more "classic" presentations that occur in adolescents and adults?
3. How does clinical mania & bipolar disorder differ in children and adolescents versus presentations in adults?
4. Contrast mood disorder comorbidity in children and adolescents with mood disorder in adulthood.
5. Describe the epidemiology of suicidal ideas, attempts, and completed suicide in childhood and adolescence.
6. What is known about the use and efficacy of antidepressants for childhood depression?
7. What are the main mood stabilizing medications used for children with bipolar disorder?
8. List the childhood disorders covered in the text and categorize them as 'very common' (point prevalence > 5%), 'common' (1-5%) or 'uncommon' (<1%) in the general population.
9. Which childhood disorders are more common in boys? In girls? Which disorders occur in a similar proportion of boys and girls?
10. Describe aspects of social phobia and generalized anxiety disorder that is unique to children?
11. What are the diagnostic features of separation anxiety disorder? How is it different from school phobia?
12. What is selective mutism? In what age range is it most common? What are the most common treatment approaches employed? What are the commonly comorbid mental disorders?
13. For many childhood anxiety and mood disorders there are few clinical trials evaluating antidepressant therapies. Even so, SSRIs have generally overtaken TCAs as the antidepressant medications of choice for children. Why?
14. What is reactive attachment disorder of infancy or early childhood? What does the case-criteria for this disorder share with the case-criteria for PTSD? What are the most important treatment approaches?
15. Do personality disorders diagnosed in childhood? Which personality disorder is the exception? Why?
16. What are the diagnostic features of attention-deficit hyperactivity disorder? What evidence suggests this disorder is a biological condition?
17. Are stimulant medications over-prescribed in US children? Take a position and defend it using statistics provided in the text, lecture, and notes.
18. What comorbid psychiatric disorders are most common in children with ADHD?
19. What psychosocial therapies are available for children with ADHD and their families?
20. What pharmacotherapies are most effective for ADHD? Which one is most frequently prescribed?
21. What medication alternatives to stimulants exist for ADHD?
22. What are the diagnostic features of conduct disorder?
23. What factors predispose a child to conduct disorder? What factors are associated with poor prognosis?
24. How do boys and girls manifest conduct disorder differently?
25. What is the general approach to treatment of conduct disorder? What are the common barriers to effective treatment?
26. What are the diagnostic features of oppositional-defiant disorder (ODD)? What differentiates it from conduct disorder? From antisocial personality disorder?
27. What is the most common comorbid psychiatric disorder in children with ODD?
28. What is a common factor that predisposes a child to ODD?
29. Name the Feeding and Elimination Disorders (FED). Describe the key diagnostic features of each.
30. Which of the FEDs is associated with a high mortality?

## Childhood Disorders – Terms & Concepts

- ★ major depressive disorder
- ★ bipolar disorder
- ★ dysthymic disorder
- ★ tricyclic antidepressants
- ★ selective serotonin reuptake inhibitors
- ★ obsessive-compulsive disorder
- ★ panic disorder
- ★ post-traumatic stress disorder
- ★ generalized anxiety disorder
- ★ benzodiazepines
- ★ buspirone
- ★ social phobia
- ★ schizophrenia
- ★ separation anxiety disorder
- ★ behavioral inhibition
- ★ school refusal
- ★ transition object
- ★ selective mutism
- ★ reactive attachment disorder
- ★ attachment
- ★ pathogenic care
- ★ attention-deficit hyperactivity disorder (ADHD)
- ★ inattention
- ★ hyperactivity
- ★ impulsivity
- ★ frontal-striatal pathways
- ★ akathisia
- ★ psychostimulants
- ★ methylphenidate
- ★ RitalinSR®



Uniformed Services University

## Childhood Disorders – Terms & Concepts

- ★ Concerta®
- ★ Metadate CD®
- ★ Ritalin LA®
- ★ dextroamphetamine (Dexedrine®)
- ★ Aderall® & Aderall XR®
- ★ dexmethylphenidate (Focalin®)
- ★ pemoline (Cylert®)
- ★ Parents Rating Scale
- ★ Wender Utah Rating Scale
- ★ conduct disorder
- ★ antisocial personality disorder
- ★ oppositional-defiant disorder
- ★ feeding & elimination disorder
- ★ pica
- ★ rumination disorder
- ★ encopresis
- ★ enuresis
- ★ insufficient nocturnal antidiuretic hormone
- ★ imipramine
- ★ desmopressin (DDAVP)



Uniformed Services University

## Overview -Childhood Disorders

- Serious and Treatable Conditions
- Precursors of Adult Psychopathology
- Co-morbidity
- "Adult" Psychiatric Disorders Apply



## Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescents

- Disruptive Behavior Disorders
- Feeding and Eating Disorders
- Tic Disorders
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence



## Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescents

### Developmental Disorders

- Mental Retardation\*
- Learning Disorders\*
  - (Academic Skills Disorders)\*
- Motor Skills Disorder\*
- Pervasive Developmental Disorders\*
- Communication Disorders\*

\*to be discussed in detail elsewhere



## Vignette Name that DX

The parents of an 8 y/o girl are called to the school to discuss her progress. The teacher reports she rarely turns in her assignments, never has the proper school supplies and needs to be told things repeatedly to make sure she gets things done. Her grades are poor and there is concern she does not read well. The teacher asks with some concern, "Are things OK at home?"

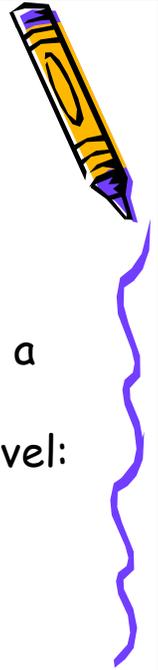
Her parents, perplexed, deny any problems at home. They report their daughter has always been somewhat of an "airhead"; not seeming to listen to things at home, needing to be told to do things repeatedly, often cannot find her schoolwork. Mom needs to pack her school bag to make sure the correct things make it to school. Unable to stay focused on schoolwork unless a parent sits with her. They report she has "always been that way" and they will be happy if she can just "get by"



## Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

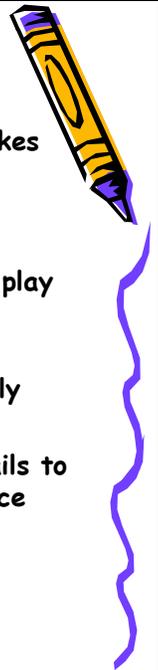
### A. Either (1) or (2):

- 1. Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:



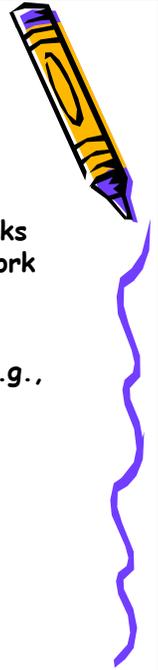
## Inattention

- a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- b. often has difficulty sustaining attention in tasks or play activities.
- c. often does not seem to listen when spoken to directly
- d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)



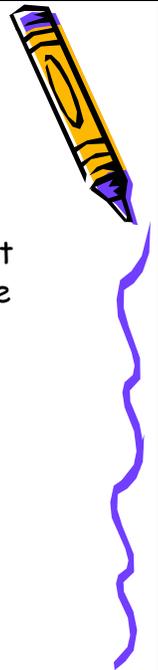
## Inattention continued

- e. often has difficulty organizing tasks and activities
- f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- h. is often easily distracted by extraneous stimuli
- i. is often forgetful in daily activities



## Hyperactivity-impulsivity

- 2. six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:



## Hyperactivity

- a. often fidgets with hands or feet or squirms in seat
- b. often leaves seat in classroom or in other situations in which remaining seated is expected
- c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- d. often has difficulty playing or engaging in leisure activities quietly
- e. is often "on the go" or often acts as if "driven by a motor"
- f. often talks excessively



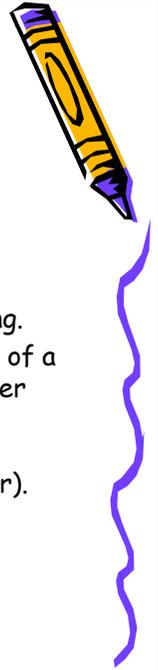
## Impulsivity

- g. often blurts out answers before questions have been completed
- h. often has difficulty awaiting turn
- i. often interrupts or intrudes on others (e.g., butts into conversations or games)



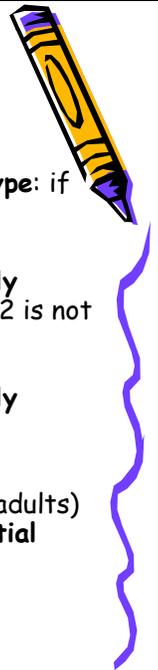
## Criteria B-E

- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present **before age 7 years**.
- C. Some impairment from the symptoms is present in **two or more settings** (e.g., at school [or work] and at home).
- D. There must be clear evidence of **clinically significant** impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).



## CODING

- Code based on type:
  - Attention-Deficit/Hyperactivity Disorder, **Combined Type**: if both Criteria A1 and A2 are met for the past 6 months
  - Attention-Deficit/Hyperactivity Disorder, **Predominantly Inattentive Type**: if Criterion A1 is met but Criterion A2 is not met for the past 6 months
  - Attention-Deficit/Hyperactivity Disorder, **Predominantly Hyperactive-Impulsive Type**: if Criterion A2 is met but Criterion A1 is not met for the past 6 months
  - Coding note: For individuals (especially adolescents and adults) who symptoms that no longer meet full criteria, "**In Partial Remission**" should be specified.



## Attention-Deficit/Hyperactivity Disorder summary

- Primary problem with inattention or hyperactivity/impulsivity or combination
- Impairment present before 7 y/o
- Six or more symptoms in each category
- Persisted for more than 6 months
- Disrupts/impairs life of patient
- Occurs in at least two different places



## ADHD - Epidemiology

- 10% boys and 2% girls carry disorder diagnosis in U.S.
- 6% of school population
- M:F > 4:1 (general pop.) to 9:1 (clinical populations)
- Dx increasing in females.
- Probable gender bias



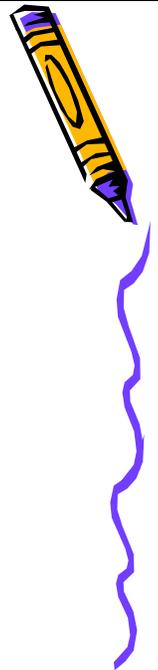
## ADHD - Etiology

- No clear simple etiology identified
- Genetic contribution based upon family studies. Seems to transmit in M>F.
- Families have higher rate of psychopathologies.



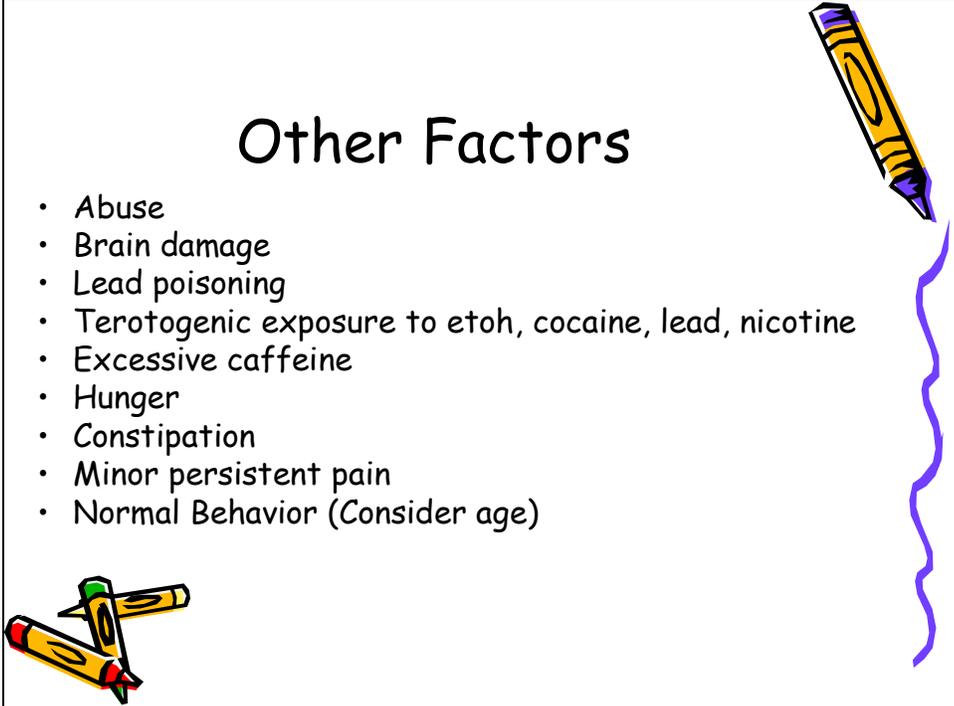
## General Medical Factors

- Medications
  - Recreational stimulants
  - Medical stimulants (pseudoephedrine)
  - Barbiturates, benzodiazepines
  - Carbamazepam
  - Theophylline
- Thyroid disorders
- Malnutrition



## Other Factors

- Abuse
- Brain damage
- Lead poisoning
- Terotogenic exposure to etoh, cocaine, lead, nicotine
- Excessive caffeine
- Hunger
- Constipation
- Minor persistent pain
- Normal Behavior (Consider age)



## ADHD - Differential Diagnosis

- Bipolar Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Learning Disorders
- Psychosocial Considerations
- COMORBIDITY WITH ALL



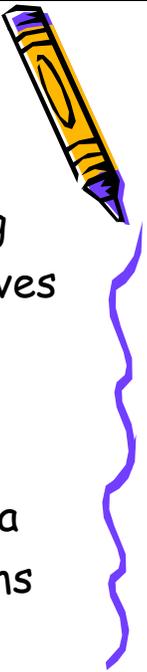
## ADHD - Pathophysiology

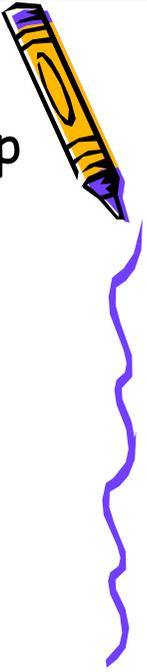
- Unknown
- Theories of Dopamine and norepinephrine
- Medications that enhance both used in treatment.
- Stimulants most effective (dopamine agonists) (75-93% response rate)



## ADHD-Developmental Psychopathology

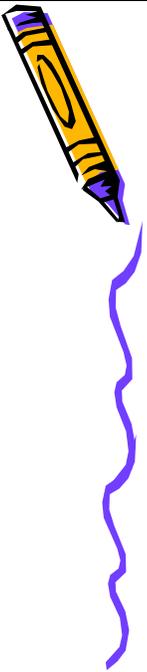
- Most cases congenital and life-long
- Traditional myth that ADHD resolves in adolescence
- NOT benign
- 30% resolve by adulthood
- 30% involve some continued residua
- 30% develop worsening of symptoms





## ADHD-Poor Prognosis Group

- Early onset aggression
- Co-morbid Conduct Disorder
- Worsening of symptoms in adolescence
  - Substance Abuse
  - Mood Disorders
  - Higher Incidence of Suicidality



## ADHD - Treatment

- Environmental changes
- Psychostimulant treatment
- Other psychopharmacology
- Behavioral/parent management
- Other treatment



## Vignette Guess the DX

- 12 y/o male who has been a "handful" all his life was recently returned home by the police for breaking the windows at school. Three months before a neighbor saw him tying fire crackers to the tails of cats and setting them off. A month ago he got even with the neighbor by beating up her 10 y/o son and threatened to kill him if he told anyone. He often carried a knife to scare kids to give him money. His mother fell to the ground crying. She thought things had gotten better after he was given 200 hours community service for stealing bikes a little over a year ago.
- You are consulted to determine "his problem"



## Diagnostic Criteria for Conduct Disorder

- A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:



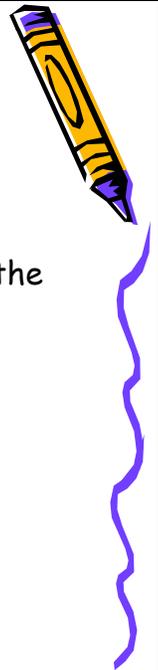
## Aggression to people and animals

1. often bullies, threatens, or intimidates others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. has forced someone into sexual activity



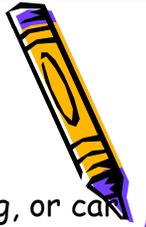
## Destruction of property

8. has deliberately engaged in fire setting with the intention of causing serious damage
9. has deliberately destroyed others' property (other than by fire setting)



## Deceitfulness or theft

10. has broken into someone else's house, building, or car
11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)



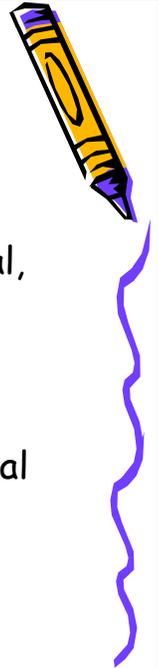
## Serious violations of rules

13. often stays out at night despite parental prohibitions, beginning before age 13 years
14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
15. is often truant from school, beginning before age 13 years



## B & C criteria

- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

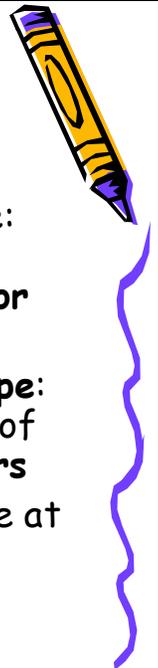


## Code based on age at onset:

Conduct Disorder, **Childhood-Onset Type**:  
onset of at least **one criterion**  
characteristic of Conduct Disorder **prior to age 10 years**

Conduct Disorder, **Adolescent-Onset Type**:  
**absence** of any criteria characteristic of  
Conduct Disorder **prior to age 10 years**

Conduct Disorder, Unspecified Onset: age at  
onset is not known



## Specify severity:

Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others

Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe"

Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others



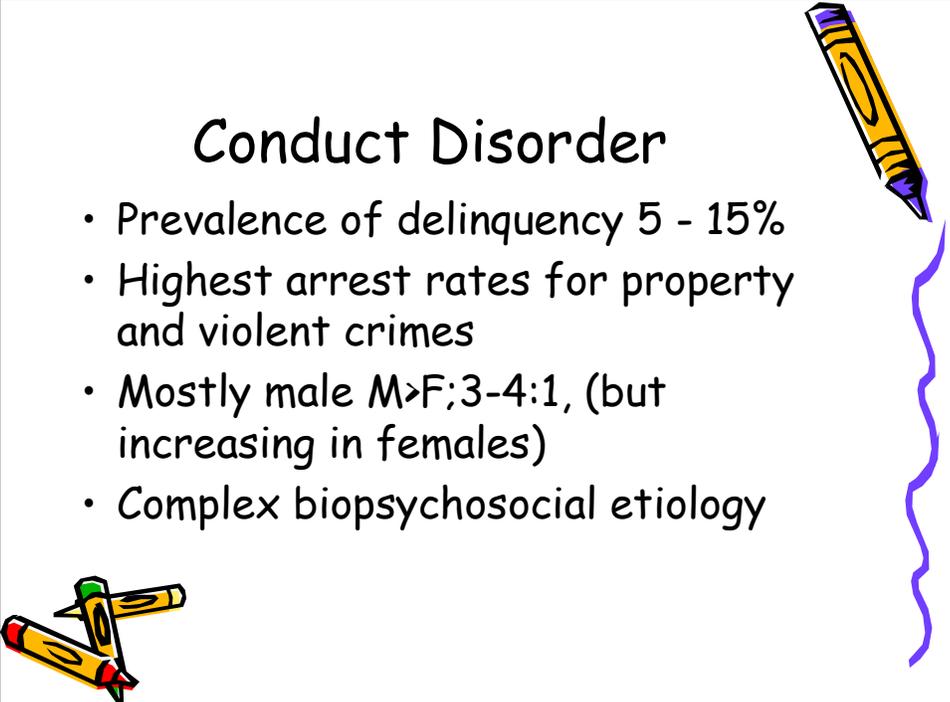
## Conduct Disorder

- Violation of personal rights of others
- Most severe behavior disorder in childhood
- Requires 12 month history of at least 3 DSM-IV criteria
  - Aggression to people and animals
  - Destruction of property
  - Deceitfulness or theft
  - Serious violations of rules



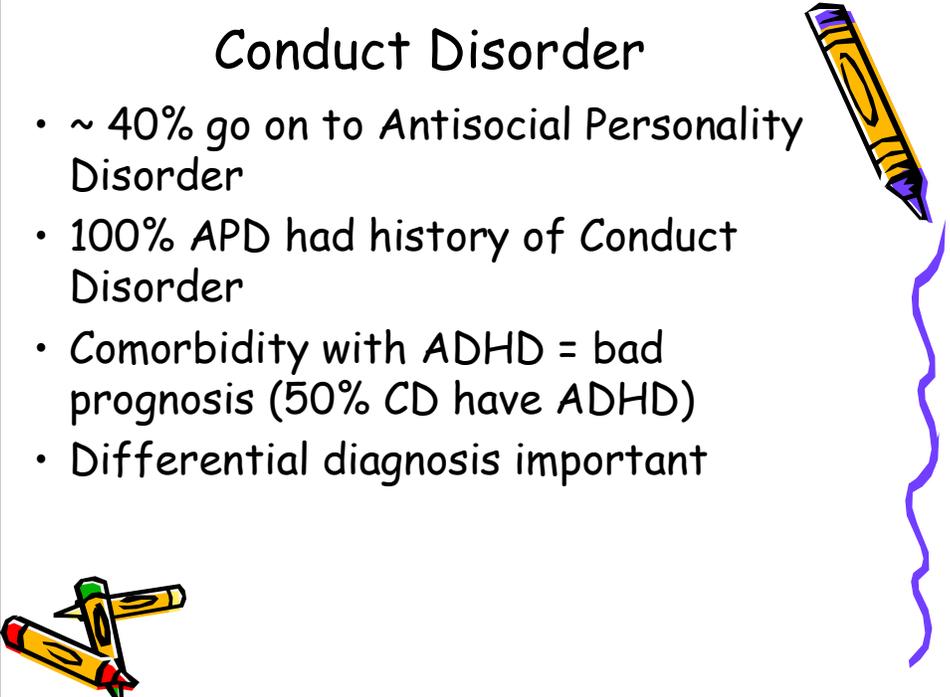
## Conduct Disorder

- Prevalence of delinquency 5 - 15%
- Highest arrest rates for property and violent crimes
- Mostly male M>F;3-4:1, (but increasing in females)
- Complex biopsychosocial etiology



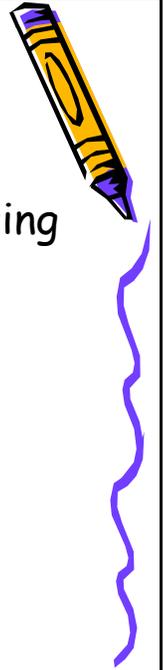
## Conduct Disorder

- ~ 40% go on to Antisocial Personality Disorder
- 100% APD had history of Conduct Disorder
- Comorbidity with ADHD = bad prognosis (50% CD have ADHD)
- Differential diagnosis important



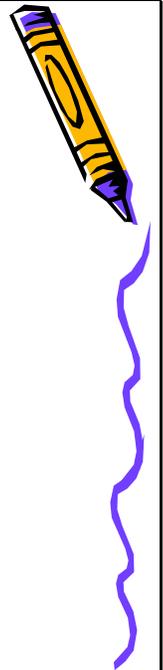
## Factors implicated in the etiology of CD

- Genetic Transmission of predisposing psychiatric disorder
- Neurobiology
- Temperament
- Other psychiatric disorders



## Poor prognosis

- Early onset
- Conduct symptoms
  - Greater frequency
  - Number
  - Variety
  - Comorbid ADHD



## Multimodal treatment

- Psychotherapeutic Interventions
  - Cognitive
  - Behavioral
  - Family
  - Group therapy; beware of contagion
  - School interventions
    - » Boot Camp not shown to be effective



## Psychopharmacology

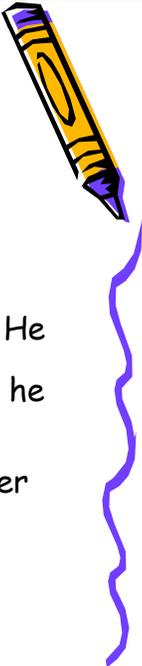
- Treat target symptoms
- Severe aggression
  - » Mood stabilizers
  - » B-Blockers
  - » Neuroleptics



## Vignette

### Name that DX

10 y/o male referred for behavioral problems. Parents describe 2 years of rudeness, disobedience, and "cheekiness". He refuses to participate in family activities and "throws a tantrum" when confronted about his behavior. He has broken furniture, kicked his mother, and smashed glass ornaments. His teacher reports he teases others, recently "cussed her out" when corrected. Causing him to be suspended from school. His grades are above average and better than last year.



## Oppositional Defiant Disorder (ODD)

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:



## ODD Criteria

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adults' requests or rules
4. often deliberately annoys people
5. often blames others for his or her mistakes or misbehavior
6. is often touchy or easily annoyed by others
7. is often angry and resentful
8. is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.



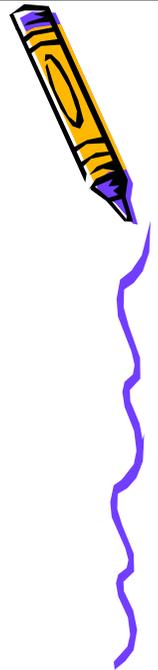
## B-D criteria

- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.
- D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.



## Proposed Etiology

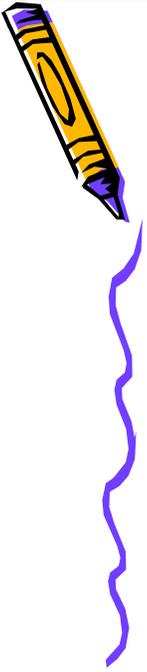
- Inconsistent parenting
- Parents model similar behaviors
- Parents with insufficient time and energy for the child
- Difficult temperament in child
- May have genetic traits to adult antisocial personality disorder.



## ODD Summary

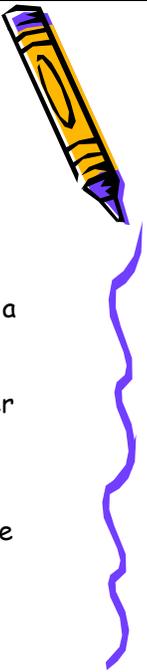
- A pattern of negativistic, hostile, and defiant behavior.
- Meets 4/8 DSM-IV criteria for six months
- 6% prevalence rate
- Temperament, psychological and familial factors likely contribute
- Distinct from, but may result in Conduct Disorder





## TREATMENT

- Similar to Conduct Disorder
- Parenting classes probably most helpful



## Vignette

A 13y/o boy treated for ADHD since age 7 keeps getting in trouble at school. Initially his pediatrician increased the stimulant medication to the maximum and nothing changed. Finally, he referred the boy to a child psychiatrist. It is learned that the boy makes noises like barking during the class. He "refuses" to keep quiet. Sometimes he makes faces at the teacher by grimacing. She has had all she can take from this trouble maker who does not respect her authority. His parents have been warned that if they don't do something fast he will be terminated from his private school.



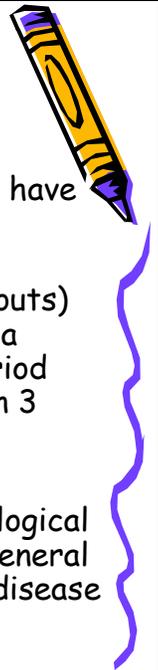
## Tourette's Disorder and other TIC Disorders

- Definition: A TIC is a sudden, rapid recurrent, nonrhythmic, stereotyped motor movement or vocalization.
- Involuntary but can be suppressed by a conscious effort
- Preceded by an "Urge" to make a certain TIC
- **FUNTIONAL IMPAIRMENT IS NOT REQUIRED!**



## Diagnostic Criteria for Tourette's Disorder

- A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.
- B. The TICS occur many times a day (usually in bouts) nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months.
- C. The onset is before age 18 years.
- D. The disturbance is not due to the direct physiological effects of a substance( e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).





## Diagnostic Criteria for Chronic Motor or Vocal Tic Disorder

- A. Single or multiple motor or vocal tics (i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations), but not both, have been present at some time during the illness.
  - B. The tics occur many times a day nearly every day or intermittently throughout a period of **more than 1 year**, and during this period there was never a tic-free period of more than 3 consecutive months.
  - C. The onset is before age 18 years.
  - D. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).
- E. Criteria have never been met for Tourette's Disorder.



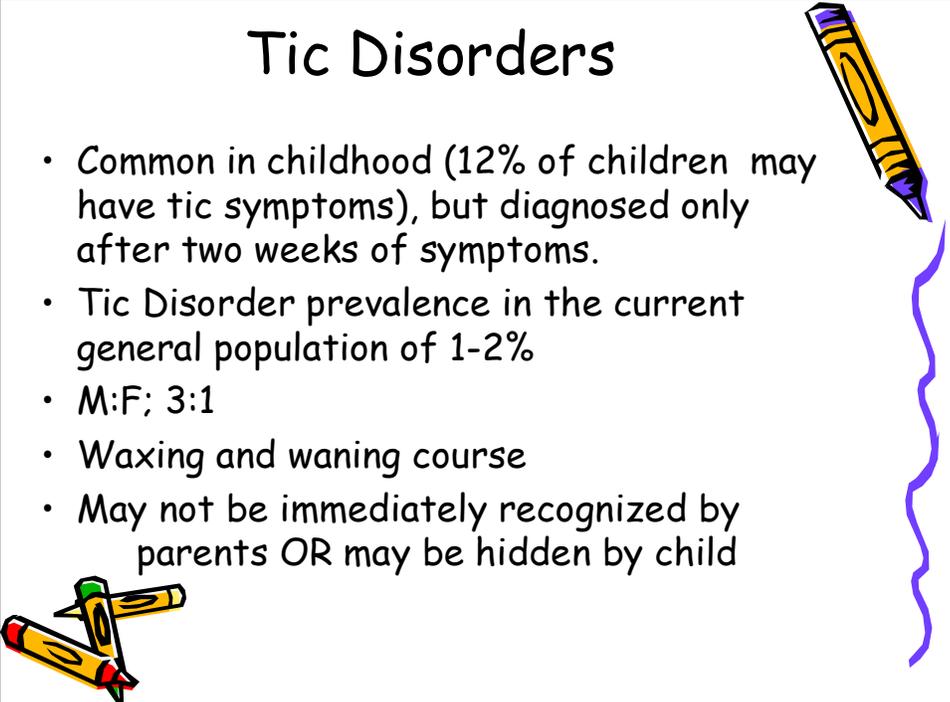
## Transient TIC Disorders

- A. Single multiple motor and/or vocal TICS (i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations)
  - B. The tics occur many times a day nearly every day or for at least 4 weeks but not longer than 12 consecutive months.
  - C. The onset is before age 18 years.
  - D. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).
- E. Criteria have never been met for Tourette's Disorder or Chronic Motor or Vocal TIC Disorder



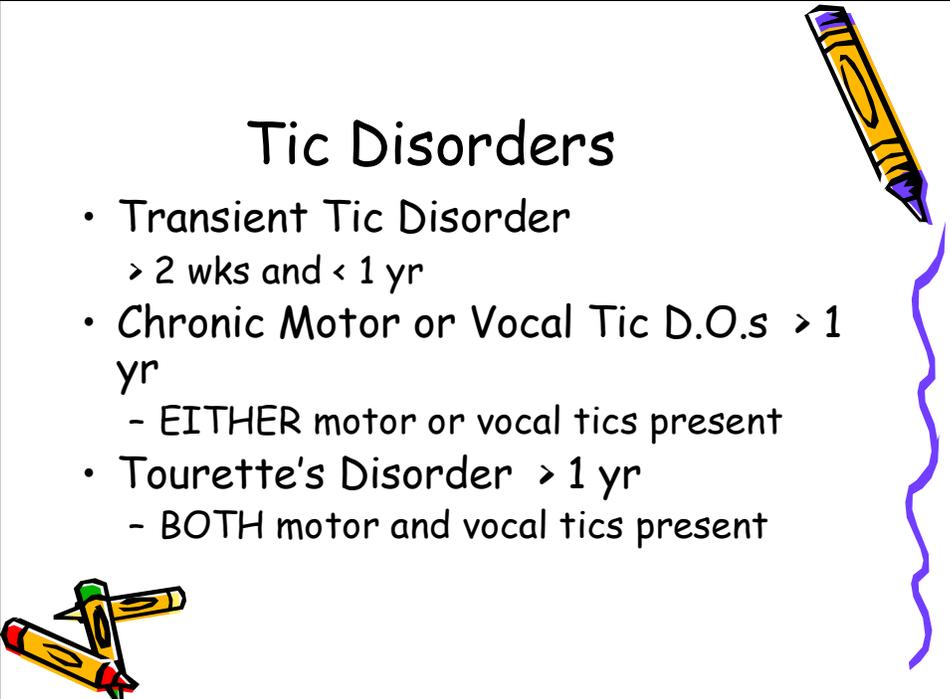
## Tic Disorders

- Common in childhood (12% of children may have tic symptoms), but diagnosed only after two weeks of symptoms.
- Tic Disorder prevalence in the current general population of 1-2%
- M:F; 3:1
- Waxing and waning course
- May not be immediately recognized by parents OR may be hidden by child



## Tic Disorders

- Transient Tic Disorder
  - > 2 wks and < 1 yr
- Chronic Motor or Vocal Tic D.O.s > 1 yr
  - EITHER motor or vocal tics present
- Tourette's Disorder > 1 yr
  - BOTH motor and vocal tics present



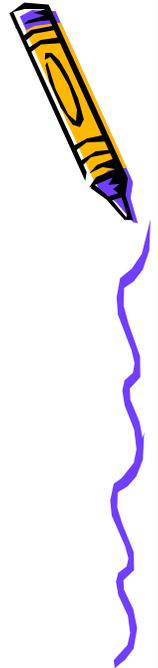
# Tourette's Disorder

- Usual onset between 2 and 13 years
- Some developmental pattern (e.g. motor tics at 7 y/o and vocal tics at 11 y/o)
- High co morbidity with ADHD and OCD
- Treatment options include psychopharmacology, individual therapy, educational interventions
- Rule of thirds
  - 1/3 recover by adolescence
  - 1/3 improve by adult hood
  - 1/3 same or worse



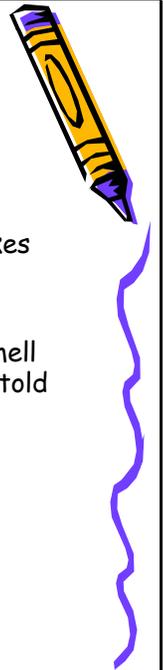
# Treatment for TICS

- Transient tics > psychoeducation
- Psychosocial;
  - School, Family, Individual treatment
- Psychopharmacology
  - $\alpha_1$  adrenergic agonists
    - Guanfacine, Clonidine
  - Neuroleptics; still DOC, most will try above first depending on severity
    - Haldol
    - Pimside (reports of Sudden Death)
    - "atypicals" now being used more
      - Risperidone



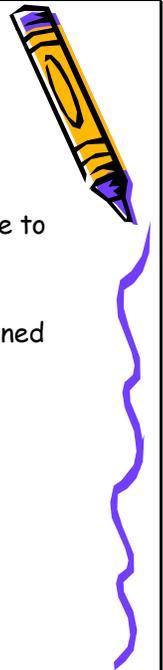
## Vignettes

1. 5 y/o male with unremitting stomach pains has coins, rocks and string on his abdominal films. "He really likes pennies" his mom says with a laugh.
2. On walking down the pediatric ward a horrendous smell becomes apparent from room 1, the room the intern told you to check on. You see a one year old with vomit everywhere smiling at you



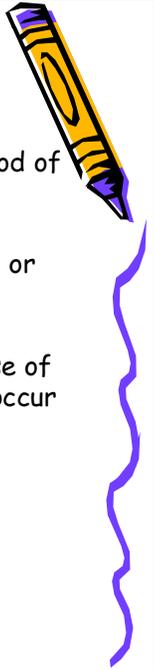
## Pica

- A. Persistent eating of nonnutritive substances for a period of at least 1 month.
- B. The eating of nonnutritive substances is inappropriate to the developmental level.
- C. The eating behavior is not part of a culturally sanctioned practice.
- D. If the eating behavior occurs exclusively during the course of another mental disorder (e.g., Mental Retardation, Pervasive Developmental Disorder, Schizophrenia), it is sufficiently severe to warrant independent clinical attention.



## Rumination Disorder

- A. Repeated regurgitation and rechewing of food for a period of at least 1 month following a period of normal functioning.
- B. The behavior is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).
- C. The behavior does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa. If the symptoms occur exclusively during the course of Mental Retardation or a Pervasive Developmental Disorder, they are sufficiently severe to warrant independent clinical attention.



## PICA and RUMINATION

- Both rare; rumination very rare
- Both more common in MR and PDD
- Pica more common than Rumination
- Etiology-
  - Strongly associated with Psychosocial problems
  - Prevalence unclear for both
  - Treatment: Behavioral for both



## Feeding Disorder of Infancy or Early Childhood

### Diagnostic Criteria

- A. Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least 1 month.
- B. The disturbance is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).
- C. The disturbance is not better accounted for by another mental disorder (e.g., Rumination Disorder) or by lack of available food.
- D. The onset is before age 6 years

\*\*\* New disorder and mostly related to Failure to Thrive



## Vignettes

1. Angry 7 y/o leaves a "present" for the child psychiatrist on his new rug in the waiting room. His mom says "oh no, he poops on my on my pillow too! I should have told you this sooner."
2. Mom proudly reports hr 7y/o slept through the night for a month without wetting the bed for the first time in his life. One night she hears a noise and on investigating sees her son standing on the ladder and peeing on the top bunk bed.



# Encopresis

- A. Repeated passage of feces into inappropriate places (e.g., clothing or floor) whether **involuntary or intentional**.
- B. At least one such event a month for at least 3 months.
- C. Chronological age is **at least 4 years** (or equivalent developmental level).
- D. The behavior is not due exclusively to the direct physiological effects of a substance (e.g., laxatives) or a general medical condition except through a mechanism involving constipation.

Code as follows:

With Constipation and Overflow Incontinence

Without Constipation and Overflow Incontinence



# Enuresis

- A. Repeated voiding of urine into bed or clothes (**whether involuntary or intentional**).
- B. The behavior is clinically significant as manifested by either a frequency of twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- C. Chronological age is **at least 5 years** (or equivalent developmental level).
- D. The behavior is not due exclusively to the direct physiological effect of a substance (e.g., a diuretic) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder).

Specify type:

Nocturnal Only;

Diurnal Only;

Nocturnal and Diurnal



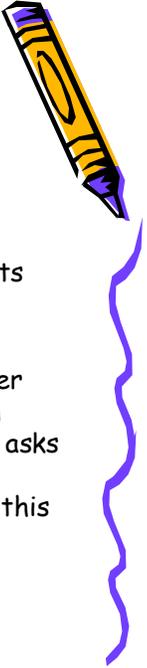
## Elimination Disorders

- Encopresis
  - Either involuntary or intentional passage of feces into inappropriate places
  - One event per month for at least 3 months
  - Chronological age at least **4 years**
- Enuresis
  - Involuntary or intentional voiding of urine into bed or clothes
  - Clinically significant frequency or distress
  - Chronological age of at least **5 years**



## Vignettes

- 10 y/o refuses to go to school. Mom reports he worries about her safety all the time. Cries in the night about dreams of harm to her. Has begun to sleep in the parents bed again.
- Teacher reports to the parents that their 8y/o daughter will not talk in school. Refuses to give answers. Children speak for her and she has a friend she confides in. She asks the parents if everything OK at home. Parents are surprised, "she is always talking". Teacher is suspicious this child is being abused.



## Separation Anxiety Disorder

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation



## Separation Anxiety Disorder

5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
7. repeated nightmares involving the theme of separation
8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated



## B-E

- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

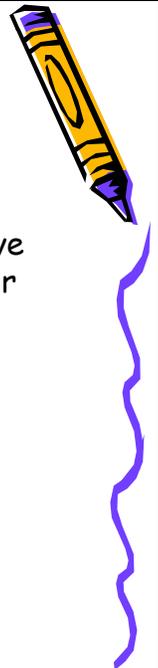


Specify if: Early Onset: if onset occurs before age 6 years



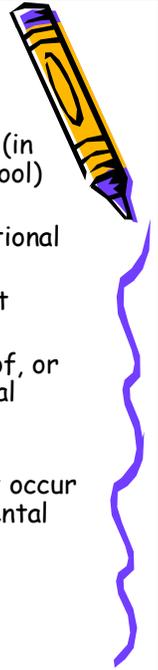
## Other Disorders of Infancy, Childhood or Adolescence

- Separation Anxiety Disorder
  - Developmentally inappropriate and excessive anxiety concerning separation from home or from attachment figures
  - Common and familial disorder
  - School absenteeism common
  - Probable risk factor for future anxiety disorders
  - Treatment includes psychopharmacology, individual and parental counseling



# Selective Mutism

- A. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.
- B. The disturbance interferes with educational or occupational achievement or with social communication.
- C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
- D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder.



# Other Disorders of Infancy, Childhood or Adolescence

- Selective Mutism
  - Failure to speak in specific social situations
  - Psychodynamic factors
  - Temperamental factors - heritable shyness
  - Treatment options include psychopharmacology, behavioral therapy and parent counseling



## Vignettes

- 6 y/o child is reported by her teachers to her third foster mother as having very few friends. Always seems "hypervigilant" and is difficult to get close to. She has been this way most of the school year but lately she seems to be extra scared, tired and thin. She seems difficult to comfort. The foster mother says, "Well she has been trouble for the past several caregivers, but don't worry I will make her come around."
- 6 y/o child is reported by her teachers to her third foster mother as having "too many friends". She is always hugging and kissing the boys and seems clingy to most of the teachers. She is not afraid of strangers and will get too close to anyone whether she knows them or not. Recently a new male cook in the cafeteria told someone he thought she was "coming on to him" he was scared and reported it. The foster mother says, "Well she has been trouble for the past several caregivers. She will hug and kiss just about anybody. We worry about someone taking advantage of her."



## Reactive Attachment Disorder of Infancy or Early Childhood

- A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):
1. persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)
  2. diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)

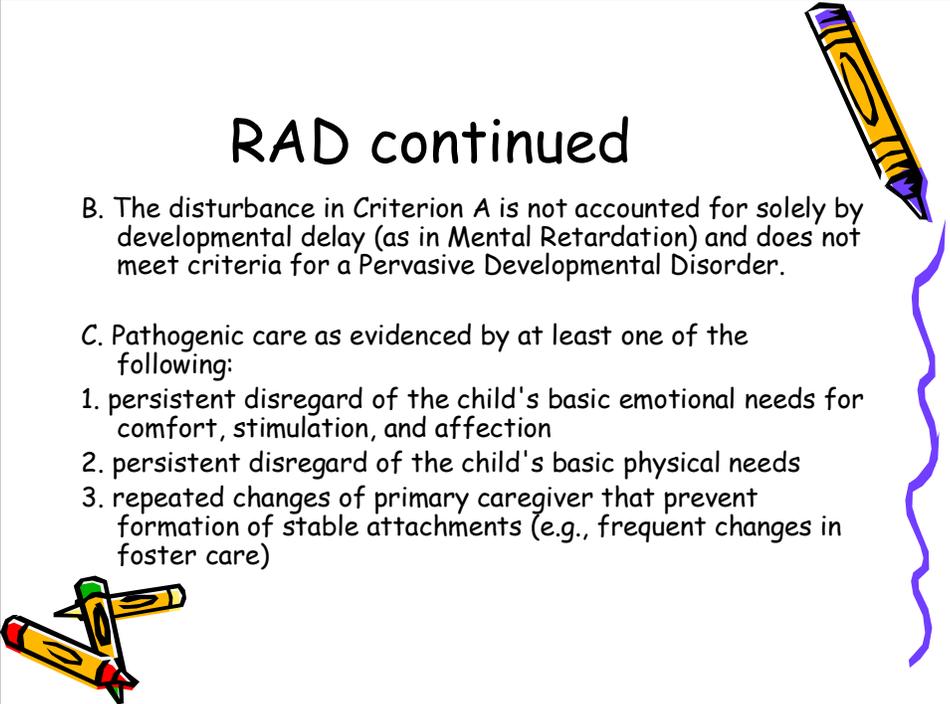


## RAD continued

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

1. persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection
2. persistent disregard of the child's basic physical needs
3. repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care)



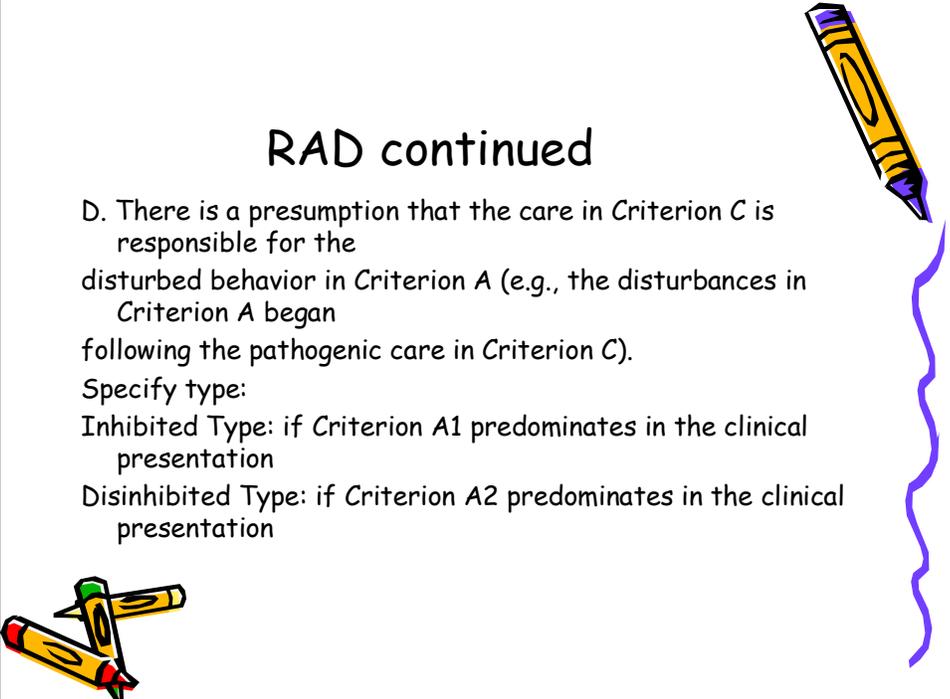
## RAD continued

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specify type:

Inhibited Type: if Criterion A1 predominates in the clinical presentation

Disinhibited Type: if Criterion A2 predominates in the clinical presentation



## Other Disorders of Infancy, Childhood or Adolescence

- Reactive Attachment Disorder
  - o Persistent failure to initiate or respond in a developmentally appropriate fashion
  - o diffuse and indiscriminate attachments
  - o generally related to child abuse or neglect
  - o Psychosocial failure to thrive
  - o Paradoxical presentation to strangers
    - o Overanxious vs. Overfriendly



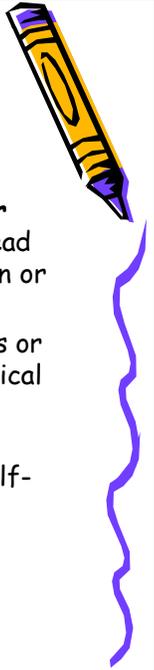
## Vignette

- Mother reports her 9 y/o son, with mild MR, sits on the floor and rocks rocks while watching TV. He gradually increases with such force that he bangs his head hard on the coffee table. Yesterday he kept hitting it until his head began to bleed. "He acts like it is nothing."



## Stereotypic Movement Disorder

- A. **Repetitive, seemingly driven, and nonfunctional motor behavior** (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or bodily orifices, hitting own body).
- B. The behavior markedly interferes with normal activities or results in self-inflicted bodily injury that requires medical treatment (or would result in an injury if preventive measures were not used).
- C. If Mental Retardation is present, the stereotypic or self-injurious behavior is of sufficient severity to become a focus of treatment.



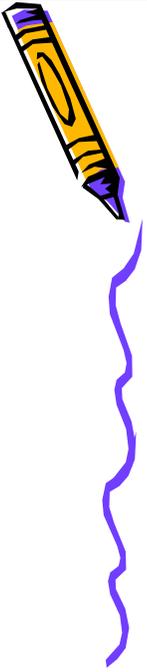
## Stereotypic Movement Disorder continued

- D. The behavior is not better accounted for by a compulsion (as in Obsessive-Compulsive Disorder), a tic (as in Tic Disorder), a stereotypy that is part of a Pervasive Developmental Disorder, or hair pulling (as in Trichotillomania).
- E. The behavior is not due to the direct physiological effects of a substance or a general medical condition.
- F. The behavior persists for 4 weeks or longer.

Specify if:

With Self-Injurious Behavior: if the behavior results in bodily damage that requires specific treatment (or that would result in bodily damage if protective measures were not used)





## Treatment

- Mostly likely behavioral
- Occasionally medications for severe cases
  - Neuroleptics
  - SSRI's



## EXTRA CREDIT

- 7 y/o boy referred for severe behavioral problems. He suddenly began to be very "hyper", constantly fidgeting, forgetful, losing things. Sudden onset of fear of the # 3. Would not write the number. Would not get out of bed when the time included three. Simultaneously developed an awkward wrinkling of his nose and forehead and kids were making fun of his "rabbit face". History is only significant for chronic OM and recurrent sore throat most recent one cultured as GABHS.
- What are your thoughts?



**Human Behavior Course  
2004**

**Personality Disorders One  
Introduction & Cluster A Disorders**

**Charles C. Engel, Jr., MD, MPH  
LTC, MC, USA  
Associate Professor of Psychiatry  
Uniformed Services University**

# HUMAN BEHAVIOR COURSE 2004

## PERSONALITY DISORDERS ONE - SLIDES

### LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slide one and slide two below.
2. Compare and contrast a dimensional trait model of personality measurement (such as Eysenck's two factor model or the 'five-factor' NEO model described in the text) and the DSM-IV categorical typology model of personality disorders? What are the advantages of the DSM model? What are the disadvantages? How is personality, as measured using a dimensional trait model, the same or different from a personality disorder assessed using a categorical typology model?
3. Describe how Chess and Thomas's work linked biological (constitutional) factors and environmental (psychosocial) factors in personality development.
4. Describe how Siever and Davis (see table 10-3 in your text) linked dimensional trait models, DSM phenomenology, clinical neuroscience, and psychological functioning to understand both the form and the function of personality disorders.
5. Review Vaillant's hierarchy of defenses (introduced in earlier lectures from Dr. Gemelli and Dr. Privitera). List the mature, neurotic, and immature defenses, and quickly review the definitions of the individual defenses.
6. What are the cluster A personality disorders? What are the similarities across disorders within this cluster of disorders?
7. Which of the cluster A disorders are 'very common' (point prevalence > 5%), 'common' (1-5%) or 'uncommon' (<1%) in the general population.
8. Know whether each cluster A personality disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.
9. What are the diagnostic features of paranoid personality disorder? Describe its pathogenesis from the perspective of both form and function.
10. What are the diagnostic features of schizotypal personality disorder? Describe its pathogenesis from the perspective of both form and function.
11. What are the diagnostic features of schizoid personality disorder? Describe its pathogenesis from the perspective of both form and function.
12. What types of medications, if any, are useful for cluster A personality disorders?
13. What types of psychosocial treatments are useful for cluster A personality disorders?

## Personality Disorders One – Terms & Concepts

- ★ categorical diagnostic approach
- ★ dimensional diagnostic approach
- ★ disjunctive diagnostic criteria
- ★ personality
- ★ traits
- ★ factor analysis
- ★ Eyesenck two-factor model
- ★ Eyesenck Personality Inventory
- ★ neuroticism
- ★ introversion
- ★ extroversion
- ★ Five-factor model
- ★ openness
- ★ agreeableness
- ★ conscientiousness
- ★ personality disorder
- ★ cluster A (odd or eccentric)
- ★ paranoid personality disorder
- ★ schizoid personality disorder
- ★ schizotypal personality disorder
- ★ cluster B (dramatic, emotional, or erratic)
- ★ antisocial personality disorder
- ★ borderline personality disorder
- ★ histrionic personality disorder
- ★ narcissistic personality disorder
- ★ cluster C (anxious or fearful)
- ★ avoidant personality disorder
- ★ dependent personality disorder
- ★ obsessive-compulsive personality disorder
- ★ temperament
- ★ behavioral inhibition



Uniformed Services University

## Personality Disorders One – Terms & Concepts 2

- ★ easy child
- ★ difficult child
- ★ slow to warm child
- ★ behavioral inhibition
- ★ adult expectations & demands
- ★ see table 10-3
- ★ externalization & projection
- ★ autistic or schizoid fantasy



Uniformed Services University

## DSM-IV Axes

- Axis I Clinical Disorders  
Other Conditions that may be a Focus of  
Clinical Attention
- Axis II Personality Disorders  
Mental Retardation
- Axis III General Medical Conditions
- Axis IV Psychosocial and Environmental  
Problems
- Axis V Global Assessment of Functioning



## Why Understanding Personality Disorders is Important

- ★ PDs cause sig't problems for those who have them
- ★ PDs cause problems for others & are expensive for society
- ★ PDs have treatment implications:
  - Often need to be focus of treatment, themselves
  - Their presence affects Axis I disorders' treatment response & prognosis
- ★ All physicians will encounter pts with them



*Uniformed Services University*

## What is "Personality"?

A characteristic manner of thinking, feeling, behaving, & relating to others.



*Uniformed Services University*

## Temperament

- ★ Heritable
- ★ Fully manifest in infancy
- ★ Stable throughout life



## Character

- ★ Individual differences in voluntary goals & values
- ★ Based on insight, learning, and intuitions & concepts of ourselves and others



## Personality Traits

- ★ Enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts.
- ★ Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute personality disorders.



Uniformed Services University

## What is a Personality Disorder?

'An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.'



Uniformed Services University

# Personality Disorders Key Points

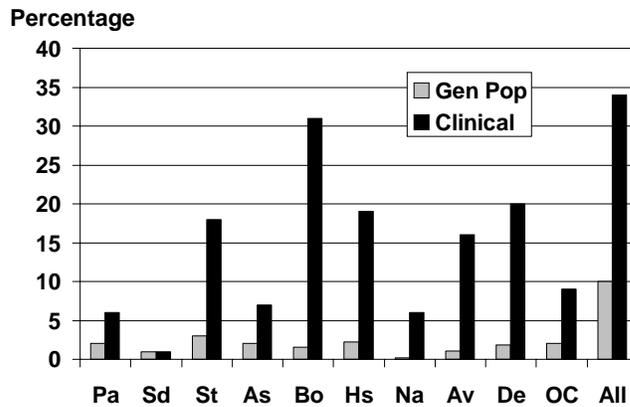
## ◆ Over-represented in clinical practice

- » Narcissistic PR ≈ 30
- » Borderline PR ≈ 20
- » Avoidant PR ≈ 15
- » Dependent PR ≈ 10

## ◆ High comorbidity

- » especially in clinical practice PR ≈ 3.4
- » axis I disorders too

# Descriptive Epidemiology Personality Disorders



## The Assessment

- ★ Requires evaluation of long-term patterns of functioning
- ★ Particular personality features must be evident by early adulthood
- ★ Rule out 'traits' emerging due to stressors or transient mental states



Uniformed Services University

## The Assessment 2

- ★ Assess stability over time and situations
- ★ Often necessary to do several interviews spaced over time
- ★ May not be considered problematic by the individual (ego-syntonic)
- ★ Consider supplementary information



Uniformed Services University

## Age Considerations

- ★ If under age 18 years, features must be present at least 1 year
- ★ Exception: antisocial personality disorder (cannot be diagnosed in individuals under age 18 years)
- ★ May not come to clinical attention until relatively late in life
- ★ Personality change after middle adulthood warrants thorough evaluation



Uniformed Services University

## Classification Approaches

Categorical: (DSM-IV)

- ★ PD's as distinct categories that are qualitatively different
- ★ Clearly demarcated from normal personality traits & from one another
- ★ Better reflects how clinicians think: a person either has a disorder or doesn't



Uniformed Services University

## Classification Approaches

### Dimensional:

- ★ PD's exist along dimensions that reflect extreme variants of normal personality
- ★ Can use many personality descriptors
- ★ Can assess the degree to which a trait is present
- ★ Can more richly and comprehensively consider problematic traits



*Uniformed Services University*

## General Diagnostic Criteria

- ★ Pattern of inner experience and behavior that deviate from the expectations of the individual's culture
- ★ Pattern is manifested in at least 2 of the following areas:
  - Affectivity
  - Interpersonal functioning
  - Impulse control
  - Cognitions



*Uniformed Services University*

## General Diagnostic Criteria

- ★ Inflexible & pervasive
- ★ Leads to clinically significant distress or impairment in areas of functioning
- ★ Stable and of long duration
- ★ Not accounted for as a manifestation of another mental disorder
- ★ Not due to the effects of a substance or medical condition



*Uniformed Services University*

## Cluster A: Odd or Eccentric

- ★ **Paranoid personality disorder** is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.
- ★ **Schizoid personality disorder** is a pattern of detachment from social relationships and a restricted range of emotional expression.
- ★ **Schizotypal personality disorder** is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.



*Uniformed Services University*

## Cluster A: Odd or Eccentric

- ★ Features:
  - Social deficits
  - Lack of relations
- ★ Treatment:
  - Structure
  - Support
  - Meds
- ★ Course/Prognosis:
  - Stable/Poor



## Paranoid Personality Disorder

- ★ Pervasive distrust and suspiciousness of others
- ★ Suspects that others are exploiting, harming, or deceiving them without sufficient basis
- ★ Preoccupied with unjustified doubts about the loyalty of friends and associates
- ★ Reluctant to confide in others due to an unwarranted fear that the information will be used against them



## Paranoid Personality Disorder

- ★ Reads hidden meanings into benign remarks
- ★ Persistently bears grudges
- ★ Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
- ★ Has recurrent suspicions, without justification, regarding fidelity of significant other



## Paranoid PD Mnemonic

### HEAD FUG\*

**H**-idden meaning read into others' remarks  
**E**-xploitation is expected from others  
**A**-ttacks on his or her character is perceived  
**D**-oubts the loyalty of others

**F**-idelity of partner is doubted  
**U**-njustified suspicions about others  
**G**-rudges are held



\* From DSM-IV Personality Disorders Explained. Robinson D. 2000

## Paranoid PD Epidemiology

### ★ Prevalence:

- General population: 0.5%-2.5%
- Inpatient Psychiatry Settings: 10%-30%
- Outpatient Psychiatry Clinics: 2%-10%

### ★ Gender:

- More common in men



Uniformed Services University

## Paranoid PD Etiology

### ★ Genetic contribution:

- Mixed results in studies looking at rel'n of PPD to schizophrenia

### ★ Possible psychosocial contributions:

- Parental modeling
- History of exploitation or abandonment
- Projection of anger & resentment onto an external group



Uniformed Services University

## Paranoid PD Differential

- ★ Delusional Disorder, Persecutory Type
- ★ Schizophrenia, Paranoid Type
- ★ Mood Disorder with Psychotic Features
- ★ Sx. assoc. with dev't of handicap
- ★ Schizoid Personality Disorder
- ★ Schizotypal Personality Disorder



## Paranoid PD in Med/Surg Settings

- ★ Patient's experience of illness:
  - Distrust & suspiciousness of others' motives
  - Fear of being harmed
- ★ Problem behaviors:
  - Misinterpretation of innocuous/helpful behaviors
  - Arguments & conflict with staff



Feder & Robbins, in Behavioral Medicine  
in Primary Care: A Practice Guide.  
Feldman & Christensen (eds.) 1998

## Paranoid PD in Med/Surg Settings

Common problematic HCP reactions:

- ★ Defensive, angry, or argumentative response that “confirms” pt.’s suspicions
- ★ Ignoring the pt.’s suspiciousness or angry stance



Uniformed Services University

Feder & Robbins, in Behavioral Medicine  
in Primary Care: A Practice Guide.  
Feldman & Christensen (eds.) 1998

## Paranoid PD in Med/Surg Settings

Management Strategies:

- ★ Pay attention & maintain empathy even when pt. irrational
- ★ Provide advanced information and give detail about risks of procedures/treatments
- ★ Inform patient of what to expect from meds, etc.
- ★ Maintain pt.’s independence
- ★ Professional, but not overly friendly, stance



Uniformed Services University

Feder & Robbins, in Behavioral Medicine  
in Primary Care: A Practice Guide.  
Feldman & Christensen (eds.) 1998

## Schizoid Personality Disorder

- ★ Pervasive pattern of detachment from social relationships and a restricted range of expression of emotion
- ★ Neither enjoys nor desires close relationships
- ★ Chooses solitary environments
- ★ Little interest in sexual experiences with others
- ★ Takes pleasure in few, if any, activities



## Schizoid Personality Disorder

- ★ Lacks close friends or confidants
- ★ Appears indifferent to praise or criticism
- ★ Shows emotional coldness, detachment, or flattened affectivity



## Schizoid PD Mnemonic

### SIR SAFE\*

**S**-olitary lifestyle

**I**-ndifferent to praise or criticism

**R**-elationships of little to no interest

**S**-exual experiences not of interest

**A**-ctivities preferred are solitary

**F**-riendships are few

**E**-motionally cold & detached



Uniformed Services University

\* From DSM-IV Personality Disorders Explained. Robinson D. 2000

## Schizoid PD

### ★ Epidemiology:

- Uncommon in clinical settings

### ★ Etiology:

- Heritability for personality dimension of introversion/extraversion
- Psychosocial models: sustained history of isolation with parental modeling of detachment



Uniformed Services University

## Schizoid PD Differential

- ★ Delusional Disorder, Persecutory Type
- ★ Schizophrenia, Paranoid Type
- ★ Mood Disorder with Psychotic Features
- ★ Autistic Disorder
- ★ Asperger's Disorder
- ★ Sx. associated with dev't of handicap
- ★ Schizotypal Personality Disorder
- ★ Paranoid Personality Disorder



Uniformed Services University

## Schizoid PD in Med/Surg Settings

- ★ Patient's experience of illness:
  - Threat to personal integrity
  - Increased anxiety due to forced interactions
- ★ Problem behaviors:
  - May delay seeking care to avoid interactions
  - May appear detached & unappreciative



Uniformed Services University

Feder & Robbins, in Behavioral Medicine  
in Primary Care: A Practice Guide.  
Feldman & Christensen (eds.) 1998

## Schizoid PD in Med/Surg Settings

### Common problematic HCP reactions:

- Overzealous attempts to connect with pt.
- Frustration at feeling unappreciated



Feder & Robbins, in Behavioral Medicine  
in Primary Care: A Practice Guide.  
Feldman & Christensen (eds.) 1998

## Schizoid PD in Med/Surg Settings

### ★ Management Strategies:

- Low-key approach/appreciate need for privacy
- Focus on technical elements of treatments
- Encourage pt. to maintain daily routines
- Do not become overly involved
- Do not push to provide social supports



Feder & Robbins, in Behavioral Medicine  
in Primary Care: A Practice Guide.  
Feldman & Christensen (eds.) 1998

## Schizotypal Personality Disorder

- ★ Social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior
- ★ Ideas of reference
- ★ Odd beliefs or magical thinking
- ★ Unusual perceptual experiences
- ★ Odd thinking and speech



Uniformed Services University

## Schizotypal Personality Disorder

- ★ Suspiciousness or paranoid ideation
- ★ Inappropriate or constricted affect
- ★ Behavior or appearance that is odd, eccentric, or peculiar
- ★ Lack of close friends or confidants
- ★ Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears



Uniformed Services University

## Schizotypal PD Mnemonic

### UFO AIDER\*

U-nusual perceptions

F-riendless

O-dd thinking, speech, & beliefs

A-ffect is constricted or inappropriate

I-deas of reference

D-oubts others – paranoid & suspicious

E-ccentric appearance & behavior

R-eluctant socially



Uniformed Services University

\* From DSM-IV Personality Disorders Explained. Robinson D. 2000

## Schizotypal PD

### ★ Epidemiology

- Prevalence in general population: 3%

### ★ Etiology

- More common in 1<sup>o</sup> relatives of individuals with schizophrenia
- Modest increase in schizophrenia & other psychotic disorders in relatives of persons with schizotypal pd



Uniformed Services University

## Schizotypal PD Differential

- ★ Delusional Disorder, Persecutory Type
- ★ Schizophrenia, Paranoid Type
- ★ Mood Disorder with Psychotic Features
- ★ Autistic Disorder
- ★ Asperger's Disorder
- ★ Communication Disorders
- ★ Schizoid Personality Disorder
- ★ Paranoid Personality Disorder



*Uniformed Services University*