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# PSYCHOLOGY: ABNORMAL

mental illness | DSM-IV classifications | psychological perspective | behavioral | medical

## MENTAL ILLNESS

### CRITERIA & DEFINITIONS

- **Statistical Model:** "Normality" is that which a majority (e.g., 68%) of the population exhibits, based upon a statistical normal curve.
- **Societal Expectations:** "Normality" is conformity to sociological roles.
- **Consensus of Opinions of Experts:** Experts (viz., psychologists and psychiatrists) stipulate what is normal.
- **Subjective Discomfort:** The person admits to a problem.
- **Social or Vocational Incapacity:** The inability to function in societal or work-defined roles.
- **Misinterpretation of Reality:** The person is out of touch with or distorting perceived "reality."
- **Immaturity:** Maturity level is below the degree of what is expected at specified age or social milieu.

**Note:** No single criterion for mental illness can describe all types of abnormalities. Defining mental illness relative to social norms or maladaptive behaviors invariably commits one to making a normative (i.e., value) judgment that one's societal norms are "correct." Hence, all definitions of mental illness invariably become theory-laden.

### THOMAS SZASZ'S OBJECTION

The concept of mental illness is a socially construced myth for the purpose of advancing certain social and political agenda. Clinical psychology is an instrument of repression to enforce conformity and stigmatize nonconformist and "deviant" people with the label "mentally ill."

### REZNEK'S DEFINITION OF MENTAL ILLNESS

Something is a mental illness if, and only if, it is an abnormal and involuntary process that does mental harm and should best be treated by medical means.

**Note:** "Abnormality" is used in the constructivist (i.e., normative) sense and not in the statistical or idealistic sense, inasmuch as society determines what is acceptable "normal" behavior.

## MEDICAL MODEL

### METHODOLOGY

1. **Describe Symptoms**
2. **Diagnose** (identify specific pathology)
3. **Etiology** (probable cause of disease)
4. **Prescribe Treatment**
5. **Prognosis** (expected course of disease)

### CAUSAL FACTORS

- **Primary Cause:** The agent believed to have initially caused the disease. In the medical model, the primary cause is assumed to be a virus, bacteria, chemical toxin such as lead poisoning, genetic inheritance, chemical disorder, or structural brain pathology.
  - **Predisposing Cause:** Organism is predisposed to disease under some circumstances (e.g., alcoholism).
  - **Precipitating Cause:** A specific event or factor triggers onset of the disease (e.g., it is suspected that Alzheimer's disease has an environmental precipitating cause).
  - **Reinforcing Cause:** Factor that maintains the disease (e.g., severe stress may reinforce the need for narcotic opiates); environmental chemicals may also reinforce the disease.

### BASIC TERMINOLOGY

- **Symptom:** The behaviorally manifest signs of a disorder.
- **Syndrome:** A collection of symptoms that identifies a disease.
- **Acute:** A disorder that has a sudden onset but is short-lived.
- **Chronic:** A persistent, long-lasting disorder.

### CAUSE OF DISORDERS

- **Chemical:** Usually, an imbalance of certain brain chemicals (e.g., it is suspected that an imbalance in the neurotransmitter serotonin plays a causal role in the onset of schizophrenia).
- **Infection** by micro-organisms (e.g., syphilitic paresis is thought to be caused by the bacteria that initially infected the subject with syphilis, resulting in the subsequent dementia).
- **Genetic:** Genetic mutations and/or predispositions may play a causal role in the onset of a disorder (e.g., manic-depressive illness is thought to have a genetic predisposing factor).
- **Constitutional Weakness:** The organism may have an enduring biological defect that pre-disposes it to some illness.
- **Physical Deprivation,** such as lack of sleep, malnutrition, etc. may play a causal role in the onset of disease.
- **Brain Pathology:** Physical brain disorder, either congenital or traumatic (e.g., head injury), as the cause of mental illness.

### CLASSIFICATION & DIAGNOSIS

The process of classifying and identifying a disease by reference to symptoms and behavior deviating from "normal." The major categorizing reference for the classification of mental disorders is the DSM (viz., Diagnostic and Statistical of Disorders in the DSM are sometimes classified unreliably and are invalid for diagnostic agreement among psychiatrists; with the exception of the diagnosis of "manic depressive illness," the inter-observer diagnostic reliability of DSM is poor). People labelled by DSM classifications are often stigmatized for life.

### ASSESSMENT TECHNIQUES

The process of identifying the nature and severity of the condition, formulating treatment goals, and evaluating the effect of the treatment.

- Medical evaluation
- Personality and environmental variables
- Interviews with patient
- Psychological tests and rating scales
- Direct observation of behavior

### TREATMENTS

- **Psychosurgery:** Partial or total frontal lobotomy, or other procedure, wherein brain tissue is severed or excised.
- **Electroconvulsive Shock Therapy (ECS):** Administering electrical current of various intensity to the brain to alleviate symptoms of severe chronic depression.
- **Psychoactive Drugs:** Alter mood or behavior by affecting metabolic processes that affect the brain. They are administered to stabilize moods (e.g., lithium for manic-depression), alleviate depressed states (e.g., Prozac), or to induce/subdue certain emotional states.

### ADVANTAGES OF MEDICAL MODEL

Promotes a more human understanding of patients, aids in the understanding of some organic mental disorders and further initiates research in brain functioning.

### DISADVANTAGES OF MEDICAL MODEL

Enviromental variables are unduly minimized or neglected; diagnostic and treatment methods are questionable, thus fostering an "institutionalization syndrome." This approach removes responsibility from the person to want to be cured; it promotes dependence upon hospitals and chemicals.

## PSYCHOLOGICAL PERSPECTIVE

As humans attempt to adapt to their environment, maladaptive behavior causes abnormal behavior. The psychological perspective assumes that both normal and abnormal adaptive patterns are learned, not inherited. Thus, treatment consists of substituting healthy adaptive behaviors for maladaptive behaviors. The goal of this approach is to explain abnormality in terms of inefficient and ineffective coping mechanisms. A psychological treatment works only if the patients actively participate in their treatment; the approach is usually ineffective in the case of involuntary institutionalization.

- **Neo-Freudians:** Concentrate on the power of the ego, instead of the id. Emphasized social interactions in the formation of personality, deemphasized instincts and biological factors. In psychotherapy, they emphasize the present, not the past, and tend to advocate shorter periods of treatment. Specific problems that could be readily treated are focused upon.

### GENERAL CAUSES OF ABNORMALITY

*These merely predispose persons to abnormal behavior*:

- **Maternal Deprivation:** Especially, orphans who are institutionalized and/or are abandoned by their natural parents.
- **Pathological Family Patterns:** Maladaptive family behavior (e.g., faulty role model) which the child imitates and internalizes; faulty relationship between parent and child (e.g., over-protective, domineering, alcoholic and/or emotionally abusive parents, etc.)
- **Psychic Trauma** (Especially in the psychoanalytic view): An early-repressed childhood traumatic experience is repressed (e.g., abandonment, death or divorce, sexual abuse, etc.) and then resurfaces later as a disorder.
- **Pathological Interpersonal Relationships:** Stressful, anxiety-causing, maladaptive personal relationships (e.g., co-dependent, narcissistic, or control-obsessive), or no relationships at all.
- **Severe Stress:** Extreme pressure on the coping mechanisms which take a destructive toll on psychological processes (e.g., post-traumatic stress disorder resulting from combat, captivity, torture, natural disasters, being kidnapped or terrorized, etc.)

### OVERVIEW OF PSYCHOLOGICAL SCHOOLS OF THOUGHT

- **Psychoanalytic:** Early development molds the personality and adaptation; the determinants of behavior are largely subconscious processes.
- **Neo-Freudian:** Focus is on pathological social and interpersonal relationships.
- **Behavioristic:** Faulty learning and conditioning processes produce abnormality; the determinants of behavior can usually be understood only by investigating overt observable behavior.
- **Humanism:** Focus is on how blocked personal growth and value conflicts lead to abnormality.

### PSYCHOANALYTIC PERSPECTIVE

- **Objective Anxiety:** Fear and detectable anxiety.
- **Neurotic Anxiety:** (i.e., "free-floating" anxiety): Fear of the actualization of repressed sexually destructive drives. Fear that the individuals will lose control and act out their drives. In such situations, the ego may create various defense mechanisms.
- **Superego Anxiety:** A guilty conscience.
- **Treatment Methodology:** Does not give direct advice, but attempts to assist patients to gain insight into the conditions of their illnesses.
- **Defense Mechanisms:** Function to keep the drives repressed, and prevent the individual from acting them out. The defense mechanism is itself subconscious, because if the person were aware of it, then the patient would be aware of the drives the mechanism is defending against.

The most productive defense mechanism is sublimation. Sublimation is the re-direction of sexual energy into productive, socially approved areas. The major function and advantages of defense mechanisms are to prevent the ego from being overwhelmed by anxiety.

- **Disadvantages of Employing Defense Mechanisms:** Emotional rigidity and avoidance of problems instead of solving them, resulting in less authenticity and spontaneity; less-efficient ego due to wasting energy.

## A COMPENDIUM: DEFENSE MECHANISMS

- **Reaction Formation:** Manifesting behaviors or proclaiming intentions the very opposite of one's actual unacceptable intentions; e.g., adulterous spouses frequently pronounce their fidelity.
- **Projection Formation:** Accusing another of the very tendencies that one finds anxiety-provoking and unacceptable in oneself; e.g., persons who have been unfaithful (or are considering the same) make frequent jealous accusations against their spouses.
- **Denial:** Denying the existence of an anxiety-provoking situation; e.g., the spouse confronted with evidence of infidelity by his/her partner simply dismisses the evidence as irrelevant because his/her partner would "never do such a thing."
- **Repression:** Excluding stressful thoughts, impulses, and memories from conscious awareness; e.g., a witness to a ghastly accident may be unable to recall any details of the event. Forgetting certain events, physical debilitation, and emotional stolidity are some manifestations of repression.
- **Displacement:** Substituting a less-threatening object for one causing anxiety and directing reactive impulses toward the substitute; e.g., a boy who is constantly belittled and teased by older classmates may go home and torment his younger sibling.
- **Regression:** Manifesting behaviors which are clearly infantile or immature relative to a person's chronological age; e.g., a young woman married to an older man may refer to him as "daddy" and act as a child when confronted with severe stress.
- **Rationalization:** Explaining away, in a seemingly logical manner, unacceptable situations, events, feelings, thoughts, or intentions. There are two basic kinds of rationalization:
  a. **Sour-Grapes Rationalization:** A desirable object/result is devalued when the individual fails to achieve it; e.g., a man whose marriage proposal is rejected may comment that "she was too pretty anyway, and would have caused me nothing but worry and insecurity." This keeps him from feeling the full extent of his sadness from being rejected.
  b. **Sweet-Lemons Rationalization:** A less-than-desirable object/result that is gained is overvalued; thus, the amount of dissatisfaction the person feels is minimized; e.g., a woman who is married to a dull, unattractive, unsuccessful man may comment "but he is always faithful and he is my guy."

# THE BEHAVIORAL MODEL

Reaction to the unscientific, and unobservable, nature of psychoanalysis and introspective psychology. This approach emphasizes the scientific method in dealing with abnormality, and only observable phenomenon are taken into consideration.

Behaviorism ordinarily presupposes that all behaviors are learned through conditioning. Cognitive behaviorism recognizes non-observable phenomenom that also affect behavior, such as thoughts and ideas (it is argued that these can be considered observable phenomena as long as we allow that the observation can be made by "an audience of one," namely, the person having the thought or idea). Behaviorism is totally deterministic and denies the existence of free will; its treatment methods are most applicable to specific disorders (e.g., phobias).

## PARADIGM OF BEHAVIORAL THERAPY

Behavior therapy includes any technique based upon conditioning principles/theory. Theory does not appeal to any cognitive causes to explain behavior unless reference to cognitive causes can be translated away operationally or "anchored" to overt observable behavior. "Exemplars" are frequently utilized as models of research strategy (e.g., Waton's "Little Albert experiment"; Pavlov's classical conditioning of dogs; Skinner's operant conditioning of pigeons, etc.)

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## LEXICON OF BEHAVIORISTIC TERMINOLOGY

- **Reinforcer:** Event, object, or stimulus that increases the frequency of the behavior it follows.
- **Stimulus:** Typically, an enviromental event that elicits a behavioral response from an organism.
- **Response:** A physiological and/or behavioral reaction to some environmental stimulus.
- **Unconditioned Response:** A seemingly previously unlearned—i.e., unconditioned—response to a stimulus; e.g., some operant conditioning learning theorists hypothesize that the only unconditioned response the human organism is born with is anxiety as a response to unexpected loud noises or sudden loss of support. It is thought that all other responses are learned through stimulus generalization, reinforcement, chaining, or shaping.
- **Conditioned Response:** Any response that is followed by a reinforcer will have the probability of its reoccurrence increased. A conditioned response occurs only when a reinforcer is present.
- **Orientation:** The propensity of an organism to attend to a novel stimulus—e.g., one notices and becomes alert when one hears an unfamiliar sound in the middle of the night.
- **Habituation:** The tendency of an organism to become less responsive and become desensitized upon repeated exposure to the same stimulus—e.g., persons living near an airport may not be bothered by the loud sound of over-flying aircraft because they have become habituated to the noise.
- **Stimulus Generalization:** The propensity of an organism to exhibit the same response to a different but similar stimulus—e.g., in Watson's "Little Albert" experiment, the infant was initially conditioned to respond with fear to a white rabbit. However, he soon generalized this response to any white furry object.
- **Extinction:** The process of disconnecting the contingency between a behavior and its consequences—e.g., in treating phobias with "systematic desensitization," the fear-provoking stimulus is gradually paired with a calm response, thus eliciting an extinction of the phobic response.

## TREATMENT METHODOLOGY

Behavior therapy is increasingly cognitivistic in its approaches as a response to the tacit recognition that appeals to some mentalistic variables which seem necessary to successfully address some disorders. Thus, systematic desensitization employs techniques of mental imagery; rational emotive therapy studies the maladaptive affect of irrational ideas. Still, these techniques seem best suited for behaviors which can be narrowly operationally specified phobias, sexual dysfunctions, etc.

# DIAGNOSTIC CLASSIFICATION OF MENTAL ILLNESS

## PROPOSED BIOLOGICAL CAUSES:

Compelling evidence suggests that schizophrenia may have an organic cause which may be hereditary. If this is true, the medical model would afford the best course of treatment.

**Causes may be:**

- **Brain abnormalities,** such as imbalances in certain neurotransmitters (e.g., serotonin).
- **Neurophysiological abnormalities,** such as faulty neuron circuitry.

**The question is:** Is brain pathology the cause or the effect of a disorder?

## CAUSAL ATTRIBUTIONS

*Proposed causal explanations for neuroses include the following*:

- **Behaviorist:** Stress is a stimulus for anxiety. The neurotic behavior functions as a negative reinforcer for the amelioration of stress; thus, the resultant reduction in anxiety prompts further avoidance responses which further reinforce the neurotic behavior, thus initiating a vicious cycle.
- **Psychoanalytic:** An unacceptable id impulse triggers anxiety, eliciting the utilization of a defense mechanism as an avoidance mechanism for the anxiety, once again instigating a vicious cycle.

Freud claims phobic reactions occurred when anxiety was displaced from an unacceptable object to a neutral object; whereas, behaviorists argue that phobia is caused by classical conditioning. Behavior modification is the most effective treatment for phobias.

- **General Proposed Eclectic Causes:** Faulty personality development due to parental dysfunction or toxic social conditions. Negative self-concept feedback from primary group in early development. Faulty learning and conditioning of maladaptive behavior patterns. Interpersonal theorists argue that a conflict between peer-group norms and parental norms can also cause neurotic behaviors.
- **Psychological and Personal Factors:** Characteristics in the subject produce the neurosis. Specific problems that could be readily treated were focused upon. Subject may view the world as threatening, dangerous, and overwhelming. As a response, he/she may build "a wall" around himself/herself to block out the perceived threat of the world, at the same time isolating himself/herself.
- **Biological Organic Defect:** No conclusive evidence exists for an organic cause of neuroses.

## TREATMENT METHODOLOGY

*Various treatment strategies have been developed and proposed for neuroses, including*:

- **Anti-Anxiety Drugs:** Sometimes thought to only "mask" the symptoms and not treat the actual disorder.
- **Behavior Modification:** Views the symptoms as the problem, and changes environmental factors that allegedly maintain the disorder.
- **Cognitive Behavior Therapy:** i.e., rational emotive therapy proposes changing deficient thought patterns of the neurotic, which may change behavior. This presupposes that cognition causes behavior and ignores the possibility that the cause of neurotic behavior may not be manifest to conscious awareness.

**WARNING:** The following summary of mental illness categories is provided only for general information purposes and/or to facilitate study in advanced courses in abnormal psychology. Any attempt to use this guide as a means of diagnosing, labeling, or categorizing any person as "mentally ill" is entirely unwarranted and inappropriate. Such diagnoses should only be attempted with the aid of a mental-health professional with credentials.

# DSM-IV CLASSIFICATIONS

The DSM-IV utilizes a multi-axial system of assessment on several axes. The five axes included in this multi-axial classification are:

**Axis I:** Clinical Disorders
*Other Conditions That May Be a Focus of Clinical Attention*
**Axis II:** Personality Disorders and Mental Retardation
**Axis III:** General Medical Conditions
**Axis IV:** Psychosocial and Environmental Problems
**Axis V:** Global Assessment of Functioning

## DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE

- **Mental Retardation:** Characterized by significantly below-average intellectual functioning accompanied by significant impairment in adaptive abilities in at least two of the following cases: self-care, home living, social skills, use of community resources, self-direction, academic skills, work, leisure, health, and safety.
- **Motor Skills Disorder:** Characterized by marked impairment in motor coordination. Diagnosis only applies if the impairment significantly restricts academic or daily living activities; the condition is not due to any known medical condition, and criteria are not met for pervasive developmental disorder.
- **Communications Disorders:** Essential feature includes significantly substandard performance on standardized measures of expressive language development on measures of both nonverbal, intellectual ability and receptive language development.
- **Pervasive Developmental Disorders:** Characterized by severe, pervasive developmental impairment, including areas: reciprocal social interaction skills, communication, skills, or the presence of stereotyped behavior, interests, and activities. The qualitative defining impairments are distinctively deviant relative to the individual's mental age or developmental level.
- **Attention-Deficit and Disruptive Behavior Disorders:** Notable feature is the presence of hyperactivity/impulsivity and inattention at levels in excess of and prevalence more frequent than is observed in individuals of comparable stages of development.
- **Feeding or Eating Disorders of Infancy or Early Childhood:** Essential feature is the presence of persistent feeding and eating disturbances; includes pica, rumination disorder, and feeding disorder of infancy or early childhood.
- **Tic Disorders:** Characterized by a sudden, rapid, recurrent, non-rhythmic, stereotyped vocalization or motor movement; includes Tourette's disorder, chronic motor or vocal tic disorder, transient tic disorder, and tic disorder NOS (Not Otherwise Specified).
- **Elimination Disorders:** Two subcategories include encopresis and enuresis. The condition is usually involuntary, and primary physiological causes should be ruled out. Encopresis involves defecation in inap-

propriate places or occasions. Enuresis involves urination in inappropriate places or occasions. To qualify for diagnosis, the condition needs to be present for prolonged periods with frequently repeated incidents.

## OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

- **Separation Anxiety Disorder:** Essential feature is the onset of excessive anxiety upon separation from home or close personal attachments. Anxiety manifest is greater than what is expected of individuals at a similar maturational level.
  - **Selective Mutism:** Characterized by a persistent failure to speak in specific social situations where speaking is expected, yet speaking in other situations. Must interfere with social, educational, or vocational achievement. Diagnosis is not warranted when condition can be explained by feelings of social or cultural awkwardness, or if disturbance can be accounted for by embarrassment related to some form of pervasive developmental disorder or psychotic disorder.
- **Reactive Attachment Disorder of Infancy or Early Childhood:** Usually associated with pathological care, the disturbance is characterized by disturbed and developmentally inappropriate social relatedness in most contexts. Onset of the disorder is generally before age five. Condition is not accounted for by only developmental delay or pervasive developmental disorder.
- **Stereotypic Movement Disorder:** Characterized by repetitive, seemingly driven, nonfunctional motor behavior. Behavior interferes with normal activities or has the propensity to cause self-inflicted injury. Behavior is not better accounted for by compulsion, a nervous tic, or a stereotype that is part of pervasive developmental disorder. Physiological effects of a substance or a general medical condition also need to be ruled out.
- **Disorders of Infancy, Childhood, or Adolescence NOS (Not Otherwise Specified):** A residual category for disorders, with onset in infancy, childhood, or adolescence, that cannot accurately be included in other classification.

## DELIRIUM, DEMENTIA, AMNESTIC & OTHER COGNITIVE DISORDERS

- **Delirium:** Essential feature of condition is a disturbance of consciousness and an alteration in cognition that develops over a short interval. Subtypes include: delirium due to general medical condition, substance-induced delirium, delirium due to multiple etiologies, and delirium NOS.
  - **Dementia:** Essential features include multiple cognitive deficits that include memory impairment. The dementias are also categorized according to presumed etiology; for example, Alzheimer's type, substance-induced, etc.
- **Amnestic Disorder:** These are disorders that include memory impairment in the absence of significant cognitive impairments. Also listed according to presumed etiology; for example, substance-induced, due to general medical condition, etc.

## MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED

- **Catatonic Disorder Due to a General Medical Condition:** Characterized by the presence of catatonia attributed to the direct physiological effects of a general medical condition. Catatonia is manifested by such symptoms as motoric immobility, excessive motor activity, extreme negativism, mutism, peculiar voluntary movement, echolalia, or echopraxia.
- **Personality Change Due to a General Medical Condition:** Indicated by the presence of a persistent personality disturbance, attributed to the direct physiological effects of a general medical condition. The personality disturbance must manifest a significant change from the individual's previous characteristic personality pattern.
- **Mental Disorder NOS Due to a General Medical Condition:** A residual category applicable to cases wherein it is established that a disturbance is due to the direct physiological effects of a general medical condition, but the criteria for any other specific mental disorders due to a general medical condition are not met.

## SUBSTANCE-RELATED DISORDERS

This broad classification encompasses any disorder related to the ingestion or exposure to a drug of abuse, the side effects of medications, or to a toxin. A wide range of substances can play a causal role in such disorders. For example, alcohol, cannabis, cocaine, hallucinogens, etc., as well as idiosyncratic reactions to various medications. Lastly, many toxins can instigate these disorders, including carbon monoxide, heavy metals, carbon dioxide, etc.

## SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS

- **Schizophrenia:** Characterized by grossly disorganized affect, behavior, and conditions. Condition lasts at least six months and includes at least one month of active phase symptoms of at least two of the following: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior. Furthermore, several subcategories of this disturbance are identified, including paranoid, disorganized, catatonic, undifferentiated and residual.
- **Schizophreniform Disorder:** Symptomatology equivalent to schizophrenia but disturbance is of less duration (one to six months) and is not accompanied by a decline in functioning.
- **Schizoaffective Disorder:** Condition characterized by a mood disorder episode wherein active-phase symptoms of schizophrenia occur with and are preceded or followed by at least two weeks of delusions and hallucinations in the absence of prominent mood symptoms.
- **Delusional Disorder:** Essential features include at least one month of non-bizarre delusions in the absence of other active phase symptoms of schizophrenia.
- **Brief Psychotic Disorder:** A psychotic disturbance with a duration of one to 30 days.
- **Shared Psychotic Disorder:** Disturbance developing in an individual influenced by someone else manifesting delusions with a similar content.
- **Psychotic Disorder Due to General Medical Condition:** Disturbance such that the psychotic symptoms are attributed to the direct physiological effect of a general medical condition.
- **Substance-Induced Psychotic Disorder:** Psychotic symptoms are attributed to the direct physiological effect of a drug, medication, or toxin.
- **Psychotic Disorder NOS:** Residual category for classifying psychotic disorders that do not meet the criteria for any specific psychotic disorder or manifest psychotic symptomatology about which there is inadequate or contradictory data.

## MOOD DISORDERS

*Depressive disorders are subcategorized as follows*:

- **Major Depressive Disorder:** Characterized by at least two weeks of depressed mood or loss of interest, accompanied by at least four additional symptoms of depression.
- **Dysthymic Disorder:** Indicated by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet the criteria for major depressive episode.
- **Depressive Disorder NOS:** Encompasses disorders with depressive features that do not meet the criteria for other specific depressive mood disorders.

*Bipolar disorders are subcategorized as follows*:

- **Bipolar I Disorder:** Indicated by at least one manic or mixed episode, with intermittent major depressive episodes.
- **Bipolar II Disorder:** Characterized by at least one major depressive episode accompanied by at least one hypomanic episode.
- **Cyclothymic Disorder:** Is evidenced by at least two years of numerous periods of hypomanic symptoms that do not meet the criteria for manic episode and numerous periods of depressive symptoms that do not meet the criteria for major depressive episode.
- **Bipolar Disorder NOS:** Includes disorders with bipolar features that nonetheless cannot be categorized in any of the specific bipolar disorders.

*Other mood disorders are subcategorized as follows*:

- **Mood Disorder Due to General Medical Condition:** Indicated by a prominent and persistent disturbance in mood attributed to the direct physiological effect of a general medical condition.
- **Substance-Induced Mood Disorder:** Indicated by a significant and persistent disturbance in mood best attributed to the direct physiological effect of a drug of abuse, a medication, another somatic treatment for depression, or exposure to a toxin.
- **Mood Disorder NOS:** A residual disorder for classifying disorders with mood symptoms that cannot be categorized as any specific mood-disorder, and are difficult to categorize as depressive disorder NOS or bipolar disorder NOS.

## ANXIETY DISORDERS

These disorders are frequently characterized by "panic attacks," discrete periods wherein the individual experiences fear, even terror, oftentimes concurrently with feelings of doom. Physiological correlates may include symptoms such as palpitation, shortness of breath, sweating, chest pain, feelings of suffocation, and a feeling of "losing control" and fear of "going crazy." Furthermore, such disorders oftentimes include elements of "agoraphobia," avoidance of, and anxiety about, places or situations, from which escape might be difficult or embarrassing.

- **Panic Disorder Without Agoraphobia:** Manifested by recurrent unexpected panic attacks, about which there is persistent concern. Panic disorder with agoraphobia would include agoraphobia as an additional element.
- **Agoraphobia Without History of Panic Disorder:** Indicated by the occurrence of agoraphobia and panic-like symptoms without a history of unexpected panic attacks.
- **Specific Phobia:** Essential feature includes clinically significant anxiety elicited by the presence of a feared object or situation, often accompanied by avoidance behavior.
- **Social Phobia:** Characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.
- **Obsessive-Compulsive Disorder:** Manifested by obsessions (causing marked anxiety and distress) and/or by compulsions (which serve to neutralize anxiety). The obsessions are frequently specific recurring thoughts, whereas compulsions are repetitious ritualistic behavior, which are performed.
- **Post-Traumatic Stress Disorder:** Manifested by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with trauma.
- **Acute Stress Disorder:** Indicted by symptoms similar to post-traumatic stress disorder, occurring in the immediate aftermath of an extremely traumatic event.
- **Generalized Anxiety Disorder:** Characterized by at least six months of persistent and excessive anxiety and worry.

Anxiety disorders due to a general medical condition, substance-induced, or NOS have similar characterizations as in previous sections.

## SOMATOFORM DISORDERS

This category encompasses disorders characterized by the presence of observable physical symptoms that are indicative of a general medical condition, yet are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder. The symptoms must cause clinically significant distress or impairment in social, vocational, or other areas of functioning. Furthermore, the symptoms must be unintentional (not under voluntary control). Some subcategories include the following:

- **Conversion Disorder:** Indicated by unexplained symptoms or deficits affecting voluntary motor or sensory functions that suggest a neurological or other general medical condition. Psychological factors are believed to be involved with the symptoms or deficits.
- **Pain Disorder**: Characterized by pain as the predominant focus of clinical attention. Psychological factors are judged to play an important role in the onset, severity, exacerbation or maintenance of the pain.
- **Hypochondriasis:** The preoccupation with the fear of having, or the idea that one is afflicted with, a serious disease based upon the individual's misinterpretation of bodily symptoms or functions.
- **Body Dysmorphic Disorder:** The preoccupation with an exaggerated or imagined effect in physical appearance.

## FACTITIOUS DISORDERS

These disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned in order to pretend to be ill. The conclusion that a particular symptom is intentionally produced is made by reference to direct evidence (for example, the individual is found to be in possession of drugs that can produce the symptoms) or by a process of elimination whereby alternative causes are ruled-out.

## DISSOCIATIVE DISORDERS

The essential feature of these disorders is a disruption in the integration of consciousness as this relates to memory, identity, or perception of the environment. Such disturbances may be gradual, transient and chronic. The following categories have been identified:

- **Dissociative Amnesia:** The inability to recall important personal information, usually of a traumatic or stressful nature, that cannot be explained with ordinary forgetfulness.
- **Dissociative Fugue:** Characterized by episodes of sudden, unexpected travel away from home or one's ordinary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity.
- **Dissociative Identity Disorder (Formerly Multiple Personality Disorder):** Essential features include the presence of two or more distinct personality states or identities that recurrently assume control of the individual's behavior, accompanied with the inability to recall important personal information that is too extensive to be accounted for by ordinary forgetfulness.
- **Depersonalization Disorder:** Characterized by a persistent and recurring feeling of being estranged from one's self, of being a spectator of one's own life, and of being detached from one's mental processes or body that is accompanied by intact reality testing (that is, the individual is aware that this is only a feeling of self-alienation and not reality as such).

## SEXUAL & GENDER IDENTITY DISORDERS

- Sexual dysfunctions are indicated by disturbances in sexual desire and in the psychophysiological changes that characterize the sexual response cycle, and cause marked distress and interpersonal difficulty. Furthermore, disturbance is not better accounted for by another Axis I disorder (except another sexual dysfunction) and is not due exclusively to the direct physiological affects of a substance or a general medical condition.
- Paraphilias are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Gender identity disorders are manifested by strong, persistent cross-gender identification accompanied with persistent discomfort with one's sex.

## SEXUAL DYSFUNCTIONS

*Sexual Desire Disorders*

- **Hypoactive Sexual Desire Disorder:** Indicated by a deficiency or absence of sexual fantasies and desire for sexual activity.

- **Sexual Aversion Disorder:** Characterized by the aversion to and active avoidance of genital sexual contact with a sexual partner.

*Sexual Arousal Disorders*

- **Female Sexual Arousal Disorder:** Indicated by the persistent, recurrent inability to attain, or maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.
- **Male Erectile Disorder:** Indicated by the persistent, recurrent inability to attain, or maintain until the completion of the sexual activity, an adequate erection.

*Orgasmic Disorders*

- **Female Orgasmic Disorders (Formerly Inhibited Female Orgasm):** Characterized by persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Since women manifest wide variability in their orgasmic response, this diagnosis should be made with care; such factors as age, sexual experience, general health, and the degree of sexual stimulation applied should all be weighed carefully.
- **Male Orgasmic Disorder (Formerly Inhibited Male Orgasm):** Characterized by a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Again, factors involving age, experience, general health, and focus and intensity of stimulation received should be carefully considered. Most commonly, this disturbance may cause the male to be unable to reach orgasm in intercourse, though orgasm can be achieved via other means (for example, autoerotically, or by a partner's manual or oral stimulation).

*Sexual Pain Disorders*

- **Dyspareunia (Not Due to a General Medical Condition):** Indicated by genital pain experienced with sexual intercourse; although most commonly present during intercourse, the pain may also be present before or after intercourse. Both males and females can be effected.
- **Vaginismus (Not Due to a General Medical Condition):** Essential features include the persistent or recurrent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration is attempted with a penis, finger, tampon, or speculum.

*Sexual Dysfunction Due To A General Medical Condition*: Indicated by the presence of a clinically significant sexual dysfunction best attributed exclusively to the direct physiological effects of a general medical condition. Disturbances may involve pain during intercourse, hypoactive sexual desire, male erectile dysfunction, etc.

*Paraphilias*

- **Exhibitionism:** Involves deriving sexual pleasure or excitement from exposing one's genitals to a stranger. Occasionally, the individual masturbates while exposing himself/herself. There is usually no attempt to initiate sexual activity with the stranger.
- **Fetishism:** Involves the utilization of non-living objects (the "fetish") for purposes of deriving sexual pleasure or producing sexual excitement. The absence of the fetish may be accompanied by erectile dysfunction in males.
- **Pedophilia:** Involves sexual activity with a prepubescent child (usually younger than 13 years of age); the pedophile must be at least 16 years of age and at least five years older than the child. Both sexual maturity of the child and the age difference must be taken into account.
- **Sexual Masochism:** Involves acts (real, not simulated) in which the individual derives sexual excitement from being humiliated, beaten, bound, or otherwise made to suffer.
- **Sexual Sadism:** Involves acts (real, not simulated) in which the individual derives sexual excitement from the physical or psychological suffering (including humiliation) of the victim.
- **Transvestic Fetishism:** Involves cross-dressing for the purpose of deriving sexual pleasure or excitement. Typically, a male masturbates while he is cross-dressed, imagining himself to be both the male subject and female object of a sexual fantasy. This disorder is only described for heterosexual males and is not indicated when the cross-dressing occurs as an element of gender identity disorder.
- **Voyeurism:** Involves the surreptitious observation of unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The act of looking is to achieve sexual excitement and possibly orgasm if masturbation is engaged in concurrently with the act of voyeurism. Generally, no sexual activity is sought with the individual observed.
- **Paraphilia NOS:** Residual category to include coding paraphilias that do not meet the criteria of the specific categories. Examples include, but are not limited to, necrophilia (corpses), partialism (exclusive focus on part of the body), zoophilia (non-human animals), coprophilia (feces), klismaphilia (enemas), urophilia (urine), and telephone scatologia (obscene phone calls).

## GENDER IDENTITY DISORDERS

*Two criteria must be satisfied for this diagnosis to apply*:

- There must be a strong and persistent cross-gender identification that is not due merely to a desire to attain the perceived cultural or social advantages of being the other sex.
- There must also be present a persistent discomfort with one's sex or a sense of inappropriateness in the gender role of that sex.

## EATING DISORDERS

- **Anorexia Nervosa:** Characterized by the individual's refusal to maintain a minimally normal body weight, intense fear of gaining weight, and significantly distorted perception of the shape and size of one's body.
- **Bulimia Nervosa:** Characterized by binge eating and inappropriate compensatory methods to prevent weight gain (for example, induced vomiting, misuse of laxatives and diuretics, etc.) Furthermore, self-evaluation is excessively influenced by body shape and weight.

## SLEEP DISORDERS

*Primary Sleep Disorders*: Are sleep disorders wherein the causal role of another mental disorder, a general medical condition, or a substance, have been ruled out. Two subcategories include:

- **Dyssomnias:** Abnormalities in the amount, quality, or timing of sleep. Hence, such disturbances as primary insomnia, primary hypersomnia, and narcolepsy would be included.
- **Parasomnias:** Indicated by abnormal behavioral or physiological events occurring in association with sleep, specific sleep stages, or sleep-wake transitions. Hence, such disturbances as nightmares, sleep terror, and sleepwalking would be included.

## IMPULSE-CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED

The essential feature of these disorders is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to self or others. Typically, the individual experiences increased tension or arousal before committing the act, followed by relief, pleasure, or gratification after completion of the act. Ensuing feelings of guilt, regret, or self-recrimination may or may not be present.

- **Intermittent Explosive Disorder:** Characterized by discrete episodes of failure to restrain aggressive impulses, resulting in serious assaults or destruction of property. The degree of aggressiveness displayed is grossly disproportionate to the objective physical or psychological provocation.
- **Kleptomania:** Indicated by the repeated failure to resist impulses to steal objects not needed for personal use or monetary value. The theft is not due to vengeance, need for survival, nor is it due to hallucinations.
- **Pyromania:** Essential feature is the ignition of fires for pleasure, gratification and relief of tension. There is a fascination with, curiosity about, and attraction to situational contexts with fire, witnessing its effects, or participating in its aftermath.
- **Pathological Gambling:** Indicated by persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits.
- **Trichotillomania:** Essential feature is the recurrent pulling out of one's hair for pleasure, gratification, or relief of tension that results in noticeable hair loss.

## ADJUSTMENT DISORDERS

Characterized by the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors. Such stressors may include a romantic break-up, business or financial difficulties, or marital discord, etc.

## PERSONALITY DISORDERS

Enduring patterns of inner experience and behavior that significantly deviates from the expectations of the individual's culture, is pervasive and inflexible, originates in adolescence or early adulthood, is stable over time, and leads to clinically significant distress or impairment in one or more important areas of functioning (e.g., social, academic, or occupational).

- **Paranoid Personality Disorder:** Indicated by a pattern of pervasive distrust and suspiciousness of others, such that their motives are interpreted as malevolent. Events and the actions of others are interpreted in the most negative light possible, and convictions of others' hostility are based on little or no objective evidence.
- **Schizoid Personality Disorder:** Essential features include a pervasive pattern of detachment from social relationships and a restricted range of emotions in interpersonal settings. The individual typically will avoid social interaction, prefers solitary activities and interests, and seems to derive little or no pleasure from sensory, bodily, or interpersonal relationships. Affect is usually "flat" and expressionless, and there is a preference for abstract intellectual interests, such as mechanical, mathematical, or computer-related pursuits.
- **Schizotypal Personality Disorder:** Characterized by a pervasive pattern of 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. Individuals will frequently have incorrect interpretations of casual incidents and external events as being especially meaningful. These beliefs are not held, however, with delusional conviction. The individual may nonetheless be superstitious or preoccupied with the paranormal to a degree inordinate for his/her specific cultural milieu. "Magical" and superstitious fallacious thinking is also common.
- **Antisocial Personality Disorder (also referred to as Psychopathy, Sociopathy, or Dyssocial Personality Disorder):** Essential features include a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Deceit, manipulation, and exploitation are central characteristics of this personality disorder. A pattern of impulsivity may also be present, such that decisions are made capriciously, with little or no forethought or planning.
- **Borderline Personality Disorder:** Indicated by a pervasive pattern of instability in interpersonal relationships, of self-image and affects, accompanied by marked impulsivity with an onset in early adulthood and present in a variety of contexts. Individual will often be intensely concerned with abandonment and will go to great lengths to avoid real or imagined abandonment. The perception of impending loss, rejection, separation, or abandonment or the loss of external stability and structure can produce profound alterations in self-image, affect, cognition and behavior.
- **Histrionic Personality Disorder:** Characterized by pervasive and excessive emotionality and attention-seeking behavior, originating in early adulthood and manifesting in a variety of contexts. Individual feels uncomfortable and unappreciated if he/she is not the center of attention. Individuals with this disorder will often behave in a melodramatic, histrionic, and flirtatious manner.
- **Narcissistic Personality Disorder:** Characterized by a pervasive pattern of grandiosity, need for admiration, and lack of empathy, with an onset in early adulthood and manifest in a variety of contexts. The individual has an exaggerated sense of self-importance, often displaying a conceited, boastful demeanor while overestimating his/her abilities and accomplishments.
- **Avoidant Personality Disorder:** Characterized by an inordinate preoccupation with being disapproved of, socially rejected, or criticized. Individual suffers from chronic feelings of inadequacy and is hypersensitive to the possible negative evaluations of others. Typically, significant interpersonal or social involvement is avoided, due to fear of being exposed, ridiculed, or embarrassed. Due to constant need for reassurance, security, and certainty of acceptance, individual often leads a rather isolated or restricted social existence.
- **Dependent Personality Disorder:** Indicated by an inordinate and chronic need to be taken care of, resulting in submissive clinging behavior and a fear of separation, abandonment, or rejection. Due to a self-perception of being unable to function without the help of others, the individual displays a variety of submissive and dependent behaviors so as to elicit care giving and nurturing behavior from others. Individual tends to be indecisive about even everyday matters, and requires much advice and reassurance from others due to his/her extremely passive nature.
- **Obsessive-Compulsive Personality Disorder:** Essential features include an extreme preoccupation with order, systematization, and organization. Many repetitive rituals are engaged in to ensure a sense of control and stability, and individual abhors any unpredictability, chaos, or spontaneity in his/her lives. Rules, orderliness, perfectionism, fastidiousness, and priggish morality often characterize behavior associated with this disorder. The punctiliousness and excessive attention to detail not only stifle any creativity, spontaneity or flexibility in the individual's life, but ultimately prove self-defeating in that the major point of the activity is defeated in as much as the inordinate time spent "perfecting" a project.
- **Personality Disorder NOS:** Residual category for classifying disorders which, while manifesting some of the criteria of the various specific personality disorders, nonetheless do not meet all the criteria for any one of them.

## OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

This broad category encompasses conditions or problems that may be a focus of clinical attention in that they are coded on Axis I and related to the previously described mental disorders in the following manners:

- Although the individual has no mental disorder, the problem is the focus of diagnosis or treatment.
- The individual suffers from a mental disorder unrelated to the problem, which is the focus of the initial diagnosis or treatment.
- The individual suffers from a mental disorder that is related to the problem, and the problem is sufficiently severe to warrant independent clinical attention.



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