

KAPLAN & SADOCK'S
STUDY GUIDE AND
SELF-EXAMINATION
REVIEW IN PSYCHIATRY

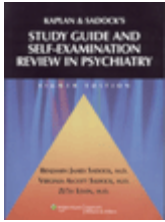
E I G H T H E D I T I O N

BENJAMIN JAMES SADOCK, M.D.
VIRGINIA ALCOTT SADOCK, M.D.
ZE'EV LEVIN, M.D.



Wolters Kluwer
Health

Lippincott
Williams & Wilkins



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition



© 2007

Lippincott Williams & Wilkins

Philadelphia

530 Walnut Street, Philadelphia, PA 19106 USA, LWW.com

978-0-7817-8043-8

© 2007 by LIPPINCOTT WILLIAMS & WILKINS, a WOLTERS KLUWER BUSINESS

530 Walnut Street, Philadelphia, PA 19106 USA, LWW.com

"Kaplan Sadock Psychiatry" with the pyramid logo is a trademark of Lippincott Williams & Wilkins.

All rights reserved. This book is protected by copyright. No part of this book may be reproduced in any form or by any means, including photocopying, or utilized by any information storage and retrieval system without written permission from the copyright owner, except for brief quotations embodied in critical articles and reviews. Materials appearing in this book prepared by individuals as part of their official duties as U.S. government employees are not covered by the above-mentioned copyright.

Printed in the USA

Library of Congress Cataloging-in-Publication Data

Sadock, Benjamin J., 1933–

Kaplan & Sadock's study guide and self-examination review in psychiatry / Benjamin James Sadock, Virginia Alcott Sadock. —8th ed.

p. cm.

Includes bibliographical references and index.

ISBN 978-0-7817-8043-8 (alk. paper)

1. Psychiatry—Examinations—Study guides. 2. Psychiatry—Examinations, questions, etc. I. Sadock, Virginia A. II. Title. III. Title: Kaplan and Sadock's study guide and self-examination review in psychiatry. IV. Title: Study guide and self-examination review in psychiatry.

RC454.K36 2007

616.890076—dc22

2007010764

Care has been taken to confirm the accuracy of the information presented and to describe generally accepted practices. However, the authors, editors, and publisher are not responsible for errors or omissions or for any consequences from application of the information in this book and make no warranty, expressed or implied, with respect to the currency, completeness, or accuracy of the contents of the publication. Application of this information in a particular situation remains the professional responsibility of the practitioner.

The authors, editors, and publisher have exerted every effort to ensure that drug selection and dosage set forth in this text are in accordance with current recommendations and practice at the time of publication. However, in view of ongoing research, changes in government regulations, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check the package insert for each drug for any change in indications and dosage and for added warnings and precautions. This is particularly important when the recommended agent is a new or infrequently employed drug.

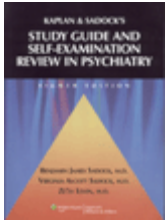
Some drugs and medical devices presented in this publication have Food and Drug Administration (FDA) clearance for limited use in restricted research settings. It is the responsibility of the health care provider to ascertain the FDA status of each drug or device planned for use in their clinical practice.

To purchase additional copies of this book, call our customer service department at (800) 638-3030 or fax orders to (301) 223-2320. International customers should call (301)223-2300.

Visit Lippincott Williams & Wilkins on the Internet: at LWW.com. Lippincott Williams & Wilkins customer service representatives are available from 8:30 am to 6 pm, EST.

10 9 8 7 6 5 4 3 2 1





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](http://www.lww.com)



Editors

Benjamin James Sadock M.D.

Menas S. Gregory Professor of Psychiatry and Vice Chairman

Department of Psychiatry, New York University School of Medicine; Attending Psychiatrist, Tisch Hospital; Attending Psychiatrist, Bellevue Hospital Center; Consulting Psychiatrist, Lenox Hill Hospital, New York, New York

Virginia Alcott Sadock M.D.

Professor of Psychiatry

Department of Psychiatry, New York University School of Medicine; Attending Psychiatrist, Tisch Hospital; Attending Psychiatrist, Bellevue Hospital Center, New York, New York

Ze'ev Levin M.D.

Clinical Associate Professor of Psychiatry

Department of Psychiatry, New York University School of Medicine, New York, New York

Contributing Editors

Matt Biel M.D.

Instructor in Psychiatry and Fellow in Child Psychiatry

New York University School of Medicine, New York, New York

Nikole Benders M.D.

Instructor in Psychiatry

New York University School of Medicine, New York, New York

Secondary Editors

Charles W. Mitchell

Acquisitions Editor

Joyce A. Murphy

Managing Editor

Katey Millet

Developmental Editor

Adam Glazer

Associate Director of Marketing

Bridgett Dougherty

Production Editor

Benjamin Rivera

Senior Manufacturing Manager

Stephen Druding

Design Coordinator

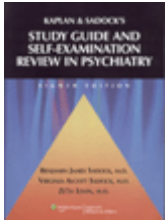
Aptara, Inc

Compositor

Quebecor World-Taunton

Printer





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



Preface

This new and improved eighth edition of *Study Guide and Self-Examination Review in Psychiatry* is designed to stand alone as a separate textbook to serve as a guide to the mastery of a tremendous amount of material relating to psychiatry and the behavioral sciences. The student will find questions of varying complexity that cover the etiology, diagnosis, and treatment of every known psychiatric disorder. This is coupled with a comprehensive discussion that covers not only correct answers but wrong answers as well. By carefully studying both questions and answers, the reader will gain a thorough understanding of material useful to prepare for examinations of all types. This book was written to meet the needs of medical students, psychiatric physicians, and mental health professionals from all fields. It is designed especially to help those preparing for the United States Medical Licensing Examination (USMLE) and the American Board of Psychiatry and Neurology (ABPN); it will also prove of value to all who want to test their knowledge in psychiatry as part of their continuing medical education.

The authors have added new and different questions to each edition of *Study Guide* and modified and updated material from earlier editions. This *Study Guide* contains more than 1,500 questions, more than any other book of its kind, and the format of each question is standardized to follow that used by the USMLE and ABPN. In addition, the allocation of topics is carefully weighted with attention to both clinical and theoretical issues.

The authors of the last edition of *Study Guide* are particularly pleased that Ze'ev Levin, M.D., a close personal and professional associate and outstanding academician, has joined them as third author. Dr. Levin is Associate Director of Residency Training in Psychiatry at NYU Medical Center and his participation has immeasurably facilitated and enhanced the preparation of this work. In addition, we wish to thank our two Contributing Editors: Matt Biel M.D. served as Contributing Editor in Child Psychiatry, and Nikole Benders, M.D. served as Contributing Editor in Adult Psychiatry.

Comprehensive Teaching System

Study Guide forms one part of a comprehensive system developed by the authors to facilitate the teaching of psychiatry and the behavioral sciences. At the head of the system is *Comprehensive Textbook of Psychiatry*, which is global in depth and scope; it is designed for and used by psychiatrists, behavioral scientists, and all other workers in the mental health field. *Kaplan & Sadock's Synopsis of Psychiatry* is a relatively brief, highly modified, original, and current version useful for medical students, psychiatric residents,

practicing psychiatrists, and other mental health professionals. A special edition of *Synopsis, Concise Textbook of Clinical Psychiatry*, covers just the diagnosis and treatment of all psychiatric disorders. Other parts of the system are the pocket handbooks: *Pocket Handbook of Clinical Psychiatry*, *Pocket Handbook of Psychiatric Drug Treatment*, *Pocket Handbook of Emergency Psychiatric Medicine*, and *Pocket Handbook of Primary Care Psychiatry*. These books cover the diagnosis and the treatment of mental disorders, psychopharmacology, psychiatric emergencies, and primary care psychiatry, respectively, and are compactly designed and concisely written to be carried in the pocket by clinical clerks and practicing physicians, whatever their specialty, to provide a quick reference. Finally, *Comprehensive Glossary of Psychiatry and Psychology* provides simply written definitions for psychiatrists and other physicians, psychologists, students, and other mental health professionals. Together, these books create a multiple approach to teaching, studying, and learning of psychiatry.

How to use This Book

Each chapter begins with an introduction that emphasizes areas of special significance about which the student should be aware. The authors have also prepared lists of helpful hints—now expanded and in alphabetical order—that present key terms and concepts essential to a basic knowledge of psychiatry. Students should be able to define and discuss each of the terms in depth as preparation for examinations.

The section *Objective Examinations in Psychiatry* provides the student with helpful hints on how to take the examinations. If the student understands how questions are constructed, his or her chances of answering correctly are greatly improved. This book defines distractors (wrong answers) as well as correct answers in each discussion.

To use this book most effectively, the student should attempt to answer all the questions in a particular chapter. By allowing about 1 minute for each answer, the student can approximate the time constraints of an actual written examination. The answers should be verified by referring to the corresponding answer section in each chapter. Pay particular attention to the discussion of the wrong answers, a feature unique to this book. If further information is needed, the reader is referred to the current editions of either the *Synopsis of Psychiatry* or the *Comprehensive Textbook of Psychiatry*.

Acknowledgements

In addition to the contributing editors mentioned above, we wish to thank Regina Furner who served as Project Editor and whose knowledge of the complex organization and format of the text was invaluable. Nitza Jones, Project Editor of *Synopsis* and *Comprehensive Textbook of Psychiatry*, also assisted in the preparation of the book. Others we wish to thank are Mryl Manley, M.D., Caroly S. Pataki, M.D., Norman Sussman, M.D., Michael Stanger, M.D., and Kathleen Rey.

We especially acknowledge James Sadock, M.D., and Victoria Gregg, M.D., for their help in their areas of expertise, emergency adult and emergency pediatric medicine, respectively.

At Lippincott Williams & Wilkins, we thank Joyce Murphy, Katey Millet, and Charley Mitchell. At Aptara we thank Judi Rohrbaugh.

We want to express our deep thanks to Robert Cancro, M.D., who retired after 28 years serving as Chairman of Psychiatry at New York University School of Medicine and who gave us his full support. He was succeeded as Chair in 2006 by Dolores Malaspina, M.D.,

to whom we extend a warm welcome as she leads the Department of Psychiatry into the 21st century.

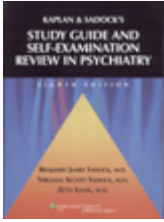
Finally, we want to acknowledge and thank Alan and Marilyn Zublatt for their generous support of this and other *Kaplan & Sadock* textbooks. Over the years they have been unselfish benefactors to many educational, clinical and research projects at the NYU Medical Center. We are deeply grateful for their help. We thank them not only for ourselves but also on behalf of all those at NYU—students, clinicians, and researchers—who have benefited from their extraordinary humanitarian vision.

B. J. S.

V. A. S.

New York University School of Medicine, New York, New York





Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins

Front of Book

[Editors](#)

[Preface](#)

Table of Contents

- 1 [The Patient–Doctor Relationship](#)
- 2 [Interviewing Techniques with Special Patient Populations](#)
- 3 [Normality](#)
- 4 [Human Development](#)
- 5 [The Brain and Behavior](#)
- 6 [Contributions of the Psychosocial Sciences to Human Behavior](#)
- 7 [Clinical Neuropsychological Testing](#)
- 8 [Theories of Personality and Psychopathology](#)
- 9 [Clinical Examination of the Psychiatric Patient](#)
- 10 [Signs and Symptoms in Psychiatry](#)
- 11 [Classification in Psychiatry and Psychiatric Rating Scales](#)
- 12 [Delirium, Dementia, and Amnesic and Other Cognitive Disorders and Mental Disorders Due to a General Medical Condition](#)
- 13 [Neuropsychiatric Aspects of Human Immunodeficiency Virus \(HIV\) Infection and Acquired Immune Deficiency Syndrome \(AIDS\)](#)
- 14 [Substance-Related Disorders](#)
- 15 [Schizophrenia](#)
- 16 [Other Psychotic Disorders](#)
- 17 [Mood Disorders](#)
- 18 [Anxiety Disorders](#)
- 19 [Somatoform Disorders](#)
- 20 [Chronic Fatigue Syndrome and Neurasthenia](#)
- 21 [Factitious Disorders](#)
- 22 [Dissociative Disorders](#)
- 23 [Human Sexuality](#)
- 24 [Gender Identity Disorders](#)
- 25 [Eating Disorders](#)
- 26 [Normal Sleep and Sleep Disorders](#)
- 27 [Impulse-Control Disorders Not Elsewhere Classified](#)
- 28 [Adjustment Disorders](#)
- 29 [Personality Disorders](#)
- 30 [Psychosomatic Medicine and Consultation-Liaison Psychiatry](#)
- 31 [Alternative Medicine and Psychiatry](#)
- 32 [Psychiatry and Reproductive Medicine](#)
- 33 [Relational Problems](#)

- 34 [Problems Related to Abuse or Neglect](#)
- 35 [Additional Conditions That May Be a Focus of Attention](#)
- 36 [Emergency Psychiatric Medicine](#)
- 37 [Psychotherapies](#)
- 38 [Biological Therapies](#)
- 39 [Child Psychiatry: Assessment, Examination, and Psychological Testing](#)
- 40 [Mental Retardation](#)
- 41 [Learning Disorders](#)
- 42 [Motor Skills Disorder: Developmental Coordination Disorder](#)
- 43 [Communication Disorders](#)
- 44 [Pervasive Developmental Disorders](#)
- 45 [Attention-Deficit Disorders \(ADHD\)](#)
- 46 [Disruptive Behavior Disorders](#)
- 47 [Feeding and Eating Disorders of Infancy or Early Childhood](#)
- 48 [Tic Disorders](#)
- 49 [Elimination Disorders](#)
- 50 [Other Disorders of Infancy, Childhood, or Adolescence](#)
- 51 [Mood Disorders and Suicide in Children and Adolescents](#)
- 52 [Anxiety Disorders of Infancy, Childhood, and Adolescence](#)
- 53 [Early-Onset Schizophrenia](#)
- 54 [Adolescent Substance Abuse](#)
- 55 [Child Psychiatry: Additional Conditions That May Be a Focus of Clinical Attention](#)
- 56 [Psychiatric Treatment of Children and Adolescents](#)
- 57 [Forensic Issues in Child and Adolescent Psychiatry](#)
- 58 [Geriatric Psychiatry](#)
- 59 [End-of-Life Care and Palliative Medicine](#)
- 60 [Forensic Psychiatry](#)
- 61 [Ethics in Psychiatry](#)

Back of Book

End Matter

Appendix

[A: Objective Examinations in Psychiatry](#)

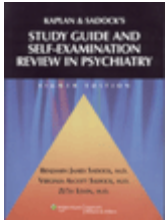
Index

[A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#)

[H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#)

[O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#)

[V](#) [W](#) [X](#) [Y](#) [Z](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](#)



1

The Patient–Doctor Relationship

The patient–doctor relationship is at the core of the practice of medicine. It is of utmost concern to all physicians and should be evaluated in all cases. It is essential that all clinicians consider the nature of this relationship, the factors in themselves and their patients that influence the relationship, and the ways in which good rapport can be achieved.

Rapport is the spontaneous, conscious feeling of harmonious responsiveness that promotes the development of a constructive therapeutic relationship. It implies an understanding and trust between the doctor and patient. Medicine is an intensely human and personal endeavor, and the patient–doctor relationship itself becomes part of the therapeutic process.

The bio-psycho-social model of disease stresses an integrated approach to human behavior and disease. Each system in this model, the biological, psychological and social, affects and is affected by the others. It does not consider illness as a direct result of a person's psychological or sociocultural makeup, but rather promotes a more comprehensive understanding of disease and treatment. This model provides a conceptual framework for dealing with disparate information and serves as a reminder that there may be important issues to consider beyond the biological.

The interactions between a doctor and patient can take different shapes, and it is helpful to be aware of the models that have been formulated to describe these interactions. The paternalistic model, the informative model, the interpretive model, and the deliberative model are guides for thinking about the patient–doctor relationship. A talented, sensitive physician uses different approaches with different patients and may have different approaches with the same patient as time and medical circumstances vary.

Doctors and patients may have divergent, distorted, and unrealistic views about each other. Transference and countertransference, terms originating in psychoanalytic theory, are hypothetical constructs that are extremely useful as organizing principles for explaining certain developments of the patient–doctor relationship that can be upsetting and that can interfere with good medical care. Students must be aware of and familiar with these concepts in order to fully understand the complexities of the patient–doctor interaction. The patient–doctor relationship is one of the most important factors in issues of treatment compliance, or adherence. Compliance decreases when communication

problems arise. Doctors should be familiar with the factors that increase and decrease treatment adherence, and the clinician must explore the reasons for noncompliance rather than dismiss the patient as uncooperative.

In addition to the vast amount of knowledge and the skills required for the practice of medicine, an effective physician must also develop the capacity for balancing compassionate concern with discompassionate objectivity, the wish to relieve pain with the ability to make painful decisions, and the desire to cure and control with an acceptance of one's human limitations. William Osler, M. D. discussed the characteristics and qualities of the physician in his book *Aequanimitas*. Although rarely reached, all students of medicine should be familiar with them, and strive to reach them.

Students should test their knowledge by addressing the following questions and answers.

Helpful Hints

The key terms listed below should be understood by the student.

- active versus passive patients
- aggression and counteraggression
- authority figures
- belligerent patients
- biopsychosocial
- biopsychosocial model
- burnout
- closed-ended questions
- compliance
- compliance versus noncompliance
- confrontation
- content versus process
- countertransference
- cultural attitudes
- defensive attitudes
- distortion
- patient-doctor models
- early social pressures
- emotional reactions
- emotionally charged statements
- empathy
- George Engel
- "good patients"
- humor
- identification
- illness behavior
- individual experience
- insight

- interpretation
- listening
- misperception
- misrepresentation

- mutual participation
- need–fear dilemma
- open-ended questions
- overcompensatory anger
- personality
- psychodynamics
- rapport
- reflection
- self-monitoring
- sick role
- socioeconomic background
- sublimation
- therapeutic limitations
- transference
- unconscious guilt
- unresolved conflicts

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

1.1 Transference feelings

- A. are based on doctors projecting their feelings to the patient
- B. is a main reason for lawsuits filed by mistreated patients
- C. do not occur with a highly experienced physician
- D. are based on a patient projecting feelings from past relationships to the doctor
- E. none of the above

1.2 Rapport is

- A. based on doctors projecting their feelings to the patient
- B. based on a patient projecting feelings from past relationships to the doctor
- C. a feeling of harmony that promotes a therapeutic relationship
- D. of little significance in obtaining the history

E. none of the above

1.3 What percent of patients comply with treatment in the medical setting at any given time?

- A. 90 percent
- B. 75 percent
- C. 50 percent
- D. 30 percent
- E. 10 percent

1.4 Illness behavior refers to

- A. the role society ascribes to the sick person
- B. being excused from responsibilities
- C. the influence of culture on illness
- D. the way the condition presents itself
- E. all of the above

1.5 Which of the following models guides us in thinking about the patient–doctor relationship?

- A. The paternalistic model
- B. The deliberative model
- C. The informative model
- D. The interpretive model
- E. All of the above

1.6 Which of the following statements about transference is *true*?

- A. Transference reactions may be strongest with psychiatrists.
- B. Transference is a conscious process.
- C. Transference occurs only in patient interactions with psychiatrists, not with clinicians from other disciplines.
- D. Transference toward physicians is exclusively positive because patients know doctors are trying to help them.
- E. Transference implies that the way a clinician interacts with their patient has no direct bearing on the emotional reactions of the patient.

1.7 Which of the following patient factors is associated with treatment compliance?

- A. Socioeconomic status
- B. Educational level
- C. Subjective feelings of distress
- D. Intelligence
- E. All of the above

1.8 Which of the following doctor factors is associated with treatment compliance?

- A. Positive physician attitude
- B. Short waiting room time
- C. Older doctors with experience
- D. Increased frequency of visits
- E. All of the above

1.9 Which of the following is considered important in establishing rapport with a patient?

- A. Putting the patient at ease
- B. Expressing compassion
- C. Evaluating a patient's insight
- D. Showing expertise
- E. All of the above

1.10 Which of the following is true about the techniques used when interviewing a patient?

- A. Confrontation is used to test a patient's ability to remain calm.
- B. Reflection allows the doctor an opportunity to share with the patient his or her personal feelings.
- C. Silence is used as a way of withholding empathy.
- D. Interpretations should be made early and as often as possible.
- E. Clarification is away for the doctor to get further details about what has already been revealed.

1.11 All of the following statements about illness behavior are correct *except*

- A. It is affected by a person's cultural beliefs about disease.
- B. It always involves the experience of illness as a loss.
- C. It involves the sick role that society ascribes to people when they are ill.
- D. It is affected by prior illness episodes of standard severity.

E. It can be affected by psychological factors such as personality.

1.12 In which instance is an autocratic patient–doctor relationship most appropriate?

- A. A patient who has a life-threatening illness with various treatment options.
- B. A woman who is a carrier of the gene for cystic fibrosis consults her doctor about whether she and her husband should conceive.
- C. A 54-year-old woman with hypertension wishes to monitor her own blood pressure at home.
- D. A 22-year-old man is brought into the emergency room with a gunshot wound to the chest.
- E. A young woman confides in her doctor about wanting to have an abortion.

1.13 Compared to nonpsychiatric medical patients, psychiatric patients

- A. do not have to deal with the stigma attached to being a patient
- B. are more likely to tolerate a traditional interview format
- C. are twice as likely to visit a primary care physician
- D. exhibit a higher degree of compliant behavior
- E. never need family members or friends to provide medical histories

1.14 Which of the following is *not* considered a necessary part of a psychiatric patient–doctor relationship?

- A. Discussion of payment
- B. The understanding that confidentiality may be broken in some situations
- C. Awareness of the consequences for missed appointments
- D. The patient’s familiarity with the doctor’s personal life
- E. Clarification of the doctor’s availability between scheduled appointments

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 1.15–1.18

1.15 Intent of question is vague

1.16 May invite yes or no answers

1.17 Low time efficiency

1.18 Patient selects topic

- A. Open-ended questions
- B. Closed-ended questions

Questions 1.19–1.23

1.19 A patient is admitted to the hospital with a sudden onset of altered mental status when found thrashing about in bed. After a workup, a physician restrains him to perform a lumbar puncture.

1.20 A 64-year-old woman with diabetes mellitus visits her physician after repeatedly drawing high blood glucose levels during home monitoring.

1.21 After a patient's complete recovery from illness, her physician continues to phone and visit her—and declares his love for her.

1.22 Three days after abdominal surgery, a 32-year-old man has mild basal rales by auscultation. His surgeon tells him to ambulate.

1.23 The doctor of a 16-year-old girl with persistent abdominal problems tells her that she must go for a lower gastrointestinal (GI) series.

- A. Active–passive model
- B. Teacher–student model
- C. Mutual participation model
- D. "Friendship" model

Questions 1.24–1.28

1.24 The ability to maintain calm and steadiness

1.25 The ability to handle stressful situations with an even temper

1.26 Forming standards, and living under their influence

1.27 Calmness of mind, bearing, and appearance

1.28 The capacity to face or endure events with courage

- A. Composure
- B. Equanimity
- C. Imperturbability
- D. Idealism
- E. Bravery

Questions 1.29–1.32

1.29 Can be upsetting and interfere with good medical care

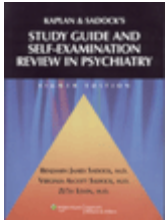
1.30 A patient sees her doctor as overly critical because her mother had always criticized her life choices

1.31 May be encouraged as integral to some intensive psychiatric treatment

1.32 A doctor is hostile to a patient who he assumes will be “difficult” and non-compliant because she reminds him of his ex-wife

- A. Transference
- B. Countertransference
- C. Both transference and countertransference





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



2 Interviewing Techniques with Special Patient Populations

Different types of patients fall under the rubric of special patient populations. They include patients with urgent issues, the severely mentally ill, patients from different cultural backgrounds, and patients with particular personality problems that make them difficult to engage.

Psychotic patients have poor reality testing and need a focused and structured interview. There are essential techniques to be aware of in the handling of delusions, hallucinations, thought disorders, and suspiciousness. Similarly, potentially suicidal patients need to be assessed in a clear, open way, with a thorough assessment of their suicidal potential.

Somatic patients are often frustrating in light of their resistance to considering a psychological exploration of their symptoms. Seductive patients often require direct responses by the clinician, to maintain boundaries. Dependent patients need firm limit setting, and demanding patients should be treated respectfully, but firmly, with a clear understanding of what will and won't be tolerated in the clinical setting.

Narcissistic patients may initially idealize the doctor and, very soon after, be contemptuous of them. Potentially violent patients need to be assessed in a way that is safe for the patient and the doctor.

Familiarity with these different types of patients and issues will help the treating clinician establish a safe space in which the patient and doctor can work together to treat the problem at hand.

Students should test their knowledge by addressing the following questions and answers.

Helpful Hints

The key terms listed below should be understood by the student.

- agitative patients
- belligerent patients
- boundary violation
- coercion

- close-ended questions
- cross cultural issues
- cultural attitudes
- defensive attitudes
- demanding patients
- dependant patients
- derailments
- emotional reactions
- emotionally charged statements
- "good patients"
- grid iron abdomen
- grievance collector
- help rejecting complainers
- isolated patients
- limit setting
- listening
- malingering
- methods of suicide
- narcissistic patients
- nationality
- noneuphemistic question
- obsessive patients
- open-ended questions
- passive suicidal patients
- personality
- psychological advantage
- psychomotor agitation
- race
- reflection
- religion
- reunion fantasy
- ruminative patients
- secondary gain
- seductive patients
- self-monitoring
- slippery slope
- somatizing patients
- thought disorder
- uncooperative patients
- world of fantasy

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

2.1 The psychiatric interview serves all of the following functions *except*

- A. to assess the nature of the problem
- B. to demonstrate to the patient their expertise
- C. to establish a therapeutic relationship
- D. to implement a treatment plan
- E. None of the above

2.2 When steering a patient in an interview, which of the following is *not* used?

- A. redirection
- B. coercion
- C. continuation

-
- D. echoing
 - E. All of the above

P.10

2.3 Which of the following is *not* a specific technique used in a psychiatric interview?

- A. Privilege
- B. Silence
- C. Confrontation
- D. Transition
- E. All of the above

2.4 When ending a psychiatric interview, the doctor should

- A. end the interview on time
- B. leave unfinished business for the next appointment
- C. give the patient the opportunity to ask questions
- D. all of the above
- E. None of the above

2.5 Confronting a patient with the topic of suicide in a psychiatric interview

- A. increases the chances of depressed patients attempting or committing suicide
- B. is necessary with all depressed patients
- C. hinders the doctor's rapport
- D. should not be done in a straightforward manner
- E. None of the above

2.6 Choose the answer that best fits the example given in the below case study:

A 45-year-old man was convinced he had acquired immune deficiency syndrome (AIDS), despite having no risk factors. He repeatedly sought out human immunodeficiency virus (HIV) testing and blood cell counts. When tests reported that he was not HIV positive, he felt considerable, but short-lived, relief. He soon began to doubt the accuracy of the tests and reporting. "Can you tell me with certainty, that there is 100 percent no chance of error?" he asked his medical doctor. Over several months, his anxiety and depression increased, and he accepted referral to a psychiatrist.

- A. A somatizing patient
- B. A depressed patient
- C. A noncooperative patient
- D. A lying patient
- E. None of the above

2.7 Which type of patient would say the following: "I have a friend who is in the business and is great friends with some very famous celebrities. I could introduce you to them..."

- A. A somatizing patient
- B. A seductive patient
- C. A noncooperative patient
- D. A lying patient
- E. None of the above

2.8 With paranoid patients a physician

- A. should be as relaxed and friendly as possible
- B. should be prepared to explain in detail every decision
- C. should not take seriously a patient's hostile or conspiratorial misperception of a neutral event
- D. must react defensively to a patient's suspicions
- E. should not allow a patient to remain evasive

2.9 Antisocial patients

- A. rarely malingering
- B. must be approached with a heightened sense of vigilance
- C. rarely present as socially adept or intelligent
- D. should never be confronted directly about inappropriate behavior
- E. seldom cause physicians to feel threatened

2.10 At the beginning of an appointment, a patient wants to discuss her perception of why she felt ill, but the physician wants to know the chronology of her symptoms. The physician should

- A. allow the patient to complete her thoughts
- B. politely interrupt the patient and continue with closed ended questions
- C. inform her that time is of the essence
- D. inform her that an extra charge will be made if more time is needed for the appointment
- E. immediately discuss how compliance will be affected by her perceptions and responses

2.11 In the interview of the psychotic patient, which of the following is *true*?

- A. Less structure works best.
- B. Open-ended questions are most useful.
- C. Delusions should be addressed with clear disbelief.
- D. Short questions are the easiest for the patient to follow.
- E. None of the above.

2.12 Mr. M, a 60-year-old man, 10 months after the death of his wife of 40 years, reluctantly told his daughter that he wished he were dead, but would never act on these wishes. Alarmed, she took him to a psychiatrist for an evaluation. Which of the following is *true*?

- A. Asking this man about suicide may increase his risk.
- B. Euphemistic inquiries about his suicide risk would foster rapport.
- C. Feeling this way is a normal grief reaction, so no action is required.
- D. Detailed questions about his suicidality are essential for prevention.
- E. His daughter has overreacted in light of the absence of described intent.

2.13 Somatizing patients



Table 2.1 Three Functions of the Medical Interview

Functions	Objectives	Skills
I. Determining the nature of the problem	1. To enable the clinician to establish a diagnosis or recommend further diagnostic procedures, suggest a course of treatment, and predict the nature of the illness	1. Knowledge base of diseases, disorders, problems, and clinical hypotheses from multiple conceptual domains: biomedical, sociocultural, psychodynamic, and behavioral 2. Ability to elicit data for the above conceptual domains (encouraging the patient to tell his or her story; organizing the flow of the interview, the form of questions, the characterization of symptoms, the mental status examination).
II. Developing and maintaining a therapeutic relationship	1. The patient's willingness to provide diagnostic information 2. Relief of physical and psychological distress 3. Willingness to accept a treatment plan or a process of negotiation	1. Defining the nature of the relationship 2. Allowing the patient to tell his or her story 3. Hearing, bearing, and tolerating the patient's expression of painful feelings 4. Appropriate and genuine interest, empathy, support, and cognitive understanding
III. Communicating information and implementing a treatment plan	1. Patient's understanding of the illness 2. Patient's understanding of the suggested diagnostic procedures 3. Patient's understanding of the treatment possibilities	1. Determining the nature of the problem (function I) 2. Developing a therapeutic relationship (function II) 3. Establishing the differences in perspective between physician and patient

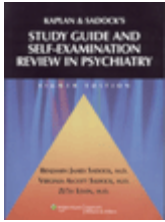
Adapted from Lazare A, Bird J, Lipkin M Jr, Putnam S. Three functions of the medical interview: An integrative conceptual framework. In: Lipkin Jr M, Putnam S, Lazare A, eds. *The Medical Interview*. New York: Springer; 1989:103.

- A. experience emotional distress in terms of physical symptoms
- B. may resist self-reflection
- C. often fear that their symptoms are not being taken seriously

- D. are often harmed by aggressive and unwarranted medical interventions
- E. all of the above

2.14 Which of the following minimizes agitation and the risk of harm by potentially violent patients?

- A. Evaluating the patient in a nonstimulating environment
- B. Asking the patient if he is carrying a weapon
- C. Heeding one's subjective sense of fear
- D. Terminating the interview if necessary
- E. All of the above



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



3

Normality

Normality and mental health are central issues in psychiatric theory and practice but are difficult to define. For example, normality has been defined as patterns of behavior or personality traits that are typical or that conform to some standard of proper and acceptable ways of behaving and being. The use of terms such as typical or acceptable, however, has been criticized because they are ambiguous, involve value judgments, and vary from one culture to another. To overcome this objection psychiatrist and historian George Mora devised a system to describe behavioral manifestations that are normal in one context but not in another, depending on how the person is viewed by the society. This paradigm, however, may give too much weight to peer group observations and judgments. The World Health Organization (WHO) defines normality as a state of complete physical, mental, and social well-being; but again, this definition is limited, because it defines physical and mental health simply as the absence of physical or mental disease.

The text revision of the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) offers no definition of normality or mental health, although a definition of mental disorder is presented. According to DSM-IV-TR, a mental disorder is conceptualized as a behavioral or psychological syndrome or pattern that is associated with distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning). In addition, the syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, such as the death of a loved one. DSM-IV-TR emphasizes that neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders.

Students should test their knowledge by addressing the following questions and answers.

Helpful Hints

The student should know the following theories, theorists and terms.

- autonomy versus shame and doubt
- conflict-free ego functions
- ego identity versus role confusion
- ego integrity versus despair

- ego mechanisms
- Erik Erikson
- Karl Jaspers
- Carl Gustav Jung
- Theodore Lidz
- life cycle theory
- generativity versus stagnation
- George Mora
- industry versus inferiority
- initiative versus guilt
- intimacy versus isolation
- mature defenses
- normality as utopia
- normality as average
- normality as process
- normality as health
- Jean Piaget
- *Three Essays on the Theory of Sexuality*
- trust versus mistrust

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

3.1 According to Dr. George Mora, a heteronormal person is

- A. seen as abnormal by his or her own society
- B. seen as unusual by members of another society
- C. seen as normal by members of another society
- D. seen as normal by his or her own society
- E. None of the above

3.2 Which of the following is not a healthy defense mechanism?

- A. Humor
- B. Suppression
- C. Sublimation
- D. Altruism
- E. Denial

3.3 Autonomous functions of the ego include

- A. perception
- B. intuition
- C. comprehension

P.15

- D. language
- E. all of the above

3.4 According to Karl Jaspers, the personal world is abnormal when

- A. it separates the person from others emotionally
- B. the person cannot live without fear, guilt, or anxiety
- C. the person cannot adjust to the external world with contentment
- D. the person does not have the ability to achieve insight into one's self
- E. all of the above

3.5 According to Theodore Lidz, which of the following is *true*?

- A. The acquisition of many abilities must wait for the physical maturation of the organism.
 - B. Cognitive development plays a significant role in creating phasic shifts.
 - C. Society establishes roles and sets expectation for persons of different ages and statuses.
 - D. Children attain many attributes and capacities for directing the self and controlling impulses.
 - E. All of the above
- Directions Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 3.6–3.9

3.6 Traditional approach

3.7 Harmonious and optimal functioning

3.8 Based on bell-shaped curve

3.9 The end result of interacting systems

- A. Normality as process
- B. Normality as health
- C. Normality as average
- D. Normality as utopia

Questions 3.10–3.14

3.10 Absolute normality cannot be obtained because the normal person must be totally aware of his or her thoughts and feelings.

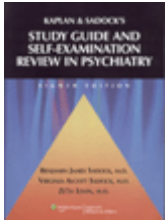
3.11 Normality is the ability to master the periods of life: trust vs. mistrust; autonomy vs. shame and doubt; initiative vs. guilt; industry vs. inferiority; identity vs. role confusion; intimacy vs. isolation; generativity vs. stagnation; and ego integrity vs. despair.

3.12 Normality is an idealized fiction.

3.13 Normality is characterized by strength of character, the capacity to deal with conflicting emotions, the ability to experience pleasure without conflict and the ability to love.

3.14 Normality is the ability to learn by experience, to be flexible, and to adapt to a changing environment.

- A. Sigmund Freud
- B. Kurt Eissler
- C. Melanie Klein
- D. Erik Erikson
- E. Laurence Kubie



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](http://www.lippincott.com)



4

Human Development

The life cycle represents the stages through which all humans pass from birth to death. The fundamental assumption of all life cycle theories is that development occurs in successive, clearly defined stages. This sequence is invariant; that is, it occurs in a particular order in every person's life, whether or not all stages are completed. A second assumption of life cycle theory is the epigenetic principle, which maintains that each stage is characterized by events or crises that must be resolved satisfactorily for development to proceed smoothly. According to the epigenetic model, if resolution is not achieved within a given life period, all subsequent stages reflect that failure in the form of physical, cognitive, social, or emotional maladjustment. A third assumption is that each phase of the life cycle contains a dominant feature, complex of features, or a crisis point that distinguishes it from phases that either preceded or will follow it.

Charting of the life cycle lies within the study of developmental psychology and involves such diverse elements as biological maturity, psychological capacity, adaptive techniques, defense mechanisms, symptom complexes, role demands, social behavior, cognition, perception, language development, and interpersonal relationships. Various models of the life cycle describe the major developmental phases but emphasize different elements. Taken together however, they demonstrate that there is an order to human life, despite the fact that each person is unique.

Jean Piaget studied the cognitive and intellectual development of children, from birth to adolescence. Not all contemporary theorists agree with his findings or observations, but his work is evocative and seminal, and offers a striking theory of cognitive development through different ages. Sigmund Freud's observations and theories about psychosexual development are provocative and challenging. No one can argue with the profound and lasting effect his thinking had on 20th-century culture nor on the increased understanding of psychodynamic forces that shape behavior. A new psychology is evolving for the current century that will rely on many of Freud's observations but which will differ in concepts still to be defined.

Erik Erikson formulated age-specific crises that he observed to occur in correlation with specific psychosocial phases. Margaret Mahler viewed development through a perspective of attachment, and defined what she felt was the challenge of the first 3 years of life, in terms of separation-individuation. More recent theorists, such as Daniel Levinson and

Carol Gilligan, have continued to expand and clarify different aspects of development and life stresses.

The student should study the questions and answers below for a useful review of all of these topics.

Helpful Hints

Readers should be aware of the following theories, theorists, and developmental stages as they relate to human development throughout the life cycle.

- adolescent homosexuality
- adoption
- adultery
- affectional bond
- age-30 transition
- age-related cell changes
- ageism
- Mary Ainsworth
- alimony
- anal personality
- attachment
- autonomous ego functions
- John Bowlby's stages of bereavement
- castration anxiety
- characteristics of thought: concrete operations formal operations preoperational phase sensorimotor phase (object permanence)
- climacterium
- cognitive decline
- concepts of normality
- core identity
- crushes
- cults
- death and children
- death criteria
- delayed, inhibited, and denied grief
- dependence
- developmental landmarks
- developmental tasks
- divorce
- dreams in children
- dual-career families
- effects of divorce
- egocentrism

Electra complex

- empty-nest syndrome
- epigenetic principle
- Erik Erikson: eight psychosocial stages
- failure to thrive
- family planning
- family size
- fathers and attachment
- feeding and infant care
- fetal development
- formal operations and morality
- foster parents
- Anna Freud
- gender expectations

-
- gender identity
 - generativity
 - genetic counseling
 - geriatric period
 - Arnold Gesell
 - goodness of fit
 - grief
 - Roy Grinker
 - Heinz Hartmann
 - hormones
 - integrity
 - intimacy
 - Carl Jung
 - Melanie Klein
 - Elisabeth Kübler-Ross
 - language development
 - learning problems
 - Daniel Levinson
 - linkage objects
 - Madonna complex
 - Margaret Mahler: infant-developmental stages
 - marriage
 - Masters and Johnson
 - masturbation
 - maternal behavior
 - maternal neglect

- menarche
- midlife crisis
- mourning
- "Mourning and Melancholia"
- mutuality
- negativism
- neural organization of infancy
- normal autistic and normal symbiotic phases
- play and pretend
- postpartum mood disorders and psychosis
- pregnancy: marriage and alternative lifestyle sexuality and prenatal diagnosis teenage
- pregnancy and childbirth
- primary and secondary sex characteristics
- pseudodementia
- psychosexual moratorium
- puberty
- racism, prejudice
- reactions to authority
- reflexes (i.e., rooting, grasp, Babinski, Moro)
- religious behavior
- remarriage
- retirement
- Dame Cicely Saunders
- school adjustment, behavior, refusal
- self-blame
- senility
- separation
- separation-individuation process: differentiation practicing rapprochement consolidation
- sex in the aged
- sibling and parental death
- sibling rivalry
- single-parent home
- smiling
- social deprivation syndromes (anaclitic depressionhospitalism)
- somnambulism
- spacing of children
- René Spitz
- spouse and child abuse
- stepparents and siblings

- stranger and separation anxiety
- stress reaction
- suicide in the aged
- Harry Stack Sullivan
- superego
- surrogate mother
- survivor guilt
- Thomas Szasz
- temperament
- thanatology
- toilet training
- uncomplicated bereavement

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

4.1 Pruning refers to

- A. excitotoxicity
- B. the addition of cells to the nervous system during development
- C. the process of eliminating the branching of dendrites of the brain
- D. the programmed elimination of neurons, synapses and axons
- E. all of the above

4.2 Which percentage of women uses alcohol during pregnancy?

- A. 10 percent
- B. 20 percent
- C. 35 percent
- D. 45 percent
- E. 60 percent

4.3 Which of the following is *not* a characteristic of fetal alcohol syndrome?

- A. Microphthalmia
- B. CNS manifestations
- C. Hyperactivity
- D. Attention deficits

E. Withdrawal-like symptoms

4.4 In which period is the “band-aid phase” present?

- A. Toddler period
- B. Preschool period
- C. Infancy period
- D. Middle years period
- E. None of the above

4.5 Which percentage of teenagers ages 15 to 19 use at least one method of birth control?

- A. 25 percent
- B. 50 percent
- C. 65 percent
- D. 75 percent
- E. 95 percent

4.6 Children born to teenage mothers have a greater chance of

- A. becoming teenage parents
- B. joining a gang
- C. dying before the age of five
- D. becoming addicted to a narcotic
- E. all of the above

4.7 The psychological separation from parents in adolescence is called

- A. first individuation
- B. second individuation
- C. third individuation
- D. fourth individuation
- E. none of the above

P.20

4.8 The transition from adolescence to young adulthood is characterized by

- A. the establishment of an adult work identity
- B. the need for an intimate relationship
- C. separation from family

- D. achievement of mental maturity
- E. none of the above

4.9 Which of the following is *true* about Piaget's approach to cognitive development?

- A. Cognitive growth occurs in invariant stages.
- B. The sensorimotor stage is from ages 2 years to 7 years.
- C. Object constancy is the ability to remember an object once it is out of sight.
- D. Preoperational thought is nonsymbolic.
- E. Concrete operational thought is illogical.

4.10 Which of the following is a factor to be considered in adolescent misuse or rejection of contraceptives?

- A. The belief that it interferes with pleasure
- B. Lack of education from schools
- C. Self-consciousness about use
- D. Access to and/or cost of contraceptives
- E. All of the above

4.11 Which of the following medical interventions requires parental consent for adolescents under the age of 16?

- A. Alcohol counseling
- B. Treatment for a sexually transmitted disease
- C. Inpatient mental health treatment
- D. Birth control pills or other contraception
- E. Treatment for an AIDS-related illness

4.12 Compared to nonadopted children, adopted children are more likely to have:

- A. problems with drug abuse
- B. aggressive behavior
- C. learning disturbances
- D. conduct disorders
- E. all of the above

4.13 According to Robert Butler, the themes of stock taking; reassessing commitments to family, work, and marriage; and dealing with parental illness and death are most common in which stage of life?

- A. Adolescence
- B. Young adulthood
- C. Old age
- D. Middle adulthood
- E. All of the above

4.14 Which of the following is not one of the basic personality traits found to remain relatively stable throughout life?

- A. Openness to experience
- B. Confidence
- C. Conscientiousness
- D. Neuroticism
- E. Extraversion

4.15 Positive physiological effects of exercise and nutrition in old age include:

- A. increased heart volume and weight
- B. increased muscle mass and body density
- C. decreased heart rate at rest
- D. decreased systolic blood pressure
- E. all of the above

4.16 In an infant, social smiling is elicited preferentially by the mother at

- A. under 4 weeks of age
- B. 4 to 8 weeks
- C. 8 to 12 weeks
- D. 3 to 4 months
- E. more than 4 months

4.17 A child will refer to him or herself by name at which age?

- A. 18 months
- B. 2 years
- C. 3 years
- D. 4 years
- E. 6 years

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 4.18–4.21

4.18 Low levels may be associated with depressed mood

4.19 Influence CNS functioning

4.20 Responsible for masculinization of males

4.21 Levels correlate with libido and are manifested by sex drive

- A. Testosterone
- B. Estrogen
- C. Both
- D. Neither

Questions 4.22–4.26

4.22 End of baby talk

4.23 Cooing

4.24 Subtleties of tone and inflection

4.25 Babbling

4.26 First sentence

- A. 2 months
- B. 6 months
- C. 1.5 to 2.5 years
- D. 3 to 5 years
- E. 5 years

P.21

Questions 4.27–4.29

4.27 Children try to conform to gain approval

4.28 Punishment and obedience to the parent are determining factors

4.29 Children comply with rules on the basis of a concept of ethical principles

- A. Pre-conventional morality
- B. Conventional role-conformity
- C. Self-accepted principles

Questions 4.30–4.33

4.30 Only discusses a particular conflict related to the immediate concerns of the family

4.31 Emphasizes helping partners cope with their problems effectively

4.32 Places emphasis on restructuring the interaction between the couple

4.33 Encourages personality growth and development

- A. Marriage counseling
- B. Marital therapy
- C. Both marriage counseling and marital therapy

Questions 4.34–4.38

4.34 Old age is a time of reconciliation with others and resolution of grief over the death of others and the approaching death of self.

4.35 The maintenance of self-esteem is a major task of old age.

4.36 People who are narcissistic and too heavily invested in body appearance are liable to become preoccupied with death.

4.37 Increased control of the ego and id with aging results in increased autonomy.

4.38 The major conflict of old age relates to giving up the position of authority and evaluating achievements and former competence.

- A. Sigmund Freud
- B. Erik Erikson
- C. Heinz Kohut
- D. Bernice Neugarten
- E. Daniel Levinson

Questions 4.39–4.43

4.39 Loss of appetite

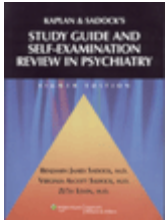
4.40 Clinically significant distress or impairment

4.41 Dysphoria triggered by reminders of the deceased

4.42 Rarely includes suicidal ideation

4.43 Diminished interest in the world

- A. Grief/bereavement
- B. Depression
- C. Both grief and depression



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



5

The Brain and Behavior

Simply defined, neuropsychiatry is the study of brain-behavior relationships. Neuropsychiatry seeks to understand how the brain, through structural and neural networks, produces and controls behavior and mental processes, including emotions, personality, thinking, learning and memory, problem solving, and consciousness. The field is concerned with how behavior may influence the brain and related physiological processes. The explosion of data derived from psychopharmacology, functional neuroimaging, and human neurogenetics makes this one of the most exciting fields of medicine. The psychiatrist must be able to critically review new data and research and apply this knowledge to evaluating new drugs, treatments, and diagnostic techniques.

A basic understanding of behavioral neuroanatomy provides knowledge of classical syndromes, such as those of lobar dysfunction. The basal ganglia, limbic structures, hypothalamus, and lobes of the cerebral cortex are of special relevance. It is also crucial to understand the ultrastructure of individual brain cells, the details of synaptic connectivity, the functional organization of the brain, and the behavioral consequences of pathological processes in the central nervous system. Students should be knowledgeable about the vast functional diversity of brain cells and their organization. Students must also have a thorough grasp of the structure and function of neurotransmission. The role of genetics in psychiatric disorders includes knowledge about gene expression, DNA replication, messenger RNA synthesis and translation into protein, and the consequences of mutations at each of these stages.

Of central importance to clinical psychopharmacology is a thorough knowledge of the neurotransmitters, including the brainstem location of the biogenic amine neurotransmitter nuclei and the widespread distribution of their axonal projections. Excitatory neurotransmitters (e.g., glutamate), inhibitory neurotransmitters (e.g., γ -aminobutyric acid [GABA]), the monoamine neurotransmitters (e.g., serotonin, dopamine, norepinephrine, epinephrine, histamine, and acetylcholine), and the peptide neurotransmitters (e.g., endorphins and enkephalins) are crucial to an understanding of current psychotherapeutic medications.

Finally, a knowledge of the major neuroimaging techniques, including clinical and research indications, and the limitations of each technique, is essential. These methods include magnetic resonance imaging (MRI), computed tomography (CT), magnetic

resonance spectroscopy (MRS), single photon emission computed tomography (SPECT), proton emission tomography (PET), electroencephalography (EEG), and magnetoencephalography (MEG), among others.

Students should test their knowledge by addressing the following questions and answers.

Helpful Hints

- aphasia: Broca's, Wernicke's, conduction, global, transcortical motor, transcortical sensory, anomic, mixed transcortical
 - apraxias: limb-kinetic, ideomotor, ideational
 - autonomic sensory and motor systems
 - basal ganglia and cerebellum and clinical syndromes
 - behavioral neuroanatomy: arousal and attention, memory, language, emotions
 - biological rhythms
 - cerebral cortex
 - chronobiology
 - cytoarchitectonics and cortical columns
 - development of cortical networks; plasticity
 - dopamine and serotonin hypothesis of schizophrenia
 - electrophysiology: membranes and charge; ion channels, action potentials, chemical neurotransmission
 - epilepsy: complex partial seizures, temporal lobe epilepsy, TLE personality, *déjà vu*
 - five primary senses (somatosensory, visual, auditory, olfaction, taste)
 - frontal, parietal, temporal and occipital lobes and clinical syndromes
 - GABA and serotonin hypothesis of anxiety disorders
 - glutamate, GABA, glycine, dopamine, norepinephrine, epinephrine, serotonin, acetylcholine, histamine, opioids, substance P, neurotensin, cholecystokinin, somatostatin, vasopressin, oxytocin, neuropeptide Y
 - gray matter and white matter
 - inheritance patterns: autosomal dominant, autosomal recessive, sex-linked
-
- ligand-gated ion channel; G protein-coupled receptor; second messenger
 - limbic system: amygdala, hippocampus, Papez circuit
 - molecular genetics: pedigree, positional cloning, candidate gene, mutations
 - neuroimaging: CT, MRI, MRS, fMRI, SPECT, PET, EEG, MEG, TMS, EP, ERP
 - neurons and glial cells
 - neurotransmitters: biogenic amines, amino acids, peptides, nucleotides, gases, eicosanoids, anandamides
 - norepinephrine and serotonin hypothesis of mood disorders
 - organization of sensory and motor systems; hemispheric lateralization
 - prefrontal lobe syndromes
 - psychoneuroendocrinology: hormones and hormone receptors, adrenal axis, thyroid axis, growth hormone, estrogens

psychoneuroimmunology: placebo effect, cancer, infection, AIDS

- synapses: presynaptic membrane, synaptic compartment, postsynaptic membrane

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

5.1 Which of the following statements concerning astrocytes is *false*

- A. They are the most numerous class of glial cells.
- B. They help form the blood-brain barrier.
- C. They remove neurotransmitters from the synaptic cleft.
- D. They may have a nutritive function.
- E. They buffer the intracellular sodium concentrations.

5.2 The site of origin of an action potential is at the

- A. synaptic cleft
- B. axon hillock
- C. Nodes of Ranvier
- D. gap junction
- E. voltage-gated sodium channel

5.3 All of the following statements about neuronal connections are true *except*?

- A. Many connections between brain regions are reciprocal.
- B. The locus ceruleus is an example of a convergent neuronal system.
- C. Visual input is conveyed in a serial or hierarchical fashion.
- D. Regions of the brain are specialized for different functions.
- E. The role of any specific brain region in the production of specific behaviors must be viewed in the context of neural connections with other brain regions.

5.4 Circadian influences arise from all of the following except

- A. pontine reticular formation
- B. suprachiasmatic nucleus
- C. hypothalamus
- D. supraoptic nucleus
- E. external cues

5.5 The basal ganglia include

- A. the lentiform nucleus
- B. the substantia nigra
- C. the subthalamic nucleus
- D. the caudate nucleus
- E. all of the above

5.6 In schizophrenia

- A. no abnormalities in neural migration have been hypothesized.
- B. reductions of 50 to 60 percent are reported in overall temporal lobe size.
- C. there is decreased prefrontal cerebral blood flow on PET scans during certain tasks (when compared to healthy controls).
- D. there is a proliferation of glial cells.
- E. there is an associated increase in the size of the amygdala.

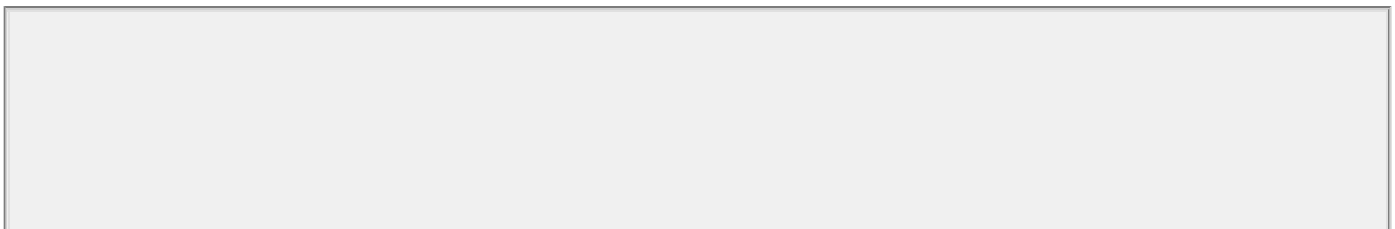
5.7 All of the following are medical causes of amnesia except

- A. Vitamin deficiencies
- B. Infection
- C. Alcoholism
- D. Migraine
- E. Cocaine intoxication

5.8 The following CT image in [Figure 5.1](#) shows enlargement of the ventricles due to atrophy of the head of the caudate nucleus. The disease displayed in this image is

- A. Alzheimer's disease
- B. Pick's disease
- C. Huntington's disease
- D. Parkinson's disease
- E. Lewy Body disease

5.9 The one advantage of CT over MRI in psychiatric clinical practice is



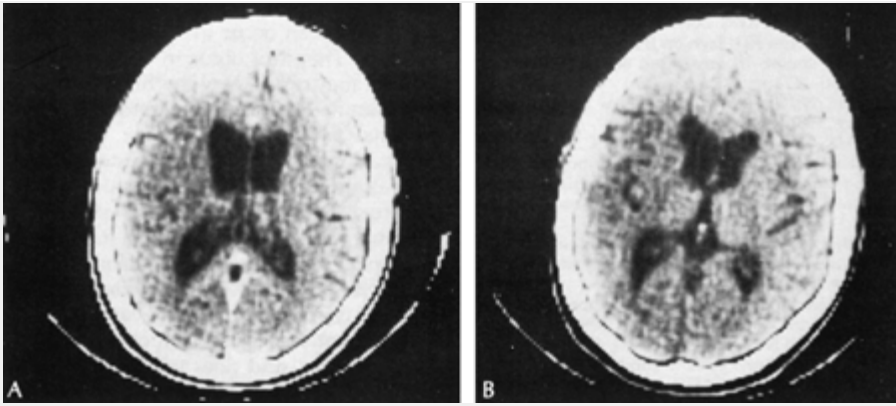


FIGURE 5.1 A and B, CT scans at two axial levels show ventricular enlargement with atrophy of the caudate nucleus, particularly the head of the caudate. (Reprinted with permission from Rowland LP, ed. *Merritt's Text book of Neurology*. 9th ed. Baltimore: Lippincott Williams & Wilkins; 1995:698.)

- A. CT has superior resolution.
- B. CT can distinguish between white matter and gray matter.
- C. CT has the ability to take thinner slices through the brain than does MRI.
- D. CT is superior in detecting calcified brain lesions.
- E. CT avoids exposing patients to radiation.

P.29

5.10 The following image in [Figure 5.2](#) shows small petechial hemorrhages in the mammillary bodies of this brain. This image most closely represents which of the following?

- A. Vascular stroke
- B. Wernicke's disease
- C. Pyridoxine deficiency
- D. Lewy Body disease
- E. Cluster headache

5.11 True statements about the relationship of GABA to seizure activity include all of the following *except*

- A. Blockage of GABA inhibition can result in seizures.
- B. Benzodiazepines and barbiturates act at GABA receptors.
- C. Manipulation of GABA-receptor function has little effect on seizure activity.
- D. Enhancement of GABA-receptor function raises the seizure threshold.

E. Reduction of GABA clearance by inhibition of GABA uptake is clinically effective in reducing seizures.

5.12 Which of the following statements about melatonin is *false*?

- A. It is released by the pineal body.
- B. It is secreted when the eye perceives light.
- C. It is synthesized from serotonin.
- D. It is involved in the regulation of circadian rhythms.
- E. It is implicated in the pathophysiology of depression.

5.13 PET and SPECT scans

- A. entail the injection of radioactively labeled drugs.
- B. provide exquisitely detailed images of brain structure.
- C. produce two-dimensional information.
- D. are similar to MRI in creating fine visual detail.
- E. are commonly used in clinical practice.

5.14 Which of the following personality disorders is most commonly associated with HIV infection?

- A. Borderline
- B. Narcissistic
- C. Antisocial
- D. Dependent
- E. Histrionic

5.15 Serotonin is

- A. primarily located in the CNS.
- B. able to cross the blood-brain barrier.

P.30

- C. not dependent on tryptophan concentration for its synthesis.
- D. directly affected by carbohydrate intake in its synthesis.
- E. synthesized from the amino acid tryptophan.

5.16 All of the following associations between aspects of the basal ganglia and their respective disorders are correct *except*

- A. subthalamic nucleus—hemiballismus
- B. caudate nucleus—obsessive-compulsive disorder

- C. caudate nucleus—Huntington's disease
- D. globus pallidus—Wilson's disease
- E. substantia nigra—Alzheimer's disease

5.17 Which of the following is commonly associated with epilepsy?

- A. Schizophreniform psychosis
- B. Depression
- C. Personality changes
- D. Hyposexuality
- E. None of the above

5.18 MRI studies

- A. prove that there are specific, structural brain changes in a significant number of schizophrenic patients.
- B. provide some evidence that there may be structural brain changes in major depressive disorder.
- C. prove that caudate enlargement occurs early in the course of schizophrenia.
- D. are inferior to CT with regard to visualizing gray versus white matter in the brain.
- E. suggest no brain changes secondary to alcohol dependence.

5.19 Techniques that reflect regional brain activity by measuring neuronal activity rather than blood flow include

- A. xenon-133 (^{133}Xe) single photon emission computed tomography (SPECT)
- B. fluorine-18 [^{18}F]-fluorodeoxyglucose (FDG) positron emission tomography (PET)
- C. technetium-99 (^{99}Tc) hexamethylpropyleneamine oxime (HMPAO) SPECT
- D. nitrogen-13 (^{13}N) PET
- E. functional magnetic resonance imaging (fMRI)

5.20 True statements regarding arousal include

- A. The ascending reticular activating system (ARAS) sets the level of consciousness.
- B. Both the thalamus and the cortex fire rhythmic bursts of neuronal activity.
- C. During wakefulness, the ARAS stimulates the thalamic interlaminar nuclei.
- D. Small discrete lesions of the ARAS may produce a stuporous state.
- E. All of the above

5.21 A patient is brought to your office for cognitive testing. The patient is given the task of scanning a long list of random letters and is told to identify only the letter "A." She is unable to continue this task for more than a minute. What is the most likely location of her lesion?

- A. thalamus
- B. lateral corticospinal tract
- C. basal ganglia
- D. frontal lobe
- E. substantia nigra

5.22 A patient with intractable epilepsy undergoes surgical removal of both hippocampi and amygdalae. Which of the following is the most likely side effect of this procedure?

- A. impaired learning ability
- B. impaired skill-related memory
- C. impaired factual memory
- D. ataxia
- E. loss of vision

5.23 A patient suffers a stroke of the left hemisphere. Which of the following is the most likely sequela?

- A. denial of illness
- B. inability to move the left hand
- C. loss of narrative aspects of dreams
- D. failure to respond to humor
- E. depression

5.24 A patient is diagnosed with temporal lobe epilepsy (TLE) but does not experience the classic grand mal seizures. Which of the following behaviors is the patient likely to exhibit?

- A. hyposexuality
- B. hypersexuality
- C. placidity
- D. hypermetamorphosis
- E. lack of emotion to visual stimuli

5.25 Korsakoff's syndrome is a classic example of which type of amnesia?

- A. Hippocampal amnesia

- B. Diencephalic amnesia
- C. Lateralized amnesia
- D. Traumatic injury-induced amnesia
- E. Transient global amnesia

Directions

Each group of questions below consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 5.26–5.30

5.26 John is a highly successful merger-acquisition attorney. Immediately after his 50th birthday, John announces he plans to give up his partnership in his law firm and investigate the Lincoln assassination, which he believes is a communist conspiracy. He spends all the family savings and is irritable with those who doubt him. He is found on the street one evening psychotic, delusional, very fidgety, and unable to sit still. His father died in a psychiatric hospital with similar symptoms.

5.27 A patient presents with loss of short-term memory, loss of sense of time, and a progressive decline in other cognitive abilities as well. This loss is variable, however, and some days are better than others. At times, she seems to suffer from episodes of acute confusion. She is quite aware of this new disability and is very bothered. Her personality remains intact, although she does experience “mood swings” regularly.

5.28 A 25-year-old homosexual man cohabitates with his partner. He has yearly serological tests and has a normal CD4 lymphocyte count. Despite feeling systemically well, he begins reporting “memory problems” with difficulty thinking and concentrating, along with an overwhelming sense of apathy. Also, he reports insomnia, morning fatigue, and poor appetite. His mini mental status exam score is 29 of 30. The neurological exam shows normal gait, strength, coordination, sensation, and cranial nerves.

5.29 A patient is suffering from rapidly progressing dementia over the last 6 months. She has become withdrawn and forgetful, and often cannot find the right words to express herself in conversation. She also has become unsteady on her feet, and frequently has spasms in her arms and legs.

5.30 A 40-year-old woman presents to your office after her family has noted her to be more aggressive and irritable. In your office, she laughs inappropriately and makes rude comments to your nurse. Loss of memory, difficulty planning, and lack of motivation are also among her complaints. Her mother and uncle developed similar signs of dementia while in their 50s.

- A. Vascular dementia
- B. Pick’s disease
- C. HIV dementia

- D. Huntington's disease
- E. Creutzfeldt-Jakob disease

Questions 5.31–5.33

5.31 A normally kind and quiet woman suddenly becomes loud, boisterous, and rude to her husband and friends. Her husband reports she shows no remorse or concern about these actions, quite a change from her usual self. She also acts strangely and inappropriately, having an affair with a 15-year-old high school sophomore.

5.32 A bank executive often referred to as a "workaholic" suddenly loses all motivation to excel on the job. Although previously in the middle of planning numerous projects, he now is unable to plan or direct the simplest of tasks. Remaining focused at work for a full 8 hours becomes nearly impossible for him, despite a previously consistent 12-hour work schedule.

5.33 A business professional is suddenly found to be mute. On further observation, she appears to be relatively akinetic as well, with hardly any initiation of movements. She understands when spoken to, but appears apathetic concerning her condition.

- A. Dorsolateral prefrontal cortex lesion
- B. Medial prefrontal cortex lesion
- C. Orbitofrontal prefrontal cortex lesion

Questions 5.34–5.38

5.34 Median and dorsal raphe nuclei

5.35 Locus ceruleus

5.36 Nucleus basalis of Meynert

5.37 Substantia nigra

5.38 Spinal cord

- A. Serotonin
- B. Glycine
- C. Norepinephrine
- D. Acetylcholine
- E. Dopamine

Questions 5.39–5.43

5.39 Telencephalon

5.40 Diencephalon

5.41 Pons

5.42 Midbrain

5.43 Cerebral cortex

- A. Prosencephalon
- B. Mesencephalon
- C. Rhombencephalon

Questions 5.44–5.47

5.44 Recognition of faces

5.45 Language functions

5.46 Prosody

5.47 Maintenance of attention

- A. Left brain localization
- B. Right brain localization

Questions 5.48–5.52

5.48 Cause(s) dry mouth, constipation, blurred vision, urinary retention

5.49 Synthesized by serotonin, released by pineal body

5.50 Amphetamines cause release, cocaine blocks uptake

5.51 Dietary variations in tryptophan can affect brain levels

5.52 Released in pulses

- A. Dopamine
- B. Serotonin
- C. Melatonin
- D. Anticholinergic drugs
- E. Growth hormone

Questions 5.53–5.55

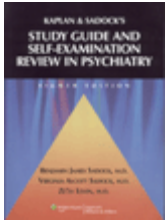
P.32

5.53 Inability to perform an isolated motor act upon command

5.54 Inability to perform components of a sequence as a whole

5.55 Inability to use the contralateral hand in the presence of

- A. Ideational apraxia
- B. Ideomotor apraxia
- C. Limb-kinetic apraxia



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



6 Contributions of the Psychosocial Sciences to Human Behavior

The psychosocial sciences include psychology, anthropology, sociology, ethology, and epidemiology, among others. Our understanding of human behavior has been enriched by the work of professionals in each of these fields.

Students should be able to define these disciplines, and a brief description of each follows: *Psychology* is concerned with behavior and its related mental and physiological processes. There are several types, ranging from *clinical psychology* that specializes in applying psychological theory to persons with emotional or behavioral disorders to *educational psychology*, which is the application of psychological principles to problems of teaching and learning. *Anthropology* is the branch of science concerned with the origin and development of humans in all their physical, social, and cultural relationships. *Sociology* is the study of the collective behaviors of human beings, including the developmental structure and interactions of their social institutions. *Ethology* is the study of animal behaviors and *epidemiology* is the study of the various factors that determine the frequency and distribution of diseases.

Jean Piaget (1896–1980) focused on the ways that children think and develop cognitive abilities, describing four major stages leading to more adult organizations of thought. John Bowlby (1907–1990) focused on the development of attachment and the belief that normal attachment in infancy is essential to ongoing healthy development. René Spitz (1887–1974) described anaclitic depression, or hospitalism, in which normal children who were separated for long periods from adequate caregiving in institutions failed to thrive and, therefore, became depressed and nonresponsive. Ethologists, such as Konrad Lorenz (1903–1989) and Harry Harlow (1905–1981), studied bonding and attachment behaviors in animals, and showed how studying animal behavior could help to illuminate human behavior.

Learning theory was developed by such behavioral researchers as Ivan Pavlov (1849–1936), John B. Watson (1878–1958), and B. F. Skinner (1904–1990). Tenets of learning theory, including operant and classical conditioning, underlie behavioral treatments of various mental disorders.

The questions and answers below will help students test their knowledge of the subjects

highlighted.

Helpful Hints

The student should know the following terms, theoreticians, and concepts.

- abstract thinking
- accommodation
- acculturation
- adaptation
- aggression
- Mary Ainsworth
- anaclitic depression
- animistic thinking
- anxiety hierarchy
- *Aplysia*
- assimilation
- attachment
- attachment phases
- attribution theory
- aversive stimuli
- basic study design
- behavior disorders
- Ruth Benedict
- bias
- biostatistics
- bonding
- John Bowlby
- catharsis
- chronic stress
- cognitive dissonance
- cognitive organization
- cognitive strategies
- cognitive triad
- concrete operations
- contact comfort
- cross-cultural studies and syndromes: *amok, latah, windigo, piblokto, curandero, esperitismo, voodoo*
- culture-bound syndromes
- deductive reasoning
- deviation, significance
- double-blind method
- drift hypothesis

- egocentric
- epidemiology
- epigenesis escape and avoidance conditioning
- ethology
- experimental neurosis
- extinction
- family types, studies
- Faris and Dunham
- fixed and variable ratios
- formal operations
- frequency
- frustration-aggression hypothesis
- genetic epistemology
- Harry Harlow
- Hollingshead and Redlich
- Holmes and Rahe
- hospitalism
- Clark L. Hull
- illness behavior
- imprinting
- incidence
- indirect surveys
- inductive reasoning
- information processing
- inhibition

-
- Eric Kandel
 - learned helplessness
 - learning theory
 - Alexander Leighton
 - H. S. Liddell
 - lifetime expectancy
 - Konrad Lorenz
 - Margaret Mead
 - Midtown Manhattan study
 - monotropic
 - Monroe County study
 - motivation
 - New Haven study
 - normative
 - object permanence

- operant and classical conditioning
- operant behavior
- organization
- Ivan Petrovich Pavlov
- phenomenological causality
- Jean Piaget
- positive and negative reinforcement
- preattachment stage
- preoperational stage
- prevalence
- protest-despair-detachment
- punishment
- randomization
- reciprocal determinism
- reciprocal inhibition
- reliability
- respondent behavior
- risk factors
- schema
- segregation hypothesis
- Hans Selye
- semiotic function
- sensorimotor stage
- sensory deprivation
- separation anxiety
- signal indicators
- B. F. Skinner
- social causation and selection theory
- social class and mental disorders
- social isolation and separation
- social learning
- sociobiology
- René Spitz
- stimulus generalization
- Stirling County study
- strange situation
- stranger anxiety
- surrogate mother
- syllogistic reasoning
- symbolization

- systematic desensitization
- tension-reduction theory
- therapist monkeys
- Nikolaas Tinbergen
- type I and type II errors
- use of controls
- validity
- variation, average
- vulnerability theory
- John B. Watson
- Joseph Wolpe

Questions/Answers

Directions

Each question or incomplete statement below is followed by five suggested responses or completions. Select the one that is best in each case.

6.1 In which of the following age groups is the stage of preoperational thought present?

- A. Birth to 2 years
- B. 2 to 7 years
- C. 7 to 11 years
- D. 11 through the end of adolescence
- E. None of the above

6.2 Premack's principle states that

- A. high frequency behaviors can be used to reinforce lowfrequency behavior
- B. a person can learn by imitating the behavior of another person
- C. persons will attribute others' behavior to stable their own personality traits
- D. the more people feel capable of controlling a threatening event, the less anxious they will be
- E. persons will attribute their own behavior to situational causes

6.3 Learning can be reflected in neural changes in which of the following ways?

- A. The growth of new neurons
- B. The expansion of existing neurons
- C. Changes in connectivity between existing neurons
- D. All of the above

E. None of the above

6.4 Cross-cultural studies

- A. are free from experimental bias
- B. show that depression is not a universally expressed symptom
- C. show that incest is not a universal taboo
- D. show that schizophrenic persons are universally stigmatized as social outcasts
- E. show that the nuclear family of mother, father, and children is a universal unit

6.5 True statements about violence and aggression include all of the following *except*

- A. In the United States, homicide is the second leading cause of death among people 15 to 25 years of age.
- B. A young black man is 8 times more likely to be murdered than is a white man of the same age.
- C. Less than 50 percent of people who commit homicides or assaultive behavior have imbibed significant amounts of alcohol immediately beforehand.
- D. The best predictor of violent acts is a previous violent act.
- E. More than 70 percent of homicides are committed with handguns.

6.6 Which of the following statements regarding punishment is *not* true?

- A. Punishment is often more useful than reinforcement.
- B. Punishment produces aggressive behavior.
- C. Punishment is less useful than extinction.
- D. Use of punishment should be carefully supervised.
- E. Self-injurious behaviors are the main instances where punishment should be used.

6.7 Which of the following chromosomal abnormalities has been implicated as having an influence on aggressive behavior?

- A. 45-XO
- B. 47-XYY
- C. 47-XXY

-
- D. 48-XXX
 - E. 47-XXX

6.8 Learned helplessness studies

- A. used Rhesus monkeys as experimental animals

- B. are used as paradigms for clinical depression in humans
- C. demonstrated that outcomes were contingent on behavior
- D. suggest that cortisol may be specifically decreased in helpless animals
- E. involved peer separations

6.9 Which of the following is *not* characteristic of a primate totally deprived of social contact?

- A. Abnormally fearful of peers
- B. Unable to nurture their young
- C. No recovery if greater than 12 months isolation
- D. Rapid reattachment if mother returns
- E. Self-orality is common

6.10 Prevalence is the

- A. proportion of a population that has a condition at one moment in time
- B. ratio of persons who acquire a disorder during a year's time
- C. risk of acquiring a condition at some time
- D. standard deviation
- E. rate of first admissions to a hospital for a disorder

6.11 Asian patients seem to achieve a clinical response comparable to those of non-Asian patients, even though they require a significantly lower dose of

- A. lithium
- B. antipsychotics
- C. tricyclics
- D. benzodiazepines
- E. all of the above

6.12 The "choo-choo" phenomenon is associated with which of the following types of social deprivation in monkeys?

- A. Total isolation-reared monkeys
- B. Mother-only-reared monkeys
- C. Peer-only-reared monkeys
- D. Partial isolation-reared monkeys
- E. Separation-reared monkeys

6.13 The increased frequency of aggressive behavior in certain children defined as abnormal has been correlated with all of the following *except*

- A. brain injury
- B. faulty identification models
- C. cultural environment
- D. violence in movies
- E. curiosity

6.14 Which of the following statistical procedures is used to evaluate the frequency of events in a population?

- A. Analysis of Variance (ANOVA)
- B. Chi-squared test
- C. T-test
- D. Discriminant analysis
- E. Z-score

6.15 Attachment theory states that

- A. Infants are generally polytropic in their attachments.
- B. Attachment occurs instantaneously between the mother and the child.
- C. Attachment is synonymous with bonding.
- D. Attachment disorders may lead to a failure to thrive.
- E. Separation anxiety is most common when an infant is

6.16 Which of the following statements regarding crossover studies is *true*?

- A. Eliminate selection bias.
- B. Is a variation of the double-blind study.
- C. Contain a treatment group and a control group.
- D. Are a type of prospective study.
- E. All of the above

Directions

Each set of lettered headings below is followed by a list of numbered phrases. For each numbered phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B

D. if the item is associated with neither A nor B

Questions 6.17–6.21

6.17 Theory is based on experimentation

6.18 Subjective methods of interpretation

6.19 Childhood experiences are the focus of the analysis

6.20 Testable hypotheses that can be evaluated through experimentation

6.21 Theory is predominantly based on case histories

A. Behavioral Model of learning

B. Psychoanalytic Model of learning

Questions 6.22–6.27

6.22 Instrumental conditioning

6.23 Learning takes place as a result of the contiguity of environmental events

6.24 Learning occurs as the consequence of action

6.25 Repeated pairing of a neutral stimulus with one that evokes a response

6.26 Ivan Petrovich Pavlov

6.27 B. F. Skinner

A. Classical conditioning

B. Operant conditioning

Directions

Each set of lettered headings below is followed by a list of numbered statements. For each numbered statement, select the *best* lettered heading. Each heading may be used once, more than once, or not at all.

Questions 6.28–6.29

6.28 When the null hypothesis is retained where it should have been rejected

6.29 When the null hypothesis is rejected where it should have been retained

A. Type I error

B. Type II error

Questions 6.30–6.34

6.30 Leads to the most rapid rate of response

6.31 Seen with the use of slot machines

6.32 Associated with scalloping

6.33 Generates an oscillating rate of response

6.34 Seen with the three-strike rule of baseball

- A. Fixed-ratio schedule
- B. Variable-ratio schedule
- C. Fixed-interval schedule
- D. Variable-interval schedule

Questions 6.35–6.38

6.35 Imprinting

6.36 Surrogate mother

6.37 Experimental neurosis

6.38 *Aplysia*

- A. Ivan Petrovich Pavlov
- B. Eric Kandel
- C. Konrad Lorenz
- D. Harry Harlow

Questions 6.39–6.42

6.39 "Secure base" effect

6.40 Protest, despair, detachment

6.41 First described anaclitic depression

6.42 Primarily associated with ethological studies

- A. John Bowlby
- B. Harry Harlow
- C. Mary Ainsworth
- D. René Spitz

Questions 6.43–6.47

6.43 Anorexic woman begins eating and gaining weight in order to get out of the hospital

6.44 Child has his favorite toy taken away every time he wets his bed

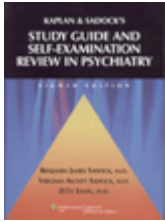
6.45 A woman gives her dog a treat every time he sits when told

6.46 A man begins leaving home earlier in the morning to avoid rush hour traffic

6.47 Dog begins salivating to the sound of a bell after learning food is coming soon after

- A. Positive reinforcement
- B. Negative reinforcement
- C. Punishment
- D. Classical conditioning





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](http://www.lww.com)



7

Clinical Neuropsychological Testing

Clinical neuropsychological tests of intelligence and personality are useful to measure specific aspects of a person's intelligence, thinking, or personality in particular clinical situations.

Intelligence testing is necessary to establish the degree of mental retardation. Neuropsychological tests help quantify and localize brain damage. The clinical neuropsychologist integrates the medical and psychosocial history with the reported complaints and the patterns of performance on neuropsychological procedures to determine whether results are consistent with a particular area of brain damage or a particular diagnosis.

The aim of neuropsychological tests is to achieve quantifiable and reproducible results that can be compared with the test scores of normal people of comparable age and demographic background. They are indicated to identify cognitive defects, to differentiate incipient depression from dementia, to determine the course of an illness, to assess neurotoxic effects, to evaluate the effects of treatment, and to evaluate learning disorders.

Projective tests present stimuli to whose meanings are not immediately obvious; the ambiguity forces the patient to project his or her own needs into the test situation. Those being tested impute meanings to the stimulus, apparently based on psychological and emotional factors.

Most commonly used assessment instruments are standardized against normal control subjects. This ensures that test administration and scoring are invariant across time and examiners. The data show whether the test is valid and reliable.

The student should be familiar with the types of neuropsychological assessment tests that are available, how they are administered, and their indications for use.

Helpful Hints

- abstract reasoning
- accurate profile
- attention

- attention-deficit/hyperactivity disorder
- average IQ
- battery tests
- behavioral flexibility
- bell-shaped curve
- Bender Visual Motor Gestalt test
- Alfred Binet
- catastrophic reaction
- clang association
- classification of intelligence
- coping phase
- dementia
- dressing apraxia
- dysgraphia
- dyslexia
- EEG abnormalities
- Eysenck personality inventory
- fluency
- full-scale IQ
- Gestalt psychology
- Halstead-Reitan
- House-Tree-Person test
- individual and group tests
- intelligence quotient (IQ)
- learning disability
- left versus right hemisphere disease
- Luria-Nebraska Neuropsychological Battery (LNNB)
- manual dexterity
- maturational levels
- memory: immediate, recent, recent past, remote
- mental age
- mental status cognitive tasks
- MMPI
- motivational aspects of behavior
- neuropsychiatric tests
- objective tests
- organic dysfunction
- orientation
- performance subtests
- perseveration

- personality functioning
- personality testing
- primary assets and weaknesses
- prognosis
- projective tests
- prosody
- psychodynamic formulations
- Raven's Progressive Matrices
- reaction times
- recall phase
- reliability
- response sets
- Rorschach test
- scatter pattern
- Shipley Abstraction test
- standardization
- Stanford-Binet
- stimulus words
- TAT
- temporal orientation
- test behavior
- validity
- verbal subtests
- visual-object agnosia
- WAIS
- WISC
- word-association technique

Questions/Answers

7.1 Which of the following about the Rorschach Test is *true*?

- A. A standard set of fifteen inkblots serves as the stimulus for the test.
- B. All the blots are black and white.
- C. It has an inquiry phase to determine aspects of the responses that are crucial to the scoring.
- D. There is no order to the ways in which the cards are shown.
- E. It is named after a German psychiatrist.

7.2 The Minnesota Multiphasic Personality Inventory (MMPI) is most correctly

described as

- A. composed of 200 questions
- B. generally used as a good diagnostic tool
- C. the most widely used personality assessment instrument
- D. a good indication of a subject's disorder when the person scores high on one particular clinical scale
- E. in the form of ten clinical scales, each of which was derived empirically from heterogeneous groups

7.3 Neuropsychological referrals are made for

- A. establishing a baseline of performance for assessing future change
- B. diagnostic purposes
- C. ascertaining if brain impairment is present
- D. planning for rehabilitation
- E. all of the above

7.4 Neuropsychological testing is used to assess

- A. normal aging
- B. early dementia
- C. competence
- D. a diagnosis of pseudodementia
- E. all of the above

7.5 Neuropsychological deficits associated with left hemisphere damage include all of the following *except*

- A. aphasia
- B. right-left disorientation
- C. finger agnosia
- D. visuospatial deficits
- E. limb apraxia

7.6 True statements about projective personality tests include

- A. They tend to be more direct and structural than objective personality instruments.
- B. The variety of responses is limited.
- C. Instructions are usually specific.
- D. They often focus on latent or unconscious aspects of personality.

E. None of the above

7.7 An intelligence quotient (IQ) of 100 corresponds to intellectual ability for the general population in the

- A. 20th percentile
- B. 25th percentile
- C. 40th percentile
- D. 50th percentile
- E. 65th percentile

7.8 After taking the Wechsler Adult Intelligence Scale(WAIS), a patient showed that poor concentration and attention had adversely influenced the answers on one of the subtests. Select the WAIS subtest that most likely screened the patient for these symptoms.

- A. arithmetic
- B. block design
- C. digit symbol
- D. comprehension
- E. picture completion

7.9 The Bender Visual Motor Gestalt test is administered to test

- A. maturation levels in children
- B. organic dysfunction
- C. loss of function
- D. visual and motor coordination
- E. all of the above

7.10 Which is *not* true of the Wisconsin Card Sorting Test?

- A. It assesses abstract reasoning
- B. The patient is told during testing whether their responses are correct or incorrect
- C. The examiner changes the principle of sorting when the task is mastered
- D. The examiner records the number of trials required to achieve ten consecutive correct responses
- E. It assesses parietal lobe dysfunction

7.11 In the Wechsler Adult Intelligence Scale (WAIS)

- A. digit span is a subtest of the verbal component of the test

- B. the average range of IQ is 100 to 120
- C. mental retardation corresponds to the lowest 1% of the population
- D. the verbal scale is more sensitive to normal aging
- E. its latest revision is designed for persons aged 16 to 60

Directions

Each group of questions below consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 7.12–7.16

P.54

7.12 The loss of gestalt, loss of symmetry, and distortion of figures

7.13 Patient not able to name a camouflaged object but able to name it when it is not camouflaged

7.14 Two or more errors or two or more 7-second delays in carrying out tasks of right-left orientation

7.15 Any improper letter sequence in spelling "earth" backward

7.16 Patient not able to name common objects

- A. Frontal lobes
- B. Dominant temporal lobe
- C. Nondominant parietal lobe
- D. Dominant parietal lobe
- E. Occipital lobe

Questions 7.17–7.21

7.17 Consists of ten tests, including the trail-making test and the critical flicker frequency test

7.18 Is extremely sensitive in identifying discrete forms of brain damage, such as dyslexia

7.19 Consists of 120 items, plus several alternative tests, applicable to the ages between 2 years and adulthood

7.20 Furnishes a description of the dynamic forces of personality through an analysis of the person's responses

7.21 A test of diffuse cerebral dysfunction to which normal children by the age of 7 years respond negatively

- A. Rorschach test
- B. Luria-Nebraska Neuropsychological Battery

- C. Halstead-Reitan Battery of Neuropsychological Tests
- D. Stanford-Binet Intelligence Scale
- E. None of the above

Questions 7.22–7.24

7.22 Wechsler Memory Scale

7.23 Wisconsin Card Sorting Test

7.24 Benton Visual Retention Test

- A. Short-term memory loss
- B. Signs of organic dysfunction
- C. Korsakoff's syndrome
- D. Posterior right hemisphere lesion
- E. Damage to frontal lobes or caudate

Questions 7.25–7.29

7.25 A broad set of complex verbal and visuospatial tasks that are normatively summarized by three scales

7.26 Impaired performance is associated with posterior lesions of either cerebral hemisphere

7.27 Series of 20 black-and-white pictures depicting individuals of different ages and sexes involved in a variety of settings

7.28 More direct than most projective tests in soliciting responses from the patient

7.29 Requires the patient to complete logical sequences

- A. Wechsler Adult Intelligence Scale (WAIS)
- B. Thematic Apperception Test (TAT)
- C. Shipley Abstraction Test
- D. Sentence Completion Test
- E. Raven's Progressive Matrices

Questions 7.30–7.34

7.30 Clock drawing and facial recognition

7.31 Finger tapping

7.32 Trail-making test

7.33 Digit span

7.34 Wisconsin Card Sorting Test

- A. Executive functions

- B. Attention and concentration
- C. Visuospatial–constructional
- D. Motor
- E. None of the above

Questions 7.35–7.37

7.35 Appropriate for children at least 6 years of age to 16 years

7.36 Appropriate for children beginning at 2 1/2 years of age

7.37 Yields a composite IQ score, and scores for verbal reasoning, abstract visual reasoning, quantitative reasoning, and short-term memory

- A. Stanford-Binet Intelligence Scale
- B. Wechsler Preschool and Primary Scale of Intelligence (WPPSI)
- C. Wechsler Intelligence Scale for Children (WISC)— Third Edition
- D. All of the above
- E. None of the above

Questions 7.38–7.42

7.38 Memory for automatic skills, like speaking grammatically or driving a car

7.39 Recall of perceived material within thirty seconds of presentation

7.40 Memory for specific events, like a phone message

7.41 Retention of information over the past few months, like current events

7.42 Memory for knowledge and facts, like the first president of the United States

- A. Immediate memory
- B. Episodic memory
- C. Semantic memory
- D. Recent past memory
- E. Implicit memory

Directions

Each set of lettered headings below is followed by a list of numbered phrases. For each numbered phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

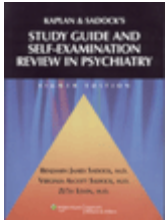
Questions 7.43–7.44

7.43 Ratings are made on the basis of mental status interview and do not require that the examiner ask any specific questions

7.44 Highly structured interview

- A. Brief Psychiatric Rating Scale (BPRS)
- B. Schedule for Affective Disorders and Schizophrenia (SADS)





Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



8 Theories of Personality and Psychopathology

All psychiatrists should be familiar with the essential aspects of certain theoretical frameworks of personality and psychopathology. Psychoanalysis is the bedrock of psychodynamic understanding and forms the fundamental point of reference for a variety of types of therapeutic intervention. It embraces not only psychoanalysis itself, but also various forms of psychoanalytically oriented psychotherapies, and related therapies involving psychodynamic concepts.

All major psychological theories of personality involve the basic premise that a person's early psychosocial development shapes what comes later: that the impact of childhood events, beliefs, experiences, and fantasies continue, consciously or unconsciously, throughout life and account for adult behavior.

The most important personality theorist of the modern era was Sigmund Freud (1856–1939). His revolutionary contributions to the understanding of the human mind and psyche continue to stimulate, provoke, and challenge students of personality and psychopathology today. His basic tenets of the unconscious mind, psychosexual development, and psychodynamics remain the bedrock of psychoanalytic theory, even though many have disagreed with, modified, or expanded on his ideas. No matter how a particular theorist may feel about Freud's ideas, each must begin with a thorough knowledge of his contributions.

There have been many psychoanalytic personality theorists with widely varying views on development. These include Alfred Adler (1870–1937), Erik Erikson (1902–1994), Karen Horney (1885–1952), Carl Gustav Jung (1875–1961), Melanie Klein (1882–1960), Harry Stack Sullivan (1892–1949), and Heinz Kohut (1913–1981). Schools of thought, encompassing a variety of different theories, include ego psychology, object relations, self psychology, and interpersonal psychology, among others. Each approach has its own perspective on personality development and the development of psychopathology.

Students should study the questions and answers below to test their knowledge in this area.

Helpful Hints

The student should know the various theorists, their schools of thought, and their theories.

- Karl Abraham
- abreaction
- acting out
- Alfred Adler
- Franz Alexander
- Gordon Allport
- analytical process
- attention cathexis
- Michael Balint
- behaviorism
- Eric Berne
- Wilfred Bion
- birth trauma
- Joseph Breuer
- cathexis
- Raymond Cattell
- character traits
- condensation
- conflict
- conscious
- day's residue
- defense mechanisms
- displacement
- dream work
- ego functions
- ego psychology
- Erik Erikson
- Eros and Thanatos
- Ronald Fairbairn
- Sandor Ferenczi
- Anna Freud
- free association
- Erich Fromm
- fundamental rule
- Kurt Goldstein
- Heinz Hartmann
- Karen Horney
- hypnosis
- hysterical phenomena
- infantile sexuality

- instinctual drives
- interpretation
- Carl Gustav Jung
- Søren Kierkegaard
- Melanie Klein
- Heinz Kohut
- latent dream
- Kurt Lewin
- libido
- libido and instinct theories
- manifest dream
- Abraham Maslow
- Adolph Meyer
- multiple self-organizations
- Gardner Murphy
- Henry Murray
- narcissism
- narcissistic, immature, neurotic, and mature defenses
- nocturnal sensory stimuli
- object constancy
- object relations
- parapraxes
- Frederick S. Perls
- preconscious
- preconscious system
- pregenital
- primary and secondary gains
- primary autonomous functions

-
- primary process
 - psychic determinism
 - psychoanalytic theory
 - psychodynamic thinking
 - psychoneurosis
 - psychosexual development
 - Sandor Rado
 - Otto Rank
 - reality principle
 - reality testing
 - regression

Wilhelm Reich

- repetition compulsion
- repression
- resistance
- secondary process
- secondary revision
- signal anxiety
- structural model
- *Studies on Hysteria*
- Harry Stack Sullivan
- symbolic representation
- symbolism
- synthetic functions of the ego
- talking cure
- *The Ego and the Id*
- *The Interpretation of Dreams*
- topographic theory
- transference
- unconscious motivation
- Donald Winnicott
- wish fulfillment

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

8.1 According to Wilhelm Reich, which of the following attributes can be recognized in a person with a compulsive character?

- A. Stiffly walking
- B. A cold appearance
- C. Excessive complaining
- D. Sexually suggestive body movement
- E. All of the above

8.2 Which of the following theorists is considered the founder of the attachment theory?

- A. Heinz Kohut
- B. Adolf Meyer

- C. John Bowlby
- D. Melanie Klein
- E. Otto Kernberg

8.3 According to Erich Fromm, which of the following character types are typical of modern capitalist society?

- A. Receptive
- B. Exploitative
- C. Hoarders
- D. Marketers
- E. All of the above

8.4 The Oedipus complex as described by Freud involves all of the following *except*

- A. intense love relationships
- B. rivalries
- C. adult sexuality
- D. both mother and father
- E. anal phase

8.5 The Oedipus complex is resolved according to Freud through

- A. the castration complex
- B. the acting out of symbolic rivalries
- C. moving on to the genital stage of development
- D. the realization of one's gender identity
- E. the identification with the opposite sex parent

8.6 According to Otto Rank, *death fear* is

- A. the fear of dying "before one's time"
- B. the fear of losing all ties in the process of becoming separate
- C. the fear of losing one's identity by fusing with another person
- D. the fear of dying usually associated with a phobia
- E. none of the above

8.7 A young woman presents to you complaining of lack of energy, trouble sleeping, depression, and hopelessness that has been present for the last year. You diagnose her with major depressive disorder. Which of the following would have been Freud's explanation of this disorder?

- A. She feels despair that her self-object needs will not be met by others.
- B. Her internal good objects have been destroyed by aggression and greed.
- C. She never mastered the trust versus mistrust stage of ego development.
- D. Her depression is actually internally directed anger.
- E. She is being persecuted by a tormenting internal object.

8.8 Erik Erikson's epigenetic principle states

- A. each sequential stage must be satisfactorily resolved for development to proceed smoothly.
- B. the genetic component of personality must be explored to fully understand the ego.
- C. each developmental stage must be completed, but in no particular order.
- D. development spans the entire life cycle, from infancy through old age and senescence.
- E. none of the above

8.9 Separation and individuation

- A. involve a "practicing" sub-phase
- B. begins at approximately 8 or 9 months of age
- C. involve attaining a sense of object permanence
- D. is based on the work of Dan Stern, M.D.
- E. has no associated anxiety

P.63

8.10 Freud declared the road to understanding the unconscious lies in which of the following?

- A. Mastering the phases of ego development
- B. Understanding infant sexuality
- C. Interpretation of dreams
- D. Instinct control
- E. Repression of preconscious desires

8.11 A patient of yours reports having recurrent dreams of snakes shedding their skins. According to Carl Gustav Jung, this image is an example of which of the following?

- A. Manifest content
- B. Archetypes
- C. Primary process

- D. Illusions
- E. Phallic symbol

8.12 You have a 72-year-old patient who has been very concerned with her appearance ever since you met her. She has had three facelifts, never leaves the house without makeup, and refuses to allow her grandchildren to call her "grandmother." Which of the following of Erikson's stages is this woman having difficulty mastering?

- A. Integrity versus despair
- B. Narcissistic
- C. Generativity versus stagnation
- D. Egocentric
- E. Identity versus role confusion

8.13 Attachment theory

- A. studies the "stranger situation"
- B. is associated with Mary Main
- C. relates patterns of adult interactions with significant objects to early infant attachment
- D. defines four categories of infant behavior
- E. all of the above

8.14 Erikson differs from Freud by his placing greater emphasis on

- A. psychosexual development
- B. object relations
- C. interpersonal relationships
- D. cultural factors in development
- E. instinctual drives

8.15 Which of the following is not considered a mature defense?

- A. Anticipation
- B. Suppression
- C. Somatization
- D. Altruism
- E. Asceticism

8.16 The work of Anna Freud, daughter of Sigmund Freud, included all of the following *except*

- A. Contradictions to her father's claims about psychosexual development
- B. Expansion on individual defense mechanisms
- C. Development of modern ego psychology
- D. Contributions to child psychoanalysis
- E. Studies on the function of the ego in personality development

8.17 According to Carl Gustav Jung, archetypes are

- A. instinctual patterns
- B. expressed in representational images
- C. expressed in mythological images
- D. organizational units of the personality
- E. all of the above

8.18 Which of the following statements regarding Freud's view of hypnosis is *not* true?

- A. Freud eventually abandoned the use of hypnosis for the use of free association.
- B. Freud believed hypnosis concealed aspects of transference.
- C. Freud believed no patient was completely refractory to hypnosis.
- D. Freud felt hypnosis encouraged the patient to please the hypnotist.
- E. None of the above

8.19 Lacanian theory

- A. places heavy emphasis on linguistics
- B. has no place for biology or drives
- C. postulates that an individual is embedded in political and societal structure
- D. views the analytical process as an effort to recognize alienation from one's true self
- E. all of the above

8.20 All of the following statements concerning the concept of the preconscious are true *except*

- A. It is those mental events brought to consciousness by focusing attention.
- B. It interfaces with both the unconscious and the conscious.
- C. It acts as a censor to unacceptable wishes and desires.
- D. It is part of the topographical model of the mind formulated by Freud.
- E. It is characterized by primary process thinking.

8.21 Which of the following about Melanie Klein is *false*?

- A. She stressed the role of intrapsychic fantasy.
- B. She coined the term "persecutory anxiety."
- C. She described the "depressive position."
- D. She denounced Freud's "death instinct."
- E. She was a child analyst.

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated

P.64

with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 8.22–8.25

8.22 The ultimate separation from dependence on and attachment to the parents.

8.23 Laying the foundation for gender identity

8.24 Further integration of oedipal identifications

8.25 Striving for separation from dependence and control by parents.

- A. Urethral Stage
- B. Genital Stage
- C. Latency Stage
- D. Anal Stage
- E. Phallic Stage

Questions 8.26–8.30

8.26 Infancy

8.27 Early childhood

8.28 Puberty and adolescence

8.29 Early adulthood

8.30 Late adulthood

- A. Basic trust versus basic mistrust
- B. Integrity versus despair
- C. Initiative versus guilt
- D. Intimacy versus isolation
- E. Identity versus role diffusion

Questions 8.31–8.35

8.31 Civilization and its Discontents

8.32 Envy and Gratitude

8.33 Schizophrenia as a Human Process

8.34 The Ego and the Mechanisms of Defense

8.35 Childhood and Society

- A. Anna Freud
- B. Erik Erikson
- C. Sigmund Freud
- D. Melanie Klein
- E. Harry Stack Sullivan

Questions 8.36–8.40

8.36 Introduced the concept of the transitional object

8.37 Believed that oedipal strivings are experienced during the first year of life, wherein gratifying experiences with the good breast reinforce basic trust

8.38 Emphasized cultural factors and disturbances in interpersonal and intrapsychic development

8.39 Introduced the concept of the corrective emotional experience

8.40 Expanded Freud's concept of narcissism; his/her theories are known as self psychology

- A. Franz Alexander
- B. Donald Winnicott
- C. Karen Horney
- D. Melanie Klein
- E. Heinz Kohut

Questions 8.41–8.45

8.41 Care

8.42 Hope

8.43 Love

8.44 Purpose

8.45 Competence

- A. Initiative versus guilt
- B. Intimacy versus isolation

- C. Trust versus mistrust
- D. Industry versus inferiority
- E. Generativity versus stagnation

Questions 8.46–8.49

8.46 A young woman gets into an argument with her boyfriend. Although very upset, she remains silent as he tells her she is worthless. Once she gets home, the young woman picks a fight with her younger sister over nothing and begins yelling at her.

8.47 A young man is very envious of his best friend. Although it is difficult to admit, he believes his friend is more successful, better looking, and is always the life of the party. To the contrary, this young man tells his family that his best friend is envious of him, despite there being no evidence that this is so.

8.48 An 18-year-old male lives alone with his mother and despises her. He is embarrassed that he has these feelings, and compensates by hovering over her, attending to her every need.

8.49 A middle-aged man has had an unconscious desire to control others for as long as he can remember. To fulfill this need, he became a prison guard.

- A. Projection
- B. Displacement
- C. Sublimation
- D. Repression
- E. Reaction formation

Questions 8.50–8.53

8.50 Unconscious thoughts and wishes

8.51 What is recalled by the dreamer

8.52 Mental operation of making the unconscious known

8.53 Work of organizing aspects of a dream into less bizarre form

- A. Manifest dream content
- B. Latent dream content
- C. Dream work
- D. Secondary revision

Questions 8.54–8.58

8.54 Humor

8.55 Displacement

8.56 Regression

8.57 Denial

8.58 Sublimation

- A. Narcissistic defense
- B. Immature defense
- C. Neurotic defense
- D. Mature defense

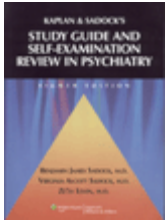
Questions 8.59–8.61

8.59 Events are causally related because of temporal or serial connections

8.60 Most logical, rational, and mature type of cognitive functioning

8.61 Undifferentiated thought that cannot separate the whole into parts

- A. Prototaxic mode
- B. Parataxic mode
- C. Syntactic mode



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



9 Clinical Examination of the Psychiatric Patient

The psychiatric evaluation comprises two sections. The first is a series of histories: psychiatric, medical, and family. The second is the mental status examination, which reviews the patient's emotional and cognitive functioning at the time of the interview. Because diagnosis in psychiatry is not etiologically based, and because it does not have any external validating criteria, a psychiatric diagnosis is as good as the knowledge and skill of the clinician making it. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic system, with which all American psychiatrists are intimately familiar, is based on descriptive phenomenology rather than inferred data, and has greatly increased the reliability of psychiatric diagnoses.

A structured history and mental status examination is a guide for organizing the patient's history. While it is not intended as a rigid plan for interviewing a patient, attending to all its sections does allow for greater completeness of assessment. It ensures that the clinician attends to issues other than only symptoms, like a developmental history, sexual history, and attention to the patient biologically, psychologically, and socially.

In this day and age of increased monitoring of medical care by third parties, the astute clinician must be aware of good documentation of care, and attend to the medical record. Reviews of cases are often conducted by persons with little or no background in psychiatry who do not recognize the complexities of psychiatric diagnosis and treatment. "Inadequate information" in a chart is unacceptable.

Similarly, psychiatrists must have a knowledge and understanding of physical signs and symptoms. They must often decide whether a patient needs a medical examination, and what that should include. There are numerous medical conditions that can manifest psychiatric symptoms. Each of these diagnoses argues for a different set of laboratory or diagnostic tests. Advances in neuropsychiatry and biological psychiatry have made laboratory tests more and more useful. Laboratory tests are also used to monitor dosing, treatment adherence, and toxic effects of various psychotropic medications.

The student should address the following questions and study the answers to gain knowledge of the clinical examination of the psychiatric patient.

Helpful Hints

Students should familiarize themselves with these terms, especially the acronyms and

names of laboratory tests.

- adulthood
- anamnesis
- antipsychotics
- appearance, behavior, attitude, and speech
- appropriateness
- carbamazepine
- catecholamines
- chief complaint
- clang associations
- concentration, memory, and intelligence
- confabulation
- consciousness and orientation
- countertransference
- CSF
- CT
- current social situation
- cyclic antidepressants
- data
- do's and don'ts of treating violent patients
- dreams, fantasies, and value systems
- DSM-IV-TR and Axes I–V
- early, middle, and late childhood history
- EEG
- eliciting delusional beliefs
- family history
- history of present illness; previous illnesses
- initial interview and greeting
- interviewing variations
- judgment and insight
- lithium
- marital history
- medical history
- mental status examination
- military history
- mood, feelings, and affect
- neologisms
- occupational and educational history
- paraphasia
- patient questions

- perception
- PET
- polysomnography
- prenatal history
- prognosis
- psychiatric history
- psychiatric report
- psychodynamic formulation
- psychosexual history
- punning
- rapport
- reliability
- religious background
- resistance
- sensorium and cognition
- sexuality
- social activity
- stress interview
- style
- subsequent interviews
- therapeutic alliance
- thought process
- time management
- transference
- treatment plan
- TRH
- TSH
- uncovering feelings
- VDRL
- word salad

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

9.1 The psychiatric history

- A. focuses exclusively on information obtained from the patient
- B. has no formal structure

- C. focuses primarily on symptoms
- D. does not address medical issues
- E. attends to the patient's anamnesis

9.2 The medical record

- A. cannot be used by regulatory agencies
- B. is absolutely confidential
- C. cannot be used in malpractice litigation
- D. is accessible to patients
- E. is used only by the treating team

9.3 Formal thought disorders include

- A. circumstantiality
- B. clang associations
- C. neologisms
- D. flight of ideas
- E. all of the above

9.4 True statements about diagnostic tests in psychiatric disorders include

- A. serum amylase may be increased in bulimia nervosa
- B. serum bicarbonate may be decreased in panic disorder
- C. decreased serum calcium has been associated with depression
- D. serum bicarbonate may be elevated in bulimia nervosa
- E. all of the above

9.5 Which of the following is *not* part of the sensorium category of the mental status examination?

- A. Fund of knowledge
- B. Abstract thinking
- C. Alertness
- D. Judgment
- E. Concentration

9.6 Tests of concentration include all of the following except

- A. calculations
- B. repeating a series of random numbers

- C. proverb interpretation
- D. spelling "world" backward
- E. repeating three or four unrelated objects after 5 to 10 minutes

9.7 Which of the following is included in the medical record of a patient admitted to an inpatient psychiatric unit?

- A. The treatment plan
- B. Summaries of case conferences
- C. Reports of diagnostic evaluations
- D. Legal admission documents
- E. All of the above

9.8 Hypothyroidism in the elderly may commonly present with all of the following *except*

- A. lassitude
- B. fatigue
- C. cognitive impairment
- D. anorexia
- E. constipation

9.9 True statements about the lengths of time drugs of abuse can be detected in urine include

- A. morphine for 8 days
- B. benzodiazepine for 2 to 3 weeks
- C. alcohol for 7 to 12 hours
- D. marijuana for 24 to 48 hours
- E. cocaine for 1 to 2 weeks

9.10 A good test for recent memory is to ask patients

- A. their date of birth
- B. what they had to eat for their last meal
- C. how many siblings they have
- D. to subtract 7 from 100
- E. who is the president of the United States

9.11 Common pretreatment lithium tests include

- A. ECG

- B. pregnancy test
- C. serum electrolytes
- D. serum BUN
- E. all of the above

9.12 Polysomnography (sleep EEG) abnormalities include

- A. a decrease in the amount of REM sleep in major depressive disorder
- B. a lengthened REM latency in major depressive disorder
- C. an increase in REM sleep in dementia
- D. an increased sleep latency in schizophrenia
- E. none of the above

9.13 The first sign of beginning cerebral disease is impairment of

- A. immediate memory
- B. recent memory
- C. long-term memory
- D. remote memory
- E. none of the above

9.14 In a psychiatric interview

- A. the psychiatrist may have to medicate a violent patient before taking a history
- B. a violent patient should be interviewed alone to establish patient–doctor relationship
- C. delusions should be challenged directly

P.73

- D. the psychiatrist must not ask depressed patients if they have suicidal thoughts
- E. the psychiatrist should have a seat higher than the patient's seat

9.15 Which of the following substances has been implicated in mood disorders with a seasonal pattern?

- A. luteotropic hormone (LTH)
- B. gonadotropin-releasing hormone (GnRH)
- C. testosterone
- D. estrogen
- E. melatonin

9.16 Each of the following statements is true *except*

- A. Sodium lactate provokes panic attacks in a majority of patients with panic disorder.
- B. Sodium lactate can trigger flashbacks in patients with posttraumatic stress disorder.
- C. Hyperventilation is as sensitive as lactate provocation in inducing panic attacks.
- D. Panic attacks triggered by sodium lactate are not inhibited by propranolol.
- E. Panic attacks triggered by sodium lactate are inhibited by alprazolam.

9.17 If a patient receiving clozapine shows a white blood count (WBC) of 2,000 per cc, the clinician should

- A. increase the dosage of clozapine at once
- B. terminate any antibiotic therapy
- C. stop the administration of clozapine at once
- D. monitor the patient's WBC every 10 days
- E. institute weekly complete blood count (CBC) tests with differential

9.18 Which of the following liability issues about the medical record are *true*?

- A. Failure to keep medical records violates state statutes.
- B. Failure to keep medical records violates licensing provisions.
- C. Psychiatrists in private practice are obligated to maintain medical records of their patients.
- D. Records need to be kept for the time determined by state laws.
- E. All of the above.

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 9.19–9.23

9.19 Elevated in alcoholism and vitamin B12 and folate deficiency

9.20 Causative agent for infectious mononucleosis; associated with depression, fatigue, and personality change

9.21 Decreased serum chloride

9.22 Psychosis, hallucinations, delirium

9.23 Biphasic or triphasic slow bursts on EEG

- A. Epstein-Barr virus (EBV)

- B. Mean corpuscular volume (MCV)
- C. Creutzfeldt-Jakob disease
- D. Bulimia nervosa
- E. Bromide intoxication

Questions 9.24–9.28

9.24 Jaundice, sense of imminent doom

9.25 Dry skin, myxedema madness

9.26 Kayser-Fleischer rings, brain damage

9.27 Abdominal crises, mood swings

9.28 Tremor, anxiety, hyperactivity

- A. Hyperthyroidism
- B. Hypothyroidism
- C. Porphyrria
- D. Hepatolenticular degeneration
- E. Pancreatic carcinoma

Questions: 9.29–9.33

9.29 Carcinoid tumors

9.30 Phenothiazine medications

9.31 Aggressive behavior

9.32 High banana intake

9.33 Suicidal patients

- A. Elevated level of 5-HIAA
- B. Decreased level of 5-HIAA

Questions 9.34–9.38

9.34 Multiple associations so that thoughts move abruptly from idea to idea

9.35 A sudden break in the flow of ideas

9.36 Overinclusion of trivial details that impedes getting to the point

9.37 A breakdown in the logical connection between ideas and overall goal-directedness

9.38 Repetition of words, phrases, or ideas that are out of context

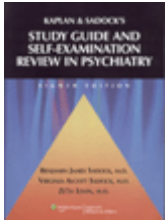
- A. Circumstantiality
- B. Derailment

C. Preservation

D. Flight of ideas

E. Thought blocking





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



10

Signs and Symptoms in Psychiatry

Signs are observations and objective findings elicited by the clinician. Symptoms are the subjective experiences described by the patient. A syndrome is a group of signs and symptoms that together make up a recognizable condition. There are hundreds of terms used to describe the signs and symptoms of psychiatric illness, and students of psychiatry are encouraged to familiarize themselves with as many as possible. The language of psychiatry is precise, and this allows clinicians to articulate their observations reliably.

In psychiatry, the presentation of signs and symptoms is not always straightforward. A patient may insist that nothing is wrong (that there are no symptoms), when it is obvious to most observers that certain behaviors or ways of thinking are bizarre, damaging, or disruptive. These might be defined as ego-syntonic symptoms. Ego-dystonic symptoms are those of which the patient is aware and that are experienced as uncomfortable or unacceptable. Another complicating factor is that a clinician may not be able to literally observe or to hear a described symptom (such as an auditory hallucination), and may have to depend on indirect evidence (for example, a patient's preoccupation or distraction) to diagnose it.

In psychiatry there are few if any pathognomonic signs and symptoms. Human behavior is too complex for this. Complicating matters further, medical conditions can frequently present initially with psychiatric signs and symptoms, and psychiatric conditions with medical ones. Medical pathology can underlie apparent psychiatric symptomatology and psychiatric syndromes can be expressed in physical terms. The skilled clinician must know when to have a heightened level of suspicion that a condition may not be what it first appears to be and must know concretely how to differentiate between them.

Students should study the questions and answers below for a useful review of these topics.

Helpful Hints

The student should be able to define and categorize the signs and symptoms and other terms listed below.

- affect and mood

- aggression
- agnosias
- anxiety
- aphasic disturbances
- cerea flexibilitas
- coma
- *déjà entendu*
- *déjà pensé*
- *déjà vu*
- delirium
- delusion
- dementia
- depersonalization
- disorientation
- distractibility
- disturbances in speech
- disturbances in the form and the content of thought
- disturbances of conation
- disturbances of consciousness and attention
- disturbances of intelligence
- disturbances of memory
- disturbances of perception, both those caused by brain diseases and those associated with psychological phenomena
- *folie à deux*
- hypnosis
- illusions
- insight and judgment
- *jamais vu*
- noesis
- panic
- phobias
- pseudodementia
- stereotypy
- synesthesia

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

10.1 Sundowning

- A. usually occurs in the young
- B. is associated with stupor
- C. occurs usually as a function of mania
- D. is a result of overmedication
- E. is associated with akathisia

10.2 Which of the following is a paramnesia?

- A. *Jamais vu*
- B. Eidetic images
- C. Repression

P.81

- D. Screen memories
- E. Lethologica

10.3 A psychiatric patient who, although coherent, never gets to the point has a disturbance in the form of thought called

- A. word salad
- B. circumstantiality
- C. tangentiality
- D. verbigeration
- E. blocking

10.4 Perceptual disturbances include all of the following except

- A. hallucinations
- B. hypnagogic experiences
- C. echolalia
- D. depersonalization
- E. derealization

10.5 Physiological disturbances associated with mood include

- A. hyperphagia
- B. anorexia
- C. hypersomnia
- D. diurnal variation
- E. all of the above

10.6 Loss of normal speech melody is known as

- A. stuttering
- B. stammering
- C. aphonia
- D. dysprosody
- E. dyslexia

10.7 Stereotypy is

- A. temporary loss of muscle tone and weakness precipitated by a variety of emotional states
- B. pathological imitation of movements of one person by another
- C. ingrained, habitual involuntary movement
- D. repetitive fixed pattern of physical action or speech
- E. subjective feeling of muscular tension and restlessness secondary to antipsychotic or other medication

10.8 Disturbances of attention include

- A. hypervigilance
- B. twilight state
- C. somnolence
- D. sundowning
- E. all of the above

10.9 Asking a patient to interpret a proverb is used as a way of assessing

- A. judgment
- B. impulse control
- C. abstract thinking
- D. insight
- E. intelligence

10.10 Alexithymia is

- A. an unpleasant mood
- B. a loss of interest in and withdrawal from pleasurable activities
- C. an inability to describe or to be aware of emotions or mood
- D. a normal range of mood, implying absence of depressed or elevated emotional state

E. a state in which a person is easily annoyed and provoked to anger

10.11 Primary process thinking is

- A. a form of magical thinking
- B. similar to that of the preoperational phase in children
- C. normally found in dreams
- D. dereistic
- E. all of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 10.12–10.16

10.12 Inability to carry out specific tasks

10.13 Inability to perform rapid alternating movements

10.14 Inability to comprehend more than one element of a visual scene at a time

10.15 Inability to recognize objects by touch

10.16 Inability to recognize one's own neurological deficit

- A. Stimulagnosia
- B. Anosognosia
- C. Apraxia
- D. Astereognosis
- E. Adiadochokinesia

Questions 10.17–10.21

10.17 "I was gigglifying, not just tempifying; you know what I mean."

10.18 "I was grocery training; but, when I ride the grocery, I drive the food everywhere on top of lollipops."

10.19 "Cain and Abel—they were cannibals. You see brothers kill brothers—that is laudable. If you ask me, though, never name your son Huxtibal. OK."

**10.20 Patient: "I never wanted." Physician: "Go on. What were you saying?"
Patient: "I don't know."**

10.21 "Tired, mired, schmired, wired."

- A. Loosening of associations

- B. Flight of ideas
- C. Clang association
- D. Blocking
- E. Neologism

Questions 10.22–10.26

- 10.22 Peculiar feelings during sleep, causing an irresistible need to move around**
- 10.23 Periods of sleepiness, alternating with confusion, hunger, and sexual activity**
- 10.24 Sudden attacks of generalized muscle weakness, leading to physical collapse while alert**
- 10.25 Sudden attacks of irresistible sleepiness**
- 10.26 Repetitive jerking of the legs during sleep, waking patients as well as their partners**

- A. Narcolepsy
- B. Cataplexy
- C. Restless legs syndrome
- D. Klein-Levin syndrome
- E. Nocturnal myoclonus

Questions 10.27–10.30

- 10.27 Borderline personality disorder**
- 10.28 Paranoid personality disorder**
- 10.29 Obsessive-compulsive personality disorder**
- 10.30 Schizoid personality disorder**

- A. Cluster A
- B. Cluster B
- C. Cluster C

Questions 10.31–10.35

- 10.31 Most are simple visual hallucinations of geometric patterns, but phenomena such as micropsia and macropsia may occur**
- 10.32 Hallucinations of one's own physical self**
- 10.33 Involve the sense of smell and are most often associated with organic brain disease or psychotic depression**
- 10.34 Occur as part of seizure activity, and are typically brief and stereotyped**
- 10.35 Formication**

- A. Haptic hallucinations
- B. Olfactory hallucinations
- C. Ictal hallucinations
- D. Autoscopie hallucinations
- E. Migrainous hallucinations

Questions 10.36–10.38

10.36 Capacity to return previously stored memories to consciousness

10.37 Capacity to add new material to memory

10.38 Capacity to hold memories in storage

- A. Registration
- B. Retention
- C. Recall

Questions 10.39–10.42

10.39 Illusion of auditory recognition

10.40 Regarding a new thought as a repetition of a previous thought

10.41 Feeling of unfamiliarity with a familiar situation

10.42 Regarding a new situation as a repetition of a previous experience

- A. *déjà vu*
- B. *déjà entendu*
- C. *déjà pensé*
- D. Jamais vu
- E. Confabulation

Questions 10.43–10.46

10.43 Exaggerated degree of retention and recall

10.44 Temporary inability to remember a name

10.45 Confusion of facts and fantasies

10.46 Sensations that accompany sensations of another modality

- A. Synesthesia
- B. Paramnesia
- C. Hypermnesia
- D. Eidetic images

Questions 10.47–10.49

10.47 Discrepancies in psychiatric evaluation caused by differences in the patient's status or in information imparted by the patient from examination to examination

10.48 Discrepancies caused by differences in perceiving and interpreting the patient's responses to questions within the interview

10.49 Discrepancies caused by differences in the observer's definition of the symptoms or signs in question

- A. Information variance
- B. Criterion variance
- C. Observation bias
- D. Validity

Questions 10.50–10.53

10.50 Coexistence of two opposing impulses

10.51 Emotional discharge after recalling a painful experience

10.52 Feeling of apprehension

10.53 Emotion resulting from doing something perceived as wrong

- A. Anxiety
- B. Ambivalence
- C. Guilt
- D. Abreaction

Questions 10.54–10.58

10.54 Fear of heights

10.55 Fear of cats

10.56 Fear of the number 13

10.57 Fear of snakes

10.58 Fear of dust

- A. Ophidiophobia
- B. Triskaidekaphobia
- C. Acrophobia
- D. Amathophobia
- E. Gatophobia

Questions 10.59–10.63

10.59 Patients believe that another person has been physically transformed into themselves

10.60 Strangers are identified as familiar persons in the patient's life

10.61 False belief that someone (usually of higher status or authority) is erotically attached to the patient

10.62 Patient believes that someone close to him or her has been replaced by an exact double

10.63 False belief about a spouse's infidelity

- A. Capgras's syndrome
- B. Frégoli's phenomenon
- C. Clérambault's syndrome
- D. Delusion of doubles
- E. Delusional jealousy

Questions 10.64–10.68

10.64 Difficulty finding the correct name for an object.

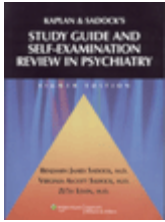
10.65 Spontaneous but incoherent speech

10.66 Inability to arrange words in proper sequence

10.67 Understanding remains but speech is grossly impaired

10.68 Involuntary obscene language

- A. Broca's aphasia
- B. Syntactical aphasia
- C. Coprohasia
- D. Amnesic aphasia
- E. Wernicke's aphasia



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



11

Classification in Psychiatry and Psychiatric Rating Scales

Advances in psychiatry are greatly shaped by its system of disease classification. Systems of classification for psychiatric diagnoses help distinguish one diagnosis from the other, so that clinicians can provide the most appropriate and effective treatment. They delineate a language common to all health care providers, so that all involved are treating and managing the same condition. They also provide a system to explore the still unknown etiology of mental disorders.

The 10th revision of *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) is the official classification system used in Europe and many other parts of the world, developed by the World Health Organization. The text revision of the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), developed by the American Psychiatric Association, is the official coding system used in the United States. It describes the manifestations of mental disorder in terms of its associated features; age, culture, and gender-related features; prevalence, incidence, and risk; course; complications; predisposing factors; familial pattern; and differential diagnosis. It is a multiaxial system that evaluated patients along several variables and contains five axes.

Psychiatric rating scales, or instruments, provide a way to quantify aspects of a patient's psyche, behavior, and relationships with other people and society. Many rating scales successfully measure carefully chosen features of well-formulated concepts. Psychiatrists who do not use these scales are left with only their clinical impressions, which does not allow for reliable comparison. Without these scales, quantitative data in psychiatry are crude. In order to ready any research article critically, a familiarity with these classification systems and rating instruments is essential.

Helpful Hints

The student should be able to define the terms below, especially the diagnostic categories.

- age of onset
- agoraphobia

- alcohol delirium
- amnesic disorders
- associated and essential features
- atheoretical
- bipolar I disorder
- body dysmorphic disorder
- classification
- clinical syndromes
- cognitive disorders
- competence
- complications
- conversion disorder
- course
- delusional disorder
- dementia precox
- depersonalization disorder
- depressive disorders
- descriptive approach
- diagnostic criteria
- differential diagnosis
- disability determination
- dissociative disorders
- dissociative fugue
- dissociative identity disorder
- DSM-IV-TR
- dysthymic disorder
- ego-dystonic and ego-syntonic
- familial pattern
- general medical conditions
- generalized anxiety disorder
- Global Assessment of Functioning Scale
- gross social norms
- highest level of functioning
- hypochondriasis
- ICD-10
- impairment
- Emil Kraepelin
- mood disorders
- multiaxial system
- obsessive-compulsive disorder

- panic disorder
- paraphilias
- partial and full remission
- personality disorders
- pervasive developmental disorders
- phobias
- posttraumatic stress disorder
- predictive validity
- predisposing factors
- premenstrual dysphoric disorder
- prevalence
- psychological factors affecting medical condition
- psychosis
- psychosocial and environmental stressors
- reality testing
- residual type
- schizophrenia
- severity-of-stress rating
- sex ratio
- sexual dysfunctions
- somatization disorder
- somatoform disorders
- validity and reliability

Classification in Psychiatry

Questions/Answers

Directions

Each of the incomplete statements below is followed by five suggested completions. Select the *one* that is *best* in each case.

11.1 Which of the following about the multiaxial diagnostic classification is *true*?

- A. Axis III lists only the physical disorders that are causative of the patient's mental disorder.
- B. Axis II consists of personality disorders only.
- C. It is a causation-driven diagnostic system.
- D. Axis IV stressors are evaluated based on the clinician's assessment of the stress that an average person with similar socio-cultural values and circumstances would experience from the psychosocial stressors.

E. Axis I precludes disorders diagnosed in infancy, childhood or adolescence.

11.2 DSM-IV-TR

- A. uses the term disorders because most of the entities lack the features necessary to warrant the term disease
- B. never specifies cause
- C. officially employs the term psychopathy as a disorder
- D. is not compatible with ICD-10
- E. none of the above

11.3 DSM-IV-TR

- A. strives to be neutral or atheoretical with regard to etiology
- B. provides specific diagnostic criteria that tend to increase the reliability of clinicians
- C. makes no mention of management or treatment
- D. provides explicit rules to be used in making a diagnosis when the clinical information is insufficient
- E. all of the above

11.4 "Not otherwise specified categories" (NOS) of DSM-IV-TR may be used when

- A. the symptoms are below the threshold for a specific disorder
- B. there is an atypical presentation
- C. the symptom pattern causes significant distress but has not been included in the DSM-IV-TR classification
- D. the cause is uncertain
- E. all of the above

11.5 True statements about DSM-IV-TR include

- A. Axis I and Axis II comprise the entire classification of mental disorders.
- B. Many patients have one or more disorders on both Axis I and Axis II.
- C. The habitual use of a particular defense mechanism can be indicated on Axis II.
- D. On Axis III, the identified physical condition may be causative, interactive, and effect, or unrelated to the mental state.
- E. All of the above

11.6 Dementia in Alzheimer's disease may be characterized by each of the following terms *except*

- A. mixed type

- B. atypical type
- C. of acute onset
- D. with late onset
- E. with early onset

11.7 The DSM-IV-TR definition of a mental disorder includes all of the following *except*

- A. significant distress
- B. significantly increased morbidity
- C. deviant behaviors that are primarily between the individual and society
- D. not merely expectable responses to particular events
- E. significant disability

Directions

Each set of lettered headings below is followed by a list of numbered phrases or statements. For each numbered phrase or statement select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 11.8–11.13

11.8 Alcohol abuse

11.9 Threat of job loss

11.10 Frequent use of denial

11.11 Mood disorder due to hypothyroidism, with depressive features

11.12 GAF = 45 (on admission), GAF = 65 (at discharge)

11.13 Mental retardation

- A. Axis I
- B. Axis II
- C. Axis III
- D. Axis IV
- E. Axis V

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

11.14 The global assessment of function

- A. is recorded on Axis IV of a multiaxial evaluation
- B. is assessed by a 50-point global assessment of functioning scale

- C. bears no relation to prognosis
- D. is a composite of social, occupational, and psychological functioning
- E. included impairment due to physical limitations

11.15 The Social and Occupational Functioning Assessment Scale (SOFAS)

- A. is scored independently from the person's psychological symptoms
- B. does not include impairment in functioning that is caused by a general medical condition
- C. may not be used to rate functioning at the time of the evaluation
- D. may not be used to rate functioning of a past period
- E. is included on Axis III

11.16 Which of the following scales is not used to rate a mood disorder?

- A. Montgomer-Asberg Scale
- B. Patterns of Individual Change Scale
- C. Beck Depression Inventory
- D. Hamilton Rating Scale
- E. Raskin Depression Rating Scale

11.17 In the Scale for the Assessment of Negative Symptoms (SANS), which of the following is assessed?

- A. Vocal inflection
- B. Sexual activity
- C. Impersistence at work
- D. Social inattentiveness
- E. All of the above

11.18 Which of the following is *true* of the Defensive Functioning Scale?

- A. Suppression is measured on the "disavowal level."
- B. Idealization is measured in the "major image-distorting level."
- C. Splitting is measured in the "minor image-distorting level."
- D. Apathetic withdrawal is measured on the "action level."
- E. Sublimation is measured on the "mental inhibitions level."

11.19 The Hamilton Anxiety Rating Scale

- A. is a ten-item scale

- B. includes an item on mood
- C. addresses suicidality
- D. is exclusively history-based
- E. excludes somatic symptoms

Directions

Each set of lettered headings below is followed by a list of numbered phrases or statements. For each numbered phrase or statement select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 11.20–11.23

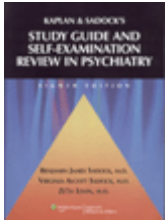
11.20 Obsessive-compulsive symptoms

11.21 Psychotic disorders

11.22 Depression and anxiety

11.23 Abnormal involuntary movements

- A. Brief Psychiatric Rating Scale
- B. Hamilton Rating Scale
- C. Yale-Brown Scale
- D. Social and Occupational Functioning Assessment Scale
- E. None of the above



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



12

Delirium, Dementia, and Amnestic and Other Cognitive Disorders and Mental Disorders Due to a General Medical Condition

In the text revision of the fourth edition of Diagnostic Statistical Manual of Mental Disorders (DSM-IV-TR) three groups of disorders—delirium, dementia, and the amnestic disorders—are characterized by the primary symptom common to all the disorders, which is an impairment in cognition (as in memory, language, or attention). Although DSM-IV-TR acknowledges that other psychiatric disorders can exhibit some cognitive impairment as a symptom, cognitive impairment is the cardinal symptom in delirium, dementia, and the amnestic disorders. Within each of these diagnostic categories, DSM-IV-TR delimits specific types.

Dementia is also characterized by marked cognitive deficits, but unlike delirium, these deficits occur in the context of a clear sensorium. The deficits include impairments in intelligence, learning and memory, language, problem solving, orientation, perception, attention and concentration, judgment, and social skills. The clinical work-up of etiology is crucial. Clinicians need to be especially familiar with dementias of the Alzheimer's type as well as vascular dementias. Knowledge of the course and prognosis of both these dementia types is essential. Principles of treatment, and perhaps most importantly, long-term management of people with these disorders, must be learned in order to most effectively assist patients and their families.

Amnestic disorders are characterized by memory impairments that are associated with significant deficits in social or occupational functioning. The amnestic disorders are causally related to general medical conditions, such as head trauma. This characteristic distinguishes them from the dissociative disorders involving memory impairments.

The questions and answers below can test knowledge of the subject.

Helpful Hints

The student should be able to define the signs, symptoms, and syndromes listed below.

- abstract attitude
- Addison's disease

- AIP
- ALS
- amnesic disorders
- anxiety disorder due to a general medical condition
- auditory, olfactory, and visual hallucinations
- beclouded dementia
- beriberi
- black-patch
- catastrophic reaction
- cognitive disorders
- confabulation
- cretinism
- Creutzfeldt-Jakob disease
- Cushing's syndrome
- delirium
- delusional disorder
- dementia
- dementia of the Alzheimer's type
- diabetic ketoacidosis
- dissociative amnesia
- Down's syndrome
- dysarthria
- epilepsy
- general paresis
- granulovacuolar degeneration
- Huntington's disease
- hypnagogic and hypnopompic hallucinations
- hypoglycemic, hepatic, and uremic encephalopathy
- intellectual functions
- interictal
- intoxication and withdrawal
- intracranial neoplasms
- Korsakoff's syndrome
- kuru
- Lilliputian hallucinations
- manifestations
- memory
- mood disorder due to a general medical condition
- multiple sclerosis
- myxedema

- neurofibrillary tangles
- normal aging
- normal pressure hydrocephalus
- orientation
- parkinsonism
- partial versus generalized seizures
- pellagra
- pernicious anemia

- personality change due to a general medical condition
- Pick's disease
- postoperative
- prion disease
- pseudobulbar palsy
- pseudodementia
- retrograde versus anterograde amnesia
- senile plaques
- short-term versus long-term memory loss
- SLE
- sundowner syndrome
- tactile or haptic hallucinations
- TIA
- transient global amnesia
- vascular dementia
- vertebrobasilar disease

P.96

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

12.1 Factors that predispose to delirium include all of the following *except*

- A. Use of bladder catheter
- B. Age older than 60
- C. Vision impairment
- D. Smoking history
- E. Abnormal glucose level

12.2 Which of the following statements about delirium is *true*?

- A. Male gender is an independent risk factor.
- B. Few hospitalized medically ill patients develop delirium.
- C. It is independent of age.
- D. It has no bearing on overall patient prognosis.
- E. Post-cardiotomy patients rarely develop delirium.

12.3 The most common cause of delirium within 3 days postoperatively in a 40-year-old man with a history of alcohol dependence is

- A. stress of surgery
- B. postoperative pain
- C. pain medication
- D. infection
- E. delirium tremens

12.4 Which of the following is a prion disease?

- A. Creutzfeldt-Jakob disease
- B. Fatal familial insomnia
- C. Variant Creutzfeldt-Jakob disease
- D. Kuru
- E. All of the above

12.5 Which clinical features may be associated with delirium?

- A. Disorganized thought processes
- B. Illusions
- C. Mood alterations
- D. Hallucinations
- E. All of the above

12.6 Dementia with Lewy bodies

- A. is a clinical diagnosis
- B. is the second most prevalent dementia subtype
- C. is commonly associated with visual hallucinations
- D. is associated with pronounced psychomotor impairment
- E. all of the above

12.7 Which of the following drugs is best used to treat acute delirium?

- A. chlorpromazine (Thorazine)
- B. diazepam (Valium)
- C. haloperidol (Haldol)
- D. amobarbital (Amytal)
- E. physostigmine salicylate (Antilirium)

12.8 In delirium

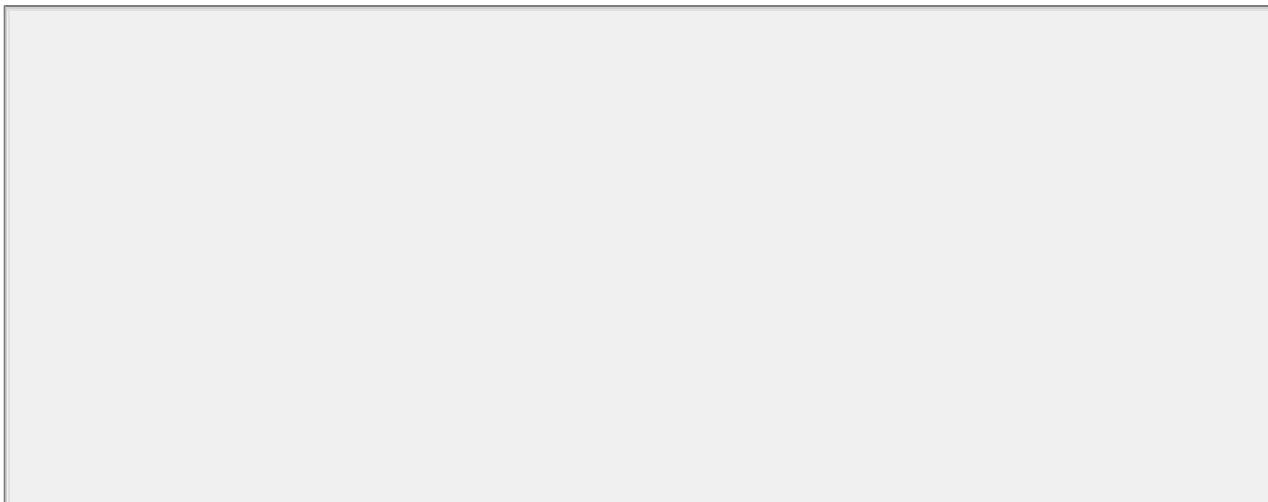
- A. epinephrine is hypothesized to be the major neurotransmitter involved
- B. the major pathway implicated is the dorsal tegmental pathway
- C. the electroencephalogram (EEG) usually shows diffuse background quickening
- D. there is hyperactivity in the nucleus accumbens
- E. the level of consciousness is preserved

12.9 Alzheimer's dementia is

- A. linked to chromosome 7
- B. a clinical diagnosis
- C. associated with hypoactive levels of acetylcholine
- D. associated with pathognomonic neurofibrillary tangles
- E. more common in men

12.10 Mr. E is 68 years old and married with two children. His wife reports changes in his memory and behavior over the last 9 years. She reports that he frequently forgets his keys, goes into the house to get something and then forgets what he wants, and that he has changed from an outgoing pleasant person, to one who avoids conversation. She says that he seems hostile at times for no apparent reason. Mr. E is in good general health, taking no medications, and his alcohol consumption is limited to two to three beers a day.

What may you observe on examination of Mr. E?



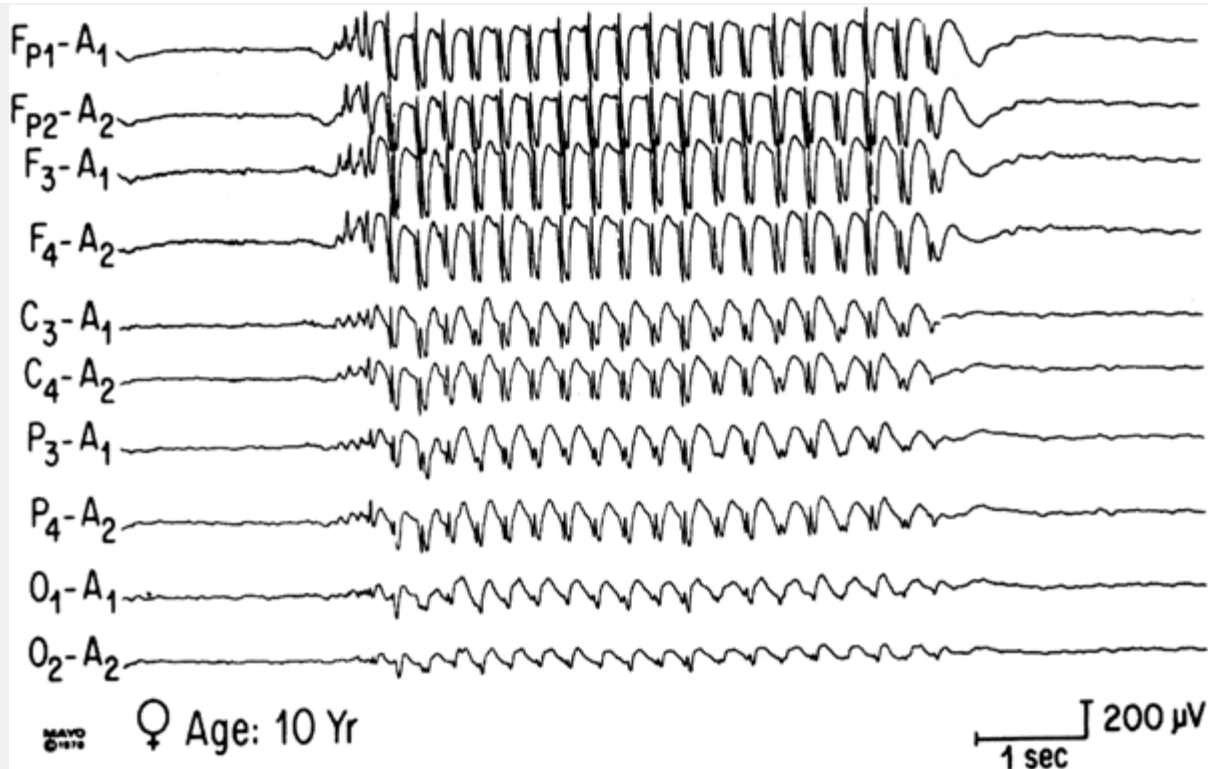


FIGURE 12.1 Electroencephalogram (EEG).

- A. Paranoid delusions
- B. Pathological crying
- C. A grasp reflex
- D. Poor hygiene
- E. All of the above

12.11 In the case described above, what is the most likely diagnosis other than dementia for Mr. E?

- A. Major depression
- B. Chronic paranoid schizophrenia
- C. Normal aging
- D. Delirium
- E. Factitious disorder

12.12 Which of the following would be consistent with the progression of Mr. E's illness?

- A. Increased agitation
- B. Frequent nighttime pacing

- C. Physical threats toward his wife
- D. Urinary incontinence
- E. All of the above

12.13 The EEG shown in [Figure 12.1](#) is an example of

- A. partial seizure
- B. grand mal epilepsy
- C. petit mal epilepsy or absence seizure
- D. psychomotor epilepsy
- E. none of the above

12.14 True statements about the epidemiology of dementia include all of the following *except*

- A. The estimated prevalence in a population over 65 years is consistently reported to be about 5 percent.
- B. Dementia of Alzheimer's type is the most common dementing disorder in North America, Scandinavia, and Europe.
- C. The risk for vascular dementia is six times greater than that for Alzheimer's among people older than 75 years.
- D. There appears to be a higher rate of vascular dementia in men, and a higher rate of Alzheimer's in women.
- E. In geriatric psychiatric populations, Alzheimer's is much more common than vascular dementia.

12.15 Delirium

- A. has an insidious onset
- B. rarely has associated neurological symptoms
- C. generally has an underlying cause residing in the central nervous system
- D. may be successfully treated with lithium
- E. generally causes a diffuse slowing of brain activity

12.16 Of the following cognitive functions, the one most likely to be difficult to evaluate and interpret on formal testing is

- A. memory
- B. visuospatial and constructional ability
- C. reading and writing
- D. abstraction

E. calculations

12.17 True statements about Alzheimer's disease include all of the following except

- A. Age at onset is earlier in patients with a family history of the disease.
- B. There is clear phenomenological separation between early-onset and late-onset cases.
- C. The early-onset type may have a more rapidly progressive course.
- D. No features of the physical examination or laboratory evaluation are pathognomonic.
- E. Brain-imaging studies are used to exclude other identifiable causes.

12.18 Creutzfeldt-Jakob disease is characterized by

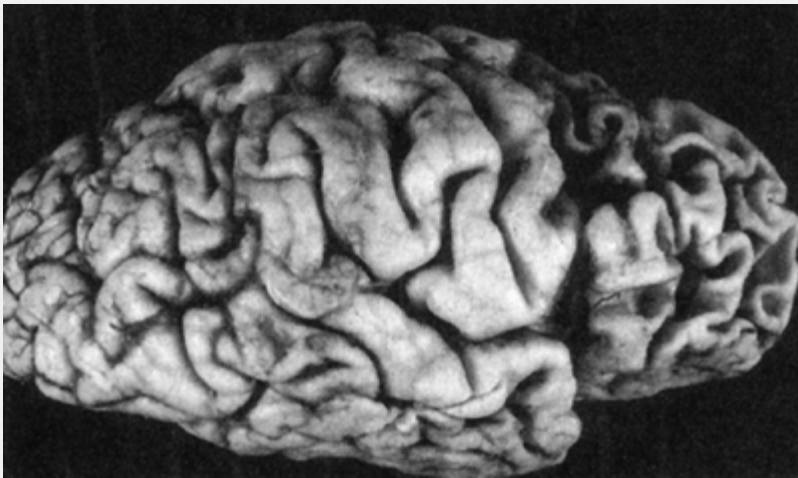


FIGURE 12.2 Pick's disease gross pathology. This demonstrates the marked frontal and temporal atrophy seen in frontotemporal dementias, such as Pick's disease. (Courtesy of Dashyant Purohit, M.D., Associate Professor, Department of Neuropathology, Mount Sinai School of Medicine, New York, NY.)

- A. rapid deterioration
- B. myoclonus
- C. diffuse, symmetric, rhythmic slow waves in EEG
- D. postmortem definitive diagnosis
- E. all of the above

12.19 Amnestic disorders

- A. are invariably persistent, lasting at least a month
- B. are defined by a better memory for remote events than recent ones
- C. do not typically impair the ability to immediately repeat a sequential string of information (e.g., digit span)
- D. typically have a gradual onset
- E. none of the above

12.20 The brain depicted in [Figure 12.2](#) shows frontal and temporal atrophy associated with frontotemporal dementia. Which of the following statements is true?

- A. Progressive nonfluent aphasia is a frontotemporal dementia.
- B. Pick's disease has its own separate diagnostic criteria in DSM-IV-TR.
- C. Frontotemporal dementia is more likely to affect older populations.
- D. Pick bodies are found in all the frontotemporal dementias.
- E. Genetic linkage to chromosome 9 has been found in frontotemporal dementia.

12.21 Amnestic disorders

- A. may be diagnosed in the context of delirium
- B. may be diagnosed in the context of dementia
- C. are secondary syndromes caused by primary etiologies
- D. are most often due to nutritional deficiencies related to chronic alcohol dependence
- E. none of the above

12.22 True statements about vascular etiologies of dementia include

- A. Together they comprise the second most common cause of dementia.
- B. It is believed that tissue damage in infarction underlies vascular dementia.
- C. The most common cause of cerebral infarction is thromboembolism from a large vessel plaque.
- D. Approximately 15 percent of cerebrovascular disease is due to cerebral hemorrhage related to hypertension.
- E. All of the above

12.23 Frontal lobe degeneration is associated with

- A. disinhibition
- B. social misconduct
- C. lack of insight

- D. apathy
- E. all of the above

12.24 Which of the following is a *true* statement about Parkinson's disease?

- A. It is a prototype of a cortical degenerative disease.
- B. It cannot be distinguished from parkinsonian syndromes that arise from a variety of causes.
- C. It is the result of the degeneration of the substantia nigra, globus pallidus, putamen, and caudate.
- D. The only cells affected are those containing dopamine.
- E. Dementia is more common in early-onset disease.

12.25 Risk factors for the development of delirium include

- A. increased severity of physical illness
- B. older age
- C. preexisting dementia
- D. the use of anticholinergics
- E. all of the above

12.26 BSE is associated with all of the following except

- A. Spongiform vacuolization
- B. Neuronal loss
- C. Astrocyte proliferation in the cerebral cortex
- D. Amyloid plaques
- E. "Bulls-Eye" rash on the thigh

12.27 Clinical characteristics of vascular dementia

- A. are the same regardless of the area of infarction
- B. are the same regardless of the number of infarctions
- C. are the same regardless of the type of vasculature involved
- D. are the same regardless of whether or not deficits accumulate or resolve quickly after small strokes
- E. none of the above

12.28 Features supportive of the diagnosis of dementia with Lewy bodies include

- A. recurrent visual hallucinations that are typically well formed and detailed
- B. fluctuating cognition with profound variations in attention and alertness

- C. spontaneous motor features of parkinsonism
- D. neuroleptic sensitivity
- E. all of the above

12.29 Vascular dementia

- A. is more common in women
- B. is primarily a large vessel disease
- C. is not associated with fundoscopic abnormalities
- D. includes Binswanger's disease
- E. is not associated with hypertension

12.30 Transient global amnesia

- A. is more common in women
- B. has a characteristically abnormal EEG pattern
- C. is associated with loss of self identity
- D. has been linked to vascular instability
- E. is more common in young people

12.31 Huntington's disease

- A. is linked to the long arm of chromosome 4
- B. affects men only
- C. is associated with "boxcar" ventricles on brain scanning
- D. shows striatal hypermetabolism on positron emission tomography (PET)
- E. is not usually associated with emotional symptoms

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be used once, more than once, or not at all.

Questions 12.32–12.36

12.32 Death occurring 15 to 20 years after the onset of the disease, with suicide being common

12.33 Slow virus, with death occurring within 2 years of the diagnosis

12.34 Manic syndrome with neurological signs in up to 20 percent of cases

12.35 Treatment of choice being a shunt

12.36 More prevalent in cold and temperate climates than in the tropics and subtropics

- A. Creutzfeldt-Jakob disease
- B. Normal-pressure hydrocephalus
- C. Neurosyphilis
- D. Huntington's disease
- E. Multiple sclerosis

Questions 12.37–12.40

12.37 Alopecia

12.38 Succimer (Chemet)

12.39 Mad Hatter syndrome

12.40 Masked facies

- A. Lead poisoning
- B. Manganese madness
- C. Mercury poisoning
- D. Thallium intoxication
- E. None of the above

Directions

Each set of lettered headings below is followed by a list of numbered phrases. For each numbered phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 12.41–12.47

12.41 Huntington's chorea

12.42 Alzheimer's disease

12.43 Early decline in calculation, naming, and copying skills

12.44 Fine and gross motor movements are generally preserved until later in the disease process

12.45 Language is relatively spared

12.46 Presenting symptoms more likely to be a personality change or mood disturbance

12.47 Presenting symptoms more often reflect cognitive impairment

- A. Lead poisoning
 - B. Manganese madness
 - C. Mercury poisoning
 - D. Thallium intoxication
 - E. None of the above
-
- A. Cortical dementia
 - B. Subcortical dementia

Questions 12.48–12.53

12.48 Hallucinations

12.49 Sundowning

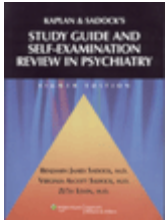
12.50 Catastrophic reaction

12.51 High mortality rate

12.52 Decreased acetylcholine activity

12.53 Insight present

- A. Delirium
- B. Dementia



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](http://www.lippincott.com)



13

Neuropsychiatric Aspects of Human Immunodeficiency Virus (HIV) Infection and Acquired Immune Deficiency Syndrome (AIDS)

AIDS and HIV-related disorders have profoundly altered health care throughout the world. The World Health Organization estimates that worldwide, 2.5 million adults and 1 million children have AIDS, and about 30 million people are infected with HIV.

At least 50 percent of people with AIDS have neuropsychiatric complications, such as HIV encephalopathy. There is an extensive array of disease processes that can affect the brain of a patient with HIV, and there are multiple psychiatric syndromes, from adjustment disorders to mood disorders to substance abuse disorders and suicide with which the psychiatrist must be familiar. Similarly, the pharmacotherapies used in the management and treatment of HIV disease and AIDS may directly affect the brain or interact with the medications used by the psychiatrist to treat the associated psychiatric syndromes.

Psychiatrists must be familiar with counseling patients about their risk factors for the disease, and the importance of HIV testing. Confidentiality issues are key in this matter. Psychotherapy plays an important role in working with this patient population, and the psychiatrist must be familiar with the range of approaches that may be appropriate for these patients: supportive, cognitive, behavioral, or psychodynamic, both as individual treatments or in groups.

The student should study the questions and answers below for a useful review of this topic.

Helpful Hints

The following terms should be known by the student.

- AIDS dementia complex
- AIDS in children
- astrocytes
- AZT

Candida albicans

- CNS infections
- confidentiality
- ddl
- ELISA
- false-positives
- high-risk groups
- HIV encephalopathy
- HIV-1 and HIV-2
- institutional care
- Kaposi's sarcoma
- neuropsychiatric syndromes
- Pneumocystis carinii pneumonia
- pretest and posttest counseling
- protease inhibitors
- psychopharmacology
- psychotherapy
- retrovirus
- safe sex guidelines
- seropositive
- T4 lymphocytes
- Toxoplasma gondii and Cryptococcus neoformans
- transmission
- tuberculosis
- wasting syndrome
- Western blot analysis
- worried well

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

13.1 All of the following tasks should be done in pretest HIV counseling except?

- A. Explore past reactions to severe stress
- B. Discuss why the test is necessary
- C. Explore high risk behaviors
- D. Avoid discussion of a positive result
- E. Document discussions in the chart

13.2 Which of the following about the pharmacotherapy of HIV disease is true?

P.110

- A. Two protease inhibitors and one reverse transcriptase is indicated.
- B. Protease inhibitors are metabolized primarily in the kidney.
- C. Zidovudine penetrates the blood-brain barrier well.
- D. A two-agent therapy is indicated in health care workers who have been pricked by a needle from an HIV-infected patient.
- E. White matter signal abnormalities on MRI in patients who are HIV positive are permanent and not responsive to anti-HIV pharmacotherapy.

13.3 In persons infected by HIV

- A. seroconversion usually occurs 2 weeks after infection
- B. the estimated length of time from infection to the development of AIDS is 5 years
- C. 10 percent have neuropsychiatric complications
- D. the T4-lymphocyte count usually falls to abnormal levels during the asymptomatic period
- E. the majority are infected by HIV type 2 (HIV-2)

13.4 True statements about the association of suicide and HIV disease include

- A. Studies suggest that patients with advanced HIV disease have a 30-fold risk of committing suicide compared to matched seronegative persons.
- B. Some reports indicate that high-risk seronegative persons have an elevated lifetime prevalence of suicidal ideation and attempt compared to community controls.
- C. Psychiatric disorder is strongly implicated in suicidal ideation and attempted suicide.
- D. HIV-infected adolescents are at a particularly high risk for suicide.
- E. All of the above

13.5 True statements associated with the treatment of delirium in HIV illness include

- A. There is no increased incidence of extrapyramidal symptoms associated with high-potency typical agents in advanced HIV illness.
- B. Patients with underlying HIV-associated dementia do not appear to be at higher risk for medication-induced movement disorders.
- C. The use of benzodiazepines alone appears to be effective in delirious states.
- D. Symptoms of delirium in HIV illness can be managed effectively with low-potency antipsychotics such as chlorpromazine.
- E. None of the above

13.6 Mania in people with AIDS

- A. may have a rate of up to ten times the general population rates
- B. may be precipitated by steroids, zidovudine, and ganciclovir
- C. is associated with personal or family history of bipolar I disorder, if the onset is early in HIV illness
- D. is associated with a higher prevalence of comorbid dementia if the onset is late in the course of HIV illness, and there is no personal or family history of mood disorders
- E. all of the above

13.7 In a test for HIV

- A. Assays usually detect the presence of viral proteins.
- B. The enzyme-linked immunosorbent assay (ELISA) is used to confirm positive test results of the Western blot analysis.
- C. The results cannot be shared with other members of a medical treatment team.
- D. Pretest counseling should not inquire why a person desires HIV testing.
- E. A person may have a true-negative result, even if the person is infected by HIV.

13.8 Neuropathic pain related to HIV

- A. is generally more effectively treated with SSRIs than with tricyclic antidepressants
- B. is rarely effectively treated with opioid analgesics
- C. is not effectively managed with anticonvulsants such as phenytoin (Dilantin) or carbamazepine (Tegretol)
- D. should not be treated with acetaminophen (Tylenol), because it may diminish the metabolism of zidovudine
- E. all of the above

13.9 Diseases affecting the central nervous system (CNS) in patients with AIDS include

- A. atypical aseptic meningitis
- B. *Candida albicans* abscess
- C. primary CNS lymphoma
- D. cerebrovascular infarction
- E. all of the above

13.10 Psychotic symptoms associated with HIV infection

- A. are usually early-stage complications

- B. are rare
- C. most often take the form of persecutory, grandiose, or somatic delusions
- D. rarely are associated with bizarre behavior
- E. are also associated with frequent and specific neurological findings

13.11 Mild neurocognitive deficits associated with HIV infection

- A. include attentional problems, slowing of information processing, and deficiencies in learning
- B. do not suggest selective involvement of subcortical structures
- C. are often characterized by confabulatory responses on formal memory testing
- D. do not occur independently of depression or anxiety
- E. are rarely associated with difficulties in abstract reasoning

P.111

13.12 Potential complications in the treatment of mania in patients with AIDS include

- A. Lithium and antipsychotic medications may be poorly tolerated by individuals with HIV-related neurocognitive disorders.
- B. Valproate is usually poorly tolerated by individuals with evidence of brain atrophy on MRI.
- C. The gastrointestinal disturbances associated with AIDS (e.g., vomiting and diarrhea) rarely affect lithium absorption or excretion.
- D. Carbamazepine may increase serum concentrations of protease inhibitors.
- E. Protease inhibitors increase valproate concentrations.

13.13 Clinical symptoms associated with HIV encephalopathy diagnosis include all of the following *except*

- A. early-onset aphasia
- B. mood and personality changes
- C. hyperreflexia and paraparesis
- D. psychomotor slowing
- E. problems with memory and concentration

13.14 Protease inhibitors can increase plasma levels of all of the following *except*

- A. bupropion
- B. fluoxetine
- C. alprazolam and zolpidem

- D. nefazodone
- E. valproate

13.15 Which of the following is true?

- A. All patients infected with HIV experience a brief flulike syndrome shortly after becoming infected
- B. In the United States, the median duration of the asymptomatic stages is twenty years
- C. During the asymptomatic period, the T4 cell count remains stable
- D. The most common infection with HIV-infected persons with AIDS is *Pneumocystis carinii* pneumonia
- E. HIV-associated dementia has no impact on prognosis

Directions

The group of questions below consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 13.16–13.20

13.16 Stavudine

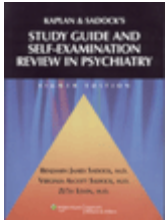
13.17 Ritonavir

13.18 Nevirapine

13.19 AZT

13.20 3TC

- A. Nucleoside reverse transcriptase inhibitor
- B. Nonnucleoside reverse transcriptase inhibitor
- C. Protease inhibitor
- D. All of the above
- E. None of the above



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



14

Substance-Related Disorders

The phenomenon of substance abuse has many implications for brain research and for clinical psychiatry. Some substances can affect both internally perceived mental states, such as mood, and externally observable activities, such as behavior. Substances can cause neuropsychiatric symptoms indistinguishable from those of common psychiatric disorders with no known causes (e.g. schizophrenia and mood disorders), and thus primary psychiatric disorders and disorders involving the use of substances are possibly related. The study of brain-altering chemicals can provide important clues regarding how the brain functions in both normal and abnormal states.

Diagnosing a psychiatric disorder in the context of substance abuse can be complicated. A careful and detailed chronological history of symptom development and its relationship to substance use is critical to clarifying diagnoses. Although a primary diagnosis may be unclear at times, what does seem clear is that substance abuse worsens the course, prognosis, and presentation of any preexisting psychiatric disorder. The schizophrenic patient abusing crack, or the depressed patient abusing cocaine or benzodiazepines, will undoubtedly be more impaired than the patient who is not. In fact, most experienced clinicians will agree that effectively treating any psychiatric disorder in the context of ongoing substance abuse is not possible.

Clinicians need to be clear about the definitions of many terms relating to substance use, including addiction, dependence, abuse, tolerance, cross-tolerance, intoxication, and withdrawal.

Each substance-related disorder also has its own definition, epidemiology, and clinical features, and skilled clinicians must be knowledgeable about each one.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know each of the terms below

- AA
- abuse

addiction

- AIDS
- Al-Anon
- alcohol delirium
- alcohol psychotic disorder
- alcohol withdrawal
- amotivational syndrome
- anabolic
- anabolic steroids
- anticholinergic side effects
- arylcyclohexylamine
- belladonna alkaloids
- binge drinking
- blackouts
- caffeine
- cocaine delirium
- cocaine intoxication and withdrawal
- cocaine psychotic disorder
- codependence
- comorbidity
- cross-tolerance
- DEA
- delta alcohol dependence
- dementia
- dispositional tolerance
- disulfiram
- DMT
- DOM
- DPT
- drug-seeking behavior
- DSM-IV-TR course modifiers
- DTS
- dual diagnosis
- fetal alcohol syndrome
- flashback
- freebase
- gamma alcohol dependence
- hallucinogen
- hallucinogen persisting perception disorder
- idiosyncratic alcohol intoxication

illicit drug use

- inhalant intoxication
- ketamine
- Korsakoff's and Wernicke's syndromes
- LAMM
- LSD
- MDMA
- methadone withdrawal
- miosis
- misuse
- MPTP-induced parkinsonism
- mydriasis
- nicotine receptor
- NIDA
- nitrous oxide
- opiate
- opioid
- opioid antagonists
- opioid intoxication
- opioid withdrawal
- pathological alcohol use
- patterns of pathological use
- PCP
- persisting amnestic disorder

-
- persisting dementia
 - physical dependence
 - psychedelics
 - psychoactive
 - psychological dependence
 - RFLP
 - "roid" rage
 - sedative-hypnoticanxiolytic
 - STP alcohol intoxication; blood levels
 - substance abuse
 - substance dependence
 - sympathomimetic signs
 - THC
 - tolerance
 - type I alcoholism
 - type II alcoholism

- volatile hydrocarbons
- WHO
- WHO definitions
- Withdrawal

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

14.1 Which of the following is not a component of acute nicotine intoxication?

- A. Bizarre dreams
- B. Lability of mood
- C. Cardiac arrhythmias
- D. Tachycardia
- E. Visual hallucinations

14.2 Mouth ulceration is associated with which of the following types of withdrawal?

- A. Cocaine
- B. Opioids
- C. Nicotine
- D. Alcohol
- E. Benzodiazepines

14.3 Laboratory tests useful in making the diagnosis of alcohol abuse or dependence include

- A. GGT
- B. MCV
- C. triglycerides
- D. all of the above
- E. none of the above

14.4 Which of the following is not a DSM-IV-TR course specifier for substance dependence remission?

- A. Early full remission
- B. Sustained partial remission

- C. Remission on agonist therapy
- D. Remission in a controlled environment
- E. None of the above

14.5 Cocaine

- A. competitively blocks dopamine reuptake by the dopamine transporter
- B. does not lead to physiological dependence
- C. induces psychotic disorders
- D. has been used by 40 percent of the United States population since 1991
- E. is no longer used as a local anesthetic

14.6 You are called for a consult on a 42-year-old woman with alcohol dependence who is complaining of persisting severe depressive symptoms despite 5 days of abstinence. In the initial stage of the interview, she noted that she had “always been depressed” and believed that she “drank to cope with the depression.” Her current complaint included a prominent sadness that had persisted for several weeks, difficulties concentrating, initial and terminal insomnia, and a feeling of hopelessness and guilt.

What is the most appropriate next step to distinguish between alcohol-induced depression and an independent major depressive episode?

- A. Trial of electroconvulsive therapy (ECT)
- B. Chronological history
- C. Proton emission tomography (PET) scan
- D. Intensive psychotherapy
- E. Antidepressant treatment

14.7 Which of the following atypical substances is also known to produce symptoms of intoxication?

- A. Catnip
- B. Betel nut
- C. Kava
- D. Benadryl
- E. All of the above

14.8 Which of the following drugs is an opioid antagonist?

- A. naloxone
- B. naltrexone
- C. nalorphine

- D. apomorphine
- E. all of the above

14.9 Which of the following statements regarding alcohol's effect on sleep is *not* true?

- A. Alcohol can significantly impair sleep patterns
- B. Alcohol increases rapid eye movement (REM) sleep
- C. Heavy drinkers often awaken at night and have difficulty going back to sleep
- D. Alcohol use tends to inhibit stage 4 sleep
- E. Alcoholics tend to have more dreams earlier in the night

14.10 The single photon emission computed tomography (SPECT) image in [Figure 14.1](#) shows multifocal areas of hypoperfusion in a patient with chronic substance abuse. The patient's ischemic cerebrovascular disorder is most likely precipitated by which of the following substances?

P.118

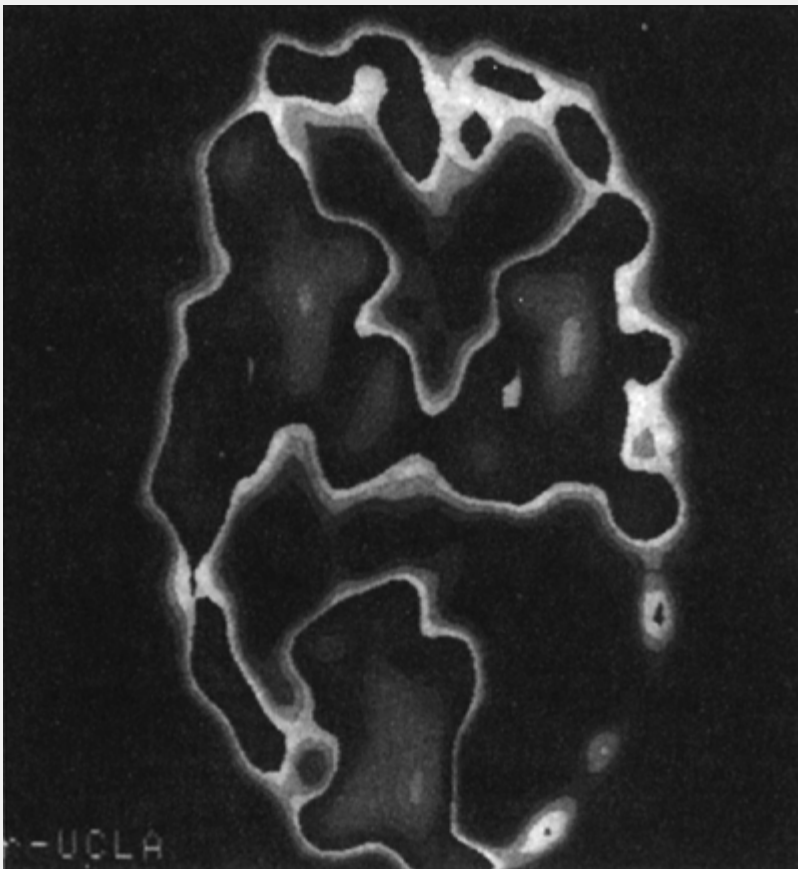


FIGURE 14.1 Reprinted with permission from Kaplan HI, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry*, 6th ed. Baltimore: Williams & Wilkins; 1995:268.

-
- A. phencyclidine (PCP)
 - B. cocaine
 - C. heroin
 - D. cannabis
 - E. barbiturates

14.11 Inhalant use most often correlates with which of the following comorbid conditions?

- A. Conduct disorder
- B. Major depression
- C. Borderline personality disorder
- D. Schizophrenia
- E. Manic episode

14.12 Amphetamines and cocaine are similar in

- A. their mechanisms of action at the cellular level
- B. their duration of action
- C. their metabolic pathways
- D. the induction of paranoia and production of major cardiovascular toxicities
- E. all of the above

14.13 Which of the following is not a therapeutic effect for which cannabinoids are commonly used?

- A. Relief of nausea and vomiting
- B. Appetite stimulant
- C. Weight loss
- D. Reduced muscle spasticity
- E. Decreased intraocular pressure

14.14 Minor signs and symptoms of the benzodiazepine discontinuation syndrome commonly include

- A. grand mal seizures
- B. psychosis
- C. nightmares
- D. hyperpyrexia
- E. death

14.15 Which of the following is contraindicated for the treatment of acute disulfiram (Antabuse) overdose?

- A. Gastric lavage
- B. Activated charcoal
- C. Syrup of ipecac
- D. Hemodialysis
- E. Decontamination

14.16 Acute PCP intoxication is *not* treated with

- A. diazepam (Valium)
- B. cranberry juice
- C. phentolamine (Regitine)
- D. phenothiazines
- E. all of the above

14.17 Which of the following is *not* a therapeutic indication for use of anabolic-androgenic steroids?

- A. Male hypogonadism
- B. Hyperthyroidism
- C. Hereditary angioedema
- D. Anemia
- E. Osteoporosis

14.18 DSM-IV-TR states specifically that the diagnosis of dependence can be applied to every class of substances *except*

- A. nicotine
- B. caffeine
- C. anabolic steroids
- D. nitrous oxide
- E. none of the above

14.19 Ms. E is a 32-year-old single, white woman employed full time at a local factory. She is a smoker, and occasionally has flares of her asthma. She typically drinks four to five mugs of coffee each day and prefers to drink it without cream, milk, or sugar. She estimates that 5 minutes usually elapse between the time she gets up in the morning and the time she has her first cup of coffee. She spaces her mugs over the course of the day, with her last mug either after lunch or with dinner. Physicians had recommended she cut down or stop her coffee use because

of complaints of mild indigestion, and she abruptly stops her caffeine intake as a result of these recommendations.

Which of the following statements regarding caffeine is *true*?

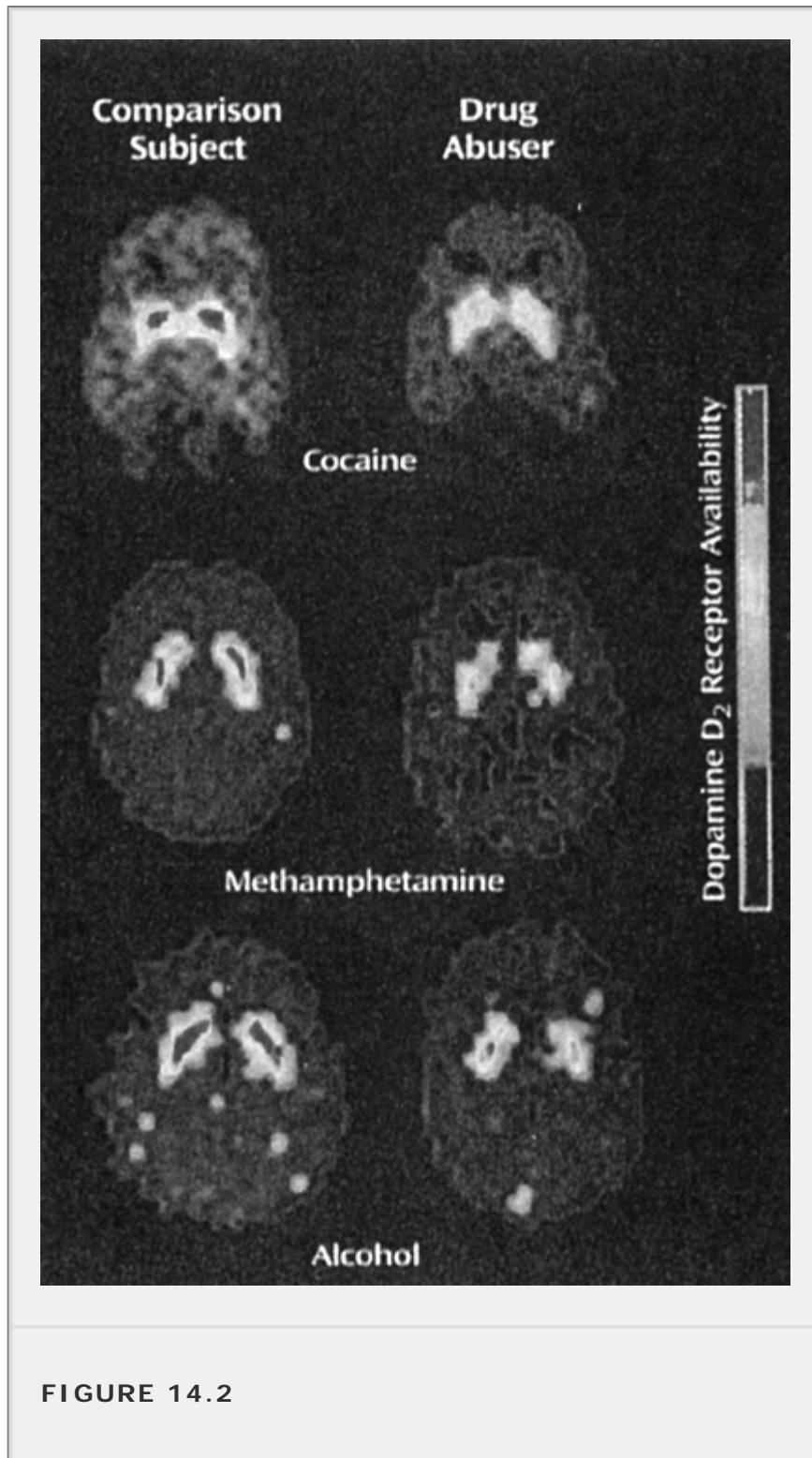


FIGURE 14.2

A. The rate of caffeine elimination is increased by smoking.

B. Caffeine's effects on the body include bronchoconstriction.

C. Caffeine is slowly absorbed and metabolized by the kidney.

- D. Caffeine increases the metabolism of the antipsychotic clozapine.
- E. Caffeine metabolism is markedly increased at the end of pregnancy.

14.20 The above patient would most likely experience all of the following due to her abruptly stopping caffeine intake *except*?

- A. Irritability
- B. Insomnia
- C. Decreased concentration
- D. Headache
- E. Muscle aches

14.21 The image in [Figure 14.2](#) shows decreased dopamine type 2 (D₂) receptor binding in the striatum in drug users compared to normal control subjects. Which of the following types of substance withdrawal is this pattern *not* typical of?

- A. Cocaine
- B. Methamphetamine
- C. Opioids
- D. Alcohol
- E. All of the above

14.22 In distinguishing schizophrenia from amphetamine-induced toxic psychosis, the presence of which of the following is most helpful?

- A. paranoid delusions
- B. auditory hallucinations
- C. clear consciousness
- D. tactile or visual hallucinations
- E. intact orientation

14.23 Which of the following statements regarding cancer and alcohol use is *correct*?

- A. Cancer may be due to the immunosuppressive effects of ethanol
- B. Cancer is the second leading cause of premature death in alcoholics
- C. Increases in breast cancer have been noted with just two drinks per day
- D. Alcohol can be directly linked to cancers of mucus membranes
- E. All of the above

14.24 Which of the following most accurately represents the percentage of 8th

graders who have experimented at least once with inhalants?

- A. 1 percent
- B. 5 percent
- C. 15 percent
- D. 30 percent
- E. 50 percent

Directions

Each set of lettered headings below is followed by a list of numbered words or phrases. For each numbered word or phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 14.25–14.29

14.25 Involved in alcohol metabolism

14.26 Converts alcohol into acetaldehyde

14.27 Inhibited by disulfiram (Antabuse)

14.28 Converts acetaldehyde into acetic acid

14.29 Decreased in Asian people

- A. Alcohol dehydrogenase
- B. Aldehyde dehydrogenase

Questions 14.30–14.34

14.30 Cause rapid eye movement (REM)–sleep suppression

14.31 Have symptoms of withdrawal that usually appear within 3 days

14.32 Are associated with high suicide potential when used alone

14.33 Are clinically used as muscle relaxants

14.34 Are antipsychotics

- A. Benzodiazepines
- B. Barbiturates

Directions

Each group of questions below consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 14.35–14.41

14.35 Ethanol

14.36 Phenobarbital

14.37 Diazepam

14.38 Heroin

14.39 PCP

14.40 Caffeine

14.41 Nicotine

- A. γ -Aminobutyric acid (GABA) receptor system
- B. Opioid receptor system
- C. Glutamate receptor system
- D. Adenosine receptor system
- E. Acetylcholine receptor system

Questions 14.42–14.46

14.42 Horizontal and vertical nystagmus

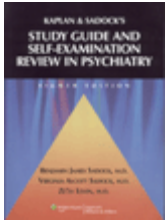
14.43 Injected conjunctiva

14.44 Atrophic nasal mucosa

14.45 Amotivational syndrome

14.46 Colorful hallucinations

- A. Cocaine
- B. Amphetamines
- C. Marijuana
- D. PCP
- E. LSD



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



15

Schizophrenia

Schizophrenia is a clinical syndrome of variable but profoundly disruptive psychopathology. It affects cognition, emotion, perception and other aspects of behavior. Although the expression of these manifestations varies across patients and over time, the effect of the illness is always severe and is usually long lasting. Schizophrenia affects just less than 1 percent of the world's population, and in the United States, has a financial cost that is estimated to exceed that of all cancers combined.

Schizophrenia is found in all societies and geographical areas. There is a slightly greater incidence in men than in women, and a greater incidence in urban versus rural areas. The illness is more severe in developed versus developing countries. Patients with schizophrenia are at increased risk for substance abuse, especially nicotine dependence. They are also at increased risk for suicidal and assaultive behavior. Approximately 10 percent of patients with schizophrenia commit suicide.

The etiology of schizophrenia is not yet known. There is considerable evidence that genetic factors make a robust contribution to the etiology. The presence of a proband with schizophrenia significantly increases the prevalence of this disorder among biological relatives.

Eight linkage sites have been identified, and specific candidate genes have been implicated. A number of potential environmental factors have also been identified that may contribute to the development of schizophrenia. These include gestational and birth complications, exposure to influenza epidemics or maternal starvation during pregnancy, Rhesus factor incompatibility, and an excess of winter births.

A central conceptual issue is whether schizophrenia is a neurodevelopmental or a neurodegenerative disorder. Both may be true, because the schizophrenia syndrome probably represents more than one disease process. The illness usually plateaus within the first 5 to 10 years of psychosis and does not manifest progressive deterioration throughout the course of life. The neuropathological investigation of the illness seems clearer. Although most studies have failed to document the presence of gliosis, the absence of gliosis does not preclude a neurodegenerative process. The preponderance of post mortem evidence is consistent with the neurodevelopmental hypothesis. This is further supported by neuropsychological, cognitive psychological, and neuroimaging findings.

Over the last 25 years, there has been a gradual evolution from conceptualizing schizophrenia as a disorder that involves discrete areas of the brain to a perspective that views it as a disorder of brain neural circuits. These models posit that a structural or functional lesion disrupts the functional capacity of the entire circuit. Major biochemical hypotheses involve dopamine, noradrenaline, serotonin, acetylcholine, glutamate and several neuromodulatory peptides or their receptors. The dopamine hypothesis is the most prominent and enduring hypothesis.

Issues relating to the reliability and validity of schizophrenia diagnoses have become more conceptual and theoretical since the development of the diagnostic system implemented in the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). The DSM approach is now the accepted diagnostic system in North America and throughout the international research community. The use of this approach has led to the reliable and consistent differential diagnosis of schizophrenia. The close connection of diagnosis and drug treatment is the dominant paradigm in drug development and is essential in registration studies seeking US Food and Drug Administration (FDA) approval of new drugs and new indications.

There is a large body of literature and scientific data regarding the pharmacological and psychosocial and rehabilitation of patients with schizophrenia. The antipsychotic drugs used to treat schizophrenia have a wide variety of pharmacological properties, but all share the capacity to antagonize postsynaptic dopamine receptors in the brain. Psychosocial and rehabilitative interventions are essential components of the comprehensive treatment of patients with schizophrenia. These include cognitive behavior therapy, supportive educationally oriented psychotherapy, family therapy and education programs, social and living skills training, supported employment programs, and supervised residential living arrangements.

Our field is at the beginning of a new century of opportunity for major breakthroughs in the treatment and prevention of schizophrenia. New paradigms providing heuristic advantage in the classification of psychopathological phenomena provide a means of addressing the problem of syndromic heterogeneity. Multidisciplinary work has become critical. Challenges in our understanding of this illness remain equally great. The complexity of this most distinctively human disease syndrome assures that the conquest of schizophrenia will be one of medicine's most difficult challenges.

Students should test their knowledge by addressing the following questions and answers.

Helpful Hints

The following names and terms, including the schizophrenic signs and symptoms listed, should be studied and the definitions learned.

- antipsychotics
- autistic disorder
- Gregory Bateson
- Eugen Bleuler
- *bouffée délirante*
- brain imaging—CT, PET, MRI
- catatonic type
- deinstitutionalization

- delusions
- dementia precox
- disorganized type
- dopamine hypothesis
- double bind
- downward-drift hypothesis
- ECT
- ego boundaries
- electrophysiology— EEG
- expressed emotion
- first-rank symptoms
- flat affect and blunted affect
- forme fruste
- fundamental and accessory symptoms
- genetic hypothesis
- hallucinations
- impulse control, suicide, and homicide
- Karl Jaspers
- Karl Kahlbaum
- Emil Kraepelin
- Gabriel Langfeldt
- mesocortical and mesolimbic tracts
- Adolf Meyer
- Benedict Morel
- neurotransmitters and neurodegeneration
- orientation, memory, judgment, and insight
- paranoia
- paranoid type
- paraphrenia
- positive and negative symptoms
- projective testing
- psychoanalytic and learning theories
- psychoimmunology and psychoendocrinology
- psychosocial treatments
- residual type
- RFLPs
- schizoaffective disorder
- Kurt Schneider
- seasonality of birth
- serotonin hypothesis

- social causation hypothesis
- soft signs
- stress–diathesis model
- Harry Stack Sullivan
- tardive dyskinesia
- the four As
- thought disorders
- undifferentiated type

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

15.1 Which of the following is *not* typically associated with catatonia?

- A. mutism
- B. verbigeration
- C. stereotypies
- D. mannerisms
- E. waxy flexibility

15.2 Late-onset schizophrenia

- A. is clinically distinguishable from schizophrenia.
- B. is more common in men.
- C. has an onset after age 60.
- D. is associated with a preponderance of paranoid symptoms.
- E. results in poorer response to antipsychotic medications.

15.3 True statements about eye movement dysfunction in schizophrenia include

- A. Eye movement dysfunction is independent of drug treatment
- B. Eye movement dysfunction is seen in first degree probands
- C. Eye movement dysfunction is associated with a frontal lobe pathology
- D. Abnormal eye movements occur more often in patients with schizophrenia compared with controls
- E. All of the above

Questions 15.4–15.5

15.4 Mr. A is a 22-year-old law student living alone in the school's dormitory. He had hopes to become a federal judge. Over the last 8 months his academic performance has declined, and he is being considered for academic probation. He has become increasingly isolated and withdrawn, and the girl he was dating broke off their relationship. He believes that she had been replaced by a look-alike from a distant planet, and that his fellow law students are conspiring against him. He believes that they snort and sneeze whenever he enters the classroom. He reports getting distracting "signals" from the television set, and that he hears voices of "the devil" calling to him. He called his father and asked for his help. Distressed, his father, himself a lawyer, brought him to the psychiatric emergency room for an evaluation. Physical examination was normal, and laboratory tests, including head computed tomography (CT) scan and urine toxicology, were negative.

Which of the following psychiatric conditions is the most likely diagnosis?

- A. brief psychotic disorder
- B. schizophreniform disorder
- C. delusional disorder
- D. schizophrenia, paranoid type
- E. malingering

P.129

15.5 Mr. C was admitted to a psychiatric unit for acute management of his symptoms. On risperidone 2 mg per day, by day 6 he was noted to be less isolated, and was less troubled by the hallucinations. On day 7, he was found in the bathroom, trying to tie a bed-sheet around his neck in an attempt to kill himself. Risk factors for suicide in this patient include:

- A. his age
- B. his sex
- C. his overly high ambitions
- D. an improvement in his condition
- E. all of the above

15.6 Persons in the United States who develop schizophrenia are more likely to

- A. have been born abroad
- B. have been born in the months from January to April
- C. have been born in the months from July to September
- D. have been exposed to the para-influenza virus
- E. none of the above

15.7 Which of the following is *true* of brain-imaging technologies in the study of schizophrenia?

- A. CT is used more than magnetic resonance imaging (MRI) in schizophrenia

research because its resolution is superior to that of MRI

B. The abnormalities reported in CT studies of patients with schizophrenia are specific for the pathophysiological processes underlying the disease

C. In studies of monozygotic twins discordant for schizophrenia, MRI studies have shown that the cerebral ventricles in the affected twins are larger than in the non-affected twins

D. PET studies have shown almost no impairment of brain areas after psychological test stimulation

E. fMRI has shown no differences in the brains of patients with schizophrenia compared with controls

15.8 The negative symptoms of schizophrenia include all of the following *except*

A. alogia

B. affective flattening

C. avolition

D. aggressivity

E. inattentiveness

15.9 False statements comparing the Serotonin-Dopamine Antagonists (SDAs) with Dopamine Receptor Antagonists include all of the following *except*

A. The SDAs produce more extrapyramidal symptoms than the dopamine receptor antagonists

B. The SDAs are less effective than the dopamine receptor antagonists for positive symptoms of schizophrenia

C. The SDAs produce more neurological adverse effects than dopamine receptor antagonists

D. The SDAs affect both serotonin and glutamate receptors

E. Dopamine receptor antagonists remain the first choice of treatment for schizophrenia

15.10 Appropriate psychosocial therapies in the management and treatment of schizophrenia include

A. social skills training

B. case management

C. individual psychotherapy

D. group therapy

E. all of the above

15.11 Clozapine (Clozaril)

- A. causes significant increases in prolactin levels
- B. is associated with a 10 to 20 percent incidence of agranulocytosis
- C. requires monthly monitoring of blood chemistry
- D. has been associated with few, if any, extrapyramidal side effects
- E. is believed to exert its therapeutic effect mainly by blocking dopamine receptors

15.12 Which of the following statements best describes a characteristic of the epidemiology of schizophrenia?

- A. Schizophrenia patients occupy about 50 percent of all hospital beds.
- B. Some regions of the world have an unusually high prevalence of schizophrenia.
- C. Female patients with schizophrenia are more likely to commit suicide than are male patients.
- D. In the northern hemisphere, schizophrenia occurs more often among people born from July to September than in those born in the other months.
- E. Reproduction rates among people with schizophrenia are typically higher than those among the general population.

15.13 Investigations into the cause of schizophrenia have revealed that

- A. no significant abnormalities appear in the evoked potentials in schizophrenic patients
- B. a monozygotic twin reared by adoptive parents has schizophrenia at the same rate as his/her twin raised by biological parents
- C. a specific family pattern plays a causative role in the development of schizophrenia
- D. the efficacy and potency of most antipsychotics correlate with their ability to act primarily as antagonists of the dopamine type 1 (D1) receptor
- E. a particular defective chromosomal site has been found in all schizophrenic patients

15.14 Epidemiological studies of schizophrenia have found all of the following except

- A. Hospital records suggest that the incidence of schizophrenia in the United States has remained unchanged for the past 100 years.
- B. The peak age of onset for schizophrenia is the same for men and women.
- C. Schizophrenia is equally prevalent among men and women.
- D. Approximately 50 percent of schizophrenic patients attempt suicide at least once in their lifetimes.
- E. The lifetime prevalence is usually between 1 and 1.5 percent of the population.

15.15 All of the following statements are factors with an increased risk of schizophrenia *except*

- A. having a schizophrenic family member
- B. having a history of temporal lobe epilepsy
- C. having low levels of monoamine oxidase, type B, in blood platelets
- D. having previously attempted suicide
- E. having a deviant course of personality maturation and development

15.16 A schizophrenic patient who states that he feels his brain burning is most likely experiencing a

- A. delusional feeling
- B. gustatory hallucination
- C. cenesthetic hallucination
- D. haptic hallucination
- E. hypnopompic hallucination

15.17 The majority of CT studies of patients with schizophrenia have reported

- A. enlarged lateral and third ventricles in 10 to 50 percent of patients
- B. cortical atrophy in 10 to 35 percent of patients
- C. atrophy of the cerebellar vermis
- D. findings that are not artifacts of treatment
- E. all of the above

15.18 In general, pooled studies show concordance rates for schizophrenia in monozygotic twins of

- A. 0.1 percent
- B. 5 percent
- C. 25 percent
- D. 40 percent
- E. 50 percent

15.19 Features weighing toward a good prognosis in schizophrenia include all of the following *except*

- A. depression
- B. a family history of mood disorders
- C. paranoid features

- D. undifferentiated or disorganized features
- E. an undulating course

15.20 Electrophysiological studies of persons with schizophrenia show

- A. decreased alpha activity
- B. spikes in the limbic area that correlate with psychotic behavior
- C. increased frontal lobe slow-wave activity
- D. increased parietal lobe fast-wave activity
- E. all of the above

15.21 With regard to the ventricular size in schizophrenia, which of the following statements is true?

- A. Ventricular enlargement is a pathognomonic finding in schizophrenia.
- B. Ventricular changes in schizophrenia are likely to be specific for the pathophysiological processes underlying this disorder.
- C. Patients with schizophrenia invariably demonstrate significant enlargement of the lateral ventricles.
- D. All of the above
- E. None of the above

15.22 MRI studies of schizophrenics have found evidence for

- A. increased cortical gray matter
- B. increased volume of the amygdala
- C. increased volume of basal ganglia nuclei
- D. increased temporal cortex gray matter
- E. increased volume of the hippocampus

15.23 Prefrontal cortex and limbic system hypotheses are the predominant neuroanatomical theories of schizophrenia because of the demonstration of

- A. decreased volume of prefrontal gray or white matter
- B. prefrontal cortical interneuron abnormalities
- C. disturbed prefrontal metabolism and blood flow
- D. disarray or abnormal migration of hippocampal neurons
- E. all of the above

15.24 The rationale for the role of excess dopamine in schizophrenia is based on observations that

- A. Dopaminergic drugs can induce paranoid psychosis.
- B. Drugs that block postsynaptic dopamine receptors reduce symptoms of schizophrenia.
- C. Metabolic alterations in limbic anatomy are consistent with a disturbance in dopamine metabolism.
- D. Increased concentrations of dopamine have been found in the amygdalas in postmortem brains of schizophrenic patients.
- E. All of the above

15.25 Possible risk factors for the development of schizophrenia include

- A. birth during winter months
- B. increased number of birth complications
- C. social class
- D. recent immigration status
- E. all of the above

15.26 True statements about structural brain abnormalities in patients with schizophrenia include

- A. abnormalities are present from birth
- B. cortical involvement is multifocal rather than diffuse

P.131

- C. abnormalities are present in a minority of patients
- D. abnormalities have not been correlated with cognitive deficits
- E. none of the above

15.27 True statements about hypothesized neurobiological models of schizophrenia include

- A. Genes function in part by increasing vulnerability to environmental factors.
- B. Environmental factors increase risk by producing subtle brain damage.
- C. The apparent lack of gliosis in postmortem studies implicates in utero factors.
- D. As the prefrontal cortex matures, behavioral and cognitive sequelae of subtle structural deficits become manifest.
- E. All of the above

15.28 In simple deteriorative disorder

- A. hallucinations are common.
- B. delusions are common.
- C. homelessness is common.

- D. early diagnosis is common.
- E. All of the above

15.29 Childhood schizophrenia

- A. is not diagnosed using the same symptoms as are used for adult schizophrenia
- B. tends to have an abrupt onset
- C. tends to have a chronic course
- D. tends to have a better prognosis than adult schizophrenia
- E. all of the above

15.30 True statements about violence and schizophrenia include all of the following *except*

- A. Patients with schizophrenia are more violent as a group than the general population.
- B. Patients with disorganized schizophrenia are at much greater risk to commit violence than those with paranoid schizophrenia.
- C. Command hallucinations do not appear to play a particularly important role in violence.
- D. Violence in a hospital setting can result from undiagnosed neuroleptic-induced acute akathisia.
- E. It is more difficult to prevent most schizophrenic homicides compared to the general population.

15.31 Mr. G, a 36-year-old man, is admitted to a psychiatric unit after having been brought to the emergency department by police. As he was walking past a hotel in the central part of the city, he saw a man and woman standing on the sidewalk about to take a photograph of a building across the street. Thinking that they were going to take his picture, he grabbed the camera, smashed it on the ground, and pulled out all the film. He explained his actions by saying the photograph would be used to control him and that it is illegal to take another person's photograph.

Mr. G has a history of multiple hospitalizations dating back to age 14. During the hospitalizations, his symptoms have been well-controlled with a variety of typical and atypical antipsychotic medications. Once discharged he begins drinking four to five beers a day, neglects getting prescriptions refilled, and stops medication when his supply runs out. He made two prior suicide attempts, both by hanging, in which he suffered no serious medical sequelae. He reports numerous blackouts from drinking, but he has never had seizures or DTs. He does not use illicit drugs.

Mr. G dropped out of high school in the 11th grade. He worked a number of short-term, unskilled jobs before going on public assistance at age 21. He lives alone, is estranged from his family, and has no friends. On examination, Mr. G is lying motionless. He makes good eye contact and says, "I'm trying not to move." He fears that if he moves he may die. He currently hears voices saying, "Be good," "Get the dog," and "He's the one." He also sees shapes, which he describes as

colored letters dancing in front of his eyes. He talks about being monitored by hidden cameras and microphones everywhere he goes in the city. He is alert and oriented. He can recall three out of three objects after 5 minutes. Concentration is impaired.

Which of the following is the most likely diagnosis for the case described above?

- A. Schizophrenia, catatonic type
- B. Schizophrenia, undifferentiated type
- C. Schizophrenia, paranoid type
- D. Delusional disorder
- E. Schizoaffective disorder

15.32 Which of the following interventions is most likely to prevent relapse in the case above?

- A. Vocational rehabilitation
- B. Increased socialization
- C. Use of a long-term depot antipsychotic
- D. Alcohol counseling
- E. Use of an atypical antipsychotic

Directions

Each group of questions consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 15.33–15.36

15.33 Latinized the term *démence précoce*

15.34 Classified patients as being afflicted with manicdepressive psychoses, dementia precox, or paranoia

15.35 Coined the term schizophrenia

P.132

15.36 Described the four As of schizophrenia—associations, autism, affect, and ambivalence

- A. Eugen Bleuler
- B. Emil Kraepelin

Questions 15.37–15.42

15.37 Sudden delusional ideas

15.38 Perplexity

15.39 Audible thoughts

15.40 Voices commenting

15.41 Thought withdrawal

15.42 The experience of having one's thoughts controlled

- A. Schneiderian first-rank symptom
- B. Schneiderian second-rank symptom

Questions 15.43–15.47

15.43 Loss of logical relations between thoughts

15.44 Creation of a new expression or word

15.45 Repetition of interviewer's words when answering a question

15.46 Words associated by sound rather than meaning

15.47 Use of words in stereotypically repetitive fashion

- A. Neologism
- B. Echolalia
- C. Verbigeration
- D. Clang association
- E. Loosening of associations

Questions 15.48–15.52

15.48 Functional inhibition of speech

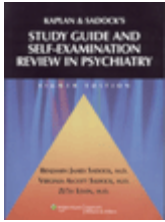
15.49 Imitation of movements

15.50 Repetitive, often bizarre, speech or behavior

15.51 Unwillingness to cooperate without apparent reason

15.52 Diminution in ability to experience pleasure

- A. Echopraxia
- B. Negativism
- C. Anhedonia
- D. Stereotypies
- E. Mutism



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



16

Other Psychotic Disorders

The disorders in this chapter occur less frequently than schizophrenia but can have profound short term or long-term psychosocial consequences. As a group, they are more poorly understood than schizophrenia, and can be difficult to distinguish from other forms of psychosis.

Brief psychotic disorder is a psychotic condition involving the sudden onset of psychotic symptoms which lasts one day or more, but less than one month. Remission is full, and the individual returns to the premorbid level of functioning. Schizophreniform disorder is conceptualized as a variant of schizophrenia. Patients with this condition are floridly psychotic, with a prodromal, active and residual phase between one and six months. If the duration of illness extends beyond six months, the diagnosis might be changed to schizophrenia. Risk factors include unemployment, residence in a metropolitan area, lowincome, being separated, widowed or divorced, young age, low education, living with non relatives, obstetric and early neonatal complications, childhood emotional problems and cannabis use.

Delusional disorders, once referred to as paranoid disorders, are diagnosed when the individual reports non-bizarre delusions for more than one month without prominent hallucinations, and with a relative preservation of functioning. Non-bizarre delusions are plausible, understandable, and derive from ordinary life experience. The course appears to be less chronic, with less associated deterioration in functioning than the course of schizophrenic patients. Shared psychotic disorder, commonly referred to as a folie a deux, refers to the condition in which two individuals with a close and generally long-term relationship, share the same delusional belief, although it may involve more than two individuals, including entire families.

Schizoaffective disorder combines the symptoms of mood disorders and schizophrenia. It may be a neurodevelopmental disorder, and gender differences parallel those seen in mood disorders. While almost 85 percent of women experience some type of mood disturbance during the postpartum period, postpartum psychosis is rare. The student should be familiar with it because infanticide may occur. Hormonal hypotheses have been posited to explain its etiology, which remains unknown however.

Knowledge of the culture-bound syndromes is increasingly important. The growing wave of immigration from developing countries to the United States over the past few decades

has meant that doctors in the United States need to acquire a basic understanding of the formulations of health and illness in the culture from which their patients come. The course of these syndromes is generally favorable, and most present as self-limiting episodes after stressful.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

Students should know the psychotic syndromes and other terms listed here.

- age of onset
- amok
- antipsychotic drugs:
 - clozapine
 - dopamine receptor antagonists
- Arctic hysteria
- atypical psychoses
- autoscopic psychosis
- *bouffée délirante*
- brief psychotic disorder
- Norman Cameron
- Capgras's syndrome
- Clérambault's syndrome
- conjugal paranoia
- Cotard's syndrome
- course
- culture-bound syndromes
- Cushing's syndrome
- delusional disorder
- delusions
- denial
- differential diagnosis
- double insanity
- EEG and CT scan
- erotomania
- Fregoli's syndrome
- Ganser's syndrome
- good-prognosis schizophrenia
- heutoscopy
- homicide
- ICD-10
- incidence

- inclusion and exclusion criteria
- *koro*
- Gabriel Langfeldt
- lifetime prevalence
- limbic system and basal ganglia
- lithium
- lycanthropy
- marital status
- mental status examination
- mood-congruent and – incongruent psychotic features
- neuroendocrine function
- neurological conditions
- neuropsychological testing
- nihilistic delusion
- paranoia
- paranoid
- pseudocommunity
- paranoid states
- paraphrenia
- *piblokto*
- postpartum blues

-
- postpartum psychosis
 - postpsychotic depressive disorder of schizophrenia
 - prognostic variables
 - projection
 - pseudocommunity
 - psychodynamic formulation
 - psychosis of association
 - psychotherapy
 - psychotic disorder not otherwise specified
 - reaction formation
 - reduplicative paramnesia
 - schizoaffective disorder
 - schizophreniform disorder
 - Daniel Paul Schreber
 - SES
 - shared psychotic disorder
 - significant stressor
 - simple schizophrenia
 - suicidal incidence

- suk-yeong
- TRH stimulation test
- wihtigo psychosis

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

16.1 Attaque de nervios:

- A. is most common in Puerto Ricans
- B. usually has no precipitating stressful event
- C. usually features a sense of being out of control
- D. is usually associated with acute fear
- E. usually results in a deteriorating course

16.2 The postpartum blues

- A. occur in up to 50 percent of women after childbirth
- B. are self-limited
- C. begin shortly after childbirth and lessens in severity over the course of a week
- D. are considered to be normal
- E. all of the above

16.3 Postpartum psychosis

- A. occurs more commonly in multigravida women
- B. is rarely correlated with perinatal complications
- C. almost always begins within eight weeks of delivery
- D. usually occurs abruptly, with no prodromal psychotic symptoms
- E. is essentially an episode of a psychotic disorder

16.4 Erotomania, the delusional disorder in which the person makes repeated efforts to contact the object of the delusion, through letter, phone call, and stalking, is also referred to as

- A. Cotard's syndrome
- B. Clérambault's syndrome
- C. Fregoli's syndrome
- D. Ganser's syndrome

E. Capgras's syndrome

16.5 A 40-year-old single unemployed man is referred by his primary care physician because of repeated consultations related to his complaint of hair loss. Multiple dermatologists had evaluated the patient, found no pathology, and told him that the minimal hair loss was normal, but he refused to accept their judgment and demanded further consultations. He told one of them "everything else about me is fine. This needs to be corrected for completeness." He had become increasingly indebted financially to pay for consultations with out-of-network providers. The most likely diagnosis in this man is:

- A. delusional disorder, somatic type
- B. hypochondriasis
- C. body dysmorphic disorder
- D. paranoid schizophrenia
- E. psychotic depression

16.6 All of the following are true statements about postpartum psychosis *except*

- A. The risk is increased if the patient had a recent mood disorder.
- B. Hallucinations involve voices telling the patient to kill her baby.
- C. It is found in 1 to 2 per 1,000 deliveries.
- D. Generally, it is not considered a psychiatric emergency.
- E. Delusional material may involve the idea that the baby is dead.

16.7 In schizoaffective disorder, all of the following variables indicate a poor prognosis *except*

- A. depressive type
- B. no precipitating factor
- C. a predominance of psychotic symptoms
- D. bipolar type
- E. early onset

16.8 A 17-year-old high school junior was brought to the emergency room by her distraught mother, who was at a loss to understand her daughter's behavior. Two days earlier, the patient's father had been buried: he had died of a sudden myocardial infarction earlier in the week. The patient had become wildly agitated at the cemetery, screaming uncontrollably and needing to be restrained by relatives. She was inconsolable at home, sat rocking in a corner, and talked about a devil that had come to claim her soul. Before her father's death, her mother reported, she was a "typical teenager, popular, a very good student, but sometimes prone to overreacting." The girl had no previous psychiatric history.

The most likely diagnosis is:

- A. grief
- B. brief psychotic disorder

- C. schizophrenia
- D. substance intoxication
- E. delusional disorder

16.9 True statements concerning the treatment of shared psychotic disorder include all of the following *except*

- A. Recovery rates have been reported to be as low as 10 percent.
- B. The submissive person commonly requires treatment with antipsychotic drugs.
- C. Psychotherapy for nondelusional members of the patient's family should be undertaken.
- D. Separation of the submissive person from the dominant person is the primary intervention.
- E. The submissive person and the dominant person usually move back together after treatment.

16.10 Most studies of normal pregnant women indicate that the percentage who report the "blues" in the early postpartum period is about

- A. 10 percent
- B. 25 percent
- C. 50 percent
- D. 75 percent
- E. 100 percent

16.11 All of the following are associated with a good prognosis in a brief psychotic disorder *except*

- A. Sudden onset of symptoms
- B. No affective symptoms
- C. Confusion during psychosis
- D. Severe precipitating stressor
- E. Few premorbid schizoid traits

16.12 The differential diagnosis of brief psychotic disorder includes

- A. substance-induced psychotic disorder
- B. psychotic disorder due to a general medical condition

- C. severe personality disorders
- D. malingering
- E. all of the above

16.13 Delusional disorder

- A. is less common than schizophrenia
- B. is caused by frontal lobe lesions
- C. is an early stage of schizophrenia
- D. usually begins by age 20
- E. is more common in men than in women

16.14 The best-documented risk factor for delusional disorder is

- A. sensory impairment
- B. recent immigration
- C. advanced age
- D. family history
- E. social isolation

16.15 Evidence that suggests delusional disorder is a separate entity from schizophrenia or mood disorders includes

- A. epidemiological data
- B. family or genetic studies
- C. natural history of the disorder
- D. premorbid personality data
- E. all of the above

16.16 Delusional disorder may include

- A. tactile hallucinations
- B. olfactory hallucinations
- C. auditory hallucinations
- D. visual hallucinations
- E. all of the above

16.17 True statements about patients with delusional disorder, erotomanic type, include:

- A. they exhibit what has been called "paradoxical conduct"

- B. the course of the disorder is invariably chronic
- C. separation from the love object is usually not an effective treatment
- D. women predominate in forensic populations
- E. all of the above

16.18 Of the following somatic treatments for delusional disorder, which is considered the *least* likely to be successful?

- A. dopamine receptor antagonists
- B. serotonin-dopamine antagonists
- C. selective serotonin reuptake inhibitors
- D. electroconvulsive treatment
- E. all of the above are considered equally effective

16.19 Puerperal psychosis

- A. has a prevalence of 10 to 15 percent
- B. usually does not occur until 2 to 3 months postpartum
- C. usually has insidious onset
- D. is most likely to occur in patients with a previous history of the disorder
- E. all of the above

16.20 Which of the following statements is *true* about brief psychotic disorder?

- A. Approximately 10 percent of patients diagnosed retain the diagnosis.
- B. Fifty percent of the cases evolve into either schizophrenia or major mood disorder.
- C. There are clear distinguishing features between brief psychotic disorder and acute-onset schizophrenia on initial presentation.
- D. Poor prognosis is associated with emotional turmoil
- E. None of the above

16.21 Ms. R, a 24-year-old woman, is brought to an emergency room by her father with a chief complaint, "I have bugs

P.144

all over my body and in my hair. They're making me weaker." Two weeks earlier, the apartment Ms. R shares with a roommate flooded after a pipe burst. Following the flood, the apartment was infested with insects. At one point, Ms. R had insects crawling in an open wound on her arm. The apartment was cleaned and fumigated, but Ms. R persisted in believing bugs were everywhere. She washed herself with alcohol several times a day and avoided seeing friends and family because of her fear that the infestation would spread to others. She believed that a cocoon was being spread over her body and that insects were crawling over her internal

organs. She spent most of the last 3 days immersed in a bathtub of water. Her roommate became alarmed and called her father, who brought her to the emergency room. She denies sleep or appetite changes, and has not experienced auditory or visual hallucinations.

Ms. R had a history of outpatient treatment for anorexia nervosa and a major depressive episode. When she was 16 she became withdrawn, tearful, preoccupied with death, had difficulty sleeping, and lost 10 pounds. She was treated with individual psychotherapy and citalopram pharmacotherapy. All symptoms of depression resolved within a month and she had no recurrence. When she was 19, coinciding with a brief modeling career, she began a severe diet, exercised intensively, and lost 25 pounds. Her menses ceased for 6 months. She resumed psychotherapy but not medication. Her modeling career ended abruptly when the agency representing her went out of business. She began a romantic relationship and went back to school. Gradually, she lost interest in dieting, her weight stabilized, and menses returned. She experimented with cocaine around that time, but claims not to have used illicit drugs for over 4 years. She drinks no more than one or two glasses of wine a week. She has been working as an administrative assistant for a recording studio and was going to work regularly and working without difficulties until the day of the flood and the infestation. She has not returned to work since.

Her blood pressure is 115/75, heart rate 70, and temperature 37C. She weighs 125 pounds and is 5 feet 6 inches tall. Physical examination is unremarkable. Routine laboratory studies, including liver function tests, are within normal limits. A urine toxicology screen is negative. She appears apprehensive. She describes feeling bugs crawling on her skin and she believes that insects have entered her body and are slowly enveloping her in a cocoon. She denies auditory hallucinations. Her thoughts are logical and goal-directed. She is alert and oriented.

Which of the following is the most likely diagnosis?

- A. Schizophrenia
- B. Cocaine-induced psychotic disorder
- C. Major depression with psychotic symptoms
- D. Delusional disorder
- E. Brief psychotic episode

16.22 The patient's belief in the case above that insects were crawling on her arm is called

- A. dyskinesia
- B. illusion
- C. formication
- D. paresthesia
- E. none of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 16.23–16.27

16.23 Delusional disorder

16.24 Schizophrenia

16.25 Mania

16.26 Depressive disorders

16.27 Cognitive disorders

- A. Delusions of guilt
- B. Delusions secondary to perceptual disturbances
- C. Grandiose delusions
- D. Bizarre delusions of being controlled
- E. Delusions of jealousy

Questions 16.28–16.32

16.28 Psychomotor retardation

16.29 Thought broadcasting

16.30 Easy distractibility with an elevated, expansive, or irritable mood

16.31 Nonbizarre persecutory or grandiose delusions

16.32 Suspiciousness and mistrust of people, without psychotic symptoms

- A. Paranoid personality disorder
- B. Delusional disorder
- C. Schizophrenia
- D. Manic episode
- E. Major depressive episode

Questions 16.33–16.37

16.33 Simple, transient delusions

16.34 Persecutory delusions

16.35 Elaborate and systematic delusions

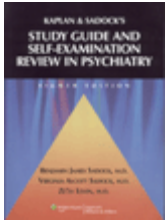
16.36 Delusions with strong affective components

16.37 Delusions associated with Alzheimer's disease

- A. Cortical impairment

B. Subcortical impairment





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



17

Mood Disorders

Mood disorders encompass a large group of psychiatric disorders in which pathological moods and related vegetative and psychomotor disturbances dominate the clinical picture. Known in previous editions of the *Diagnostic and Statistical Manual of Mental Disorders* as *affective disorders*, the term *mood disorders* is preferred today because it refers to sustained emotional states, not merely to the external (affective) expression of the present emotional state. Mood disorders are best considered as syndromes (rather than discrete diseases) consisting of a cluster of signs and symptoms, sustained over a period of weeks to months, that represent a marked departure from a person's habitual functioning and tend to recur, often in periodic or cyclical fashion.

Mood disorders can sometimes be difficult to diagnose, given the subjective nature of the symptoms. All people have normal periods of feeling either blue or elated, and most of these obviously are not diagnosable as disorders. A mood disorder is characterized by the intensity, duration, and severity of the symptoms. People with mood disorders cannot control their symptoms, the most severe of which are psychotic. Symptoms interfere with normal thought process and content, and cognitive, speech, and social functioning. Many people with depressive disorders unfortunately go untreated, as their symptoms are minimized or misinterpreted. People with bipolar disorders are more often treated, as their symptoms more frequently are bizarre or disruptive enough to bring them to medical and psychiatric attention.

Mood disorders are caused by a complex interplay of biological and psychological factors. Biologic theories involve the role of the biogenic amines, in particular dysfunction in the norepinephrine, serotonin, dopamine, and GABA neurotransmitter systems. Most antidepressant medications involve complex manipulations of these systems. There appears to be dysregulation as well in the adrenal, thyroid, and growth hormone axes, all of which have been implicated in the etiology of mood disorders. Abnormalities in the sleep cycle and in regulation of circadian rhythms have also been studied.

Genetics always play an important role in the etiology of mental disorders, but genetic input is especially relevant in mood disorders. Bipolar I disorder is one of the most genetically determined disorders in psychiatry. However, as with any mental disorder, psychosocial factors play a crucial role in the development, presentation, course, and prognosis of mood disorders. Issues of real and symbolic loss, family relationships and

dynamics, environmental stress, and unconscious conflicts all strongly contribute to and determine mood symptoms. Some clinicians believe that these factors are particularly important in the first episodes of mood disorders, but in one form or another they play a role in all episodes.

Skilled clinicians will be knowledgeable about all available treatment modalities, their indications, side effects, limitations, and advantages. They will know how best to combine different treatments, and which treatments are most effective for which disorders, from psychopharmacologic interventions, to the different psychotherapies, to electroconvulsive therapy (ECT).

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know the following terms that relate to mood disorders.

- adrenal axis
- affect
- age-dependent symptoms
- amphetamine
- antipsychotics
- anxiety-blissfulness psychosis
- atypical features
- biogenic amines
- bipolar I disorder
- bipolar II disorder
- carbamazepine
- catatonic features
- clinical management
- cognitive, behavioral, family, and psychoanalytic therapies
- cognitive theories
- cyclothymic disorder
- depression rating scales
- depressive equivalent
- differential diagnosis
- double depression
- dysthymic (early and late onset) disorder
- ECT
- euthymic
- folie á double forme
- folie circulaire
- forme fruste
- GABA
- genetic studies

- GH
- 5-HT
- hypomania
- hypothalamus
- incidence and prevalence
- Karl Kahlbaum
- kindling
- Heinz Kohut
- Emil Kraepelin
- learned helplessness
- LH, FSH

-
- life events and stress
 - lithium
 - major depressive disorder
 - mania
 - MAOIs
 - melancholic features
 - melatonin
 - mild depressive disorder
 - mixed episode
 - mood
 - mood-congruent and incongruent psychotic fear
 - neurological, medical, and pharmacological causes of mood disorders
 - norepinephrine
 - phototherapy
 - postpartum onset
 - premenstrual dysphoric disorder
 - premorbid factors
 - pseudodementia
 - rapid cycling
 - REM latency, density
 - RFLP
 - seasonal pattern
 - Sex ratios of disorders
 - SSRI
 - suicide
 - T3
 - thymoleptics
 - TSH, TRH
 - vegetative functions

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

17.1 Dysthymic Disorder

- A. usually begins in adulthood
- B. does not respond to anti-depressants
- C. presents with symptoms of lack of say in life and preoccupation with inadequacy
- D. is usually limited to one or two episodes
- E. is characteristically marked by psychomotor agitation or psychomotor retardation

17.2 The person *least* likely to develop major depressive disorder (MDD) in their lifetime is

- A. 10-year-old boy diagnosed with dysthymia
- B. Identical twin of an MDD patient who committed suicide
- C. 12-year-old girl mourning the death of her mother
- D. 19-year-old female who was raped 3 weeks ago
- E. 60-year-old male with pancreatic cancer

17.3 The defense mechanism most commonly used in depression is

- A. projection
- B. introjection
- C. sublimation
- D. undoing
- E. altruism

17.4 Which of the following is not a change in brain function associated with severe depression?

- A. Increased REM sleep
- B. Impaired cellular immunity
- C. Hypocortisolism
- D. Increased glucose metabolism in the amygdala
- E. Decreased anterior cerebral blood flow

17.5 Which of the following is *not* part of the DSM-IV-TR criteria for diagnosing atypical depression?

- A. Shortening of REM latency
- B. Mood reactivity
- C. Significant weight gain
- D. Hypersomnia
- E. Leaden paralysis

17.6 Reactive depression can best be compared to

- A. Adjustment Disorder
- B. Oppositional Defiant Disorder
- C. Conduct Disorder
- D. Atypical Depression
- E. Schizoaffective Disorder

17.7 L-Tryptophan

- A. is the amino acid precursor to dopamine
- B. has been used as an adjuvant to both antidepressants and lithium
- C. has been used as a stimulant
- D. has not been associated with any serious side effects
- E. all of the above

17.8 Common features of normal bereavement include

- A. Marked psychomotor retardation
- B. Mummification
- C. Suicidal ideation
- D. Guilt of omission
- E. All of the above

17.9 Drugs that may precipitate mania include all of the following *except*

- A. bromocriptine
- B. isoniazid
- C. propranolol
- D. disulfiram
- E. all of the above

17.10 Which of the following statements regarding mood disorders is *false*?

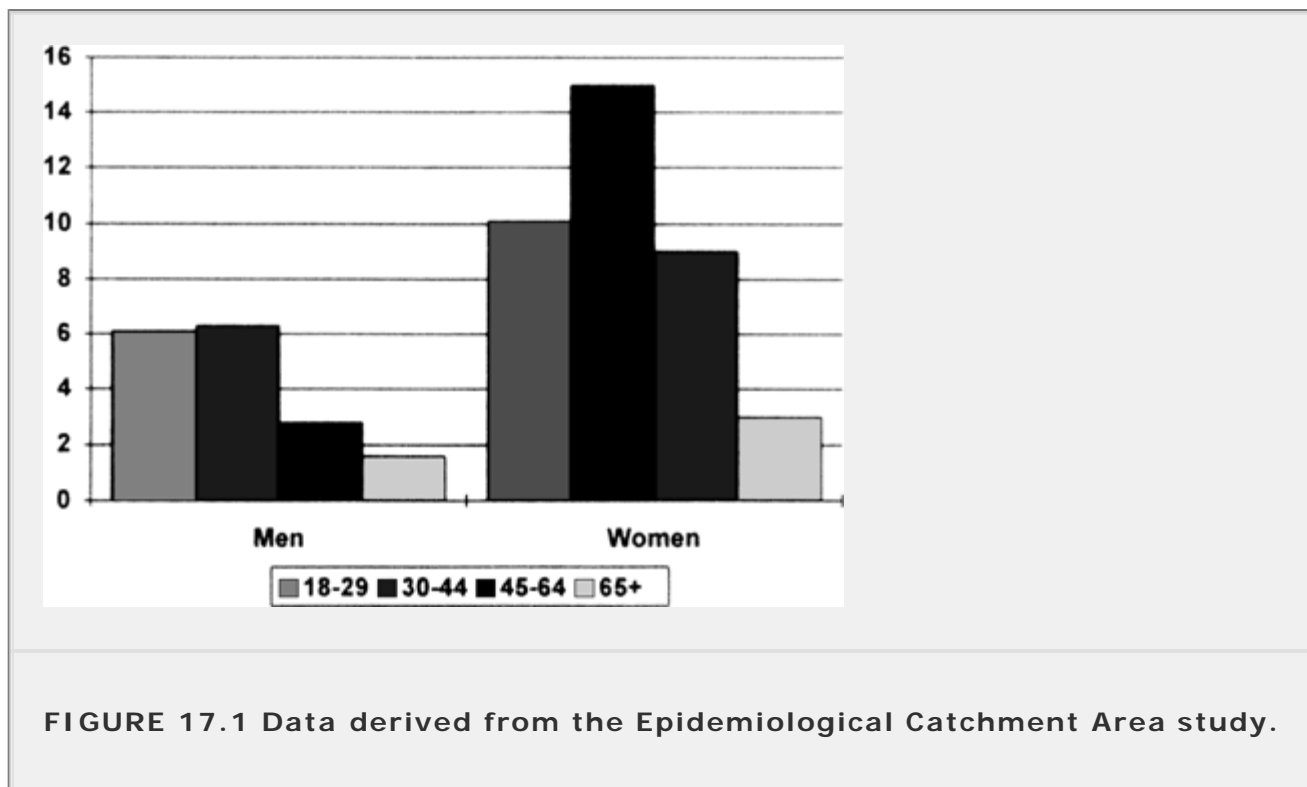
- A. Approximately 15 percent of depressed patients will eventually commit suicide.
- B. Depressive disorders are more common in women
- C. Incidence of depression in younger age groups is increasing
- D. Manic forms of mood disorders predominate in men
- E. 1 out of 4 patients with an acute depressive episode will have recurrences throughout life

P.152

17.11 Which of the following statements regarding hypomanic episodes is *false*?

- A. It is characterized by mild elevations of mood
- B. Patients often experience increased energy levels
- C. It is ego-syntonic
- D. It often progresses to manic psychosis
- E. It can be mobilized by antidepressant use

17.12 [Figure 17.1](#) depicts the distribution, according to age and sex, of which of the following?



- A. incidence of anorexia nervosa
- B. prevalence of mood disorders
- C. incidence of obsessive-compulsive disorder

- D. prevalence of schizophrenia
- E. incidence of somatization

17.13 Which of the following statements regarding ECT is *false*?

- A. ECT should be used in cases of psychotic depression only
- B. Bilateral ECT is somewhat more effective than unilateral ECT
- C. Retrograde memory impairment is a common side effect
- D. ECT is often used for refractory mood disorders
- E. 8 to 12 treatments are usually needed for symptomatic remission

17.14 The most consistent computer tomography (CT) and magnetic resonance imaging (MRI) abnormality observed in depressive disorders is

- A. ventricular enlargement
- B. increased frequency of hyperintensities in subcortical regions
- C. cortical atrophy
- D. sulcal widening
- E. none of the above

17.15 Which of the following statements regarding rapid cycling bipolar disorder is *true*?

- A. More common in men than women
- B. Often responds to tricyclic antidepressants
- C. Defined as at least 4 episodes per month
- D. Alcohol, stimulants, or caffeine use are risk factors
- E. Hospitalization of these patients is rare

17.16 All of the following statements regarding Bupropion (Wellbutrin) are true *except*

- A. Acts as a dopamine reuptake inhibitor
- B. Rapid onset of action
- C. No sexual dysfunction or weight gain associated with its use
- D. Can be used for smoking cessation
- E. Side effects include insomnia and GI distress

17.17 All of the following statements regarding cyclothymic disorder are true *except*

- A. Symptoms must be present for at least 2 years

- B. Occurs at the same rate in men and women
- C. Symptoms may satisfy criteria for major depression
- D. Consists of hypomania alternating with depressed mood
- E. Lifetime prevalence rate is about 0.4 to 1 percent

17.18 A 35-year-old female has just been diagnosed with major depressive disorder. For the past 8 months, she has suffered from depressed mood, decreased energy and concentration, and loss of interest in previously enjoyed activities. Although she never attempted suicide, she acknowledges that she thought she would probably jump off a local bridge if she ever had the chance. She denies

P.153

any history of excessively elevated moods. You decide to start her on antidepressant therapy. Two weeks later, this patient is at greatest risk for

- A. Medication noncompliance
- B. Suicide completion
- C. Manic episode
- D. Hypomanic episode
- E. Extrapyrarnidal symptoms

17.19 Which of the following antidepressants would not be the best choice for the above patient with a history of suicidal ideation?

- A. SSRI
- B. MAOI
- C. TCA
- D. Bupropion (Wellbutrin)
- E. Venlafaxine (Effexor)

17.20 Serotonin

- A. is an important regulator of sleep, appetite, and libido
- B. helps to regulate circadian rhythms
- C. permits or facilitates goal-directed motor and consummatory behavior in conjunction with norepinephrine and dopamine
- D. stores are increased by transient stress and depleted by chronic stress
- E. all of the above

17.21 The *highest* suicide rates are in which of the following age groups?

- A. Under age 15
- B. 15 to 24 year olds

- C. 25 to 44 year olds
- D. 45 to 64 year olds
- E. Over age 65

17.22 Features of anhedonia may include all of the following *except*

- A. Difficulty describing or being aware of emotions
- B. Derealization
- C. Loss of pleasure
- D. Inability to experience normal emotions
- E. Withdrawal from interests

17.23 Mirroring, twinship, and idealization are terms associated with

- A. Sigmund Freud
- B. Melanie Klein
- C. Edith Jacobson
- D. Heinz Kohut
- E. Charles Brenner

17.24 Psychomotor retardation is characterized by all of the following *except*

- A. Paucity of spontaneous movements
- B. Reduced speech amplitude and flow
- C. Indecisiveness
- D. Poor concentration
- E. Restlessness

17.25 Mr. Mis an 87-year-old man who, 6 weeks after coronary artery bypass graft, complicated by pneumonia and renal insufficiency, was admitted to an inpatient rehabilitation service for management of physical deconditioning. Psychiatry was consulted 10 days after admission to rule out depression in the context of persistent low appetite and energy associated with suboptimal participation in rehabilitation. Mr. M reported no prior psychiatric history. He had worked as a chemist until retirement nearly two decades earlier. Laboratory examination revealed a low hematocrit of 21 and moderately elevated blood urea nitrogen of 65. On interview, Mr. M demonstrated psychomotor slowing and bland affect. He denied depression, hopelessness, worthlessness, or suicidal ideation. He expressed a desire to recover from his debilitated state, but acknowledged uncertainty that he was capable of doing so. He also complained of extreme weakness. He stated, "I just don't seem to have an appetite anymore." Cognition largely was intact; there was mild short-term memory deficit. The most likely diagnosis in this patient is:

- A. Major depressive disorder

- B. Mood disorder secondary to a general medical condition
- C. Dementia
- D. Delirium
- E. Anxiety disorder with depressed mood

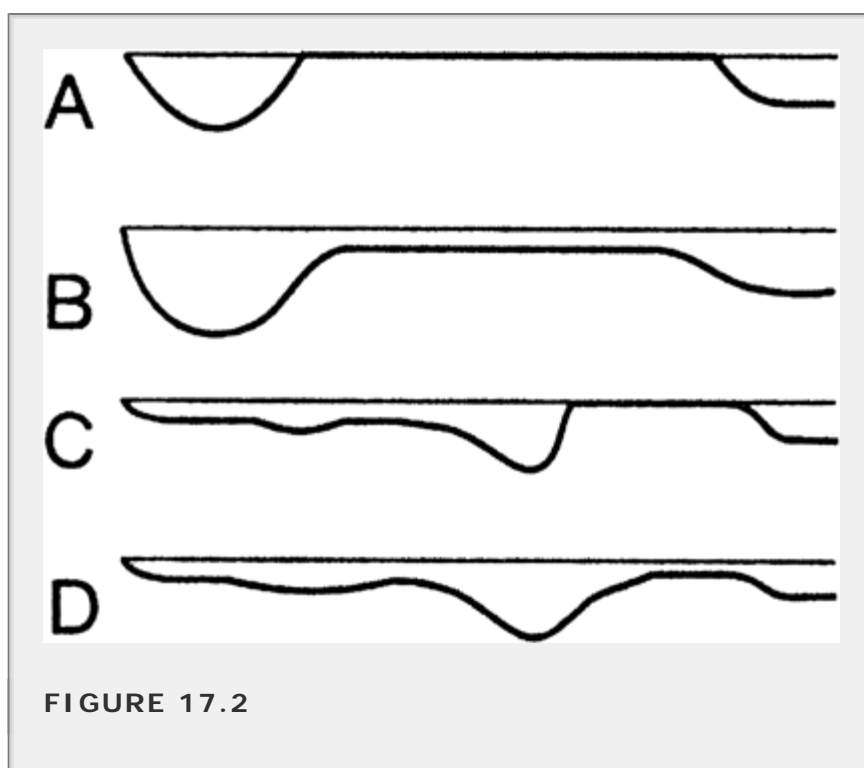
17.26 Double depression is characterized by

- A. Two episodes of major depressive disorder per month consistently
- B. Superimposed bipolar II disorder and atypical depression
- C. Recurrent major depressive disorder superimposed with dysthymic disorder
- D. Two family members suffering from major depressive disorder concurrently
- E. Recurrent major depressive disorder with current symptoms twice as disabling as usual

17.27 Which of the graphs in [Figure 17.2](#) depicts the prototypical course of double depression?

- A. A
- B. B
- C. C
- D. D
- E. None of the above

17.28 Which graph in [Figure 17.2](#) depicts the pattern with the best future prognosis?



A. A

B. B

C. C

P.154

D. D

E. None of the above

17.29 A 57-year-old female presents to you after being diagnosed with major depressive disorder. She has been depressed ever since the death of her husband 2 years earlier. She has been taking the same antidepressant since her diagnosis 1 year ago, with no relief of her symptoms. She states that she would like your help in ending her life. The best option for your next step is:

A. Respect the patient's wishes as she is of sound mind

B. Seek to more adequately treat her depression

C. Seek family members to make a more informed decision

D. Contact the hospital ethics committee

E. Obtain information from the state regarding physician-assisted suicide laws

17.30 A suicidal patient with chronic depressive disorder presents to your office very frustrated and in tears. He tells you he can't stop thinking about ending his life because he is so depressed. You ask him if he has a plan and he details where he could buy a handgun and where he would go to shoot himself. You fear the patient will carry out this plan because he has not had adequate control of his symptoms since his last antidepressant change 1 month ago. You discuss inpatient hospitalization for medication stabilization, but the patient refuses. You're next step in management of this patient would best be:

A. Admit the patient to the hospital anyway

B. Give the latest antidepressant more time to take affect

C. Change to another class of antidepressant

D. Try to persuade the patient to admit himself to the hospital

E. Initiate psychotherapy to discuss the reasons behind the suicidal thoughts

17.31 The following situations call for a break in doctor-patient confidentiality *except*

A. Patient with bipolar I disorder admits he is homosexual

B. Patient with schizoaffective disorder hallucinates that he can fly

C. Patient with major depressive disorder who is sexually promiscuous contracts syphilis

D. Patient with a delusional disorder thinks his boss is out to get him and threatens to kill her

E. Patient with conduct disorder thrives on the sexual abuse of young children

17.32 A 40-year-old woman presents complaining of depressed mood, insomnia, difficulty concentrating, and decreased interests for the last 2 months. Her symptoms began after discovering her husband was having an extramarital affair. She tells you she feels betrayed and foolish for not realizing what was going on behind her back. She barely eats and has not returned the phone calls of her family and friends. She states "life is just not worth living." What would be the most appropriate next step in her management?

A. Suggest you meet with her husband

B. Prescribe an SSRI

C. Inquire about suicidal thoughts

D. Recommend electroconvulsive therapy

E. Recommend supportive psychotherapy

17.33 A 35-year-old male is being seen in your office for major depressive disorder. He reports feelings of worthlessness, depressed mood, and insomnia for the last 7 months. He also tells you he occasionally hears voices talking about him and telling him to kill himself. You decide to start Risperdal to treat these auditory hallucinations. Risperdal acts by blocking which receptor?

A. Histamine-1 receptors

B. Dopamine-D2 receptors

C. Alpha-1 adrenergic receptors

D. Muscarinic cholinergic receptors

E. None of the above

17.34 Which of the following is the best predictor of likelihood of attempting suicide in future?

A. Gender

B. Alcohol abuse

C. Unemployment

D. Prior suicide attempt

E. Recent divorce

17.35 A 27-year-old patient has been diagnosed with bipolar disorder. Before starting this patient on lithium for mood stabilization, which of the following laboratory tests should be obtained?

A. Thyroid function tests, creatinine, liver function tests

- B. Thyroid function tests, complete blood count, pregnancy test
- C. Thyroid function tests, liver function tests, pregnancy test
- D. Thyroid function tests, creatinine, pregnancy test
- E. Thyroid function tests, creatinine, complete blood count

17.36 A 33-year-old female presents to you for evaluation of depressed mood, decreased concentration, and anhedonia

P.155

for the last month. She has been hesitant to start pharmacotherapy for her symptoms, but finally agrees to try medication. You start her on fluoxetine. Two weeks later, she presents to your office in tears reporting no change in her mood. The most appropriate next step is:

- A. Increase dose of fluoxetine
- B. Change to another SSRI
- C. Discontinue fluoxetine and start amitriptyline
- D. Continue fluoxetine and add amitriptyline
- E. Continue fluoxetine at same dose

17.37 A young married woman new to your practice suffers from bipolar disorder and has been taking lithium with good effect. She calls you frantic one afternoon because she has just learned she is pregnant and is concerned about the effects of lithium on her child. Which of the following is her child at greatest risk for?

- A. Cardiac anomalies
- B. Craniofacial defects
- C. Neural tube defects
- D. Mental retardation
- E. Genital anomalies

17.38 A 64-year-old woman with an extensive smoking history has recently been diagnosed with small cell lung cancer. She develops a depressed mood, decreased interests, and difficulty concentrating soon thereafter, as she reports she cannot stop thinking about how worthless her life has been. She eats incessantly and has gained 10 pounds in the last 5 weeks; she also reports increased sleep. You decide to prescribe phenelzine for her symptoms of atypical depression. Which of the following is contraindicated in those patients taking phenelzine?

- A. Fluoxetine
- B. Valproic Acid
- C. Trazodone
- D. Lithium
- E. Clomipramine

17.39 Ms. S, a 24-year-old woman, is brought for a psychiatric consultation by her mother who complains of bizarre behavior. One month ago Ms. S was fired from her job at a local bookstore because of frequently arriving late and not performing her duties adequately. She states that she fell in love with another employee and tried to get his attention and spend time with him, even though he seemed uninterested. Over the past 3 months she increased her use of alcohol and marijuana to three beers a day and two to three joints per day. Her mother reports a 2-week history of increased energy, eating little, talking a great deal, and interrupting others frequently. A week ago Ms. S reported that her former work colleagues were plotting against her and attempting to control her by broadcasting thoughts into her brain. She did not sleep the last 2 nights. Ms. S has no significant psychiatric or medical history. She takes no medications.

Physical examination reveals a blood pressure of 135/75, heart rate of 84, and a temperature of 37C. Her conjunctivae are pink and her pupils are equal, 3 mm and reactive to light. Deep tendon reflexes are normal throughout. Urine toxicology reveals the presence of cannabinoids. On mental status testing, her mood is euphoric, her speech is pressured, and she is emotionally labile and irritable. Her thinking is illogical and disorganized. She denies hallucinations. She is alert and oriented to person, place, and time. Immediate recall and recent and remote memory are intact. Throughout the interview she is preoccupied by thoughts of the coworker with whom she has fallen in love.

Ms. S is admitted to a psychiatric unit and treatment is initiated with haloperidol, 10 mg/day, which is increased to 20 mg/day on day 5 because of continued agitation. On day 6 she becomes withdrawn and uncommunicative. She is diffusely rigid with a temperature of 39C. Her white blood count is 14,300 and her CPK 2,100. Several blood cultures are negative.

Which of the following is the most likely diagnosis at the time of admission?

- A. Schizophrenia
- B. Delusional disorder, erotomanic type
- C. Marijuana-induced psychotic disorder
- D. Bipolar disorder
- E. Schizoaffective disorder, bipolar type

17.40 Which of the following is the most likely explanation for her behavior on day 6?

- A. Worsening psychosis
- B. Anticholinergic delirium
- C. Neuroleptic malignant syndrome
- D. Marijuana-induced delirium
- E. Occult infection

17.41 Which of the following pharmacologic approaches is most appropriate on day

6?

- A. Increase dose of haloperidol
- B. Stop haloperidol and add risperidone
- C. Stop haloperidol, add bromocriptine, and seek medical consultation
- D. Continue the same dose of haloperidol and add risperidone
- E. Continue the same dose of haloperidol and add benztropine

Directions

Each set of lettered headings below is followed by a list of phrases or statements. For each numbered phrase or statement, select:

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 17.42–17.45

P.156

17.42 Cardiotoxic

17.43 Causes weight gain

17.44 Acts as an NE partial agonist

17.45 Teratogenic

- A. Clozapine
- B. Imipramine

Directions

Each group of questions consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 17.46–17.50

17.46 Depression is a result of aggressive impulses directed against an ambivalently loved internalized object

17.47 Negative cognitive schemata lead to depressive symptoms

17.48 Learned helplessness as a model for depression

17.49 Established manic-depressive illness as a nosological and disease entity

17.50 Coined the term psychobiology to emphasize that both psychological and

biological facts could cause depression

- A. Sigmund Freud
- B. Adolph Meyer
- C. Aaron Beck
- D. Emil Kraepelin
- E. Martin Seligman

Questions 17.51–17.54

17.51 The genetic predisposition to develop major depressive disorder is probably greater during the 30s, and the predisposition to develop bipolar disorder is greatest during the 20s

17.52 The uncertainty of employment among college graduates and the trend to delay marriage during the 1990s

17.53 The association between age and suicide in white males

17.54 People born between 1915 and 1925 exhibit lower suicide rates at all ages than either those born in 1900 or 1940

- A. Period effects
- B. Age effects
- C. Cohort effects
- D. All of the above
- E. None of the above

Questions 17.55–17.58

17.55 Never any history of acute mania

17.56 Typically has psychotic features present

17.57 Symptoms of hypomania are present

17.58 Can present with atypical features

- A. Unipolar depression
- B. Bipolar II depression
- C. Both
- D. Neither

Questions 17.59–17.61

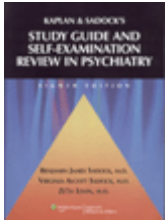
17.59 Depressive Disorder with atypical features

17.60 Refractory Mood Disorder

17.61 Seasonal Affective Disorder

- A. Light Therapy
- B. Electroconvulsive Therapy
- C. Tricyclic Antidepressant
- D. MAOI Antidepressant





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



18

Anxiety Disorders

Anxiety disorders are among the most prevalent psychiatric conditions in the United States. Further, studies have persistently shown that they produce inordinate morbidity, use of health care services, and functional impairment. Combined with the acknowledgment that many people suffering from anxiety never present for treatment, these facts emphasize the importance of clinical research and exploration of this field. Defining anxiety disorders can be problematic, as there exists a fine line between normal adaptive anxiety and pathologic functioning. The revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) attempts to do this by delineating a number of specific anxiety disorders with clear diagnostic criteria. These include panic disorder, agoraphobia, posttraumatic stress disorder (PTSD), and generalized anxiety disorder, among others.

Anxiety disorders, like most psychiatric disorders, are usually the result of a complex interplay of biological, psychological, and psychosocial elements. Treatment of these disorders can be correspondingly complex. Understanding the neuroanatomy and molecular biology of anxiety promises new insights into etiology and more effective treatments in the future. There is currently an array of treatment approaches from the psychoanalytic, to cognitive, to behavioral, to psychopharmacologic. Many times, a combination of these treatments is utilized to best address the multiplicity of etiologic forces.

Another fascinating aspect of anxiety disorders is the exquisite interplay of genetic and experiential factors. Students should also be aware of the role of specific neurotransmitters in the development of anxiety, and the mechanisms of anxiolytic medications.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know the following names, cases, terms, and acronyms related to anxiety disorders.

- acute stress disorder

- adrenergic
- aggression
- ambivalence
- anticipatory anxiety
- anxiety
- *Aplysia*
- aversive conditioning
- benzodiazepines
- cerebral cortex
- cleanliness
- clomipramine (Anafranil)
- conflict
- counterphobic attitude
- Jacob M. DaCosta
- Charles Darwin
- disorders associated with anxiety
- dopamine
- ego-dystonic
- fear
- Otto Fenichel
- flooding
- Sigmund Freud
- GABA
- generalized anxiety disorder
- hypnosis
- imipramine (Tofranil)
- implosion
- intrapsychic conflict
- isolation
- lactate infusion
- limbic system
- Little Albert
- Little Hans
- locus ceruleus and raphe nuclei
- magical thinking
- MHPG
- mitral valve prolapse
- MMPI, Rorschach
- norepinephrine
- numbing

obsessive-compulsive disorder (OCD)

- panic attack
- panic disorder
- panicogens
- peripheral manifestations
- PET
- phobias: agoraphobia social specific
- PTSD
- propranolol (Inderal)
- reaction formation
- repression
- secondary gain
- serotonin
- shell shock
- sleep EEG studies
- soldier's heart
- stress
- systematic desensitization
- thought stopping
- time-limited psychotherapy
- trauma
- undoing
- John B. Watson
- Joseph Wolpe

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

18.1 Physiological activity associated with PTSD include all *except*

- A. Decreased parasympathetic tone
- B. Elevated baseline heart rate
- C. Increased circulating thyroxine
- D. Excessive sweating
- E. Increased blood pressure

18.2 Mr. F sought treatment for symptoms that he developed in the wake of an automobile accident that had occurred approximately 6 weeks before his

psychiatric evaluation. While driving to work on a mid-January morning, Mr. F lost control of his car on an icy road. His car swerved out of control into oncoming traffic, collided with another car, and then hit a nearby pedestrian. After referral, Mr. F reported frequent intrusive thoughts about the accident, including nightmares of the event and recurrent intrusive visions of his car slamming into the pedestrian. He reported that he had altered his driving route to work to avoid the scene of the accident and that he found himself switching the TV channel whenever a commercial for snow tires appeared. Mr. F described frequent difficulty falling asleep, poor concentration, and an increased focus on his environment, particularly when he was driving. Which of the following is the most appropriate diagnosis for this patient?

- A. Generalized anxiety disorder
- B. Post-traumatic stress disorder
- C. Acute stress disorder
- D. Adjustment disorder
- E. Panic disorder

18.3 Which of the following statements regarding anxiety and gender differences is true?

- A. Women have greater rates of almost all anxiety disorders.
- B. Gender ratios are nearly equal with OCD.
- C. No significant difference exists in average age of anxiety onset.
- D. Women have a twofold greater lifetime rate of agoraphobia than men.
- E. All of the above

18.4 Anxiety disorders

- A. are greater among people at lower socioeconomic levels
- B. are highest among those with higher levels of education
- C. are lowest among homemakers
- D. have shown different prevalences with regard to social class but not ethnicity
- E. All of the above

18.5 The risk of developing anxiety disorders is enhanced by

- A. Eating disorders
- B. Depression
- C. Substance abuse
- D. Allergies
- E. All of the above

18.6 Which of the following is *not* typical of the course of panic disorder?

- A. Onset is typically in late adolescence or early adulthood
- B. Tends to exhibit a fluctuating course
- C. Typical patients exhibit a pattern of chronic disability
- D. Majority of patients live relatively normal lives
- E. All of the above

18.7 Which of the following examples or situations is most likely to cause PTSD?

- A. Involvement in an earthquake
- B. Being diagnosed with cancer
- C. Rape
- D. Witnessing a crime
- E. Observing a flood

18.8 Which of the following is the most common symptom pattern associated with OCD?

- A. Obsession of doubt
- B. Obsession of contamination
- C. Intrusive thoughts
- D. Obsession of symmetry
- E. Compulsive hoarding

18.9 Which of the following is *not* a component of the DSMIV- TR diagnostic criteria for OCD?

- A. Obsessions are acknowledged as excessive or unreasonable
- B. There are attempts to ignore or suppress compulsive thoughts or impulses
- C. Obsessions or compulsions are time consuming, and take more than 1 hour a day
- D. Children need not recognize their obsessions are unreasonable
- E. The person recognized the obsessional thoughts as a product of outside themselves

18.10 All of the following have been noted through brain imaging in patients with panic disorder *except*

- A. Magnetic resonance imaging (MRI) studies have shown pathological involvement of the temporal lobes
- B. Generalized cerebral vasoconstriction
- C. Right temporal cortical atrophy

D. Increased blood flow to the basal ganglia

P.167

E. Positron Tomographic Emission scans have implicated dysregulation of blood flow in panic disorder

18.11 Buspirone acts as a

A. serotonin partial agonist useful in treatment of generalized anxiety disorder

B. dopamine partial agonist useful in the treatment of generalized anxiety disorder

C. serotonin partial agonist useful in the treatment of OCD

D. dopamine partial agonist useful in the treatment of OCD

E. none of the above

18.12 Mr. A was a successful businessman who presented for treatment after a change in his business schedule. Although he had formerly worked largely from an office near his home, a promotion led to a schedule of frequent out-of-town meetings requiring weekly flights. Mr. A reported being "deathly afraid" of flying. Even the thought of getting on an airplane led to thoughts of impending doom in which he envisioned his airplane crashing to the ground. These thoughts were associated with intense fear, palpitations, sweating, clamminess, and stomach upset. Although the thought of flying was terrifying enough, Mr. A became nearly incapacitated when he went to the airport. Immediately before boarding, Mr. A would often have to turn back from the plane, running to the bathroom to vomit. Which of the following is the most appropriate treatment for this patient who has another flight scheduled tomorrow?

A. Lorazepam

B. Paroxetine

C. Beta agonists

D. Exposure therapy

E. None of the above

18.13 Tourette's disorder has been shown to possibly have a familial and genetic relationship with

A. panic disorder

B. social phobia

C. generalized anxiety disorder

D. OCD

E. none of the above

18.14 Unexpected panic attacks are required for the diagnosis of

A. panic disorder

- B. social phobia
- C. specific phobia
- D. generalized anxiety disorder
- E. all of the above

18.15 A patient with OCD might exhibit all of the following brain-imaging findings except

- A. abnormalities in frontal lobes, cingulum, and basal ganglia
- B. decreased caudate volumes bilaterally compared with normal controls
- C. lower metabolic rates in basal ganglia and white matter than in normal controls
- D. longer mean T1 relaxation times in the frontal cortex than normal controls
- E. significantly more gray matter and less white matter than normal controls

18.16 Isolated panic attacks without functional disturbances

- A. are uncommon
- B. occur in less than 2 percent of the population
- C. are part of the criteria for diagnostic panic disorder
- D. usually involve anticipatory anxiety or phobic avoidance
- E. none of the above

18.17 Sigmund Freud postulated that the defense mechanisms necessary in phobias are

- A. repression, displacement, and avoidance
- B. regression, condensation, and projection
- C. regression, repression, and isolation
- D. repression, projection, and displacement
- E. regression, condensation, and dissociation

18.18 Which of the following choices most accurately describes the role of serotonin in OCD?

- A. Serotonergic drugs are an ineffective treatment.
- B. Dysregulation of serotonin is involved in the symptom formation.
- C. Measures of platelet binding sites of titrated imipramine are abnormally low.
- D. Measures of serotonin metabolites in cerebrospinal fluid are abnormally high.
- E. None of the above

18.19 Therapy for phobias may include all of the following except

- A. propranolol (Inderal)
- B. systematic desensitization
- C. phenelzine (Nardil)
- D. flooding
- E. counterphobic attitudes

18.20 First-line medication treatments of anxiety disorders may generally include all of the following *except*

- A. fluoxetine (Prozac)
- B. fluvoxamine (Luvox)
- C. venlafaxine (Effexor)
- D. diazepam (Valium)
- E. nefazodone (Serzone)

18.21 Induction of panic attacks in patients with panic disorder can occur with

- A. yohimbine
- B. carbon dioxide
- C. doxapram

-
- D. cholecystokinin
 - E. all of the above

P.168

Directions

Each set of lettered headings below is followed by a list of numbered words or phrases. For each numbered word or phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 18.22–18.25

18.22 Higher rates for women than for men

18.23 Lifetime prevalence of 3 to 5.6 percent

18.24 Lifetime prevalence of 0.6 to 6 percent

18.25 Relatives have higher rates of this disorder than relatives of controls

- A. Panic disorder
- B. Agoraphobia

Questions 18.26–18.30

18.26 Response rates between 60 and 80 percent have been reported to buspirone

18.27 Patients with the disorder may still be responsive to buspirone after being exposed to benzodiazepine

18.28 Buspirone's use is limited to potentiating the effects of other antidepressants and counteracting the adverse sexual effects of selective serotonin reuptake inhibitors (SSRIs)

18.29 Relapse rates are generally high after discontinuation of medication

18.30 Tricyclic drugs have been reported to worsen anxiety symptoms in patients where first symptoms were precipitated by cocaine use

- A. Generalized anxiety disorder
- B. Panic disorder

Questions 18.31–18.34

18.31 Produces 80 to 90 percent panic-free status in panic disorder within at least 6 months of treatment

18.32 May be nearly twice as effective in the treatment of social phobia as a more educational-supportive approach

18.33 Goals are more ambitious and require more time to achieve

18.34 Combining treatment with medication may be superior to either treatment alone

- A. Cognitive-behavioral therapy
- B. Psychodynamic therapy

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 18.35–18.39

18.35 Fear of dirt and germs

18.36 Fear of heights

18.37 Fear of strangers

18.38 Fear of dogs

18.39 Fear of cats

- A. Acrophobia
- B. Cynophobia
- C. Mysophobia
- D. Xenophobia
- E. Ailurophobia

Questions 18.40–18.42

18.40 The cell bodies of the neurotransmitter's neurons are confined primarily to the locus ceruleus

18.41 Benzodiazepines enhance the neurotransmitter's effects at its receptors

18.42 The cell bodies of the neurotransmitter's neurons are localized primarily within the raphe nuclei

- A. Norepinephrine
- B. Serotonin
- C. β -Aminobutyric acid (GABA)

Questions 18.43–18.46

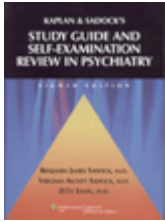
18.43 A patient is presented with photographs of snakes while practicing various relaxation techniques to overcome fear; gradually he practices relaxation while in the presence of live snakes.

18.44 A patient with OCD attempts to use public telephones and doorknobs while intentionally refraining from washing her hands afterwards.

18.45 A patient is asked to imagine his wartime experiences as vividly as possible, in order to confront his memory of the traumatic events.

18.46 A patient breathes through a thin straw in order to produce the sensation of not getting enough air; this activity produces a similar sensation to the distressing feeling of getting on an airplane.

- A. In vivo exposure
- B. Interoceptive exposure
- C. Systematic desensitization
- D. Imaginal exposure



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



19

Somatoform Disorders

The term *somatoform* is derived from the Greek word *soma*, which means body. Somatoform disorders are a broad group of illnesses that have bodily signs and symptoms as a major component. These disorders encompass mind-body interactions in which the brain, in ways still not well understood, sends various signals that impinge on the patient's awareness, indicating a serious problem in the body. Additionally, minor or as yet undetectable changes in neurochemistry, neurophysiology, and neuroimmunology may result from unknown mental or brain mechanisms that cause illness.

The fourth revised edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) classifies them as somatization disorder, conversion disorder, hypochondriasis, body dysmorphic disorder, and pain disorder, as well as undifferentiated somatoform disorder not otherwise specified.

Before a somatoform disorder is diagnosed, the clinician must initiate a thorough medical evaluation to rule out the presence of actual medical pathology. A certain percentage of these patients will turn out to have real underlying medical pathology, but it does not usually account for the symptoms described by the patient. The disorders may be chronic or episodic, they may be associated with other mental disorders, and the symptoms described are always worsened by psychological stress.

Treatment is often very difficult, as the symptoms tend to have deeply rooted and unconscious psychological meanings for most patients, and these are patients who do not or cannot express their feelings verbally. Unconscious conflicts are expressed somatically and seem to have a particular tenaciousness and resistance to psychological treatment.

Treatment involves both biological and psychological strategies, including cognitive-behavioral treatments, psychodynamic therapies, and psychopharmacologic approaches. If other psychiatric disorders, such as depression or anxiety disorders, are also present, they must be treated concomitantly. Different medications are effective with the range of disorders and the student should be knowledgeable about this.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should be able to define the terms listed below.

- amobarbital (Amytal) interview
- anorexia nervosa
- antidepressants
- antisocial personality disorder
- astasia-abasia
- autonomic arousal disorder
- biofeedback
- body dysmorphic disorder
- Briquet's syndrome
- conversion disorder
- cytokines
- depression
- differential diagnosis
- dysmorphophobia
- endorphins
- generalized anxiety disorder
- hemianesthesia
- hypochondriasis
- hysteria
- identification
- instinctual impulse
- *la belle indifférence*
- major depressive disorder
- malingering
- pain disorder
- pimozide (Orap)
- primary gain and secondary gain
- pseudocyesis
- pseudoseizures
- secondary symptoms
- somatization disorder
- somatoform disorder not otherwise specified
- somatosensory input
- stocking-and-glove anesthesia
- symbolization and projection
- undifferentiated somatoform disorder
- undoing

Questions/Answers

Directions

Each of the statements or questions below is followed by five suggested responses or completions. Select the one that is best in each case.

19.1 Which of the following is *not* a recommended treatment strategy for a patient with somatization disorder?

- A. Increasing the patient's awareness that psychological factors may be involved
- B. Several different clinicians involved in caring for the patient

P.177

- C. Avoiding additional laboratory and diagnostic procedures
- D. Seeing patients during regularly scheduled visits at regular intervals
- E. Listening to somatic complaints as emotional expressions rather than medical complaints

19.2 Which of the following is a theory for the etiology of hypochondriasis?

- A. Symptoms are viewed as a request for admission to the sick role made by a person facing challenges in his or her life.
- B. Persons with hypochondriasis have low thresholds for, and low tolerance of, physical discomfort.
- C. Aggressive and hostile wishes toward others are transferred (through repression and displacement) into physical complaints.
- D. Hypochondriasis is a variant form of other mental disorders, such as depressive or anxiety disorders.
- E. All of the above

19.3 Body dysmorphic disorder is associated with

- A. major depressive disorder
- B. obsessive-compulsive disorder
- C. social phobia
- D. family history of substance abuse
- E. all of the above

19.4 Pseudocyesis

- A. involves abdominal enlargement, breast engorgement, and labor pains at the expected date of delivery
- B. is listed as a specific somatoform disorder in the 10th edition of International Classification of Diseases (ICD-10)
- C. can be explained by medical conditions involving endocrine changes

- D. all of the above
- E. none of the above

19.5 Conversion reactions

- A. are always transient
- B. are invariably sensorimotor as opposed to autonomic
- C. conform to usual dermatomal distribution of underlying peripheral nerves
- D. seem to change the psychic energy of acute conflict into a personally meaningful metaphor of bodily dysfunction
- E. all of the above

19.6 Characteristic signs of conversion disorder include all of the following *except*

- A. astasia-abasia
- B. stocking-and-glove anesthesia
- C. hemianesthesia of the body beginning precisely at the midline
- D. normal reflexes
- E. cogwheel rigidity

19.7 All of the following mental disorders are frequently seen in patients with somatization disorder (relative to the general population) *except*

- A. schizophrenia
- B. generalized anxiety disorder
- C. obsessive-compulsive personality disorder
- D. bipolar I disorder
- E. major depressive disorder

19.8 Medical disorders to be considered in a differential diagnosis of somatization disorder include

- A. multiple sclerosis
- B. systemic lupus erythematosus
- C. acute intermittent porphyria
- D. hyperparathyroidism
- E. all of the above

19.9 The most frequently occurring of the somatoform disorders is

- A. conversion disorder
- B. somatization disorder

- C. hypochondriasis
- D. pain disorder
- E. body dysmorphic disorder

19.10 A patient with somatization disorder

- A. presents the initial physical complaints after age 30
- B. has had physical symptoms for 3 months
- C. has complained of symptoms not explained by a known medical condition
- D. usually experiences minimal impairment in social or occupational functioning
- E. may have a false belief of being pregnant with objective signs of pregnancy, such as decreased menstrual flow or amenorrhea

19.11 Many patients with pseudoseizures have

- A. interictal EEG abnormalities
- B. neuropsychological impairment
- C. abnormalities on MRI and CT scan
- D. true convulsions or other true neurological conditions
- E. all of the above

19.12 The most accurate statement regarding pain disorder is

- A. Peak ages of onset are in the second and third decades.
- B. First-degree relatives of patients have an increased likelihood of having the same disorder.
- C. It is least common in persons with blue-collar occupations.
- D. It is diagnosed equally among men and women.
- E. Depressive disorders are no more common in patients with pain disorder than in the general public.

19.13 In body dysmorphic disorder

- A. plastic surgery is usually beneficial.
- B. a comorbid diagnosis is unusual.

-
- C. anorexia nervosa may also be diagnosed.
 - D. some 50 percent of patients may attempt suicide.
 - E. serotonin-specific drugs are effective in reducing the symptoms.

19.14 True statements about hypochondriasis include all of the following *except*

- A. Depression accounts for a major part of the total picture in hypochondriasis.
- B. Hypochondriasis symptoms can be part of dysthymic disorders, generalized anxiety disorder, or adjustment disorder.
- C. Hypochondriasis is a chronic and somewhat disabling disorder.
- D. Recent estimates are that 4 to 6 percent of the general medical population meets the specific criteria for the disorder.
- E. Significant numbers of patients with hypochondriasis report traumatic sexual contacts, physical violence, and major parental upheaval before the age of 17.

19.15 Historically, conversion disorders have been associated with

- A. Pierre Briquet
- B. Jean-Martin Charcot
- C. Sigmund Freud
- D. Pierre Janet
- E. all of the above

19.16 Mrs. J, 30-year-old woman, is referred for psychiatric evaluation by her internist after her fourth request for mammography in 6 months. Two years ago a close friend died of breast cancer. Since that time, she has been preoccupied with the possibility that she also has the disease. She examines herself several times a day and when she finds something that seems unusual she goes to her doctor for medical evaluation. Initially, the doctor's reassurance was enough to convince her that her fears were exaggerated. However, over the past year she has required a mammogram to prove to herself that she does not have cancer. Each time when the mammography is reported to be normal, she is momentarily relieved but within several days starts to doubt the accuracy of the test and suspects that she does have undetected cancer. There are periods in which she is so convinced that she becomes despondent and is unable to do normal work around the house. She has started to neglect her 3-year-old son because of painful thoughts that he will be left motherless. She now spends several hours a day searching the internet for information on breast cancer or in breast cancer support chat rooms. She is married to a successful architect, and by mutual agreement she quit her job as a financial analyst 3 years ago in order to spend full time at home with her son. She is friends with several of the mothers in her son's play group and occasionally sees colleagues from her former office. Despite her concerns, her health is good. Her most recent physical examination was unremarkable except for small bruises over both breasts that were the result of repeated self-examination. She drinks an occasional glass of wine with meals. She smoked marijuana in college but has not used any illicit drugs for 6 years. After psychiatric examination, she appears mildly anxious. She describes herself as being at her wits' end, saying that the fear of cancer is ruining her life. She acknowledges that the fear is greatly exaggerated, but she feels powerless to control it. She denies ever having had hallucinations. She is alert, oriented, her memory is good, and concentration is mildly impaired. Which of the following is the most likely diagnosis?

- A. Obsessive-compulsive disorder

- B. Major depressive disorder with psychotic features
- C. Delusional disorder
- D. Hypochondriasis
- E. Body dysmorphic disorder

19.17 In the case above, which of the following is the most likely outcome without treatment?

- A. Complete recovery
- B. Chronic waxing and waning of symptoms
- C. Development of cognitive impairment
- D. Development of physical impairment
- E. Development of psychotic symptoms

19.18 A 34-year-old woman presented with chronic and intermittent dizziness, paresthesias, pain in multiple areas of her body, and intermittent nausea and diarrhea. She reported that these symptoms had been present most of the time, although they had been undulating since she was approximately 24. In addition, she complained of mild depression, was disinterested in many things in life, including sexual activity, and had been to many doctors to try to find out what was wrong with her. Physical examination, including a neurological exam, was normal. There were no abnormalities on laboratory testing. Her doctor diagnoses somatization disorder. Which of the following about this disorder is true?

- A. The symptoms typically begin in middle age.
- B. These patients usually give a very thorough and complete report of their symptoms.
- C. It occurs more commonly in men.
- D. It is more common in urban populations.
- E. These patients are no more likely to develop another medical illness than people without the disorder.

19.19 Hypochondriacs

- A. are often thatophobic
- B. seek treatment more than explanations
- C. are usually women
- D. do not respond to reassurance
- E. in postmortem examinations have a greater degree of upper GI inflammation and congestion than normal controls

19.20 Conversion disorder

- A. usually has a chronic onset
- B. is commonly comorbid with a schizoid personality disorder
- C. is associated with antisocial personality disorder
- D. is associated with symptoms that conform to known anatomical pathways
- E. responds well to a confrontation of the “false nature” of the symptoms

Directions

Each set of lettered headings below is followed by a list of numbered phrases. For each numbered phrase, select:

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 19.21–19.24

19.21 Categories of somatoform disorders include somatization, hypochondriasis, and pain disorder

19.22 Notes that when physical disorders are present, they cannot account for patients’ symptoms or distress

19.23 Body dysmorphic disorder is considered a subcategory of hypochondriacal disorder

19.24 Includes the diagnosis neurasthenia, which has symptoms that overlap with anxiety and depression

- A. DSM-IV-TR
- B. ICD-10

Questions 19.25–19.26

19.25 Estimated lifetime prevalence of between 4 and 11 percent

19.26 Course is generally chronic and relapsing

- A. Undifferentiated somatoform disorder
- B. Somatization disorder

Questions 19.27–19.31

19.27 Affects women more than men

19.28 Most often begins during a person’s teens

19.29 Responds to antidepressants

19.30 May involve serotonin in its pathophysiology

19.31 Is commonly associated with anorexia nervosa

- A. Somatization disorder
- B. Pain disorder

Questions 19.32–19.37

19.32 Prevalence is highest in rural areas and among the poorly educated.

19.33 Is associated with Pierre Briquet.

19.34 Comorbidity with an Axis II disorder is common.

19.35 Only one or two complaints.

19.36 Is chronic and relapsing, by definition.

19.37 Most symptoms remit spontaneously.

- A. Somatization disorder
- B. Conversion disorder

Questions 19.38–19.42

19.38 A diagnostic category for patients with somatic symptoms not covered in other somatoform disorders

19.39 Patients have physical complaints not accounted for by another mental disorder

19.40 Examples are autonomic arousal disorder (involving the autonomic nervous system) and neurasthenia (involving sensations of fatigue)

19.41 Defined by unexplained physical effects lasting for at least 6 months that are below the threshold for diagnosing somatization disorder

19.42 A patient's somatic complaints may not have met the 6-month criterion of other somatoform disorders

- A. Undifferentiated somatoform disorder
- B. Somatoform disorder not otherwise specified

Questions 19.43–19.47

19.43 Beliefs and symptoms may reach delusional intensity

19.44 Has high rates of coexisting depressive and anxiety disorders

19.45 Patients actively seek out attention for their symptoms

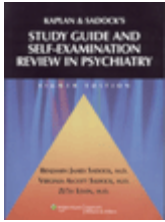
19.46 Causes persistent distress or interference with personal functioning

19.47 May be related to the defense mechanisms of repression and displacement

- A. Hypochondriasis

B. Body dysmorphic disorder





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



20

Chronic Fatigue Syndrome and Neurasthenia

Chronic fatigue syndrome (referred to as myalgic encephalomyelitis in the United Kingdom and Canada) is characterized by 6 months or more of severe, debilitating fatigue, often accompanied by myalgia, headaches, pharyngitis, low-grade fever, cognitive complaints, gastrointestinal symptoms, and tender lymph nodes. The search for an infectious cause of chronic fatigue syndrome has been active because of the high percentage of patients who report abrupt onset after a severe flulike illness.

In 1988, the U.S. Centers for Disease Control and Prevention (CDC) defined specific diagnostic criteria for chronic fatigue syndrome. Since then, the disorder has captured the attention of both the medical profession and the general public. The problems associated with studying chronic fatigue syndrome are of great interest in the United States today. The disorder is classified in the 10th revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) as an ill-defined condition of unknown etiology under the heading "Malaise and Fatigue" and is subdivided into asthenia and unspecified disability.

The student should study the questions and answers below for a useful review of this syndrome.

Helpful Hints

Student should know the terms listed here

- anhedonia
- asthenia
- autonomic nervous system
- George Miller Beard
- CDC guidelines
- chronic fatigue syndrome
- chronic stress
- depletion hypothesis
- endocrine disorders
- environmental components

- epidemiology
- Epstein-Barr virus
- etiology
- flu-like illness
- growing pains
- ICD-10 classification
- immune abnormalities
- incidence and prevalence
- insight-oriented psychotherapy
- laboratory examination
- major depression
- malaise
- methylphenidate (Ritalin)
- nervous diathesis
- nervous exhaustion
- neurasthenia
- neuroendocrine dysregulations
- pathognomonic features
- pharmacotherapy
- premature diagnostic closure
- spontaneous recovery
- supportive treatment
- treatment options
- undifferentiated somatoform disorder
- unspecified disability

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five lettered responses or completions. Select the *one* that is most appropriate in each case.

20.1 Chronic fatigue syndrome

- A. is associated with antibodies to the Epstein-Barr virus
- B. is observed primarily in the elderly
- C. has no comorbidity with major depressive disorder
- D. shows responsiveness to NSAIDS (non steroidal anti-inflammatory drugs)
- E. is twice as likely to occur in women as in men

20.2 Which of the following about neurasthenia is *true*?

- A. The term was coined by Sigmund Freud.
- B. It is most commonly diagnosed in the central United States.
- C. It is thought to be the result of unconscious psychological conflict.
- D. It has a biphasic course, occurring most often in adolescence and middle age.
- E. Bodily complaints dominate the clinical picture.

20.3 A highly accomplished energetic 40-year-old woman was referred for psychiatric consultation after her physicians were unable to offer a definitive physiological diagnosis despite extensive medical workup after the acute onset of profound fatigue occurring in the wake of a mild viral illness. This fatigue caused her to be totally incapacitated and bedridden for many months and left her feeling quite helpless and distraught. The fatigue slowly improved over many years.

Which of the following about chronic fatigue syndrome is *true*?

- It is associated with neurally mediated hypotension.
- It has minimal association with depressive syndromes.
- The symptoms often respond to evening primrose oil.
- It is associated with infection with Babesia microti.
- It is more severe in patients who have a dysregulated immune system.

20.4 Chronic fatigue syndrome

- is proved to be a viral or postviral syndrome
- has not been linked with fibromyalgia
- has been viewed as a vehicle for negotiation of change in interpersonal worlds
- patients in magnetic resonance imaging studies (MRI) displayed a specific pattern of white matter abnormality
- prevalence reports show that fewer than 10 percent of cases have antecedent psychiatric disorders

20.5 True statements about chronic fatigue syndrome include

- Studies indicate that many chronic fatigue syndrome patients have somatization disorder.
- The syndrome is most likely to be a heterogeneous condition with fatigue as a final common pathway.
- Treatment is invariably physiologic.
- Cognitive-behavioral therapy (CBT) has been shown to have little or no impact on the disability and symptoms of patients.
- None of the above

20.6 The symptoms of neurasthenia include

paresthesia

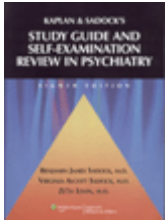
tachycardia

headaches

physical aches and pains

all of the above





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



21

Factitious Disorders

According to the American Heritage Dictionary, the word *factitious* means “artificial; false,” derived from the Latin word *factitious* which means “made by art.” Those with factitious disorder simulate, induce, or aggravate illness, often inflicting painful, deforming, or even life-threatening injury on themselves or those under their care. Unlike malingers who have material goals, such as monetary gain or avoidance of duties, factitious disorder patients undertake these tribulations primarily to gain the emotional care and attention that comes with playing the role of the patient. In doing so, they practice artifice and art, creating hospital drama that often causes frustration and dismay. Clinicians may thus dismiss, avoid, or refuse to treat factitious disorder patients. Strong countertransference of clinicians can be major obstacles toward the proper care of these patients who arguably are among the most psychiatrically disturbed.

The best known factitious disorder is perhaps factitious disorder with predominantly physical signs and symptoms, popularly known as Munchausen syndrome. This presentation involves persons who travel from hospital to hospital, gaining admission, receiving multiple diagnoses and treatments, until they are found out by staff, and then quickly move on to the next hospital to repeat the same rituals again. Common complaints or presenting symptoms include hematomas, abdominal pain, fever, and seizures. Patients have been known to do such bizarre things as inject themselves with feces to induce infections or to willingly undergo repeated unnecessary surgeries.

Despite potentially high stakes, relatively little empirical knowledge is available about the etiology, epidemiology, course and prognosis, and effective treatment of factitious disorders. Most knowledge comes from case reports, information that is frequently suspect, given the false, unreliable nature of the information these patients give. The DSM-IV-TR categories for the disorder include predominantly physical signs and symptoms, predominantly psychological signs and symptoms, both physical and psychological signs and symptoms, and factitious disorder not otherwise specified.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should be able to define each of these terms.

- approximate answers
- as-if personality
- borderline personality disorder
- Briquet's syndrome
- depressive-masochistic personality
- dissociative disorder not otherwise specified
- factitious disorder:
 - by proxy
 - not otherwise specified
 - with predominantly physical signs and symptoms
 - with predominantly psychological signs and symptoms
- Ganser's syndrome
- gridiron abdomen
- identification with the aggressor
- impostorship
- malingering
- Munchausen syndrome
- pseudologia fantastica
- pseudomalingering
- regression
- schizophrenia
- sick role
- somatoform disorders
- substance abuse
- symbolization
- unmasking ceremony

Questions/Answers

Directions

Each of the questions incomplete statements below is followed by five suggested responses completions. Select the *one* that is *best* in each case.

21.1 Factitious disorder

- A. occurs more frequently in women than in men
- B. is associated with a history of childhood abuse
- C. is not associated with economic gain
- D. may result in death due to needless medical interventions
- E. all of the above

21.2 Ganser's syndrome

- A. is a factitious disorder
- B. is more common in women than in men

P.191

- C. is associated with a severe personality disorder
- D. has a chronic remitting and relapsing course
- E. is motivated by involuntary phenomena

21.3 Which of the following occurs in factitious disorder by proxy?

- A. The mother has had some medical education
- B. The patient fails to respond to appropriate treatments
- C. Maternal lying is observed
- D. Unexplained illnesses have occurred in the mother
- E. All of the above

21.4 Which of the following symptoms would a patient with Munchausen syndrome most likely present with?

- A. Depression
- B. Amnesia
- C. Pain disorder
- D. Hemoptysis
- E. Psychosis

21.5 Factitious disorders are best treated by which of the following?

- A. Immediate discharge from the hospital
- B. Focusing on management rather than cure
- C. Confrontation about the patient's deceit
- D. Performing only minimally invasive procedures to satisfy the patient
- E. Using low-dose neuroleptics to decrease the patient's physical distress

21.6 Which of the following is the gold standard for diagnosis of factitious disorder by proxy?

- A. Discovery of illness-inducing agents in the caregiver's possession
- B. Finding inconsistencies in the medical records
- C. Confession by the child
- D. Improvement when the child is removed from the caretaker

E. Direct observation of the caretaker doing harm

21.7 You are interviewing a patient to determine if a factitious disorder is present. You ask him to give you the sum of 2 plus 2. He replies, "5." Which of the following diagnoses is most likely?

- A. Briquet's syndrome
- B. Malingering
- C. Ganser's syndrome
- D. Munchausen syndrome
- E. None of the above

21.8 You begin treatment of a new patient with a previously known history of factitious disorder. Within the first few sessions, you also become aware that this patient meets criteria for a diagnosis of antisocial personality disorder as well. Which of the following statements regarding this patient is true?

- A. Persons with both of these disorders do not usually volunteer for invasive procedures.
- B. Persons with both of these disorders have repeated hospitalizations.
- C. It is rare for persons with factitious disorder to also present with antisocial traits.
- D. Factitious disorder symptoms almost always precede antisocial traits.
- E. All of the above.

21.9 You are asked by the court to evaluate a 21-year-old man arrested in a robbery because his lawyer raised the issue of his competence to stand trial. He has no known psychiatric history, and no psychotic symptoms have been previously reported. During the interview the man appears calm and in control, sits slouched in the chair, and has good eye contact. His affect shows a good range. His thought processes are logical, sequential, and spontaneous even when he describes many difficulties with his thinking. He seems guarded in his answers, particularly to questions about his psychological symptoms.

He claims to have precognition on occasion, knowing, for instance, what is going to be served for lunch in the jail, and that he does not like narcotics because Jean Dixon doesn't like narcotics either, and she is in control of his thoughts. He states that he has seen a vision of General Lee in his cell as well as "little green men from Mars," and that his current incarceration is a mission in which he is attempting to be an undercover agent for the police, although none of the local police realize this. Despite the overtly psychotic nature of these thoughts as described, the patient does not seem to be really engaged in the ideas; he seems to be simply reciting a list of what appears to be crazy rather than recounting actual experiences and beliefs. When the interviewer expresses some skepticism about his described beliefs, he responds by saying that he has "many other crazy ideas" that he can share.

Which of the following is the most likely diagnosis?

- A. malingering
- B. schizophrenia, paranoid type
- C. factitious disorder with predominantly psychological symptoms
- D. delusional disorder
- E. Capgras's syndrome

21.10 Factitious disorder patients with Munchausen syndrome are typically

- A. middle-aged men
- B. unmarried
- C. unemployed
- D. estranged from their families
- E. all of the above

21.11 Patients with factitious disorders, either physical or psychological, most often demonstrate

- A. a below-average IQ
- B. a formal thought disorder
- C. poor sexual adjustment

P.192

- D. generally adequate frustration tolerance
- E. all of the above

21.12 True statements about patients with factitious disorder with predominantly psychological signs and symptoms include

- A. Virtually all patients with this type of factitious disorder have a personality disorder.
- B. The rate of suicide is generally reported to be low in this population.
- C. Prognosis is slightly better than for most other Axis I disorders.
- D. Factitious psychosis, in particular, almost never represents the prodrome to an authentic psychosis.
- E. None of the above

21.13 Clinical indicators of poor treatment responsiveness in patients with factitious disorders include

- A. the coexistence of other Axis I disorders, such as mood, anxiety, or substance-related disorders
- B. borderline or antisocial elements

- C. religious affiliations
- D. capacity to accept confrontation in therapy
- E. all of the above

21.14 The differential diagnosis of a factitious disorder includes

- A. somatization disorder
- B. hypochondriasis
- C. antisocial personality disorder
- D. malingering
- E. all of the above

21.15 Factitious disorders

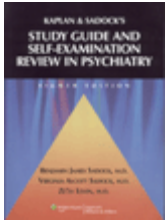
- A. usually begin in childhood
- B. are best treated with psychoactive drugs
- C. usually have a good prognosis
- D. are synonymous with Ganser's syndrome
- E. may occur by proxy

21.16 True statements about factitious disorder by proxy include all of the following *except*

- A. The average length of time to establish a diagnosis after the initial presentation is about 2 months.
- B. Often a sibling has died of undiagnosed causes before the disorder is recognized.
- C. The disorder currently accounts for fewer than 1,000 of the almost 3 million cases of child abuse reported each year in the United States.
- D. Prevalence of the disorder has been estimated to be approximately 5 percent in children presenting with allergies.
- E. The prevalence of the disorder in life-threatening episodes treated with cardiopulmonary resuscitation has been estimated to be as high as 9 percent.

21.17 The perpetrators in factitious disorder by proxy

- A. often suffer from psychotic or dissociative disorders
 - B. rarely have personal histories of factitious or somatoform disorders
 - C. most often suffered direct abuse in childhood themselves
 - D. are commonly unresponsive to their infants when their behavior is unwitnessed
 - E. all of the above
-



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



22

Dissociative Disorders

Most persons see themselves as human beings with one basic personality; they experience a unitary sense of self. Persons with dissociative disorders, however, have lost the sense of having one consciousness. They feel as though they have no identity, they are confused about who they are, or they experience multiple identities. Everything that usually gives persons their unique personalities—their integrated thoughts, feelings, and actions—is abnormal in persons with dissociative disorders. The revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) classifies dissociative disorders as dissociative amnesia, dissociative fugue, dissociative identity disorder (or more popularly, multiple personality disorder), depersonalization disorder, and dissociative disorder not otherwise specified.

Normal people can experience feelings of dissociation or depersonalization under a variety of circumstances, such as fatigue, isolation, or hypnosis. These feelings tend to be temporary, and, while perhaps briefly uncomfortable, are not experienced as overly distressful. Dissociative disorders are much more severe and disabling. Pathological dissociative states are associated with histories of childhood physical, emotional, and sexual abuse, or may be seen in people who have undergone traumatic wartime or disaster experiences. A careful and thorough medical evaluation is necessary to rule out any possible organic cause for the dissociative symptoms.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The terms below relate to dissociative disorders and should be defined.

- anterograde amnesia
- approximate answers
- automatic writing
- brainwashing
- coercive persuasion
- continuous amnesia

crystal gazing

- denial
- depersonalization
- derealization disorder
- dissociation
- dissociative amnesia
- Dissociative Experience Scale
- dissociative fugue
- dissociative identity disorder
- dissociative trance
- dominant personality
- double orientation
- doubling
- epidemiology of dissociative disorders
- false memory syndrome
- Ganser's syndrome
- hemidepersonalization
- highway hypnosis
- hypnotizability
- Korsakoff's syndrome
- localized amnesia
- malingering
- multiple personality disorder
- paramnesia
- possession state
- reduplicative paramnesia
- repression
- retrograde amnesia
- secondary gain
- selective amnesia
- sleepwalking disorder
- temporal lobe functions
- transient global amnesia
- unitary sense of self
- wandering

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested

responses or completions. Select the one that is best in each case.

22.1 Reduplicative paramnesia is a condition of which of the following disorders:

- A. Dissociative identity disorder
- B. Dissociative fugue
- C. Depersonalization disorder
- D. Dissociative amnesia
- E. Déjà vu

22.2 Which of the following statements regarding transient global amnesia is false?

- A. It is an acute retrograde amnesia
- B. It affects recent memories more than remote memories
- C. It usually lasts 6 to 24 hours
- D. It complete recovery does not occur
- E. It is most often caused by transient ischemic attacks

22.3 The mental status examination of a patient with dissociative identity disorder would most likely reveal which of the following?

- A. Normal exam
- B. Orientation difficulties

P.197

- C. Impaired recent memory
- D. Flat affect
- E. Decreased concentration

22.4 The first stage in coercive processes such as brainwashing is

- A. the emergence of a new pseudoidentity
- B. inflicting pain
- C. the idealization of captors
- D. the development of dissociative state
- E. traumatic infantilism

22.5 You begin therapy with a young woman who has a very limited memory of her childhood years but knows that she was removed from her parents due to abuse and neglect.

She frequently cannot account for hours and even days of her life. Occasionally, she does not remember how or when she arrived at a particular location. She also finds clothes in her closet that she does not like and cannot remember buying. Her

friends are puzzled because sometimes she acts in a childish, dependent way; other times she is uncharacteristically aggressive and hostile.

Which of the following is the most likely diagnosis?

- A. Dissociative amnesia
- B. Schizophrenia
- C. Depersonalization disorder
- D. Dissociative identity disorder
- E. Somatization disorder

22.6 Dissociative fugue

- A. has new identities that are more complete than in dissociative identity disorder
- B. identities can alternate as in dissociative identity disorder
- C. occurs more often during wartime and natural disasters
- D. is caused by heavy alcohol use
- E. all of the above

22.7 Patients with dissociative amnesia

- A. do not retain the capacity to learn new information
- B. commonly retain awareness of personal identity, but have amnesia for general information
- C. present very similarly to patients with dementia
- D. typically behave in a confused and disorganized way
- E. none of the above

22.8 Dissociative amnesia is thought to be

- A. the least common of the dissociative disorders
- B. more common in women than men
- C. more common in older adults than younger
- D. decreased in times of war and natural disaster
- E. none of the above

22.9 Organic amnesias are distinguished from dissociative amnesias by which of the following?

- A. They do not normally involve recurrent identity alteration.
- B. The amnesia is not selectively limited to personal information.
- C. The memories do not focus on an emotionally traumatic event.

- D. The amnesia is more often anterograde than retrograde.
- E. All of the above

22.10 DSM-IV-TR includes dissociative symptoms in the criteria for all but which of the following mental disorders?

- A. acute stress disorder
- B. somatization disorder
- C. posttraumatic stress disorder
- D. obsessive-compulsive disorder
- E. none of the above

22.11 Depersonalization disorder is characterized by

- A. impaired reality testing
- B. ego-dystonic symptoms
- C. occurrence in the late decades of life
- D. gradual onset
- E. a brief course and a good prognosis

22.12 All of the following are true statements about dissociative fugue except

- A. It is a rare type of dissociative disorder.
- B. It is not characterized by behavior that appears extraordinary to others.
- C. It is characterized by a lack of awareness of the loss of memory.
- D. It is usually a long-lasting state.
- E. Recovery is spontaneous and rapid.

22.13 The most common cause of organic fugue is probably

- A. head trauma
- B. hypoglycemia
- C. epilepsy
- D. brain tumors
- E. migraines

22.14 Culture-bound syndromes in which dissociative fugue is a prominent feature include

- A. *latah*
- B. *amok*

- C. *grisi siknis*
- D. *piblokto*
- E. all of the above

22.15 The mainstay of treatment of dissociative fugue is

- A. psychodynamic psychotherapy
- B. hypnosis
- C. sodium amobarbital interviewing
- D. antidepressant medication
- E. none of the above

22.16 A patient normally without cognitive deficits, who seems out of touch with the environment and in a dream-like state for a brief period of time, and who has amnesia regarding the experience when it is ended is likely to have

P.198

- A. dementia
- B. dissociative fugue
- C. localized amnesia
- D. generalized amnesia
- E. sleepwalking disorder

22.17 Patients predisposed to dissociative fugue include those with all of the following *except*

- A. mood disorders
- B. schizophrenia
- C. histrionic personality disorders
- D. heavy alcohol abuse
- E. borderline personality disorders

22.18 Which of these statements regarding the prognosis of dissociative identity disorder is incorrect?

- A. Recovery is generally complete.
- B. The earlier the onset of dissociative identity disorder, the poorer the prognosis is.
- C. The level of impairment is determined by the number and types of various personalities.
- D. Individual personalities may have their own separate mental disorders.
- E. One or more of the personalities may function relatively well.

Directions

These lettered headings are followed by a list of numbered phrases. For each numbered phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 22.19–22.22

22.19 More likely to involve interruption of the episodic autobiographical memory

22.20 More likely to involve interruption of general cognitive functioning

22.21 More likely to involve interruption of language capacity

22.22 More likely to be localized

- A. Dissociative amnesia
- B. Amnesia secondary to organic etiology

Directions

The lettered headings below are followed by a list of numbered statements. For each numbered statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 22.23–22.26

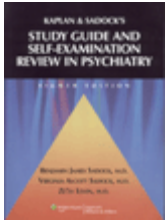
22.23 A 25-year-old man comes to the emergency room and cannot remember his name

22.24 A 35-year-old man states that his body feels unreal, not attached to him

22.25 A 16-year-old girl is found in another city far from her home and does not recall how she got there

22.26 A 30-year-old woman suddenly has a newchild-like voice in the interview

- A. Dissociative amnesia
- B. Dissociative fugue
- C. Dissociative identity disorder
- D. Depersonalization disorder



Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



23

Human Sexuality

Sexuality is determined by anatomy, physiology, psychology, the culture in which one lives, one's relationship with others, and developmental experiences throughout the life cycle. It includes the perception of being male or female and all those thoughts, feelings, and behaviors connected with sexual gratification and reproduction, including the attraction of one person to another.

Abnormal sexuality is defined as that which is destructive, compulsive, associated with overwhelming guilt and anxiety, unable to be directed toward a partner, and is generally pervasive, recurrent, and habitual. The revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSMIV-TR) broadly classifies sexual disorders as sexual dysfunctions, paraphilias, and sexual disorder not otherwise specified. There is also a classification for gender identity disorders, and this will be discussed in [Chapter 24](#).

Sexual Dysfunctions Describe Disturbed sexual desire and psychophysiologic changes in the sexual response cycle. Paraphilias are characterized by recurrent sexual urges or fantasies involving unusual objects, activities, or situations. Sexual disorder not otherwise specified describes sexual dysfunction not classifiable in any other category.

There are several terms related to human sexuality that are often misunderstood and misused. Sexual identity is a person's biological sexual characteristics, including genes, external and internal sexual organs, hormonal makeup, and secondary sex characteristics. Gender identity is a person's sense of being female or male. Sexual orientation describes the object of a person's sexual impulses: heterosexual, homosexual, or bisexual. Sexual behavior is the physiological experience triggered by psychological and physical stimuli.

Clinicians should be familiar with the sexual disorders as well as with the variety of treatments available to address these disorders. Students should study the following questions and answers related to the topic for a helpful review.

Helpful Hints

The student should know the following terms and their definitions.

- anorgasmia
- autoerotic asphyxiation

- biogenic versus psychogenic
- bisexuality
- castration
- chronic pelvic pain
- clitoral versus vaginal orgasm
- coming out
- coprophilia
- cystometric examination
- desensitization therapy
- Don Juanism
- dual-sex therapy
- dyspareunia
- erection and ejaculation
- excitement
- exhibitionism
- female orgasmic disorder
- female sexual arousal disorder
- fetishism
- frotteurism
- FSH
- gender role
- heterosexuality
- HIV, AIDS
- homophobia
- homosexuality
- hymenectomy
- hypoactive sexual desire disorder
- hypoxyphilia
- incest
- infertility
- intersexual disorders
- intimacy
- Alfred Kinsey
- libido
- male erectile disorder
- male orgasmic disorder
- William Masters and Virginia Johnson
- masturbation
- moral masochism
- necrophilia

- nocturnal penile tumescence
- orgasm
- orgasm disorders
- orgasmic anhedonia
- paraphilias
- penile arteriography
- Peyronie's disease
- phases of sexual response
- postcoital dysphoria
- postcoital headache
- premature ejaculation
- prenatal androgens
- prosthetic devices
- psychosexual stages
- rape (male and female)
- refractory period
- resolution
- retarded ejaculation
- retrograde ejaculation
- satyriasis
- scatologia
- sensate focus
- sex addiction
- sexual arousal disorders
- sexual aversion disorder
- sexual desire disorders
- sexual dysfunction not otherwise specified
- sexual identity and gender identity
- sexual masochism and sexual sadism
- sexual orientation distress
- sexual pain disorders

-
- spectating
 - spouse abuse
 - squeeze technique
 - statutory rape
 - steal phenomenon
 - sterilization
 - stop–start technique
 - sympathetic and parasympathetic nervous systems
 - telephone scatologia

- transvestic fetishism
- tumescence and detumescence
- unconsummated marriage
- urophilia
- vagina dentata
- vaginismus
- vaginoplasty
- voyeurism
- zoophilia

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

23.1 Sexuality depends on which of the following psychosexual factors?

- A. Sexual Identity
- B. Gender Identity
- C. Sexual orientation
- D. Sexual behavior
- E. All of the above

23.2 With regard to innervation of sex organs, all of the following are true *except*

- A. Penile tumescence occurs through the synergistic activity of parasympathetic and sympathetic pathways.
- B. Clitoral engorgement results from parasympathetic stimulation.
- C. Vaginal lubrication results from sympathetic stimulation.
- D. Sympathetic innervation is responsible for ejaculation.
- E. Sympathetic innervation facilitates the smooth muscle contraction of the vagina, urethra, and uterus during orgasm.

23.3 *Primal scene* is a term used by Freud which described

- A. a person's first coitus
- B. genital self-stimulation in children under 24 months old
- C. sexual learning adversely affected by abusive adults
- D. a child seeing sex between their parents
- E. None of the above

23.4 Among the following, the sexual dysfunction not correlated with phases of the sexual response cycle is

- A. sexual aversion disorder
- B. vaginismus
- C. premature ejaculation
- D. post-coital dysphoria
- E. male erectile disorder

23.5 Paraphilias

- A. are usually not distressing to the person with the disorder
- B. are found equally among men and women
- C. according to the classic psychoanalytic model, are due to a failure to complete the process of genital adjustment
- D. with an early age of onset are associated with a good prognosis
- E. such as pedophilia usually involve vaginal or anal penetration of the victim

23.6 When compared to children of heterosexual parents, children of gay and lesbian parents

- A. have significantly different outcomes in gender identity
- B. have significantly different outcomes in gender role
- C. have significantly different outcomes in sexual orientation
- D. may have to struggle with their difference from heterosexual families
- E. all of the above

23.7 Mr. C a 35-year-old man, is referred from prison for a psychiatric evaluation because of exposing his genitals and masturbating in front of female corrections officers. He has been arrested for public masturbation and as a repeat offender is being held in jail prior to his first court hearing. He acknowledges the behavior and explains that he thought it would be sexually exciting to the officers and that they might want to have sex with him.

As an adolescent, Mr. C had numerous sexual encounters with other adolescents, with prepubertal children, and with adults of both sexes. He began going to pornographic movie theaters in his late teens, where he would always masturbate and, on occasion, have an anonymous sexual encounter with a stranger. During his 20s, he began masturbating in public with the belief that it would lead to sex with strangers. However, on those rare occasions when his exposure did lead to a proposition for sexual favors, he became frightened and ran away. He discovered that squeezing the urethra at the head of his penis would help delay orgasm, and he used the technique to prolong masturbation. When he learned (erroneously) that this would cause retrograde ejaculation into the bladder, he began to eat his own semen and drink his urine, variously describing the reasons for so doing as

“saving sperm” or “as a perfect source of protein.” He acknowledged that the practice does not literally save sperm and that most people would think it bizarre.

Mr. C had two psychiatric hospitalizations 8 and 12 years ago, each for hallucinations and paranoid delusions in the context of crack cocaine use. He insists that he has

P.204

never had hallucinations when he was not using cocaine. He has used no illicit drugs for the past 5 years, but he drinks one or two beers each night and once or twice a month he will drink to the point of being unsteady on his feet and slurring his words. He has five prior arrests for public indecency but until now has never served time in jail. Mr. C has never married and denies ever having had a long-term romantic relationship. He graduated from high school and works the late-night shift at a local convenience store.

Which of the following is the most likely Axis I diagnosis?

- A. Social phobia
- B. Exhibitionism
- C. Schizophrenia
- D. Obsessive-compulsive disorder
- E. Sexual aversion disorder

23.8 In the case described above, which of the following is the most likely Axis II diagnosis?

- A. Antisocial personality disorder
- B. Borderline personality disorder
- C. Obsessive-compulsive personality disorder
- D. Histrionic personality disorder
- E. Schizotypal personality disorder

23.9 In the case described above, without treatment, which of the following is the most likely long-term course for Mr. C’s Axis I condition?

- A. Gradual decrease in symptomatic behavior
- B. Progressive functional deterioration
- C. Development of a recurrent psychotic disorder
- D. Progression to pedophilia
- E. Progressive cognitive deterioration

23.10 Which of the following statements about fetishism is *false*?

- A. A fetish is an inanimate object that is used as the preferred or necessary adjunct to sexual arousal.
- B. A fetish may be integrated into sexual activity with a human partner.

- C. A fetish is a device that may function as a hedge against separation anxiety.
- D. A fetish is a device that may function to ward off castration anxiety.
- E. Fetishism is a disorder found equally in males and females.

23.11 Research has indicated that

- A. a majority of married people are unfaithful to their spouses
- B. the median number of sexual partners over a lifetime for men is six and for women two
- C. vaginal intercourse is considered the most appealing type of sexual experience by a large majority of men and women
- D. masturbation is more common among those 18 to 24 than among those 24 to 34 years old
- E. the percentage of single women reporting "usually or always" having an orgasm during intercourse is greater than the percentage of married women reporting this

23.12 Measures used to help differentiate organically caused impotence from functional impotence include

- A. monitoring of nocturnal penile tumescence
- B. glucose tolerance tests
- C. follicle-stimulating hormone (FSH) determinations
- D. testosterone level tests
- E. all of the above

23.13 Psychiatric interventions used to assist the paraphilia patient include

- A. dynamic psychotherapy
- B. external control
- C. cognitive-behavioral therapy
- D. treatment of comorbid conditions
- E. all of the above

23.14 Which of the following substances has not been associated with sexual dysfunction?

- A. cocaine
- B. trazodone
- C. amoxapine
- D. antihistamines
- E. all of the above

23.15 In the most severe forms of paraphilia

- A. persons never experience any sexual behavior with partners
- B. the specific paraphilia imagery or activity is absolutely necessary for any sexual function
- C. the need for sexual behavior consumes so much money, time, concentration, and energy that the person describes self as out of control
- D. orgasm does not produce satiety in the same way it typically does for age mates
- E. all of the above

23.16 Which of the following conditions is classified as a psychological or behavioral disorder associated with sexual development or orientation?

- A. fetishism
- B. voyeurism
- C. frotteurism
- D. necrophilia
- E. transsexualism

23.17 Premature ejaculation

- A. is less common among college-educated men than among men with less education
-
- P.205
- B. is mediated via the sympathetic nervous system
 - C. is strongly influenced by the sex partner in an ongoing relationship
 - D. is defined within a specific time frame
 - E. all of the above

23.18 True statements about what research has shown about gay men and lesbians include

- A. A majority of lesbians and gay men report being in a committed romantic relationship.
- B. Lesbian couples tend more frequently to be sexually exclusive than male couples.
- C. Gay men and lesbians, in comparison with heterosexual couples, generally have more equality in their relationships.
- D. Gay men and lesbians report the same degree of global satisfaction in their relationships as heterosexual men and women.
- E. All of the above

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 23.19–23.23

23.19 Avoidance of genital sexual contact with a sexual partner

23.20 Patient has few or no sexual thoughts or fantasies

23.21 Recurrent and persistent inhibition of female orgasm

23.22 Recurrent pain during intercourse

23.23 Involuntary and persistent constrictions of the outer onethird of the vagina

- A. Vaginismus
- B. Sexual aversion disorder
- C. Anorgasmia
- D. Hypoactive sexual desire disorder
- E. Dyspareunia

Questions 23.24–23.26

23.24 Rubbing up against a fully clothed woman to achieve orgasm

23.25 Sexual urges by heterosexual men to dress in female clothes for purposes of arousal

23.26 Preoccupation with fantasies and acts that involve observing people who are naked or engaging in sexual activity.

- A. Fetishism
- B. Voyeurism
- C. Frotteurism
- D. Exhibitionism
- E. Sexual masochism
- F. Sexual sadism
- G. Transvestic fetishism

Questions 23.27–23.29

23.27 Intercourse is interdicted initially

23.28 Raises the threshold of penile excitability

23.29 Attempts to decrease “spectatoring”

- A. Sensate focus exercises
- B. Squeeze technique

Questions 23.30–23.34

23.30 Vaginal lubrication

23.31 Orgasmic platform

23.32 Testes increase in size by 50 percent

23.33 Slight clouding of consciousness

23.34 Detumescence

- A. Desire phase
- B. Excitement phase
- C. Orgasm phase
- D. Resolution phase

Questions 23.35–23.39

23.35 Sense of maleness or femaleness

23.36 The object of a person's sexual impulses

23.37 Chromosomes

23.38 Gonads and secondary sex characteristics

23.39 Desire and fantasies

- A. Sexual identity
- B. Gender identity
- C. Sexual orientation
- D. Sexual behavior

Questions 23.40–23.46

23.40 Interruption in production of testosterone

23.41 Genotype is XXY

23.42 Assigned as males or females, depending on morphology of genitals

23.43 Excess androgens in fetus with XX genotype

23.44 Absence of second female sex chromosome (XO)

23.45 Inability of tissues to respond to androgens

23.46 Both testes and ovaries

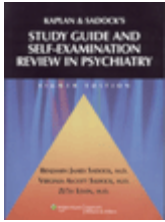
- A. Virilizing adrenal hyperplasia (adreno-genital syndrome)
- B. Turner's syndrome
- C. Klinefelter's syndrome
- D. Androgen insensitivity syndrome (testicularfeminizing syndrome)

E. Enzymatic defects in XY genotype (e.g., 5- α -reductase deficiency, 17-hydroxysteroid deficiency)

F. Hermaphroditism

G. Pseudohermaphroditism





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



24

Gender Identity Disorders

Gender identity refers to the sense one has of being male or being female which corresponds, normally, to the person's anatomical sex. The revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) define gender identity disorders (GID) as a group whose common feature is a strong, persistent preference for living as a person of the other sex. The affective component of gender identity disorders is gender dysphoria, discontent with one's designated birth sex and a desire to have the body of the other sex, and to be regarded socially as a person of the other sex. Gender identity disorder in adults was referred to in early versions of the DSM as transsexualism.

In DSM-IV-TR, no distinction is made for the overriding diagnostic term gender identity disorder as a function of age. In children, it may be manifested as statements of wanting to be the other sex and as a broad range of sex-typed behaviors conventionally shown by children of the other sex. Gender identity crystallizes in most persons by age 2 or 4 years.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know the gender identity syndromes and terms listed below.

- adrenogenital syndrome
- agenesis
- ambiguous genitals
- androgen insensitivity syndrome
- asexual
- assigned sex
- Barr chromatin body
- bisexuality
- buccal smear
- cross-dressing

cross-gender

- cryptorchid testis
- dysgenesis
- effeminate boys and masculine girls
- gender confusion
- gender identity
- disorder not otherwise specified
- gender role
- genotype
- hermaphroditism
- heterosexual orientation
- homosexual orientation
- hormonal treatment
- intersex conditions
- Klinefelter's syndrome
- male habitus
- phenotype
- prenatal androgens
- pseudohermaphroditism
- rough-and-tumble play
- sex of rearing
- sex-reassignment surgery
- sex steroids
- sexual object choice
- testicular feminization syndrome
- transsexualism
- transvestic fetishism
- Turner's syndrome
- virilized genitals
- X-linked

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is *best* in each case.

24.1 In gender identity disorders

- A. there is no distinction made for age
- B. there is discontent with one's designated birth sex
- C. there is a desire to have the body of the other sex

- D. there is a wish to be regarded socially as a person of the other sex
- E. all of the above

24.2 Which of the following is true?

- A. girls with congenital virilizing adrenal hyperplasia are less interested in dolls
- B. polycystic ovaries has not been considered as associated with transexualism
- C. mothers, more than fathers, give negative responses to boys playing with dolls
- D. boys with GID are more likely to be right-handed than control boys
- E. boys with GID generally tend to have more sisters than brothers

24.3 Sex reassignment

- A. is often the best solution in treating gender dysphoria
- B. usually involves a full-time social transition to living in the desired gender before hormonal treatment
- C. includes daily doses of oral estrogen in persons born male
- D. may involve sex reassignment surgery
- E. all of the above

P.216

24.4 Gender constancy

- A. is a task of separation-individuation
- B. has no age-related stage-like sequence because it is inherent
- C. includes a sense of "gender stability"
- D. cannot be tested in the clinical situation
- E. none of the above

24.5 In patients born with ambiguous genitalia, which of the following is the predominant factor by which assigned sex is determined?

- A. Wishes of the parents
- B. Genetic phenotype and potential for reproduction
- C. Extent of virilization
- D. Surgical team capabilities
- E. Wishes of the patient at time of puberty

24.6 A boy with gender identity disorder

- A. usually begins to display signs of the disorder after age 9

- B. experiences sexual excitement when he cross-dresses
- C. has boys as his preferred playmates
- D. is treated with testosterone
- E. may say that his penis or testes are disgusting

24.7 Girls with gender identity disorder in childhood

- A. regularly have male companions
- B. may refuse to urinate in a sitting position
- C. may assert that they have or will grow a penis
- D. may give up masculine behavior by adolescence
- E. all of the above

24.8 Which of the following statements does not apply to the treatment of gender identity disorder?

- A. Adult patients generally enter psychotherapy to learn how to deal with their disorder, not to alter it.
- B. Before sex-reassignment surgery, patients must go through a trial of cross-gender living for at least 3 months.
- C. A one-to-one play relationship is used with boys in which adults role-model masculine behavior.
- D. Hormonal therapy is not required as a preceding event in sex-reassignment surgery.
- E. During hormonal treatments, both males and females need to be watched for hepatic dysfunction and thromboembolic phenomena.

24.9 In biological men undertaking estrogen hormone treatment, all of the following side effects are common *except*

- A. Testicular atrophy
- B. Change in pitch of voice
- C. Diminished erectile capacity
- D. Breast enlargement
- E. Decrease in density of body hair

24.10 True statements about the epidemiology of gender identity disorders include

- A. As many as five boys are referred for each girl referred.
- B. Among a sample of 4- to 5-year-old boys referred for a range of clinical problems, the reported desire to be the opposite sex was 15 percent.
- C. Most parents of children with gender identity disorder report that cross-gender

behaviors were apparent before age 3.

D. The prevalence rate of transsexualism is estimated to be about 1 case per 10,000 males.

E. All of the above

24.11 In biological women undertaking testosterone hormone treatment, all of the following side effects are common *except*

A. Temporary deepening of vocal pitch

B. Enlargement of clitoris

C. Increased libido

D. Male hair pattern

E. Increased muscle mass

24.12 In a patient with Turner's Syndrome, all of the following are common findings *except*

A. Atypical female sex identification

B. Gonadal dysgenesis

C. Female genitalia

D. Small uterus

E. Dyspareunia

Directions

The lettered heading below are followed by a list of numbered statements. For each numbered statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 24.13–24.17

24.13 A 17-year-old girl presented to a clinic with primary amenorrhea and no development of secondary sex characteristics. She was short in stature and had a webbed neck.

24.14 A baby was born with ambiguous external genitalia. Further evaluation revealed that both ovaries and testes were present.

24.15 A baby was born with ambiguous external genitalia. Further evaluation revealed that ovaries, a vagina, and a uterus, were normal and intact.

24.16 A buccal smear from a phenotypically female patient revealed that the patient was XY. A further workup revealed undescended testes.

24.17 A tall, thin man presented for infertility problems was found to be XXY.

A. Klinefelter's syndrome

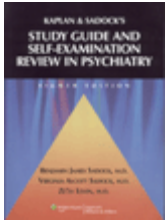
B. Turner's syndrome

C. Congenital virilizing adrenal hyperplasia

D. True hermaphroditism

E. Androgen insensitivity syndrome





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



25

Eating Disorders

Despite their often innocuous, culturally syntonous origins, eating disorders have undoubtedly been present in various forms for thousands of years, but their prevalence has increased substantially since the 1950s. They now present as common and serious clinical syndromes. Eating disorders have some of the highest rates of premature mortality in psychiatry—up to 19 percent within 20 years of onset among those initially requiring hospitalization. For this reason, eating disorders, defined as severe disturbances in eating behavior in the revised 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), remain an important focus for the psychiatrist, with the goal of engraving on the public consciousness the presence and seriousness of the disorders.

Anorexia nervosa is defined as occurring at onset in a person, usually an adolescent girl, who refuses to maintain a minimally normal body weight, fears gaining weight, and has a disturbed perception of body shape and size. Bulimia nervosa is characterized by a person engaging in binge eating and using inappropriate and dangerous compensatory methods, such as induced vomiting or use of laxatives, to prevent weight gain. Besides those who clearly fit diagnostic criteria for these disorders, there are many others who may exhibit various aspects and degrees of them. Bulimia nervosa is more common than anorexia nervosa.

Eating disorder patients tend to be high achievers and perfectionistic and come from families with similar characteristics. Psychological struggles center around issues of autonomy and control, as well as on conflicts surrounding sexual maturation. There is often a family history of depression. Biological treatments for both disorders may involve the use of antidepressants, with serotonin and norepinephrine neurotransmitters being particularly implicated.

Anorexia nervosa and bulimia nervosa are strikingly similar in some regards but differ dramatically in others. The student needs to be aware of these differences as well as of the various treatments available. Family therapy has traditionally been considered a mainstay of treatment, especially with younger anorexic patients. Treatment in some severe cases of both disorders is ineffective, and death can result.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

These terms relate to impulse-control disorders and should be defined by the student.

- alopecia
- anticonvulsants
- attention-deficit/hyperactivity disorder
- behavior therapy
- benzodiazepines
- biofeedback
- desperate stage
- enuresis
- epileptoid personality
- 5-HIAA
- hydroxyzine hydrochloride
- hypnotherapy
- impulse-control disorder
- impulse-control disorder not otherwise specified
- intermittent explosive disorder
- kleptomania
- limbic system
- lithium
- lust angst
- multidetermined
- oniomania
- parental factors
- pathological gambling
- pleasure principle, reality principle
- progressive-loss stage
- psychodynamics
- pyromania
- social gambling
- SSRIs
- testosterone
- trichophagy
- trichotillomania
- winning phase

Questions/Answers

Directions

Each of the incomplete statements below is followed by five suggested completions. Select the *one* that is *best* in each case.

25.1 Which of the following is the most common comorbid disorder associated with anorexia nervosa?

- A. Depression
- B. Social phobia
- C. Obsessive-compulsive disorder
- D. Bulimia
- E. Body dysmorphic disorder

25.2 Which of the following is not an endocrine or structural change noted as a result of starvation?

P.221

- A. Hypercortisolemia
- B. Thyroid suppression
- C. Enlarged ventricles
- D. Increased total brain volume
- E. Gonadotropin-releasing hormone suppression

25.3 Which of the following percentages below expected weight does an anorexic patient generally fall before being recommended for inpatient hospitalization?

- A. 20 percent
- B. 40 percent
- C. 60 percent
- D. 80 percent
- E. None of the above

25.4 Pickwickian syndrome is

- A. when persons eat excessively after they have had their evening meal
- B. binge eating without the inappropriate compensatory behaviors
- C. when a person is 100 percent over desirable weight with cardiorespiratory pathology
- D. when obese persons feel their bodies are grotesque and loathsome
- E. sudden, compulsive ingestion of very large amounts of food in a short time

25.5 Which of the following statements regarding anorexia and bulimia is false?

- A. Bulimia patients find the disorder more ego-dystonic than do anorexic patients.

- B. Both anorexia and bulimia have increased incidences of familial depression.
- C. Anorexic patients are generally more angry and impulsive than bulimic patients.
- D. Bulimia nervosa is more prevalent than anorexia nervosa.
- E. Bulimia nervosa often has a later age of onset than anorexia nervosa.

25.6 Which of the following professionals is most likely to develop anorexia nervosa?

- A. Executive chef working exclusively in food preparation
- B. Female stock broker with stressful job demands
- C. Male advertising executive with a history of depression
- D. Ballet dancer vying for the lead role in her next production
- E. Actress from upper economic class background

25.7 Treatments that have shown some success in ameliorating anorexia nervosa include

- A. cyproheptadine
- B. electroconvulsive therapy (ECT)
- C. chlorpromazine
- D. fluoxetine
- E. all of the above

25.8 Ms. L was a gaunt 15-year-old high-school student evaluated at the insistence of her parents, who were concerned about her weight loss. She was 5 feet 3 inches tall and had reached her greatest weight, 100 pounds, a year earlier. Shortly thereafter she decided to lose weight to be more attractive. She felt "chubby" and thought she would be more appealing if she were thinner. First she eliminated all carbohydrate-rich foods, and gradually intensified her dieting until she was eating only a few vegetables a day. She also started a vigorous exercise program. Within 6 months, she was down to 80 pounds. She then became preoccupied with food and started collecting recipes from magazines in order to prepare gourmet meals for her family. She had difficulty sleeping and was irritable and depressed, having several crying spells every day. Her menses started the previous year, but she had only a few normal periods.

Ms. L had always had high grades in school and had spent a great deal of time studying. She had never been active socially and had never dated. She was conscientious and perfectionistic in everything she undertook. She had never been away from home longer than a week. Her father was a business manager. Her mother was a housewife who for the past 2 years had a problem with hypoglycemia and was on a low-carbohydrate diet.

During the interview, Ms. L said she felt fat, even though she weighed 80 pounds, and she described a fear of losing control and eating so much food that she would become obese. She did not feel she was ill and thought that hospitalization was

unnecessary.

The diagnosis of anorexia nervosa can be made on the basis of Ms. L's

- A. 20-pound weight loss
- B. feeling fat at a weight of 80 pounds and a height of 5 feet 3 inches
- C. having had only a few normal periods
- D. fear of becoming obese
- E. all of the above

25.9 Features associated with anorexia nervosa include

- A. normal hair structure and distribution
- B. the fact that 7 to 9 percent of those affected are male
- C. onset between the ages of 10 and 30
- D. mortality rates of 20 to 25 percent
- E. all of the above

25.10 The binge-eating/purging type of anorexia nervosa when compared to the restricting type is more often associated with

- A. suicide attempts
- B. drug abuse
- C. premorbid obesity
- D. familial obesity
- E. all of the above

25.11 Studies suggest that

- A. The overall incidence of anorexia nervosa has decreased in the last 50 years.

P.222

- B. The overall incidence of bulimia nervosa has increased in the last 50 years.
- C. The incidence rate of anorexia nervosa in industrialized countries is approximately 20 per 100,000 population per year.
- D. The lifetime prevalence rate of anorexia nervosa in the United States has been estimated to be 5 percent.
- E. Bulimia nervosa has a prevalence rate of about 10 percent in adolescents and young adult women.

25.12 Medical complications of eating disorders related to weight loss include all of the following *except*

- A. erosion of dental enamel with corresponding decay

- B. bradycardia
- C. constipation and delayed gastric emptying
- D. abnormal taste sensation
- E. osteoporosis

25.13 Ipecac intoxication is associated with

- A. pericardial pain and cardiac failure
- B. dyspnea
- C. generalized muscle weakness
- D. hypotension
- E. all of the above

25.14 Characteristic laboratory test results in anorexia nervosa include

- A. ST-segment and T-wave changes on electrocardiogram
- B. decreased serum cholesterol levels
- C. increased fasting serum glucose concentrations
- D. decreased serum salivary amylase concentrations
- E. all of the above

25.15 Biological complications of eating disorders may include

- A. salivary gland and pancreatic inflammation
- B. gastric or esophageal tearing or rupture
- C. cardiac arrhythmias, loss of cardiac muscle, and cardiomyopathy
- D. leukopenia
- E. all of the above

25.16 Which of the following features can be associated with bulimia nervosa?

- A. undeveloped breasts
- B. abnormal insulin secretion
- C. widespread endocrine disorder
- D. a previous episode of anorexia nervosa
- E. body weight at least 15 percent below normal

25.17 Anorexia nervosa has a mortality rate of up to approximately

- A. 1 percent
- B. 18 percent

- C. 30 percent
- D. 42 percent
- E. 50 percent

Directions

The questions below consist of lettered headings followed by a list of numbered phrases. For each numbered phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 25.18–25.25

25.18 Severe weight loss and amenorrhea

25.19 Visual agnosia, compulsive licking and biting, hypersexuality

25.20 After 5 to 10 years, at least 50 percent will be markedly improved

25.21 Higher fatality rate

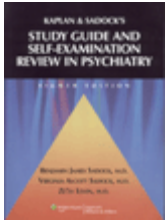
25.22 Family therapy is not widely used

25.23 Cognitive-behavioral therapy is the benchmark, first-line treatment

25.24 Decreased appetite only occurs in the most severe stages

25.25 Body weight of less than 85 percent of the patient's expected weight

- A. Anorexia nervosa
- B. Bulimia nervosa



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



26

Normal Sleep and Sleep Disorders

Sleep is absolutely essential for normal, healthy function. The importance to the psychiatrist lies in the fact that sleep disorders are very common, with insomnia being the most frequently reported. The revised 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) organizes the disorders first as primary ones (dyssomnias and parasomnias), then as those related to another mental disorder (such as anxiety, depression, or mania), as due to a general medical condition (the physiological effects of the condition of the sleep-wake cycle), and as substance-induced, due to either intoxication or withdrawal, and from either recreational drugs or medications.

To understand sleep disorders, one must first have a solid understanding of the processes involved in normal sleep. Normal sleep has two essential phases: nonrapid eye movement sleep (NREM) and rapid eye movement sleep (REM). NREM sleep is composed of stages 1 through 4, and is characterized as the phase of sleep associated with a strong reduction in physiological functioning. REM sleep, on the other hand, is characterized by a highly active brain with physiological levels similar to the awake state.

REM sleep is associated with dreaming and is characterized by low-voltage random fast activity with sawtooth waves. The four stages of NREM sleep are qualitatively different, with such differences being displayed in electroencephalogram (EEG) voltages and wave forms. NREM sleep normally changes over to the first REM episode about 90 minutes after a person falls asleep. In disorders such as depression and narcolepsy, this latency is markedly shortened, and REM sleep begins much sooner. Many antidepressants act to suppress REM sleep, thus effectively increasing this latency period back toward normal.

The necessary amount of sleep can vary greatly from person to person. Many factors interfere with sleep, from emotional or physical stress, to multiple substances and medications. Sleep deprivation can lead to ego disorganization, hallucinations, and delusions, and has been shown to lead to death in animals. Students should be aware of how biological rhythms can affect sleep, and how the 24-hour clock affects the natural body clock of 25 hours. Dyssomnias are disturbances in the amount, quality, or timing of sleep, and parasomnias are abnormal or physiological events that occur in connection with various sleep stages or during the sleep-wake transition. To effectively treat sleep disorders, the clinician must have a firm understanding of normal sleep and the factors that interfere with it.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know and be able to define each of these terms.

- acetylcholine
- advanced sleep phase syndrome
- alveolar hypoventilation syndrome
- circadian rhythm sleep disorder
- delayed sleep phase syndrome
- dysesthesia
- dyssomnias
- EEG
- familial sleep paralysis
- hypersomnia
- idiopathic CNS hypersomnolence
- insomnia:
 - nonorganic
 - organic
 - persistent
 - primary
 - secondary
 - transient
- jactatio capitis nocturna
- K complexes
- Kleine-Levin syndrome
- melatonin
- microsleeps
- narcolepsy
- nightmare disorder
- nightmares
- normal sleep
- paradoxical sleep
- parasomnias
- paroxysmal nocturnal hemoglobinuria
- *pavor nocturnus, incubus*
- poikilothermic
- REM, NREM
- REM latency
- sleep apnea
- sleep deprivation, REM-deprived

- sleep drunkenness
- sleep paralysis, sleep attacks
- sleep patterns
- sleep-related abnormal swallowing syndrome
- sleep-related asthma
- sleep-related bruxism
- sleep-related cardiovascular symptoms
- sleep-related cluster headaches and chronic paroxysmal hemicrania
- sleep-related epileptic seizures
- sleep-related gastroesophageal reflux
- sleep-related (nocturnal) myoclonus syndrome
- sleep spindles
- sleep terror disorder
- sleepwalking disorder
- slow-wave sleep (SWS)
- somniloquy
- somnolence
- L-Tryptophan
- variable sleepers

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

26.1 Sleep is best described as the integrated product of the following two factors

- A. transition from day to night (dusk) and night to day (dawn)
- B. Melatonin peak and temperature nadir
- C. age and health
- D. sleep homeostat and the circadian clock
- E. seasonality and photoperiods

26.2 Which of the following is the treatment of choice for patients with obstructive sleep apnea?

- A. Benzodiazepines
- B. Nasal continuous positive airway pressure
- C. Weight loss
- D. Uvulopalatoplasty

E. Theophylline

26.3 Which of the following is a component of good sleep hygiene?

- A. Take daytime naps as needed
- B. Establish physical fitness with exercise in the evening
- C. Eat larger meals near bedtime
- D. Arise at the same time daily
- E. All of the above

26.4 Sleep latency is defined as

- A. Period of time from the onset of sleep until the first REM period of the night
- B. Period of time from turning out the lights until the appearance of stage 2 sleep
- C. Time of being continuously awake from the last stage of sleep until the end of the sleep record
- D. Period of time from the onset of sleep until the first sleep spindle
- E. None of the above

26.5 You begin treating a blind woman who presents with difficulty sleeping. This patient is most likely to be experiencing which of the following circadian disturbances?

- A. Delayed sleep phase syndrome
- B. Advanced sleep phase syndrome
- C. Non-24-hour sleep-wake cycle
- D. Irregular sleep-wake rhythm
- E. No disturbances

26.6 All of the following statements regarding nightmares are true *except*

- A. Massive autonomic signs often accompany nightmares in children
- B. REM-suppressing drugs can bring about nightmares
- C. Creative people have been shown to have nightmares more frequently
- D. Children who have nightmares do not awaken confused
- E. Nightmares occur in as much as 50 percent of children aged 3 to 6

26.7 An experiment is performed in which sleeping patients are awakened at the beginning of REM cycles. They are then allowed to sleep with repeated interruption. Which of the following will be the result of this experiment?

- A. Decrease in the length of REM periods

- B. Increase in the number of REM periods
- C. More frequent nighttime awakenings
- D. Increase in REM latency
- E. No change in sleep patterns

26.8 True statements about circadian processes include all of the following *except*

- A. It is easier to shift sleep-wake rhythms to earlier rather than later.
- B. Circadian rhythms are endogenously regulated.
- C. Slow-wave activity is driven mainly through homeostatic processes, whereas REM sleep is driven by the circadian system.
- D. A circadian clock may be located in the retina.
- E. Exposure to bright light in the evening and darkness in the morning may help with jet lag when traveling westward.

26.9 Antidepressant effects have been linked to

- A. total sleep deprivation
- B. selective REM sleep deprivation
- C. sleep deprivation in the last half of the night
- D. all of the above
- E. none of the above

26.10 The characteristic 4-stage pattern of EEG changes from a wakeful state to sleep are

- A. regular activity, delta waves at three to seven cycles a second, sleep spindles and K complexes
- B. regular activity at three to seven cycles a second, delta waves, sleep spindles, and K complexes
- C. regular activity, sleep spindles and K complexes, delta waves at three to seven cycles a second
- D. regular activity, delta waves, sleep spindles and K complexes at three to seven cycles a second
- E. regular activity at three to seven cycles a second, sleep spindles and K complexes, delta waves

26.11 An 11-year-old girl asked her mother to take her to a psychiatrist because she feared she was going crazy. Several times during the past 2 months she had awakened confused about where she was until she realized that she was on the living room couch or in her little sister's bed, even though she went to bed in her own room. When she woke

up in her older brother's bedroom, she became concerned and felt guilty about it. Her younger sister said that she had seen the patient walking during the night, looking like "a zombie," that she did not answer when called, and that she had walked at night several times but usually went back to her bed. The patient feared she had amnesia because she had no memory of anything happening during the night.

Which of the following statements about the patient's disorder is false?

- A. Usually the disorder begins between the ages of 4 and 8 and peaks at age 12.
- B. Patients often have vivid hallucinatory recollections of an emotionally traumatic event with no memory upon awakening.
- C. There is no impairment in consciousness several minutes after awakening.
- D. The disorder is more commonly seen in girls than in boys.
- E. There is a tendency for the disorder to run in families.

26.12 In REM sleep

- A. there is infrequent genital tumescence
- B. cardiac output is decreased
- C. cerebral glucose metabolism is decreased
- D. respiratory rate is decreased
- E. brain temperature is decreased

26.13 Anatomical sites implicated in the generation of NREM sleep include

- A. basal forebrain area
- B. thalamus and hypothalamus
- C. dorsal raphe nucleus
- D. medulla
- E. all of the above

26.14 [Figure 26.1](#) illustrates the stages of a patient's sleep pattern.

Which of the following statements regarding this sleep pattern is true?

- A. The sleep pattern is abnormal because of the shortened latency of REM sleep.
- B. The sleep pattern represents human sleep between the ages of newborn and young adult.
- C. The sleep pattern is consistent with that found in a patient with depression.
- D. The sleep pattern is consistent with that found in a patient with narcolepsy.
- E. The sleep pattern is normal.

26.15 During REM sleep

- A. the pulse rate is typically five to ten beats below the level of restful waking
- B. a poikilothermic condition is present
- C. frequent involuntary body movements are seen
- D. dreams are typically lucid and purposeful
- E. sleepwalking may occur

26.16 The symptoms of narcolepsy include all of the following *except*

- A. catalepsy
- B. daytime sleepiness
- C. hallucinations
- D. sleep paralysis
- E. cataplexy

P.230

26.17 Which of the following statements about the sleep stage histograms shown in [Figure 26.2](#) is true?

- A. A is characteristic of obstructive sleep apnea syndrome.
- B. A is characteristic of anxiety disorder.
- C. B is characteristic of major depressive disorder.
- D. A is characterized by an abnormal latency to REM sleep.
- E. Both are within normal limits.

26.18 True statements about sleep in the elderly include all of the following *except*

- A. After the age of 65, one-third of women and one-fifth of men report that they take over 30 minutes to fall asleep.
- B. The incidence of nocturnal myoclonus increases with age.
- C. Average daily total sleep time decreases after the age of 65.
- D. Death rates are higher in the elderly both in people who sleep more than 9 hours and those who sleep fewer than 5 hours.
- E. Individuals with periodic limb movements sleep about an hour less per night than controls.

26.19 Many benzodiazepine hypnotic medications cause

- A. profound hypersomnia during withdrawal
- B. increases in slow wave sleep
- C. reductions in REM sleep
- D. abnormally decreased EEG beta and sleep spindle activity

E. all of the above

26.20 Which of the following features is *not* typical of REM sleep?

- A. Dreams are typically concrete and realistic.
- B. Polygraph measures show irregular patterns.
- C. The resting muscle potential is lower in REM sleep than in a waking state.
- D. Near-total paralysis of the postural muscles is present.
- E. A condition of temperature regulation similar to that in reptiles occurs.

26.21 Which of the following statements does *not* correctly describe sleep regulation?

- A. Melatonin secretion helps regulate the sleep-wake cycle.
- B. Destruction of the dorsal raphe nucleus of the brainstem reduces sleep.
- C. L-Tryptophan deficiency is associated with less time spent in NREM sleep.
- D. REM sleep can be reduced by increased firing of noradrenergic neurons.
- E. Disrupted REM sleep patterns in patients with depression show shortened REM latency.

Directions

Each group of questions below consists of lettered headings followed by a list of numbered words or phrases. For each numbered word or phrase, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 26.22–26.31

26.22 Sleepwalking

26.23 Bed-wetting (enuresis)

26.24 Paroxysmal hemicrania

26.25 Erections

26.26 D sleep

26.27 Paradoxical sleep

26.28 Slow wave sleep (SWS)

26.29 EEG synchronized sleep

26.30 Most occurs in the last half of the night

26.31 Autonomic functioning is usually slow and steady

- A. REM sleep
- B. NREM sleep

Questions 26.32–26.36

26.32 Urge to move the legs

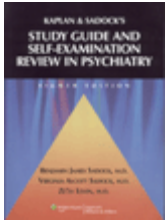
26.33 Brownish-red morning urine

26.34 Patient wakes up screaming

26.35 Head banging

26.36 Damage to the teeth

- A. Sleep terror disorder
- B. Nocturnal myoclonus
- C. Jactatio capitis nocturnus
- D. Sleep-related hemolysis
- E. Sleep-related bruxism



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



27

Impulse-Control Disorders Not Elsewhere Classified

Impulsive behavior can be quite common in the personalities of normal individuals. However, the hallmark of impulse-control disorders is the individual's inability to stop impulses that may cause harm to themselves or others. The revised 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) lists several impulse-control disorders that are not classified under any other diagnostic heading in DSM-IV-TR, but are nonetheless serious enough to be highlighted. These are intermittent explosive disorder, kleptomania, pyromania, pathological gambling, trichotillomania, and impulse-control disorder not otherwise specified. These disorders are all quite different in their epidemiology, etiology, psychodynamic formulation, course, prognosis, and treatment, but share other characteristics. Affected individuals often feel anxiety or tension in considering these behaviors, and this anxiety or tension is relieved or diminished once the impulse is acted on.

Intermittent Explosive Disorder is evidenced by episodes of acting out aggression and causing bodily harm and/or property destruction. Kleptomania is evidenced by acting out the impulse to steal objects without the motive of monetary gain. Pyromania is evidenced by the uncontrollable urge to set fires. Pathological Gambling is evidenced by habitual, self-destructive gambling. Trichotillomania is evidenced by recurrent hair pulling resulting in significant hair loss, often to the point of baldness or to removing eyebrows and lashes.

As with most psychiatric disorders, both biological and psychological components contributing to the etiology of these disorders have been studied and identified. Biological investigations have been particularly relevant to the understanding of violent impulse-control disorders. Studies include investigations of the limbic system of the brain, the effects of testosterone, histories of head trauma and childhood abuse, childhood histories of attention deficit/hyperactivity disorder, and CSF levels of 5-hydroxyindolacetic acid (5-HIAA), a metabolite of serotonin. Alcohol abuse has been associated with some of the more violent impulse-control disorders and can act as a facilitator to losing control. Unfulfilled narcissistic, dependency, and self-object needs have also been implicated, as are exposure to parental impulse-control problems during development.

The student should study the questions and answers below for a useful review of these

disorders.

Helpful Hints

These terms relate to impulse-control disorders and should be defined by the student.

- alopecia
- anticonvulsants
- attention-deficit/hyperactivity disorder
- behavior therapy
- benzodiazepines
- biofeedback
- desperate stage
- enuresis
- epileptoid personality
- 5-HIAA
- hydroxyzine hydrochloride
- hypnotherapy
- impulse-control disorder
- impulse-control disorder not otherwise specified
- intermittent explosive disorder
- kleptomania
- limbic system
- lithium
- lust angst
- multidetermined
- oniomania
- parental factors
- pathological gambling
- pleasure principle, reality principle
- progressive-loss stage
- psychodynamics
- pyromania
- social gambling
- SSRIs
- testosterone
- trichophagy
- trichotillomania
- winning phase

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

27.1 Which of the following is a component of kleptomania?

- A. Persons often do not have the means to pay for items they steal
- B. Stealing occurs in order to meet personal needs
- C. Stealing is often planned and carefully carried out

P.238

- D. Persons never feel guilt or remorse following the theft
- E. It is characterized by mounting tension before the act

27.2 Which of the following is *not* one of the phases typically seen in pathological gamblers?

- A. Winning phase
- B. Progressive-loss phase
- C. Risk-taking phase
- D. Desperate phase
- E. Hopeless phase

27.3 All of the following have been noted to have an association with pyromania *except*?

- A. Mild retardation
- B. Delinquency
- C. Cruelty to animals
- D. Obsession with firefighters
- E. Alcohol use disorders

27.4 The term *epileptoid personality* has been used in reference to patients with which of the following?

- A. Seizure disorder
- B. Intermittent explosive disorder
- C. Pyromania
- D. Kleptomania
- E. Trichotillomania

27.5 A 28-year-old man had been repeatedly brutalized by his alcoholic mother throughout childhood and early adolescence. He felt particularly humiliated when she would slap his face during frequent bouts of uncontrollable anger. One evening,

while they were drinking at a local tavern, a friend playfully slapped his cheek. The patient suddenly "saw red," broke a beer bottle over the man's head, and then mauled him severely. Which of the following defense mechanisms is this patient with intermittent explosive disorder exhibiting?

- A. Identification with the aggressor
- B. Passive-aggressive behavior
- C. Regression
- D. Controlling
- E. Reaction formation

27.6 Which of the following is *not* a neuroendocrine change noted in patients with abnormal aggression?

- A. Deranged serotonin neurotransmission
- B. Low CSF levels of 5-hydroxyindolacetic acid (5-HIAA)
- C. Decreased platelet serotonin reuptake
- D. Elevated CSF testosterone
- E. Increased glucose metabolism

27.7 True statements about pathological gambling include

- A. Rates of pathological gambling are lower in locations where gambling is legal.
- B. Rates of pathological gambling are lower among the poor and minorities.
- C. Rates of pathological gambling have been shown to be lower in high school students than in the general population.
- D. The natural history of the illness has been divided into four phases: winning, losing, desperation, and hopelessness.
- E. All of the above

27.8 Which of the following drugs has been found to cause a paradoxical reaction of dyscontrol in some cases of impulse-control disorder?

- A. lithium
- B. phenytoin
- C. carbamazepine
- D. trazodone
- E. benzodiazepines

27.9 All of the following have been identified as predisposing factors for the development of pathological gambling *except*

- A. loss of a parent before the child is 15 years old

- B. childhood enuresis
- C. attention-deficit/hyperactivity disorder
- D. inappropriate parental discipline
- E. family emphasis on material symbols

27.10 People with trichotillomania

- A. often have family histories of tics
- B. often respond preferentially to serotonergic agents
- C. have an increased prevalence of mood and anxiety disorders
- D. often require a biopsy to confirm the diagnosis
- E. all of the above

27.11 Intermittent explosive disorder

- A. is relatively common
- B. is characterized by discrete periods of aggressive episodes
- C. is associated with lower than expected rates of depressive disorders in first-degree relatives of patients
- D. is typically seen in small men with avoidant personality features
- E. none of the above

27.12 Which of the following selections is *not* associated with intermittent explosive disorder?

- A. Patients may feel helpless before an episode.
- B. The disorder usually grows less severe with age.
- C. A predisposing factor in childhood is encephalitis.
- D. Dopaminergic neurons mediate behavioral inhibition.
- E. Neurological examination can show left-right ambivalence.

Directions

Each set of lettered headings below is followed by a list of numbered words or phrases. For each numbered word or phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 27.13–27.17

27.13 Chronic condition

27.14 Recognized as a discrete disease entity by DSM-IV-TR

27.15 Preponderance in women

27.16 Increased lifetime rate of major mood disorders

27.17 Treatment has included both psychological and pharmacological modalities

- A. Compulsive buying
- B. Kleptomania

Questions 27.18–27.23

27.18 More common in females than in males

27.19 Onset generally in childhood

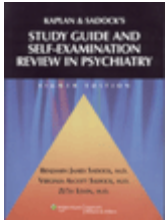
27.20 Sense of gratification or release during the behavior

27.21 Treated with lithium

27.22 Associated with truancy

27.23 May be a response to an auditory hallucination

- A. Trichotillomania
- B. Pyromania



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



28

Adjustment Disorders

Adjustment disorders are short-term maladaptive reactions to what a layperson would call a personal calamity but in psychiatric terms would be referred to as a psychosocial stressor. An adjustment disorder is expected to remit soon after the stressor ceases or, if it persists, a new level of adaptation is achieved.

According to the text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), symptoms must appear within 3 months of a stressor's onset. The nature and severity of the stressors are not specified. However, the stressors are more often everyday events that are ubiquitous (e.g., loss of a loved one, change of employment or financial situation) rather than rare, catastrophic events (e.g., natural disasters, violent crimes). The disturbance must not fulfill the criteria for another major psychiatric disorder or bereavement (not considered a mental disorder, although it may be a focus of clinical attention). The symptoms of the disorder usually resolve within 6 months, although they may last longer if produced by a chronic stressor or one with long-lasting consequences.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know these terms and types (including case examples) of adjustment.

- acute stress reaction
- adjustment disorder:
 - with anxiety
 - with depressed mood
 - with disturbance of conduct
 - with mixed anxiety and depressed mood
 - with mixed disturbance of emotions and conduct
- adolescent onset
- bereavement
- crisis intervention

- good-enough mother
- maladaptive reaction
- mass catastrophes
- posttraumatic stress disorder
- psychodynamic factors
- psychosocial stressor
- recovery rate
- resilience
- secondary gain
- severity of stress scale
- vulnerability
- Donald Winnicott

Questions/Answers

Directions

Each of the statements or questions below is followed by five suggested responses or completions. Select the one that is best in each case.

28.1 Which of the following is not a classification of adjustment disorder in DSM-IV-TR?

- A. With disturbance of conduct
- B. With depressed mood
- C. With psychotic features
- D. With mixed disturbance of emotions and conduct
- E. With anxiety

28.2 Which of the following stressors most often leads to psychological impairment that could be diagnosed as an adjustment disorder?

- A. rape
- B. loss of a job
- C. a plane crash
- D. all of the above
- E. none of the above

28.3 Adjustment disorders

- A. must remit within 6 months following the cessation of the stressor
- B. are in response, most often, to everyday events rather than rare, catastrophic events

- C. have subtypes indicating that almost any subthreshold condition associated with a psychosocial stressor may meet criteria for the disorder
- D. as a diagnosis may be used excessively and incorrectly by clinicians
- E. all of the above

28.4 Adjustment disorder

- A. correlates with the severity of the stressor
- B. occurs more often in males than in females
- C. is a type of bereavement

P.244

- D. usually requires years of treatment
- E. occurs in all age groups

28.5 Factors affecting the relationship of stress to the development of psychopathology include

- A. preexisting mood symptomatology
- B. preexisting adaptive skills
- C. genetic influence
- D. the nature of the preexisting event
- E. all of the above

28.6 The rate of reliability in the diagnosis of adjustment disorders is

- A. considered good
- B. improved by the variability produced by cultural expectations regarding reactions to and management of stressful events
- C. increased by the absence of any impairment criteria in the diagnostic algorithm that defines maladaptation to stress
- D. consistent with the fact that measurement of psychosocial stress on Axis IV has been found to be questionable
- E. none of the above

28.7 The symptomatic profile and level of impairment in adjustment disorders with depressed mood has been found to be quite similar to

- A. dysthymic disorder
- B. major depressive disorder
- C. bipolar I disorder
- D. all of the above
- E. none of the above

Directions

Each set of lettered headings below is followed by a list of numbered phrases. For each numbered phrase, select:

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 28.8–28.12

28.8 Places adjustment disorders in the same category as reactions to severe stress

28.9 Notes that once a stressor (or its consequences) has ceased, an adjustment disorder may not persist for more than 6 more months

28.10 Stipulates that onset of symptoms of an adjustment disorder must occur within 1 month of exposure to a psychosocial stressor

28.11 Notes that the criteria of another disorder (e.g., antisocial personality disorder) may be fulfilled in an adjustment disorder

28.12 Includes adjustment disorders with depressed mood, anxiety, and disturbance of conduct

- A. DSM-IV-TR
- B. ICD-10

Questions 28.13–28.17

28.13 Often require a longer recovery time from an adjustment disorder

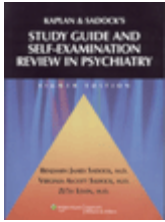
28.14 Common precipitating stressor for an adjustment disorder may be divorce

28.15 Males and females equally diagnosed with adjustment disorders

28.16 The age group in which adjustment disorders are most frequently diagnosed

28.17 Females are diagnosed with adjustment disorders twice as often as males

- A. Adolescents
- B. Adults



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



29

Personality Disorders

Personality disorders are common and chronic. Approximately 10 to 20 percent of the population suffers from them; at least one in every five to ten people in a community has a personality disorder. These patients have chronic impairment in their ability to work and love. They consume a large portion of community service, social welfare benefits, and public health resources. About fifty percent of all psychiatric patients have personality disorders, which in and of themselves are predisposing factors for other psychiatric disorders.

According to *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) the critical criterion for distinguishing deviant personality traits is the prevalence or existence of longterm maladaptation and inflexibility that are manifested as subjective distress or socio-occupational functional impairment, or both. Personality disorders are classified into three clusters, each sharing clinical features. Cluster A includes three disorders with odd, aloof features, such as paranoid, schizoid, and schizotypal. Cluster B includes four disorders with dramatic, impulsive, and erratic features, such as borderline, antisocial, narcissistic, and histrionic. Cluster C includes three disorders sharing anxious and fearful features, such as avoidant, dependent, and obsessivecompulsive.

Patients with personality disorders typically blame other people for unfavorable circumstances for their own problems. Most of these patients perceive their own deviant behaviors as appropriate and adequate. In light of this, patients with personality disorders try to change others, not themselves, and most people with these disorders seldom seek or accept treatment. Typically, they seek help when their maladaptive behaviors culminate in severe marital, family, and career problems or for comorbid anxiety, depression, substance abuse, or eating disorders.

It is hard to find a psychotherapeutic method that has not been tried to treat personality disorders. Each school of psychotherapy provides a specific understanding of behavior and a particular method of intervention. In practice, many of these schools overlap or complement each other.

Agrowing body of evidence demonstrates that pharmacotherapy is at least equally important to psychotherapy in the overall treatment of these disorders. Pharmacotherapy is aimed at correcting neurobiological dispositions to underlying deviant traits or at correcting target symptoms of these disorders.

The terms personality, temperament, motivation, character and psyche are often used interchangeably. This is misleading, and the student is encouraged to review and distinguish these terms with more clarity. Students should also familiarize themselves with the complicated questions surrounding these disorders: are they clinical or social diagnoses, what is the categorical versus dimensional approach to these disorders, how are they measured?

The student should study the questions and answers below for a useful review of all these disorders.

Helpful Hints

The student should be able to define the terms that follow.

- acting out
- alloplastic
- ambulatory schizophrenia
- anankastic
- antisocial
- as-if personality
- autoplatic
- avoidant
- borderline
- Briquet's syndrome
- castration anxiety
- chaotic sexuality
- character armor
- Stella Chess, Alexander Thomas
- clusters A, B, and C
- counterprojection
- denied affect
- dependent
- depressive
- dissociation
- ego-dystonic
- ego-syntonic
- emotionally unstable personality
- endorphins
- Erik Erikson
- extroversion
- fantasy
- free association
- genetic factors
- goodness of fit

- histrionic
- hypochondriasis
- idealization/devaluation
- ideas of reference
- identity diffusion
- inferiority complex
- internal object relations
- introversion
- isolation
- Carl Gustav Jung
- Heinz Kohut
- *la belle indifférence*
- macropsia
- magical thinking
- mask of sanity
- micropsychotic episodes
- narcissistic
- object choices
- obsessive-compulsive
- oral character
- organic personality disorder

-
- panambivalence
 - pananxiety
 - panphobia
 - paranoid
 - passive-aggressive
 - personality
 - platelet MAO
 - projection
 - projective identification
 - psychotic character
 - Wilhelm Reich
 - repression
 - saccadic movements
 - Leopold von Sacher-Masoch
 - Marquis de Sade
 - sadistic personality
 - sadomasochistic personality
 - schizoid
 - schizotypal

- secondary gain
- self-defeating personality
- self-mutilation
- splitting
- three Ps
- timid temperament
- turning anger against the self

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is *best* in each case.

29.1 Traits that have been identified as forming the stylistic components of behavior known as *temperament* include all of the following *except*

- A. harm avoidance
- B. novelty seeking
- C. shyness
- D. persistence
- E. reward dependence

29.2 True statements about diagnosing specific personality disorders include

- A. Diagnosis may not be made in children.
- B. Antisocial personality disorder may be diagnosed in individuals under 18.
- C. There is a potential sex bias in diagnosing personality disorders.
- D. Real gender differences do not exist in the prevalence of personality disorders.
- E. None of the above

29.3 Which of the following biological factors pertaining to personality disorders is true?

- A. Compulsive traits are associated with high levels of testosterone
- B. Low platelet monoamine oxidase levels have been noted in some patients with histrionic personality disorder
- C. Antisocial personalities may have fast wave activity on EEG
- D. Smooth pursuit eye movements are saccadic in persons who are introverted
- E. 5-HIAA levels have been found to be high in suicide attempters

29.4 Antisocial personality disorder is associated with an increased risk for

- A. major depressive disorder
- B. anxiety disorders
- C. somatization disorder
- D. borderline personality disorder
- E. all of the above

29.5 Persons with narcissistic personality disorders

- A. may benefit from a psycho-analytic treatment approach
- B. are usually immune to criticism
- C. are easy to treat
- D. handle aging well
- E. are unlikely to feel depressed

29.6 The etiology of borderline personality disorder involves

- A. childhood trauma
- B. vulnerable temperament
- C. biological vulnerabilities
- D. familial aggregation
- E. all of the above

29.7 Basic rules with regard to the treatment of patients with personality disorders include all of the following *except*

- A. a passive therapist
- B. use of pharmacotherapy
- C. supervision and a support network for therapists
- D. rare use of pure supportive psychotherapy
- E. frequent sessions

29.8 Defense mechanisms

- A. are unconscious processes
- B. are implemented to abolish anxiety and depression
- C. are employed to resolve internal conflicts
- D. in personality disorder patients are often rigid and intractable
- E. all of the above

29.9 Spectrum disorders

- A. aggregate in the same family
- B. co-occur in the same person
- C. sometimes reflect differential expression of the same liability
- D. may be phenotypically distinguishable
- E. all of the above

29.10 Otto Kernberg's borderline level of personality organization involves

- A. a lack of anxiety tolerance

P.250

- B. a blurring of boundaries between the self and other
- C. is centered around splitting
- D. alternating perceptions of the self and other as all-good or all-bad
- E. all of the above

29.11 Schizotypal personalities

- A. are usually socially gregarious
- B. occur more commonly in women with fragile X syndrome
- C. demonstrate a full affective range
- D. commonly suffer from mania
- E. are not any more prevalent with schizophrenia than any other personality disorders

29.12 True statements about the aspects of personality called temperament include all of the following *except*

- A. They are heritable.
- B. They are observable early in childhood.
- C. They are relatively stable in time.
- D. They are inconsistent in different cultures.
- E. They are predictive of adolescent and adult behavior.

29.13 Individuals high in novelty seeking are most likely

- A. impulsive
- B. disorderly
- C. easily bored
- D. extravagant
- E. all of the above

29.14 True statements about paranoid personality disorder include

- A. Patients are at decreased risk for major depression.
- B. It may be a prepsychotic antecedent of delusional disorders, paranoid type.
- C. Impairment is frequently severe.
- D. The disorder is not complicated by brief psychotic disorder.
- E. All of the above

29.15 Borderline personality disorder is associated with

- A. decreased risk for psychotic symptoms
- B. increased risk for premature death
- C. decreased risk for other coexisting personality disorders
- D. decreased risk for bulimia
- E. decreased risk for posttraumatic stress disorder

29.16 Which of the following statements about borderline personality disorder is false?

- A. Patients with borderline personality disorder have more relatives with mood disorders than do control groups.
- B. Borderline personality disorder and mood disorders often coexist.
- C. First-degree relatives of persons with borderline personality disorder show an increased prevalence of alcohol dependence.
- D. Smooth-pursuit eye movements are abnormal in borderline personality disorder.
- E. Monoamine oxidase inhibitors are used in the treatment of borderline personality disorder patients.

29.17 The defense mechanism most often associated with paranoid personality disorder is

- A. hypochondriasis
- B. splitting
- C. isolation
- D. projection
- E. dissociation

29.18 A pervasive pattern of grandiosity, lack of empathy, and need for admiration suggests the diagnosis of which of the following personality disorders?

- A. schizotypal
- B. passive-aggressive

- C. borderline
- D. narcissistic
- E. paranoid

29.19 Mr. S was a 45-year-old postal service employee who was evaluated at a clinic specializing in the treatment of depression. He claimed to have felt constantly depressed since the first grade, without a period of normal mood for more than a few days at a time. His depression was accompanied by lethargy, little or no interest or pleasure in anything, trouble in concentrating, and feelings of inadequacy, pessimism, and resentment. His only periods of normal mood occurred when he was home alone, listening to music or watching TV. On further questioning, Mr. S revealed that he could never remember feeling comfortable socially. Even before kindergarten, if he was asked to speak in front of a group of family friends, his mind would go blank. He felt overwhelming anxiety at children's social functions, such as birthday parties, which he either avoided or attended in total silence. He could answer questions in class only if he wrote down the answers in advance; even then, he frequently mumbled and could not get the answer out. He met new children with his eyes lowered, fearing their scrutiny, expecting to feel humiliated and embarrassed. He was convinced that everyone around him thought he was "dumb or a jerk." During the past several years, he had tried several therapies to help him get over his shyness and depression.

Mr. S had never experienced sudden anxiety or a panic attack in social situations or at other times. Rather, his anxiety built gradually to a constant level in anticipation of social situations. He had never experienced any psychotic symptoms.

The best diagnosis in the patient above is

- A. avoidant personality disorder
- B. schizoid personality disorder
- C. schizotypal personality disorder
- D. social phobia
- E. adjustment disorder with anxiety

P.251

Directions

Each group of questions consists of lettered headings followed by a list of numbered statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 29.20–29.27

29.20 Borderline personality disorder

29.21 Avoidant personality disorder

29.22 Narcissistic personality disorder

29.23 Obsessive-compulsive personality disorder

29.24 Paranoid personality disorder

29.25 Reward dependence

29.26 Novelty seeking

29.27 Harm avoidance

A. Cluster A

B. Cluster B

C. Cluster C

Questions 29.28–29.32

29.28 Strikingly odd or eccentric behavior

29.29 Magical thinking

29.30 Ideas of reverence

29.31 Formerly called latent schizophrenia

29.32 Suspiciousness or paranoid ideation

A. Schizoid personality disorder

B. Schizotypal personality disorder

Questions 29.33–29.36

29.33 Aggression as a result of feeling threatened

29.34 Aggression seen often in patients with frontal lobe lesions

29.35 Aggression with intact impulse control

29.36 Unprovoked aggression associated with cerebral instability

A. ictal aggression

B. affective aggression

C. predatory aggression

D. organic-like aggression

E. None of the above

Questions 29.37–29.40

29.37 Involves rational concepts about oneself and one's relationships

29.38 Involves basic emotions

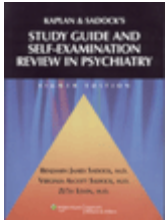
29.39 Involves intuitive self-awareness

29.40 A dynamic system that is constantly evolving

A. character

- B. temperament
- C. personality
- D. psyche
- E. All of the above





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



30

Psychosomatic Medicine and Consultation-Liaison Psychiatry

It is likely that no real “interface” existed between psychiatry and medicine until the early 20th century. Undoubtedly there was interest in applying psychiatry to patients with medical problems, but pursuit of this interest was usually quite personal and not formalized. Today, psychosomatic medicine has been a specific area of study within the field of psychiatry for more than 75 years. It is informed by two basic assumptions: There is a unity of mind and body (reflected in the term mind-body medicine); and psychological factors must be taken into account when considering all disease states.

The revised 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) includes a classification specifically for psychological factors affecting medical conditions, and characterizes the factors as having to have a significant effect on the course or outcome of the condition, or place the patient at significantly higher risk for an adverse outcome. The nature of the various psychological factors are delineated in DSMIV- TR and include mental disorder, psychological symptoms, personality traits or coping styles, maladaptive health behaviors, and unspecified psychological factors. DSM-IV-TR does not stipulate that these factors must directly cause the medical condition, but it does specify that there must be a close temporal relationship between the factors and the condition.

Consultation-liaison (C-L) psychiatry is the study, practice, and teaching of the relation between medical and psychiatric disorders. In C-L psychiatry, psychiatrists serve as consultants to medical colleagues (either another psychiatrist or, more commonly, a non-psychiatric physician) or to other mental health professionals (psychologist, social worker, or psychiatric nurse). C-L psychiatry is associated with all the diagnostic, therapeutic, research, and teaching services that psychiatrists perform in the general hospital and serves as a bridge between psychiatry and other specialties. Virtually every major system of the body has been investigated with regard to the relationship between psychological factors and disease. Psychological factors affecting the cardiovascular, respiratory, immune, endocrine, gastrointestinal, and dermatologic systems are well known. Even the apparently simple act of correctly following a medication regimen can be complicated, and perhaps undermined, by unaddressed or unrecognized psychological factors.

Psychosomatic concepts have contributed greatly to many approaches to medical care.

Concepts derived from the field of psychosomatic medicine influenced the emergence of complementary and alternative medicine (CAM) which relies heavily on examining psychological factors in the maintenance of health and also influenced the field of holistic medicine with its emphasis on examining and treating the whole patient, not just his or her disease or disorder. The concepts of psychosomatic medicine also influenced the field of behavioral medicine, which integrates the behavioral sciences and the biomedical approach to the prevention, diagnosis, and treatment of disease.

The student should study the questions and answers below for a useful review of these factors.

Helpful Hints

These terms relating to psychophysiological medicine should be defined.

- AIDS
- Franz Alexander
- alexithymia
- allergic disorders
- analgesia
- atopic
- autoimmune diseases
- behavioral medicine
- behavior modification deconditioning program
- biofeedback
- bronchial asthma
- bulimia nervosa and anorexia nervosa
- C-L psychiatry
- cardiac arrhythmias
- cell-mediated immunity
- chronic pain
- climacteric
- command hallucination
- compulsive personality traits
- congestive heart failure
- conversion disorder
- coronary artery disease
- crisis intervention
- Jacob DaCosta
- diabetes mellitus
- dialysis dementia
- Flanders Dunbar
- dysmenorrhea
- dysthymic disorder
- essential hypertension

- fibromyalgia
 - Meyer Friedman and Roy Rosenman
 - general adaptation syndrome
 - giving up–given up concept
-

- gun-barrel vision
- hay fever
- hemodialysis units
- Thomas Holmes and Richard Rahe
- humoral immunity
- hyperhidrosis
- hyperthyroidism
- hyperventilation syndrome
- hypochondriasis
- ICUs
- idiopathic amenorrhea
- IgM and IgA
- immediate and delayed hypersensitivity
- immune disorders
- immune response
- life-change units
- low back pain
- menopausal distress
- migraine
- myxedema madness
- neurocirculatory asthenia
- obesity
- obsessional personalities
- oral-aggressive feelings
- organ transplantation
- pain clinics
- pain threshold and perception
- pancreatic carcinoma
- Papez circuit
- peptic ulcer
- personality types
- pheochromocytoma
- PMS
- postcardiotomy delirium
- premenstrual dysphoric disorder
- propranolol (Inderal)

- pruritus
- psyche and soma
- psychogenic cardiac nondisease
- psychophysiological
- psychosomatic
- Raynaud's phenomenon
- relaxation therapy
- rheumatoid arthritis
- Hans Selye
- skin disorders
- social readjustment rating scale
- somatization disorder
- specific versus nonspecific stress
- specificity hypothesis
- surgical patients
- systemic lupus erythematosus
- tension headaches
- tension myositis syndrome (TMS)
- thyrotoxicosis
- type A and type B personalities
- ulcerative colitis
- undermedication
- vasomotor syncope
- vasovagal attack
- Wilson's disease

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the *one* that is *best* in each case.

30.1 Antidepressants should be used cautiously in cardiac patients due to increased risk of which of the following?

- A. Hypertension
- B. Suicide
- C. Conduction side effects
- D. Noncompliance
- E. All of the above

30.2 Which of the following is *not* a medical cause of hallucinations?

- A. Alcohol use
- B. Alcohol withdrawal
- C. Cocaine use
- D. Hyperthyroidism
- E. None of the above

30.3 Which of the following statements regarding the Social Readjustment Rating Scale is not true?

- A. It is based on the work of Thomas Holmes and Richard Rahe.
- B. It suggests marriage is a more stressful event than divorce.
- C. The life event incurring the most life change units is death of a spouse.
- D. It helps correlate life stress with subsequent illness.
- E. Accumulating 200 or more life change units increases the risk for illness.

30.4 Which of the following is the most common reason for a consultation-liaison psychiatrist to be consulted?

- A. Anxiety
- B. Depression
- C. Disorientation
- D. Treatment problems
- E. Sleep disorders

30.5 You are the C-L psychiatrist called to consult on a patient who is scheduled for a liver transplant. You learn the patient now needs a transplant after he was infected with hepatitis C due to promiscuous sexual activity. Which of the following is this patient at increased risk for?

- A. Medication noncompliance
- B. Major depression
- C. Organ rejection
- D. Adjustment disorder
- E. Suicide

30.6 Which of the following statements regarding tension headaches is true?

- A. Competitive personalities are prone to tension headaches.
- B. Antianxiety agents have been shown effective in treatment.
- C. Psychotherapy is effective for treatment of chronic tension headaches.

- D. Antidepressants can be helpful in some cases of tension headaches.
- E. All of the above.

30.7 Which of the following is *not* a physiological response of the GI system to acute stress?

- A. Increased resting tone of the upper esophageal sphincter
- B. Decreased contraction amplitude in the distal esophagus
- C. Decreased antral motor activity in the stomach

P.258

- D. Reduced migrating motor function in the small intestine
- E. Increased myoelectrical motility in the large intestine

30.8 Which of the following statements regarding psychiatric disorders and asthma is *true*?

- A. Type B personalities have been associated with an increased prevalence of asthma.
- B. Approximately one-third of persons with asthma also have panic disorder.
- C. Patients with asthma have excessive dependency needs.
- D. Fear may directly trigger asthma attacks.
- E. All of the above

30.9 Which of the following statements regarding psychogenic excoriations is *true*?

- A. Scratching does not occur in response to an itch.
- B. Lesions are typically found in hard to reach areas.
- C. The behavior never becomes ritualistic.
- D. Freud believed the skin is susceptible to unconscious sexual urges.
- E. All of the above

30.10 Dialysis dementia

- A. Can occur after a patient's first dialysis treatment
- B. Is a common occurrence
- C. Can cause seizures and dystonias
- D. Rarely leads to depression and suicide
- E. All of the above

30.11 A review of the impact of biobehavioral factors on adult cancer pain concluded that

- A. there was a consistent role of personality factors
- B. the relationship to affective states was major
- C. environmental influences were strong
- D. all of the above
- E. none of the above

30.12 A major advance in DSM-IV-TR in regard to the diagnostic criteria for psychological factors affecting medical condition is that it allows for emphasis on

- A. environmental stimuli
- B. psychological stimuli
- C. somatoform disorders
- D. conversion disorder
- E. all of the above

30.13 A decrease in T lymphocytes has been reported in all of the following *except*

- A. bereavement
- B. caretakers of patients with dementia of the Alzheimer's type
- C. women who are having extramarital affairs
- D. nonpsychotic inpatients
- E. medical students during final examinations

P.259

30.14 True statements about the effects of psychosocial interventions in cancer outcomes and prognosis include

- A. There is no evidence that psychotherapy influences the outcome of metastatic breast cancer.
- B. The mortality rates and recurrence rates in patients with malignant melanoma have been shown to be greater in patients who did not receive a structured group intervention than in those who did.
- C. Group behavioral intervention in patients with breast cancer does not appear to have any effect on lymphocyte mitogen responses.
- D. A lack of social support and depression has not been shown to be linked to diminished immune responses in women with breast cancer.
- E. Hypothalamic-pituitary-adrenal axis hypoactivity induced by exposure of rats to stress is associated with increased tumor growth.

30.15 Exposure of rats to stress reliably

- A. decreases plasma concentrations of ACTH

- B. decreases plasma concentrations of corticosterone
- C. increases secretion of growth hormone
- D. increases secretion of CRF in locus ceruleus
- E. all of the above

30.16 The most frequent functional gastrointestinal disorder is

- A. functional abdominal bloating
- B. functional chest pain
- C. functional heartburn
- D. irritable bowel syndrome
- E. globus

30.17 True statements about research in psychocardiology include

- A. The most consistent psychological correlates of hypertension are inhibited anger expression and excessive anger expression.
- B. Stress leads to excess secretion of epinephrine, which raises cardiac contractility and conduction velocity.
- C. Cardiac surgery patients at greatest risk for complications are depressed and in denial about their anxiety.
- D. Mental stress leads to diminished cardiac perfusion.
- E. All of the above

30.18 True statements about type A behavior include

- A. Once coronary artery disease is present, global type A behavior appears to increase the risk of subsequent cardiac morbidity.
- B. Of all the elements of the syndrome, hostility has been found to be the most toxic element.
- C. Global type A behavior consistently predicts risk of coronary artery disease.
- D. Expressive hostility and antagonistic interactions appear to be least strongly related to the risk of coronary artery disease in women.
- E. Lifestyle modification has little effect on revascularization.

30.19 True statements about obesity include

- A. The number of obese Americans is less than that of nonobese Americans.
- B. The prevalence of obesity in America has doubled since the early 1900s.
- C. Higher rates of obesity are linked with lower socioeconomic and educational levels and type of diet.
- D. Its prevalence in children appears to be stabilized and even decreasing.

E. All of the above

30.20 A 53-year-old male patient is found to have an occipital lobe tumor. He would be least likely to exhibit which of the following symptoms and complaints?

- A. Paranoid delusions
- B. Visual hallucinations
- C. Headache
- D. Papilledema
- E. Homonymous hemianopsia

30.21 In evaluating patients with complaints of chronic pain of whatever cause, the physician must be alert to

- A. use of over-the-counter medications
- B. alcohol dependence
- C. withdrawal symptoms during the evaluation
- D. an underlying medical illness
- E. all of the above

30.22 A highly emetogenic anticancer agent is

- A. cisplatin
- B. doxorubicin
- C. vincristine
- D. vinblastine
- E. bleomycin

30.23 Psoriasis has been shown to be

- A. unaffected by such psychosocial interventions as meditation or relaxation
- B. associated with lower levels of anxiety and depression than in the general population
- C. triggered by external factors such as cold weather and physical trauma
- D. rarely associated with personality disorders
- E. none of the above

30.24 Antidepressants have been shown to be helpful in the treatment of

- A. idiopathic pruritus
- B. urticaria
- C. vulvodynia

- D. glossodynia
- E. all of the above

30.25 Which of the following statements about psychoneuroimmunology is true?

- A. Immunological reactivity is not affected by hypnosis.
- B. Lymphocytes cannot produce neurotransmitters.
- C. The immune system is affected by conditioning.
- D. Growth hormone does not affect immunity.
- E. Marijuana does not affect the immune system.

30.26 Phantom limb occurs after leg amputation in what percentage of patients?

- A. 98 percent
- B. 90 percent
- C. 80 percent
- D. 50 percent
- E. 10 percent

30.27 In the psychotherapeutic treatment of patients with psychosomatic disorders, the most difficult problem is patients'

- A. resistance to entering psychotherapy
- B. erotic transference to the psychotherapist
- C. positive response to the interpretation of the physiological meaning of their symptoms
- D. overemphasis of the psychological component of their physiological symptoms
- E. none of the above

Directions

The questions below consist of five lettered headings followed by a list of numbered phrases. For each numbered item, select the one lettered heading that is most closely associated with it.

Each lettered heading may be selected once, more than once, or not at all.

Questions 30.28–30.32

30.28 Dementia syndrome with global impairment and seropositivity

30.29 Resemblance to steroid psychosis

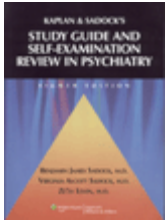
30.30 Explosive anger and labile mood

30.31 Symptoms of a classic panic attack

30.32 Sense of imminent doom

- A. Wilson's disease
- B. Pheochromocytoma
- C. Systemic lupus erythematosus
- D. Acquired immune deficiency syndrome (AIDS)
- E. Pancreatic cancer





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



31

Alternative Medicine and Psychiatry

It has always been important for physicians to ask about and to try to understand the health beliefs and behaviors of their patients. The new and increasing popularity in the United States of alternative therapies means that there are a larger range of health-related behaviors now than most American physicians learned about in medical school. Amazingly, many of the alternative therapies discussed in this chapter pre-date conventional treatments by hundreds and even thousands of years. These therapies have been “conventional” medicine for hundreds of millions of people who have used them throughout the centuries, and people continue to use them today. Unfortunately, alternative methods are not always without their own risk, ranging from simple ineffectiveness to actual harm.

The power of suggestion has been shown to play a significant role in both alternative and more traditional medical and psychiatric treatments. One major difference between traditional and nontraditional methods, however, is that most alternative treatments have not been extensively tested or subjected to controlled studies. Thus, the mechanisms of action, the role of psychology in their effectiveness, and their systemic impact and long-term effects have not been identified adequately. Clinicians may keep an open mind about these treatments until such studies can be performed, but should also refrain from endorsing or recommending treatments with which they are unfamiliar.

In psychiatry, patients often ask questions about alternative treatments, ranging from St. Johns Wortt to acupuncture. Psychiatrists should feel comfortable indicating which treatments they are familiar with and which they are not, and which treatments they feel comfortable accepting and which they do not. If they are knowledgeable about particular alternative treatments and feel that they might be effective in a specific patient, then this can be discussed. Patients are always free to seek care from practitioners who use alternative methods, and no physician should feel pressured to recommend or support any treatments outside their area of expertise, or that they feel are not indicated, effective, or evaluated sufficiently.

The National Institutes of Health (NIH) established an Office of Alternative Medicine (OAM) in 1991 to attempt to evaluate and test many nontraditional, alternative treatments ([Table 31.1](#)). The student should study this table and the questions and answers below for a useful review of this field.

Helpful Hints

Students should know the following terms.

- acupressure
- acupuncture
- Alexander technique
- allopathy
- aromatherapy
- Ayurveda
- Bates method
- bioenergetics
- biofeedback
- chelation therapy
- chiropractic
- color therapy
- complementary medicine
- dance therapy
- diet and nutrition
- endorphins
- environmental medicine
- essential oils
- Moshe Feldenkrais
- Max Gerson
- Samuel Hahnemann
- herbal medicine
- holistic medicine
- homeopathy
- hypnosis
- light therapy
- macrobiotics
- massage
- meditation
- moxibustion
- naturopathy
- nutritional supplements
- Office of Alternative Medicine (OAM)
- osteopathy
- ozone therapy
- past life
- prana
- psychosomatic approach

- reflexology
- Reiki
- Ida Rolf
- scientific method
- shamanism
- sound therapy
- Rudolf Steiner
- yin and yang
- yoga



Table 31.1 Complementary and Alternative Medicine Practices

Whole Medical Systems	Biologically Based Practices	Manipulative and Body-Based Practice
Anthroposophically extended medicine	Cell treatment	Acupressure or acupuncture
Ayurveda	Chelation therapy	Alexander technique
Environmental medicine	Diet	Aromatherapy
Homeopathy	–Atkins diet	Biofield therapeutics
Kampo medicine	–Macrobiotic diet	Chiropractic medicine
Native American medicine	–Ornish diet	Feldenkrais method
Naturopathic medicine	–Pritikin diet	Massage therapy
Tibetan medicine	–Vegetarian diet	Osteopathic medicine
Mind-Body Interventions	–Zone diet	Reflexology
Art therapy	Dietary supplements	Rolfing

Biofeedback	Gerson therapy	Therapeutic touch
Dance therapy	Herbal products	Trager method
Guided imagery	–Echinacea	Energy Medicine
Humor therapy	–St. John’s Wort	Blue light treatment and artificial treatment
Meditation	–Ginkgo biloba extract	Electroacupuncture
Mental healing	–Ginseng root	Electromagnetic field
Past life therapy	–Garlic supplements	Therapy
Prayer and counseling	–Peppermint	Electrostimulation and neuromagnetic
Psychotherapy	Metabolic therapy	stimulation
Sound, music therapy	Megavitamin	Magnetoresonance therapy
Yoga exercise	Nutritional supplements	Qi Gong
Traditional Chinese medicine	Oxidizing agents (ozone, hydrogen peroxide)	Reiki Therapeutic touch Zone therapy

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the one that is best in each case.

31.1 The Alexander technique focuses on improvement of which of the following for better health?

- A. Creativity
- B. Posture
- C. Nutrition
- D. Sleep habits
- E. Hygiene

31.2 Which of the following statements regarding herbal medicines is *true*?

- A. They are subjected to Food and Drug Administration (FDA) approval.
- B. Uniform standards for quality control do exist.
- C. At least 25 percent of current medicines are derived from the ingredients of plants.
- D. Toxic results due to overdose are extremely rare.
- E. Herbal medicines originated in the United States.

31.3 Massage therapy is believed to affect the body in all of the following ways *except*

- A. Circadian rhythm regulation
- B. Increased blood circulation
- C. Improved lymph flow
- D. Improved muscle tone
- E. Tranquilizing effect on the mind

Directions

Each of the three incomplete statements below refers to one of the six lettered terms. Choose the most appropriate term for each statement.

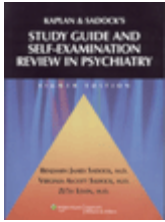
Questions 31.4–31.6

31.4 The medicine taught in U.S. schools

31.5 Similar methods of practice to those of allopathy

31.6 A term coined by Samuel Hahnemann, M.D.

- A. Allopathy
 - B. Homeopathy
 - C. Osteopathy
 - D. Biomedicine
 - E. Technomedicine
 - F. Herbal medicine
-



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



32

Psychiatry and Reproductive Medicine

The physiological processes associated with menarche, menstrual cycling, pregnancy, postpartum, and menopause occur within the context of a woman's psychological and interpersonal life, interfacing with psychosocial functioning throughout adolescence, young adulthood, midlife, and late life. Reproductive events and processes have both physiological and psychological concomitants. The fields of psychiatry and reproductive medicine are just beginning to elaborate the multiple mechanisms by which psyche and soma interact to determine a woman's gynecological and psychological function.

These issues can include the role of psychogenic stress in reproductive dysfunction, changes in sexuality associated with aging, psychological repercussions of infertility, possible psychogenic causes of pelvic pain, premenstrual dysphoric disorder, and psychological and physiologic responses to menopause. Psychiatry may be helpful in addressing a range of issues related to pregnancy, from the impact of emotional support during labor, to the phenomenon of hyperemesis gravidarum, to the safe utilization of psychiatric medications during pregnancy.

Clinicians must be aware of various postpartum conditions, such as postpartum depression and psychosis, and how to distinguish these very serious and potentially life-threatening disorders from the normal "baby blues" that many women experience.

Disorders of sexual development, such as adrenogenital syndrome, testicular feminization, and Turner's syndrome (XO gonadal dysgenesis), are unusual conditions that can raise a number of complex and painful parental and physician decisions, which may include psychiatric consultation.

The student should study the questions and answers below for a useful review of these issues.

Helpful Hints

Each of the following terms should be defined by the student.

- aging changes in sexuality
- amenorrhea
- anovulation

- artificial insemination
- "baby blues"
- disorders of sexual development
- dyspareunia
- estrogen replacement
- FDA rating of drug safety
- fetal sex steroids
- functional hypothalamic anovulation
- disorders of sexual development
- GnRH secretion
- gonadotropins
- hormone replacement therapy
- hyperemesis gravidarum
- hypothalamic-pituitary-adrenal axis
- infertility
- lesbian and gay parents
- pelvic pain
- postpartum depression
- postpartum psychosis
- pregnancy and labor
- premenstrual dysphoric disorder
- psychogenic stress
- sexual response cycle

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

32.1 Which of the following statements regarding puberty and vulnerability to depression is true?

- A. Before puberty, boys are more vulnerable to depressive illness than girls.
- B. Before puberty, girls are more vulnerable to depressive illness than boys.
- C. Depression does not occur in the prepubertal period.
- D. After puberty, depressive illness is less prevalent across both sexes.
- E. None of the above

32.2 Which of the following statements regarding the changes in sexual response that occur with aging is true?

- A. Less stimulation is required to achieve an erection.
- B. There is a shorter phase of sexual excitement.
- C. There is no change in the length of the refractory period following orgasm.
- D. Increased intensity of ejaculation occurs.
- E. Many changes begin before the 5th decade of life.

32.3 Fetal sex steroid exposure exerts primarily organizational effects upon the fetal

- A. central nervous system (CNS)
- B. testes
- C. ovary
- D. neuromuscular system
- E. cardiovascular system

32.4 Pseudocyesis is

- A. Another name for Braxton-Hicks contractions (i.e., false labor)
- B. When the father of a child undergoes a simulated labor as if he were giving birth
- C. The development of the classic symptoms of pregnancy in a nonpregnant woman
- D. Falsely elevated hCG levels occurring with choriocarcinoma and hydatidiform moles
- E. Masking of the symptoms of postpartum depression

32.5 True statements about the relationship between psychogenic stress and reproductive dysfunction include

- A. In women with functional amenorrhea, the activity of the hypothalamic-pituitary-adrenal axis is increased.
- B. There appears to be a dose-response relationship between the severity and number of stressors and the proportion of women who develop anovulation.
- C. Various personality characteristics such as perfectionism and unrealistic expectations have been linked to the development of anovulation.
- D. In FHA, pharmacological intervention alone does not lead to spontaneous recovery.
- E. All of the above

32.6 Premenstrual dysphoric disorder

- A. is associated with hormonally abnormal menstrual cycles
- B. is associated with changing levels of sex steroids that accompany an ovulatory

menstrual cycle

C. is seen in approximately 50 percent of women

D. is not treated with SSRIs

E. all of the above

32.7 It is generally considered safest to perform a tubal ligation at which of the following times?

A. Immediately postpartum

B. Laparoscopy several weeks after delivery

C. Open procedure several weeks after delivery

D. Open procedure 6 months after delivery

E. Hysterectomy is the safest method of sterilization

32.8 Continuous emotional support during labor reduces

A. the rate of cesarean section

B. the duration of labor

C. the use of anesthesia

D. the use of oxytocin

E. all of the above

32.9 Hyperemesis gravidarum

A. may be associated with women who have histories of anorexia nervosa or bulimia nervosa

B. has a poor prognosis for mother and fetus

C. is rarely chronic or persistent

D. is definitively caused by psychological factors

E. none of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered statements. For each numbered statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be used once, more than once, or not at all.

Questions 32.10–32.16

32.10 Occurs in 10 percent of women who give birth

32.11 Can last months to years if untreated

32.12 No association with history of a mood disorder

32.13 Causes tearfulness

32.14 Often associated with thoughts of hurting the baby

32.15 Often associated with anhedonia

32.16 Can include suicidal thoughts

- A. Postpartum depression
- B. "Baby blues"
- C. Both
- D. Neither

Questions 32.17–32.20

32.17 Masculinized genitalia are usually recognized in the delivery room; however, the internal reproductive tract is normal and puberty usually occurs at the expected time with adequate treatment.

32.18 Ovaries do not contain responsive oocytes because of premature atresia of oocytes or failure of germ cell migration.

32.19 Gonads are testes but the fetus is phenotypically female.

32.20 Caused by a gonad that fails to secrete testosterone; generally the uterus, tubes, and vagina are present.

- A. Adrenogenital syndrome
- B. Turner's syndrome (XO gonadal dysgenesis)
- C. Testicular feminization
- D. XY gonadal dysgenesis
- E. Hermaphroditism

Questions 32.21–32.25

32.21 Testes increase in size

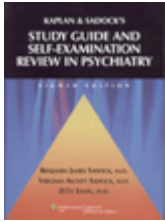
32.22 Muscular contractions occur

32.23 Testes descend

32.24 Sexual fantasies

32.25 Vaginal lubrication

- A. Desire
- B. Excitement
- C. Orgasm
- D. Resolution



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



33

Relational Problems

Relational disorders require a different clinical approach than other disorders. Instead of focusing primarily on the link between symptoms, signs, and the workings of the individual mind, the clinician must also focus on interactions between the individuals involved and how these interactions are related to the general and other medical or psychiatric symptoms in a meaningful way.

People in intimate relationships with each other often experience problems. This may especially be the case when the relationships are affected by the presence of a mental disorder or medical condition. The revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) attempts to formally classify problems in relationships, and this classification is meant to be employed when the focus of clinical attention is the impaired relationship. The specific relational problems indicated in DSM-IV-TR are those between parents and children, and between partners or siblings, as well as those seen in the context of a mental disorder or general medical condition. There is also a category for relational problems not otherwise specified.

An example of a relational problem related to a mental disorder might be the impaired interaction between a mother and her schizophrenic daughter, or the interaction between a brother of normal intelligence and his developmentally delayed sibling. An example of a relational problem related to a general medical condition might be the inability of a husband and wife to have sexual relations because of the husband's diabetes, and the wife's subsequent extramarital affair. A parent-child relational problem might arise in the context of divorce and remarriage, when the child must adjust to a new stepparent or to living for periods of time with each parent.

The student should study the questions and answers below for a useful review of these problems.

Helpful Hints

Each of the following terms should be defined by the student.

- communication problems
 - negative
 - distorted

- noncommunication
- day care centers
- divorce and remarriage
- dual obligation
- environmental factors
- family characteristics
- family system
- family therapy
- marital roles
- parent–child problem
- partner relational problem
- physician marriages
- physician’s responsibility
- polysomnographic findings
- premature child
- prevention
- psychotherapy
- psychotic symptoms
- racial and religious prejudice
- relational problem due to mental disorder or medical condition
- sibling relational problem
- sibling rivalry

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

33.1 A 15-month-old toddler is observed in a playroom with her mother. The toddler is actively playing with toys and occasionally engages her mother in the play as well. A stranger enters the room, and the child appears hesitant initially, but ultimately plays with the stranger also. When her mother leaves the room, the toddler is visibly upset and cries. When her mother returns to the room, she is happy to see her and gives her mother a hug before returning to play.

This child is exhibiting which type of attachment?

- A. Secure attachment
- B. Anxious-resistant attachment
- C. Anxious-avoidant attachment
- D. Insecure attachment
- E. Intermediary attachment

33.2 A 26-year-old married woman has recently learned she is pregnant. Her husband is an alcoholic, and has a history of childhood ADHD for which he still takes medication. This is his second marriage. They both work

P.278

as lawyers in a prestigious law firm and are financially well-off. The woman is concerned about her husband's temper, which she believes stems from his father having physically abused him.

Which of the following does not put this woman at an increased risk of domestic violence at this time?

- A. Alcoholic husband
- B. Pregnancy
- C. History of child abuse
- D. History of divorce
- E. History of ADHD

33.3 Chris is a 13-year-old boy who lives with his parents and 6-year-old sister. His sister was recently diagnosed with leukemia, and has begun chemotherapy treatments.

Chris's parents are extremely worried about their daughter and give her constant attention. Chris feels anger toward his sister for getting all the attention and begins playing roughly with her whenever he gets the chance.

Which of the following defense mechanisms best describes this behavior?

- A. Acting out
- B. Sublimation
- C. Projection
- D. Denial
- E. Repression

33.4 Mr. K is a 43-year-old who owns his own contracting company and loves his job. His father recently helped him expand his business by giving him a generous financial contribution. Because of this contribution, his father now feels he is entitled to more of a say in the day-to-day activities of the company. Mr. K is beginning to feel smothered and questions whether he should have accepted the gift from his father. He now dreads going to work because he knows his father will call with even more changes he would like implemented. He tells you he feels like he is being treated like a child.

Mr. K is being challenged by his father in which of the following areas?

- A. Autonomy
- B. Triangulation
- C. Identity

D. Achievement

E. Financially

33.5 Four-year-old identical twins Mark and Michael are active and rambunctious. Their parents enforce only a few rules in the household, and feel their children should be free to explore their environment as they choose. When the twins do break rules, they are reasoned with and then allowed to continue play, usually without punishment.

Mark and Michael's parents are exhibiting which of the following types of parenting styles?

A. Authoritarian

B. Permissive

C. Authoritative

D. Naturalist

E. Secure

33.6 Based on the above case, Mark and Michael are most likely to exhibit which of the following childhood characteristics?

A. Withdrawn and conflicted

B. Accepting and engaged

C. High social and cognitive functioning

D. Aggressive, impulsive, low achievement

E. Rejecting and neglecting

Directions

For each numbered statement, select the *one* lettered diagnosis that is most closely associated with it. Each lettered heading may be used once, more than once, or not at all.

Questions 33.7–33.10

33.7 A 32-year-old recently married man has remained good friends with one of his ex-girlfriends; the man's wife resents this relationship and always starts arguments with the ex whenever she calls their house. Otherwise, things have been very good between the couple.

33.8 A teenage girl is angry with her parents for snooping in her room, and is becoming increasingly withdrawn and rebellious.

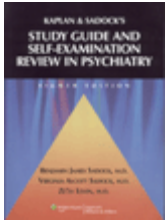
33.9 A 60-year-old woman with breast cancer has a radical mastectomy; she and her husband now get into constant fights because she is no longer interested in sex.

33.10 The youngest son in a family of four has a personality just like his oldest brother; as a result, the two have always bickered and gotten into fist fights since

they were children.

- A. Relational problem linked to a mental disorder or general medical condition
- B. Parent–child relational problem
- C. Partner relational problem
- D. Sibling relational problem
- E. Relational problem not otherwise specified





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



34

Problems Related to Abuse or Neglect

Abuse and neglect of children and adults are major public health concerns in the United States. According to the U.S. Department of Health and Human Services, there are an estimated 900,000 children who are victims of child abuse or neglect each year. More than 60 percent of child victims experienced neglect.

The actual occurrence rates are likely to be higher than estimates, because many maltreated persons go unrecognized, and many are reluctant to report the abuse. Child fatalities are the most tragic consequence of maltreatment, as an estimated 1,500 children died due to abuse or neglect in 2003. Problems related to abuse and neglect are defined as physical abuse of a child or adult, sexual abuse of a child or adult (including rape, sexual coercion, and sexual harassment), and neglect of a child.

More than 50 percent of abused or neglected children were born prematurely or had low birth weight. Many abused children are perceived by their parents as difficult, slow in development or mentally retarded, bad, selfish, or hard to discipline. More than 80 percent of abused children are living with married parents at the time of the abuse and 90 percent of abusing parents were abused by their own parents.

The only sure way of proving infant abuse or neglect, other than catching the perpetrator in the act, is to show that significant recovery occurs when the caretaking is altered. All markedly deprived infants should warrant an investigation of the social and environmental conditions of the family and the psychological status of the parent in order to determine the factors responsible for inadequate and destructive treatment. Parents who abuse substances, who suffer from psychotic or pronounced mood disorders, or who are severely personality disordered are at higher risk for impaired judgment and potentially abusive behavior.

Child abuse and neglect may be suspected when a child appears unduly afraid (especially of the parents), the child is kept confined for overly long periods of time, the child shows evidence of repeated skin or other injuries, the child is undernourished, the child is dressed inappropriately for the weather, the child cries often, and the child has bruising/pain/itching in the genital or anal region or repeated urinary tract infections and vaginal discharges. Unusually precocious knowledge of sexual acts may indicate sexual abuse. Clinicians are required to report suspected cases of child abuse or neglect and must be familiar with the current laws and regulations in their individual states.

Sexual or physical abuse of adults, including the elderly, is also a major problem in the United States. Spouse abuse, for example, is thought to occur in as many as 12 million families in this country, and there are estimated to be almost 2 million battered wives. The age range for rape cases in the United States is reported to be from infancy to the 80s and 90s, and the FBI reports that there are more than 80,000 rapes each year. It has been estimated that only 10 to 25 percent of rapes are ever reported to the proper authorities. About 10 percent of rapes are perpetrated by close relatives, and 50 percent are committed by men known to varying degrees by the victim. Elder abuse is seen in nursing homes and other institutions, as well as in some private households where the demands of caring for a frail, helpless, or demented person can lead individuals to commit acts of physical or sexual abuse.

The student should study the questions and answers below for a useful review of these problems.

Helpful Hints

The student should know the following words and terms.

- annual deaths
- child abuse
- child pornography
- dysthymic disorder
- emotional deprivation
- environmental factors
- family characteristics
- functional impairment
- genetic factors
- hyperactivity
- incest: father–daughter mother–son
- irritable versus depressed mood
- learning disability
- low-birth-weight child
- major depressive disorder
- mania
- mood disorders
- National Committee for the Prevention of Child Abuse
- physician's responsibility
- polysomnographic findings
- precocious sexual behavior
- premature child
- prevention
- psychotic symptoms
- retinal hemorrhages
- secondary complications

- suicide
- symmetrical injury patterns

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is best in each case.

34.1 Workplace violence is documented to be increased in all of the following professions *except*

- A. Law enforcement
- B. Computer specialists
- C. Mental health workers
- D. Taxi drivers
- E. Bartenders

34.2 Which of the following statements regarding torture is false?

- A. It is the infliction of physical or mental suffering.
- B. It is practiced in 125 countries around the world.
- C. It is always used to get victim to reveal compromising information.
- D. It is an underrecognized problem.
- E. Survivors of torture experience symptoms associated with PTSD and major depressive disorder.

34.3 True statements about typical physical injuries related to abuse include all of the following *except*

- A. Less than 50 percent of serious intracranial injuries sustained in the first year of life result from physical abuse.
- B. Subdural bleeding ranks among the most dangerous inflicted injuries.
- C. Retinal tearing can be caused by shaking injuries.
- D. Falls from 1 to 3 feet rarely result in subdural hematomas or clavicle fractures.
- E. Bilateral black eyes immediately following facial trauma generally indicates intentional injury.

34.4 Secondary victimization is characterized by all of the following *except*

- A. Disbelief and denial
- B. Discounting

- C. Blaming the victim
- D. Verbal abuse
- E. Stigmatization

34.5 Which of the following statements about rape is incorrect?

- A. Rapes are usually premeditated.
- B. Rape most often occurs in a woman's own neighborhood.
- C. Fifty percent of all rapes are perpetrated by close relatives of the victim.
- D. The age range reported for rape cases in the United States is 15 months to 82 years.
- E. According to the Federal Bureau of Investigation, more than 80,000 rapes are reported each year.

34.6 Spouse abuse is

- A. carried out by men who tend to be independent and assertive
- B. a recent phenomenon
- C. least likely to occur when the woman is pregnant
- D. directed at specific actions of the spouse
- E. an act that is self-reinforcing

34.7 Carol, 4 years of age, had a change in her behavior at preschool approximately 3 months after the birth of her sister. Her teacher saw Carol push other children and hit a classmate with a wooden block, causing a laceration of the child's lip. When Carol's teacher took her aside to talk about her behavior, she noticed what seemed to be belt marks on Carol's abdomen and forehead. Carol has also been reluctant to run outside with the other kids when it is time to go home.

Which of the following is the most likely diagnosis in this case?

- A. Child abuse
- B. Child neglect
- C. Normal behavior
- D. Conduct disorder
- E. Oppositional defiant disorder

34.8 Which of the following forms of incest is most common?

- A. Father-son
- B. Brother-brother
- C. Mother-daughter
- D. Father-daughter

E. Uncle–niece

34.9 Which of the following statements about rape is *false*?

- A. About 10 to 25 percent of rapes are reported to authorities.
- B. The greatest danger of rape exists for women aged 16 to 24.
- C. Most men who commit rape are between 25 and 44 years of age.
- D. Alcohol is involved in at least 75 percent of forcible rapes.
- E. About 50 percent of rapes are committed by strangers.

34.10 Which of the following is the correct order of the five phases of child sexual abuse?

- A. Engagement, Secrecy, Sexual Interaction, Suppression, Disclosure
- B. Sexual Interaction, Secrecy, Disclosure, Suppression, Engagement
- C. Engagement, Sexual Interaction, Secrecy, Disclosure, Suppression
- D. Secrecy, Engagement, Sexual Interaction, Suppression, Disclosure
- E. Secrecy, Sexual Interaction, Engagement, Disclosure, Suppression

P.282

34.11 The parents of a 9-year-old boy were divorced, and he spent the summers visiting his father. When he returned from visitation, the mother noticed injuries: a healing cut on the boy's right ear and a collection of superficial, vertical scratches from his umbilicus to his pubis. She had the boy disrobe and took Polaroid photographs of his abdomen.

Several days later, the mother took the boy and the photographs to the boy's regular psychotherapy appointment.

She told the therapist that she was concerned that the boy had been physically and sexually abused.

What is the most appropriate next step of the psychotherapist?

- A. Notify child protective services
- B. Talk to the boy about where the injuries came from
- C. Call the boy's father and inquire about abuse
- D. Refer the family to a general internist
- E. Tell the mother she has nothing to worry about

34.12 Which of the following statements about incest is true?

- A. About 15 million women in the United States have been the victims of incestuous attacks.
- B. One-third of incest cases occur before the age of 9.

- C. It is most frequently reported in families of low socioeconomic status.
- D. Father–daughter incest is the most common type.
- E. All of the above

34.13 Which of the following provides the best proof that child abuse is occurring?

- A. Significant recovery when the caretaking is altered
- B. Child shows evidence of repeated skin injuries
- C. Failure to thrive
- D. Child is dressed inappropriately for the weather
- E. Unusual knowledge of sexual acts

Directions

The questions below consist of lettered headings followed by a list of numbered statements. For each numbered statement, select:

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 34.14–34.17

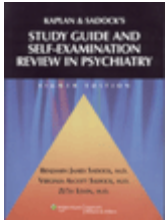
34.14 Father of an 8-year-old boy fails to enforce the boy’s school attendance

34.15 Teenage mother repeatedly slaps her toddler and refuses to give him any more to eat after he spills food on the floor

34.16 Twelve-year-old female is kicked out of her home after lying to her mother

34.17 Husband verbally threatens and belittles his wife when she spends too much money

- A. Abuse
- B. Neglect



Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



35

Additional Conditions That May Be a Focus of Attention

There are many types of problems that bring persons into contact with the mental health care system. Once in the system, persons with a condition that may be a focus of clinical attention should have a thorough neuropsychiatric evaluation, which may or may not uncover a mental disorder. The category of conditions that are not diagnosable mental disorders is important to psychiatrists because these conditions may accompany mental illness or may be harbingers of underlying mental disorders. The revised 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) lists and describes 13 such conditions that may or may not be associated with mental disorders, and may or may not be precursors of mental disorders. However, all of these conditions can be identified only when they are not directly attributable to a specific mental or neurological disorder. These 13 conditions are noncompliance with treatment, malingering, adult antisocial behavior, child or adolescent antisocial behavior, borderline intellectual functioning, age-related cognitive decline, bereavement, academic problem, occupational problem, identity problem, religious or spiritual problem, acculturation problem, and phase-of-life problem.

Malingering is the conscious and intentional feigning of physical or psychological symptoms for some clearly definable goal, such as to avoid responsibilities or to receive free compensation. Clinically, it is often crucial to distinguish malingering from true mental illnesses such as factitious, somatoform, or dissociative disorders. Malingering may be associated with child, adolescent, or adult antisocial behavior, which is characterized by engaging in illegal or immoral activities. However, the antisocial behavior in these conditions never reaches the level necessary to diagnose an antisocial personality disorder.

Bereavement is a condition that can become the focus of clinical attention, even if it does not progress to the outright acute mental disorder of depression. The clinician must be aware of the difference between normal bereavement and depression and be alert for the development of more serious symptoms.

Examples of an occupational problem include job dissatisfaction and uncertainty about career choices. A phase-of-life problem might be associated with such major life-cycle changes as starting college, getting married, or having children. Stress during times of

cultural transitions, such as moving to a new country or entering the military, can lead to an acculturation problem. Young people who join cults might provide examples of a religious or spiritual problem. Age-related cognitive decline must be distinguished from dementia, while borderline intellectual functioning must be distinguished from diagnosable developmental delays or specific learning disorders. Academic problem, identity problem, and noncompliance with treatment are the remaining conditions addressed in this chapter and the student should be able to describe and recognize their characteristics.

The student should study the questions and answers below for a useful review of these conditions.

Helpful Hints

The students should know the following terms.

- acculturation problem
- adherence
- adoption studies
- age-associated memory decline
- antisocial behavior
- bereavement
- brainwashing
- compliance
- conditioning
- coping mechanisms
- cults
- cultural transition
- culture shock
- dual-career families
- job-related stress
- kleptomania
- malingering
- marital problems
- mature defense mechanisms
- medicolegal context of presentation
- noncompliance
- noncustodial parent
- normal grief
- occupational problem
- patient–doctor match
- phase-of-life problem
- religious or spiritual problem
- sociopathic
- stress
- superego lacunae

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

35.1 Brainwashing

- A. is the deliberate creation of cultural shock
- B. relies on both mental and physical coercion
- C. is often followed by guilt and depression
- D. was first practiced on U.S. prisoners
- E. All of the above

35.2 Adult antisocial behavior differs from antisocial personality disorder in that:

- A. Antisocial behavior does not require a previous diagnosis of conduct disorder
- B. Antisocial behavior occurs more often in females
- C. Antisocial behavior is considered a mental disorder
- D. Antisocial behavior must begin before age 25
- E. None of the above

35.3 Malingering should be strongly suspected in all of the following cases *except*

- A. When an attorney refers the patient to the clinician
- B. When the patient has antisocial personality disorder
- C. With a marked discrepancy exists between the claimed stress and objective findings
- D. When the patient is incarcerated
- E. When there is a lack of cooperation during examination and treatment

35.4 Academic problems

- A. cannot be diagnosed if due to a mental disorder
- B. can be diagnosed only if they are the result of factors external to the student, such as family difficulties or social stressors
- C. are evidenced by a pattern of academic underachievement or a decline from a previous level of functioning
- D. intelligence tests are rarely useful in making the diagnosis
- E. none of the above

35.5 Occupational problems as defined by DSM-IV-TR can be associated with

- A. suicide risk
- B. domestic violence
- C. working teenagers
- D. loss of a job
- E. all of the above

35.6 Exit therapy is designed to help people

- A. with adult antisocial behavior
- B. with acculturation problems
- C. who are involved in cults
- D. with occupational problems
- E. in bereavement

35.7 True statements about compliance include

- A. Noncompliance is more common and roughly double among inpatients than among outpatients.
- B. Modification in lifestyles is more easily achieved than medication compliance.
- C. Compliance is a particular problem in disorders such as glaucoma.
- D. Compliance is improved if patients view their disease as not terribly serious.
- E. None of the above

35.8 Malingered amnesia is

- A. probably the least common clinical presentation of malingering
- B. difficult to feign
- C. easy to detect
- D. more convincing when global rather than spotty and episode-specific
- E. none of the above

35.9 Borderline intellectual functioning

- A. is defined as an IQ below 70
- B. is essentially the same as mental retardation
- C. is usually diagnosed after completion of school
- D. is present in approximately 14 percent of the general population
- E. none of the above

35.10 Which of the following is not considered a mental disorder?

- A. Factitious disorder
- B. Antisocial personality disorder
- C. Malingering
- D. Hypochondriasis
- E. Somatization disorder

35.11 Antisocial behavior is generally characterized by

- A. poor intelligence
- B. heightened nervousness with neurotic manifestations
- C. often successful suicide attempts
- D. lack of remorse or shame
- E. all of the above

35.12 Which of the following statements involving women in the work force is *false*?

- A. More than 50 percent of all mothers in the work force have preschool-aged children.
- B. Specific issues that should be addressed are provisions for child care or for care of elderly parents.
- C. Managers are more sensitive to crises in women employees' lives than in men employees' lives.
- D. Ninety percent of women and girls alive today in the United States will have to work to support themselves.
- E. Managers often ignore the stress placed on a worker by the illness of a child.

35.13 A person who malingers

- A. often expresses subjective, ill-defined symptoms
- B. should be confronted by the treating clinician
- C. is usually found in settings with a preponderance of women
- D. rarely seeks secondary gains
- E. can achieve symptom relief by suggestion or hypnosis

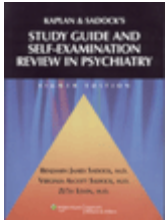
35.14 Causes of workplace distress include all of the following *except*

- A. Having too much to do
- B. Having too little to do
- C. Working for unhelpful managers

D. Being distracted at work by family problems

E. Entering the military





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



36

Emergency Psychiatric Medicine

Emergency psychiatry refers to the management of disorders of mood, thought, and behavior at a time of crisis. It entails assessment, development of a differential diagnosis of psychiatric and other medical causes of presenting symptoms, and diagnostic-specific pharmacotherapy, medical and surgical therapy, psychotherapy, and sociotherapy. Psychiatric emergencies are often particularly disturbing because they do not just involve the body's reactions to an acute disease state, as much as actions directed against the self or others. These emergencies, such as suicidal acts, homicidal delusions, or a severe inability to care for oneself, are more likely than medical ones to be sensationalized when they end up on the front pages of newspapers. Although the emergency room is a poor substitute for continuing care by a mental health professional in an outpatient setting, many individuals without a usual source of care, particularly the uninsured, use emergency care clinicians for primary care.

Psychiatric emergencies arise when mental disorders impair people's judgment, impulse control, or reality testing. Such mental disorders include all the psychotic disorders, manic and depressive episodes in mood disorders, substance abuse, borderline and antisocial personality disorders, and dementias. There may also be emergencies related to particularly severe reactions to psychiatric medications, such as neuroleptic malignant syndrome or acute agranulocytosis, which must be recognized, diagnosed, and treated immediately.

The most common psychiatric emergency is suicide, which is reported to be the eighth leading cause of death in the United States. Clinicians must be aware of the relevant risk factors for suicide (such as age, sex, race, marital status, occupation, family history, physical and mental health, and past suicidal behavior), but must also be aware that the suicidal patient they are evaluating in the emergency room may not necessarily have any of them. Major depressive disorder, alcohol abuse, and schizophrenia are all associated with a higher than usual risk for suicide, as is a positive family history for suicide. Genetic influence in the expression of suicidal behavior has been postulated, and there appears to be substantiating evidence for this in twin and adoption studies. However, a behavior as complex as suicide cannot be reduced to any simplistic biological formulation.

Psychiatrists must learn how to evaluate a suicidal or homicidal patient and must learn how to ask the questions that will help reveal the suicidal or homicidal plan or intent. A

skilled clinician will combine this information with a sense of the person's overall risk, based on detailed knowledge of the person's history as well as overall knowledge of suicidal and homicidal behaviors in the context of mental impairment.

The student should study the questions and answers below for a useful review of this subject.

Helpful Hints

These terms relate to psychiatric emergencies and should be defined.

- acute intoxication
- adolescent suicide
- age of suicide
- akinetic mutism
- alcohol dependence
- alcohol withdrawal
- alkalosis
- amnesia
- anniversary suicide
- anorexia nervosa
- bulimia nervosa
- copycat suicides
- delirious state
- delirium
- dementia
- drugs and suicide
- DTs
- Emile Durkheim
- dysmenorrhea
- ECT
- exhaustion syndrome
- grief and bereavement
- headache
- 5-HIAA in CSF
- hyperthermia
- hypertoxic schizophrenia
- hyperventilation
- hypnosis
- hypothermia
- inpatient vs. outpatient treatment
- insomnia
- lethal catatonia
- method

- miosis
- mood disorders
- "Mourning and Melancholia"
- mydriasis
- nystagmus
- opioid withdrawal:
- anxiolytic
- hypnotic
- sedative
- panic disorder
- platelet MAO activity
- posttraumatic stress disorder mania
- premenstrual dysphoric disorder
- prevention center
- psychiatric interview
- psychotic disorders
- psychotic withdrawal
- restraints
- suicidal depression

-
- suicidal thoughts
 - suicidal threats
 - suicide:
 - altruistic
 - anomic
 - egoistic
 - suicide belt
 - suicide rate
 - Thanatos
 - violence and assaultive behavior
 - Wernicke's encephalopathy
 - Werther's syndrome

P.292

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

36.1 The first task in evaluating violent behavior should be

- A. establishing a treatment plan

- B. obtaining information from observers
- C. ascertaining degree of injuries
- D. determination of cause
- E. admission to the hospital

36.2 Which of the following most closely represents Freud's theory on suicide?

- A. Suicide represents aggression turned inward against an introjected love object
- B. Suicide as inverted homicide because of a patient's anger toward another person
- C. Suicide as an unconscious wish for revenge
- D. Suicide consists of three components: the wish to kill, the wish to be killed, and the wish to die
- E. None of the above

36.3 The use of restraints in an emergency setting should include all of the following principles *except*

- A. Explanation to the patient why he or she is being placed in restraints
- B. Patients should be restrained with legs spread-eagled
- C. Patient's head should be raised slightly
- D. Leather restraints should be used as they are the safest and surest
- E. Once in restraints, there is no need for antipsychotic medications

36.4 Which of the following is *not* an indication for the use of psychotropic medication in the psychiatric emergency room?

- A. Assaultive behavior
- B. Massive anxiety
- C. Extrapyramidal reactions
- D. Anticholinergic intoxication
- E. None of the above

36.5 Which of the following statements regarding emergency room visits is *true*?

- A. More psychiatric emergency visits occur during the night hours.
- B. Married persons use psychiatric emergency rooms more often.
- C. Approximately 50 percent of the persons using emergency rooms are violent.
- D. There are more psychiatric emergency visits on weekends.
- E. All of the above

36.6 Which of the following statements correctly defines *anomic suicide*?

- A. Suicide among those persons not strongly integrated into any social group.
- B. Suicide among those persons whose integration into society is disturbed.
- C. Suicide among those whose integration into a group is excessive.
- D. Suicide among those who reject society as a whole.
- E. None of the above.

36.7 Which of the following neurobiological findings is associated with suicide?

- A. increased 5-hydroxyindoleacetic acid (5-HIAA) levels in the cerebrospinal fluid (CSF)
- B. changes in the dopaminergic system
- C. serotonin deficiency
- D. increased levels of platelet monoamine oxidase (MAO)
- E. normal findings on electroencephalogram (EEG)

36.8 Among men, suicide peaks after age 45; among women, it peaks after age

- A. 35
- B. 40
- C. 45
- D. 50
- E. 55

36.9 [Figure 36.1](#) shows the U.S. distribution, according to race and sex, of which of the following?

- A. The prevalence of schizophrenia
- B. Rates of alcohol-related disorders
- C. Rates of suicide attempts (successful and unsuccessful)
- D. Death rates for suicide
- E. Prevalence of bipolar disorder

36.10

Your patient is a 25-year-old female graduate student in physical chemistry who was brought to the emergency room by her roommates, who found her sitting in her car with the motor running and the garage door closed. The

P.293

patient had entered psychotherapy 2 years before, complaining of long-standing unhappiness, feelings of inadequacy, low self-esteem, chronic tiredness, and a generally pessimistic outlook on life. While she was in treatment, as before, periods of well-being were limited to a few weeks at a time. During the 2 months before her emergency room visit, she had become increasingly depressed, had had

difficulty in falling asleep and trouble in concentrating, and had lost 10 pounds. The onset of those symptoms coincided with a rebuff she had received from a chemistry instructor to whom she had become attracted.

The treatment of the patient could include

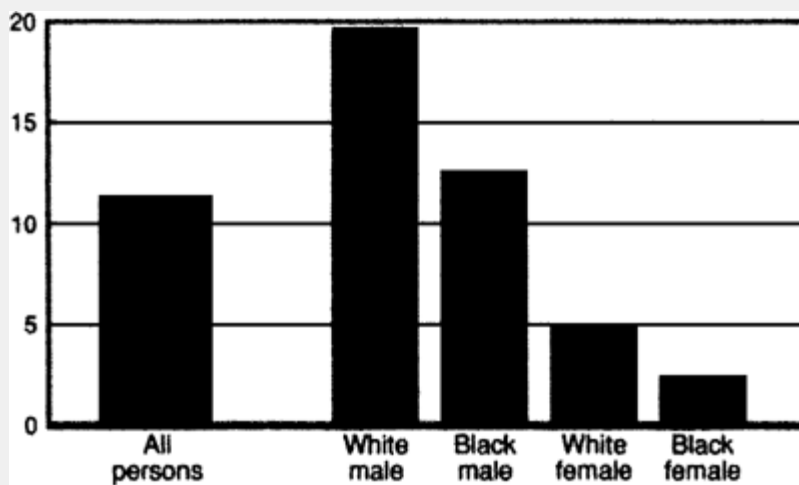


FIGURE 36.1 Reprinted with permission from National Center for Health Statistics. Health, United States, 1991. Hyattsville, MD: Public Health Service; 1992.

- A. hospitalization
- B. outpatient psychotherapy
- C. antidepressants
- D. electroconvulsive therapy
- E. all of the above

36.11 Suicide rates

- A. have remained relatively stable except for 15- to 24-year-olds, whose rates have decreased two- to threefold
- B. have averaged five per 1,000,000 in the 20th century
- C. make suicide the 8th leading cause of death in the United States
- D. reflect about 10,000 suicides each year in the United States
- E. none of the above

36.12 Suicide among schizophrenic patients

- A. is low
- B. is approximately 10 percent

- C. occurs most often in the later years of the illness
- D. occurs most often in older, women patients
- E. is most frequently secondary to command hallucinations

36.13 Increased rates of suicide attempts occur in patients with

- A. panic disorder
- B. social phobia
- C. personality disorders
- D. substance abuse
- E. all of the above

36.14 True statements about suicide in the elderly include

- A. Compared to other age groups, those 65 and older have the highest risk of committing suicide.
- B. The suicide rate for the elderly is more than ten times that of young persons.
- C. The least frequent means of committing suicide in the elderly is with a firearm.
- D. Alcoholism is less likely to be associated with suicide in the elderly than in younger people.
- E. All of the above

36.15 True statements about patients with parasuicidal behavior include

- A. About 50 percent are found to have a personality disorder at psychiatric assessment.
- B. About 40 percent have made previous attempts.
- C. About 1 percent of persons who attempt suicide will commit suicide during the following year.
- D. Suicide risk is particularly high during the first year after a suicide attempt.
- E. All of the above

36.16 The presence of medical illness should be strongly considered when

- A. Psychiatric symptoms appear suddenly in a previously well-functioning person.
- B. There is a reported personality change or marked lability of mood.
- C. Psychotic symptoms appear for the first time after the age of 30.
- D. Temperature, pulse, or respiratory rate is increased.
- E. All of the above

36.17 Suicidal behavior

- A. tends not to be familial
- B. is not associated with a family history of suicide
- C. has been found to have the same concordance rate in dizygotic as in monozygotic twins
- D. occurs more frequently in the biological relatives of adoptees who commit suicide than in the adoptive relatives
- E. none of the above

Directions

The group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 36.18–36.23

36.18 Treated with propranolol (Inderal)

36.19 Toxic interaction with meperidine hydrochloride (Demerol)

36.20 Phenothiazines contraindicated

36.21 Fever, pancytopenia, hypoglycemic coma, renal failure

36.22 Pale, cyanotic, respiratory depression, pinpoint pupils

36.23 Seizure with withdrawal

A. Opioid OD

B. Barbiturates

C. Phencyclidine (PCP) OD

D. Monoamine oxidase inhibitors (MAOIs)

E. Acetaminophen (Tylenol) OD

P.294

Questions 36.24–36.27

36.24 Bromide intoxication

36.25 Korsakoff's syndrome

36.26 Idiosyncratic alcohol intoxication

36.27 Wernicke's encephalopathy

A. Delirium, mania, depression, psychosis

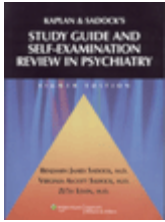
B. Marked aggressive and assaultive behavior

C. Alcohol stigmata, amnesia, confabulation

D. Mental confusion, oculomotor disturbances, cerebellar ataxia

E. None of the above





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](http://www.lippincott.com)



37

Psychotherapies

The variety of psychotherapies in psychiatry reflects the multi-etiological theoretical basis of the field in general. Skilled clinicians are aware of all available therapies, but may choose to focus their treatments on just one, or utilize different aspects of the different therapies, depending on the problem or the patient.

Most of the important and useful theories recognize that human behavior and emotion cannot be reduced to a simple biological versus psychological equation, and that a true understanding of human functioning begins with adhering to a bio-psycho-social etiologic model.

Students should be aware of the theories that underlie the different therapies, as well as the indications and contraindications proposed for each. The student should be familiar with the most prominent therapies, which include psychoanalytic, supportive, cognitive, behavioral, family, group, brief therapies, and some of the manualized treatments like dialectical behavior therapy for borderline patients.

The psychoanalytic therapies are based on Freudian principles of a dynamic unconscious and psychic determinism, and they are all oriented toward the patient's acquisition of insight. Psychoanalysis is a treatment unto itself that differs from psychoanalytic psychotherapy and brief dynamic therapies. Students should understand the differences between these treatments, and their differing goals, techniques, and interventions. Supportive psychotherapy has its roots in analytic theory, but focuses on strengthening healthy defenses to maximize function.

Cognitive therapies or cognitive-behavioral therapies are usually short-term structured treatments that aim to correct illogical or irrational thinking, which can lead to dysfunctional attitudes and behaviors. Behavioral therapies focus on overt, observable behaviors and are unconcerned with underlying causes. These therapies are based on learning theory, which posits that learned behavior is reinforced and conditioned in a variety of ways.

Family therapies are based on general systems theory and focus on patterns of family communication and interaction. Group therapies run the theoretical gamut and may be supportive, psychoanalytic, cognitive, or behavioral in their orientation. Dialectical behavior therapy (DBT) a manualized treatment, cognitive-behavioral in theoretical

background, is designed to treat the destructive behaviors associated with borderline personality disorder. There are many other therapies, like biofeedback, eye-movement desensitization and reprogramming (EMDR) and interpersonal psychotherapy for depression with which the student should be familiar.

The student should study the questions and answers below to test his or her knowledge of the subject.

Helpful Hints

The names of the workers, their theories, and the therapy techniques should be known to the student.

- AA, GA, OA
- abreaction
- analyst incognito
- Anna O.
- assertiveness
- authority anxiety
- autogenic therapy
- aversive therapy
- Michael Balint
- Aaron Beck
- behavioral medicine
- bell and pad
- Hippolyte Bernheim
- Murray Bowen
- cognitive rehearsal
- cognitive triad of depression
- cohesion
- combined individual and group psychotherapy
- confidentiality
- countertransference
- crisis intervention
- crisis theory
- day's residue
- disorders of self-control
- disulfiram (Antabuse) therapy
- double and multiple double
- dyad
- early therapy
- ego psychology
- eye-roll sign
- H.J. Eysenck
- family group therapy

- family sculpting
- family systems
- family therapy
- flexible schemata
- flooding
- galvanic skin response
- genogram
- Gestalt group therapy
- graded exposure
- group psychotherapy
- guided imagery
- hierarchy construction
- homogeneous versus heterogeneous groups
- hypnosis
- hypnotic capacity and induction
- hysteria
- identified patient
- implosion

-
- insight-oriented psychotherapy
 - intellectualization, interpretation
 - interpersonal psychotherapy
 - Jacobson's exercise
 - Daniel Malan
 - mental imagery
 - mirror technique
 - Jacob Moreno
 - operant conditioning
 - parapraxes
 - participant modeling
 - patient–therapist encounter
 - peer anxiety
 - positive reinforcement
 - psychodrama
 - psychodynamic model
 - psychotherapeutic focus
 - psychotherapy
 - reality testing
 - reciprocal inhibition
 - relaxation response

- resistance
- reward of desired behavior
- Carl Rogers
- role reversal
- rule of abstinence
- schemata
- Paul Schilder
- self-analysis
- self-help groups
- self-observation
- Peter Sifneos
- B.F. Skinner
- splitting
- structural model
- structural theory
- *Studies on Hysteria*
- supportive therapy
- systematic desensitization
- tabula rasa
- testing automatic thoughts
- token economy
- transactional group therapy
- transference, transference neurosis, negative triangulation
- universalization
- ventilation and catharsis

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the one that is best in each case.

37.1 Which of the following is an important patient requisite of suitability for psychoanalysis?

- A. high anxiety
- B. strong dependency issues
- C. the ability to form a relationship
- D. poor impulse control
- E. alexithymia

37.2 Supportive psychotherapy

- A. places major etiological emphasis on intrapsychic events
- B. is indicated primarily for patients whose potential for decompensation is low
- C. involves genetic interpretations
- D. involves the judicious suspension of therapeutic neutrality
- E. facilitates a regressive transference

37.3 In the last session of a long-term therapy, the patient talked at great length about car problems he had encountered on the way to the session. The therapist commented, "I think you'd rather talk about your car than face the sadness you're feeling about our last session."

The therapist's intervention is an example of

- A. a clarification
- B. an empathic validation
- C. an affirmation
- D. a confrontation
- E. an interpretation

37.4 Brief focal psychotherapy

- A. is very helpful for self-destructive acting out patients
- B. does not focus on transference
- C. involves a detached therapist
- D. involves setting a termination date in advance
- E. usually lasts less than ten to twelve sessions

37.5 Ms. A, a 29-year-old never-married vice president in a successful business, presented with a 9-month history of depression. She described her involvement in a relationship with her superior at work, which they both desired but which work policy forbade. Her symptoms emerged under the pressure she felt to resolve this situation, from which she saw no way out. Neither she nor her boyfriend wanted to leave their jobs, and neither wanted their relationship to end, yet exposure of their secret threatened both their jobs.

The therapist thought the patient would benefit from Interpersonal Psychotherapy to treat her depression. IPT

- A. would focus on Ms. A's past relationships as a guide for managing this one
- B. is an open-ended treatment
- C. would focus on Ms. A's unresolved grief
- D. places the patient in the sick role

E. involves a passive therapist

37.6 Dialectical behavior therapy (DBT)

A. is a cognitive behavioral treatment

B. has not been empirically evaluated for efficacy

C. does not directly target suicidal behavior

D. focuses on patient insight

E. favors in-patient treatment when self-destructive risk is high

37.7 A spiritual assessment

A. involves learning about the patient's beliefs

B. addresses issues of meaninglessness

C. empowers the patient to find inner resources of strength

D. is completed during the social history section of the history and physical

E. all of the above

P.302

37.8 Flooding

A. is synonymous with "explosion"

B. involves relaxation exercises

C. is a hierarchical exposure technique

D. works best with specific phobias

E. is indicated in anxious patients who are psychologically fragile because of its rapid response rate

37.9 The goals of social skills training include all of the following *except*

A. decreasing social anxiety

B. generalization of the acquired skills to similar situations

C. acquisition of conversational skills

D. acquisition of insight into the social deficit

E. relearning of social skills

37.10 Which of the following methods is not used in biofeedback?

A. Electromyography

B. Electroencephalography

C. Galvanic skin response

- D. Strain gauge
- E. All of the above

37.11 Systematic desensitization is applicable in the treatment of

- A. obsessive-compulsive disorder
- B. sexual disorders
- C. stuttering
- D. bronchial asthma
- E. all of the above

37.12 All of the following are considered to be possible flexible boundary issues in psychotherapy *except*

- A. self-disclosure by the therapist
- B. physical contact between therapist and patient
- C. sexual contact between therapist and patient
- D. gift-giving and receiving
- E. extra-analytic contacts

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 37.13–37.17

37.13 Patient's agreement to tell the therapist everything, without selection

37.14 Saying whatever comes to mind

37.15 Analyst's way of listening to the patient

37.16 The relationship between two adults entering into a joint venture

37.17 Unconscious ideas are prevented from reaching awareness

- A. free association
- B. fundamental rule
- C. free floating attention
- D. resistance
- E. working alliance

Questions 37.18–37.22

37.18 The sense that the group is working together toward a common goal

37.19 The process in which the expression of emotion by one member stimulates the awareness of similar emotions in another member

37.20 The act of one member helping another

37.21 The awareness of the patient that he or she is not alone in having problems

37.22 The expression of suppressed feelings to other group members

- A. contagion
- B. altruism
- C. ventilation
- D. cohesion
- E. universalization

Questions 37.23–37.26

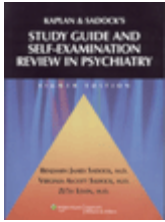
37.23 Focuses on a person's differentiation from their family of origin

37.24 Emphasizes individual freedom from unconscious patterns of anxiety and projection rooted in the past in the context of the family system

37.25 Every action in a family produces a reaction in one or more of its members

37.26 Families are viewed as single interrelated systems

- A. the Bowen model
- B. the structural model
- C. the psychodynamic-experiential model
- D. the general systems model



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



38

Biological Therapies

The use of drugs to treat psychiatric disorders is often the foundation for a successful treatment approach that can also include other types of interventions such as psychotherapy or behavioral therapies. As knowledge about the biology of normal and abnormal brain function continues to grow, the practice of clinical psychopharmacology continues to evolve in scope and effectiveness. Those involved in the prescribing and clinical follow-up of psychiatric drug treatments must remain current with the research literature, including the emergence of new agents, the demonstration of new indications for existing agents, and the identification and treatment of drug-related adverse effects. The emergence of new drugs and new indications is one of the most exciting areas of psychiatry.

The practice of pharmacotherapy in psychiatry should not be oversimplified—for example, it should not be reduced to a one-diagnosis-one-drug approach. Many variables affect the practice of psychopharmacology, including drug selection and administration; the psychodynamic meaning to the patient; and family and environmental influences. Some patients may view drug treatment as a panacea; others may view it as an assault. The patient, the patient's relatives, and the nursing staff must be instructed on the reasons for the drug treatment as well as the expected benefits and potential risks. In addition, the clinician may find it useful to explain the theoretical basis for pharmacotherapy to the patient and other involved parties.

Drugs must be used in effective dosages for sufficient periods, as determined by previous clinical investigations and clinical experience. Subtherapeutic doses and incomplete therapeutic trials should not be used simply because the psychiatrist is excessively concerned that the patient will develop adverse effects. The use of dosages that are too low or durations that are too short merely exposes patients to some risk, without providing them the maximum chance of therapeutic benefit. Treatment response and the emergence of adverse effects must be monitored closely; drug dosage should be adjusted accordingly, and appropriate treatments for emergent adverse effects must be instituted as quickly as possible.

Students need to be aware of the pharmacokinetics and pharmacodynamics of psychiatric medications, including absorption, distribution, bioavailability, metabolism, and excretion, as well as receptor affinities, dose-response curves, therapeutic indices, the development

of tolerance and withdrawal syndromes, therapeutic indications, adverse effects, drug–drug interactions, and signs and symptoms of overdose. Modifications of dosages or specific drug indications for special populations, such as children, the elderly, suicidal patients, and those with medical conditions, must be understood.

The student should study the questions and answers below for a useful review of these therapies.

Helpful Hints

The student should know these terms and specific drugs.

- adjuvant medications
- adrenergic blockade
- akathisia
- allergic dermatitis
- amantadine (Symmetrel)
- anticholinergic side effects
- anticonvulsants
- antidepressants
- antipsychotics
- anxiolytics
- apnea
- artificial hibernation
- atropine sulfate
- benzodiazepine receptor agonists and antagonists
- Lucio Bini
- biotransformation
- bipolar I disorder, bipolar II disorder
- BPH
- bupropion
- buspirone (BuSpar)
- John Cade
- carbon dioxide therapy
- cardiac effects
- catatonia
- Ugo Cerletti
- cholinergic rebound
- clomipramine (Anafranil)
- clonazepam (Klonopin)
- clonidine (Catapres)
- CNS depression
- combination drugs
- continuous sleep treatment

CYP enzymes

- D2 receptors
- DEA
- demethylation
- depot preparations
- distribution volume
- dopamine receptor antagonists
- dose-response curve
- downregulation of receptors
- drug-assisted interviewing
- drug holidays
- drug-induced mania
- drug interactions
- drug intoxications
- drug selection
- dystonias

-
- eating disorders
 - Ebstein's anomaly
 - ECT
 - ECT contraindications
 - EEG, EMG
 - electrolyte screen
 - electrosleep therapy
 - epileptogenic effects
 - extrapyramidal side effects
 - FDA
 - fluoxetine (Prozac)
 - fluvoxamine (Luvox)
 - generalized anxiety disorder
 - geriatric patients
 - half-life
 - haloperidol (Haldol)
 - hematological effects
 - hemodialysis
 - hydroxylation and glucuronidation
 - hypertensive crisis
 - idiopathic psychosis
 - impulse-control disorders
 - informed consent
 - insulin coma therapy

- intoxication and withdrawal syndromes
- jaundice
- light therapy
- lipid solubility
- lithium
- MAOIs
- medication-induced movement disorders
- megadose therapy
- megavitamin therapy
- melatonin
- mesocortical
- mesolimbic
- metabolic enzymes
- metabolites
- methadone
- Egas Moniz
- monoamine hypothesis
- mood stabilizers
- movement disorders
- mute patients
- narcotherapy
- narrow-angle glaucoma
- neuroendocrine tests
- neuroleptic malignant syndrome
- noncompliance
- noradrenergic, histaminic cholinergic receptors
- obsessive-compulsive disorder
- oculogyric crisis
- orthomolecular therapy
- orthostatic (postural) hypotension
- overdose
- panic disorder with agoraphobia
- parkinsonian symptoms
- paroxetine (Paxil)
- pharmacodynamics
- pharmacokinetics
- phosphatidylinositol
- photosensitivity
- physostigmine
- pill-rolling tremor

- pilocarpine
- plasma levels
- positive and negative symptoms
- potency, high and low
- prolactin
- prophylactic treatment
- protein binding
- psychosurgery
- rabbit syndrome
- rapid neuroleptization
- Rauwolfia serpentina
- receptor blockade
- renal clearance
- retinitis pigmentosa
- retrograde ejaculation
- reuptake blockade
- schizoaffective disorder
- schizophrenia
- secondary depression
- secondary psychosis
- serotonin-dopamine antagonists
- sertraline (Zoloft)
- side-effect profile
- sleep deprivation
- SSRIs
- status epilepticus
- stereotactic
- sudden death
- sympathomimetic
- tapering
- tardive dyskinesia
- TD50
- teratogenic
- TFT
- therapeutic index
- therapeutic trial
- tonic, clonic phase
- transcranial magnetic stimulation (TMS)
- treatment-resistant patients
- tricyclic and tetracyclic drugs

I-Triiodothyronine

- triplicate prescription
- use in pregnancy
- Julius Wagner-Jauregg
- weight gain
- Zeitgebers
- zolpidem

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the *one* that is *best* in each case.

38.1 Bupropion

- A. does not act on the serotonergic system
- B. has an associated withdrawal syndrome linked to its discontinuation
- C. is not secreted in breast milk
- D. has a 1 percent seizure risk with doses above 400 mg/day
- E. is associated with significant drug-induced orthostatic hypotension

38.2 A patient being treated for alcohol dependence is started on acamprosate. Which of the following is *true*?

- A. Acamprosate produces aversive side effects if combined with alcohol.
- B. Acamprosate is a dopamine antagonist.
- C. Abrupt withdrawal of acamprosate is associated with autonomic instability.
- D. Acamprosate may be used to treat alcohol withdrawal.
- E. Patients with severe renal impairment should not be given acamprosate.

38.3 A 28-year-old man, diagnosed with Psychosis not otherwise specified was started on haloperidol 2 mg by mouth twice a day. On the sixth day of treatment, he developed a high white count, hyperthermia, severe muscular rigidity, confusion, and increased blood pressure and pulse rate. You suspect he has neuroleptic malignant syndrome. Which of the following about this condition is *true*?

- A. It usually occurs when patients are neuroleptic naïve.
- B. It is more common in the elderly.
- C. It is not associated with low-potency neuroleptics.
- D. Women are affected more frequently than men.
- E. Antiparkinsonian agents have been used to reduce the muscle rigidity.

38.4 Restless leg syndrome

A. is associated with painful dysesthesias

P.308

B. peaks in old age

C. responds to SSRIs

D. responds to dopamine receptor agonists

E. abates during sleep

38.5 Which of the following about clonidine is true?

A. Patients usually develop tolerance to clonidine-induced sedation.

B. Patients who overdose on clonidine present with dilated pupils.

C. It is primarily a presynaptic alpha-2 adrenergic receptor antagonist.

D. It results in a decrease in the amount of norepinephrine released from the presynaptic nerve terminals.

E. Often causes tachycardia.

38.6 Sildenafil

A. is rapidly absorbed after a fatty meal

B. is mostly excreted in the urine

C. decreases levels of cyclic guanosine monophosphate

D. is a nitric oxide enhancer

E. carries a high risk of priapism

38.7 In treating bipolar disorder

A. lamotrigine is more effective in lengthening the intervals between manic episodes than between depressive episodes

B. lithium exerts its antimanic effects over 1 to 3 weeks

C. lithium prevents relapse of mania in about fifty percent of patients

D. about 10 percent of patients with acute mania respond to valproate

E. carbamazepine is most useful in prior lithium responders

38.8 Which of the following tricyclic drugs is *least* associated with anticholinergic effects?

A. Amitriptyline (Elavil)

B. Clomipramine (Anafranil)

C. Desipramine (Norpramin)

- D. Imipramine (Tofranil)
- E. Trimipramine (Surmontil)

38.9 Which of the following is *true*?

- A. Lithium is not excreted in breast milk
- B. Lithium is unsafe in the elderly
- C. Lithium is contraindicated in patients with sick sinus syndrome
- D. Lithium cardiotoxicity is more prevalent in people on a high-salt diet
- E. Obesity is associated with lower rates of lithium clearance

38.10 Well-controlled studies have supported the use of carbamazepine (Tegretol) for which of the following disorders?

- A. Anorexia nervosa
- B. Insomnia
- C. Neuroleptic-induced parkinsonism
- D. Mania
- E. Social phobia

38.11 An internist calls you to ask about selecting a serotonin reuptake inhibitor for a patient of hers who is depressed. She tells you that the patient has never been treated with an antidepressant before, is on no other medications, and has no serious medical problems. Which of the following is *true*?

- A. Not all the SSRIs are equally effective in treating depression.
- B. Most of the SSRIs have similar serum half lives.
- C. The SSRIs have a narrow therapeutic index.
- D. Paroxetine has significant anticholinergic activity at higher dosages.
- E. The metabolites of citalopram have significant pharmacologic activity.

38.12 Which of the following is *true* about monoamine oxidase inhibitors (MAOIs)?

- A. The risk of tyramine-induced hypertension is high for someone on moclobemide.
- B. White wine together with an MAOI may precipitate a tyramine-induced hypertensive crisis
- C. Alkalinization of the urine hastens the excretion of MAOIs.
- D. People should continue to restrict tyramine-rich foods for at least one month after they stop MAOI treatment.
- E. Lithium together with an MAOI may induce a serotonin syndrome.

38.13 Which of the following is the most common adverse effect of olanzapine

(Zyprexa)?

- A. Constipation
- B. Orthostatic hypotension
- C. Sedation
- D. Tardive dyskinesia
- E. Weight gain

38.14 Potential treatments for the adverse sexual effects of the serotonin-specific reuptake inhibitors include each of the following drugs *except*

- A. amantadine (Symmetrel)
- B. bromocriptine (Parlodel)
- C. cyproheptadine (Periactin)
- D. liothyronine (Cytomel)
- E. yohimbine (Yocon)

38.15 Which of the following is the most important factor determining a successful response to treatment with naltrexone (ReVia)?

- A. Abstinence from opioids during therapy
- B. Dosage
- C. Duration of therapeutic trials
- D. Ability to start and stop naltrexone without physical consequences
- E. Psychosocial factors

P.309

38.16 The calcium channel blockers

- A. are first-line mood stabilizing agents
- B. are minimally absorbed after oral use
- C. have been shown to be effective in the treatment of depression
- D. have been shown to be beneficial in Tourette's disorder
- E. cause side effects secondary to their vasodilatory properties

38.17 A 32-year-old woman with a first episode of depression, and no prior treatment history, is started on thyroid hormone after three weeks of partial response to nortryptaline 75 mg/day. Which of the following is *true*?

- A. Laboratory values of thyroid hormone will help in assessing response to the hormone.
- B. The doctor waited the correct amount of time before beginning his augmentation strategy.

- C. Levothyroxine (T4) is the thyroid hormone most used for this purpose.
- D. Fifty percent of antidepressant nonresponders become treatment responders using thyroid hormone.
- E. She should be advised not to become pregnant on thyroid hormones, as they are associated with multiple serious congenital malformations.

38.18 Which of the following about the rash associated with lamotrigine is true?

- A. A serious rash may develop in almost 25 percent of patients taking lamotrigine.
- B. The development of a rash is not related to how the medication is administered.
- C. Approximately 8 percent of patients develop a benign maculopapular rash.
- D. There is no evidence to suggest that the rash is age related.
- E. Immediate discontinuation of the drug upon development of a rash prevents the subsequent development of a life-threatening rash.

38.19 Carbamazepine may decrease drug plasma concentrations of which of the following agents?

- A. Haloperidol (Haldol)
- B. Bupropion (BuSpar)
- C. Birth control pills
- D. Methadone (Dolophine)
- E. All of the above

38.20 Factors associated with a more favorable antimanic response to valproate than to lithium include

- A. rapid cycling
- B. mixed or dysphoric mania
- C. mania associated with medical or neurological illness
- D. comorbid substance abuse or panic attacks
- E. all of the above

38.21 Of the following, the most common adverse effect of valproate is

- A. reversible thrombocytopenia
- B. hair loss
- C. diarrhea
- D. persistent elevation of hepatic transaminases
- E. ataxia

38.22 Which statement is *not* true about the atypical antipsychotics?

- A. They all have proven efficacy as treatments for schizophrenia.
- B. They all have low D₂ receptor blocking effects compared with typical antipsychotics.
- C. They may have a reduced risk of extrapyramidal side effects compared to older agents.
- D. They have proven efficacy as treatments for acute mania.
- E. They have similar receptor affinities.

38.23 Which of the following drugs or foods is *not* contraindicated for concurrent administration with triazolobenzodiazepines such as alprazolam (Xanax), based on inhibition of the hepatic enzyme cytochrome P450 (CYP) 3A4?

- A. Cisapride (Propulsid)
- B. Grapefruit juice
- C. Nefazodone (Serzone)
- D. Venlafaxine (Effexor)
- E. All of the above

38.24 Carbamazepine affects each of the following organ systems *except*

- A. dermatological
- B. hematopoietic
- C. hepatic
- D. pulmonary
- E. renal

38.25 Which of the following drug interactions is *true*?

- A. Nicotine lowers concentrations of tricyclic antidepressants.
- B. Clozapine should not be prescribed together with carbamazepine.
- C. Indomethacin increases lithium levels.
- D. None of the above
- E. All of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered words or phrases. For each numbered word or phrase, select the *one* lettered heading that is most closely associated with it. Each heading may be selected once, more than once, or not at all.

38.26 seizures

38.27 ovarian cysts

38.28 QTc prolongation

38.29 diabetes

38.30 Stevens Johnson syndrome

- A. bupropion
- B. valproate
- C. ziprasidone
- D. carbamazepine
- E. valproate

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

38.31 A 28-year-old woman is brought to the emergency room heavily sedated, with a suspected overdose on sleeping medications. Flumazenil is considered as treatment. Which of the following is *true*?

- A. She should be given at least ten minutes of a cumulative dose of flumazenil before you rule out a benzodiazepine as the cause of her sedation.
- B. Flumazenil will have no effect if she overdosed on zolpidem.
- C. Your biggest concern about giving her flumazenil is that you may precipitate the onset of seizures.
- D. Flumazenil will reverse the effects if she took barbiturates.
- E. Flumazenil is administered as a rapid bolus injection.

38.32 True statements about pharmacodynamics include

- A. Haldol is less potent than chlorpromazine.
- B. Haldol is more clinically effective than chlorpromazine.
- C. The therapeutic index for Haldol is high.
- D. The therapeutic index for lithium is high.
- E. None of the above

38.33 Of the following biological treatments the most teratogenic is

- A. Electroconvulsive therapy (ECT)
- B. Haloperidol (Haldol)

- C. Fluoxetine (Prozac)
- D. Lithium (Eskalith)
- E. Lorazepam (Ativan)

38.34 Blockade of muscarinic acetylcholine receptors causes all of the following side effects *except*

- A. mydriasis
- B. urinary retention
- C. delayed ejaculation
- D. photophobia
- E. orthostatic hypotension

38.35 True statements about SSRI drug interactions include

- A. SSRIs plus phenobarbital leads to increased SSRI concentration.
- B. SSRIs plus codeine leads to decreased codeine concentration.
- C. SSRIs plus clozapine lead to increased clozapine concentration.
- D. Prozac plus alprazolam leads to decreased alprazolam concentration.
- E. Prozac plus carbamazepine leads to decreased carbamazepine concentration.

38.36 Increased lithium concentrations are associated with all of the following drug interactions *except*

- A. theophylline
- B. furosemide
- C. salt restriction
- D. indomethacin
- E. ibuprofen

38.37 Which of the following is true?

- A. Ramelteon acts on benzodiazepine receptors.
- B. Diazepam is short acting.
- C. The benzodiazepines modulate gamma-aminobutyric acid activity.
- D. Benzodiazepine use in pregnant patients should be confined to the third trimester.
- E. Tolerance to the sedative effect of zolpidem occurs often.

38.38 Significant valproate interactions include

- A. increased free valproate levels with aspirin
- B. decreased concentration of phenobarbital with valproate
- C. decreased lamotrigine levels with valproate
- D. decreased valproate levels with fluoxetine
- E. increased valproate levels with carbamazepine

38.39 Anticholinergic prophylaxis should be used routinely

- A. past the second week of treatment with an antipsychotic medication
- B. when the equivalent of greater than 12 mg a day of haloperidol is required of high-potency antipsychotics
- C. in young women on low-potency antipsychotic medication
- D. in elderly patients
- E. prior to side effects such as parkinsonism activity

38.40 True statements about gabapentin include

- A. Gabapentin is metabolized almost exclusively in the liver.
- B. Gabapentin overdose is associated with serious toxicity.
- C. Studies suggest that gabapentin may be less useful in the treatment of bipolar II disorder than of bipolar I disorder.
- D. Abrupt discontinuation of gabapentin may cause a withdrawal syndrome.
- E. Gabapentin interacts with hepatic enzymes and may both inhibit and induce them depending on dose.

38.41 Zolpidem

- A. may be used as a muscle relaxant
- B. reaches peak plasma levels in about 4 to 6 hours
- C. is solely indicated as a hypnotic

P.311

- D. is generally associated with rebound insomnia after discontinuation of its use for short periods
- E. is not contraindicated for use by nursing mothers

38.42 Which of the following statements regarding transcranial magnetic stimulation is *true*?

- A. It does not require general anesthesia.
- B. Seizures do not appear to be required for therapeutic effects.
- C. Optimal stimulation patterns for TMS in psychiatric disorders are not yet known.

- D. It is a noninvasive CNS stimulant.
- E. All of the above

38.43 Dantrolene is a potentially effective treatment for each of the following disorders *except*

- A. acute mania
- B. catatonia
- C. malignant hyperthermia
- D. neuroleptic malignant syndrome
- E. serotonin syndrome

38.44 Data supporting the traditional dopamine hypothesis of schizophrenia include each of the following *except*

- A. correlation of a decrease in plasma concentrations of homovanillic acid with improvement in symptoms
- B. PET scan data correlating D2 receptor occupancy with antipsychotic efficacy
- C. precipitation of psychosis with amphetamines
- D. the clinical efficacy of clozapine (Clozaril)
- E. correlation of D2 receptor affinity with the clinical efficacy of dopamine receptor antagonists

38.45 SSRIs are indicated for all of the following *except*

- A. Attention-deficit/hyperactivity disorder
- B. Premature ejaculation
- C. General Anxiety Disorder
- D. Panic Disorder
- E. Trichotillomania

38.46 Of the following, β -adrenergic receptor antagonists are generally most effective in the treatment of

- A. panic disorder
- B. generalized anxiety disorder
- C. alcohol withdrawal
- D. akathisia
- E. psychogenic seizures

38.47 Factors that predict a better response to carbamazepine (Tegretol) than to lithium (Eskalith) in bipolar I disorder include each of the following *except*

- A. comorbid seizure disorder
- B. dysphoric mania
- C. first episode of mania
- D. negative family history
- E. rapid cycling

38.48 Which of the following drugs has the fastest onset of action against acute mania?

- A. Carbamazepine (Tegretol)
- B. Haloperidol (Haldol)
- C. Lithium (Eskalith)
- D. Risperidone (Risperdal)
- E. Valproate (Depakote)

38.49 Which of the following dopamine receptor antagonists would probably be the safest to use for psychotic symptoms due to a brain tumor?

- A. Chlorpromazine (Thorazine)
- B. Fluphenazine (Prolixin)
- C. Mesoridazine (Serentil)
- D. Sulpiride (Dogmatil)
- E. Thioridazine (Mellaril)

38.50 Anticholinergic drugs are indicated for treatment of all of the following *except*

- A. neuroleptic-induced parkinsonism
- B. Huntington's chorea
- C. neuroleptic-induced acute dystonia
- D. idiopathic Parkinson's disease
- E. medication-induced postural tremor

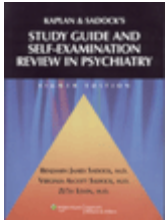
38.51 Which of the following is *true*?

- A. Memantine is potent inhibitor of cholinesterase.
- B. Tacrine causes relatively few serious side effects.
- C. Donepezil selectively inhibits acetyl-cholinesterase within the CNS.
- D. Rivastigmine is hepatotoxic.
- E. Donepezil is especially indicated in severe stages of Alzheimer's type dementia.

38.52 Mirtazapine

- A. is highly sedating
- B. decreases appetite
- C. causes an irreversible neutropenia
- D. lowers the seizure threshold
- E. causes nausea





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



39

Child Psychiatry: Assessment, Examination, and Psychological Testing

Psychiatric evaluation of a child is initiated to develop a formulation of the child's overall functioning including longstanding and current behavioral and emotional difficulties. It is essential to assess the developmental patterns of a child during an evaluation, because psychiatric disorders in this age group often emerge as a failure to achieve developmental milestones. Developmental considerations include expected skills in social, motor, language, and intellectual domains. During the evaluation, the clinician must integrate the contributions of many different factors that have affected the child, including biological growth and health, mood and behavioral symptoms, and family, school, and environmental factors. At the end of the evaluation, the extent to which the child's development has not met expectations for his or her chronological age is determined, and the degree of impairment due to behavioral and emotional factors is established. In addition, an assessment of environmental factors that may either exacerbate or improve the child's overall functioning is considered.

A comprehensive evaluation of a child includes interviews with the parents, the child, and other family members; gathering information regarding the child's current school functioning; and often, a standardized assessment of the child's intellectual level and academic achievement. In some cases, standardized measures of developmental level and neuropsychological assessments are useful. Psychiatric evaluations of children are rarely initiated by the child, so clinicians must obtain information from the family and the school to understand the reasons for the evaluation. In some cases, the court, or a child protective service agency may initiate a psychiatric evaluation. Children can be excellent informants about symptoms related to mood and inner experiences such as psychotic phenomena, sadness, fears, and anxiety, but they often have difficulty with the chronology of symptoms and are sometimes reticent about reporting behaviors that have gotten them into trouble. Very young children often cannot articulate their experiences verbally and do better showing their feelings and preoccupations in a play situation.

The student should study the questions and answers below for a useful review of this field.

Helpful Hints

The student should be able to define these terms.

- AAMD
- achievement tests
- adaptive functioning
- Bayley Infant Scale of Development
- borderline intellectual functioning
- Cattell Infant Scale
- Child Behavior Checklist
- chromosomal abnormality
- cri-du-chat syndrome
- developmental tests
- DISC-R (Diagnostic Interview Schedule for Children-Revised)
- Down's syndrome
- fragile X syndrome
- intelligence quotient (IQ)
- K-SADS (Kiddie Schedule for Affective Disorders and Schizophrenia)
- Lesch-Nyhan syndrome
- mental deficiency
- mental retardation
- neurofibrillary tangles
- neurofibromatosis
- nondisjunction
- PKU
- Prader-Willi syndrome
- prenatal exposure
- rubella
- Turner's syndrome
- Vineland Adaptive Behavior Scales
- WHO
- WISC-III (Wechsler Intelligence Scale for Children—Third Edition)

Questions/Answers

Directions

Each question or incomplete statement below is followed by five suggested responses or completions. Select the one that is best in each case.

39.1 Which of the following statements about the distinctive features of child psychopathology is *true*?

- A. Co-existence of more than one psychiatric diagnosis is rare in children.

- B. Depression commonly presents with excessive guilt, hopelessness, and anhedonia in children.
- C. Emotional disturbances in childhood are characterized by specific, pathognomonic symptoms.
- D. Fears, tantrums, or moodiness are relatively common in children and occur transiently at different stages.
- E. None of the above

39.2 Which of the following tools is considered most appropriate to facilitate the play component of an interview?

- A. Stock characters (such as Barbie or Disney figures)
- B. Elaborate toys
- C. Puppets
- D. Chess
- E. Video games

39.3 Projective techniques include

- A. Picture drawing
- B. Asking the child to name three wishes
- C. Asking the child to tell about a dream, a book, a movie, or a TV program
- D. Sentence completion task
- E. All of the above

39.4 Structured assessment instruments for infants and young children

- A. yield diagnoses
- B. include the Denver Developmental Screening Test (Denver II) and the Bayley Scales
- C. are highly reliable in predicting later performance on IQ assessment
- D. show only fair reliability and validity
- E. all of the above

39.5 Of the following diagnostic laboratory tests used in evaluation of children presenting with psychiatric problems, the one most likely to impact ultimate diagnosis is:

- A. Computed Tomography (CT) scan
- B. Thyroid Function Test
- C. Magnetic Resonance Imaging (MRI)

D. Positron Emission Tomography (PET)

E. Chromosomal Analysis

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 39.6–39.10

39.6 Measures receptive word understanding, with resulting standard scores, percentiles, and age equivalents

39.7 Measures communication, daily living skills, socialization, and motor development, yielding a composite expressed in a standard score, percentile, and age equivalents

39.8 Generates stories from picture cards of animals that reflect interpersonal functioning

39.9 Measures functioning in reading, spelling, and arithmetic, with resulting grade levels, percentiles, and standard scores

39.10 Measures verbal, performance, and full-scale ability, with

A. Vineland Adaptive Behavior Scales

B. Children's Apperception Test (CAT)

C. Wide-Range Achievement Test-Revised (WRAT-R)

D. Peabody Picture Vocabulary Test-Revised (PPVT-R)

E. Wechsler Intelligence Test for Children-Third Edition (WISC-III)

Questions 39.11–39.15

Which test would be most helpful in the psychiatric evaluation of a child presenting with the symptoms described in the cases below?

39.11 A 6-year-old boy is highly aggressive and becomes very angry when he doesn't get his way. He has always been prone to severe tantrums and has difficulty with his behavior and mood in school. At home, he is considered manageable, although he seems to have a short attention span. He breaks new toys in a matter of minutes. He is unable to play with peers because of frequent fights.

39.12 A 9-year-old girl is clingy with her mother and will not speak to strangers. She is willing to answer specific questions but not to describe her thoughts or feelings. When she is stressed, she tends to withdraw and become tearful.

She seems to be unusually sensitive to criticism and will not join in a group activity.

39.13 A 7-year-old boy has a poor vocabulary and is noted to be unable to follow

directions, as well as clumsy and slow. Although he is friendly and good-natured, he has been brutally picked on by peers, who say that he doesn't understand the rules of games. His teacher is concerned about his comprehension.

39.14 A 2-year-old boy has not yet begun to walk, speaks only 2 to 3 words, and often seems disinterested in his surroundings.

P.324

39.15 An 11-year-old girl is increasingly struggling with academic performance, manifesting particular difficulty with mathematics concepts. She is otherwise functioning well, with excellent social skills and warm relationships with friends and family members. She recently had intelligence testing and scored within normal range in all subsets and in full-scale IQ.

- A. WISC-III
- B. Child Behavior Checklist (CBCL)
- C. Children's Apperception Test (CAT)
- D. Woodcock-Johnson Psycho-Educational Battery-Revised (W-J)
- E. Bayley Scales of Infant Development II

Questions 39.16–39.19

39.16 Resemble clinical interviews more closely

39.17 K-SADS (Kiddie Schedule for Affective Disorders and Schizophrenia) and CAS (Child Assessment Scale)

39.18 Particularly appropriate for clinically based research in which subtle diagnostic distinctions may be critical for defining samples

39.19 Investigate issues of prevalence of disorders, developmental patterns of psychopathology, and psychosocial correlates of disorders

- A. Structured interviews
- B. Semi-structured interviews
- C. Both
- D. Neither

Directions

Each question or incomplete statement below is followed by five suggested responses or completions. Select the one that is *best* in each case.

39.20 Techniques that are helpful in eliciting information and feelings from a school-aged child include all of the following *except*

- A. Asking multiple-choice questions
- B. Asking the child to draw a family
- C. Using Donald Winnicott's "squiggle game"
- D. Using only open-ended questions

E. Using indirect commentary

39.21 Which of the following statements about personality tests for children is true?

- A. Personality tests and tests of ability have equal reliability and validity.
- B. Both the Children Apperception Test (CAT) and the Thematic Apperception Test (TAT) use pictures of people in situations.
- C. The Rorschach test has not been developed for children or adolescents.
- D. The Mooney Problem Checklist is a self-report inventory.
- E. None of the above

39.22 [Figure 39.1](#) is part of a series of drawings used to test children for

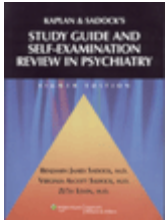
- A. Response to frustration
- B. Psychosis
- C. Depression
- D. Impulsivity
- E. Anxiety

39.23 Neurological soft signs include all of the following *except*

- A. Contralateral overflow movements
- B. Learning disabilities
- C. Asymmetry of gait
- D. Nystagmus
- E. Poor balance

39.24 Minor physical anomalies include all of the following *except*

- A. Multiple hair whorls
- B. Low-set ears
- C. High-arched palate
- D. Flattened philtrum
- E. Persistent Babinski reflex



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



40

Mental Retardation

Accurately defining mental retardation has challenged clinicians over the centuries. In the 1800s, the notion that mental retardation was based primarily on a deficit in social or moral reasoning was promoted. Since then, the addition of intellectual deficit was added to the concept of inadequate social function. All current classification systems retain the understanding that mental retardation is based on more than intellectual deficits, that is, it also depends upon a lower than expected level of adaptive function. According to the fourth text revision of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), a diagnosis of mental retardation can be made only when both the IQ, as measured by a standardized test, is subaverage and a measure of adaptive function reveals deficits in at least two of the areas of adaptive function.

According to DSM-IV-TR, mental retardation is defined as significantly subaverage general intellectual functioning resulting in, or associated with, concurrent impairment in adaptive behavior and manifested during the developmental period, before the age of 18. The diagnosis is made regardless of whether the person has a coexisting physical disorder or other mental disorder. Mental retardation diagnoses are coded on Axis II in the DSM-IV-TR.

Approximately 85 percent of persons who are mentally retarded fall within the mild mental retardation category (IQ between 50 and 70). The adaptive functions of mildly retarded persons are effective in several areas, such as communications, self-care, social skills, work, leisure, and safety. Mental retardation is influenced by genetic, environmental, and psychosocial factors, and in past years, the development of mild retardation was often attributed to severe psychosocial deprivation. More recently, however, researchers have increasingly recognized the likely contribution of a host of subtle biological factors including chromosomal abnormalities, subclinical lead intoxication, and prenatal exposure to drugs, alcohol, and other toxins. Furthermore, evidence is increasing that subgroups of persons who are mentally retarded, such as those with fragile X syndrome, Down's syndrome, and Prader-Willi syndrome, have characteristic patterns of social, linguistic, and cognitive development and typical behavioral manifestations. The DSM-IV-TR has included in its text on mental retardation additional information regarding etiological factors and their association with mental retardation syndrome (e.g., fragile X syndrome).

Helpful Hints

The student should define these terms.

- adaptive functioning
- Bayley Infant Scale of Development
- borderline intellectual functioning
- Cattell Infant Scale
- causative factors
- chromosomal abnormality
- *cri-du-chat* syndrome
- CVS (chorionic villi sampling) and amniocentesis
- degrees of mental retardation (mild, moderate, severe, profound)
- Down's syndrome
- fetal alcohol syndrome
- fragile X syndrome
- intelligence quotient (IQ)
- Lesch-Nyhan syndrome
- mental deficiency
- mental retardation
- neurofibrillary tangles
- neurofibromatosis
- PKU
- Prader-Willi syndrome
- prenatal exposure
- primary, secondary, and tertiary prevention
- rubella
- Special Olympics
- Turner's syndrome
- Vineland Adaptive Behavior Scales
- WHO

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is best in each case.

40.1 DSM-IV-TR lists the prevalence of mental retardation in the United States as

- A. 1 percent
- B. 3 percent
- C. 5 percent

- D. 6 percent
- E. None of the above

40.2 When IQ is used as the sole criterion for mental retardation, the prevalence rate is estimated to be

- A. 0.5 percent
- B. 1 percent
- C. 2 percent
- D. 3 percent
- E. 10 percent

40.3 A decline in IQ begins at approximately 10 to 15 years in which of the following disorders?

- A. Down's syndrome
- B. Fragile X syndrome
- C. Cerebral palsy
- D. Nonspecific mental retardation
- E. Fetal alcohol syndrome

40.4 The most common inherited cause of mental retardation is

- A. Down's syndrome
- B. Fragile X syndrome
- C. Fetal alcohol syndrome
- D. Prader-Willi syndrome
- E. None of the above

40.5 Which of the following disorders is least often associated with Fragile X syndrome?

- A. Autistic disorder
- B. Schizotypal personality disorder
- C. Attention-deficit/hyperactivity disorder
- D. Bipolar disorder
- E. Social anxiety disorder

40.6 Among all known causes of mental retardation, which of the following syndromes is *least* associated with comorbid Axis I psychiatric disorder?

- A. Down's syndrome
- B. Fragile X syndrome
- C. Nonspecific type
- D. Fetal alcohol syndrome
- E. Prader-Willi syndrome

40.7 Mild mental retardation has been associated with

- A. Nonspecific causes
- B. Prader-Willi syndrome
- C. Females with fragile X syndrome
- D. Poor socioeconomic background
- E. All of the above

40.8 Moderate mental retardation

- A. Reflects an IQ range of 25 to 40
- B. Is seen in approximately 3 to 4 percent of persons with mental retardation
- C. Has an identifiable organic etiology in the vast majority of cases
- D. Usually is associated with the ability to achieve academic skills at the second- to third-grade level
- E. All of the above

40.9 Common manifestations of anxiety in persons with mental retardation include

- A. Aggression
- B. Agitation
- C. Repetitive behaviors
- D. Self-injury
- E. All of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 40.10–40.14

40.10 Attributed to a deletion in chromosome 15

40.11 Most commonly occurs via autosomal recessive transmission

40.12 Abnormalities involving chromosome 21

40.13 Occurs via a chromosomal mutation at Xq27.3

40.14 Example of a genomic imprinting

- A. Prader-Willi syndrome
- B. Down's syndrome
- C. Fragile X syndrome
- D. Phenylketonuria (PKU)

Questions 40.15–40.18

40.15 Neurofibromatosis

40.16 Tuberous sclerosis

40.17 Crouzon's syndrome

40.18 Cockayne's syndrome

- A. Trisomy 21
- B. Autosomal dominant
- C. Autosomal recessive
- D. X-linked semidominant

Questions 40.19–40.23

40.19 Mental retardation with periventricular intracerebral calcifications, jaundice, microcephaly, and hepatosplenomegaly

40.20 Progressive encephalopathy and mental retardation in 50 percent of children born to mothers with this disorder

40.21 An X-linked mental retardation syndrome that is degenerative and affects only females

40.22 Diffuse demyelination of cerebral cortex leading to visual and intellectual impairment, seizures, and spasticity; accompanied by adrenocortical insufficiency.

P.335

40.23 Mental retardation, microcephaly, microphthalmia, congenital heart disease, deafness, and cataracts

40.24 Mental retardation, diffuse intracerebral calcifications, hydrocephalus, seizures, and chorioretinitis

- A. Adrenoleukodystrophy
- B. Rett's disorder
- C. Acquired immune deficiency syndrome (AIDS)
- D. Rubella
- E. Cytomegalic inclusion disease/cytomegalic virus (CMV)

F. Toxoplasmosis

Questions 40.25–40.28

40.25 May have particular weakness in expressive communication and grammar

40.26 Particular difficulties in visual-spatial processing skills

40.27 Weaker in sequential processing than in simultaneous processing

40.28 Even or near-even performance across various cognitive domains

- A. Nonspecific mental retardation
- B. Boys with fragile X syndrome
- C. Down's syndrome
- D. Williams' syndrome

Questions 40.29–40.33

40.29 High rates of temper tantrums, aggression, excessive daytime sleepiness, emotional lability, obsessions, and compulsions

40.30 Microcephaly, short stature, midface hypoplasia, mild to moderate mental retardation

40.31 Associated with increased incidence of thyroid abnormalities, congenital heart disease, leukemia, and early-onset Alzheimer's disease

40.32 Ataxia, chorea, renal dysfunction, gout, self-mutilation

40.33 Café-au-lait spots, short stature, macrocephaly

- A. Fetal alcohol syndrome
- B. Down's syndrome
- C. Lesch-Nyhan syndrome
- D. Prader-Willi syndrome
- E. Neurofibromatosis

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

40.34 All of the following chromosomal aberrations associated with Down's syndrome lead to a phenotypic expression of the disorder *except*

- A. Patients have 45 chromosomes
- B. Patients have three copies of chromosome 21
- C. Patients have 47 chromosomes
- D. Patients have 46 chromosomes, but two, usually 15 and 21, are fused

E. Patients have mosaicism, with normal and trisomic cells in various tissues

40.35 The genetic finding most closely linked to advancing maternal age is

- A. Translocation between chromosomes 14 and 21
- B. Mitotic non-disjunction of chromosome 21
- C. Partially trisomic karyotype
- D. Meiotic nondisjunction of chromosome 21
- E. All of the above

40.36 Which of the following chromosomal abnormalities is most likely to cause mental retardation?

- A. Extra chromosome 21 (trisomy 21)
- B. Fusion of chromosomes 21 and 15
- C. XO (Turner's syndrome)
- D. XXY (Klinefelter's syndrome)
- E. XXYY and XXXY (Klinefelter's syndrome variants)

40.37 Mental retardation should be diagnosed when the intelligence quotient (IQ) is below

- A. 100
- B. 85
- C. 70
- D. 65
- E. 60

40.38 Fragile X syndrome

- A. Has a phenotype that includes postpubertal microorchidism
- B. Affects only males
- C. Usually causes severe to profound mental retardation
- D. Has a phenotype that includes a large head and large ears
- E. All of the above

40.39 The mentally retarded child shown in [Figure 40.1](#) demonstrates the characteristic facial features and high degree

of social responsiveness suggestive of which of the following etiologies?



FIGURE 40.1 Courtesy of Ludwik S. Szymanski, M.D.

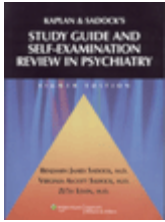


FIGURE 40.2 Courtesy of Ludwik S. Szymanski, M.D.

- A. Autosomal dominant inheritance
- B. Prenatal substance exposure
- C. Trisomy 21
- D. Enzyme deficiency
- E. Abnormality in sex chromosomes

40.40 The physical phenotype shown in [Figure 40.2](#), including long facial contour, large anteverted ears, and macroorchidism (not shown) in this young adult with mental retardation is consistent with which of the following diagnoses?

- A. Prader-Willi syndrome
- B. Down's syndrome
- C. Klinefelter's syndrome
- D. Fetal alcohol syndrome
- E. Fragile X syndrome



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



41

Learning Disorders

Learning disorders refer to a child's or adolescent's deficits in acquiring expected skills in reading, writing, speaking, use of listening, reasoning, or mathematics, compared with other children of the same age and intellectual capacity. Learning disorders are not uncommon; they affect at least 5 percent of school-age children. This represents approximately half of all public school children who receive special education services in the United States. In 1975, Public Law 94-142, the "Education for All Handicapped Children Act," mandated all states to provide free and appropriate educational services to all children. Since that time, the number of children identified with learning disorders has increased, and a variety of definitions of learning disabilities has arisen. The 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) introduced the term learning disorders, formerly called academic skills disorders. All of the current learning disorder diagnoses require that the child's achievement in that particular learning disorder is significantly lower than expected and that the learning problems interfere with academic achievement or activities of daily living.

Learning disorders often make it agonizing for a child to succeed in school and, in some cases, lead to eventual demoralization, low self-esteem, chronic frustration, and poor peer relationships. Learning disorders are associated with higher than average risk of a variety of comorbid disorders including attention-deficit/hyperactivity disorder (ADHD), communication disorders, conduct disorders, and depressive disorders. Adolescents with learning disorders are about 11/2 times more likely to drop out of school, approximating rates of 40 percent. Adults with learning disorders are at increased risk for difficulties in employment and social adjustment. Learning disorders can be associated with other developmental disorders, major depressive disorder, and dysthymic disorder.

Genetic predisposition, perinatal injury, and neurological and other medical conditions may contribute to the development of learning disorders, but many children and adolescents with learning disorders have no specific risk factors. Learning disorders are, nevertheless, frequently found in association with conditions such as lead poisoning, fetal alcohol syndrome, and in utero drug exposure.

Helpful Hints

The student should be able define these terms related to learning disorders.

- academic skills disorders
- dyslexia
- hearing and vision screening
- phoneme
- right–left confusion
- spatial relations
- visual-perceptual deficits
- word additions
- word distortions
- word omissions

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

41.1 Common elements in the definition of reading disorder include

- A. its underlying cause is central nervous system dysfunction
- B. an uneven pattern of cognitive functioning
- C. a discrepancy between learning potential and actual reading achievement
- D. difficulty in single-word decoding
- E. All of the above

41.2 A recently proposed definition of dyslexia includes which of the following components?

- A. It is one of several distinct learning disabilities not characterized by difficulties in single-word decoding.
- B. It does not usually reflect insufficient phonological processing.
- C. It is not the result of sensory impairment.

P.342

- D. It rarely includes a conspicuous problem with acquiring proficiency in writing and spelling.
- E. None of the above

41.3 The psychiatric syndrome most often comorbid with mathematical disorder is

- A. anxiety
- B. depression
- C. reading disorder

- D. attention-deficit/hyperactivity disorder
- E. None of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered words or phrases. For each numbered word or phrase, select the *one* lettered heading that is most closely associated with it. Each heading may be selected once, more than once, or not at all.

Questions 41.4–41.7

41.4 Used to be known as dyslexia

41.5 Spelling skills deficit is an example

41.6 Usually diagnosed later than the other learning disorders

41.7 Reported to occur frequently in children born in May, June, and July

- A. Reading disorder
- B. Mathematics disorder
- C. Disorder of written expression
- D. Learning disorder not otherwise specified

Questions 41.8–41.12

41.8 The study of this disorder has been neglected even though it appears to occur with the same frequency as learning disorders in other areas.

41.9 The etiology is unknown.

41.10 Higher monozygotic than dizygotic concordance rates.

41.11 The diagnosis is generally not made until the second or third grade.

41.12 Brain anomalies are inferred but not demonstrated conclusively.

- A. Reading disorder
- B. Mathematics disorder
- C. Both
- D. Neither

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

41.13 Reading disorder is characterized by all of the following *except*

- A. Impairment in recognizing words
- B. Poor reading comprehension

- C. Increased prevalence among family members
- D. Occurrence in three to four times as many girls as boys
- E. Omissions, additions, and distortions of words in oral reading

41.14 Which of the following statements does *not* characterize mathematics disorder?

- A. It is more common in boys than girls.
- B. The prevalence is estimated to be about 6 percent in school-age children with normal intelligence.
- C. It includes impairment in addition, subtraction, multiplication, and division.
- D. It is usually apparent by the time a child is 8 years old.
- E. All of the above

41.15 Disorder of written expression

- A. presents earlier than do reading disorder and communication disorders
- B. occurs only in children with reading disorder
- C. is not diagnosed until the teenage years
- D. includes disability in spelling, grammar, and punctuation
- E. is always self-limited

41.16 Disorder of written expression is often associated with

- A. reading disorder
- B. mixed expressive-receptive language disorder
- C. developmental coordination disorder
- D. mathematics disorder
- E. All of the above

41.17 Janet, age 11, has a long history of school problems. She failed first grade and was removed from a special classroom in second grade after arguing and fighting repeatedly with her peers. She is currently in a regular sixth grade class and is struggling academically: she is failing reading and English and is barely passing in math and science; her performance in art and sports is significantly better. Her teacher describes Janet as “a slow learner with a poor memory,” and notes that Janet does poorly in group settings and requires considerable individual attention in class.

Janet has no history of medical problems, and her developmental history was unremarkable—she sat up at 6 months, walked at 12 months, and began speaking at 16 months. Examination revealed an open and friendly girl who bristled at questions about her academic difficulties. She complained of being “teased” and “bossed around” by children at school but described a number of friendships with

peers in her neighborhood. Intelligence testing revealed a full-scale IQ of 97. Wide-range achievement testing produced grade-level scores of 2.8 for reading, 3.3 for spelling, and 4.3 for arithmetic.

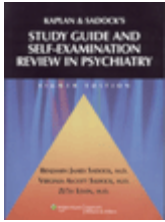
The most likely diagnosis is

- A. disorder of written expression
- B. expressive language disorder
- C. phonological disorder

P.343

- D. reading disorder
- E. none of the above





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](http://www.lippincott.com)



42

Motor Skills Disorder: Developmental Coordination Disorder

Developmental coordination disorder is a condition characterized by low performance in daily activities that require coordination below what is expected for age and intellectual level. According to the text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, the disorder may present with delays in achieving motor milestones such as sitting, crawling, and walking.

Developmental coordination disorder may also be manifested by clumsy gross and fine motor skills, resulting in poor performance in sports and even poor handwriting. A child with developmental coordination disorder may bump into things more often than siblings or drop things. In the 1930s, the term *clumsy child syndrome* began to be used in the literature to denote a condition of awkward motor behaviors that could not be correlated with any specific neurological disorder or damage. This term continues to be used to identify imprecise or delayed gross and fine motor behavior in children, resulting in subtle motor inabilities, but often significant social rejection. Currently, there are indications that perinatal problems such as prematurity, low birth weight, and hypoxia may contribute to the emergence of developmental coordination disorders. Children with developmental coordination disorder are at higher risk for language and learning disorders. There is a strong association between speech and language problems and coordination problems, as well as an association of coordination difficulties with hyperactivity, impulsivity, and poor attention span.

The student should study the questions and answers below for a useful review of this disorder.

Helpful Hints

The student should be able to define the terms listed here.

- attention-deficit/hyperactivity disorder
- Bender Visual Motor Gestalt test
- Bruininks-Oseretsky Test of Motor Development
- catching a ball

- cerebral palsy
- clumsiness
- conduct disorder
- deficits in handwriting
- delayed motor milestones
- expressive language disorder
- eye–hand coordination
- fine motor skills
- finger tapping
- Frostig Movement Skills Test Battery
- Gerstmann syndrome
- graphemes
- gross motor skills
- informal motor skills screening
- learning disorders
- linguistic, perceptual, mathematical and attentional skills
- perceptual motor training
- psychoeducational tests
- remedial treatments
- shoelace tying
- social ostracism
- temperamental attributes
- unsteady gait

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

42.1 Manifestations of developmental coordination disorder include:

- A. delays in reaching motor milestones such as sitting and crawling
- B. avoidance of participation in sports activities with peers
- C. messy or illegible writing

- D. difficulty learning feeding skills
- E. all of the above

42.2 Which of the following tests is *not* helpful in demonstrating developmental coordination disorder?

- A. Bender Visual Motor Gestalt test
- B. Verbal subsets of the Wechsler Intelligence Scale for Children—Third Edition (WISC-III)
- C. Bruiniks-Oseretsky Test of Motor Development
- D. Frostig Movement Skills Test Battery
- E. None of the above

42.3 Which of the following is a risk factor for developmental coordination disorder?

- A. Birth in May, June, or July
- B. Borderline intellectual functioning
- C. Frequent episodes of *otitis media* in the first two years of life
- D. Prematurity
- E. Dysfunctional family

42.4 Which of the following statements is *false*?

- A. Children with developmental coordination disorder may resemble younger children motorically.
- B. Developmental coordination disorder commonly occurs in conjunction with a communication disorder.
- C. Children with developmental coordination disorder during early childhood typically develop age-expected fine motor and gross motor coordination skills by early adolescence.
- D. Prematurity, low birth weight, neonatal malnutrition, and perinatal hypoxia are all risk factors for developmental coordination disorder.
- E. Medical causes of motor deficits such as cerebral palsy or muscular dystrophy must be ruled out prior to making a diagnosis of developmental coordination disorder.

Directions

The group of questions below consists of lettered headings followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 42.5–42.8

42.5 Facial grimaces when child is asked to make hand movements

42.6 Clinician tracks how long a child can stick out his tongue

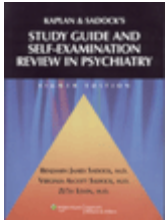
42.7 Child tends to throw a ball too hard and inaccurately at short distances

42.8 Inability to follow directions to hold a comb with the right hand, pass it to the

left hand, and use it to comb hair from front to back

- A. Dyspraxia
- B. Synkinesia
- C. Impersistence
- D. Asymmetries
- E. Hypertonus





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



43

Communication Disorders

Spoken language is an essential part of communicating ideas, social interactions, and academic understanding. Effective communication for a child or adolescent includes proficiency in both language and speech skills. The text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) includes four specific communication disorders and one residual category. Two of the communication disorders (expressive and mixed receptive-expressive communication disorder) are language disorders; the other two (phonological disorder and stuttering) are speech disorders. A child with a language disorder may have a limited vocabulary, speak in short simple sentences, and tell stories in a disorganized and incomplete manner. A child with a speech disorder may attempt to use appropriate descriptive words but has difficulty pronouncing the speech sounds correctly and may either omit sounds or pronounce sounds in an unusual way. A child with stuttering generally has acquired a normal vocabulary, but speech fluency is disrupted by pauses, sound repetitions, or sound prolongations.

Language usage includes four components: phonology, grammar, semantics, and pragmatics. Phonology refers to the ability to produce sounds that constitute words in a given language and the skills to discriminate the various phonemes (sounds that are made by a letter or group of letters in a language). To imitate words, a child must be able to produce the sounds of a word. Grammar designates the organization of words and the rules for placing words in an order that makes sense in that language. Semantics refers to the organization of concepts and the acquisition of words themselves. A child draws from a mental list of words to produce sentences. Pragmatics has to do with skill in the actual use of language and the "rules" of conversation, including pausing so that a listener can answer a question and knowing when to change the topic when there is a break in a conversation. By age 2 years, toddlers may know up to 200 words, and by age 3 years, most children understand the basic rules of language and can converse effectively.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

These terms relate to communication disorders and should be known by the student.

- ambilaterality
- articulation problems
- audiogram
- baby talk
- cluttering
- comprehension
- decoding
- developmental coordination disorders
- dysarthria
- encoding
- expressive language disorder
- fluency of speech
- language acquisition
- lateral slip and palatal lisp
- maturational lag
- misarticulation
- mixed receptiveexpressive language disorder
- neurodevelopmental delays
- omissions
- phoneme
- phonological disorder
- semantogenic theory of stuttering
- sound distortion
- spastic dysphonia
- speech therapy
- standardized language test
- stuttering
- substitution
- time patterning of speech

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the *one* that is *best* in each case.

43.1 Normal development in a 3-year-old child includes:

- A. Use of 900 to 1,000 words
- B. Speech is usually understood by strangers
- C. Follows three-step commands

D. Use of conjunctions (e.g., if, but, because)

E. Discusses feelings

43.2 Which of the following is a true statement about diagnosis of communication disorders?

A. Substantial deficits in receptive language do not preclude the diagnosis of expressive language disorder.

P.349

B. Substantial deficits in nonverbal intelligence do not preclude the diagnosis of expressive language disorder.

C. If both expressive and receptive deficits occur in the absence of nonverbal deficits, the diagnosis of mixed receptive-expressive language disorder is not appropriate.

D. If language and nonverbal functioning are both substantially below age-level expectations, the diagnosis of mental retardation should be made.

E. None of the above

43.3 Which of the following is a true statement about presentation and course of developmental expressive language deficits?

A. Less than 20 percent of "late talkers" achieve language skills within the normal range during the preschool years.

B. Most "late talkers" who recover during preschool appear to be at relatively high risk for severe learning and behavioral problems during their early school years.

C. Expressive language disorder often appears in the absence of comprehension problems, whereas receptive dysfunction generally diminishes proficiency in expressive language.

D. There is clear consensus among experts that intervention to improve expressive language should only be provided for children whose problems persist to age 4 or 5.

E. None of the above

43.4 Children with expressive language disorder are distinguishable from children with pervasive developmental disorders in that they

A. appropriately use gestures to communicate

B. are noted to use symbolic or imaginary play

C. readily form meaningful and warm social relationships

D. show significant frustration with the inability to communicate verbally

E. All of the above

Directions

Each group of questions below consists of lettered headings followed by a list of

numbered phrases or statements. For each numbered phrase or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 43.5–43.9

43.5 Disturbance in the programming of speech movements associated with a primary insult to the left cerebral hemisphere

43.6 Organic causes include endocrine dysfunction and laryngeal papillomas

43.7 Use of sentences that are short, incomplete, or ungrammatical

43.8 In DSM-IV-TR, this category encompasses speech sound problems that have no known cause and presumably reflect developmental difficulties in acquiring the sound system of a language

43.9 Associated with cleft lip and palate

- A. Expressive language disorder
- B. Phonological disorder
- C. Voice disorder
- D. Verbal apraxia
- E. None of the above

Questions 43.10–43.12

43.10 Phonological disorder

43.11 Stuttering disorder

43.12 Mixed receptive-expressive language disorder

- A. A child sings normally
- B. A child cannot understand language
- C. A child has an abnormally loud voice
- D. A child substitutes and omits speech sounds
- E. None of the above

Questions 43.13–43.17

43.13 This disorder may include dysarthria and apraxia when occurring in the context of neurological disorders such as cerebral palsy or head injury.

43.14 A child with this disorder may appear to be deaf.

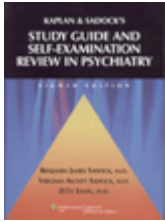
43.15 This disorder is most commonly seen in males.

43.16 Cluttering, a dysrhythmic speech pattern with jerky spurts of words, is often an associated feature of this disorder.

43.17 This disorder has two peaks of onset: between 2 and 3 1/2 years and between 5 and 7 years.

- A. Expressive language disorder
- B. Mixed receptive-expressive language disorder
- C. Phonological disorder
- D. Stuttering
- E. All of the above





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



44

Pervasive Developmental Disorders

The pervasive developmental disorders include a group of conditions in which there are delay and deviance in the development of social skills, language and communication, and behavioral repertoire. Children with pervasive developmental disorders often exhibit idiosyncratic intense interest in a narrow range of activities, resist change, and are not appropriately responsive to the social environment. These disorders affect multiple areas of development, manifest early in life, and cause persistent dysfunction. Autistic disorder, the best known of these disorders, is characterized by sustained impairment in comprehending and responding to social cues, aberrant language development and usage, and restricted, stereotypical behavioral patterns. According to the text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders (DSMIV-TR)*, to meet criteria for autistic behavior, abnormal functioning in at least one of the above areas must be present by age 3. More than two thirds of children with autistic disorder have mental retardation, although it is not required for the diagnosis.

DSM-IV-TR includes five pervasive developmental disorders: autistic disorder, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified. Rett's disorder appears to occur exclusively in girls; it is characterized by normal development for at least 6 months, stereotyped hand movements, a loss of purposeful motions, diminishing social engagement, poor coordination, and decreasing language use. In childhood disintegrative disorder, development progresses normally for the first 2 years, after which the child shows a loss of previously acquired skills in two or more of the following areas: language use, social responsiveness, play, motor skills, and bladder or bowel control.

Asperger's disorder is a condition in which the child is markedly impaired in social relatedness and shows repetitive and stereotyped patterns of behavior without a delay in language development. In Asperger's disorder, a child's cognitive abilities and adaptive skills are normal.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know the following terms related to pervasive developmental

disorders.

- abnormal relationship
- acquired aphasia
- Asperger's disorder
- attachment behavior
- autistic disorder
- brain volume
- childhood disintegrative disorder
- childhood schizophrenia
- communication disorder
- concordance rate
- congenital deafness
- congenital physical anomaly
- congenital rubella
- CT scan
- dermatoglyphics
- disintegrative (regressive) psychosis
- dread of change
- echolalia
- echolalic speech
- educational and behavioral treatments
- EEG abnormalities
- ego-educative approach
- encopresis
- enuresis
- extreme autistic aloneness
- eye contact
- failed cerebral lateralization
- grand mal seizure
- haloperidol (Haldol)
- Heller's syndrome
- hyperkinesia
- hyperserotonemia
- hyperuricosuria
- "idiot savant"
- insight-oriented psychotherapy
- islets of precocity
- Leo Kanner
- language deviance and delay
- low-purine diet

- mental retardation
- monotonous repetition
- organic abnormalities
- pain threshold
- parental rage and rejection
- perinatal complications
- pervasive developmental disorder
- physical characteristics
- PKU
- play
- prevalence
- pronominal reversal
- psychodynamic and family causation
- Purkinje's cells
- Rett's disorder
- ritual
- rote memory
- seizures
- self-injurious behavior
- separation anxiety
- sex distribution
- social class
- splinter function
- stereotypy
- tardive and withdrawal dyskinesias
- temporal lobe
- tuberous sclerosis
- vestibular stimulation
- voice quality and rhythm DSM

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

44.1 Which of the following features does *not* distinguish autistic disorder from mixed receptive-expressive language disorder?

- A. Echolalia
- B. Stereotypies

- C. Imaginative play
- D. Associated deafness
- E. Family history of speech delay

44.2 Neurological-biochemical abnormalities associated with autistic disorder include

- A. grand mal seizures
- B. ventricular enlargement on computed tomography (CT) scan
- C. electroencephalogram (EEG) abnormalities
- D. increased total brain volume
- E. all of the above

44.3 True statements about autistic disorder include which of the following?

- A. Girls outnumber boys in individuals with autism without mental retardation.
- B. There is an established and conclusive association between autism and upper socioeconomic status.
- C. Prevalence rates may be as high as 1 in 1000 children.
- D. Abnormalities in functioning must be present by age 2 to meet DSM-IV-TR diagnostic criteria.
- E. All of the above

44.4 True statements about the role of genetics in autistic disorder include which of the following?

- A. Twin studies indicate only moderate concordance for monozygotes.
- B. Family studies show a prevalence of approximately 2 to 3 percent of autism among siblings of children with autism.
- C. Unaffected siblings are not at increased risk for language problems.
- D. It is clear that what is inherited is a specific predisposition to autistic disorder.
- E. The role of genetic factors in autistic disorder is not well established.

44.5 The most frequent *presenting* complaint of parents about their autistic child is

- A. their lack of interest in social interaction.
- B. their lack of usual play skills.
- C. their difficulty tolerating change and variations in their routines.
- D. delays in the acquisition of language.
- E. stereotyped movements.

44.6 Relative strengths of autistic children in psychological testing include which of the following?

- A. Block design and digit recall
- B. Verbal concept formulation
- C. Integration skills
- D. Similarities and comprehension
- E. Abstract reasoning

44.7 What percentage of autistic individuals exhibits special abilities or splinter (savant) skills?

- A. Less than 1 percent
- B. 10 percent
- C. 25 percent
- D. 50 percent
- E. 80 percent

44.8 Rett's disorder

- A. is seen only in boys.
- B. does not involve motor abnormalities.
- C. is associated with normal intelligence.
- D. shows no loss of social skills.
- E. none of the above

44.9 Childhood disintegrative disorder is

- A. characterized by behaviors markedly different than those seen in autistic disorder
- B. more common in boys than girls
- C. always characterized by a gradual onset
- D. notable in that acquired self-help skills do not deteriorate
- E. all of the above

44.10 Asperger's disorder is characterized by delays in

- A. self-help skills
- B. curiosity about the environment
- C. nonverbal communication
- D. receptive language
- E. none of the above.

44.11 James, a 4-year-old boy, is referred for a psychiatric evaluation at the suggestion of his preschool teacher, who noticed unusual interactions with other children. He is an only child who started preschool 4 months ago. He seldom plays with other children, preferring to play with a specific toy truck or toy dog. He spends much of the morning with the toy, moving it back and forth in a repetitive pattern. If he is unable to find the toy, or if another child is playing with it, he sits on the floor and wails until it is found and given to him. On the occasions when he approaches another child, it is in a blunt, verbose way, devoid of give-and-take, and other children tend to avoid him. The teacher never observes reciprocal interactions, and James never seems to catch on to what is happening in games. He approaches adults in a similar blunt, one-sided manner.

James was the product of a full-term vaginal delivery without complications. His mother describes him as a fussy baby who did not like being held. She and his

P.355

father cannot remember James smiling as a baby or ever wanting to play peek-a-boo, despite their efforts to engage him. He talked before he walked and was speaking two to three word sentences by age 2. Because of his early and rich vocabulary, his parents assumed that he was probably gifted. He achieved bowel control at 3 years and bladder control at 4 years, with the exception of occasional nighttime accidents. He is able to dress and bathe himself with minimal help. He enjoys looking at pictures in his parents' art books and tends to return to the same pages again and again. His parents say that James's play at home is similar to what his teacher describes at school. He almost never initiates an activity or engages in reciprocal play. They assumed that his preference for being left alone was due to his superior intelligence. He sleeps and eats well. They have never observed or heard anything that would lead them to believe that James was experiencing hallucinations.

On examination James is found to be at the 30th percentile for height and weight for his age. He is well-developed and there are no facial abnormalities. His vocabulary is above average for his age, and he talks freely but without engaging in back-and-forth conversation. He avoids eye contact with the examiner and tends not to respond to questions or commands. When he is allowed to choose a toy, he selects a truck and spends several minutes spinning one of the wheels backward and forward.

Which of the following is the most likely diagnosis in the case described above?

- A. Fetal alcohol syndrome
- B. Autistic disorder
- C. Down's syndrome
- D. Childhood schizophrenia
- E. Asperger's disorder

44.12 What is the most likely cause of James' difficulties?

- A. Neurodevelopmental abnormalities
- B. Maternal neglect

- C. Autosomal recessive inheritance
- D. Lead poisoning
- E. Chromosomal nondisjunction

44.13 Based on the case above, which of the following interventions is most likely to be helpful?

- A. Risperidone therapy
- B. Psychodynamic play therapy
- C. Social skills training
- D. Methylphenidate therapy
- E. Interpersonal psychotherapy

Directions

Each group of questions below consists of lettered headings followed by a list of numbered statements. For each numbered word or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 44.14–44.18

44.14 Normal development for the first 6 months, followed by a progressive encephalopathy

44.15 A better prognosis than other pervasive developmental disorders because of the lack of delay in language and cognitive development

44.16 Some but not all of the features of autistic disorder

44.17 Several years of normal development followed by a loss of communication skills, a loss of reciprocal social interaction, and a restricted pattern of behavior

44.18 Occurrence at a rate of two to ten cases per 10,000 and characterized by impairment in social interaction, communicative language, or symbolic play before age 3.

- A. Autistic disorder
- B. Childhood disintegrative disorder
- C. Pervasive developmental disorder not otherwise specified
- D. Asperger's disorder
- E. Rett's disorder

Questions 44.19–44.22

44.19 This opiate antagonist is being investigated in the treatment of autism.

44.20 This drug has both dopamine (D2) and serotonin (5-HT) antagonist properties.

44.21 This drug has been shown to reduce lability and stereotypic behaviors, but is also associated with withdrawal dyskinesias.

44.22 This drug is used to decrease obsessive-compulsive and stereotypic behaviors.

- A. Risperidone (Risperdal)
- B. Haloperidol (Haldol)
- C. Naltrexone (ReVia)
- D. Selective serotonin reuptake inhibitors

Questions 44.23–44.27

44.23 Onset is usually later and outcome involved less impairment

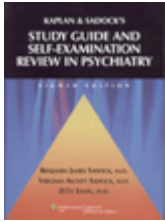
44.24 Motor clumsiness is more common

44.25 Qualitative impairments in social interaction and restricted patterns of interest

44.26 Withdrawn in the presence of others

44.27 Aggression and self-injurious behaviors are more common

- A. Autistic disorder
- B. Asperger's disorder
- C. Both
- D. Neither



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



45

Attention-Deficit Disorders (ADHD)

Attention-deficit/hyperactivity disorder (ADHD) consists of a persistent pattern of inattention and/or hyperactive and impulsive behavior that is more severe than expected in children of that age and level of development. To meet the criteria for the diagnosis of ADHD, some symptoms must be present before the age of 7 years, although many children are not diagnosed until they are older than 7 years when their behaviors cause problems in school and other places. To meet diagnostic criteria for ADHD, impairment from inattention and/or hyperactivity/impulsivity must be present in at least two settings and interfere with developmentally appropriate functioning socially, academically, and in extracurricular activities. The disorder must not take place in the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and must not be better accounted for by another mental disorder.

The disorder has been identified in the literature for many years under a variety of terms. In the early 1900s, impulsive, disinhibited, and hyperactive children—many of whom had neurological damage caused by encephalitis—were grouped under the label hyperactive syndrome. In the 1960s, a heterogeneous group of children with poor coordination, learning disabilities, and emotional lability but without specific neurological damage were described as having minimal brain damage. Since then, other hypotheses have been put forth to explain the origin of the disorder, such as genetically based condition involving abnormal arousal and poor ability to modulate emotions. This theory was initially supported by the observation that stimulant medications help produce sustained attention and improve these children's ability to focus on a given task. Currently, no single factor is believed to cause the disorder, although many environmental variables may contribute to it and many predictable clinical features are associated with it.

Students should test their knowledge by addressing the following questions and answers.

Helpful Hints

The student should know the following terms.

- adult manifestations
- ambidexterity
- antidepressant

- body anxiety
- clonidine (Catapres)
- developmentally inappropriate attention
- disinhibition
- disorganized EEG pattern
- distractibility
- EEG findings
- emotional lability
- genetic-familial factors
- growth suppression
- hyperactivity-impulsivity
- hyperkinesia
- impaired cognitive performance
- inattention
- learning disorders
- locus ceruleus
- matching familiar faces
- minimal brain damage
- nonfocal (soft) signs
- perceptual-motor problems
- PET scan
- poor motor coordination
- rebound effect
- right–left discrimination
- school history
- secondary depression
- soft neurological signs
- sympathomimetic

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

45.1 Which of the following statements regarding ADHD is *true*?

- A. ADHD occurs in about 1 percent of prepubertal elementary school children in the United States.
- B. ADHD remains one of the least-validated disorders in psychiatry.
- C. Parents of children with ADHD show increased incidence of alcohol use disorders.
- D. Symptoms of ADHD rarely appear before the age of 5.

E. None of the above

45.2 Findings from neuroimaging studies of subjects with ADHD include which of the following?

- A. Reduced perfusion in bilateral frontal areas on PET scan
- B. Increased perfusion in prefrontal, striatal, and thalamic regions in response to methylphenidate administration on PET scan

P.361

- C. Dorsal anterior cingulate cortex (DACC) dysfunction on functional MRI scan
- D. abnormalities in fronto-striatal brain regions on various imaging techniques
- E. All of the above

45.3 Which of the following statements describing the genetics of ADHD is *true*?

- A. The risk of ADHD for a sibling of a child proband with ADHD increases up to five times in some studies.
- B. Children with ADHD are at no greater risk of developing conduct disorder than children of similar ages without ADHD.
- C. Concordance rates for ADHD range from 25 to 40 percent for monozygotic twins.
- D. Concordance rates for ADHD range from 5 to 10 percent for dizygotic twins.
- E. The heritability of inattention-related behaviors is estimate to range between 40 and 55 percent.

45.4 Possible acquired etiological influences in ADHD include

- A. low socioeconomic status
- B. elevated intake of sugar-containing foods during early childhood
- C. high birth weight (above 4,000 g)
- D. prenatal exposure to alcohol and/or nicotine
- E. all of the above

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 45.5–45.9

45.5 This drug is favored in children with ADHD and a history of severe tic disorders and may be particularly helpful when ADHD symptoms are pronounced in the late afternoon or evening.

45.6 This drug has a short half-life, and has been shown to improve symptoms in approximately 75 percent of ADHDdiagnosed children.

45.7 This drug may be favored in children who suffer significant rebound symptoms from stimulants, or in children with comorbid ADHD and depression.

45.8 This drug has a half-life of 8-12 hours and is approved in children as young as 3-years-old for treatment of ADHD.

45.9 Growth suppression occurs during treatment with this drug, but studies indicate that children recoup the growth when given “drug holidays” over weekends and vacations.

- A. Methylphenidate (Ritalin)
- B. Dextroamphetamine (Dexedrine)
- C. Bupropion (Wellbutrin)
- D. Clonidine (Catapres)
- E. None of the above

Questions 45.10–45.13

45.10 Most common

45.11 Least common

45.12 Most children identified as having this subtype were 3 to 4 years younger than children diagnosed with other subtypes.

45.13 These children are often described as sluggish, anxious, and sleepy.

- A. ADHD, inattentive type
- B. ADHD, hyperactive-impulsive type
- C. ADHD, combined type
- D. All of the Above
- E. None of the above

45.14 Which of the following statements aboutADHD is false?

- A. Children with ADHD can have inattention with no hyperactivity or impulsivity.
- B. Children with ADHD may have symptoms of hyperactivity but not inattention.
- C. The disturbance in behavior must occur in at least two settings.
- D. Children can meet the criteria for ADHD with impulsive symptoms only.
- E. Many children with ADHD have many symptoms of inattention, hyperactivity, and impulsivity.

45.15 The first symptom of ADHD to remit is usually

- A. hyperactivity

- B. distractibility
- C. careless mistakes in schoolwork
- D. impulsivity
- E. learning difficulties

45.16 The hyperactive and impulsive child is often

- A. accident prone
- B. explosively irritable
- C. unable to resist blurting out answers
- D. excessively talkative
- E. all of the above

45.17 Diana is a 9-year-old girl brought in for her first psychiatric consultation by her parents, who were troubled by Diana's behavior during the Thanksgiving holiday. Diana's mother described Diana's propensity toward interrupting others' conversations, her inability to stay seated at the dinner table for longer than several minutes at a time, and her frequent, brief, but very noticeable bouts of sullen mood.

Both parents reported that Diana's "quirks" have been observable throughout her life. They described her as "moody," "stubborn," "turbo-charged," "impulsive," and "a bit aggressive with others," traits which they've noticed since she was an infant. They've also been concerned among themselves about Diana's limited friendships, noting, "She doesn't seem to get many invitations for play dates." They wondered whether Diana's tendencies toward bossiness and quick bursts of temper, which they'd

P.362

long observed at home, were impairing her ability to form strong ties with peers.

Academically, Diana thrived in certain classes, particularly those in which she was immediately engaged with the material, but she also struggled mightily with certain subjects, particularly reading and writing. She seemed to grasp new concepts at first before falling off and losing interest in the task. She was frequently frustrated with herself and openly self-critical. She left materials scattered around the classroom and frequently forgot necessary papers or books at home. Distractibility also caused significant problems; teachers frequently commented on the need to seat Diana away from the windows and at the front of the class in an effort to maintain her focus on the lesson. The teacher also commented that Diana rarely stayed in her seat for more than a few minutes at a time and made frequent visits to the bathroom and drinking fountain.

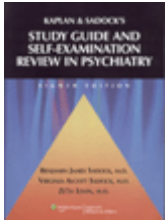
At home, she and her sister frequently argued, and Diana at times was physically aggressive with her sister, though never harmed her in any significant way. Diana was noted to be quick to anger and quick to cry, and had "bad afternoons" in which she sulked and didn't respond to consoling. She was described as somewhat uncoordinated by her parents; sports at school were always difficult for her.

Diana was resistant to meeting with the psychiatrist and was feeling "grouchy"

when the interview began. She expressed frustration over her difficulties at school and acknowledged her struggles with paying attention and with sitting still; she volunteered feeling that "I'm stupider than the other kids and I hate it." She spoke of several friends at school but also acknowledged, "We fight sometimes" and expressed her hope that she might "get a best friend someday." During the interview, after initially sitting in a chair with her arms crossed, she walked around the psychiatrist's office, examining objects within reach, and at one point perching perilously on the edge of an end table in an effort to reach a book, responding only to the psychiatrist's repeated insistence that she not climb on the furniture.

The diagnosis in the case above is

- A. ADHD
- B. Anxiety Disorder
- C. Bipolar I Disorder
- D. Conduct Disorder
- E. Expressive Language Disorder



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



46

Disruptive Behavior Disorders

Oppositional and aggressive behaviors during childhood are among the most frequent reasons that a given youth is referred for mental health evaluation. Many youth who exhibit negativistic or oppositional behaviors will find other forms of expression as they mature and will no longer demonstrate these behaviors in adulthood. However, children who develop enduring patterns of aggressive behaviors that begin in early childhood and violate the basic rights of peers and family members may be destined to an entrenched pattern of conduct disorder behavior over time.

Controversy has arisen as to whether a set of "voluntary" antisocial behaviors can be construed as a psychiatric disorder, or can be better accounted for as maladaptive responses to overly harsh or punitive parenting, or strategies that have survival value in chronically threatening environmental situations. Longitudinal studies have demonstrated that for some youth, early patterns of disruptive behavior may become a lifelong pervasive repertoire culminating in adult antisocial personality disorder. The origin of stable patterns of disruptive behavior is widely accepted as a convergence of multiple contributing factors including biological, temperamental, learned, and psychological conditions.

Disruptive behavior disorders can be divided into two distinct constellations of symptoms categorized as oppositional defiant disorder and conduct disorder, both of which result in impaired social or academic function in a child. Some defiance and refusal to comply with adult requests is developmentally appropriate and marks growth in all children, yet children with certain disorders are themselves impaired by the frequency and severity of their disruptive behaviors.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should be able to define the following terms.

- ADHD
- autonomy
- child abuse

- CNS dysfunction
- comorbid disorders
- harsh child-rearing structure
- issues of control
- mood disorders
- negativistic relationships
- normative oppositional stages
- parental psychopathology
- poor peer relationships
- poor self-esteem
- socioeconomic deprivation
- temperamental predispositions
- terrible twos
- truancy
- violation of rights

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

46.1 Oppositional defiant disorder

- A. is associated with major antisocial violations
- B. is defined as part of a developmental stage
- C. is limited to a particular age group
- D. most commonly emerges in late-preschool–or early school–aged children
- E. diagnosis implies less circumscribed disturbances of greater severity than in conduct disorder

46.2 In oppositional defiant disorder

- A. The average age of onset is 3 years.
- B. Boys always outnumber girls, regardless of age range.
- C. Occurrence is mostly in cohorts of middle to higher socioeconomic status.
- D. Point prevalence has been reported to average around 6 percent.
- E. All of the above

46.3 True statements about oppositional defiant disorder include

- A. In one study, about one-third of boys with the disorder progress to develop

conduct disorders.

B. Ninety percent of boys with conduct disorder have

P.367

fulfilled criteria for oppositional defiant disorder previously in their lives.

C. The disorder has been linked to the presence of anxious-avoidant parental attachment.

D. Twenty-five percent of children with this disorder will have no further diagnosis.

E. All of the above

46.4 The most common comorbidity with oppositional defiant disorder is

A. attention-deficit/hyperactivity disorder

B. dysthymic disorder

C. major depressive disorder

D. early-onset bipolar I disorder

E. anxiety disorders

46.5 In conduct disorder

A. Symptoms are clustered in two areas.

B. Subtyping is allowed based on the age of onset of symptoms.

C. At least five of a list of 15 antisocial behaviors must be present.

D. All behaviors must have been present in the last 6 months.

E. All of the above

46.6 Factors associated with conduct disorder include

A. chronic illness

B. disturbed laterality and language performance

C. viewing televised or other media violence

D. temperament

E. all of the above

46.7 The most virulent comorbid condition of conduct disorder is considered to be

A. paranoid psychotic disorders

B. substance-use disorders

C. oppositional defiant disorder

D. attention-deficit/hyperactive disorders

E. major depressive disorder

46.8 Oppositional defiant disorder is characterized by all of the following *except*

- A. negativistic behavior
- B. placing blame on others
- C. physical aggression
- D. difficulty in school
- E. theft

Directions

These lettered headings are followed by a list of numbered statements. For each numbered statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be used once, more than once, or not at all.

Questions 46.9–46.11

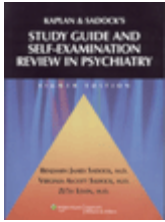
46.9 It may be diagnosed when symptoms occur exclusively with attention-deficit/hyperactivity disorder, learning disorders, and mood disorders.

46.10 It may be equally prevalent in adolescent boys and adolescent girls.

46.11 The patient often bullies, threatens, or intimidates others.

- A. Oppositional defiant disorder
- B. Conduct disorder





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



47

Feeding and Eating Disorders of Infancy or Early Childhood

Feeding and eating disorders of infancy or early childhood include persistent symptoms of inadequate food intake, recurrent regurgitation and rechewing of food, or repeated ingestion of nonnutritive substances. Because very young children depend upon parents or caregivers to feed them and provide meals, these disorders are often conceptualized as reflecting, in part, an interaction between the child and parent. The text revision of the 4th edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) includes three distinct disorders of feeding and eating in this age group: pica, rumination disorder, and feeding disorder of infancy or early childhood. There is a high rate of spontaneous recovery from all of these feeding disorders, although a subset of infants refuses to eat and has persistent eating problems throughout childhood.

In DSM-IV-TR, pica is described as persistent eating of nonnutritive substances for at least 1 month. The behavior must be developmentally inappropriate, not culturally sanctioned, and sufficiently severe to merit clinical attention. Pica is diagnosed even when these symptoms occur in the context of another disorder such as autistic disorder, schizophrenia, or Kleine-Levin syndrome. Pica appears much more frequently in young children than in adults; it also occurs in persons who are mentally retarded.

Among adults, certain forms of pica, including geophagia (clay eating) and amylophagia (starch eating), have been reported in pregnant women.

In DSM-IV-TR, rumination disorder is described as an infant's or child's repeated regurgitation and rechewing of food, after a period of normal functioning. The symptoms last for at least 1 month, are not caused by a medical condition, and are severe enough to merit clinical attention. The onset of the disorder generally occurs after 3 months of age; once the regurgitation occurs, the food may be swallowed or spit out. Infants who ruminate are observed to strain to bring the food back into their mouths and appear to find the experience pleasurable. The infants are often brought for evaluation because of failure to thrive. The disorder is rare in older children, adolescents, and adults. It varies in severity and is sometimes associated with medical conditions, such as hiatal hernia, that result in esophageal reflux. In its most severe form, the disorder can be fatal.

According to DSM-IV-TR, feeding disorder of infancy or early childhood is a persistent

failure to eat adequately, reflected in significant failure to gain weight or in significant weight loss over 1 month. The symptoms are not better accounted for by a medical condition or by another mental disorder and are not caused by lack of food. The disorder has its onset before the age of 6 years.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know the following terms.

- amylophagia
- anemia
- behavioral interventions
- cultural practices
- esophageal reflux
- failure to thrive
- geophagia
- hiatal hernia
- impoverished environments
- intestinal parasites
- iron deficiency
- lead poisoning
- mental retardation
- nutritional deficiencies
- overstimulation
- parental neglect and deprivation
- positive reinforcement
- psychosocial dwarfism
- regurgitation
- self-stimulation
- spontaneous remission
- zinc deficiency

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the *one* that is *best* in each case.

47.1 Feeding disorder of infancy or early childhood

- A. has narrow DSM-IV-TR diagnostic criteria that address the specificity of various feeding disorders

- B. has been reported in 1 to 2 percent of infants and toddlers
- C. may have an age of onset after 6 years
- D. does not necessarily result in significant failure to gain weight
- E. none of the above

47.2 Pica

- A. is usually diagnosed most easily when the child is under two years of age
- B. decreases in prevalence with increasing severity of mental retardation
- C. is not diagnosed if symptoms occur in the context of another disorder, including schizophrenia and autistic disorder
- D. is diagnosed even if symptoms are culturally accepted
- E. none of the above

47.3 Behaviors which may be related to pica include

- A. Nail biting
- B. Thumb sucking
- C. Delays in speech and psychosocial development
- D. Bulimia nervosa
- E. All of the above

47.4 A diagnosis of rumination disorder

- A. is commonly made in older children and adolescents
- B. cannot be made in individuals with mental retardation or a pervasive developmental disorder
- C. cannot be due to an associated gastrointestinal condition
- D. is not made in children with a prior period of normal functioning.
- E. occurs more often in females than in males

47.5 Susan was admitted to the hospital at age 6 months for evaluation of failure to gain weight. She had been born into an impoverished family after an unplanned, uncomplicated pregnancy. During her first 4 months of life, she gained weight steadily. Beginning in her 5th month, she was noted to regurgitate milk after feedings, in the following manner: she would open her mouth and elevate her tongue after feedings, thrust her tongue forward and backward, after which milk would appear at the back of her mouth. She would then vigorously suck her thumb and other fingers, and milk would continue to be regurgitated into her mouth. Her weight leveled off and then began to decrease during this time. In the two months prior to the onset of this behavior, Susan had multiple caregivers and received little attention from her parents. Nevertheless, she smiled often and was responsive to all of her caregivers.

The most likely diagnosis is

- A. Rumination disorder
- B. Reactive attachment disorder
- C. Pica
- D. Failure to thrive
- E. None of the above

47.6 All of the following behaviors are association with the disorder *except*

- A. sucking noises
- B. rechewing food
- C. reswallowing food
- D. mutism
- E. appearance of satisfaction

Directions

The questions below consist of lettered heading followed by a list of numbered phrases. For each numbered phrase, select the correct heading.

Questions 47.7–47.14

47.7 May lead to lead poisoning and toxoplasmosis.

47.8 This disorder falls under the ICD-10 diagnostic category of “Feeding Disorders of Infancy and Childhood,” but forms its own diagnostic category in DSM-IV-TR.

47.9 The onset may occur at any age in life, including adolescence and adulthood.

47.10 High rate of spontaneous remission

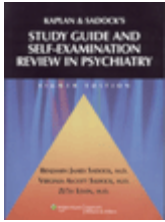
47.11 Reinforcement by pleasurable self-stimulation

47.12 Associated with failure to thrive

47.13 Associated with adolescent- and adult-onset eating disorders

47.14 Associated with pregnant women

- A. Rumination disorder
- B. Pica
- C. Both
- D. Neither



Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



48

Tic Disorders

Tics are defined as rapid and repetitive muscle contractions resulting in movements or vocalizations that are experienced as involuntary. Children and adolescents may exhibit tic behaviors that occur after a stimulus or in response to an internal urge.

Tic disorders are a group of neuropsychiatric disorders that generally begin in childhood or adolescence and may be constant or wax and wane over time. Although tics are not volitional, in some individuals they may be suppressed for periods. The most widely known and most severe tic disorder is Gilles de la Tourette syndrome, also known as Tourette's disorder. The text revision of the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) includes several other tic disorders such as chronic motor or vocal tic disorder, transient tic disorder, and tic disorder not otherwise specified. While tics have no particular purpose, they often consist of motions that are used in volitional movements.

Motor and vocal tics are divided into simple and complex types. Simple motor tics are those composed of repetitive, rapid contractions of functionally similar muscle groups—for example, eye blinking, neck jerking, shoulder shrugging, and facial grimacing. Common simple vocal tics include coughing, throat clearing, grunting, sniffing, snorting, and barking. Complex motor tics appear to be more purposeful and ritualistic than simple tics. Common complex motor tics include grooming behaviors, the smelling of objects, jumping, touching behaviors, echopraxia (imitation of observed behavior), and copropraxia (display of obscene gestures). Complex vocal tics include repeating words or phrases out of context, coprolalia (use of obscene words or phrases), palilalia (a person's repeating his or her words), and echolalia (repetition of the last-heard words of others).

Some persons with tic disorders can suppress the tics for minutes or hours, but others, especially young children, either are not cognizant of their tics or experience their tics as irresistible. Tics may be attenuated by sleep, relaxation, or absorption in an activity. Tics often, but not always, disappear during sleep.

According to DSM-IV-TR, tics in Tourette's disorder are multiple motor tics and one or more vocal tics. The tics occur many times a day for more than 1 year. Tourette's disorder causes distress or significant impairment in important areas of functioning. The disorder has an onset before the age of 18 years, and it is not caused by a substance or by a general medical condition.

Georges Gilles de la Tourette first described a patient with what was later known as Tourette's disorder in 1885, while he was studying with Jean-Martin Charcot in France. De la Tourette noted a syndrome in several patients that included multiple motor tics, coprolalia, and echolalia.

The student should study the following questions and answers for a useful review of these disorders.

Helpful Hints

The terms that follow relate to tic disorders and should be known by the student.

- attention-deficit/hyperactivity disorder
- barking
- behavioral treatments
- benztropine (Cogentin)
- Jean Charcot
- clonidine (Catapres)
- compulsions
- coprolalia
- dopamine antagonists and stimulants
- dystonia
- echokinesis
- echolalia
- echopraxia and copropraxia
- encephalitis lethargica
- eye blinking
- facial grimacing
- Gilles de la Tourette
- grunting
- Hallervorden-Spatz disease
- hemiballism
- Huntington's chorea
- hyperdopaminergia
- Lesch-Nyhan syndrome
- motor tic
- neck jerking
- obsessive-compulsive disorder
- palilalia
- Pelizaeus-Merzbacher disease
- pimozide (Orap)
- poststreptococcal syndromes
- shoulder shrugging
- simple or complex tic

- stereotypy
- Sydenham's chorea
- tardive dyskinesia
- torsion dystonia
- Tourette's disorder
- transient tic disorder
- tremor
- vocal tic
- Wilson's disease

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the *one* that is *best* in each case.

48.1 Which of the following symptoms is required for diagnosis of Tourette's disorder according to DSM-IV-TR criteria?

- A. Vocal tic
- B. Multiple motor tics
- C. Symptoms occurring for at least 1 year
- D. Onset before age 18
- E. All of the above

48.2 Which of the following statements about the epidemiology of Tourette's disorder is true?

- A. The lifetime prevalence of Tourette's disorder is estimated at one per 10,000.
- B. The average age of onset of the motor component of the disorder is 7 years old.
- C. The average age of onset of the vocal component of the disorder is 7 years old.
- D. Prevalence of Tourette's disorder is similar in boys and girls.
- E. All of the above

48.3 In Tourette's disorder, the initial tics are in the

- A. Face and neck
- B. Arms and hands
- C. Body and lower extremities
- D. Respiratory system
- E. Alimentary system

48.4 True statements about Tourette's disorder include which of the following?

- A. The most frequent initial symptom is mental coprolalia.
- B. Coprolalia usually begins around 6 to 8 years of age and occurs in about 5 percent of cases.
- C. Most complex motor and vocal symptoms emerge virtually simultaneously with the initial symptoms.
- D. Attention-Deficit/Hyperactivity Disorder (ADHD) is rarely diagnosed in children who are later diagnosed with Tourette's disorder.
- E. Typically, behavioral symptoms, such as hyperactivity, are evident several years before or concurrent with the initial symptoms.

48.5 If onset is after age 18, which of the following tic disorders may be diagnosed?

- A. Transient tic disorder
- B. Chronic motor or vocal tic disorder
- C. Tourette's disorder
- D. Tic disorder not otherwise specified
- E. All of the above

48.6 The dopamine system has been hypothesized to be involved in the development of tic disorders because:

- A. Haloperidol (Haldol) suppresses tics
- B. Pimozide (Orap) suppresses tics
- C. Methylphenidate (Ritalin) exacerbates tics
- D. Pemoline (Cylert) exacerbates tics
- E. All of the above

48.7 Which of the following statements concerning evidence supporting genetic factors as likely to play a role in the development of Tourette's disorder is false?

- A. Concordance for Tourette's disorder is significantly higher in monozygotic than in dizygotic twins.
- B. Sons of men with Tourette's disorder are at highest risk of developing the disorder.
- C. First-degree relatives of probands with Tourette's disorder are at higher-than-average risk for developing Tourette's disorder and chronic tic disorder.
- D. First-degree relatives of probands with Tourette's disorder are at higher-than-average risk for developing obsessive-compulsive disorder, and up to 40 percent of patients with Tourette's disorder also have obsessive-compulsive disorder.

E. None of the above

48.8 Which of the following distinguishes transient tic disorder from chronic motor or vocal tic disorder and Tourette's disorder?

- A. age of onset
- B. the presence of motor tics only
- C. the presence of vocal tics only
- D. the presence of both motor and vocal tics
- E. temporal progression of the tic symptoms

48.9 Which of the following is not an appropriate pharmacologic treatment for tic disorders?

- A. Methylphenidate
- B. Guanfacine
- C. Risperidone
- D. Clonidine
- E. Haloperidol

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases. For each numbered phrase, select the *one* lettered heading most associated with it. Each heading may be used once, more than once, or not at all.

Questions 48.10–48.12

48.10 May be mistaken for a volitional act.

P.377

48.11 Sniffing, grunting, or yelping.

48.12 Brisk movements.

- A. tonic tic
- B. dystonic tic
- C. clonic tic
- D. simple phonic tic
- E. complex tic

Questions 48.13–48.17

48.13 Associated with obsessive-compulsive behavior.

48.14 Possible autoimmune response to streptococcal antigens.

48.15 Self-limiting syndrome.

48.16 Chronic illness with a waxing and waning course.

48.17 More common in males.

- A. Tourette's disorder
- B. Sydenham's chorea
- C. Both
- D. Neither

Questions 48.18–48.21

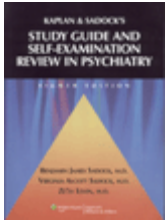
48.18 Repetitive vocalizations

48.19 Premonitory sensation

48.20 Description of movements as intentional in response to urges or sensations

48.21 Association with mental retardation or dementing process

- A. Tic disorders
- B. Non-tic movement disorders
- C. Both
- D. Neither



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



49

Elimination Disorders

Enuresis and encopresis are the two elimination disorders described in the text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). These disorders are considered only when a child is chronologically and developmentally beyond the point at which it is expected that these functions can be mastered. Normal development encompasses a range of time in which a given child is able to devote the attention, motivation, and physiological skills to exhibit competency in elimination processes. Encopresis is defined as a pattern of passing feces into inappropriate places, whether the passage is involuntary or intentional. The pattern must be present for at least 3 months; the child's chronological age must be at least 4 years. Enuresis is the repeated voiding of urine into clothes or bed, whether the voiding is involuntary or intentional.

The behavior must occur twice weekly for at least 3 months or must cause clinically significant distress or impairment socially or academically. The child's chronological or developmental age must be at least 5 years.

Bowel and bladder control develops gradually over time. Toilet training is affected by many factors, such as a child's intellectual capacity and social maturity, cultural determinants, and the psychological interactions between child and parents. The normal sequence of developing control over bowel and bladder functions is the development of nocturnal fecal continence, diurnal fecal continence, diurnal bladder control, and nocturnal bladder control.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know the following terms.

- abnormal sphincter contractions
- aganglionic megacolon
- behavioral reinforcement
- bell (or buzzer) and pad

- diurnal bowel control
- ego-dystonic enuresis
- fluid restriction
- functionally small bladder
- genitourinary pathology and other organic disorders
- Hirschsprung's disease
- imipramine
- intranasal desmopressin (DDAVP)
- laxatives
- low nocturnal antidiuretic hormone
- neurodevelopmental problems
- nocturnal bowel control
- obstructive urinary disorder abnormality
- olfactory accommodation
- overflow incontinence
- poor gastric motility
- psychosocial stressors
- rectal distention
- regression
- thioridazine
- toilet training

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is best in each case.

49.1 According to DSM-IV-TR enuresis can be defined as repeated voiding of urine into bed or clothes in children over the age of

- A. 2 years
- B. 3 years
- C. 4 years
- D. 5 years
- E. no defined age

49.2 True statements about enuresis include

- A. The majority of enuretic children wet intentionally.
- B. There is a correlation between enuresis and psychological disturbance that increases with age.

- C. Children with enuresis are no more likely to have developmental delays than other children.
- D. There is no evidence for a genetic component to enuresis.
- E. Children living in socially disadvantaged environments do not have an increased incidence of enuresis.

49.3 In DSM-IV-TR, qualifiers to the diagnosis of enuresis include

- A. Minimum duration of symptom
- B. Diurnal vs. nocturnal enuresis

P.380

- C. Combined nocturnal and diurnal pattern
- D. Physical causes such as bladder infection must be excluded
- E. All of the above

49.4 The incidence of obstructive urinary tract lesions in children with enuresis has been reported at approximately

- A. 1.5 percent
- B. 3.5 percent
- C. 10 percent
- D. 15 percent
- E. 25 percent

49.5 True statements about enuresis include

- A. The vast majority of enuretic children experience spontaneous resolution of the problem.
- B. Medications are generally the first step in the treatment of childhood enuresis.
- C. Psychotherapy is never indicated as part of the treatment of enuresis.
- D. The success rate for behavioral interventions is nearly 40 percent.
- E. Classical conditioning methods (bell and pad) are ineffective in children with concomitant psychiatric disorders.

49.6 True statements about encopresis include

- A. No significant relationship exists between encopresis and enuresis.
- B. Less than 25 percent of children with encopresis have constipation.
- C. Psychological factors are often relevant when encopresis occurs after a previous period of fecal continence.
- D. The symptom must occur at least once weekly for 3 months as part of DSM-IV-TR criteria for the diagnosis of encopresis.

E. None of the above

Directions

The lettered headings below are followed by a list of numbered phrases. For each numbered phrase, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 49.7–49.8

49.7 More likely to have developmental delays and associated enuresis

49.8 More often diagnosed with conduct disorder

- A. primary encopresis
- B. secondary encopresis

Questions 49.9–49.15

49.9 This disorder is more common in females.

49.10 Psychopharmacological intervention for this disorder often provides symptomatic improvement, but is of limited utility as relapse tends to occur as soon as the drug is withdrawn.

49.11 Although physiological factors likely play a significant role in this disorder, structural abnormalities are rarely the cause of symptoms.

49.12 At age 7 years, approximately 1.5 percent of boys have this disorder.

49.13 At age 5 years, approximately 7 percent of boys have this disorder.

49.14 To be diagnosed with this disorder, a child must have a chronological or developmental age of 5 years.

49.15 To be diagnosed with this disorder, a child must have a chronological or developmental age of 4 years.

- A. encopresis
- B. enuresis

Directions

The statement below is followed by five suggested responses.

Select the one that is best.

49.16 Tim, age 6, was referred to the clinic by his pediatrician because of persistent soiling. Tim's mother reported that he had never gained control of his

bowel habits. After a febrile illness at age 2, he developed constipation, and required laxatives and suppositories as treatment. Following this episode, there was an alternating pattern of constipation, when he did not move his bowels for several days, and diarrhea, when he soiled his pants many times a day.

At age 4, he again took laxatives for a period of time and his stools became softer and more regular. His mother began to toilet train him at that time. He was made to sit on the toilet each evening until he "performed." Although he usually managed to produce a tiny amount of stool during these sessions, he continued to soil his pants frequently during the day. This pattern continued until the time of referral.

Tim himself had been distressed about his soiling since starting school, fearing that others would notice when he stained his clothes or when he smelled after a soiling episode. He was anxious when sitting on the toilet in the evenings and insisted that his mother stay in the bathroom with him. He was also enuretic at night. He became dry by day at age 3 but continued to wet at night; because waking him at night has not prevented his wetting, his mother still put him in diapers to sleep.

Apart from the problems of soiling and wetting, his mother felt that Tim was a normal little boy who was happy and outgoing. His developmental milestones were all a little behind those of his older sisters. He sat at 7 months, walked at 18 months, and spoke his first words at about 18 months as well.

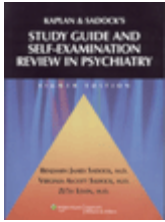
In the interview Tim was shy at first, clinging to his mother. However, he allowed her to leave the room after a short period and became more assertive and outgoing in her absence. He played with family figures in the dollhouse and portrayed the little boy figure on the toilet and all the other members of the family observing his efforts.

P.381

The pediatrician's report indicated that a full medical workup revealed no general medical condition that could account for the soiling. On physical exam, a fecal mass was palpated in Tim's lower abdomen, and soft feces were present in his rectum.

The diagnosis in this case is

- A. encopresis
- B. enuresis
- C. conduct disorder
- D. Hirschsprung's disease
- E. childhood schizophrenia



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



50

Other Disorders of Infancy, Childhood, or Adolescence

Reactive attachment disorder (RAD) is a clinical disorder characterized by aberrant social behaviors in a young child reflecting an environment of maltreatment that interfered with the development of normal attachment behavior. Unlike most disorders in the text revision of the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), a diagnosis of RAD is based on the presumption that the etiology is directly linked to environmental deprivation experienced by the child. The diagnosis of reactive attachment disorder is a relatively recent entity, added to the 3rd edition of DSM (DSM-III) in 1980. The formation of this diagnosis is largely based on the building blocks of attachment theory, which described the quality of a child's generalized affective relationship with primary caregivers, usually parents. This basic relationship is the product of a young child's need for protection, nurturance and comfort and the interaction of the parents and child in fulfilling these needs.

Stereotypic movements are repetitive voluntary, often rhythmic movements that occur in normal children, and occur with increased frequency in children carrying the diagnoses of pervasive developmental disorder and mental retardation syndromes. These movements appear to be purposeless but in some cases, such as body rocking, head rocking or hand flapping, they may be either self-soothing or self-stimulating. In other cases, stereotypic movements such as head banging, face slapping, eye poking, or hand biting may cause significant self-harm. Nail biting, thumb sucking, and nose picking are generally not included as symptoms of stereotypic movement disorder since they rarely cause impairment.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should know the following terms.

- anticipatory anxiety
- behavioral inhibition
- delayed language acquisition

- desensitization
- driven, nonfunctional behavior
- dyskinesic movements
- emotional and physical neglect
- external life stressors
- failure to respond socially
- failure to thrive
- generalized anxiety
- head banging and nail biting
- indiscriminate familiarity
- inhibition to speak
- lack of stable attachment
- Lesch-Nyhan syndrome
- major attachment figure
- multimodal treatment approach
- nonverbal gestures
- panic disorder
- pathogenic caregiving
- psychopharmacologic interventions
- "psychosocial dwarfism"
- school phobia
- school refusal
- selective mutism
- self-injurious stereotypic acts
- sensory impairments
- separation anxiety
- shyness
- social anxiety
- social phobia
- specific phobia
- stereotypic movements
- stress anxiety
- temperamental constellation

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

50.1 Stereotypic movement disorder

- A. Includes trichotillomania
- B. Includes stereotypy that is part of a pervasive developmental disorder
- C. Is not diagnosed if mental retardation is present
- D. Includes tics and compulsions
- E. None of the above

50.2 Which of the following accurately describes head banging, one example of a stereotypic movement?

- A. Has a prevalence of approximately 1 percent in child populations
- B. Affects males three times more commonly than females

P.384

- C. Typically begins after the age of 12 months
- D. Is relatively common after the age of 3 years
- E. Is rarely self-limiting

50.3 The most widely used intervention in the treatment of stereotypic movements is

- A. Clomipramine (Anafranil)
- B. Desipramine (Norpramin)
- C. Haloperidol (Haldol)
- D. Chlorpromazine (Thorazine)
- E. Behavioral modification

50.4 [Figure 50.1A](#) shows a 3-month-old baby boy whose weight is 1 ounce over birth weight. His history of care taking had been characterized by persistent disregard for his basic needs for comfort, affection, stimulation, and nourishment. Upon his hospitalization, the infant's head circumference was normal, as was his bone age. While he failed to show normal spontaneous activity, his growth hormone levels were in the normal range. This infant's symptoms typify a classic disorder of infancy. Which, if any, symptom is at odds with the diagnosed disorder?

- A. Insufficient spontaneous activity
- B. Normal head circumference for age
- C. Normal bone age
- D. Normal levels of growth hormone
- E. None of the above

Directions

Each group of questions below consists of lettered headings followed by a list of

numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 50.5–50.6

50.5 Linked to institutionalization or exposure to multiple caregivers prior to age 5

50.6 Linked to early childhood maltreatment

- A. Reactive attachment disorder, inhibited type
- B. Reactive attachment disorder, disinhibited type
- C. Both
- D. Neither

Questions 50.7–50.10

50.7 Pervasive developmental disorder must be ruled out in order for the diagnosis to be made.

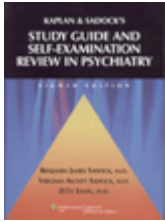
50.8 Includes some symptoms, such as rocking or thumb sucking, that are considered developmentally normal self-comforting behaviors in very young children.

50.9 May be associated with multiple foster care placements in early childhood.

- A. Reactive attachment disorder
- B. Stereotypic movement disorder
- C. Both
- D. Neither



FIGURE 50.1 Reprinted with permission from Barton Schmitt, M.D., Children's Hospital, Denver, CO.



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



51

Mood Disorders and Suicide in Children and Adolescents

Mood Disorders and Suicide in Children and Adolescents Mood disorders appear in children of all ages, and may consist of enduring patterns of disturbed mood; diminished enthusiasm in play activities, sports, friendships, or school; and a general feeling of worthlessness. The core features of major depression are similar in children, adolescents, and adults, with the expression of these features modified to match the age and maturity of the individual.

Mood disorders among children and adolescents have been increasingly diagnosed and treated with a variety of modalities.

Although clinicians and parents have always recognized that children and adolescents may experience transient sadness and despair, it has become clear that persistent disorders of mood occur in children of all ages and under many different circumstances.

Two criteria for mood disorders in childhood and adolescence are a disturbance of mood, such as depression or elation, and irritability.

Although diagnostic criteria for mood disorders in the text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) are almost identical across all age groups, the expression of disturbed mood varies in children according to their age. Young, depressed children commonly show symptoms that appear less often as they grow older, including mood-congruent auditory hallucinations, somatic complaints, withdrawn and sad appearance, and poor self-esteem.

Symptoms that are more common among depressed youngsters in late adolescence than in young childhood are pervasive anhedonia, severe psychomotor retardation, delusions, and a sense of hopelessness. Symptoms that appear with the same frequency regardless of age and developmental status include suicidal ideation, depressed or irritable mood, insomnia, and diminished ability to concentrate.

Developmental issues, however, influence the expression of all symptoms. For example, unhappy young children who exhibit recurrent suicidal ideation are generally unable to think of a realistic suicide plan or to put their ideas into action. Children's moods are especially vulnerable to the influences of severe social stressors, such as chronic family

discord, abuse and neglect, and academic failure. Many young children with major depressive disorder have histories of abuse or neglect.

Children with depressive disorders in the midst of toxic environments may have remission of some or many depressive symptoms when the stressors diminish or when the children are removed from the stressful environment. Bereavement often becomes a focus of psychiatric treatment when children have lost a loved one, even when a depressive disorder is not present.

Depressive disorders and bipolar I disorder are generally episodic, although their onset may be insidious. Manic episodes are rare in prepubertal children but fairly common in adolescents.

Attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct disorder may occur among children who later experience depression. In some cases, conduct disturbances or disorders may occur in the context of a major depressive episode and resolve with the resolution of the depressive episode. Clinicians must clarify the chronology of the symptoms to determine whether a given behavior (such as poor concentration, defiance, or temper tantrums) was present before the depressive episode and is unrelated to it or whether the behavior is occurring for the first time and is related to the depressive episode.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should study the following terms.

- academic failure
- anhedonia
- antisocial behavior and substance abuse
- bereavement
- boredom
- copycat suicides
- cortisol hypersecretion
- developmental symptoms
- double depression
- environmental stressors
- family history
- hallucinations
- inpatient vs. outpatient treatment
- insidious onset
- irritable mood
- lethal methods
- poor concentration
- poor problem solving
- precipitants of suicide
- psychosocial deficits

- REM latency
- sad appearance
- social withdrawal
- somatic complaints
- temper tantrums
- toxic environments

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

51.1 Which of the following statements about the epidemiology of mood disorders in children and adolescents is true?

- A. Major depressive disorder in preschool-age children is fairly common; a typical estimate of prevalence in epidemiologic studies is three percent.
- B. Depression is more common among boys than girls among school-age children.
- C. Major depression is more common than dysthymia among school-age children.
- D. Dysthymia rarely progresses to major depression among children and adolescents.
- E. Among adolescents, about 15 to 20 percent of community samples have major depressive disorder.

51.2 True statements about the phenomenology of bipolar disorder in children and adolescents include all of the following *except*

- A. Prepubertal children very rarely exhibit discrete episodes of mania or depression.
- B. Some clinicians ascribe symptoms such as extreme mood variability, aggressive behavior, and high rates of distractibility and impulsivity to pediatric bipolar disorder, though controversy exists over this diagnosis.
- C. Psychotic symptoms such as hallucinations and delusional thought content are rare in adolescent mania.
- D. Among adolescents, depressive episodes characterized by severely depressed mood, psychosis, psychomotor retardation, and hypersomnia may be predictive of later development of bipolar disorder.
- E. Antidepressant medications may trigger hypomania or mania in children and adolescents with no known history of bipolar disorder.

51.3 Major depressive disorder in school-aged children

- A. may present as irritable mood rather than depressed mood
- B. usually includes pervasive anhedonia

- C. includes mood-congruent auditory hallucinations less commonly than in adults with the same disorder
- D. is never diagnosed in the context of bereavement
- E. none of the above

51.4 Which of the following statements is true of suicide in adolescence?

- A. Completed suicide decreases in incidence with increasing age.
- B. Completed suicide is more common in girls than in boys.
- C. Suicide attempts are always associated with a mood disorder.
- D. Suicide attempts often precipitated by arguments with family members, girlfriends, or boyfriends.
- E. The most common method used in completed suicide among adolescents in the United States is toxic ingestion.

51.5 Which of the following is not a true statement regarding suicide among children and adolescence?

- A. Suicide is the third leading cause of death among persons 15 to 24 years of age in the United States.
- B. Risk factors for completed suicide include family history of suicidal behavior, exposure to family violence, impulsivity, substance use, mood disorder, and availability of lethal means.
- C. High levels of serotonin and its metabolites have been found postmortem in the brains of individuals who completed suicide.
- D. One-third of individuals who complete suicide had at least one prior attempt.
- E. A history of aggressive behavior is an important predictor of increased risk for suicide.

51.6 Which of the following symptoms presents with similar frequency among children, adolescents, and adults with major depressive disorder?

- A. Suicidal ideation
- B. Somatic complaints
- C. Mood-congruent auditory hallucinations
- D. Pervasive anhedonia
- E. None of the above

51.7 Which of the following treatments have demonstrated efficacy in treating adolescent depression based upon controlled clinical trials?

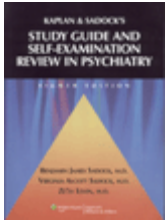
- A. Cognitive-behavioral psychotherapy
- B. Interpersonal psychotherapy

C. Fluoxetine

D. All of the above

E. None of the above





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



52

Anxiety Disorders of Infancy, Childhood, and Adolescence

There are four categories of anxiety disorder in children. The first is obsessive-compulsive disorder (OCD). OCD is characterized by the presence of recurrent intrusive thoughts associated with anxiety or tension and/or repetitive purposeful mental or physical actions aimed at reducing fears and tensions caused by obsessions. It has become increasingly clear that the majority of cases of OCD begin in childhood or adolescence. The clinical presentation of OCD in childhood and adolescence is similar to that in adults and the only alteration in diagnostic criteria in the text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) for children is that they do not necessarily demonstrate awareness that their thoughts or behaviors are unreasonable.

The second category is posttraumatic stress disorder (PTSD). PTSD is characterized by a set of symptoms such as reexperiencing symptoms, distressing recollections, persistent avoidance, and hyperarousal in response to exposure to one or more traumatic events. PTSD is the only disorder described in DSM-IV-TR in which the etiologic factors, exposure to an extreme traumatic stressor either directly or as a witness, is the first diagnostic criterion of the disorder. Many children and adolescents are exposed to traumatic events ranging from direct experiences with physical or sexual abuse, domestic violence, motor vehicle accidents, severe medical illnesses or natural or human created disasters, leading to full PTSD in some, and at least some PTSD symptoms in many others. Although the presence of posttraumatic stress symptoms has been described among adults for more than a century, it was first officially recognized as a psychiatric disorder in 1980 with the publication of DSM-III. Recognition of its frequent emergence in children and adolescence has broadened over the last decade.

The third category includes separation anxiety disorder, generalized anxiety disorder and social phobia. Separation anxiety disorder is diagnosed when developmentally inappropriate and excessive anxiety emerges related to separation from the major attachment figure. Generalized anxiety disorder is characterized by chronic generalized anxiety not limited to any particular idea, object, or event.

The fourth category is selective mutism. Selective mutism is characterized in a child by persistent failure to speak in one or more specific social situations most typically

including the school setting. The most recent conceptualization of selective mutism highlights the relationship between underlying social anxiety and the resulting failure to speak. Most children with the disorder are completely silent during the stressful situations, while some may verbalize almost inaudibly single-syllable words. Children with selective mutism are fully capable of speaking competently when not in a socially anxiety-producing situation.

The student should study the questions and answers below for a useful review of these disorders.

Helpful Hints

The student should be able to define the following terms.

- adoption studies
- age of onset
- anticipatory
- aphonia
- asthma
- attention-deficit/hyperactivity disorder (ADHD)
- β -adrenergic receptor antagonists
- cannabis-induced
- central noradrenergic system
- cognitive-behavioral
- comorbid disorders
- EEG
- exposure therapy
- family studies
- free-floating
- genetics
- impulse control
- kleptomania
- life events
- neurochemical
- neuroimaging
- panic disorder
- performance
- psychotherapy
- rating scales
- religious ritual
- self-cutting
- separation
- separation anxiety disorder
- serotonergic system
- situational

- startle reflex
- stranger
- striatum
- substance abuse
- temperament
- thalamus
- Tourette's syndrome
- trait

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

52.1 OCD in children is characterized by all of the following *except*

- A. intrusive thoughts
- B. anxiety
- C. awareness that thoughts are unreasonable
- D. response to serotonergic agents
- E. male predominance

52.2 Which of the following is *not* a true statement about the genetics of OCD?

- A. There is an increased risk of OCD in first degree relatives.
- B. Subclinical syndromes occur in family pedigrees.
- C. OCD is related to Tourette's disorder.
- D. There is a linkage to chromosome 21.
- E. Tics are highly correlated to OCD.

52.3 Pediatric autoimmune neuropsychiatric disorders associated with streptococcus (PANDAS) are characterized by all of the following *except*

- A. an autoimmune process
- B. inflammation of the basal ganglia
- C. thalamo-cortical dysfunction
- D. obsessive thinking
- E. lower limb paralysis

52.4 Habit disturbances that stem from separation anxiety include

- A. nail biting
- B. thumb sucking
- C. masturbation
- D. temper tantrums
- E. all of the above

52.5 Separation anxiety in children is characterized by

- A. fears that a loved one will be hurt
- B. fears about getting lost
- C. irritability
- D. animal and monster phobias
- E. all of the above

52.6 An 8-month-old infant who is separated from his mother for the first time goes through three well-defined sequential stages. In order they are

- A. Protest, detachment, and despair
- B. Protest, despair, and detachment
- C. Detachment, despair, and protest
- D. Despair, protest, and detachment
- E. Detachment, protest, and despair

52.7 Psychoanalytic bases for anxiety in the child has been ascribed to

- A. dependency
- B. fear of the superego
- C. symbiosis
- D. castration fears
- E. all of the above

52.8 There is clinical evidence to support which of the following as predisposing toward overanxious disorders in children

- A. Large families
- B. First-born children
- C. Low socioeconomic status
- D. Low expectations
- E. Last-born children

52.9 Which of the following statements is not true about separation anxiety in infants?

- A. It is not a universal phenomenon in infants.
- B. It emerges in infants less than one year of age.
- C. It has survival value.
- D. It peaks between 9 months and 18 months.
- E. It is pathological in about 15 percent of infants.

52.10 Which of the following statements is true about preschoolers?

- A. Approximately 10 percent will meet criteria for an anxiety disorder
- B. About 6 percent will suffer from generalized anxiety disorder
- C. Approximately 3 percent will suffer from separation anxiety disorder
- D. About 2 percent will suffer from social phobia
- E. All of the above

52.11 Extremely shy children show all of the following *except*

- A. high resting heart rate
- B. low cortisol levels
- C. insecure attachment
- D. elevated urinary catecholamines
- E. dilation of the pupil during cognitive tasks

52.12 Fear in children may be produced by which of the following?

- A. Direct modeling by the parents
- B. Parental overprotection
- C. Anger
- D. Temperamental predisposition
- E. All of the above

52.13 Separation anxiety disorder

- A. is a developmental phase
 - B. affects up to 4 percent of school-aged children
 - C. has its most common onset at 1 to 2 years of age
 - D. it less serious when it occurs in adolescence
 - E. always involves refusal to go to school
-

52.14 In the differential of PTSD the clinician should consider which of the following conditions?

- A. Obsessive-compulsive disorder
- B. Social phobia
- C. Bereavement
- D. Disruptive behavior disorder
- E. All of the above

52.15 Conditions associated with PTSD in children include all of the following *except*

- A. decreased intracranial volume
- B. increased corpus callosum area
- C. low IQ
- D. depression
- E. physical abuse

52.16 Selective mutism

- A. has an age of onset from 2 to 3 years old
- B. rarely manifests outside of the home
- C. may develop gradually or suddenly
- D. is unrelated to temper tantrums
- E. all of the above

Directions

Each set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the one lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 52.17–52.20

52.17 Thought stopping

52.18 Physical sensations experienced

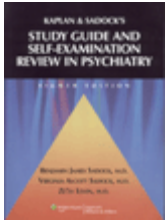
52.19 Inaccurate thought processing

52.20 Support

- A. Parental treatment
- B. Gradual exposure
- C. Cognitive processing

D. Stress inoculation





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



53

Early-Onset Schizophrenia

Schizophrenia usually has its onset in late adolescence or early adulthood, but it does (rarely) present in children 10 years of age or younger. Schizophrenia with childhood onset is conceptually the same as schizophrenia in adolescence and adulthood. When schizophrenia occurs in prepubertal children, it more commonly occurs in males. Psychosocial stressors are known to influence the course of schizophrenia, and the same stressors may possibly interact with biological risk factors in the emergence of the disorder. Schizophrenia in prepubertal children includes the presence of at least two of the following: hallucinations, delusions, grossly disorganized speech or behavior, and severe withdrawal for at least 1 month. Social or academic dysfunction must be present, and continuous signs of the disturbance must persist for at least 6 months. The diagnostic criteria for schizophrenia in children are identical to the criteria for the adult form, except that instead of showing deteriorating functioning, children may fail to achieve their expected levels of social and academic functioning.

Before the 1960s, the term childhood psychosis was applied to a heterogeneous group of pervasive developmental disorders without hallucinations and delusions. In the 1960s and 1970s, children with evidence of a profound psychotic disturbance early in life often were observed to be mentally retarded, socially dysfunctional with severe communication and language impairments, and without a family history of schizophrenia. In children with psychoses that emerged after the age of 5, however, auditory hallucinations, delusions, inappropriate affects, thought disorder, and normal intelligence were manifest, and these children often had a family history of schizophrenia; they were viewed as exhibiting schizophrenia, whereas the younger children were identified as having a pervasive developmental disorder.

In the 1980s, schizophrenia with childhood onset was formally separated from autistic disorder. This change reflected evidence accrued during the 1960s and 1970s that the clinical picture, family history, age of onset, and course of the two disorders differed. However, some researchers remained of the opinion that a subgroup of autistic children would eventually develop schizophrenia. In general, schizophrenia is easily differentiated from autistic disorder. Most children with autistic disorder are impaired in all areas of adaptive functioning from early life onward. The onset is almost always before 3 years of age, whereas the onset of schizophrenia usually is in adolescence or young adulthood. Schizophrenia in prepubertal children is much rarer than in adolescence and young

adulthood, and there are practically no reports of an onset of schizophrenia before 5 years of age. According to the text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IVTR), schizophrenia can be diagnosed in the presence of autistic disorder.

The second controversy concerned applying adult diagnostic criteria for schizophrenia to children. Several reports indicate that some children do have hallucinations, delusions, and thought disorders typical of schizophrenia, but normal developmental immaturities in language development and in separating reality from fantasy sometimes make it difficult to diagnose schizophrenia in children ages 5 to 7 years.

The student should study the questions and answers below for a useful review of the condition.

Helpful Hints

The student should understand these terms.

- agranulocytosis
- autistic disorder
- childhood psychosis
- clozapine (Clozaril)
- comorbidity
- delayed motor development
- developmental level and age -appropriate presentations
- diagnostic stability
- disturbed communication
- expressed emotion
- family support
- haloperidol (Haldol)
- high-risk children
- hypersalivation
- persecutory delusions
- pervasive developmental disorders
- premorbid disorders
- premorbid functioning
- risperidone (Risperdal)
- schizotypal personality
- sedation
- social rejection
- tardive dyskinesia
- transient phobic hallucinations
- visual hallucinations

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

53.1 Which of the following statements about schizophrenia among prepubertal children is *true*?

- A. Abnormalities on CT and EEG are found in children with schizophrenia but cannot be used to make the diagnosis.
- B. Childhood-onset schizophrenia is not associated with social withdrawal.
- C. Marked deterioration in functioning is required to make the diagnosis.
- D. Childhood-onset schizophrenia is more common than autistic disorder.
- E. None of the above

53.2 Predictors of poor prognosis in schizophrenia with childhood onset include all of the following *except*

- A. Misdiagnosed schizophrenia in a child with bipolar I disorder
- B. Onset before 10 years of age
- C. Premorbid diagnoses of attention-deficit/hyperactivity disorder (ADHD) and learning disorders
- D. Lack of family support
- E. Delayed motor milestones and delayed language acquisition

53.3 Which of the following is helpful in distinguishing childhood-onset schizophrenia from autistic disorder?

- A. Age of onset of symptoms
- B. Intelligence
- C. Presence of formal thought disorder
- D. Family history of schizophrenia
- E. All of the above

53.4 All of the following statements regarding hallucinations in prepubertal children are true *except*

- A. Auditory and visual hallucinations occur commonly in childhood-onset schizophrenia.
- B. Auditory hallucinations occur in childhood mood disorders.
- C. Auditory hallucinations may occur in children exposed to extreme stress.
- D. Childhood-onset schizophrenia cannot be diagnosed in the absence of hallucinations.

E. Visual hallucinations are pathognomonic in childhood schizophrenia

53.5 Schizophrenia

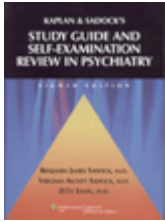
- A. is rare prior to age 13
- B. has a rate of onset that increases sharply in adolescence
- C. occurs predominantly in males among children with the disorder
- D. appears to be essentially the same heterogeneous disorder in children as in adults
- E. all of the above

53.6 Which of the following statements regarding childhood-onset schizophrenia is true?

- A. Command hallucinations do not occur among children with schizophrenia.
- B. Rates of schizophrenia are less common among parents of patients with childhood-onset schizophrenia than among parents of patients with adult-onset schizophrenia.
- C. Among children with schizophrenia, there is often a premorbid history of behavioral disturbances, delayed motor milestones, and delayed language acquisition.
- D. Symptoms of childhood schizophrenia respond more robustly to antipsychotic medication than do symptoms of adult-onset schizophrenia.
- E. Childhood-onset schizophrenic patients are usually mildly to moderately mentally retarded.

53.7 All of the following are true statements about the course and prognosis of depression in children and adolescents *except*

- A. Early onset predicts a poorer prognosis.
- B. There is no increased risk of later developing bipolar disorder among adolescents with a major depressive episode as compared with nondepressed teens.
- C. Depressive disorders are associated with long-term peer relationship difficulties.
- D. Risk of suicide is significant among adolescents with major depressive disorder.
- E. Short-term complications include poor academic achievement



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



54

Adolescent Substance Abuse

Adolescent substance use and abuse remain serious concerns regarding today's youth. Estimates of nearly 25 percent have been made of illicit drug use among adolescents from 12 to 17 years of age. Approximately one of five adolescents has used marijuana or hashish. Approximately one-third of adolescents have used cigarettes by age 17 years. Studies of alcohol use among adolescents in the United States have shown that by 13 years of age, one-third of boys and almost one fourth of girls have tried alcohol. By 18 years of age, 92 percent of males and 73 percent of females reported trying alcohol, and 4 percent reported using alcohol daily. Of high school seniors, 41 percent reported using marijuana; 2 percent reported using the drug daily. Emergency room visits for heroin use among 18- to 25-year-olds increased over 50 percent from 1997 to 2000.

Drinking among adolescents follows adult demographic drinking patterns: The highest proportion of alcohol use occurs among adolescents in the Northeast; whites are more likely to drink than are other groups; among whites, Roman Catholics are the least likely nondrinkers. The four most common causes of death in persons between the ages of 10 and 24 years are motor vehicle accidents (37 percent), homicide (14 percent), suicide (12 percent), and other injuries or accidents (12 percent). Of adolescents treated in pediatric trauma centers, more than one-third are treated for alcohol or drug use.

Studies considering alcohol and illicit drug use by adolescents as psychiatric disorders have demonstrated a greater prevalence of substance use, particularly alcoholism, among biological children of alcoholics than among adopted youngsters. This finding is supported by family studies of genetic contributions, by adoption studies, and by observing children of substance users reared outside the biological home.

During the past decade, several risk factors have been identified for adolescent substance abuse. These include high levels of family conflict, academic difficulties, comorbid psychiatric disorders such as conduct disorder and depression, parental and peer substance use, impulsivity, and early onset of cigarette smoking.

The greater the number of risk factors, the more likely it is that an adolescent will be a substance user.

The student should study the questions and answers below for a useful review of these abuses.

Helpful Hints

The student should be able to define the following terms.

- aerosols
- Al-Anon
- Alateen
- Alcoholics Anonymous (AA)
- Antabuse
- cocaine
- comorbidity
- demographic drinking patterns
- gateway drug
- genetic contributions and adoption studies
- glue
- high-risk behaviors
- inhalants
- marijuana
- Narcotics Anonymous (NA)
- polysubstance abuse
- severity-oriented rating scales
- substance abuse
- substance dependence
- substance intoxication
- substance withdrawal
- 12-step program

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five responses or completions. Select the one that is best in each case.

54.1 Which of these substances is most commonly abused by adolescents?

- A. Marijuana
- B. Alcohol
- C. Cocaine
- D. Methylenedioxymethamphetamine (MDMA, "ecstasy")
- E. Lysergic acid diethylamide (LSD)

54.2 Which of the following statements about adolescent substance abuse is *true*?

- A. Substance use among adolescents does not differ between males and females.
 - B. White and Hispanic students are less likely than African-American students to report lifetime alcohol use and heavy episodic use.
-

P.401

- C. White and Hispanic students are less likely than African-American students to report both lifetime and current marijuana use.
- D. Students who are not college-bound have higher rates of alcohol, cigarette, and illicit drug use than collegebound youths.
- E. None of the above

54.3 Which of these psychiatric disorders is most commonly associated with substance abuse in adolescents?

- A. Conduct Disorder
- B. Attention-Deficit/Hyperactivity Disorder (ADHD)
- C. Schizophrenia
- D. Generalized Anxiety Disorder
- E. None of the above

54.4 Which of the following psychiatric symptoms commonly co-occur with adolescent substance use disorders?

- A. Suicidal ideation and suicide attempts
- B. Panic attacks
- C. Reexperiencing, numbing, and avoidance
- D. Bingeing and purging
- E. All of the above

54.5 Which of the following statements regarding adolescent substance abuse is *true*?

- A. Use of marijuana is the strongest predictor of future cocaine use.
- B. Prevalence rates for cocaine use are currently lower among adolescents than among adolescents in the 1990s.
- C. Children of alcohol abusers have a 25 percent chance of themselves developing alcohol abuse.
- D. Inhalants are most commonly used by younger adolescents, and their use declines with age.
- E. All of the above

54.6 Which of the following statements about adolescents and adults with substance use disorders is *true*?

- A. Relapse in adults is primarily influenced by social pressure for use, whereas in adolescents situations involving negative affect more strongly contribute to relapse.
- B. Compared with adults, adolescents have a lower level of return to substance use after treatment.
- C. Adolescents are no likelier to experience noxious or adverse reactions to substances than more experienced adult users.
- D. Comorbid conduct disorder in adolescents with substance use disorders predicts lower rates of treatment completion and future abstinence.
- E. None of the above

54.7 Successful substance abuse prevention programs appear to be those that

- A. target salient risk factors
- B. teach skills
- C. have follow-up
- D. take into account the socioeconomic and cultural realities of targeted communities
- E. All of the above

54.8 The treatments of choice for alcohol abuse in adolescents includes all of the following *except*

- A. Drug-specific counseling
- B. Self-help groups
- C. Relapse prevention programs
- D. Treatment with disulfiram and/or acamprosate
- E. Individual psychotherapy

54.9 Risk factors for the development of adolescent substance abuse include all of the following *except*

- A. Early onset of cigarette smoking
- B. Diminished parental supervision
- C. Pervasive developmental disorder
- D. Parental substance abuse
- E. Conduct disorder

54.10 The four leading causes of death among young people aged 15 to 24, all of which are correlated with substance abuse, include all of the following *except*

- A. Motor vehicle accidents (MVA)
- B. Cancer

- C. Homicide
- D. Suicide
- E. Non-MVA accidents

Questions 54.11–54.15

54.11 Only category in DSM-IV-TR in which caffeine is included.

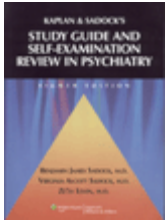
54.12 A maladaptive pattern of substance use, causing clinically significant impairment or distress, manifested by tolerance, withdrawal, and inability to decrease use.

54.13 A reversible syndrome caused by a substance, involving behavioral or psychological changes.

54.14 A maladaptive pattern of substance use causing impairment manifested by diminished performance in school or work, recurrent use in hazardous situations, substancerelated legal issues, and continued use despite recurrent social and interpersonal problems.

54.15 A substance-specific syndrome caused by the cessation or reduction in use of a substance causing distress and impairment.

- A. Substance abuse
- B. Substance dependence
- C. Substance intoxication
- D. Substance withdrawal



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



55

Child Psychiatry: Additional Conditions That May Be a Focus of Clinical Attention

This section covers borderline intellectual functioning, academic problem, antisocial behavior, and identity problem. Borderline intellectual functioning, according to the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSMIV- TR), is a category that can be used when the focus of clinical attention is on a child or adolescent's IQ in the 71 to 84 range.

The intellectual functioning of children plays a major role in their adjustment to school, social relationships, and family function.

Children who cannot quite understand class work and may also be slow in understanding rules of games and the "social" rules of their peer group are often bitterly rejected. Some children with borderline intellectual functioning can mingle socially better than they can keep up academically in class. In these cases, the strengths of these children may be peer relationships, especially if they excel at sports, but eventually, their academic struggles will take a toll on self-esteem if they are not appropriately remediated.

DSM-IV-TR refers to academic problem as a problem that is not caused by a mental disorder or, if caused by a mental disorder, is severe enough to warrant clinical attention. This diagnostic category is used when a child or adolescent is having significant academic difficulties that are not deemed to be due to a specific learning disorder or communication disorder or directly related to a psychiatric disorder. Nevertheless, intervention is necessary because the child's achievement in school is significantly impaired.

Therefore, a child or adolescent who is of normal intelligence and is free of a learning disorder or a communication disorder but is failing in school or doing poorly falls into this category.

According to DSM-IV-TR, child or adolescent antisocial behavior refers to behavior that is not caused by a mental disorder and includes isolated antisocial acts, not a pattern of behavior.

This category covers many acts by children and adolescents that violate the rights of others, such as overt acts of aggression and violence and covert acts of lying, stealing,

truancy, and running away from home. Certain antisocial acts, such as fire setting, possession of a weapon, or a severe act of aggression toward another child, require intervention for even a single occurrence.

Sometimes, children without a pattern of recurrent aggression or antisocial behavior become involved in occasional, less severe behavior that nevertheless require some intervention. The DSM-IV-TR definition of conduct disorder requires a repetitive pattern of at least three antisocial behaviors for at least 6 months, but childhood or adolescent antisocial behavior may consist of isolated events that do not constitute a mental disorder but do become the focus of clinical attention.

According to DSM-IV-TR, identity problem refers to uncertainty about issues such as goals, career choice, friendships, sexual behavior, moral values, and group loyalties. An identity problem can cause severe distress for a young person and can lead a person to seek psychotherapy or guidance. Identity problem is, however, not recognized as a mental disorder in DSM-IV-TR. It sometimes manifests in the context of such mental disorders as mood disorders, psychotic disorders, and borderline personality disorder.

The student should study the questions and answers below for a useful review of these conditions.

Helpful Hints

The student should be able to define the following terms.

- abulia
- academic failure
- achievement tests
- adaptive function
- adolescent turmoil
- comorbid disorders
- dysfunctional family
- Erik Erikson
- hyperactivity and impulsivity
- identity formation
- irreconcilable conflicts
- juvenile delinquent
- learning disorder
- mental retardation
- parental criminality
- performance anxiety
- physical abuse
- role diffusion
- sense of self
- sexual orientation
- substance use
- superego
- tutoring

- underachievement
- "V" code
- violation of rights

Questions/Answers

Directions

The incomplete statement below is followed by five suggested completions. Select the *one* that is best.

55.1 Which of the following aspects of a child's peer relationships should be assessed when evaluating for identity problems?

- A. Number of friends
- B. Quality of friendships
- C. Behavioral and emotional difficulties of friends
- D. Friends' attitudes towards school and achievement
- E. All of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 55.2–55.4

55.2 Deterioration in occupational, school, or social functioning

55.3 Subjective anxiety and confusion

55.4 Disturbances in thinking processes, such as flight of ideas or thought blocking

- A. Identity problem
- B. Normal adolescence
- C. Both
- D. Neither

Questions 55.5–55.8

55.5 Coded on Axis II in DSM-IV-TR nosology

55.6 Must be differentiated from conduct disorder

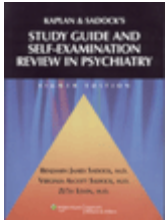
55.7 Consists of isolated events rather than a pattern of behavior

55.8 Normal intelligence and no learning disorder or communication disorder, but

the child is failing in school

- A. Academic problem
- B. Childhood or adolescent antisocial behavior
- C. Borderline intellectual functioning





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



56

Psychiatric Treatment of Children and Adolescents

To approach a child therapeutically, one must have a sense of normal development for a child of a given age as well as an understanding of the life story of the particular child. Wide normal variation exists with respect to how facile children are at describing their emotions in words and the level of motivation with which they engage in this process. Individual psychotherapy with children focuses on improving children's adaptive skills in and outside the family setting. Treatment reflects an understanding of children's developmental levels and shows sensitivity toward families and environments in which children live. Most children do not seek psychiatric treatment; they are taken to a psychotherapist because of a disturbance noted by a family member, a schoolteacher, or a pediatrician. Children often believe that they are being taken for treatment because of their misbehavior or as a punishment for wrongdoing.

In individual psychotherapy, psychodynamic approaches are sometimes mixed with supportive and behavioral management techniques. Individual therapy is frequently associated with family therapy, group therapy, and, when indicated, pharmacotherapy.

The goal of therapy is to help develop good coping and conflict-resolution skills in children who are having trouble achieving or resolving developmental tasks that can lead to difficulties fulfilling later developmental capacities.

An evaluation for the use of medication in children must include a thorough physical examination, an assessment of the child's caregivers' abilities to monitor medication compliance and risks, and a rigorous diagnostic evaluation. Often, the success of drug trials hinges on the physician being available on a daily basis, especially at the beginning. An understanding of childhood pharmacokinetics is essential. Children, compared to adults, have greater hepatic capacity, more glomerular filtration, and less fatty tissue. Thus, many drugs are eliminated more quickly in children than in adults, are less often stored in fat, and have shorter half-lives. The goals of pediatric psychopharmacology include decreasing maladaptive behaviors and increasing adaptive functioning in academic and social settings.

Cognitive dulling must be avoided. Indications for the use of medications in children and adolescents include behavioral and emotional problems associated with mental

retardation, learning disorders, autistic disorder, attention-deficit/hyperactivity disorder, conduct disorder, Tourette's disorder, enuresis, separation anxiety disorder, schizophrenia, mood and anxiety disorders, obsessive-compulsive disorder, eating disorders, and sleep disorders.

Clinicians must be aware of the indications, side effects, and risk to benefit ratios associated with each of the medications used in treatment of children and adolescents. Electroconvulsive therapy (ECT) is not indicated in childhood or adolescence.

The student should study the questions and answers below for a useful review of these treatments.

Helpful Hints

These terms should be known and defined by the student.

- acting out
- action-oriented defenses
- activity group therapy
- ADHD
- anticonvulsants
- atypical puberty
- autistic disorder
- behavioral contracting
- bell-and-pad conditioning
- biological therapies
- cardiovascular effects
- child guidance clinics
- child psychoanalysis
- classical and operant conditioning
- cognitive therapy
- combined therapy
- communication disorders
- compliance
- conduct disorder
- confidentiality
- conflict-resolution skills
- depressive equivalents
- developmental fluidity
- developmental lines
- developmental orientation
- dietary manipulation
- ECT
- enuresis
- externalization
- family systems theory

- filial therapy
- group living
- group selection criteria
- group therapy
- growth suppression
- haloperidol (Haldol)
- hospital treatment
- interview techniques
- learning-behavioral theories
- lithium

-
- liver to body-weight ratio
 - MAOIs
 - masked depression
 - milieu therapy
 - modeling theory
 - mood disorders
 - obsessive-compulsive disorder
 - parent groups
 - parental attitudes
 - pharmacokinetics
 - play group therapy
 - playroom
 - psychoanalytic theories
 - psychoanalytically oriented therapy
 - puberty and adolescence (differentiation)
 - regression
 - relationship therapy
 - remedial and educational psychotherapy
 - renal clearance
 - residential and day treatment
 - risk to benefit–ratio analysis
 - same-sex groups
 - schizophrenia
 - self-observation
 - sequential psychosocial capacities
 - sleep terror disorder
 - substance abuse
 - suicide
 - supportive therapy

- sympathomimetics
- tardive dyskinesia
- therapeutic interventions
- therapeutic playroom
- Tourette's disorder
- tricyclic drugs
- violence

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

56.1 Cognitive-behavioral therapy is useful in the treatment in which of the following disorders or situations?

- A. Conduct disorder
- B. Adolescent depression in a group setting
- C. Obsessive-compulsive disorder
- D. Socially rejected children
- E. All of the above

56.2 In attention-deficit/hyperactivity disorder

- A. Treatment with stimulant medication alone is maximally effective in older children and adolescents.
- B. Stimulant medication equally improves the full range of symptoms of children with the disorder, including comorbid behavioral disturbances.
- C. Treatment with stimulant medication alone tends to significantly improve outcomes for children with oppositional and aggressive behavior, academic underachievement, and poor peer relationships.
- D. Presence of aggression in children and parents are strong predictors of poor outcome in treatment of ADHD.
- E. All of the above

56.3 Parent-child conflict is a risk factor for

- A. Depression
- B. Poor treatment outcome in depression
- C. Relapse after treatment for depression
- D. Cognitive distortions that negatively bias perceptions
- E. All of the above

56.4 The systems approach to family therapy

- A. Places more emphasis on the meaning of a child's symptoms for the larger family than on the child's specific symptoms
- B. Maintains that all things are interdependent and nothing changes without everything else changing
- C. Sees symptoms as serving a purpose for the family system
- D. Views each family member as acting in a way that opposes symptomatic improvement in the presenting patient
- E. All of the above

56.5 With regard to adverse effects of medications in children and adolescents

- A. Tardive dyskinesia has not been observed in this age group
- B. Withdrawal dyskinesias do occur in this age group
- C. Anticholinergic and cardiovascular side effects are rarely seen in this age group
- D. There is less risk for adverse effects in this age group as compared with adults
- E. None of the above

56.6 Which theorist described a series of "developmental pathways," for example a pathway that connects a child's capacity to play to the adult's capacity to work?

- A. Sigmund Freud
- B. Anna Freud
- C. Donald Winnicott
- D. Melanie Klein
- E. Margaret Mahler

56.7 In terms of pharmacokinetics, as compared to adults, children have

- A. Lower hepatic capacity
- B. Lower glomerular filtration rates
- C. More fatty tissue
- D. Increased half-lives of medications
- E. None of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be

Questions 56.8–56.15

56.8 A 12-year-old boy performs 3 hours of daily compulsive hand washing and has extreme difficulty going to school because of contamination fears

56.9 A 10-year-old girl became oppositional and defiant shortly after her mother married a man with three children

56.10 A 15-year-old girl has lost 25 percent of her body weight and cannot control her purging behaviors

56.11 A 17-year-old girl has recently been discharged from an inpatient unit after a suicide attempt in the midst of a severe depression

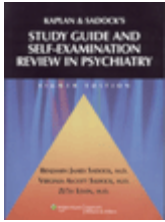
56.12 A 14-year-old girl has not been in school for several weeks because she has been bothered by derogatory auditory hallucinations; she is not suicidal or homicidal

56.13 An 8-year-old boy will not attend sleepover parties because of his bedwetting

56.14 A 7-year-old boy is about to be suspended from school because of his inability to sit in his seat and stay on task as well as his provocative behavior toward his classmates

56.15 A 9-year-old boy with chronic vocal and motor tics, as well as significant impulsivity and frequent aggressive behavior toward his peers at school and siblings; this patient's tics were severely exacerbated during a prior trial of methylphenidate.

- A. Interpersonal, cognitive, and/or psychodynamic therapy plus fluoxetine
- B. Response prevention plus sertraline
- C. Guanfacine
- D. Social skills group plus methylphenidate
- E. Desmopressin (DDAVP) nasal spray plus behavioral conditioning
- F. Family therapy
- G. Partial hospital plus risperidone
- H. Inpatient unit with psychodynamic, family, and behavioral interventions



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



57

Forensic Issues in Child and Adolescent Psychiatry

Child and adolescent psychiatrists are increasingly sought out by patients and attorneys for evaluations and expert opinions related to child custody and criminal behaviors perpetrated by minors, and to evaluate the relations between traumatic life events and the emergence of psychiatric symptoms in children and adolescents. In medicine, ethics historically has alluded to moral obligations as well as to the accepted behavior that physicians follow; on the broadest scale, the Hippocratic oath summarizes ethical values in medicine. During the past few decades, however, new ethical and moral dilemmas have arisen with the growth of medical knowledge and technology. The traditional ethical tenet that physicians must consider each patient above all else has often been challenged. For example, a patient may be kept alive for long periods while in a coma or a pregnant woman's life may be saved by aborting her fetus.

Society's view of children and their rights has evolved dramatically in the 20th century. The institution of a juvenile court system about 100 years ago was an acknowledgment that children must be protected and provided for differently than adults. In 1980, the American Academy of Child and Adolescent Psychiatry published a code of ethics that was developed to publicly endorse the ethical standards of this discipline.

The code is based on the assumption that children are vulnerable and unable to take adequate care of themselves, but as they mature, their capacity to make judgments of, and choices about, their well-being develop as well. The code has several caveats: from the standpoint of child and adolescent psychiatrists, issues of consent, confidentiality, and professional responsibility must be seen in the context of overlapping and potentially conflicting rights of children, parents, and society.

Students should study the questions and answers below for a useful review of basic issues.

Helpful Hints

These terms should be known and defined by the student.

- adjudicated delinquent
- adjudication

- “best interests of the child”
- breach of confidentiality
- child custody evaluation
- confidentiality
- delinquent act
- disposition
- intake
- joint custody
- juvenile court
- mediation
- proof beyond a reasonable doubt
- rehabilitation
- status offenses
- “tender-years” doctrine
- waiver of confidentiality

Questions/Answers

Directions

The incomplete statement below is followed by five suggested completions. Select the *one* that is best.

57.1 Breach of confidentiality by a psychiatrist is required in all of the following situations *except*

- A. A suicidal adolescent patient
- B. A homicidal adolescent patient
- C. Disclosure of sexual abuse by a patient
- D. A child custody evaluation
- E. Drug or alcohol use by an adolescent patient

Directions

Each set of lettered headings below is followed by a list of numbered statements. For each numbered statement, select

- A. if the item is associated with A only
- B. if the item is associated with B only
- C. if the item is associated with both A and B
- D. if the item is associated with neither A nor B

Questions 57.2–57.7

57.2 Rights to legal counsel, Fifth Amendment privilege, and notice of charges

57.3 Pretrial hearing, trial, sentencing

57.4 Trial by jury

57.5 Intake, adjudication, disposition

57.6 Disposition occurs immediately after confession

57.7 Trial only by judge, without a jury

A. Juvenile court system

B. Adult court system

Questions 57.8–57.10

57.8 Young children are usually better off with their mothers.

57.9 Current law in the United States.

57.10 There may be a situation in which custody should reside with a non-parent.

A. "Tender-years" doctrine

B. "Best interests of the child" doctrine

Directions

The group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 57.11–57.14

57.11 Specified that the standard "beyond a reasonable doubt" must be followed in delinquency hearings

57.12 Specified that juveniles have the right to confront witnesses in delinquency trials

57.13 Identified clinicians' duties to warn third parties of imminent danger

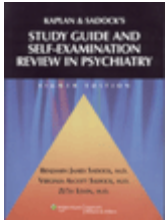
57.14 Determined that all handicapped children should be provided a free and appropriate public education in the least restrictive environment

A. "In re Gault" case

B. "In re Winship" case

C. Tarasoff I and Tarasoff II rulings

D. Education for All Handicapped Children Act of 1975



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



58

Geriatric Psychiatry

Geriatric psychiatry is concerned with preventing, diagnosing, and treating psychological disorders in older adults. It is also concerned with promoting longevity; persons with a healthy mental adaptation to life are likely to live longer than those stressed with emotional problems. Mental disorders in the elderly often differ in clinical manifestations, pathogenesis, and pathophysiology from disorders of younger adults and do not always match the categories in the text revision of the 4th edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). Diagnosing and treating older adults can present more difficulties than treating younger persons because older persons may have coexisting chronic medical diseases and disabilities, may take many medications, and may show cognitive impairments.

Prevalence data for mental disorders in elderly persons vary widely, but a conservatively estimated 25 percent have significant psychiatric symptoms. The number of mentally ill elderly persons is expected to rise to 20 million by the middle of the century. The American Board of Psychiatry and Neurology established geropsychiatry (from the Greek *geros* ["old *age*"] and *iatros* ["physical"]) as a subspecialty in 1991, and today geriatric psychiatry is one of the fastest growing fields in psychiatry.

Predisposing psychosocial risk factors for mental disorders in the elderly include many losses, such as those of social roles, autonomy and independence, family and friends, health, and finances. There is a high prevalence of cognitive disorders in older people, ranging from what are considered minor age-related memory impairments, termed benign senescent forgetfulness, to full-blown dementias, such as Alzheimer's disease. Dementia is the second most common cause of disability in people over 65 years of age, after arthritis. In the United States, about 5 percent of people over 65 years of age have severe dementia, and about 15 percent have mild dementia. Over the age of 80 years, about 20 percent have severe dementia.

The student should study the questions and answers below for a useful review of these issues in this field.

Helpful Hints

Each of the following terms relating to geriatric issues should be defined.

adaptational capacity

- advocacy
- agedness
- agitation and aggression
- akathisia
- alcohol- and other substance -use disorders
- Alzheimer's disease
- anoxic confusion
- anxiety disorder
- benign senescent forgetfulness
- benzodiazepines
- cerebral anoxia
- code of ethics
- cognitive functioning
- consent for disclosure of information
- conversion disorder
- delirium
- dementia
- dementing disorder
- depression
- developmental phases
- diabetes
- disorders of awareness
- drug blood level
- elder abuse
- hypochondriasis
- hypomanic disorder
- ideational paucity
- insomnia
- l-dopa (Larodopa)
- late-onset schizophrenia
- LH
- lithium
- loss of mastery
- manic disorder
- MMSE (Mini-Mental Status Examination)
- mood disorder
- neurosis
- norepinephrine
- nutritional deficiencies

obsessive-compulsive disorder

- organic mental disorder
- orientation
- overt behavior
- paradoxical reaction
- paraphrenia
- presbyopia
- psychopharmacology
- psychotropic danger
- ranitidine (Zantac)

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

58.1 Which of the following is true?

- A. The prevalence of dementia is higher in institutionalized patients than in patients in the community.
- B. The prevalence of Alzheimer's disease is higher in African Americans compared to Caucasians.

P.419

- C. Approximately 60 percent of dementias in Asian populations are of the vascular type.
- D. Depression is a risk factor for dementia.
- E. All of the above

58.2 Anxiety disorders in the elderly

- A. are uncommon
- B. are more common in men
- C. most commonly present as phobic disorder
- D. most commonly present as panic disorder
- E. increase in prevalence with increasing age

58.3 Which of the following statements about the biology of aging is *false*?

- A. Each cell of the body has a genetically determined life span.
- B. The optic lens thins.
- C. The T-cell response to antigens is altered.

- D. A decrease in melanin occurs.
- E. Brain weight decreases.

58.4 Which of the following statements about learning and memory in the elderly is false?

- A. Complete learning of new material still occurs.
- B. On multiple choice tests, recognition of correct answers persists.
- C. Simple recall remains intact.
- D. IQ remains stable until age 80 years.
- E. Memory-encoding ability diminishes.

58.5 In the physical assessment of the aged, which of the following statements is false?

- A. Toxins of bacterial origin are common.
- B. The most common metabolic intoxication causing mental symptoms is uremia.
- C. Cerebral anoxia often precipitates mental syndromes.
- D. Severe vitamin deficiencies are common.
- E. Nutritional deficiencies may cause mental symptoms.

58.6 In a neuropsychological evaluation

- A. verbal memory is measured by reading patients a list of words and then having them repeat the words recalled
- B. information processing speed is measured by having patients rapidly complete rote tasks
- C. word retrieval is measured by having patients provide precise names for pictured objects
- D. visual perception is measured by having patients identify missing parts of pictured objects
- E. all of the above

58.7 Creutzfeldt Jakob disease is

- A. not an inherited disease
- B. associated with agnosia
- C. infectious
- D. another name for Kuru
- E. associated with tau-containing intra-neuronal inclusion bodies

58.8 Elderly persons taking antipsychotics are especially susceptible to the

following side effects *except*

- A. tardive dyskinesia
- B. akathisia
- C. a toxic confusional state
- D. paresthesias
- E. dry mouth

58.9 Abnormalities of cognitive functioning in the aged are most often due to

- A. depressive disturbances
- B. schizophrenia
- C. medication
- D. cerebral dysfunctioning or deterioration
- E. hypochondriasis

58.10 Neuro-imaging of brains in Alzheimer's disease

- A. reveals T2 hyper-intensities on MRI
- B. reveals reductions in the entorhinal cortex on volumetric MRI
- C. reveals reductions in the cerebral metabolic rate for glucose (CMRgl)
- D. all of the above
- E. none of the above

58.11 Which of the following is *true*?

- A. The prevalence of major depression is higher in the elderly than in younger patients.
- B. Older adults experience sadness more than younger people.
- C. Aging results in a decreased ability to inhibit negative emotions.
- D. Emotional distress increases with age.
- E. In general, elderly African Americans are less distressed than elderly Caucasians.

58.12 Which of the following statements about the pharmacological treatment of the elderly is *false*?

- A. The elderly use more medications than any other age group.
- B. 25 percent of prescriptions are for those over age 65 years.
- C. In the United States, 250,000 people a year are hospitalized because of adverse reactions to medications.
- D. About 25 percent of hypnotics dispensed in the United States each year are to those over age 65 years.

E. About 70 percent of the elderly use over-the-counter (OTC) medications.

58.13 All of the following risk factors for dementia of the Alzheimer's type are regarded as confirmed *except*

- A. apolipoprotein E genotype
- B. Down's syndrome
- C. family history
- D. aluminum
- E. age

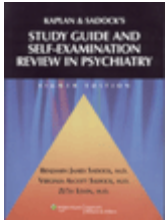
P.420

58.14 Possible protective factors against dementia include

- A. anti-inflammatory drugs
- B. estrogen replacement therapy
- C. red wine
- D. education
- E. all of the above

58.15 Sleep changes associated with normal aging include

- A. reduction in stage 4 sleep
- B. increased fragmentation of sleep
- C. reduction in REM sleep
- D. disruption of the circadian sleep-wake rhythm
- E. all of the above



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



59

End-of-Life Care and Palliative Medicine

End of *life* refers to all those issues involved in caring for the terminally ill. It begins when curative therapy ceases and encompasses the following areas: (1) communication of prognosis to family and patient, and defining the patient's understanding of his or her illness; (2) advance directives about life-sustaining treatment; (3) the need for hospitalization and hospice care; (4) legal and ethical matters; (5) bereavement support and psychiatric care; and finally (6) palliative care to relieve pain and suffering. The hospice movement began in the early 1960s, and provides a place (it may be an institution or a home) where a multidisciplinary team provides round-the-clock coverage to the terminal patient.

The control of pain is a primary goal, and narcotics are provided without fear of addiction. Effective pain management is critical, and physicians must use narcotics as liberally as they are needed and tolerated. This aspect of care is difficult for many doctors, who have been trained to use narcotics sparingly, if at all, out of fear of creating addictions, and who may also have become desensitized to or skeptical of expressions of pain in their patients. Hospice care's essential goal is to allow dying patients and their families to conduct their final interactions with as much dignity and control as possible.

A living will is a legal document in which patients provide instructions to their doctors about what life-support measures they will and will not accept. The American Medical Association (AMA) states that doctors can withhold all life-support treatment, including food and water, from patients in irreversible comas, as long as the diagnosis is confirmed adequately. In these cases, a physician does not intentionally cause the person's death (euthanasia) but rather, in consultation with the patient's family or guardian, lets the patient die. Euthanasia, or physician-assisted suicide, is defined as the doctor's deliberate act to kill a patient by directly administering a lethal dose of some drug or other agent. The ethical issues surrounding euthanasia are profound.

The student should study the questions and answers below for a useful review of this field.

Helpful Hints

The student should know and define the following terms.

advance directives

- DNI
- DNR
- end-of-life symptoms
- euthanasia (active, passive, involuntary, voluntary)
- health care proxies
- hospice
- hydromorphone
- living wills
- maintenance versus prn analgesics
- mercy killing
- morphine
- neonatal and child end -of-life decisions
- neuropathic pain
- opioids
- pain suppression pathways
- palliative versus curative treatment
- Patients Self- Determination Act
- physician-assisted suicide
- psychogenic pain
- psychotoxicity
- somatic pain
- Uniform Rights of the Terminally Ill Act
- visceral pain

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the one that is best in each case.

59.1 A risk factor for the development of aversive reactions in physicians is when

- A. the physician identifies the patient with someone in his or her own life
- B. the physician is dealing with a sick family member
- C. the physician feels professionally insecure

- D. the physician is fearful of death and disability
- E. all of the above

P.425

59.2 The most common cause of undertreatment in patients is

- A. lack of knowledge or resources
- B. lack of communication between the doctor and patient
- C. patients with high pain threshold
- D. when inexperienced doctors are overanxious
- E. noncompliance

59.3 Of the following drugs, the least likely to cause psychotoxicity is

- A. morphine
- B. levorphanol (Levo-Dromoran)
- C. methadone (Dolophine)
- D. hydromorphone (Dilaudid)
- E. none of the above

59.4 Which of the following is not true regarding patients with strong religious beliefs?

- A. Patients with strong religious beliefs are often better able to deal with end of life issues.
- B. Patients with strong religious beliefs may explain illness as a test of their faith.
- C. Patients with strong religious beliefs may see suffering as having redemptive values.
- D. Patients with strong religious beliefs have a higher pain threshold.
- E. Patients with strong religious may be strengthened by their illness.

59.5 Advance directives

- A. are legally binding in all 50 states
- B. include living wills
- C. include health care proxies
- D. include DNR and DNI
- E. all of the above

59.6 When communicating with a severely ill child, all of the following are true *except*

- A. The doctor must let the ill child know they will never be abandoned.
- B. Parents may tell the child about their illness.
- C. The physician may tell the child that he or she is going to die.
- D. A doctor may sedate the child to limit anxiety about bad news.
- E. The physician must clarify what the child already knows about their illness.

59.7 Which of the following limits anxiety in terminally ill children?

- A. Adequate relief of physical symptoms
- B. Consistent contact with parents
- C. Child-friendly hospital environment
- D. Avoiding prolonged separation
- E. All of the above

59.8 What percentage of cancer patients are said to suffer from excruciating pain if left untreated?

- A. 10 percent
- B. 20 percent
- C. 50 percent
- D. 75 percent
- E. 90 percent

59.9 Adequate palliative pain control should be sought in all of the following conditions *except*

- A. AIDS
- B. Advanced multiple sclerosis
- C. Pancreatic cancer
- D. Coma
- E. Metastatic melanoma

59.10 Which of the following statements regarding pain control is *true*?

- A. Providing patients with medications as needed (PRN) is the best option.
- B. Rescue doses of medications should not be made available.
- C. Around the clock medication administration does not provide the best pain control.
- D. Faster pain control is achieved with PRN doses.
- E. Maintenance pain dosing allows for an early and preemptive response.

59.11 All of the following statements regarding pain and psychiatric illness are true *except*

- A. Patients with a history of substance abuse should never be given opioids.
- B. Treatment of pain can improve mental illness.
- C. Treatment of mental illness can improve pain.

D. Patients with pain have higher incidences of depression.

E. Psychiatric patients' pain is often dismissed.

59.12 Mr. S is a 50-year-old male with newly diagnosed metastatic small cell lung cancer. He was noted by his family to be anxious, to the point of having panic symptoms when his wife would leave his bedside to attend to chores. He would start hyperventilating; would feel short of breath; would become restless and unable to concentrate on anything; and would be overwhelmed with morbid ruminations about his future. He was upset and felt guilty at having become overly dependent on his wife.

All of the following interventions would help this patient *except*

A. Relaxation and breathing exercises

B. Clonazepam

C. Psychoanalysis

D. Meditation

E. Fluoxetine

59.13 A psychiatric consultation was sought to evaluate depression in a 56-year-old male with pancreatic cancer. His

P.426

severe back pain was being well-treated with morphine. The patient was noted by the inpatient staff to be more withdrawn, disengaged, and quiet, making poor eye contact and sleeping most of the day. On examination, the psychiatric consultant found the man to be difficult to arouse and to be mildly confused and disoriented. His speech was slow and his thought process disorganized. He admitted to intermittently experiencing visual hallucinations that he had been too embarrassed to report earlier to the nursing staff. The man was diagnosed with a hypoactive delirium secondary to opioid medications.

Which of the following is the most appropriate next step in his management?

A. Decrease dose of morphine

B. Decrease frequency of morphine

C. Discontinue morphine

D. Add an antipsychotic

E. Do nothing

59.14 When should the transition to palliative care be made?

A. At diagnosis of illness

B. At realization illness is not curable

C. When nearness of death is acknowledged

D. When the physician has no more options to consider

E. None of the above

59.15 Which of the following is a legitimate reason to withhold PCA opioid pain medications from children?

- A. Possibility of addiction
- B. Sedation
- C. Injudicious use/Overmedication
- D. Non-terminal disease
- E. None of the above

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the *one* lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 59.16–59.21

59.16 Occurs in 80 percent of terminal lung cancer patients

59.17 May follow pelvic radiation

59.18 Common in end-state multiple sclerosis

59.19 Most common occurrence in terminal illness

59.20 Occurs in the majority of all terminal patients

59.21 Opioids may be of use

- A. Delusions
- B. Fatigue or weakness
- C. Dysphagia
- D. Incontinence
- E. Dyspnea or cough

Questions 56.22–56.26

59.22 Mercy killing

59.23 Physician withholds artificial life-sustaining measures

59.24 Physician deliberately intends to kill a patient to alleviate or prevent suffering

59.25 Imparting of information or means that enable a person to take his or her own life

59.26 Palliative care designed to alleviate the suffering of a dying patient

- A. Euthanasia

- B. Physician-assisted suicide
- C. Both
- D. Neither

Questions 59.27–59.30

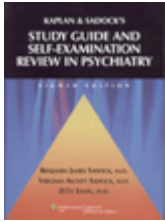
59.27 Sense of pain in a limb that has been amputated

59.28 Diaphragmatic pain referred to the shoulder

59.29 Bone metastases

59.30 Somatization disorder

- A. Somatic pain
- B. Visceral pain
- C. Neuropathic pain
- D. Psychogenic pain
- E. None of the above



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



60

Forensic Psychiatry

Forensic psychiatry is the branch of medicine that deals with disorders of the mind and their relation to legal principles. The word forensic means belonging to the courts of law. At various stages in their historical development, psychiatry and the law have converged. Today, the two disciplines often intersect, especially when dealing with the criminal who, by violating the rules of society secondary to mental disorder, adversely affects the functioning of the community. Traditionally, the psychiatrist's efforts help explain the causes and, through prevention and treatment, reduce the self-destructive elements of harmful behavior. The lawyer, as the agent of society, is concerned that the social deviant is a potential threat to the safety and security of other persons. Both psychiatry and the law seek to implement their respective goals through the application of pragmatic techniques based on empirical observations.

Psychiatrists can act as either witnesses of fact or expert witnesses. As a witness of fact, a psychiatrist is acting as an ordinary witness, someone who has observed something and is being called to describe it in open court. This can include simply reading portions of a medical record into the legal record, but does not include expressing opinions or reporting others' statements.

An expert witness is one who is accepted by the court and by advocates of both sides of the case as qualified to perform expert functions, and whose qualifications may include education, publications, and board certifications. Expert witnesses may render opinions, for example, that a patient meets the legal criteria for a guardian appointment. Psychiatrists often act as expert witnesses and may be hired by the defense or prosecution to provide opinions. This may lead to the common situation in which two psychiatrists representing two different sides provide diametrically opposed opinions about the case under dispute. The result can be confusion both on the parts of juries and the public about the value of psychiatric testimony, as well as cynicism and disillusionment. Many experts in forensic psychiatry believe that this problem could be minimized if the testifying psychiatrists were appointed by, and reported only to, the court.

The student should study the questions and answers below for a useful review of all of these topics.

Helpful Hints

The student should be able to define each of these terms and know each of these cases.

- abandonment
- actus reus
- alliance threat
- antisocial behavior
- battery
- Judge David Bazelon
- civil commitment
- classical tort
- competence to inform
- competency
- confidentiality
- consent form
- conservator
- court-mandated evaluation
- credibility of witnesses
- culpability
- custody
- disclose to safeguard
- discriminate disclosure
- documentation
- Durham rule
- duty to warn
- emancipated minor
- emergency exception
- forced confinement
- the four Ds
- Gault decision
- going the extra mile
- habeas corpus
- hearsay
- informal admission
- informed consent
- insanity defense
- involuntary admission
- irresistible impulse
- judgment
- leading

Questions/Answers

- A. malpractice
- B. mature minor rule
- C. medical expert
- D. mens rea
- E. mental-health information service
- F. M’Naghten rule
- G. model penal code
- H. O’Connor v Donaldson
- I. parens patriae
- J. peonage
- K. plea bargaining
- L. pretrial conference
- M. probationary status
- N. right to treatment
- O. right-wrong test
- P. rules of evidence
- Q. seclusion and restraint
- R. state training school standards
- S. Thomas Szasz
- T. Tarasoff v Regents of University of California (I and II)
- U. task-specific competence
- V. temporary admission
- W. testamentary capacity
- X. testator
- Y. testimonial privilege
- Z. voluntary admission
- AA. Wyatt v Stickney

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested

responses or completions. Select the *one* that is *best* in each case.

60.1 A tort is a

- A. wrongdoing
- B. writ
- C. subpoena
- D. judgment
- E. good deed

60.2 An example of a tort is when a doctor

- A. hugs a patient
- B. dates a family member of a former patient
- C. tells a patient that sex with him or her is therapeutic
- D. maintains confidentiality in the face of a subpoena
- E. lists the adverse effects of drugs when prescribing

60.3 Psychiatrists can be sued for

- A. battery
- B. invasion of privacy
- C. misrepresentation
- D. false imprisonment
- E. all of the above

60.4 The most frequent issue involving lawsuits against psychiatrists is

- A. suicide
- B. improper use of restraints
- C. sexual involvement
- D. drug reactions
- E. violence

60.5 Durable Power of Attorney

- A. is an attorney whose main expertise is psychiatric malpractice cases
- B. is power which permits the patient to have visitation rights
- C. is a document that permits the doctor to breach confidentiality
- D. is a document that permits persons to make provisions for their decision-making capacity
- E. has a limited duration of time

60.6 Involuntary termination of treatment of a patient by a therapist

- A. may result in a malpractice claim of abandonment
- B. cannot be done during a patient emergency
- C. requires careful documentation
- D. should include transfer of services to others
- E. all of the above

60.7 A person considered competent to be executed

- A. must be aware of the punishment
- B. must know its purpose
- C. may come to whatever peace is appropriate with religious beliefs
- D. might recall forgotten details of the events
- E. all of the above

60.8 Pick the best answer regarding *Dusky v United States*:

- A. Harmless mental patients cannot be confined against their wills without treatment if they can survive outside.
- B. An involuntary patient who is not receiving treatment has a constitutional right to be discharged.
- C. A test of competence was approved to see if a criminal defendant can rationally consult with a lawyer and has a factual (and rational) understanding of the proceedings against him or her.
- D. Civilly committed persons have a constitutional right to adequate treatment.
- E. A clinician must notify the intended victim(s) when there is an imminent threat posed by his or her patient.

60.9 In a child-custody dispute, which of the following is *not true*?

- A. A natural parent has the inherent right to be named custodial parent.
- B. The best interest of the mother may be served by naming her as the custodial parent.
- C. More fathers are asserting custodial claims.
- D. Courts presume that a child is best served by maternal custody when the mother is a good and fit parent.
- E. In 5 percent of all cases, fathers are named the custodians.

60.10 Confidential communications can be shared with which of the following *without* the patient's consent?

- A. A medical or psychiatric consultant
- B. The patient's family
- C. The patient's attorney
- D. The patient's previous therapist
- E. An insurer of the patient

60.11 Product rule is concerned with

- A. testimonial privilege
- B. involuntary admission
- C. criminal responsibility
- D. competency to stand trial
- E. all of the above

60.12 Negligent prescription practices may include

- A. prescribing the wrong dosages
- B. unreasonable mixing of drugs
- C. failure to disclose side effects

-
- D. poor hand writing
 - E. all of the above

P.433

60.13 The Gault decision applies to

- A. minors
- B. habeas corpus
- C. informed consent
- D. battery
- E. none of the above

60.14 Situations in which there is an obligation on the part of the physician to report to authorities information that may be confidential include

- A. suspected child abuse
- B. the case of a patient who will probably commit murder and can only be stopped by notification of police
- C. the case of a patient who will probably commit suicide and can only be stopped by notification of police
- D. the case of a patient who has potentially life-threatening responsibilities (for example, airline pilot) and who shows marked impairment of judgment

E. all of the above

60.15 Of the following, which is the *least* common cause of malpractice claims against psychiatrists by patients?

- A. suicide attempts
- B. improper use of restraints
- C. failure to treat psychosis
- D. sexual involvement
- E. substance dependence

60.16 Which of the following is *not* one of the basic elements of the insanity defense?

- A. Presence of a mental disorder
- B. Presence of a defect of reason
- C. Finding of incompetence to stand trial
- D. Lack of knowledge of the nature of the act
- E. Incapacity to refrain from the act

60.17 A 43-year-old prisoner is found to have major depressive disorder. The correctional psychiatrist wants to start him on antidepressant therapy due to the severity of his disease.

Hewas very often in solitary confinement for violent behavior with correctional staff. The prisoner refuses to take any medications, stating he doesn't want to complicate his life any more by having to take drugs everyday.

Correctional officers tell you it would be a security risk to have this prisoner out of his cell every day for treatment anyway.

What is the most appropriate next step in his management?

- A. Don't give the prisoner antidepressants, as he has the right to refuse.
- B. Don't give the prisoner antidepressants, as it is a security risk.
- C. Don't give the prisoner antidepressants, as it is not a medical emergency.
- D. Give the prisoner antidepressants, as he does not have the right to refuse.
- E. Do nothing, and observe the prisoner for worsening symptoms.

60.18 Which of the following statements regarding juvenile detention centers is *true*?

- A. Suicide in juvenile detention centers occur 4 times as often as in the general population.
- B. Suicide prevention guidelines are strictly enforced in juvenile detention centers.

- C. Prevalence of mental illness in detention centers is extensively researched.
- D. Juvenile detention centers are long-term facilities for juveniles convicted of a crime.
- E. More than 80 percent of incarcerated boys meet the criteria for PTSD.

60.19 A 30-year-old white woman was admitted to a local hospital because of cocaine abuse and major depression with suicidal ideation. She had been referred to the hospital after being arrested for cocaine use. She had a history of bipolar disorder since childhood.

Which of the following is the most appropriate discharge plan for this patient?

- A. Discharge to local jail
- B. Discharge to home
- C. Discharge to care of her family
- D. Discharge to psychiatric ward within a correctional facility
- E. Discharge to substance abuse detoxification center

60.20 In the case above, the patient cut her wrists four days later.

The most appropriate next step is

- A. Dismiss this act as it is manipulative
- B. Treat her as she has documented mental illness
- C. Continue to withhold psychiatric medications
- D. Continue one-on-one suicidal watch
- E. Complete examination by a mental health professional

60.21 In the case above, two days later, her family succeeded in obtaining a court order for the patient to get medication for her psychiatric illness. Which medication should this patient be given at this time?

- A. Haloperidol
 - B. Imipramine
 - C. Lorazepam
 - D. Carbamazepine
 - E. Lithium
- GRBT167-60 GRBT167-Sadock-v4.cls PRINTER: TO COME March 20, 2007
13:30 434 60. Forensic Psychiatry

60.22 A 42-year-old, single, male patient committed suicide while on a 4-hour therapeutic pass from the hospital before anticipated discharge. The patient was hospitalized with a diagnosis of major depression, single episode, and suicidal ideation. The patient steadfastly denied suicidal thoughts or impulses after

admission. He experienced moderate to severe depression, anhedonia, global insomnia, hopelessness, agitation, and loss of appetite.

The patient signed a suicide prevention contract, promising to inform the psychiatrist immediately of any suicidal ideation or impulses. After antidepressant treatment was started, the patient's energy level improved.

The man's family sued the psychiatrist for wrongful death. The expert found no evidence in the psychiatric record that a formal suicide risk assessment was conducted before the pass was issued. During the trial, the psychiatrist testified that he did a formal suicide risk assessment, but that it was an oversight that he did not record it.

Which of the following is the most likely outcome of a trial under these circumstances?

- A. The psychiatrist is not liable as a formal assessment of suicide risk was done.
- B. The psychiatrist is not liable as adequate medical treatment was started.
- C. The psychiatrist is not liable as the patient contracted for safety.
- D. The psychiatrist is liable since a formal assessment of suicide risk was not documented.
- E. The psychiatrist is liable as antidepressant therapy is known to increase risk for suicide.

60.23 A 45-year-old male has a documented history of paranoid schizophrenia. Upon returning home from work one day, he finds his wife in bed with another man. He immediately grabs a butcher knife and kills both his wife and her lover. He then systematically attempts to dispose of the bodies, but is caught in the act.

What is the most likely outcome of a trial under these circumstances?

- A. Guilty charge
- B. Not guilty by reason of insanity
- C. Guilty by mens rea
- D. Guilty by actus reus
- E. Not guilty by reason of diminished capacity

60.24 In the case above, which of the following is the most appropriate placement for this man?

- A. Prison
- B. Mental hospital
- C. Home confinement
- D. Jail facility
- E. Local lockup

60.25 A 34-year-old mentally retarded woman is arrested for killing her mother. At her trial, neither the defense nor the prosecution puts the woman on the stand as her communication skills are poor, and she is never fully evaluated by a psychiatrist before or during the trial. She is found guilty of murdering her mother and is sent to prison. Her father, although devastated, tells a lawyer his daughter is severely mentally retarded and can not possibly be held responsible for the murder.

Which of the following is the lawyer most likely to claim to appeal the decision?

- A. Automatism defense
- B. Testimonial privilege
- C. Habeas corpus
- D. Parens patriae
- E. Respondeat superior

60.26 If a patient threatens to harm another person

- A. Psychiatrists in all states are required by law to perform some intervention to prevent the harm from occurring
- B. Psychiatrists in all states are permitted by law to perform some intervention to prevent the harm from occurring
- C. The duty to protect patients and endangered third parties should be considered a professional obligation and only secondarily a legal issue
- D. The Tarasoff duty applies only in state in which there is a duty to warn and to protect
- E. Psychiatrists cannot intervene as they must protect the confidentiality privilege

60.27 Incompetence

- A. is determined by a clinician
- B. is a global assessment of mental function
- C. can be presumed if a patient is psychiatrically institutionalized
- D. is rendered by virtue of a patient having a mental disability
- E. refers to a court adjudication

Directions

Each group of questions below consists of lettered headings followed by a list of numbered phrases or statements. For each numbered phrase or statement, select the one lettered heading that is most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 60.28–60.31

60.28 Patient voluntarily requests

60.29 Prevent significant disruption to treatment program

60.30 Part of ongoing behavior therapy

60.31 For punishment

- A. Indications for seclusion and restraint
- B. Contraindications to seclusion and restraint

P.435

Questions 60.32–60.36

60.32 Known commonly as the right-wrong test

60.33 A person charged with a criminal offense is not responsible for an act if the act was committed under circumstances that the person was unable to resist because of mental disease

60.34 An accused is not criminally responsible if his or her unlawful act was the product of mental disease or mental defect.

60.35 As a result of mental disease or defect, the defendant lacked substantial capacity either to appreciate the criminality of his or her conduct or to conform the conduct to the requirement of the law.

60.36 The defendant suffered some impairment (usually but not always because of mental illness) sufficient to interfere with the ability to formulate a specific element of the particular crime charged.

- A. Irresistible impulse
- B. M’Naghten rule
- C. Model penal code
- D. Durham rule
- E. Diminished capacity

Questions 60.37–60.41

60.37 Harmless mental patients cannot be confined against their wills.

60.38 Standards were established for staffing, nutrition, physical facilities, and treatment.

60.39 The purpose of involuntary hospitalization is treatment.

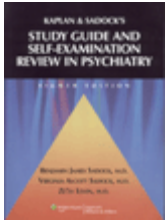
60.40 A patient who is not receiving treatment has a constitutional right to be discharged.

60.41 All forced confinements because of mental illness are unjust.

- A. Rouse v Cameron
- B. Wyatt v Stickney
- C. O’Connor v Donaldson
- D. The Myth of Mental Illness

E. None of the above





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



61

Ethics in Psychiatry

Ethics in psychiatry refers to the principles of conduct that govern the behavior of psychiatrists as well as other mental health professionals. Ethics as a discipline deals with what is good and what is bad, what is right and what is wrong, and moral duties, obligations, and responsibilities.

Psychiatrists routinely confront basic ethical issues, in particular through the imposing of involuntary treatments on patients against their wills. These issues highlight the profound ethical dilemmas between autonomy and beneficence that psychiatrists and their patients deal with continually. In other words, it is the potential—and common—conflict between the right of patients to self-determination and the duty of psychiatrists to act in the best interest of their patients. Beneficence refers to “the duty to do no harm,” and autonomy to a patient’s right to choose. It is easy to see how in psychiatry these concepts can be highly complex, leading to conflicting interpretations and opinions about appropriate care. Psychiatry has a less-than-illustrious history with regard to adequately safeguarding the rights of mentally ill patients, and this history has led to an extensive involvement of the legal system in all aspects of psychiatric involuntary care and decision making.

Major ethical theories underlie most of the ethical questions routinely faced by psychiatrists, and clinicians need to be aware of how these theories conceptualize the issues. These theories include utilitarian theory, which postulates that a fundamental obligation in decision making is to produce the greatest possible benefit to the greatest number of people. Utilitarian theory is most often the basis of large societal decisions about the allocation of services and resources. Autonomy theory postulates that the patient–doctor relationship is one between two equal parties, and that patients are self-governing, with a fundamental right to self-determination in medical and psychiatric decision making.

Truth telling, confidentiality, informed consent, the right to refuse treatment, the right to die, limitations on the right of psychiatrists to involuntarily treat and hospitalize people, and sexual contact with patients are all examples of ethical concerns addressed by ethical theory.

The student should study the questions and answers below for a useful review of this topic.

Helpful Hints

The student should be able to define each of these terms and know each of these cases.

- autonomy theory
- best-interests principle
- confidentiality
- Cruzan v Missouri
- decisional capacity
- duty of beneficence
- duty to protect
- individual paternalism
- informed consent
- Planned Parenthood v Casey
- Principles of Medical Ethics, with annotations
- especially applicable to psychiatry
- professional standards
- right to die
- right to health care
- Roe v Wade
- state paternalism
- substituted-judgment principle
- surrogate decision making
- Tarasoff I and II
- utilitarian theory

Questions/Answers

Directions

Each of the questions or incomplete statements below is followed by five suggested responses or completions. Select the *one* that is *best* in each case.

61.1 An autonomous choice is

- A. made with informed consent of the patient
- B. made by the family of the patient
- C. made by the patient after coercion
- D. made by the patient who is confused
- E. None of the above

61.2 A boundary violation occurs in all of the following situations *except*

- A. When the doctor accepts tickets to a football game

- B. When the doctor hugs the patient after a session
- C. When confidentiality is breached
- D. When the doctor's needs are gratified at the expense of the patient
- E. When the doctor has sexual relations with a former patient

61.3 Which of the following about confidentiality is true?

- A. Confidentiality does not need to be maintained after that patient is deceased.
- B. Confidentiality prevents the psychiatrist from releasing information about a patient to an insurance company.
- C. Video-taped segments of a therapy session cannot be used at a workshop for professionals.
- D. A physician is obligated to report a suspicion of child abuse in a state that requires such reporting.
- E. Informing one's spouse of the identity of one's patient violates the ethical principle of confidentiality.

61.4 Choose the best answer about *Cruzan v Missouri Board of Health*:

- A. All patients hold the right to have life support withdrawn.
- B. Early-stage fetuses have no legal standing.
- C. Only conscious patients can have life-sustaining treatment withdrawn.
- D. All competent patients can refuse medical care.
- E. None of the above

61.5 In the *Tarasoff* case

- A. The principle of beneficence outweighed the principle of justice.
- B. The principle of beneficence outweighed the principle of nonmaleficence.
- C. The principle of justice outweighed the principle of nonmaleficence.
- D. The principle of nonmaleficence outweighed the principle of justice.
- E. None of the above

61.6 *Tarasoff II*

- A. requires that therapists report a patient's fantasies of homicide
- B. reinforces that a therapist has only the duty to warn
- C. expands on the earlier ruling to include the duty to protect
- D. states that usually the patient must be a danger both to a person and property
- E. none of the above

Directions

The set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 61.7–61.12

61.7 Sexual relations with a family member of a patient.

61.8 Discussing cases with spouse.

61.9 Confidentiality must be maintained after the death of a patient.

61.10 The psychiatrist can make a determination of suicide as a result of mental illness for insurance purposes solely from reading the patient's records.

61.11 Dating a patient 1 year after discharge is ethical.

61.12 The psychiatrist may divulge information about the patient if the patient desires.

A. Yes

B. No

Directions

The group of lettered headings below is followed by a list of numbered phrases. For each numbered phrase, select

A. if the item is associated with A only

B. if the item is associated with B only

C. if the item is associated with both A and B

D. if the item is associated with neither A nor B

Questions 61.13–61.17

61.13 Preserving patient confidentiality versus protecting endangered third parties.

61.14 Patient–therapist sexual relations.

61.15 Choice between two ethically legitimate alternatives.

61.16 Compromise of an ethical principle, usually because of self-interest.

61.17 American Psychiatric Association (APA) may expel or suspend members from the organization.

A. Ethical dilemma

B. Ethical conflict

Directions

The set of lettered headings below is followed by a list of numbered words or statements. For each numbered word or statement, select the *one* lettered heading most closely associated with it. Each lettered heading may be selected once, more than once, or not at all.

Questions 61.18–61.21

61.18 The right of the patient to self-determination.

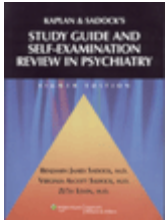
61.19 The duty of the physician to act in the best interest of the patient.

61.20 The duty of the physician to inflict no harm on the patient.

61.21 Refers to the changing social, political, religious and legal mores of the moment.

- A. Nonmaleficence
- B. Autonomy
- C. Beneficence
- D. Justice





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



A: Objective Examinations in Psychiatry

There is a wide variety of objective multiple-choice question formats. They range from case histories followed by a series of questions relating to diagnosis, laboratory findings, treatment complications, and prognosis to the most widely used form, known as the one-best-response type, wherein a question or incomplete statement is followed by four or five suggested answers or completions, with the examinee being directed to select the one best answer. The multiple-choice questions are described as objective because the correct response is predetermined by a group of experts who compose the items, eliminating the observer bias seen in ratings of essay questions. The responses are entered on an answer sheet, which is scored by machine, giving a high degree of reliability. Two basic item types are used with the greatest frequency, one-best-response type (type A) and matching type (type B), which are detailed in [Table A.1](#).

The case history or situation type of item consists of an introductory statement that may be an abbreviated history, with or without the results of the physical examination or laboratory tests, followed by a series of questions, usually of the A type. In similar fashion, charts, electroencephalograms, pictures of gross or microscopic slides, or even patients' graphs may be presented, again followed by the one-best-response type or matching type.

Present testing procedures using objective multiple-choice items are highly effective in regard to reliability and validity in measuring the examinee's knowledge and its application. Experienced test constructors are able to develop items based on a given content and to word the answers in a neutral fashion. Thus, correct and incorrect responses are similar in style, length, and phrasing. However, no matter how well constructed a test is, with a high degree of reliability and validity for a large group of examinees, it is subject to inaccuracies about individual testees. Some examinees underscore, and others overscore, depending on their experience and test-taking skills, known as testmanship. In the final analysis, there is no substitute for knowledge, understanding, and clinical competence when a physician is being evaluated. However, some suggestions and clues inevitably appear in the most carefully composed and edited multiple-choice test. To improve one's testmanship, one should consider the following:

1. There is no penalty for a wrong response in the objective-type multiple-choice question. The testee has a 20 percent chance of guessing correctly when there are five options. Therefore, no question should be left unanswered.

2. In medicine it is rare for anything to be universally correct or wrong. Thus, options that imply “always” or “never” are more likely to be incorrect than otherwise.
3. Especially in psychiatry, many words are often needed to include the exceptions or qualifications in a correct statement. Thus, the longest option is likely to be the correct response. Test constructors who are also aware of this fact often try to lengthen the shorter incorrect responses by adding unnecessary phrases, but that tactic can readily be detected by experienced test takers.
4. The use of a word like “possibly,” or “may,” or “sometimes” in an option often suggests a true statement, whereas choices with universal negative or positive statements tend to be false.
5. Each distractor that can be ruled out increases the percentage chance of guessing correctly. In a five-choice situation, being able to discard three options increases the percentage from 20 percent to 50 percent and enables the examinee to focus on only the two remaining choices.
6. With questions in which one cannot rule out any of the distractors and these suggestions do not apply, the testee should always select the same lettered option. The examination constructors try to distribute the correct answers among the five options. In some tests the middle, or C, response is correct more often than the others.

Examinations are constructed for the most part by persons from the cultural background in which the test originates. Therefore, those who have been trained abroad and whose native languages are not English are often slower in reading the items and have less time to reflect on the options.

A significant contribution to the evaluation of clinical competence is the development of patient management–problem tests. Those tests try to simulate an actual clinical situation, with emphasis on a functional problem-solving, patient-oriented approach. From thousands of reported examples of outstandingly good or poor clinical performance, test designers defined the major areas of performance, such as history taking, physical examination, use of diagnostic procedures, laboratory tests, treatment, judgment, and continuing care. Armed with that information, the test designers evolved a type of test known as programmed testing. The test provides feedback of information to the examinee, who can use these data in the solution of additional problems about the same patient.

The format starts with general patient information, which gives historical data. The section may be followed by a

P.447

P.448

summary of the physical examination and positive elements in the psychiatric status. Then the testees are presented with a series of problems, each with a variable number of options. If the examinees select an option, they receive the results of the laboratory test they requested, the patients’ reaction to the medication they ordered, or just a confirmation of the order. The examinees may select as few or as many options as befits good clinical judgment. The testees lose both credit and informational feedback if they do not select an important and necessary option. They may also lose credit by selecting unnecessary or dangerous options.

Type A: One-best-response type

Each item consists of an introductory statement or question, known as the stem, followed by four or five suggested responses. The incorrect options are known as distractors, as differentiated from the correct response. Some of the distractors may be true in part, but the one *best* response of those offered must be selected to receive full credit.

DIRECTIONS: Each of the statements or questions below is followed by five suggested responses or completions. Select the one that is best in each case.

1. A 2-year-old boy occasionally plays with his older sister's doll, imitating her activities. This implies

- A. pathological problems with sibling rivalry
- B. undue identification with his mother
- C. future problems with heterosexual orientation
- D. development of problems with gender identity
- E. natural exploration of his environment

Stem

Distractors

Choices or Options

Correct Response

2. Children in the fourth grade in urban area schools who cannot read are most commonly

- A. isolated from peers
- B. mentally retarded
- C. culturally disadvantaged
- D. brain damaged
- E. handicapped by a major perceptual deficiency

Stem

Distractors

Correct Responses

Choices or Options

disadvantaged

deficiency

Distractor

Type B: Matching type

DIRECTIONS: Each group of questions consists of five lettered headings, followed by a list of numbered words or phrases. For each numbered word or statement, select the one lettered heading or component that is most closely associated with it.

Questions 3–8

- A. Mood disorder
- B. Psychotic disorder
- C. Chromosomal abnormality
- D. Cognitive disorder
- E. None of the above

- 3. Delusional disorder
- 4. Conversion disorder
- 5. Down's syndrome
- 6. Bipolar disorder
- 7. Obsessive-compulsive disorder
- 8. Wernicke's syndrome

Correct responses

- B
- E
- C
- A
- E
- D

The use of "None of the above" in a type A or B question of ten makes the item more difficult and tends to lower the percentage of candidates giving correct responses. It should also be noted that the same response may be used more than once.

Type C:

A modified form of the matching type (type C) is also used. It necessitates the ability to compare and contrast two entities, such as diagnostic procedures, treatment modalities, or causes. The association is on an all-or-none basis. For instance, even if a treatment is only occasionally used or associated with a given disorder, it is to be included as a correct response.

DIRECTIONS: Each set of lettered headings below is followed by a list of numbered words or phrases. For each of the numbered words or phrases select

- A. if the item is associated with *A only*
- B. if the item is associated with *A only*
- C. if the item is associated with *both A and B*
- D. if the item is associated with *neither A nor B*

Questions 9–13

- A. Down's syndrome (mongolism)
- B. Tuberous sclerosis (epiloia)
- C. Both
- D. Neither

- 9. Mental deficiency
- 10. Nodular type of skin rash
- 11. Higher than chance association with leukemia
- 12. Chromosomal nondisjunction
- 13. Specific disorder of amino acid metabolism

Correct responses

- C
- B
- A
- A
- D

Adapted from Small SM. Role of examinations in psychiatry. In: Kaplan HI, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry*. 6th ed. Baltimore: Williams & Wilkins; 1995:2734.



Table A.1 Types of Items Used in Multiple Choice Questions

Having completed problem 1 about a patient, the testee is usually given some additional follow-up information, and the procedure is repeated for problems 2, 3, and so on. An oversimplified and much abbreviated example is as follows:

A young college student has been hyperactive, has slept poorly, and has lost weight during the past month. He has been known to use cannabis and possibly other substances on many occasions. Last night he became excited, thought he was going insane, and complained of a rapid pounding sensation over his heart. He was taken to the emergency room by his roommate. No history of prior psychiatric difficulty was obtained. Physical examination reveals a temperature of 99.5°F, pulse rate of 108 per minute, respiration rate of 22 per minute, and a blood pressure of 142/80 mm Hg. His pupils are dilated but react to light, his mouth is dry, and the rest of the examination is noncontributory except for a generalized hyperreflexia. On psychiatric examination he is irritable, restless, and very suspicious. He states that people are after him and wish to harm him. He is well oriented.

1. At this time you would
 - A. order morphine sulfate, 30 mg, intramuscularly
 - B. inquire about drug usage
 - C. order an electrocardiogram
 - D. tell the patient that no one wants to harm him and that it is all his imagination
 - E. arrange for hospitalization plus many additional options

Of the choices given, the feedback on B could be "Roommate states patient was taking amphetamines." D feedback: "Patient becomes excited and refuses to answer questions." E feedback: "Arrangements made."

2. The following morning, after a restless sleep, the patient continues to express fears of being harmed. You would now order
 - F. chlorpromazine, 100 mg, three times daily
 - G. urine screen for drugs
 - H. projective psychological tests
 - I. imipramine, 50 mg, four times daily and other options

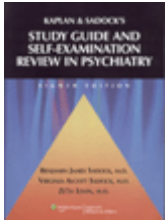
The feedback on F might be "Patient quieter after a few hours." G feedback: "Ordered." H feedback: "Patient uncooperative." I feedback: "Order noted."

Although programmed testing differs from the real-life situation—in which the physician has to originate his orders or recommendations, rather than selecting them from a given set of options—it does simulate the clinical situation to a great extent. Examinees like this type of test and readily appreciate its clinical significance and relevance.

Various modifications of patient management problems have been introduced. It seems that the format, coupled with other forms of testing, is a favorable development in approaching the goal of a standardized, reliable, and valid means of evaluating some major components of clinical competence.

New methods of testing using computer-based systems for objective evaluation of clinical competence are being developed and tested. They are useful in patient management problems because they provide extensive and instantaneous feedback. They also provide contemporaneous scoring, so the testee knows the result of the test upon completion.





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins

INDEX



Page numbers refer to the printed edition, page links direct to the first pages of the corresponding chapters

A

- AAI *See* Adult Attachment Interview
- AAS *See* Anabolic-androgenic steroids
- Abandonment charge [435](#)
- Abreactions [82](#) [87](#)
- Abstract reasoning [74](#)
- Abstract thinking [84](#)
- Abuse *See also specific types of abuse*
 - emotional [284](#)
 - physical [284](#)
 - physical injuries related to [281](#) [282](#)
 - problems related to [280–284](#)
 - psychological [284](#)
 - reporting [284](#)
 - spouse [281](#)
 - pregnancy and [283](#)
- Academic problem [285](#) [286](#) [287](#) [404](#)
- Acamprosate [312](#)
 - alcohol dependence [307](#)
- Acculturation problem [285](#)
- Acetaminophen (Tylenol)
 - overdose [298](#)
 - zidovudine metabolism influenced by [113](#)
- Acetylcholine [31](#)
- Acquired immune deficiency syndrome (AIDS) [267](#)
 - CNS diseases in [110](#)
 - incidence [109](#)
 - mania in people with [110](#)
 - treatment of [111](#)
 - neuropsychiatric aspects of [109–115](#)
 - pharmacotherapies for [109](#)
- Action potential
 - origin [28](#) [32](#)
 - propagation [32](#)
- Acute confusion, causes [36](#) [36](#)
- ADAMHA *See* Alcohol, Drug Abuse, and Mental Health Administration
- Adaptation syndrome [262](#)
- ADHD *See* Attention-deficit/hyperactivity disorder

Adiadochokinesia [81](#) [85](#)

Adjustment disorders [157](#) [169](#) [243–247](#) [405](#)
age and [246–247](#)
classification [243](#)
clinical presentation [244](#)
with depressed mood [244](#) [246](#)
diagnosis
 criteria [243](#) [245](#)
 incorrect [245](#)
with disturbance of conduct [244](#)
DSM-IV-TR characteristics of [245](#)
gender differences in [246](#)
with mixed anxiety [244](#)
with mixed disturbance of emotions and conduct [244](#)
preexisting adaptive skills [245](#)
preexisting life events [245](#)
preexisting mood symptomatology and [245](#)
prognosis [245](#) [247](#)
reliability studies in [246](#)
stressors precipitating [244–245](#) [247](#)
as transitional diagnostic category [246](#)
unspecified [244](#)

Adolescence *See also* Minors; Puberty
bipolar disorder in [388](#) [389](#)
contraceptive use and [20](#) [22–23](#)
depression in [271](#) [273](#) [398](#) [399](#)
forensic psychiatry [415–417](#)
MDD in
 CBT for [390](#)
 interpersonal therapy for [390](#)
 symptoms presenting [388](#) [389–390](#)
mood disorders in [387–390](#)
 epidemiology [388–389](#)
 prevalence rates [389](#) [389](#)
 symptoms [387](#)
morality and [25](#)
psychiatric treatment [407–414](#)
psychosocial separation from parents in [19–20](#) [22](#)
substance abuse during [400–403](#)
 psychiatric disorders related to [401](#) [402](#)
 risk factors [401](#) [403](#)
 treatment [402–403](#)
suicide in [387–390](#)
 risk factors [389](#)
young adulthood and transition from [20](#) [22](#)

Adopted children [20](#) [23](#)

ADOS-G *See* Autism Diagnostic Observation Schedule-Generic

β -Adrenergic receptor antagonists [311](#) [319–320](#)

Adriamycin *See* Doxorubicin

Adult Attachment Interview (AAI) [66](#)

Adulthood

middle [23](#)
young, adolescent transition into [20](#) [22](#)
Advance directives [425](#) [427–428](#) See also *specific advance directives*
Aequanimitas (Osler) [1](#) [8](#)
Affective disorders See Schedule for Affective Disorders and Schizophrenia
Aggression [41](#)
 affective [255](#)
 aggressive fantasy materials and [46](#)
 alcohol and [44](#)
 in children [42](#) [46](#)
 chromosomal abnormalities influencing [41–42](#) [45](#)
 conduct disorder and [370](#)
 distinguishing types of [255](#)
 factors influencing [46](#)
 impulsive [241](#)
 neuroendocrine change and [238](#)
 organic-like [255](#)
 predatory [255](#)
 punishment and [44](#)
 unprovoked [255](#)
Agoraphobia [165](#) [168](#) [172](#)
 prevalence, lifetime [168](#) [172](#)
AIDS See Acquired immune deficiency syndrome
Ainsworth, Mary [43](#)
 attachment and [50](#)
Alcohol See also Fetal alcohol syndrome
 abstinence [123](#)
 drugs for [314](#)
 adolescent use of [400](#) [401–402](#)
 aggression and [44](#)
 amnesia and [103](#)
 cancer and use of [119](#) [125](#)
 counseling [138](#)
 delirium caused by withdrawal of [100](#)
 depression and [117](#) [121](#)
 dissociative fugue and [200](#)
 disulfiram and [123](#)
 emergencies [299](#)
 impulse control disorders and [237](#)
 metabolism [125](#)
 obstructive sleep apnea and [231](#)
 pregnancy and use of [19](#) [21](#)

 pyromania and [239](#)
 rape and [283](#)
 sleep and effect of [117](#) [122](#)
 suicide and [296](#) [296](#)
Alcohol abuse/dependence
 in adolescents, treatment of [401](#) [403](#)
 biological therapy [307](#)
 diagnosis [117](#) [120–121](#)

state markers and screening for [120](#) [120](#)

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) [124](#)

Alexander technique [269–270](#) [270](#)

Alexithymia [81](#) [159](#)

Allopathy [270](#)

Alprazolam (Xanax) [315](#)

- anxiety attacks and [77](#)
- drug/foods administered concurrent with [309](#) [315](#)
- HIV treatment with [115](#)

Alternative medicine [268–270](#) [269](#) See also Office of Alternative Medicine

Alternative psychiatry [268–270](#)

Altruism [157](#) [305](#)

Alzheimer's dementia [90](#) [96](#)

- diagnosis [103](#) [104](#)
- disease [33](#) [97](#)
- in elderly [418](#) [420](#)
- in elderly, risk factors [419](#) [422](#)
- neurotransmitters implicated in [101](#)
- onset [103](#)
- prevalence [102](#)
- survival [101](#)
- symptoms presenting in [103](#)

Amantadine (Symmetrel) [320](#)

- CJD [103](#)
- serotonin-specific reuptake inhibitor sexual effects and [308](#) [313](#)

Ambien See Zolpidem

Ambiguous genitalia [216](#) [217](#)

Ambivalence [82](#) [87](#)

Amenorrhea See also Functional hypothalamic amenorrhea

- anorexia nervosa and [225](#)
- starvation-produced [223](#)

Amitriptyline (Elavil) [320](#)

- anorexia nervosa [223](#)
- anticholinergic effects [308](#) [312](#)
- HIV-related headache treated with [113](#)
- kleptomania [242](#)
- side effects [161](#)

Amnesia See also Dissociative amnesia

- alcohol and [103](#)
- causes [28](#) [36](#) [288](#)
- dementia and symptoms of [200](#)
- generalized [200](#)
- head trauma and [103–104](#)
- Korsakoff's syndrome and [37](#)
- localized [200](#)
- malingered [286](#) [288](#)
- medical causes of [33](#)
- onset [103](#)
- organic, dissociative distinguished from [197](#)
- transient [103](#)
- transient global [99](#) [103](#) [106](#) [196](#) [198](#)

Amnesic disorders [95–108](#)
causes [199](#)
feature, essential of [104](#)

Amoxapine
anticholinergic effects [312](#)
sexual dysfunction caused by [209](#)

Amphetamines [118](#)
dependence [122](#)
disorders related to [122](#)
dopamine influenced by [39](#)
paranoid psychosis induced by [136](#)
toxic psychosis induced by [125](#)
schizophrenia distinguished from [119](#)

Anabolic steroid use [123–124](#)

Anabolic-androgenic steroids (AAS)
indication for use of [118](#)
medical applications of [123–124](#)
use [123–124](#)

Anaclitic depression [50](#)

Anafranil *See* Clomipramine

Analgesia *See* Patient-controlled analgesia; *specific analgesics*

The Analysis of the Self (Kohut) [69](#)

Analysis of Variance (ANOVA) [46](#)

Anamnesis [73–74](#) [74](#)

Androgen insensitivity syndrome [219](#)

Anhedonia [132](#) [140](#)
depression and [159](#)
features [153](#)

Anomic suicide [292](#)

Anorexia nervosa
age of onset [220](#)
amenorrhea and [225](#)
binge-purge type [221](#) [223](#)
body dysmorphic disorder and [222](#)
bulimia nervosa and [225](#)
distinguishing [225](#)
decreased appetite in [226](#)
defined [220](#)
depression comorbid with [220](#)
diagnosis [224](#)
criteria for [226](#)
laboratory tests [224–225](#)
example [221](#)
features associated with [221](#) [223](#)
incidence [224](#)
inpatient hospitalization for [221](#)
laboratory test results in [222](#)
metabolic changes in [225](#)
mortality rate [222](#) [223](#) [225](#)
pain disorder and [184](#)
physiological changes in [225](#)

- prevalence [158](#)
- profession and [221](#) [223](#)
- recovery [225](#)
- restrictive type [223](#)
- somatization disorder and [184](#)
- subtypes [223](#)
- treatment [220](#) [221](#) [223](#) [225](#)
 - family therapy [225](#)
 - medications for [223](#)
- Anosognosia [81](#) [85](#)
- ANOVA See Analysis of Variance
- Antabuse See Disulfiram
- Anthropology [40](#)
- Anticancer agents [259](#)
- Anticholinergic drugs [31](#)
 - delirium and [162](#)
 - indications [311](#)
 - receptors [39](#)
- Antidepressants
 - anxiety disorder [172](#)
 - cardiac patient use of [257](#) [259](#)
 - glossodynia [259](#)
 - idiopathic pruritus [259](#)
 - medication noncompliance [158](#)
 - REM sleep and [227](#)
 - side effects [259](#)
 - sleep and [227](#) [228](#)
 - somatization disorder [184](#)
 - suicidal ideation and [153](#)
 - suicide and [158](#) [159](#) [259](#)
 - tricyclic [42](#) [45–46](#)
 - side effects of [155](#) [162](#)
 - urticaria [259](#)
 - vulvodynia [259](#)
- Antilirium See Physostigmine salicylate
- Antipanic medications [168](#) [173](#)
- Antipsychotics [313](#) See also *specific antipsychotics*
 - Asian patients and [42](#) [45–46](#)
 - atypical [309](#)
 - NMS and [162](#)
 - second-generation [314–315](#)
 - side effects, elderly and [419](#) [421](#)
- Antisocial behavior [286](#) [289](#) [404](#) [406](#)
 - adolescent [285](#)
 - adult [285](#) [286](#)
 - child [285](#)
 - differential diagnosis [406](#)
- Antisocial patients
 - impulse control disorders and [252](#)
 - interviewing [10](#) [12–13](#)
 - malingering [12](#)

Antisocial personality disorder [249](#) [287](#)
conversion disorder and [183–184](#)
factitious disorder and [194](#)
HIV and [34](#)
inhalant use and [122](#)

Anxiety [82](#) *See also* Hamilton Anxiety Rating Scale; *specific anxieties*
adjustment disorder with mixed [244](#)
attachment and [50](#)
in children, psychoanalytic bases for [392](#) [394](#)
comorbidity [169](#)
death [428](#)
defined [87](#)
Hamilton Rating Scale for [94](#)
mental retardation and [334](#) [337](#)
neurotransmitters associated with [168](#) [174](#)
reactions [395](#)
stranger [394](#)
terminally ill children [425](#) [428](#)

Anxiety disorders [165–175](#) [166](#) *See also* Overanxious disorder
of adolescence [391–396](#)
antidepressants for [172](#)
in children [391–396](#)
predisposing factors [392](#) [394](#)
prevalence [395](#)
stressors for [394](#)
defined [165](#)
diagnostic criteria [165](#)
in elderly [419](#) [420](#)
exposure therapy [168](#) [175](#)
factors influencing [169](#)
GABA and [175](#)
gender differences in [169](#)
generalized [165](#) [169](#)
genetic factors in [165](#)
of infancy [391–396](#)
in preschoolers [392](#) [395](#)
prevalence [165](#)
risk of developing [166](#)
disorders that enhance [169](#)
serotonin and [168](#) [174](#)
treatment [165](#)
medication [167](#)

Aphasias [83](#) [88](#)
primary progressive [104](#)

Apomorphine [117](#) [122](#)
Apoptosis [21](#)
Apperception [84](#)
Apraxias [31–32](#) [39](#) [81](#) [85](#)
verbal [351](#)
Archetypes [63](#) [66](#) [67](#)

Arousal [30](#)
brain and [36](#)
disorder [185](#)

Articulation disorder [351](#)

Asperger's disorder [353](#) [354](#)
causes [355](#) [358](#)
characteristics [358](#)
diagnosis [359](#)
etiology [358](#)
example [354–355](#) [358](#)
interventions [355](#) [358](#)
treatment [358](#)

Astemizole (Hismanal) [315](#)

Astereognosis [81](#) [85](#)

Asthma [261](#)
psychiatric disorders and [258](#)

Astrocytes [28](#)

Ativan See Lorazepam

Attachment [47](#) See also Adult Attachment Interview; Bonding
anxiety and [50](#)
anxious-avoidant [278–279](#)
anxious-resistant [278](#)
defined [50](#)
in infancy [50](#)
normal [47](#)
secure [277](#) [278](#)
separation anxiety and [47](#)

Attachment disorders See also Reactive attachment disorder
characteristics [46–47](#)
symptoms [394](#)

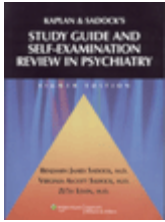
Attachment theory [42](#) [46–47](#) [62](#) [63](#) [65](#) [66–67](#)

Attaque de Nervios [142](#)
features [144–145](#)

Attention
brain and [36](#)
defined [84](#)
disturbances [81](#) [84](#)
maintenance [39](#)

Attention-deficit/hyperactivity disorder (ADHD) [360–365](#)
acquired etiological influences in [361](#) [363](#)
comorbid disorders [364–365](#)
course [364](#)
diagnosis [362](#)
age at [363–364](#)
criteria [360](#)
example [361–362](#)
genetics [361](#) [362–363](#)
mathematical disorder and [342](#) [343](#)
neuroimaging [360–362](#)
oppositional defiant disorder and [368](#)
remission [364](#)

substance exposure in utero and [363](#)
subtypes [363](#)
symptom remittance and [361](#)
treatment [363](#) [408](#) [410](#)
Attribution theory [44](#)
Autism Diagnostic Observation Schedule-Generic (ADOS-G) [331](#)
Autistic disorder [353](#) [354](#)
biological abnormalities [356](#)
characteristics [355–356](#) [358–359](#)
DSM-IV-TR [353](#)
gender differences [356](#)
genetics in [354](#) [355–356](#)
medication [359](#)
mental retardation and [356](#) [357](#)
neurological-biochemical abnormalities associated with [354](#) [356](#)
parental presenting complaint and [354](#) [356–357](#)
prevalence [356](#)
psychological testing [354](#) [357](#)
risk factors [356](#)
schizophrenia differentiated from [397–399](#)
special abilities exhibited in [354](#) [357](#)
speech and [356–357](#)
splinter skills exhibited in [354](#) [357](#)
Automatism [438](#)
Autonomous choice [441–443](#)
Autonomy [278](#) [279](#)
Avoidance [171](#)
Avoidant personality disorder [254](#) [255](#)
example [250](#)
Axis I personality disorders [91–92](#)
Axis II personality disorders [91–92](#) [333](#)
somatization and [185](#)
Axis III personality disorders [91–92](#)
Axis IV personality disorders [90–91](#) [92](#)
Axis V personality disorders [92](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



B

"Bad" mother [159–160](#)

Barbiturates [320](#)

fugue states caused by [200](#)

GABA receptors and [34](#)

GABA system and influence of [120](#) [125–126](#)

REM sleep and influence of [119–120](#) [125](#)

withdrawal [119–120](#) [125](#)

Basal ganglia [28](#) [32](#) [35](#)

disorders associated with [30](#)

Battery [437](#)

Bayley Scales of Infant Development II [326](#) [331](#)

Behavior *See also* Child Behavior Checklist; Vineland Adaptive Behavior Scales; *specific behaviors*

brain and [27–39](#)

inhibition [241](#)

manifestations in [15](#)

pica-related [372](#) [373](#)

Premack's principle [43](#)

psychosocial science contributions to [40–51](#)

psychosomatic medicine and [256](#)

rumination disorder-associated [372](#) [373](#)

theories [48](#) [48](#)

therapies [300](#)

stereotypic movement [384](#) [385](#)

in vitro immune suppression and [262](#) [262](#)

Behavioral inhibition [392](#) [395](#)

Behavioral Rating Scale [326](#)

Bender, Loretta [56](#)

face-hand test [58](#)

neurological soft signs [331–332](#)

Bender Visual Motor Gestalt test [53](#) [56](#) [56](#) [57](#)

Beneficence [441](#)

Benton Visual Retention Test [54](#) [58](#)

Benzodiazepine discontinuation syndrome [123](#) [123](#)

Benzodiazepines [320](#)

Asian patients and [42](#) [45–46](#)

dependence [123](#)

discontinuation syndrome [118](#)
flumazenil and [316](#)
GABA receptors and [34](#)
intermittent explosive disorder [240](#)
metabolism, ethnic differences in [46](#)
panic disorder [173](#)
phobia [170](#)
psychotic emergency [294](#)
REM sleep and [230](#)
withdrawal [119–120](#) [125](#)

Bereavement See Grief/bereavement

“Best interests of the child” doctrine [416](#)

Bethanechol (Urecholine) [312](#)

Binge-eating disorder [223](#)

Binswanger’s disease [106](#)

Biofeedback [302](#) [304](#)

Biological therapies [306–321](#)
 teratogenicity [310](#)

Biopsychosocial model of disease [1](#)

Bipolar disorder
 in adolescents [388](#) [389](#)
 biological therapy [308](#)
 in children [388](#) [389](#)
 diagnosis [161–162](#)
 example [155](#)
 lithium [154](#) [157](#)
 L-tryptophan [157](#)
 pharmacologic treatment of [155](#)
 rapid cycling [158](#)
 treatment [154](#) [157](#) [312](#)
 discharge plan and [433](#) [437](#)

Bipolar I disorder [155](#) [164](#)
 genetics in [150](#)
 MRI scans [158](#)
 MRI studies of [35](#)
 rapid cycling [152](#)

Bipolar II disorder [155](#) [164](#)
 hypomania and [157](#)

Birth complications, schizophrenia and [137](#)

Birth control See *also* Contraceptives
 teenage use of [19](#) [22](#)

Birth control pills [309](#)

Bleuler, Eugen [131–132](#) [139](#)

Blocking [83](#)

BMI See Body mass index

Body dysmorphic disorder [176](#) [177–178](#)
 anorexia nervosa and [222](#)
 cause [180](#)
 as comorbid condition [180](#) [182](#)
 factors predisposing to [180](#)
 hypochondriasis and [179](#) [186](#)

suicide and [182](#)
treatment [181](#)
Body mass index (BMI) [265](#)
Bonding [47](#)
Borderline intellectual functioning [285](#) [289](#) [404](#)
 defined [406](#)
 mental retardation and [289](#)
Borderline level of personality organization [249–250](#) [253](#)
Borderline personality disorder [249](#) [250](#) [252](#) [254](#) [255](#)
 hallmarks [254](#)
 personality disorders co-occurring with [254](#)
Boundary violation [441](#) [443](#)
Bovine spongiform encephalopathy (BSE) [100](#) [103](#) [105](#)

P.452

Bowlby, John [43](#)
 attachment theory [47](#) [50](#) [62](#) [65](#) [66–67](#)
 behavior and [40](#)
BPRS See Brief Psychiatric Rating Scale
Brain See *also* Neuroanatomy; Neuroimaging
 activity, techniques reflecting [30](#) [35–36](#)
 adult [21](#)
 arousal and [36](#)
 attention and [36](#)
 basal ganglia in [28](#) [32](#)
 behavior and [27–39](#)
 cortex lesion [31](#) [38](#)
 depression and [151](#) [157](#)
 dysfunctions, cognitive tests for [57](#)
 fetal [21](#)
 glial cells in [32](#)
 hemispheres
 cognitive functioning and [55](#) [56](#)
 neuropsychological testing and [56](#) [56](#)
 localization [31](#) [39](#)
 neuropsychiatry [27](#)
 regions [32](#)
 stroke [30](#) [36](#)
Brainwashing [197](#) [286](#) [287](#)
 stages [198–199](#)
Breath holding [385](#)
Brief Psychiatric Rating Scale (BPRS) [54–55](#) [60](#)
Briquet, Pierre
 conversion disorder and [178](#) [183](#)
 somatization and [185](#)
Briquet's syndrome [193](#)
Bromide intoxication [298–299](#)
Bromocriptine (Parlodel) [319](#)
 mania precipitated by [151](#) [157](#)
 NMS [162](#)
 serotonin-specific reuptake inhibitor sexual effects and [308](#) [313](#)
BSE See Bovine spongiform encephalopathy

Bulimia nervosa

anorexia nervosa and [225](#)

distinguishing [225](#)

CBT [226](#)

characteristics [220](#)

features associated with [222](#)

incidence [222](#) [224](#)

pica and [373](#)

prevalence [224](#)

recovery [225](#)

treatment [220](#)

Bupropion (Wellbutrin) [152](#) [307](#)

ADHD [363](#)

carbamazepine decrease in plasma concentrations of [309](#)

depression [159](#)

HIV treatment with [115](#)

sexual adverse effects and [313](#)

side effects [158](#) [311–312](#) [315](#)

BuSpar See Buspirone

Buspirone (BuSpar) [167](#)

anxiety disorder [170](#) [174](#)

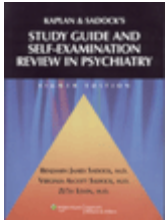
intermittent explosive disorder [240](#)

panic disorder [173](#)

Butler, Robert

middle adulthood and [23](#)

stock taking and [20](#)



Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



C

- Caffeine [118–119](#)
 - elimination [124](#)
 - mechanism of action [126](#)
 - use [124](#)
 - withdrawal [124](#)
- Calan *See* Verapamil
- Calcium channel blockers [309](#) [314](#)
- Calculations [74](#)
- CAM *See* Complementary and alternative medicine
- Cancer *See also* Anticancer agents
 - alcohol use and [119](#) [125](#)
 - depression and [425–426](#) [429](#)
 - interventions [425](#) [429](#)
 - pain in [425](#) [428](#)
 - biobehavioral factor influence on [258](#)
 - psychosocial interventions in [258](#)
- Cannabinoids
 - medical uses of [122](#)
 - therapeutic effect of [118](#)
- Cannabis
 - medical uses of [122](#)
 - physical effects of [120](#) [126](#)
- Capgras's syndrome [193](#)
- Capsaicin (Dolorac) [113](#)
- Captopril [315](#)
- Carbamazepine (Tegretol) [308](#) [312–315](#) [320](#)
 - clozapine and [309](#)
 - drug plasma concentrations decreased by [309](#)
 - HIV-related mania treated with [114](#)
 - intermittent explosive disorder [240](#)
 - response predictors for [311](#)
 - side effects [315](#)
- Carbon dioxide
 - panic attack induction with [167](#)
 - panic attacks induced by [172](#)
- Card Sorting Test [54](#) [59](#)
- CAT *See* Children's Apperception Test

Catalepsy [234](#)
Cataplexy [234](#)
Catatonia [128](#) [132](#)
 associated features [132](#)
Caudate nucleus [35](#)
CBT See Cognitive behavior treatment
Celexa See Citalopram
Central nervous system (CNS)
 diseases
 in AIDS patients [110](#)
 degenerative [99](#) [107](#)
 HIV and infections of [113](#)
 nicotine and effects of [120](#) [126](#)
Cerebral disease
 first sign of beginning [72](#)
 memory impairment and [76](#)
Cerebrovascular disease, dementia caused by [104](#)
Character, defined [255](#)
Child abuse [208–209](#) [281](#) [283](#) See also Sexual abuse
 confidentiality and [161](#)
 factitious disorder by proxy and [192–194](#)
 incidence [280](#)
 proving [280](#) [282](#) [284](#)
Child Behavior Checklist [323–324](#) [330–331](#)
Child custody
 confidentiality and [416](#)
 disputes [432](#) [436](#)
Child molestation [207](#)
Child psychiatry [322–332](#) [404–406](#)
 assessment
 instruments for [323](#) [325–326](#)
 tests for [326](#) [329](#)
 development and [324–325](#)
 diagnostic laboratory tests for [323](#) [326](#)
 drawing and [324](#) [324](#) [325](#)
 evaluation [322](#)
 forensic issues in [415–417](#)
 interview in [323](#) [324](#) [331](#)
 play and [325](#)
 projective techniques [323](#) [325](#)
Childhood and Society (Erikson) [69](#)
Children See also Feeding disorders of infancy/early childhood; Preschool period; Thomas Achenbach's Child Behavior Checklist; Toddler period; Wechsler Intelligence Scale for Children
 aggression in [42](#) [46](#)
 antisocial behavior in [285](#)
 anxiety disorders in [391–396](#)
 predisposing factors [392](#) [394](#)
 prevalence [395](#)
 stressors for [394](#)
 anxiety in, psychoanalytic bases for [392](#) [394](#)

bipolar disorder in [388](#) [389](#)
CBT in [408](#) [409–410](#)
depression in [398](#) [399](#)
development [18](#)
disintegrative disorder in [353](#) [354](#) [357–358](#)
dysthymic disorder in [156](#) [388](#)
eating disorders in [371–374](#)
end-of-life care for [425](#) [428](#)
fear in [392](#) [395](#)
of gay/lesbian parents [203](#) [207](#)
grief/bereavement in [395](#)
identity problems in [405](#)
MDD in [388–390](#)
medications [407](#) [408](#) [410–414](#)
mental status examination in [326](#) [327](#)
mood disorders in [387–390](#)
 epidemiology [388–389](#)
 prevalence rates [389](#) [389](#)
 symptoms [387](#)
neglect [280](#) [284](#)
neuropsychological testing, clinical in [59–60](#)
OCD in [391](#) [395](#)
 characteristics [392](#) [393](#)
 treatment [393](#)
pharmacological agents and [407](#) [408](#) [410–414](#)
phobias in [391](#) [395](#)
psychiatric evaluation [322](#)
psychopathology [323–325](#)
psychosis [397](#)
psychotherapies [407](#) [412](#)
PTSD in [391](#) [393](#) [395](#)
 conditions associated with [393](#) [395](#)
 treatment [396](#)
schizophrenia in [131](#) [138](#) [358](#) [397–399](#)
 autism differentiated from [397–399](#)
 defined [398](#) [399](#)
 diagnostic criteria [397](#)
 hallucinations and [398](#) [399](#)
 prevalence [398](#)
 prognosis [398](#) [399](#)
 risk factors for [137–138](#)
 symptoms [398](#)
 treatment [398](#) [399](#)
selective mutism in [391](#)
separation anxiety disorder in [391](#) [392](#) [394](#)
suicide in [388](#) [389](#)
of teenage mothers [19](#)
terminally ill [425](#) [428](#)

Chlordiazepoxide, withdrawal [123](#)

Chlorpromazine (Thorazine) [320](#)

- anorexia nervosa [221](#) [223](#)
- delirium in HIV treated with [112](#)
- HIV-related mania treated with [114](#)
- overdose [298](#)
- potency [316](#)
- stereotypic movement disorder [385](#)

Cholecystikinin, panic attack induction with [168](#) [172](#)

Cholinergic drug, receptors [39](#)

“Choo-choo” phenomenon [42](#) [46](#) [46](#)

Chromosomal abnormalities

- aggression influenced by [41–42](#) [45](#)
- Down’s syndrome [337](#)
- mental retardation caused by [335](#) [339](#)

Chronic fatigue syndrome [187–189](#)

- cause [188](#)
- characteristics [187](#)
- criteria [189](#)
- depression and [188](#)
- diagnostic criteria [187](#)
- ICD-10 classification of [187](#)
- neuroimaging [189](#)
- NMH and [188](#)
- prevalence [188](#)
- psychiatric factors [189](#)
- treatment [188](#) [189](#)

Cigarettes, adolescent use of [400](#)

Cimetidine (Tagamet) [157](#)

Circadian biological influences [32](#)

Circadian cycle

- seasonality [231](#)
- sleep and [231](#)
- sleep-wake cycle and [232](#)

Circadian disturbances [228](#)

Circadian influences [28](#)

Circadian processes [228](#)

Circumstantiality [83](#)

Cisapride (Propulsid) [309](#) [315](#)

Citalopram (Celexa) [313](#)

- anxiety disorders [172](#)

Civilization and Its Discontents (Freud, Sigmund) [69](#)

CJD *See* Creutzfeldt-Jakob disease

CL psychiatry *See* Consultation-liaison psychiatry

Clang association [132](#) [139](#)

Classical conditioning [42](#) [48](#)

- learning [50](#)

Clock Drawing [54](#) [59](#)

Clomipramine (Anafranil)

- anticholinergic effects [308](#) [312](#)
- anxiety disorder [174](#)

- body dysmorphic disorder [181](#)
- somatization disorder [184](#)
- stereotypic movement disorder [385](#)
- Clonazepam (Klonopin)
 - HIV pain and [113](#)
 - HIV-related mania treated with [114](#)
- Clonidine [308](#)
 - ADHD [363](#)
 - side effects [312](#)
 - tic disorder [376](#) [378](#)
- Clozapine (Clozaril) [315](#)
 - carbamazepine and [309](#)
 - caudate volume enlargement [35](#)
 - concentration [317](#)
 - schizophrenia and [129](#) [319](#)
 - teratogenic effects of [155](#) [162](#)
 - WBC and [73](#) [77](#)
- Clozaril See Clozapine
- Clumsy child syndrome [345](#)
- Cluttering [352](#)
- CMV See Cytomegalic virus
- CNS See Central nervous system
- Cocaine [117](#) [118](#)
 - adverse effects of using [120](#) [126](#)
 - amphetamines and [122](#)
 - complications [120](#) [126](#)
 - dopamine influenced by [39](#) [121](#)
 - incidence of use [121](#)
 - ischemic cerebrovascular disorder and [122](#)
 - medical applications [121](#)
 - paranoid psychosis induced by [136](#)
 - psychotic disorders induced by [121](#)
 - SPECT image and [117](#) [118](#)
 - withdrawal [124](#)
- Cockayne's syndrome [334](#) [338](#)
- Code of ethics [415](#)
- Coercive processes [197](#)
 - stages [198–199](#)
- Cognitive behavior treatment (CBT) [303](#)
 - in adolescents [408](#) [409–410](#)
 - bulimia nervosa [226](#)
 - in children [408](#) [409–410](#)
 - MDD in adolescence and [390](#)
 - panic disorder [168](#) [173–174](#)
 - paraphilia [209](#)
 - techniques [411](#)
- Cognitive development [18](#) [20](#) [22](#)
- Cognitive disorders
 - delusions and [144](#) [149](#)
 - due to general medical condition [95–108](#)
- Cognitive functioning

age-related decline in [285](#)
brain dysfunction and tests of [57](#)
brain hemispheres linked to [55](#) [56](#)
depression and [55](#)
in elderly [419](#) [421](#)
testing and evaluation/interpretation of [97](#) [102–103](#)

Cognitive testing [30](#)
Cognitive therapies [300](#)
Cogwheel rigidity [181](#)
Cohesion [305](#)
Communication disorders [348–352](#)
 diagnosis [348–350](#)
 DSM-IV-TR [348](#)
Competent to be executed [432](#) [436](#)
Complementary and alternative medicine (CAM) [256](#)
Compulsions [170](#) *See also* Obsessive-compulsive disorder
Compulsive buying [241](#)
 comorbid disorders [242](#)
 prevalence [241–242](#)
 treatment [242](#)
Compulsive character [62](#) [65](#)
Computed tomography (CT) [27](#) *See also* Single photon emission computed tomography
 depressive disorder abnormality on [152](#)
 Huntington's disease on [29](#)
 MRI v. [28–29](#) [33](#)
 schizophrenia studies with [130](#) [135](#)

Concentration
 defined [74](#)
 tests [72](#) [74](#)

Concrete operations [43](#)
Condensation [171](#)
Conditioned response [48](#)
Conduct disorder [157](#) [366–368](#) [404](#)
 adjustment disorder with [244](#)
 aggression and [370](#)
 comorbid condition with [367](#) [369](#)
 diagnosis [368](#) [370](#)
 differential diagnosis [369](#)
 factors associated with [367](#) [368–369](#)
 family and [369](#)
 gender differences [369](#)
 inhalant use and [122](#)
 model [368](#) [369](#)
 onset subtypes of [370](#)
 prevalence [369](#) [370](#)
 symptoms [368](#)
 temperament and [368–369](#)

Confabulation [82](#) [87](#)
Confidentiality
 AIDS/HIV and [109](#)
 breach in [415](#) [416](#) [433](#) [437](#)

breaking [154](#) [161](#)
child/adolescent psychiatry [415–417](#)
consent to share and [432](#) [436](#)
ethics in [442](#) [443](#) [444–445](#)
exceptions to [417](#)
legal obligations to report information and [433](#) [437](#)
rapport and [4](#)
Confrontation [5](#)
Congenital virilizing adrenal hyperplasia [215](#) [219](#) [219](#)
hormones [217](#)
Consultation-liaison (CL) psychiatry [256–267](#)
defined [256](#)
indications [257](#) [260](#)
transplantation and [260–261](#)
Contagion [305](#)
Contraceptives
adolescents and use of [20](#) [22–23](#)
availability [23](#)
education [23](#)
Controlling [240](#)
Conventional role-conformity [21](#)
Conversion disorders [176–178](#) [180–183](#)
antisocial personality disorder and [183–184](#)
chronic [180](#)
incidence [181](#)
prevalence [185](#)
signs of [177](#) [181](#)
socioeconomic factors in [185](#)
Coprolalia [378](#)
Coronary artery disease, type A behavior and [264–265](#) [264](#)
Correctional facilities, psychiatric facilities within [438](#)
Cortex lesions [31](#) [38](#)
Corticobasal degeneration [104](#)
Corticosteroids [123](#)
Countertransference [3](#)
defined [4](#)
patient-doctor relationship and [1](#) [8](#)
Court system
adult [416](#)
forensic psychiatry in [416](#) [417](#)
juvenile [416](#) [417](#)
Crack cocaine [121](#)
complications [120](#) [126](#)

Creutzfeldt-Jakob disease (CJD) [31](#) [38](#) [97–98](#) [99](#) [103](#) [107](#)
clinical symptoms [103](#)
diagnosis [103](#)
in elderly [419](#) [421](#)
onset age in [103](#)
treatment [103](#)
Cross-cultural studies [41](#) [44](#)

Cross-dressing, GID and [217](#)

Crossover studies [42](#) [47](#)

Crouzon's syndrome [334](#) [338](#)

Cruzan v. Missouri Board of Health [442](#) [443](#)

CT See Computed tomography

Culture-bound syndrome [141](#)

 dissociative fugue and [197](#)

 fugue and [200](#)

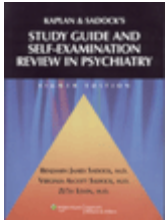
Cyclothymic disorder [152](#) [158](#)

Cyproheptadine (Periactin)

 anorexia nervosa [221](#) [223](#)

 serotonin-specific reuptake inhibitor sexual effects and [308](#) [313](#)

Cytomegalic virus (CMV) [334–335](#) [338](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



D

Dantrium See Dantrolene

Dantrolene (Dantrium) [311](#) [319](#)

NMS [312](#)

DBT See Dialectical behavior therapy

Death fear [62](#) [65–66](#)

Death instinct [68](#)

Debtors Anonymous [242](#)

Defense mechanisms [14](#) [15](#) [64](#) [69–70](#) [70](#) [157](#) [249](#) See also *specific defense mechanisms*

altruism as [15](#) [16](#)

depression and [151](#)

Freud, Sigmund, and [157](#)

humor as [15](#)

immature [67](#)

intermittent explosive disorder and [238](#)

mature [63](#) [67](#)

paranoid personality disorder [250](#)

parent-child relations and [278](#) [279](#)

personality disorder [253](#)

phobia [167](#) [171](#)

sublimation as [15](#)

suppression as [15–16](#)

Defensive Functioning Scale [92](#)

levels [93](#)

Déjà entendu [82](#) [87](#)

Déjà pensé [82](#) [87](#)

Déjà vu [82](#) [87](#) [198](#)

Delinquency, pyromania and [239](#)

Delirium [95–108](#) [101](#)

alcohol withdrawal-caused [100](#)

anticholinergic drugs and [162](#)

causes [96](#) [100](#) [102](#)

clinical features associated with [96](#)

dementia differentiated from [99](#) [108](#)

EEG [102](#)

epidemiology [105](#)

factors predisposing to [96](#)

- features of [100](#)
- HIV and treatment of [110](#) [112](#)
- incidence [100](#) [105](#)
- neurological symptoms [102](#)
- onset [102](#)
- prevalence [105](#)
- risk factors for development of [98](#) [99](#) [100](#) [105](#)
- treatment [96](#) [100–101](#)
- tremens [100](#)
- Delusion(s) [83](#) *See also* Paranoid delusions
- cognitive disorders and [144](#) [149](#)
- defined [88](#)
- depression and [144](#) [149](#)
- erotomantic [162](#)
- mania and [144](#) [149](#)
- misidentification [88](#)
- psychotic disorder [144](#) [149](#)
- schizophrenia and [162](#)
- Delusional disorder [132](#) [141](#) [143](#)
- age of onset in [146](#)
- brain pathology and [144](#) [149](#)
- cause [146](#)
- delusions in
 - development of [147](#)
 - types of [144](#) [145](#) [149](#)
- erotomantic type [143](#)
- genetic factors in [146](#)
- hallucinations in [147](#)
- incidence [146](#)
- precipitating factors [146–147](#)
- prevalence [146](#)
- risk factors [143](#) [146](#) [146](#)
- somatic treatments [143](#)
- somatic type [145](#)
 - example of [142](#)
- treatment [143](#) [147–148](#)
- Dementia [95–108](#) *See also* Alzheimer's dementia; Pseudodementia; Vascular dementia
- in Alzheimer's disease [90](#)
- amnesia symptoms in [200](#)
- cerebrovascular diseases causing [104](#)
- characteristics of [96](#) [101](#)
- clinical patterns of
 - cortical [99](#) [107–108](#)
 - subcortical [99](#) [107–108](#)
- course [101](#)
- degenerative [104](#)
- delirium differentiated from [99](#) [108](#)
- depression-related-cognitive dysfunction distinguished from [101](#) [102](#)
- dialysis [258](#) [261](#)
- in elderly [418](#) [420](#)
 - protective factors against [420](#) [422](#)

- epidemiology [97](#)
- frontal lobe [104](#)
- frontotemporal [98](#) [98](#) [104](#)
- HIV [30–31](#) [37–38](#)
- incidence [102](#)
- with Lewy bodies [96](#) [98–100](#) [100](#) [106](#) [106](#)
- neuropsychological memory testing and [55](#)
- prevalence, age and [102](#)
- progression [97](#)
- semantic [104](#)
- Dementia precox [139](#)
- Demerol See Meperidine
- Denver Developmental Screening Test (Denver III) [326](#)
- Denver III See Denver Developmental Screening Test
- Depakene See Valproate
- Depakote See Divalproex
- Dependent patient, interviewing [9](#)
- Depersonalization [83](#)
- Depersonalization disorder [196](#) [197](#) [198](#)
 - age of onset [200](#)
 - characteristics [200](#) [201](#)
- Depressed affect [155](#) [162](#)
- Depression [21](#) See also Antidepressants; *specific types of depression*
 - adjustment disorder and [244](#) [246](#)
 - in adolescents [271](#) [273](#) [398](#) [399](#)
 - alcohol and [117](#) [121](#)
 - anhedonia and [159](#)
 - anorexia nervosa and [220](#)
 - atypical [157](#)
 - diagnosing [151](#)
 - brain function changes and [151](#) [157](#)
 - cancer patients and [425–426](#) [429](#)
 - characteristics of [25–26](#)
 - in children [398](#) [399](#)
 - chronic fatigue syndrome [188](#)
 - cognitive functioning and [55](#)
 - cognitive model [155](#) [163](#)
 - defense mechanisms in [151](#)
 - delusions and [144](#) [149](#)
 - dementia distinguished from cognitive dysfunction related to [101](#) [102](#)
 - double [153](#) [154](#) [160](#)
 - ECT [158](#)
 - in elderly [419](#) [421](#)
 - Erikson view of [66](#)
 - Freud, Sigmund, view of [66](#) [159](#)
 - gender difference in [272](#)
 - grief/bereavement and [25](#)
 - Hamilton Rating Scale for [94](#)
 - interpersonal psychotherapy [301](#) [303](#)
 - Klein view of [66](#)
 - Kohut view of [66](#)

learned helplessness and [45](#) [163](#)
propranolol-caused [157](#)
puberty and [271](#) [273](#)
reactive [151](#) [157](#)
recurrence rate [157](#)
REM sleep and [157](#) [233–235](#)
risk factors [156](#)
schizotypal personality disorder and concurrent [253](#)
sleep deprivation and [233](#)
suicidal thoughts and [76](#) [161](#)
theories [159–160](#)
treatment [161](#)

Depressive disorders
chronic, management and [154](#)
CT abnormality in [152](#)
MRI [152](#) [158](#) [158](#)

Derealization [83](#)

Dermatological diseases [261](#)

Desipramine (Norpramin)
anorexia nervosa [223](#)
anticholinergic effects [308](#) [312](#)
HIV pain and [113](#)
HIV-related headache treated with [113](#)

Desmopressin
in children [414](#)
enuresis [382](#)

Desyrel See Trazodone

Detention centers, juvenile [433](#) [437](#)

Deteriorative disorder [131](#)
characteristics [138](#)
schizophrenia and [138](#)
violence and [138](#)

Development [18–26](#) See also Denver Developmental Screening Test; Psychomotor
Development index; Psychosocial development theory
addition of cells during [21](#)
age-expected norms in [23–24](#)
“band-aid phase” in [19](#) [22](#)
bladder/bowel control and [379](#) [382](#)

child psychiatry and [322](#) [324–325](#)
childhood [18](#)
cognitive [18](#) [20](#) [22](#)
communication and [348](#)
Erikson’s stages of [64](#) [67](#) [68–69](#)
gender differences in [65](#)
infancy period [22](#)
intellectual [18](#)
landmarks of normal [23–24](#) [24](#)
language [24](#) [349](#) [350](#)
life cycle and [18](#)
life stresses and [18](#)

Mahler's conceptualization of process of [66](#)
mental retardation and sequence of [335](#) [338](#)
mood disorders and [387](#)
morality and [25](#)
personality and [23](#) [25](#)
preschool period [22](#)
psychosexual [18](#) [68](#) [68](#)
schedules of [23](#)
sex hormone levels and [24](#)
toddler period [22](#)

Developmental coordination disorder [345–347](#)
diagnostic categories [347](#)
features [347](#)
manifestations [345–346](#)
risk factors [346–347](#)
tests for demonstrating [346](#)

Dexamethasone [314](#)

Dextroamphetamine [363](#)

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)
adjustment disorders in [243](#) [245](#)
anxiety disorders defined [165](#)
autistic disorder [353](#)
communication disorders [348](#)
development [91](#)
developmental coordination disorder [345](#)
dissociative disorders classified by [196](#)
eating disorders defined in [220](#)
factitious disorder categories in [190](#)
feeding disorders of infancy/early childhood [371](#)
GID defined by [215](#)
impulse control disorder defined by [237](#)
kleptomania recognized by [241](#)
learning disorders in [341](#)
mental disorders in [14](#) [90](#) [91](#)
mental retardation in [333](#)
neurasthenia classified in [188](#)
NOS in [90](#) [91](#)
OCD diagnosis and [166](#)
panic disorder diagnostic criteria and [171](#)
paraphilias in [209](#)
personality categorized in [82](#) [85](#)
personality disorders [248](#)
pica [371](#) [373](#)
psychiatry classification in [90](#)
RAD [385](#)
relational problems classified in [277](#)
rumination disorder [371](#) [373](#)
schizophrenia diagnostic system in [127](#)
sexual disorders classified by [202](#)
sexual dysfunctions [206](#)
sexual response cycle defined in [213](#)

sleep disorders in [227](#)
somatoform disorder classification in [176](#)
 NOS [179](#) [185](#)
stereotypic movement disorder [384–385](#)
tic disorders [375](#)

Dialectical behavior therapy (DBT) [300](#) [301](#) [303](#)

Dialysis dementia [258](#) [261](#)

Diazepam (Valium) [316](#) [317](#)
 anxiety disorders [172](#)
 GABA system and influence of [120](#) [126](#)
 panic disorder [173](#)
 PCP intoxication [123](#)
 withdrawal [123](#)

Dietary supplements [270](#)

Digit span [54](#) [59](#)

Dilantin *See* Phenytoin

Dilaudid *See* Hydromorphone

Diminished capacity [438](#) [440](#)

Discriminate analysis [46](#)

Disease classification, system of [89](#)

Disease models, biopsychosocial [1](#)

Disintegrative disorder, childhood [353](#) [354](#) [357–358](#)

Disorder, term [91](#)

Disorders of written expression [342–344](#)

Displacement [64](#) [70](#) [171](#)

Disruptive behavior disorders [366–370](#) [395](#)

Dissociation [171](#) [254](#)
 defined [198](#)
 Ganser's syndrome and [192](#)

Dissociative amnesia [196](#) [197](#) [199](#) [200](#)
 characteristics [201](#)
 incidence [199](#)
 memory and [201](#)

Dissociative disorders [196–201](#)
 diagnosis [199](#)
 DSM-IV-TR classification of [196](#)
 fugue and [200](#)
 NOS [196](#)
 OCD and [197](#)

Dissociative fugue [196](#) [197](#) [200](#)
 alcohol and [200](#)
 characteristics [200](#) [201](#)
 culture-bound syndrome [197](#)
 predisposing factors [198](#) [200–201](#)
 prevalence rate [199](#)
 treatment [197](#)

Dissociative identity disorder [196](#) [197](#) [201](#)
 characteristics [201](#)
 mental status examination [196–197](#)
 personalities [199](#)
 prognosis [198](#)

- symptoms [199](#)
- Disulfiram (Antabuse)
 - alcohol abstinence and [123](#)
 - alcohol metabolism and [125](#)
 - mania precipitated by [151](#) [157](#)
 - overdose [118](#)
- Divalproex (Depakote) [173](#)
- DNI See Do not intubate
- DNR See Do not resuscitate
- Do not intubate (DNI) [428](#)
- Do not resuscitate (DNR) [428](#)
- Documentation of care [71](#)
 - litigation and [434](#) [438](#)
- Dolophine See Methadone
- Dolorac See Capsaicin
- Domestic violence [278](#) [279](#)
 - pregnancy and [283](#)
- Donepezil [311](#) [321](#)
- Dopamine [31](#)
 - amphetamine influence on [39](#)
 - Asian patients and [42](#) [45](#)
 - cocaine influence on [39](#) [121](#)
 - metabolism [136](#)
 - receptor antagonists, SDAs compared with [129](#)
 - schizophrenia and [130](#) [136](#) [311](#)
 - substance withdrawal and [119](#) [119](#)
 - tic disorders and [376](#) [377](#)
- Dopram See Doxapram
- Double orientation [198](#)
- Double-blind studies [47](#)
- Down's syndrome [335](#) [339](#) [358](#)
 - chromosomal aberrations associated with [335](#) [337](#) [339](#)
 - mental retardation caused by [336](#)
 - psychiatric disorders in patients with [337](#)
- Doxapram (Dopram)
 - panic attack induction with [167](#)
 - panic attacks induced by [172](#)
- Doxepin [312](#)
- Dream interpretation
 - Freud, Sigmund [66](#) [67](#) [70](#)
 - Jung [63](#)
- Dreaming [235](#)
- Drug abuse See Substance abuse
- DSM-IV-TR See *Diagnostic and Statistical Manual of Mental Disorders*
- Durable Power of Attorney [432](#) [435](#)
- Durham rule* [440](#)
- Dusky v. United States* [432](#) [436](#)
- Dysarthria [351](#)
- Dyskinesia [148](#)
- Dyslexia, defined [341–343](#)
- Dysmorphic features, child [332](#)

Dyspareunia [205](#) [211](#)

Dysphoria See Gender dysphoria

Dyspraxia [347](#) [351](#)

Dysprosody [81](#) [84](#)

Dyssomnias [227](#)

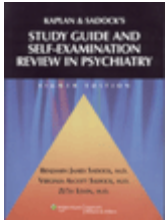
Dysthymic disorder [151](#)

antidepressants [156](#)

in children [156](#) [388](#)

profile for [156](#)

symptoms [156](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



E

- Eating disorders [220–226](#)
biological complications [222](#)
diagnosis [222](#)
DSM-IV-TR definition of [220](#)
epidemiology [224](#)
infancy/early childhood [371–374](#)
medical complications [222](#) [224](#)
mood disorders and [222](#)
prevalence [220](#)
psychiatric disorders and comorbid [222](#)
- Ebstein's anomaly, lithium and [161](#)
- Echolalia [132](#) [140](#)
- Echopraxia [132](#) [140](#)
- ECT See Electroconvulsive therapy
- Education for All Handicapped Children Act of 1975 [341](#) [417](#)
- EEG See Electroencephalography
- Effexor See Venlafaxine
- Ego [14–16](#)
The Ego and the Mechanisms of Defense (Freud, Anna) [69](#)
- Ego-dystonic symptoms [80](#)
- Ego-syntonic symptoms [80](#)
- Eidetic images [82](#) [83](#) [87](#)
- Ejaculation
premature [204–205](#) [210](#)
treatment [211–212](#)
retarded [212](#)
- Elavil See Amitriptyline
-
- Elderly See *also* Geriatric psychiatry
cognitive functioning [419](#) [421](#)
depression in [419](#) [421](#)
exercise in [20](#) [23](#)
hypothyroidism in [72](#) [75](#)
neuropsychological evaluation [419](#) [421](#)
nutrition in [20](#) [23](#)
physical assessment [419](#) [420](#)
sleep in [230](#) [420](#) [422–423](#)

suicide in [293](#) [296–297](#)
thyroid disease in [72](#) [75](#)
Electroconvulsive therapy (ECT) [152](#)
 anorexia nervosa [221](#) [223](#)
 depression treated with [158](#)
 kleptomania [242](#)
Electroencephalography (EEG) [27](#)
 delirium [102](#)
 petit mal seizure [97](#)
 polysomnography abnormalities and [72](#) [76](#)
 REM sleep [235](#)
 wakeful state to sleep [233](#)
Electromyography (EMG) [304](#)
Electrophysiological studies, schizophrenic patient [130](#) [135](#)
Elimination disorders [379–382](#) *See also specific elimination disorders*
ELISA *See* Enzyme-linked immunosorbent assay
EMDR *See* Eye-movement desensitization and reprogramming
Emergency psychiatric medicine [291–299](#)
Emetogenicity [265](#) [266](#)
EMG *See* Electromyography
Encephalitis
 HIV [114](#)
 impulsive behavior and [241](#)
Encephalopathy, HIV and [111](#) [114](#)
Encopresis [379](#) [380](#)
 defined [379](#) [382](#)
 diagnostic criteria [382](#)
 example [380–381](#)
 gender difference [382](#)
 primary [380](#)
 secondary [380](#)
 stress and [381](#)
End of life
 defined [424](#)
 symptoms [429](#) [430](#)
End-of-life care [424–430](#)
 in children [425](#) [428](#)
 pain control and [424](#)
 religious beliefs and [425](#) [427](#)
 undertreatment in [425](#) [426](#)
Enuresis [235](#) [379](#)
 defined [379](#) [382](#)
 diagnosis [379–381](#)
 diagnostic criteria [381](#)
 factors influencing [381](#)
 gender difference [382](#)
 genetics in [381](#)
 obstructive urinary tract lesions and [380](#) [381](#)
 prevalence [381](#)
 primary [381](#)
 psychological factors and [381](#)

- secondary [381](#)
- treatment [381](#) [382](#)
- Envy and Gratitude* (Klein) [69](#)
- Enzyme-linked immunosorbent assay (ELISA) [112](#)
- Epigenetic principle [62](#) [66](#)
- Epilepsy *See also* Seizures; *specific epilepsies*
 - associations [30](#)
 - fugue and [200](#)
 - intractable [30](#)
 - psychiatric disorders and [35](#)
- Epileptoid personality [238](#) [239](#)
- Erikson, Erik [21](#)
 - age-specific crises and [18](#)
 - Childhood and Society* [69](#)
 - depression as viewed by [66](#)
 - development and [67](#)
 - personality [25](#)
 - stages of [64](#) [68–69](#)
 - epigenetic principle [62](#) [66](#)
 - Freud, Sigmund, v. [63](#)
 - identity and [405](#)
 - integrity v. despair and [63](#)
 - normality and [15](#)
 - psychosocial development theory [66](#) [70](#)
- Erotomania [142](#) [145](#) [147](#)
 - characteristics [147](#)
 - course [147](#)
 - delusional belief [162](#)
 - violence and [147](#)
- Escitalopram [313](#)
- Eskalith *See* Lithium
- Estrogen [20](#)
 - development and [24](#)
 - hormone therapy, men undergoing [216](#) [218](#)
- Ethanol [120](#) [125–126](#)
- Ethical confidence [444](#)
- Ethical conflicts [442](#) [445–446](#)
- Ethical dilemmas [442](#) [445–446](#)
- Ethical theories [441](#)
- Ethics
 - confidentiality and [442](#) [443](#)
 - defined [441](#)
- Ethology [40](#)
- Euthanasia [424](#)
 - defined [429–430](#)
 - ethical issues [424](#)
 - types [430](#)
- Exhibitionism [209](#) [211](#)
 - diagnosis [207](#)
 - example [203–204](#)
 - prognosis [208](#)

schizotypal personality disorder and [204](#)
treatment [204](#)

Exit therapy [288](#)

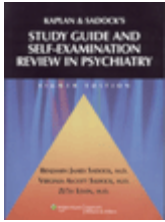
Experimental neurosis [50](#)

Exposure therapy, anxiety disorder [168](#) [175](#)

Eye movement dysfunction, schizophrenia and [128](#) [132](#)

Eye-movement desensitization and reprogramming (EMDR) [300](#)





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



F

- Face-hand test [58](#)
- Facial Recognition [54](#) [59](#)
- Factitious disorder [190–195](#)
 - age at onset [194](#)
 - antisocial personality disorder and [194](#)
 - defined [190](#)
 - demographic patterns [193–194](#)
 - DSM-IV-TR categories of [190](#)
 - hypochondriasis differentiated from [194](#)
 - Münchhausen syndrome and [191](#)
 - personality disorder and [193](#) [194](#)
 - presentation [191–192](#) [194](#) [195](#)
 - prevalence [192](#)
 - prognosis [192](#)
 - by proxy [191](#) [192](#) [194](#)
 - child abuse and [192–193](#)
 - confirming [193](#) [195](#) [195](#)
 - sick role and [195](#) [195](#)
 - signs [192](#) [194](#)
 - somatization disorder differentiated from [194](#)
 - symptoms [192](#) [194](#)
 - syndromes [192](#)
 - treatment [191](#) [194](#)
 - poor, responsiveness [192](#)
 - psychiatric therapy [193](#)
- Failure to thrive [47](#)
 - feeding/eating disorders and [373–374](#)
 - RAD and [384](#) [385](#)
- Family
 - conduct disorder and [369](#)
 - extended [44](#)
 - gay/lesbian [207](#)
 - nuclear [44](#)
- Family therapies [300](#) [408](#) [410](#) [412–413](#)
 - anorexia nervosa [225](#)
- Fatal familial insomnia (FFI) [100](#)
- FDG See *Fluorine-18* [¹⁸F]-fluorodeoxyglucose

Fear [395](#)
in children [392](#) [395](#)
Feeding disorders of infancy/early childhood [371–374](#)
DSM-IV-TR [371](#)
incidence [372](#)
severe [373](#)
symptoms [372](#)
Female orgasmic disorder [205](#) [211](#)
Fetal alcohol syndrome [19](#) [335](#) [339](#) [358](#)
characteristics [21](#)
mental retardation caused by [336](#)
Fetal sex steroid [272](#) [273](#)
Fetishism [204](#) [208](#) [209](#) [210](#) [211](#)
transvestic [209](#) [211](#)
FFI See Fatal familial insomnia
FHA See Functional hypothalamic amenorrhea
Finger Tapping [54](#) [59](#)
5-HIAA See Serotonin metabolite 5-hydroxyindoleacetic acid
Fixed-interval schedule [43](#)
Fixed-ratio schedule [43](#)
Flooding [302](#) [303](#)
Flumazenil
benzodiazepines and [316](#)
side effects [315–316](#)
sleeping medication overdose [310](#)
Fluorine-18 [¹⁸F]-fluorodeoxyglucose (FDG) [35](#)
Fluoxetine (Prozac)
anorexia nervosa [221](#) [223](#)
anxiety disorders [167](#) [172](#)
body dysmorphic disorder [181](#)
in children [414](#)
concurrent drug administration with [315](#)
dose increase in [161](#)
HIV treatment with [115](#)
intermittent explosive disorder [240](#)
kleptomania [242](#)
MDD in adolescence [390](#)
mood disorder [154–155](#)
as phenelzine contraindication [155](#)
somatization disorder [184](#)
Fluphenazine (Prolixin) [320](#)
brain tumor psychotic symptoms [311](#)

Fluvoxamine (Luvox)
anxiety disorders [167](#) [172](#)
caffeine elimination and [124](#)
kleptomania [242](#)
fMRI See Functional MRI
Forensic psychiatry [431–440](#)
adolescent [415–417](#)
child [415–417](#)

defined [431](#)
legal cases affecting [440](#)
Formal operations [43](#)
Formication [148](#) [260](#)
example of [143–144](#)
Fragile X syndrome [335](#) [336](#) [336](#) [340](#)
disorders associated with [334](#) [336](#)
IQ decline and [334](#) [336](#)
mental retardation caused by [336](#) [338](#)
Free association [67](#) [305](#)
Freedom from Distractibility Index [60](#)
Freud, Anna [63](#)
child psychotherapy [412](#)
defense mechanisms and [67](#)
The Ego and the Mechanisms of Defense [69](#)
Freud, Sigmund [21](#)
child psychotherapy [412](#)
Civilization and Its Discontents [69](#)
conversion and [178](#) [183](#)
death instinct and [68](#)
defense mechanisms and [157](#)
depression viewed by [159](#)
dreams and [66](#) [70](#)
Erikson v. [63](#)
hypnosis viewed by [63](#) [67](#)
The Interpretation of Dreams [67](#)
MDD explained by [62](#) [66](#)
“Mourning and Melancholia” [159](#)
neurasthenia and [188](#)
normality and [15](#)
Oedipus complex [62](#) [65](#)
personality development and [25](#)
phobia defense mechanisms and [167](#) [171](#)
pleasure principle [48](#)
primal scene described by [203](#) [206](#)
psychoanalytic personality and [61](#)
psychoneural project for mental phenomena and [155](#) [162](#)
psychosexual development [18](#) [68](#)
psychotherapies and [300](#)
suicide theory of [292](#) [294](#)
topographical model of mind by [67–68](#)
transference and [67](#)
unconscious, understanding and [63](#)
Fromm, Erich [62](#)
characteristics typical of modern capitalist society identified by [65](#)
individuation, retreat from and [65](#)
Frontal lobe degeneration [98](#)
Frotteurism [209](#) [210](#) [211](#)
Fugue *See also* Dissociative fugue
culture-bound psychiatric syndromes and [200](#)
epilepsy and [200](#)

organic [197](#)

states [200](#)

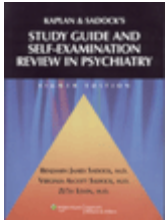
Functional hypothalamic amenorrhea (FHA) [273–274](#)

Functional impairment, depression and [25](#)

Functional MRI (fMRI) [34](#)

Furosemide, lithium interactions with [317](#)





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



G

GABA

- anxiety disorders and [175](#)
- barbiturate influence on [120](#) [125–126](#)
- diazepam influence on [120](#) [126](#)
- ethanol influence on [120](#) [125–126](#)
- receptors
 - barbiturates and [34](#)
 - benzodiazepines and [34](#)
 - seizure activity and [29](#) [34](#)

Gabapentin (Neurontin) [310](#) [318](#)

- HIV treatment with [115](#)
- panic disorder [173](#)

GAF See Global Assessment of Functioning

Galantamine [321](#)

Ganciclovir [112](#)

Ganser's syndrome [190–191](#)

- classification [193](#)
- dissociation and [192](#)
- personality disorder and [192](#)

Gastrointestinal (GI) system

- disorder, functional [258](#) [263–264](#) [263](#)
- psychiatric comorbidity [263](#)
- stress and response of [257–258](#) [261](#)

Gault decision [433](#) [436–437](#)

Gay men [205](#) [210](#)

- children of [203](#) [207](#)

Gender constancy [216](#) [217](#)

Gender dysphoria [217](#)

Gender identity [202](#) [206](#)

- defined [214](#)

Gender identity disorders (GID) [215–219](#)

- age and [215](#) [216–217](#)
- assessing [217](#)
- DSM-IV-TR definition of [215](#)
- epidemiology [216](#)
- female [216](#) [217](#)
- hormone influence on [217](#)

male [216](#) [217](#)
prevalence [218](#)
treatment [216](#)

Geriatric psychiatry [418–423](#)
Alzheimer's dementia and, risk factors [419](#) [422](#)
Alzheimer's disease and [418](#) [420](#)
anxiety disorders [419](#) [420](#)
CJD [419](#) [421](#)
dementia and [418](#) [420](#)
 protective factors [420](#) [422](#)
learning and [419](#) [420](#)
memory and [419](#) [420](#)
pharmacological treatment [419](#) [421](#)

Geropsychiatry *See* Geriatric psychiatry

Gerstmann-Straüssler syndrome (GSS) [100](#)

GHRH *See* Growth hormone-releasing hormone

GHRIF *See* Growth hormone-release-inhibiting factor

GI system *See* Gastrointestinal system

GID *See* Gender identity disorders

Gilled de la Tourette syndrome *See* Tourette's disorder

Glial cells [32](#)

Global Assessment of Functioning (GAF) [92](#) [93](#)

Globus pallidus [35](#)

Glossodynia [259](#) [267](#)

Glycine [31](#)
 spinal cord and [38](#)

"Good" mother [160](#)

"Good-enough mothering" [69](#)

Grand mal epilepsy [101](#)

Grief/bereavement [21](#) [157](#) [285](#)
 characteristics of [25–26](#)
 in children [395](#)
 depression and [25](#)
 features of normal [151](#)

Group therapies [300](#)
 schizophrenia [134](#)

Growth hormone [31](#) [39](#)

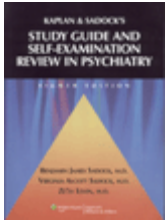
Growth hormone-release-inhibiting factor (GHRIF) [39](#)

Growth hormone-releasing hormone (GHRH) [39](#)

GSS *See* Gerstmann-Straüssler syndrome

Guanfacine [376](#) [378](#)

Guilt [82](#) [87](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](#)



H

- Habeas corpus [434](#) [437](#) [438–439](#)
- Halcion See Triazolam
- Haldol See Haloperidol
- Hallucinations [82](#) [83](#) [86](#) See also Hypnagogic experiences
 - autoscopic [82](#) [86](#)
 - causes [260](#)
 - delusional disorder [147](#)
 - gustatory [82](#) [86](#)
 - hepatic [82](#) [86](#)
 - hypnagogic [234](#)
 - ictal [82](#) [86](#)
 - Lilliputian [82](#) [86](#)
 - medical cause of [257](#)
 - migrainous [82](#) [86](#)
 - olfactory [82](#) [86](#)
 - schizophrenia and [130](#) [135](#)
 - childhood-onset [398](#) [399](#)
- Hallucinogens [120](#) [126](#)
- Haloperidol (Haldol) [307](#) [320](#) [321](#)
 - autism [359](#)
 - bipolar disorder [155](#)
 - carbamazepine decrease in plasma concentrations of [309](#)
 - delirium [96](#) [100–101](#)
 - delirium in HIV treated with [112](#)
 - HIV-related mania treated with [114](#)
 - mania [311](#)
 - potency [316](#)
 - stereotypic movement disorder [385](#)
 - tic disorder [376](#) [378](#)
- Halstead-Reitan Battery of Neuropsychological Tests [54](#) [57–58](#)
- Hamilton Rating Scale
 - anxiety [94](#)
 - depression [94](#)
- Harlow, Harry
 - behavior and [40](#) [43](#)
 - ethological studies [50](#)
 - isolation and separation studies by [45](#)

surrogate mother [50](#)
Harm avoidance [250](#) [253](#)
Head banging [236](#) [383–385](#)
Headaches
 HIV-related [113](#)
 tension [257](#) [261](#)
Health Care Proxy [427–428](#)
Hemolysis, sleep-related [236](#)
Herbal medicine [269](#) [270](#)
Hermaphroditism, characteristics [219](#)
Heteronormal [14](#)
Hippocratic oath [415](#)
Hismanal [315](#)

P.458

History, psychiatric evaluation [71](#) [72](#)
 anamnesis in [73–74](#) [74](#)
 judgement assessment in [74](#)
HIV *See* Human immunodeficiency virus
Hollister, Leo [123](#)
Homeopathy [270](#)
Homicidal patient, evaluating [291](#)
Homicide
 confidentiality and [416](#)
 prevalence [44](#)
 schizophrenic [138](#)
Hormone therapy
 estrogen, men undergoing [216](#) [218](#)
 sex reassignment and [217](#)
 testosterone, women undergoing [216](#) [218](#)
Hormones *See also specific hormones*
 GID and influence of [217](#)
 mood disorders and [76–77](#)
Horney, Karen
 neuroses, causes and [69](#)
 psychoanalytic personality and [61](#)
Hospice care [424](#)
Human immunodeficiency virus (HIV)
 antipersonality disorder and [34](#)
 antiretroviral agents for [114–115](#) [115](#)
 counseling [112](#) [113](#)
 delirium treatment and [110](#) [112](#)
 dementia [30–31](#) [37–38](#)
 encephalitis and [114](#)
 encephalopathy diagnosis in [111](#) [114](#)
 incidence [109](#)
 infections secondary to [113](#) [115](#)
 mania and [112](#)
 treatment of [114](#)
 mood disorders in [112](#)
 neurocognitive deficits associated with [110](#)
 neurocognitive disorder associated with [114](#)

neuropathic pain related to [110](#)
neuropsychiatric aspects of [109–115](#)
pain as symptom in [112–113](#)
personality disorders and [29](#)
pharmacotherapies for [109–110](#)
pretest, counseling [109](#) [111](#) [113](#)
psychotic symptoms associated with [110](#) [113–114](#)
seroconversion and [111](#)
serum testing [112](#)
suicide and [110](#) [112](#)
teenage birth control use and [22](#)
test [110](#) [112](#) [113](#)
types [111](#)
zidovudine for [111](#)

Humor [15](#)

Huntington's disease [31](#) [33](#) [37](#) [99](#)
course [107](#)
CT image of [29](#)
emotional symptoms [106](#)
imaging [106](#)
onset [107](#)

Hydromorphone (Dilaudid) [427](#)

Hyperactivity [361](#) [364](#)

Hyperemesis gravidarum [272](#) [275](#)

Hypermnesia [82](#) [87](#)

Hypersomnia
periodic [85](#)
profound [235](#)

Hypertension [264](#)

Hypertonus [347](#)

Hypnagogic experiences [83](#)

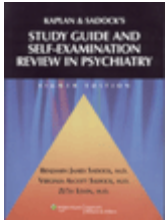
Hypnosis [63](#) [67](#)

Hypoactive desire disorder [205](#) [210–211](#)

Hypochondriacs [178](#)
onset [183](#)
thanatophobia and [183](#)

Hypochondriasis [176](#) [178](#)
age at onset [182](#)
body dysmorphic disorder and [179](#) [186](#)
course [183](#)
diagnostic criteria [182](#)
etiology [177](#)
example [178](#)
factitious disorder differentiated from [194](#)
personality disorders and [254](#)
prevalence [182](#)
primary [182](#)
psychiatric disorder comorbidity with [182](#)
sick role [179](#)
symptoms [179](#)
theories [179](#)

treatment [178](#) [183](#)
Hypomanic episodes [152](#)
 bipolar II disorder and [157](#)
Hypothyroidism [72](#) [75](#)
Hypotonus [347](#)
Hysterectomy [274](#)
Hysteria [182](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](#)



- I
- Ibuprofen [315](#)
 - lithium interactions with [317](#)
- ICD-10 *See International Statistical Classification of Diseases and Related Health Problems*
- Idealization [159](#)
- Identification with aggressor and [239–240](#)
- Identity *See also specific identities*
 - confusion [405](#)
 - formation [405](#)
- Identity disorder *See specific identity disorders*
- Identity problems [285](#) [404](#)
 - assessment [405](#)
 - in children [405](#)
 - differential diagnosis [405–406](#)
- Idiopathic pruritus [259](#)
- Illness behavior [2–3](#) [5](#)
 - assessment [5](#)
 - defined [4](#)
 - factors influencing [4](#) [5](#)
- Illusion [148](#)
- Imipramine (Tofranil) [316](#)
 - anticholinergic effects [308](#) [312](#)
 - cardiotoxicity [155](#) [162](#)
 - HIV-related headache treated with [113](#)
 - kleptomania [242](#)
 - panic disorder [174](#)
- Impotence
 - functional [204](#)
 - organically caused [204](#) [208](#)
 - psychologically caused [208](#)
- Imprinting [50](#)
- Impulse control [84](#)
- Impulse control disorders [237–242](#) *See also specific impulse control disorder*
 - alcohol and [237](#)
 - antisocial patients and [252](#)
 - drugs and [238](#)
 - DSM-IV-TR defined [237](#)

NOS [237](#)

Impulsive behavior [241](#)

Impulsivity [361](#)

"In re Gault" [417](#)

In vitro immune suppression [262](#) [262](#)

Incest [282](#)

- forms of [281](#)
- incidence [284](#)

Incompetence [434](#) [439](#)

Inderal See Propranolol

Individuation [22](#) [62](#)

Indomethacin [315](#)

- lithium interactions with [317](#)

Infancy period [22](#) See also Feeding disorders of infancy/early childhood

- anxiety disorders [391–396](#)
- attachment in [50](#)
- development in [22](#)
- eating disorders [371–374](#)

Informed consent [437](#)

Inhalant use

- adolescent [119](#) [402](#)
- comorbid conditions [118](#)
- disorders related to [122](#)
- prevalence [119](#) [125](#)

Inositol [173](#)

Insanity defense [433](#) [434](#) [437](#) [438](#)

Insight [84](#)

Insomnia [227](#) See also Fatal familial insomnia

Instrumental conditioning [48–49](#)

Intelligence

- neuropsychological testing, clinical [52](#)
- scales [56](#)
- testing, mental retardation and [52](#)

Intelligence quotient (IQ) [53](#) [56](#)

- fragile X syndrome and defining [334](#) [336](#)
- mental retardation and [57](#) [333](#) [334](#) [336](#)
- diagnosing [335](#) [336](#)

Intermittent explosive disorder [237](#) [238](#)

- causes [239](#)
- defense mechanisms and [238](#)
- identification with aggressor and [239–240](#)
- incidence [241](#)
- manifestation [239](#)
- neurobiological studies [240](#)
- treatment [240](#)

International Statistical Classification of Diseases and Related Health Problems (ICD-10)

- chronic fatigue syndrome classification in [187](#)
- pica in [373](#)
- somatoform disorders described in [179](#) [184](#)

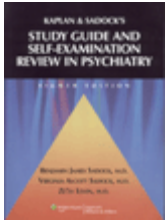
The Interpretation of Dreams (Freud, Sigmund) [67](#)

Intersexual disorders [214](#)

Interviewing [2](#) *See also* Adult Attachment Interview
child psychiatry [323](#) [324](#) [331](#)
ending [12](#)
functions of [11](#) [11](#)
psychiatric [9](#) [10](#) [72-73](#)
suicidal thoughts and [10](#) [12](#) [76](#)
techniques for [11-12](#)
questions [3](#) [6-7](#) [7](#) [13](#)
rapport and [5](#)
special patient population [9-17](#)
questions for [9-11](#)
steering a patient and [9-10](#) [11](#)
treatment compliance and [13](#)
violence and [13](#) [76](#)
Ipecac intoxication [222](#) [224](#)
Ischemic cerebrovascular disorder [122](#)

P.459

Islets of precocity [357](#)
Isolation [171](#) [254](#)
Isolation studies [45](#)
Isoniazid (Nydrazid) [151](#) [157](#)
Isoptin *See* Verapamil



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](#)



J

Jamais vu [82](#) [83](#) [87](#)

Jet lag [232](#)

Judgment [435](#)

assessment [74](#)

defined [84](#)

Jung, Carl Gustav

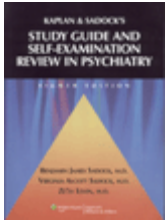
archetypes [63](#) [66](#) [67](#)

dream interpretation [63](#)

DSM development and [91](#)

psychoanalytic personality and [61](#)





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



K

Kegel's exercises [212](#)

Kernberg, Otto

borderline level of personality organization [249–250](#) [253](#)

personality/psychopathology theories of [65](#)

Klein, Melanie [63](#)

child psychotherapy [412](#)

death instinct expanded on by [68](#)

depression viewed by [66](#) [159–160](#)

Envy and Gratitude [69](#)

normality and [15](#)

personality/psychopathology theories of [65](#)

psychoanalytic personality and [61](#)

psychoanalytic theory modified by [69](#)

Kleine-Levin syndrome [85](#) [225](#)

Kleptomania [237](#) [239](#) [241](#)

characteristics [239](#)

component [237–238](#)

DSM-IV-TR recognition of [241](#)

features [239](#)

mood disorders and [242](#)

treatment [242](#)

Klinefelter's syndrome [219](#)

Klonopin See Clonazepam

Klüver-Bucy syndrome [225](#)

Kohut, Heinz [21](#)

The Analysis of the Self [69](#)

depression as viewed by [66](#)

mood disorder terms [153](#)

narcissistic personality disorders [252](#)

personality development and [25](#)

personality/psychopathology theories of [65](#)

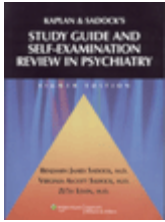
psychoanalytic personality and [61](#)

self psychology [159](#)

Korsakoff's syndrome [30](#) [37](#)

Kraepelin, Emil [131–132](#) [139](#)

manic-depressive illness [155](#) [163](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



L

- La belle indifférence [181](#)
- Labor, emotional support during [272](#) [275](#)
- Lacanian theory [63](#) [67](#)
- Lamotrigine
 - bipolar disorder [312](#)
 - rash associated with [309](#) [314](#)
- Language
 - brain hemisphere linked with [55](#)
 - components [348](#)
 - development [24](#) [349](#) [350](#)
- Language deficits, developmental expressive [349](#)
- Language disorders [348](#)
 - developmental coordination disorders and [345](#)
 - expressive [344](#) [349](#) [351](#)
 - characteristics [351](#)
 - diagnosis [349](#) [350](#)
 - differential diagnosis [350](#)
 - schizophrenia and [132](#) [139](#)
- Larodopa *See* Levodopa
- L-asparaginase, fugue states caused by [200](#)
- "Late talkers" [351](#)
- Lead poisoning [107](#)
- Learned helplessness
 - depression and [45](#)
 - studies [42](#) [163](#)
- Learning [41](#)
 - behavioral model [42](#) [47](#)
 - classical conditioning and [50](#)
 - in elderly [419](#) [420](#)
 - neurons and [44](#)
 - neurophysiology [50](#)
 - psychoanalytical model [42](#) [47](#)
 - social theory of [43](#)
- Learning disorders [341–344](#) *See also specific learning disorders*
 - comorbid disorders [341](#)
 - development [341](#)
 - developmental coordination disorders and [345](#)

NOS [343](#)

Legal responsibility, determining [440](#)

Lesbians [205](#) [210](#)
children of [203](#) [207](#)

Lethologica [82](#) [83](#) [87](#)

Levallorphan [122](#)

Levinson, Daniel [21](#)
development and [18](#)
personality development and [25](#)

Levodopa (Larodopa) [320](#)
paranoid psychosis induced by [136](#)

Levothyroxine [314](#)

Lewy bodies, dementia with [96](#) [98–100](#) [100](#) [106](#) [106](#)

Lewy body disease [33](#)

Life cycle
charting [18](#)
development and [18](#)
phasic nature of [16](#)
stages [18](#)
theory [18](#)

Life fear [65–66](#)

Life stresses [18](#)

Life-support measures [424](#)

Liothyronine [313](#) [314](#)

Lithium (Eskalith) [308](#) [313](#) [320](#)
antimanic response, favorable to [309](#) [314](#)
Asian patients and [42](#) [45–46](#)
bipolar disorder [154](#) [157](#)
blood levels [75–76](#)
carbamazepine side effects [315](#)
contraindications [312](#)
drug interactions [317](#)
Ebstein's anomaly and [161](#)
HIV-related mania treated with [114](#)
intermittent explosive disorder [240](#)
kleptomania [242](#)
onset of action [312](#)
pregnancy and [155](#) [161](#) [316](#)
pretreatment, tests [72](#)
response predictors for [311](#)
side effects [161](#)
theophylline and [310](#)
therapeutic index [316](#)
WBC and [76](#)

Living will [424](#) [427](#)

Loosening of associations [132](#) [139](#)

Lorazepam (Ativan) [299](#)
phobia [167](#) [170](#)

Lorenz, Konrad [43](#)
behavior and [40](#)
imprinting and [50](#)

Loss of autonomy [209](#)

L-Tryptophan [151](#)

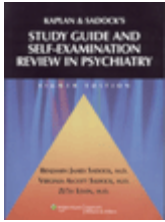
 bipolar disorder [157](#)

 REM sleep and [235](#)

Ludiomil See Maprotiline

Luria-Nebraska Neuropsychological Battery [54](#) [57–58](#)

Luvox See Fluvoxamine



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



M

- Mad Hatter syndrome [107](#)
- Magnetic resonance imaging (MRI) [27](#) [33](#) *See also* Functional MRI
 - bipolar I disorder [35](#) [158](#)
 - CT v. [28–29](#) [33](#)
 - depressive disorder [152](#) [158](#) [158](#)
 - MDD [35](#)
 - schizophrenia and studies of [130](#)
 - studies [30](#)
 - substance abuse disorder [35](#)
- Magnetic resonance spectroscopy (MRS) [27](#)
- Magnetoencephalography (MEG) [27](#)
- Mahler, Margaret
 - child psychotherapy [412](#)
 - development and [18](#) [66](#)
- Major depressive disorder (MDD) [25–26](#) [62](#)
 - in adolescents
 - CBT for [390](#)
 - interpersonal therapy for [390](#)
 - symptoms presenting [388](#) [389–390](#)
 - alcohol-induced mood disorder distinguished from [121](#)
 - body dysmorphic disorder as comorbid condition [180](#)
 - in children [388–390](#)
 - example [152–153](#)
 - MRI studies of [35](#)
 - recurrent [160](#)
- Male-male relationship, developmental stages [210](#)
- Malingering [132](#) [193](#) [285–289](#)
 - antisocial patient [12](#)
 - characteristics [289](#)
 - example [191](#)
 - features [289](#) [290](#)
- Malpractice litigation [433](#) [437](#)
 - medical records and [77](#)
 - sexual involvement with patients and [437](#)
- Manganese madness [99](#) [107](#)
- Mania
 - in AIDS patients [110](#)

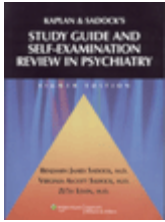
treatment of [111](#)
delusions [144](#) [149](#)
drugs precipitating [151](#)
haloperidol [311](#)
HIV and [112](#)
treatment of [114](#)
Manic episode [144](#) [149](#)
Manic-depression [155](#) [163](#) [164](#)
MAOI *See* Monoamine oxidase inhibitors

Maprotiline (Ludiomil)
anticholinergic effects [312](#)
panic disorder [173](#)
Marijuana *See also* Cannabinoids; Cannabis
adolescent use of [400](#)
as "gateway drug" [402](#)
medical uses [122](#)
Marijuana-induced state [162](#)
Marital therapy [21](#) [25](#)
Marriage counseling [21](#) [25](#)
Masochism [209](#) [211](#)
Massage therapy [269](#) [270](#)
Maternal age, genetic findings and [335](#) [339](#)
Mathematical disorder
ADHD and [342](#) [343](#)
characteristics [342](#) [344](#)
gender difference [344](#)
genetic factors in [343–344](#)
MDD *See* Major depressive disorder
MDMA *See* Methylenedioxymethamphetamine
Medical conditions
mood disorders due to [160](#)
psychological factors affecting [258](#)
sexual dysfunction due to [206](#)
Medical problems, psychiatric symptoms and [73](#) [78–79](#) [78](#)
Medical record [71](#)
inpatient unit [75](#) [75](#)
liability issues in [73](#) [77](#)
patient right to [74](#)
Medication noncompliance [257](#) [259–260](#) [288](#)
antidepressants and [158](#)
Medications *See also* Negligent prescription practices
adverse effects [413](#)
children/adolescent use of [407](#) [408](#) [410–414](#)
drug-drug interactions and prescribing [259](#)
MEG *See* Magnetoencephalography
Melatonin [29](#) [31](#) [34](#) [39](#)
mood disorders and [76](#)
Memory [36](#) [54](#) [60](#) [74](#) *See also* Screen memory; Wechsler Memory Scale
dissociative amnesia and [201](#)
in elderly [419](#) [420](#)

episodic [60](#)
functions, stages of [82](#) [86–87](#)
 recall [82](#) [86–87](#)
 registration [82](#) [86–87](#)
 retention [82](#) [86–87](#)
immediate [60](#)
impairment, cerebral disease and [76](#)
implicit [60](#)
laterality [37](#)
neuropsychological testing [54](#) [55](#) [60](#)
recent [74](#)
 tests for [72](#)
recent past [60](#)
remote [60](#) [74](#)
semantic [60](#)
short-term [60](#)
Mental disorders
 defined [14](#) [90](#)
 DSM-IV-TR classification of [91](#)
 DSM-IV-TR definition of [90](#)
 due to general medical condition [95–108](#)
 laboratory findings in [77](#) [77](#)
 sleep disorders related to [227](#)
 somatization disorder and [177](#) [181](#)
 somatoform disorders and comorbid [179](#) [186](#)
Mental health *See also* Alcohol, Drug Abuse, and Mental Health Administration
 defined [15](#)
 normality and [14](#)
Mental retardation [333–340](#) *See also* Psychomotor retardation
 anxiety and [334](#) [337](#)
 autism and [356](#) [357](#)
 borderline intellectual functioning and [289](#)
 causes [334](#) [336](#) [337](#) [338](#)
 chromosomal abnormalities causing [335](#) [339](#)
 CMV exposure in utero and [334–335](#) [338](#)
 defined [333](#)
 development sequence and [335](#) [338](#)
 diagnosis, IQ and [335](#) [336](#)
 DSM-IV-TR [333](#)
 incidence [336](#)
 intelligence testing and [52](#)
 IQ and [57](#) [333–336](#)
 mild [334](#) [337](#)
 moderate [334](#) [337](#)
 prevalence [333–334](#) [336](#)
 profound [337](#)
 pyromania and [239](#)
 severe [337](#)
Mental status examination
 child [326](#) [327](#)
 dissociative identity disorder [196–197](#)

- psychiatric evaluation [71](#)
- psychiatric rating scales and [94](#)
- sensorium category of [72](#)
- Meperidine (Demerol) [115](#)
- Mercury poisoning [99](#) [107](#)
- Mercy killing [430](#) See also Euthanasia
- Mesencephalon [31](#) [38](#) [39](#)
- Mesoridazine [320](#)
- Methadone (Dolophine) [122](#)
 - carbamazepine decrease in plasma concentrations of [309](#)
- Methamphetamine [122](#)
- Methylenedioxymethamphetamine (MDMA) [115](#)
- Methylphenidate (Ritalin)
 - ADHD [363](#)
 - paranoid psychosis induced by [136](#)
- Meyer, Adolf
 - personality/psychopathology theories of [65](#)
 - psychobiology [155](#) [162](#)
- Midazolam (Versed) [115](#)
- Minnesota Multiphasic Personality Inventory (MMPI) [53](#) [55](#)
- Minors [23](#)
- Mirroring [159](#)
- Mirtazapine (Remeron) [321](#)
 - sexual adverse effects and [313](#)
- MMPI See Minnesota Multiphasic Personality Inventory
- Moclobemide [313](#)
- Monkey isolation/separation studies [45](#) [46](#) [46](#)
- Monoamine oxidase inhibitors (MAOI) [161](#) [308](#)
 - side effects [313](#)
- Monosymptomatic hypochondriacal psychosis [145](#)
- Monozygotic twins
 - mood disorders in [156](#)
 - schizophrenia in [130](#) [133–135](#)
- Mood
 - defined [84](#)
 - physiological disturbances associated with [83](#)
- Mood disorders [150–164](#) [151](#)
 - in adolescents [387–390](#)
 - epidemiology [388–389](#)
 - prevalence rates [389](#) [389](#)
 - symptoms [387](#)
 - by age, factors influencing prevalence of [155](#) [163](#)
 - atypical symptoms [155](#) [164](#)
 - in children [387–390](#)
 - epidemiology [388–389](#)
 - prevalence rates [389](#) [389](#)
 - symptoms [387](#)
 - diagnosis [150](#)
 - DSM-IV-TR diagnostic criteria [387](#)
 - eating disorders and [222](#)
 - genetics and [150](#)

HIV and [112](#)
kleptomania and [242](#)
medical conditions and [160](#)
melatonin and [76](#)
monozygotic twins [156](#)
postpartum psychosis and [145](#)
prevalence [152](#) [152](#)
 factors influencing [155](#) [163](#)
 lifetime [152](#) [158](#)
 rates [389](#) [389](#)
scales for rating [92](#)
secondary to general medical condition [153](#)
substances implicated in [73](#) [76–77](#)
symptoms [150](#)
Mooney Problem Checklist [331](#)
Morality
 defined [25](#)
 development and [25](#)
Morning sickness [275](#)
Motor behavior [84](#)
Motor skills disorder [345–347](#)
“Mourning and Melancholia” (Freud, Sigmund) [159](#)
MRI See Magnetic resonance imaging
MRS See Magnetic resonance spectroscopy
Multiaxial diagnostic classification [90](#)
Multiple sclerosis [107](#)
Munchausen syndrome [190](#) [192–193](#)
 factitious disorder with [191](#)
 presentation [191](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



N

Nalorphine [117](#) [122](#)

Naloxone [117](#) [122](#)

Naloxone hydrochloride (Narcan) [298](#)

Naltrexone [117](#) [122](#)

 alcohol abstinence [314](#)

 autism [359](#)

 successful response to treatment, indicators [308](#)

Naproxen [315](#)

Narcan See Naloxone hydrochloride

Narcissism [69](#)

Narcissistic patient, interviewing [9](#)

Narcissistic personality disorder [249](#) [250](#) [254](#)

 treatment [252](#)

Narcolepsy [233](#) [234](#)

 symptoms [229](#)

Narcotics, pain control and [424](#)

P.461

Nardil See Phenelzine

Nasal continuous positive airway pressure (nCPAP) [231](#)

nCPAP See Nasal continuous positive airway pressure

Necrophilia [210](#)

Nefazodone (Serzone)

 alprazolam and concurrent administration of [309](#) [315](#)

 anxiety disorders [167](#) [172](#)

 HIV treatment with [115](#)

 panic disorder [173](#)

Negativism [132](#) [140](#)

Neglect

 child

 incidence [280](#)

 proving [280](#) [284](#)

 physical [284](#)

 problems related to [280–284](#)

Negligent prescription practices [432–433](#) [436](#)

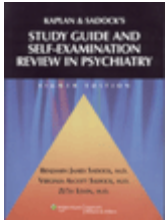
Neologism [132](#) [139](#)

Neural tube

 defects [161](#)

primary vesicles identified in [38](#) [39](#)
Neurally mediated hypotension (NMH)
chronic fatigue syndrome and [188](#)
medications [188](#)
Neurasthenia [185](#) [187–189](#)
DSM-IV-TR classification of [188](#)
signs [189](#) [189](#)
symptoms [188](#) [189](#) [189](#)
Neuroanatomy
basal ganglia [32](#)
behavioral [27](#)
schizophrenia and [28](#) [130](#) [136](#)
Neurocognitive disorder, HIV-associated [114](#)
Neurofibromatosis [334](#) [335](#) [338](#) [339](#)
Neuroimaging *See also specific techniques*
ADHD [360–362](#)
chronic fatigue syndrome [189](#)
OCD [167](#) [171](#)
panic disorder [166–167](#) [170](#)
pseudoseizure [181](#)
schizophrenia and [129](#)
techniques [27](#)
Neuroleptic malignant syndrome (NMS)
antipsychotics and [162](#)
example [155](#)
treatment [162](#) [312](#)
Neurological soft signs [324](#) [331–332](#)
Neuronal connections [28](#)
convergent [32](#)
divergent [32](#)
Neurontin *See* Gabapentin
Neuropsychiatry [27](#)
Neuropsychological deficits [53](#)
elderly assessment of [419](#) [421](#)
Neuropsychological referrals [55](#)
Neuropsychological testing, clinical [52–60](#) *See also specific neuropsychological tests*
aim of [52](#)
brain hemisphere damage and [56](#) [56](#)
brain regions and [53–54](#)
in children [59–60](#)
intelligence [52](#)
memory [55](#) [60](#)
personality [52](#)
projective [52](#) [53](#)
Neuropsychology [53](#)
Neurosyphilis [107](#)
Neurotransmitters
Alzheimer's disease and [101](#)
anxiety [168](#) [174](#)
Nicotine *See also* Cigarettes, adolescent use of; Tobacco withdrawal
CNS effects of [120](#) [126](#)

intoxication [117](#) [120](#)
Night terrors [231–232](#)
Night-eating syndrome [223](#)
Nightmares [228](#) [231–232](#)
 defined [231](#)
NMH See Neurally mediated hypotension
NMS See Neuroleptic malignant syndrome
Nocturnal myoclonus [234](#) [236](#)
Nocturnal penile tumescence [208](#)
Non-REM (NREM) sleep [227](#) [229](#) [235](#)
 anatomical sites implicated in generation of [229](#) [233](#)
 stages [227](#) [235](#)
Nonsteroidal anti-inflammatory drugs (NSAIDs) [315](#)
Norepinephrine [31](#)
Normality
 as average [16–17](#)
 in context [15](#)
 defined [14](#) [15](#)
 as health perspective [16](#)
 as process [17](#)
 psychoanalytic concepts of [17](#)
 as utopia [16](#)
Norpramin See Desipramine
Nortriptyline (Pamelor)
 anticholinergic effects [312](#)
 HIV pain and [113](#)
 HIV-related headache treated with [113](#)
 kleptomania [242](#)
Norvir See Ritonavir
NOS See Not otherwise specified
“Not guilty by reason of insanity” [434](#) [438](#)
Not otherwise specified (NOS)
 categories [90](#)
 diagnosis [91](#)
 dissociative disorder [196](#)
 impulse control disorders [237](#)
 learning disorders [343](#)
 paraphilia [209](#)
 PDD [353](#) [358](#)
 relational problems [279](#)
 sexual disorders [202](#)
 sexual dysfunction [206](#)
 somatoform disorders [176](#)
 tic disorder [375](#)
Novelty seeking [250](#) [253](#)
 advantages [253](#)
 disadvantages [253](#)
NREM sleep See Non-REM sleep
NSAIDs See Nonsteroidal anti-inflammatory drugs
Null hypothesis [49](#)
Nydrazid See Isoniazid



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



O

OAM See Office of Alternative Medicine

Obesity [259](#)

defined [265](#)

prevalence [265](#)

Object relations theory [69](#)

Obsessions [170](#)

Obsessive-compulsive disorder (OCD)

body dysmorphic disorder as comorbid condition [180](#)

in children [391](#) [395](#)

characteristics [392](#) [393](#)

treatment [393](#)

compulsions [170](#)

diagnostic criteria [166](#)

dissociative symptoms in [197](#)

genetics [392](#) [393](#)

neuroimaging [167](#) [171](#)

obsessions in [170](#)

prevalence [158](#)

serotonin in [167](#) [171-172](#)

symptom pattern associated with [166](#) [170](#)

tic disorder, motor and [171](#) [378](#)

Tourette's disorder and [167](#) [170-171](#)

Obsessive-compulsive personality disorder [255](#)

Obsessive-compulsive symptoms, Yale-Brown Scale for [94](#)

Obstructive sleep apnea [228](#)

treatment [231](#)

Occupational problem [285](#) [286](#) [287-288](#)

Occupational psychiatry [290](#)

OCD See Obsessive-compulsive disorder

Oedipus complex [62](#)

phallic period and [65](#)

resolution [65](#)

Office of Alternative Medicine (OAM) [268](#) [269](#)

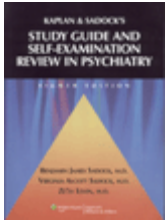
Olanzapine (Zyprexa)

adverse effects [308](#) [313](#)

delirium in HIV treated with [112](#)

HIV-related mania treated with [114](#)

side effects [315](#)
Oligodendrocytes [32](#)
Operant conditioning [42](#) [48–50](#)
 positive reinforcement and [50–51](#)
Opioid antagonists [117](#) [122](#) *See also specific opioid antagonists*
Opioids
 brain receptor binding of [120](#) [126](#)
 pain control [427](#) [427](#)
 pain medication, children and [426](#) [429](#)
 psychotoxicity [426–427](#)
 withdrawal [124](#)
Oppositional defiant disorder [157](#) [366–367](#)
 ADHD and [368](#)
 characteristics [367](#) [369–370](#)
 comorbidity [367](#) [368](#)
 diagnosis [367](#)
 differential diagnosis [368](#)
 epidemiological data for [367](#)
 prevalence [370](#)
 psychological factors in [367](#)
 treatment [368](#)
Organic dysfunction [58](#)
Orinase *See* Tolbutamide
Osler, William [1](#) [8](#)
Osteopathy [270](#)
Overanxious disorder [394](#)
Overarousal hypothesis [233](#)



Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



P

Pain

cancer, biobehavioral factor influence on [258](#)
chronic [259](#) [261](#)
control
 end-of-life care and [424](#)
 opioid [427](#) [427](#)
 palliative [425](#) [428](#)
neuropathic, HIV-related [110](#)
psychiatric complications [261](#)

psychiatric illnesses and [425](#) [428](#)
self-medication for [265](#)
types of, in dying patient [430](#) [430](#)
undertreatment [426](#)

Pain disorder [176](#) [177](#)

age of onset [181](#)
anorexia nervosa and [184](#)
prevalence [181](#)

Palliative medicine [424–430](#)

transition to [426](#) [429](#)

Pamelor See Nortriptyline

PANDAS See Pediatric autoimmune neuropsychiatric disorders associated with streptococcus

PANESS See Physical and Neurological Examination for Soft Signs

Panic attacks

induction [77](#) [167–168](#) [172](#)
isolated [167](#)
lactate provocation of [77](#)
prevalence, lifetime [168](#) [172](#)
unexpected [167](#)

Panic disorder [165](#) [169](#)

age of onset for [169](#)
course [166](#)
 fluctuating [169–170](#)
diagnostic criteria [171](#)
neuroimaging [166–167](#) [170](#)
prevalence, lifetime [168](#) [172](#)

- treatment [168](#) [173](#)
 - cognitive behavior [168](#) [173–174](#)
 - psychodynamic psychotherapy [168](#) [174](#)
- Paramnesias [80–81](#) [82](#) [83](#) [87](#)
 - reduplicative [198](#)
- Paranoid delusions
 - mania and [162](#)
 - occipital lobe tumor and [259](#)
- Paranoid disorder [141](#)
- Paranoid patients, interviewing [12](#)
- Paranoid personality disorder [144](#) [149](#) [250](#) [254](#) [255](#)
 - defense mechanisms associated with [250](#)
 - hallmarks [254](#)
 - personality disorders co-occurring with [254](#)
 - projection and [254](#)
- Paranoid psychosis, drug-induced [136](#)
- Paraphilias [202](#) [203](#) [207](#)
 - age of onset [207](#)
 - cause [207](#)
 - CBT [209](#)
 - DSM-IV-TR [209](#)
 - NOS [209](#)
 - psychiatric intervention for [204](#) [208](#)
 - psychotherapy [209](#)
 - severity [209](#)
- Parasuicidal behavior [293](#) [297](#)
- Parens patriae [438](#)
- Parental consent, medical interventions requiring [20](#) [23](#)
- Parent-child conflict [408](#) [410](#)
- Parenting styles [279](#)
- Paresthesia [144](#) [149](#)
- Parkinson's disease [33](#) [98](#) [105](#)
 - impairment, measuring [105](#)
 - medication-induced [105](#)
 - subcortical diseases and [105](#)
- Parlodel See Bromocriptine
- Paroxetine (Paxil) [313](#)
 - anxiety disorders [172](#)
- Paroxysmal hemicrania [235](#)
- Passive-aggressive behavior [240](#)
- Passive-aggressive personality disorder [254](#)
- Pathological gambling [237](#) [238](#)
 - course [240](#)
 - development [238](#)
 - incidence [240](#)
 - phases [238](#) [239](#) [240](#)
 - predisposing factor [240](#)
- Patient-controlled analgesia (PCA) [429](#)
- Patient-doctor relationship [1–8](#)
 - autocratic [3](#) [5–6](#)
 - biopsychosocial model of disease and [1](#)

- countertransference in [1](#)
- malpractice and [437](#)
- models of [1](#) [2](#) [7](#)
 - active-passive [3](#) [7](#)
 - deliberate [1](#) [4](#)
 - “friendship” [3](#) [7](#)
 - informative [1](#) [4](#)
 - interpretive [1](#) [4](#)
 - mutual participation [3](#) [7](#)
 - paternalistic [1](#) [4](#) [5–6](#)
 - teacher-student [3](#) [7](#)
- psychiatric [3](#) [6](#)
- rapproach in [1](#)
- self-disclosure in [6](#)
- therapeutic process and [1](#)
- transference and [1](#) [4](#) [8](#)
- Patients [12](#)
 - expectations [8](#)
 - interviewing [9–13](#)
 - nonpsychiatric [3](#)
 - psychiatric [3](#) [6](#)
 - clinical examination in [71–79](#)
 - test determination for [74](#)
 - clinical examination of [71–79](#)
 - test determination for [74](#)
 - treatment compliance and [6](#)
 - special
 - interviewing techniques for [9–17](#)
 - types of [9](#)
 - treatment [13](#)
 - violent [76](#)
- Patterns of Individual Change Scale (PICS) [93](#)
- Pavlov, Ivan Petrovich [43](#)
 - behavior and [40](#)
 - conditioned response and [48](#)
 - experimental neurosis [50](#)
- Pavlovian experiment [48](#)
- Paxil *See* Paroxetine
- PCA *See* Patient-controlled analgesia
- PCP *See* Phencyclidine
- PDD *See* Pervasive developmental disorders
- Peabody Picture Vocabulary Test for Children-Third Edition (WISC-III) [326](#) [331](#)
- Pediatric autoimmune neuropsychiatric disorders associated with streptococcus (PANDAS) [392](#) [393](#)
- Pedophilia [207](#) [209](#)
- Perceptual disturbances [81](#) [82](#) [83](#) [86](#) *See also specific perceptual disturbances*
- Periactin *See* Cyproheptadine
- Persistence [251](#) [253](#)
- Personality *See also* Minnesota Multiphasic Personality Inventory; Temperament
 - anxious and fearful types [82](#) [85–86](#)
 - defined [255](#)

development and [23](#) [25](#)
dramatic, emotional, and erratic types [82](#) [85](#)
DSM-IV-TR categorical approach to [82](#) [85](#)
neuropsychological testing, clinical [52](#)
odd or eccentric types [82](#) [85](#)
tests [56](#) [324](#)
 projective [53](#)
theories of [61–70](#)
Personality disorders [86](#) [208](#) [248–255](#) *See also specific personality disorders*
 biological factors pertaining to [249](#)
 clusters [248](#) [251](#) [255](#)
 A [248](#)
 B [248](#)
 C [248](#)
 co-occurring [252](#) [254](#)
 defense mechanisms [253](#)
 diagnosis [249](#)
 age and [251](#)
 sex bias in [251](#)
 DSM-IV-TR [248](#)
 factitious disorder and [193](#) [194](#)
 Ganser's syndrome [192](#)
 HIV and [29](#) [34](#)
 hypochondriasis and [254](#)
 incidence [248](#)
 pharmacotherapy [248](#) [252](#)
 psychotherapy [252](#)
 somatization disorder and [185](#)
 treatment [249](#)
Pervasive developmental disorders (PDD) [349](#) [351](#) [353–360](#) [385](#)
 NOS [353](#) [358](#)
PET *See* Proton emission tomography
Petit mal seizures [101](#)
 EEG [97](#)
 incidence [101](#)
Phantom limb [259](#) [267](#) [430](#)
Pharmacokinetics [412–414](#)
Pharmacological agents
 abuse and classes of [124](#)
 children and use of [407](#) [408](#) [410–414](#)
 dose-response curve [316](#) [316](#)
Pharmacological treatment [419](#) [421](#)
Pharmacotherapy [248](#) [252](#)
 HIV/AIDS [109–110](#)
Phase-of-life problem [285](#)
Phencyclidine (PCP)
 brain receptor sites [120](#) [126](#)
 effects of [120](#) [126](#)
 intoxication [123](#)
Phenelzine (Nardil)
 fluoxetine a contraindication to [155](#)

phobia [172](#)
Phenobarbital [120](#) [125–126](#)
Phenothiazine
 fugue states caused by [200](#)
 intermittent explosive disorder [240](#)
 PCP intoxication [123](#)
Phentolamine (Regitine)
 overdose [298](#)
 PCP intoxication [123](#)
Phenytoin (Dilantin) [315](#)
 HIV pain and [113](#)
 intermittent explosive disorder [240](#)
Pheochromocytoma [267](#)
Phobias [82–83](#)
 body dysmorphic disorder as comorbid condition [180](#)
 in children [391](#) [395](#)
 classification [174](#)

P.463

 defense mechanisms [167](#) [171](#)
 defined [88](#)
 Freud, Sigmund, views on [171](#)
 psychodynamic themes in [171](#)
 social [255](#)
 in children [391](#)
 specific [88](#) [88](#)
 subtypes [168](#) [174](#)
 therapy [167](#) [172](#)
 treatment [170](#)
 example of [167](#)
Phonological disorder [344](#) [351](#) [352](#)
 characteristics [352](#)
Physical and Neurological Examination for Soft Signs (PANESS) [332](#)
Physical anomalies, minor [324](#)
 child [332](#)
Physician-assisted suicide [154](#) [160](#) [424](#) [430](#)
Physicians *See also* Psychiatrists
 aversive reactions in [424–426](#)
 death anxiety in [426](#) [427](#)
Physiological disturbances [81](#)
 mood-associated [83](#)
Physostigmine salicylate (Antilirium)
 anticholinergic effects and [312](#)
 delirium [101](#)
Piaget, Jean
 behavior and [40](#)
 development and [18](#) [20](#) [22](#)
 morality and [25](#)
 sensorimotor and [43](#)
Pica [371](#) [372](#)
 adult [371](#) [373](#)
 behaviors related to [372](#) [373](#)

bulimia nervosa and [373](#)
DSM-IV-TR [371](#) [373](#)
forms [373](#)
ICD-10 [373](#)
pregnancy and [374](#)
prevalence [373](#)
Pick's disease [30–31](#) [33](#) [38](#)
 diagnosis [104](#)
Pickwickian syndrome [221](#) [223](#)
PICS *See* Patterns of Individual Change Scale
Pimozide (Orap) [147](#)
Pleasure principle [48](#)
PMS *See* Premenstrual syndrome
Poikilothermia [234](#)
Polycystic ovaries [217](#)
Polysomnography abnormalities [72](#)
 psychiatric illness and [76](#)
Postpartum blues [142](#)
 incidence [143](#) [145](#)
 postpartum depression v. [275](#) [275](#)
 postpartum psychosis v. [146](#)
Postpartum depression, postpartum blues v. [275](#) [275](#)
Postpartum psychosis [141](#) [142](#)
 mood disorders and [145](#)
 postpartum blues v. [146](#)
 risk [145](#)
 symptoms [145](#)
Posttraumatic stress disorder (PTSD) [165](#) [245](#)
 cause [166](#)
 characteristics [169](#) [170](#)
 in children [391](#) [393](#) [395](#)
 conditions associated with [393](#) [395](#)
 treatment [396](#)
 example of [166](#)
 genetic contributions to [246](#)
 physiological activity associated with [166](#)
 physiological arousal and [168–169](#)
 symptoms [169](#) [170](#)
Prader-Willi syndrome [334](#) [335](#) [337](#) [339](#)
Preconsciousness [63](#)
Pre-conventional morality [21](#)
Pregnancy *See also* Pseudocyesis
 alcohol use during [21](#)
 incidence of [19](#)
 domestic violence and [279](#) [283](#)
 lithium and [155](#) [161](#) [316](#)
 pica and [374](#)
 psychiatry and [271](#)
 teenage [22](#)
Premack's principle [41](#) [43](#)
Premenstrual syndrome (PMS) [274](#)

Preoperational thought [41](#) [43](#)
Preschool period [22](#)
 anxiety disorders [392](#) [395](#)
Prevalence, defined [42](#) [45](#)
Primal scene [203](#) [206](#)
Prion disease [96](#) [100](#) [103](#)
Processing Speed Index [60](#)
Product rule [432](#) [436](#)
Projection [64](#) [70](#) [157](#) [171](#)
 paranoid personality disorder and [254](#)
Projective techniques [323](#) [325](#)
Prolixin See Fluphenazine
Propranolol (Inderal) [313](#) [320](#)
 depressive symptoms caused by [157](#)
 intermittent explosive disorder [240](#)
 PCP overdose [298](#)
 phobia [172](#)
Propulsid See Cisapride
Prosencephalon [31](#) [38](#) [39](#)
Protease inhibitors [111](#)
Proton emission tomography (PET) [27](#) [29](#) [34](#)
 neuroimaging [33](#)
Proverb interpretation [74](#) [81](#) [84](#)
 cognitive functioning and [102–103](#)
Prozac See Fluoxetine
Pruning [19](#)
 defined [21](#)
Pruritus [267](#)
Pseudocyesis [177](#) [180](#) [272](#) [273](#) [274](#)
Pseudodementia [55](#)
Pseudoseizures [177](#) [181–182](#)
 neuroimaging [181](#)
Psoriasis [259](#) [265–266](#)
 psychosocial therapy [266–267](#)
Psyche, defined [255](#)
Psychiatric diagnoses
 classification systems for [89](#)
 in Down's syndrome patients [337](#)
Psychiatric disorders
 adolescent substance abuse and [401](#) [402](#)
 asthma and [258](#)
 chronic fatigue syndrome and [189](#)
 diagnostic tests in [72](#)
 eating disorders and comorbid [222](#)
 epilepsy and [35](#)
 genetics and [27](#)
 GI disorders and [263](#)
 hypochondriasis comorbidity with [182](#)
 medical problems that present as symptoms of [73](#) [78–79](#) [78](#)
 psychological changes in [73](#) [77–78](#)
 substance abuse and [116](#)

- suicide and [112](#)
- Psychiatric emergencies [291](#)
 - psychotropic medication use in [292](#) [294](#)
 - substance overdose as [298](#)
- Psychiatric evaluation
 - child [322](#)
 - difficulties in [82](#) [87](#)
 - history [71](#) [72](#)
 - judgement assessment in [74](#)
 - mental status examination [71](#)
- Psychiatric illness
 - pain and [425](#) [428](#)
 - polysomnography abnormalities and [72](#) [76](#)
 - puerperal psychosis risk and [148](#) [148](#)
- Psychiatric intervention, paraphilia [204](#) [208](#)
- Psychiatric rating scales [89–94](#)
 - characteristics [94](#)
 - comprehensive [94](#)
 - measurement of pathology in [93](#)
 - mental status examination and [94](#)
 - specific [94](#)
- Psychiatric therapy, factitious disorder [193](#)
- Psychiatric treatment [407–414](#)
- Psychiatrists
 - confidentiality and [6](#)
 - countertransference and [8](#)
 - as expert witness [431](#)
 - lawsuits against [432](#) [435](#)
 - suicide and [435](#)
 - malpractice claims against [433](#) [437](#)
 - missed appointment policies and [66](#)
 - payment of fees and [6](#)
 - self-disclosure and [6](#) [304](#)
 - sexual involvement with patients and [437](#) [442](#) [444–445](#)
 - transference and [8](#)
 - as witness of fact [431](#)
- Psychiatry *See also specific types of psychiatry*
 - classification in [89–92](#)
 - ethics in [441–445](#)
 - occupational/industrial [290](#)
 - pregnancy and [271](#)
 - reproductive medicine and [271–276](#)
 - signs/symptoms in [80–88](#)
- Psychoanalysis [61](#) *See also Freud, Sigmund*
 - benefits [302](#)
 - Klein modification of [69](#)
 - suitability requisites for [301](#)
- Psychobiology [155](#) [162](#)
- Psychocardiology [258](#) [264](#)
- Psychodynamics
 - behavioral theory and [48](#) [48](#)

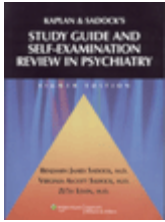
psychotherapy [168](#) [174](#)
Psychogenic excoriations [258](#)
Psychological impairment, stressors leading to [243](#)
Psychological testing, autism [354](#) [357](#)
Psychology [40](#)
Psychomotor agitation [160](#)
Psychomotor Development index [326](#)
Psychomotor epilepsy [101](#)
Psychomotor retardation [144](#) [149](#) [153](#) [160](#)
Psychoneuroimmunology [259](#) [266](#) [267](#)
Psycho-oncology [262](#)
Psychopathic personality [91](#)
Psychopathology
 child [323–325](#)
 stress and development of [244](#)
 theories of [61–70](#)
Psychopathy [91](#)
Psychopharmacology [306](#)
Psychosexual development [18](#) [68](#) [68](#)

P.464

Psychosis

 amphetamine-induced toxic [125](#)
 schizophrenia distinguished from [119](#) [125](#)
 childhood [397](#)
 HIV and associated [113–114](#)
Psychosocial development theory [66](#) [70](#)
Psychosocial sciences [40–51](#)
Psychosocial therapy
 interventions [258](#)
 psoriasis [266–267](#)
 schizophrenia [133–134](#)
Psychosomatic disorders [264](#)
 psychotherapeutic treatment of [259](#)
Psychosomatic illness, treatment [267](#)
Psychosomatic medicine [256–257](#)
Psychostimulants [235](#)
Psychotherapeutic drugs, adverse effects [316](#) *See also specific psychotherapeutic drugs*
 rating scale assessment of [94](#)
Psychotherapies [300–305](#) *See also specific psychotherapies*
 boundary issues in [302](#) [304](#) [305](#)
 brief focal [301](#) [303](#)
 child [407](#) [412](#)
 dissociative fugue [200](#)
 interpersonal [300](#) [301](#)
 depression [303](#)
 models [305](#)
 paraphilia [209](#)
 personality disorder [252](#)
 psychodynamic [168](#) [174](#)
 psychosomatic disorder [259](#)
 schizophrenia [134](#)

supportive [302–303](#)
therapist interventions in [301](#) [303](#)
Psychotic disorders [141–149](#) *See also specific psychotic disorders*
brief [132](#) [141](#)
diagnosis of [145](#)
differential diagnosis of [143](#) [146](#)
example of [142](#)
prognosis [143](#)
prognostic features [146](#)
cocaine-induced [121](#)
delusions in [144](#) [149](#)
Psychotic episodes
brief [148](#)
example of [143–144](#)
florid [145](#)
Psychotic patient, interviewing [9](#) [10](#) [13](#)
Psychotoxicity [425–427](#)
Psychotropic medication [292](#) [294](#)
PTSD *See* Posttraumatic stress disorder
Puberty [271](#) [273](#)
Puerperal psychosis [143](#) [148](#)
incidence [148](#)
presentation [148](#)
prognostic features [148](#)
psychiatric illness and risk of [148](#) [148](#)
Punishment [41](#) [44–45](#) [51](#)
Pyromania [237](#) [238](#) [239](#)
age of onset [242](#)
comorbid disorders [239](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](http://www.lippincott.com)



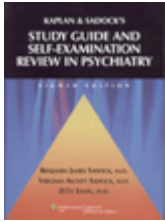
Q

Questions

close-ended [3](#) [6-7](#) [7](#) [13](#)

open-ended [3](#) [6-7](#) [7](#) [13](#)





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



R

RAD See Reactive attachment disorder

Ramelteon [317](#)

Rank, Otto

death fear [62](#) [65–66](#)

life fear [65–66](#)

normality and [16](#)

Rape [281](#) [283](#)

alcohol and [283](#)

incidence [280](#)

Rapid eye movement (REM) sleep [227](#) [229](#) [233](#) [235](#) See also Non-REM sleep

antidepressants and [227](#)

barbiturates and [119–120](#) [125](#)

benzodiazepine and [230](#)

depression and [157](#) [233–235](#)

deprivation [232–233](#)

EEG [235](#)

L-tryptophan and [235](#)

poikilothermia and [234](#)

Rapport [1](#) [2](#)

confidentiality [4](#)

defined [4](#)

establishing [5](#) [5](#)

interviewing and [5](#)

Raven's Progressive Matrices [54](#) [58](#)

rCBF See Regional cerebral blood flow

Reaction formation [64](#) [70](#) [240](#)

Reactive attachment disorder (RAD) [383](#) [384](#) [385](#)

disinhibited type [384](#) [385](#)

DSM-IV-TR [385](#)

failure to thrive and [384](#) [385](#)

inhibited type [384](#) [385](#)

subtypes [385](#)

Reading disorders [341](#)

birth month and [343](#)

characteristics [342](#) [344](#)

defined [343](#)

example [342–344](#)

- genetic factors in [343–344](#)
- Recent Life Change Questionnaire [260](#)
- Reduplicative paramnesia [196](#)
- Reflexes present at birth [22](#)
- Regional cerebral blood flow (rCBF) [36](#)
- Regitine See Phentolamine
- Regression [171](#) [240](#)
- Reich, Wilhelm [62](#)
 - compulsive character [65](#)
 - DSM development and [91](#)
- Reinforcement [43](#) [44](#)
 - defined [49](#)
 - negative [43](#) [51](#)
 - positive [43](#)
 - operant conditioning and [50–51](#)
 - schedules [49](#) [49](#)
- Relational problems [277–279](#)
 - DSM-IV-TR classification of [277](#)
 - medical condition-related [278](#) [279](#)
 - parent-child [277–279](#)
 - sibling relational [278](#) [279](#)
- Religious beliefs, end-of-life care and [425](#) [427](#)
- Religious problem [285](#)
- REM latency [232](#)
- REM sleep See Rapid eye movement sleep
- Remeron See Mirtazapine
- Repression [64](#) [70](#) [83](#) [171](#)
- Reproductive medicine [271–276](#)
- Resistance [305](#)
- Respondeat superior [438–439](#)
- Restless leg syndrome [307–308](#) [312](#)
- Restraints
 - indications/contraindications for [439](#) [439](#)
 - use of [292](#) [294](#)
- Rett's disorder [353](#) [354](#) [357](#)
 - characteristics [358](#)
- Reward dependence [251](#) [253](#)
- Rhombencephalon [31](#) [38](#) [39](#)
- Rhythmic activities [386](#)
- Risperdal See Risperidone
- Risperidone (Risperdal) [320](#)
 - autism [359](#)
 - bipolar disorder [155](#)
 - delirium in HIV treated with [112](#)
 - HIV-related mania treated with [114](#)
 - MDD [154](#)
 - psychosis [161](#)
 - suicide risk factors and [129](#)
 - tic disorder [376](#) [378](#)
- Ritalin See Methylphenidate
- Ritonavir (Norvir) [115](#)

Rivastigmine [321](#)

Ropinirole [312](#)

Rorschach test [53](#) [54](#) [55](#) [55](#) [58](#)

Rosenzweig Picture-Frustration Study [324](#) [331](#)

Rumination disorder [371](#)

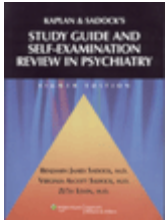
adult [373](#)

behaviors associated with [372](#) [373](#)

diagnosis [372](#) [373](#)

DSM-IV-TR [371](#) [373](#)

example [372](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



S

Sadism [209](#) [211](#)

SADS See Schedule for Affective Disorders and Schizophrenia

Same-sex marriages [210](#)

SANS See Scale for the Assessment of Negative Symptoms

Scale for the Assessment of Negative Symptoms (SANS) [92](#) [93](#)

Schedule for Affective Disorders and Schizophrenia (SADS) [54–55](#) [60](#)

Schedule of Recent Experience (SRE) [260](#)

Schizoaffective disorder [141](#) [157](#) [162](#)

course [145](#)

prognosis [142](#) [145](#)

Schizoid personality disorder [254–255](#)

Schizophrenia [127–140](#) See also Schedule for Affective Disorders and Schizophrenia

amphetamine-induced toxic psychosis distinguished from [119](#) [125](#)

anhedonia [132](#) [140](#)

birth complications and [137](#)

birth month and [129](#) [133](#) [136–137](#)

catatonic type of [132](#)

cause of [129](#) [134](#)

in children [131](#) [138](#) [358](#) [397–399](#)

CT studies of [130](#) [135](#)

delusions and [162](#)

deteriorative disorder and [138](#)

development, risk factors for [130](#)

diagnosis [127](#) [138](#)

criteria [132](#) [133](#)

dopamine and [130](#) [136](#) [311](#)

drug-induced paranoid psychosis and [136](#)

early-onset [397–399](#)

electrophysiological studies in [130](#) [135](#)

environmental factors [127](#)

epidemiology of [129](#)

factors in [134](#)

studies [129–130](#)

etiology [127](#)

eye movement dysfunction in [128](#) [132](#)

four As of [139](#)

functional inhibition of speech/vocalization [132](#) [140](#)
gender differences in [134](#)
genetic factors [127](#) [130](#) [133](#) [134](#)
hallucinations and [130](#) [135](#)
homicide and [138](#)
incidence [127](#)
language disorders and [132](#) [139](#)
late-onset [128](#) [132](#)
manifestations [127](#)
monozygotic twins and [130–135](#)
MRI studies of [130](#)
negativism [132](#) [140](#)
neologism creation and [132](#) [139](#)
neuroanatomy and [28](#) [130](#) [136](#)
neurobiology [131](#) [137](#)
neuroimaging [33](#) [129](#)
paranoid type [132](#)
 example of [128](#)
prevalence [134](#) [158](#)
prognosis [130](#) [135](#)
psychosocial therapies [133–134](#)
psychotherapy [134](#)
rehabilitation [127](#)
risk factors for [130](#) [134–135](#)
sexual behavior and [207](#)
stereotyped behavior [132](#) [140](#)
structural abnormalities in [130–131](#) [137](#)
subtype [138](#)
suicide and [132–134](#) [293](#) [295–296](#)
symptoms of, negative [129](#) [133](#)
treatment [133–134](#) [319](#)
 drug [127](#)
 psychosocial therapies [129](#)
undifferentiated type [131](#)
ventricular size in [130](#) [135–136](#)
violence and [131](#) [138](#)
Schizophrenia as a Human Process (Sullivan) [69](#)
Schizophreniform disorder [132](#) [141](#)
Schizotypal personality disorder [250](#) [254](#) [255](#)
 biological features [251–252](#)
 characteristics [253](#)
 depression concurrent with [253](#)
 exhibitionism and [204](#)
 manifestation [255](#)
Schneider, Kurt [132](#) [139](#) [139](#) [156](#)
Schwann cells [32](#)
Scopophilia [211](#)
Screen memory [83](#)
SD See Standard deviation
SDAs See Serotonin-Dopamine Antagonists
Seclusion, indications/contraindications [439](#) [439](#)

Secure base effect [50](#)

Seductive patient [12](#)
interviewing [9](#)

Seizures *See also* Petit mal seizures; Pseudoseizures
GABA and [29](#) [34](#)
induction of, by suggestion [181–182](#)
partial [101](#)

Seldane *See* Terfenadine

Selective mutism [393](#) [396](#)
in children [391](#)
diagnostic criteria [396](#) [396](#)

Selective serotonin reuptake inhibitors (SSRIs) [313](#)
autism [359](#)
efficacy [319](#)
indication [311](#)
restless leg syndrome and [312](#)

Self psychology [159](#)

Self-accepted principles [21](#)

Self-efficacy theory [44](#)

Sensorimotor [43](#)

Sensory disturbances [82](#) [85](#)

Sentence Completion Test [54](#) [59](#)

Separation [62](#)

Separation anxiety [47](#)
habit disturbances stemming from [392](#) [393–394](#)
in infants [392](#) [394–395](#)

Separation anxiety disorder, in children [391](#) [392](#) [394](#)
prevalence [395](#)
stages [392](#) [394](#)

Separation studies [45](#)

Serotonin [29–30](#) [31](#) [153](#) *See also* Selective serotonin reuptake inhibitors
anxiety disorder and [168](#) [174](#)
neurotransmission [159](#)
OCD and [167](#) [171–172](#)
peripheral [34–35](#)
suicide and [295](#)
synthesis [34](#)

Serotonin metabolite 5-hydroxyindoleacetic acid (5-HIAA) [73](#) [79](#)

Serotonin syndrome [161](#)

Serotonin-Dopamine Antagonists (SDAs) [133](#)
dopamine receptor antagonists compared with [129](#)

Sertraline (Zoloft)
anxiety disorders [172](#)
somatization disorder [184](#)

Serzone *See* Nefazodone

Sex assignment
examples [217](#)
pediatric [217](#)

Sex organ innervation [203](#) [206](#)

Sex reassignment [215](#) [217](#)
cross-gender living trial before [217](#)

hormone therapy and [217](#)

Sexual abuse [206](#) [280](#)

- child [281](#)
- phases [283–284](#)
- proving [280](#) [282](#)
- confidentiality and [416](#)

Sexual adjustment, adult [65](#)

Sexual arousal disorders [206](#)

Sexual aversion disorder [205](#) [210–211](#)

Sexual behavior [202](#) [206](#)

- defined [214](#)
- schizophrenia and [207](#)

Sexual desire disorders [206](#)

Sexual development disorders [271](#)

- in phenotypic girls [275–276](#)

Sexual disorders *See also* Intersexual disorders

- DSM-IV-TR classification of [202](#)

Sexual dysfunction [202](#)

- DSM-IV-TR categories of [206](#)
- due to medical condition [206](#)
- sexual response cycle and [203](#)
- substance-induced [206](#) [209](#)
- treatment [205](#) [211](#)

Sexual identity [202](#) [206](#)

- defined [214](#)

Sexual intercourse [204](#)

- teenage [22–23](#)

Sexual orientation [202](#) [206](#)

- defined [214](#)

Sexual response cycle [203](#) [205](#) [213–214](#)

- aging and [271](#) [273](#)
- desire phase [213](#)
- excitement phase [213](#)
- female [213](#)
- male [213](#)
- orgasm phase [213](#)
- orgasmic platform [213](#)
- resolution phase [213](#)
- stages [276](#)

Sexuality [202–214](#) *See also* Sexual adjustment, adult

- abnormal [202](#)
- psychosexual factors [203](#) [206](#)
- statistics [208](#)

Sexually transmitted diseases (STDs) [22](#)

Shared psychotic disorder [141](#)

- treatment [143](#) [145](#)

Shipley Abstraction Test [54](#) [59](#)

Sick role [5](#)

- defined [4](#)
- factitious disorder by proxy and [195](#)
- factors influencing [5](#)

Signs, in psychiatry [80–88](#)
Sildenafil [308](#) [312](#)
Silence [5](#)
Simultagnosia [81](#) [85](#)
Single photon emission computed tomography (SPECT) [27](#) [29](#) [34](#)
 blood flow assessment with [36](#)
 cocaine and [117](#) [118](#)
 neuroimaging [33](#)
Skinner, B.F.
 behavior [40](#)
 conditioning [48](#)
 instrumental conditioning [48](#)
Sleep [32](#) *See also* Non-REM sleep; Obstructive sleep apnea; Rapid eye movement sleep
 alcohol effect on [117](#) [122](#)
 antidepressants and [227](#) [228](#)
 circadian cycle and [231](#)
 EEG of wakeful state [233](#)
 in elderly [230](#) [420](#) [422–423](#)
 hemolysis related to [236](#)
 homeostat of [230–231](#)
 hygiene [228](#) [231](#)
 importance [227](#)
 normal [227–236](#)
 oscillatory processes [230–231](#)
 patterns
 change in [234](#)
 example [229](#) [229](#)
 normal [233](#)
 psychostimulants and [235](#)
 regulation [230](#)
 sedative-promoted [234–235](#)
 sensory symptoms during [82](#) [85](#)
 stage, histograms of [230](#) [230](#)
 time, total [234](#)

Sleep deprivation [227](#) [232](#)
 depression and [233](#)
 morbidity associated with [232](#)
 partial [232](#)
 total [232](#)
Sleep disorders [227–236](#) *See also specific sleep disorders*
 DSM-IV-TR [227](#)
 hallucinations and [234](#)
 medical condition-related [227](#)
 mental disorder-related [227](#)
 primary [227](#)
 substance-induced [227](#)
Sleep latency [228](#) [231](#)
Sleep paralysis [234](#)
Sleep phase syndromes
 advanced [231](#)

delayed [231](#)

Sleep terror disorder [236](#)

Sleep-related bruxism [236](#)

Sleep-wake cycle [231](#)

- circadian rhythm and [232](#)
- shifting [232](#)

Sleepwalking disorder [200](#) [233](#) [235](#)

- example [197–198](#)

Social and Occupational Functioning Assessment Scale (SOFAS) [92](#) [93](#)

Social isolation [45](#)

Social learning theory [43](#)

Social Readjustment Rating Scale [257](#) [260](#) [260](#)

Social skills training [302](#) [303](#)

Social smiling [20](#)

Sodium lactate, panic attacks induced by [77](#) [172](#)

SOFAS *See* Social and Occupational Functioning Assessment Scale

Somatic delusions [145](#)

Somatic patient [12](#)

- interviewing [9](#) [10–11](#) [13](#)
- treatment [13](#)

Somatization disorder [176](#) [177](#) [182–183](#)

- anorexia nervosa and [184](#)
- axis II personality disorders and [185](#)
- course [181](#)
- defined [184](#)
- example [178](#)
- factitious disorder differentiated from [194](#)
- mental disorders and [177](#) [181](#)
- physical illness with [179](#)
- prevalence [158](#)

 - gender difference in [184](#)
 - socioeconomic factors in [185](#)

- symptoms [181](#)
- treatment [176–177](#) [179](#)

 - antidepressant [184](#)

Somatoform disorders [176–186](#)

- conditions commonly confused with [181](#) [181](#)
- defined [176](#)
- diagnosis [176](#) [181](#) [181](#)
- DSM-IV-TR classification [176](#)
- ICD-10 description of [179](#) [184](#)
- mental disorders, comorbid [179](#) [186](#)
- NOS [176](#) [185](#)

 - pseudocyesis as [180](#)

- treatment [176](#)
- undifferentiated [179](#) [184](#) [185](#)

SPECT *See* Single photon emission computed tomography

Spectrum disorders [249](#) [253](#)

Speech disorders [81](#) [84](#) [348](#) *See also specific speech disorders*

- autism and [356–357](#)

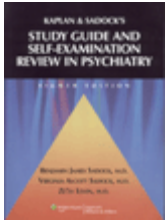
Speech, functional inhibition of [132](#) [140](#)

Speech sound production disorder [351](#)
Spiritual assessment [301](#) [303](#)
Spiritual problem [285](#)
Spitz, René [43](#)
 anaclitic depression and [50](#)
 behavior and [40](#)
Splinter skills [354](#) [357](#)
Splitting [254](#)
SRE *See* Schedule of Recent Experience
SSRIs *See* Selective serotonin reuptake inhibitors
Standard deviation (SD) [45](#)
Stanford-Binet Intelligence Scale [54](#) [58](#)
Starvation
 amenorrhea produced by [223](#)
 biochemical changes [222–223](#)
 endocrine changes in [220–221](#)
 structural changes in [220–221](#)
STDs *See* Sexually transmitted diseases
Stereotyped behavior [140](#)
Stereotypic movement disorder [383–385](#)
 DSM-IV-TR [384–385](#)
 pharmacological treatment [385](#)
Stereotypic movements [383](#)
 treatment [384](#) [385](#)
Stereotypy [81](#) [385](#)
Sterilization [274](#)
Steroids *See also* Anabolic steroid use; Fetal sex steroid
 fugue states caused by [200](#)
Stranger anxiety [394](#)
Stranger situation [66](#)
Stress *See also* Life stresses
 cardiac change and [264](#)
 encopresis and [381](#)
 exposure, studies on [258](#)
 GI system response to [257–258](#) [261](#)
 immune function and [262–263](#)
 psychopathology development and [244](#)
 research on [260](#)
Stress disorder, acute [245](#) *See also* Posttraumatic stress disorder
 characteristics of [169](#)
Stressors
 adjustment disorder precipitated by [244–245](#) [247](#)
 severity [244–245](#)
Stroke, left hemisphere [30](#) [36](#)
Stroop test [105](#)
Stuttering [352](#)
Subcortical diseases [105](#)
Sublimation [64](#) [70](#) [157](#)
Subpoena [435](#)
Substance abuse [116](#) *See also* Alcohol, Drug Abuse, and Mental Health Administration;
specific substances

ADHD and maternal [363](#)
adolescent [400–403](#)
 psychiatric disorders related to [401](#) [402](#)
 risk factors [401](#) [403](#)
 treatment [402–403](#)
atypical [117](#) [121](#)
defined [403](#)
disorders, MRI studies of [35](#)
impulse control disorders and [238](#)
laboratory tests for detection of [74](#)
overdose [298](#)
pharmacological agent classes for [124](#)
prevention programs [401](#) [403](#)
psychiatric disorder in context of [116](#)
remission [121](#)
sexual dysfunction due to [206](#) [209](#)
sleep disorders induced by [227](#)
suicide and [296](#)
terms related to [116](#)
urine detection of [72](#) [74](#) [74](#)
Substance dependence
 defined [403](#)
 diagnosis [118](#)
 remission [117](#)
Substance intoxication, defined [403](#)
Substance withdrawal [119](#) [119](#)
Substance-related disorders [116–126](#)
Substantia nigra [35](#)
Succimer (Chemet) [107](#)
Suicidal behavior [293](#) *See also* Parasuicidal behavior
 genetic factors in [297–298](#)
Suicidal ideation [25](#) [154](#) [160–161](#)
 antidepressants and [153](#)
 depression and [161](#)
 grief and [157](#)
 management of [154](#)
 psychiatric interview and [10](#) [12](#) [76](#)
 psychotherapy [161](#)
Suicidal patient
 evaluating [291](#)
 treating [293](#) [295](#)
Suicide *See also* Physician-assisted suicide
 in adolescents [387–390](#)
 risk factors [389](#)
 alcohol and [296](#) [296](#)
 anomic [292](#)
 antidepressant medication and [158](#) [159](#) [259](#)
 attempted [161](#) [297](#)
 body dysmorphic disorder and [182](#)
 in children [388](#) [389](#)
 confidentiality and [416](#)

death rates [292](#) [293](#) [295](#)
in elderly [293](#) [296–297](#)
factors influencing [294](#)
Freud, Sigmund, theory on [292](#) [294](#)
HIV infection and [110](#) [112](#)
incidence [159](#)
 peaks of [292](#)
interventions [161](#)
juvenile detention centers and [437](#)
lawsuits against psychiatrists and [435](#)
predicting attempted [154](#)
prevalence [159](#)
psychiatric disorders and [112](#)
rates [293](#) [295](#)
 age groups with highest [153](#)
risk factors for [129](#) [291](#)
schizophrenia and [132–134](#) [293](#) [295–296](#)
serotonin and [295](#)
social categories [294–295](#)
substance abuse and [296](#)
Sulfonamides [315](#)
Sullivan, Harry Stack
 modes of experiencing/thinking about world described by [65](#) [70](#)
 psychoanalytic personality theory [61](#)
 Schizophrenia as a Human Process [69](#)
Sulpiride [320](#)
Sundowner's syndrome [83](#)
Sundowning [80](#)
 defined [83](#)
Surmontil See Trimipramine
Surrogate mother [50](#)

Sydenham's chorea [378](#)
Symmetrel See Amantadine
Symptoms, in psychiatry [80–88](#)
Synesthesia [82](#) [87](#)
Synkinesia [347](#)
Systematic desensitization [304](#)
Systemic lupus erythematosus [267](#)
Systems theory [410](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



T

- Tacrine [321](#)
- Tagamet See Cimetidine
- Tangentiality [83](#)
- Tarasoff case [442](#) [443](#)
- Tarasoff duty [434](#) [438](#)
- Tarasoff I [417](#)
- Tarasoff II [417](#) [442](#) [444](#)
- TAT See Thematic Apperception Test
- TBI See Traumatic brain injury
- Teenage mothers [22](#)
- Tegretol See Carbamazepine
- Temperament [249](#) [250](#) [253](#)
 - conduct disorder and [368–369](#)
 - defined [255](#)
 - traits [250](#)
- Temporal lobe epilepsy (TLE) [6](#) [30](#)
- “Tender-years” doctrine [416](#)
- Terfenadine (Seldane) [315](#)
- Termination of treatment, involuntary [432](#) [435–436](#)
- Testimonial privilege [438](#)
- Testosterone [20](#)
 - development and [24](#)
 - hormone therapy, women undergoing [216](#) [218](#)
- Thallium intoxication [99](#) [107](#)
- Thanatophobia [183](#)
- Thematic Apperception Test (TAT) [54](#) [58](#) [326](#) [331](#)
 - card [58](#) [59](#)
- Theophylline
 - lithium and [310](#)
 - obstructive sleep apnea [231](#)
- Therapeutic process [1](#)
- Thinking
 - defined [84](#)
 - process
 - disturbances in [84](#)
 - primary [81](#)
- Thioridazine [320](#)

Thomas Achenbach's Child Behavior Checklist [218](#)
Thorazine See Chlorpromazine
Thorndike, Edward L. [48–49](#)
Thought blocking [132](#) [140](#)
Thought broadcasting [144](#) [149](#)
Thought disorders [72](#) [78](#)
 thought formation and [74](#)
Thought disturbances [81](#) [85](#)
Thought formation [74](#)
Thyroid disease [72](#) [75](#) See also Hypothyroidism
TIA See Transient global amnesia
Tic disorders [375–378](#)
 age of onset [375–377](#)
 differential diagnosis [376](#) [377–378](#)
 dopamine and [376](#) [377](#)
 DSM-IV-TR [375](#)
 motor [375](#)
 chronic [376](#) [377–378](#)
 OCD and [171](#)
 NOS [375](#)
 OCD and [171](#) [378](#)
 pharmacologic treatment [376](#) [378](#)
 transient [375](#)
 vocal [375](#) [376](#) [377–378](#)
Tics
 classification [376–378](#)
 clonic [376–378](#)
 defined [376–378](#)
 differential diagnosis [377](#) [378](#)
 motor [376–378](#)
 phonic [376–378](#)
TLE See Temporal lobe epilepsy
TMS See Transcranial magnetic stimulation
Tobacco withdrawal [117](#)
Toddler period [22](#)
Tofranil See Imipramine
Tolbutamide (Orinase) [315](#)
Tort [432](#) [435](#)
Torture [281](#)
 defined [282](#)
 psychiatric symptoms in survivors of [282](#)
 purpose [282](#)
Tourette's disorder [375](#)
 diagnostic criteria [376](#) [377](#)
 differential diagnosis [376](#) [377–378](#)
 epidemiology [376](#) [377](#)
 OCD and [167](#) [170–171](#)
 streptococcal infection and [378](#)
 tics in [376](#) [377](#)
Trail-Making Test [54](#) [59](#)
Transcranial magnetic stimulation (TMS) [318–319](#)

Transference [2](#) [3](#)
defined [3](#)
Freud, Sigmund, and [67](#)
patient-doctor relationship and [1](#) [4](#) [8](#)
psychiatry and [4](#)
reactions [4](#)

Transient global amnesia [99](#) [196](#) [198](#)

Transient ischemic attacks (TIA) [198](#)

Transplantation [260–261](#)

Transsexualism [204](#) [210](#) [215](#)
prevalence [218](#)

Transvestic fetishism [211](#)

Trauma *See also* Posttraumatic stress disorder
amnesia and head [103–104](#)

Traumatic brain injury (TBI) [37](#)

Trazodone (Desyrel)
intermittent explosive disorder [240](#)
kleptomania [242](#)
sexual dysfunction caused by [209](#)

Treatment compliance [2](#) [286](#) [288](#) *See also* Medication noncompliance
antidepressants and [158](#)
factors associated with [2](#) [4](#)
incidence [4](#)
increased [5](#)
interview and [13](#)
prisoner [433](#) [437](#)
psychiatric patients and [6](#)

Treatment noncompliance [285](#)

Tremors [347](#)

Trial-and-error learning [49](#)

Triazolam (Halcion)
fugue states caused by [200](#)
HIV treatment with [115](#)

Trichotillomania [237](#) [238](#) [239](#)
age of onset [242](#)
course [240–241](#)
diagnosis [241](#)

Tricyclic antidepressants *See also specific tricyclic antidepressants*
Asian patients and [42](#) [45–46](#)
side effects of [155](#) [162](#)

Trimipramine (Surmontil) [308](#) [312](#)

Trisomy [335–336](#) [335](#) [340](#)

T-test [46](#)

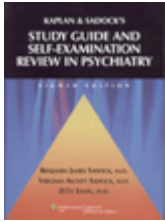
Tubal ligation [272](#)

Tuberous sclerosis [334](#) [338](#)

Turner's syndrome [216](#) [218–219](#) [218](#) [276](#)

Twinship [159](#)

Type A behavior [258](#)
coronary artery disease and [264–265](#) [264](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](#)



U

Undertreatment [425](#) [426](#)

Undoing [157](#)

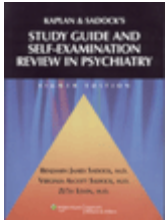
Universalization [305](#)

Urecholine See Bethanechol

Urine, drug abuse detection in [72](#) [74](#) [74](#)

Urticaria [259](#) [267](#)





Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



V

Vaginismus [211](#)

Valium *See* Diazepam

Valproate (Depakene) [312](#) [320](#)

adverse effects [309](#)

antimanic response, favorable to [309](#) [314](#)

HIV treatment with [115](#)

HIV-related mania treated with [114](#)

interactions [310](#) [317](#)

kleptomania [242](#)

side effects [314](#) [315](#)

Variable-interval schedule [43](#)

Variable-ratio schedule [43](#)

Vascular dementia [30–31](#) [37](#) [99](#)

acute onset [92](#)

clinical characteristics of [98](#) [105](#)

etiologies of [98](#)

infarctions and [105–106](#)

Vasectomy [274](#)

Venlafaxine (Effexor)

alprazolam and concurrent administration of [309](#) [315](#)

anxiety disorders [167](#) [172](#)

depression [159](#)

Ventilation [305](#)

Verapamil (Calan, Isoptin) [173](#)

Verbigeration [83](#) [132](#) [139](#)

Versed *See* Midazolam

Victimization, secondary [281](#) [283](#)

Vineland Adaptive Behavior Scales [326](#)

Violence [41](#) [44](#) *See also* Intermittent explosive disorder

deteriorative disorder and [138](#)

domestic [278](#) [279](#)

erotomania and [147](#)

explosive [241](#)

predictors [44](#) [44](#)

schizophrenia and [131](#) [138](#)

workplace [281](#) [282](#)

Violent patients [76](#)

evaluating [292](#) [294](#)

interviewing [76](#)

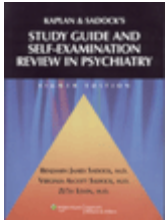
potentially, interviewing [9](#) [11–13](#)

precautions [76](#)

Voice disorders [351](#)

Voyeurism [209](#) [210](#) [211](#)

Vulvodynia [259](#) [267](#)



Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 Lippincott Williams & Wilkins



W

WAIS See Wechsler Adult Intelligence Scale

Wake time after sleep onset (WASO) [234](#)

WASO See Wake time after sleep onset

WBC See White blood count

WCST See Wisconsin Card Sorting Test

Wechsler Adult Intelligence Scale (WAIS) [53](#) [54](#) [56-58](#) [326](#)

Wechsler Intelligence Scale for Children (WISC) [54](#) [58-60](#)

Wechsler Memory Scale [54](#) [58](#)

Wechsler Preschool and Primary Scale of Intelligence (WPPSI) [59-60](#)

Wellbutrin See Bupropion

Wernicke's disease [29](#)

characteristics [33](#)

White blood count (WBC)

clozapine and [73](#) [77](#)

lithium and [76](#)

Wide-Range Achievement Test-Revised (WRAT-R) [326](#)

Wilson's disease [267](#)

Winnicott, Donald [69](#)

child psychotherapy [412](#)

WISC See Wechsler Intelligence Scale for Children

WISC-III See Peabody Picture Vocabulary Test for Children-Third Edition

Wisconsin Card Sorting Test (WCST) [53](#) [54](#) [57](#) [58](#)

Parkinson's disease impairment measured by [105](#)

W-J See Woodcock-Johnson Psycho-Educational Battery-Revised

Woodcock-Johnson Psycho-Educational Battery-Revised (W-J) [331](#)

Word salad [83](#)

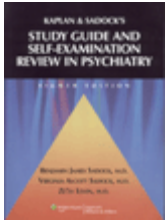
Workplace distress [287](#)

WPPSI See Wechsler Preschool and Primary Scale of Intelligence

WRAT-R See Wide-Range Achievement Test-Revised

Writ [435](#)





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

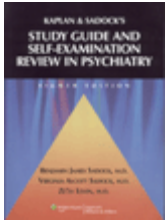
© 2007 [Lippincott Williams & Wilkins](http://www.lippincott.com)



X

Xanax See Alprazolam





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](#)



Y

Yale-Brown Scale for obsessive-compulsive symptoms [94](#)

Yocon See Yohimbine

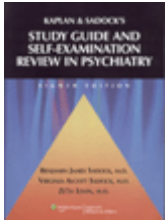
Yohimbine (Yocon)

panic attack induction with [167](#)

panic attacks induced by [172](#)

serotonin-specific reuptake inhibitor sexual effects and [308](#) [313](#)





Kaplan & Sadock's Study Guide and Self Examination Review in Psychiatry 8th Edition

© 2007 [Lippincott Williams & Wilkins](#)

← ↑ →

Z

Zeitgebers [32](#) [232](#)

Zidovudine

acetaminophen and metabolism of [113](#)

HIV [111](#)

HIV-related headache treated with [113](#)

mania in HIV caused by [112](#)

Zoloft See Sertraline

Zolpidem (Ambien) [310–311](#) [317](#) [318](#)

HIV treatment with [115](#)

Z-score [46](#)

Zyprexa See Olanzapine

← ↑ →

Psychiatry

Reinforce your knowledge with this easy-to-use guide!

KAPLAN & SADOCK'S
**STUDY GUIDE AND
SELF-EXAMINATION
REVIEW IN PSYCHIATRY**