Psychology

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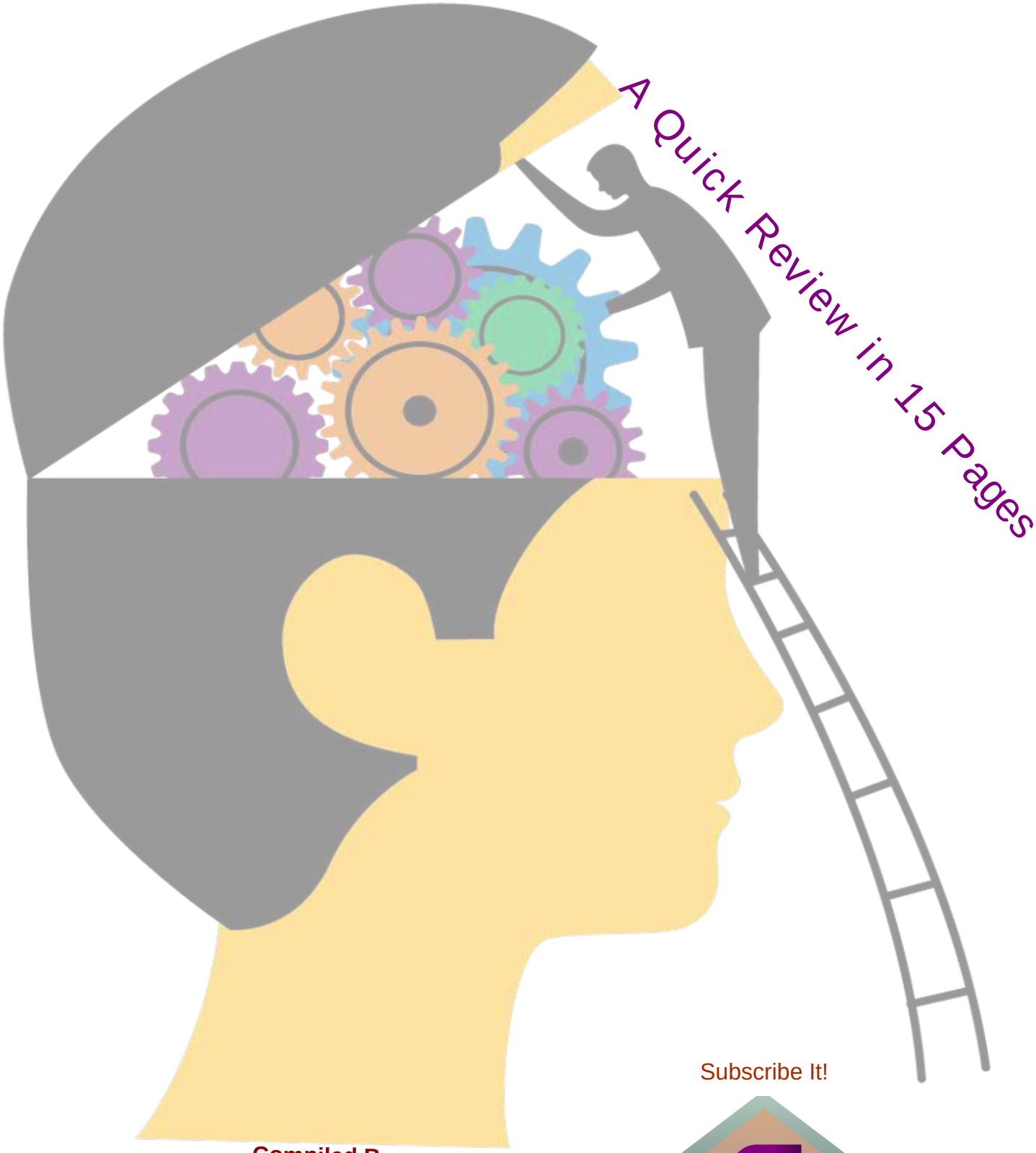

A Quick Review in 15 Pages

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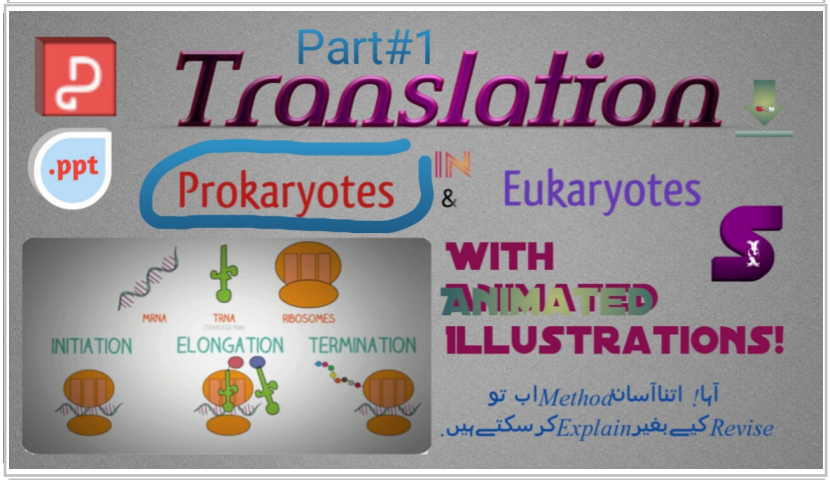

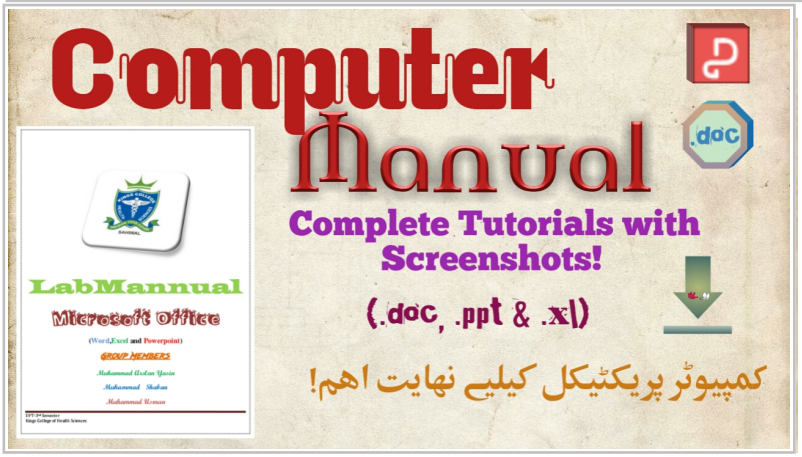

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PSYCHOLOGY

THE BASIC PRINCIPLES OF PSYCHOLOGY FOR INTRODUCTORY COURSES

INTRODUCTION

- **DEFINITION:** Scientific study of behavior and mental processes and how they are affected by an organism's physical and mental state and external environment
- **GOALS:** Describe, understand, predict and control (or modify) behavior or mental processes
- **PSYCHOLOGY AS A SCIENCE:**

1. **Descriptive studies** - describe but not explain
   a. **Case history** - description of one individual
   b. **Observation**
      i. **Naturalistic** - natural environment
      ii. **Laboratory** - setting controlled by researcher
   c. **Surveys** - questionnaires and interviews
   d. **Tests -**
      i. **Reliability** - used to measure whether individual differences in test scores are due to actual differences in the characteristic being measured or due to chance errors and fluctuations
      ii. **Validity** - refers to the extent to which a test measures what it purports; the **validity** of a test must be empirically established – relating the test to particular criterion that it claims to measure
2. **Correlational Studies** - strength of relationships between variables, does not show causation
3. **Experiment** - researcher controls variable(s) to discover its effect on other variables
   a. **Independent variable** - manipulated/controlled by researcher
   b. **Dependent variable** - measured by researcher (data)
   c. **Experimental and control groups** - only experimental group exposed to independent variable, otherwise treated the same
   d. Change in dependent variable caused by independent variable, since all else remained the same
   e. **Confounding Variable** - an observed effect that may be due to an intervening third variable between the dependent and independent variables; the **confounding variable** must be systematically controlled or, if possible, eliminated, otherwise obtained results are invalidated
   f. **Inferred Variable** - a non-observable variable that is inferred as the mediator between two observed events; for instance, inferring the experience of "fear" from certain measurable physiological anxiety responses; it is frequently difficult to avoid circular explanations in positing an inferred variable
   g. **Subject Variable -** a condition that is part of the subject's make-up and cannot be assigned randomly; e.g., sex, height, hair-color etc; because of their non-randomnizability, causal conclusions cannot be derived from **subject variable** experiments
   h. **Non-Subject Variable -** a characteristic that is not part of a subject's make-up, and thus can be randomly assigned; e.g., whether the subject received a certain drug or a placebo

LEARNING

Change in behavior as a result of experience

- **CLASSICAL CONDITIONING**

1. **Pavlov's** studies
   a. Unconditioned stimulus (**UCS**) - food - elicits an unconditioned response (**UCR**) - salivation
   b. Pair neutral stimulus - tone - with **UCS** - food
   c. Neutral stimulus becomes conditioned stimulus (**CS**) - tone - which elicits conditioned response **CR** - salivation
2. Principles of classical conditioning
   a. **Extinction** - when the **CS** is not presented with the **UCS**, it will diminish
   b. **Stimulus** generalization - similar stimuli may elicit the same response as the **CS**

LEARNING *CONTINUED*

   c. **Stimulus** discrimination - different responses are made to stimuli which are similar to the **CS**

- **OPERANT CONDITIONING**

1. **Reinforcer (reward)** - increases response probability
   a. **Positive reinforcement** - response followed by presentation of reinforcing stimulus
   b. **Negative reinforcement** - response followed by removal of unpleasant stimulus
2. **Punishment** - stimulus that follows response decreases probability response will occur
3. **Principles of Operant Conditioning**
   a. **Extinction** - response no longer reinforced
   b. **Stimulus generalization** - response will occur to similar stimuli
   c. **Stimulus discrimination** - responses do not occur to different stimuli
   d. **Timing of reinforcers** - the sooner a reinforcer or punisher follows an action, the greater its effect
   e. **Schedules of reinforcement**
      i. **Continuous reinforcement** - a particular response is always reinforced
      ii. **Intermittent reinforcement** - reinforcing only some responses
      (a) **fixed ratio (FR)** - reinforcement after a fixed number of responses, high rates of responding
      (b) **variable ratio (VR)** - reinforcement after average number of responses, very high, steady rates of responding
      (c) **fixed interval (FI)** - reinforcement after fixed amount of time, scalloped response pattern
      (d) **variable interval (VI)** - reinforcement after a variable amount of time, low, steady rate of response
   f. **Shaping** - reinforce successive approximations to the desired response
   g. **Chaining** - a method of connecting responses into a sequence of behaviors; at the end of the chain there must always be a *reinforcer*; the chain is constructed by beginning at the end and working backward; all behaviors have to be previously conditioned into the organism's repertoire
4. **Cognitive Behavior Modification**

The principles of learning theory are applied to alter undesirable thoughts, rather than only observable behaviors

   a. **Social Learning Theory** - (**Bandura**) four processes which influence learning are:
      i. Attention
      ii. Memory
      iii. Behavior
      iv. Motivation
   b. Specific cognitive processes that are recognized:
      i. Attribution
      ii. Expectancy
      iii. Logical
      iv. Verbal
      v. Imaginable
   c. **Rational emotive therapy** - (**Ellis**) considers the central core of dysfunctional behavior to be due to irrational beliefs; the therapy focuses on the alteration of these irrational beliefs
   d. **Problem-solving therapy** - focuses on enhancing the patient's ability to make decisions and solve problems in stressful or difficult situations
   e. **Paradoxical intervention** - patients are instructed to purposely perform undesirable symptomatic behaviors on command in an effort to demonstrate their ability to gain control over these behaviors
   f. **Attribution therapy** - attempts to facilitate the patient's ability to re-attribute undesirable feelings and symptoms to something less threatening and more acceptable

BIOLOGICAL BASES OF PSYCHOLOGY

- **STRUCTURE OF THE NERVOUS SYSTEM**

1. **Central** - brain and spinal cord
2. **Peripheral** - sensory and motor nerves which transmit information
   a. **Somatic** - control skeletal muscles
   b. **Autonomic** - regulates internal organs and glands
      i. **Parasympathetic** - conserves energy
      ii. **Sympathetic** - expends energy

- **COMMUNICATION WITHIN NERVOUS SYSTEM**

1. **Neuron** - basic unit of nervous system
   a. **cell body** - keeps neuron alive
   b. **dendrites** - receive information from other neurons
   c. **axons** - send information to other neurons
   d. **myelin** - insulates axon to enable information to be transmitted faster
2. **Communication between Neurons**
   a. **Synapses** - gaps between neurons
   b. Message travels through **axon** to **synaptic knob** on axon's tip
   c. **Synaptic vesicles** open and release **neurotransmitter** into **synaptic gap**
   d. **Neurotransmitter** fits into **receptor** sites on receiving **dendrite**, causing it to be more or less likely to fire

- **THE BRAIN**

1. **Hindbrain**
   a. Medulla, pons, reticular activating system, cerebellum
   b. Responsible for reflexive, automatic behavior
2. **Midbrain** - information conduit
3. **Forebrain**
   a. **Thalamus** - directs sensory messages
   b. **Hypothalamus** - emotion and survival drives
   c. **Pituitary gland** - controls many other endocrine glands
   d. **Cerebral cortex**
      i. **Occipital lobes** - vision
      ii. **Parietal lobes** - sensory information
      iii. **Temporal lobes** - process sounds
      iv. **Frontal lobes** - motor movements
4. **Two brain hemispheres**
   a. Each one controls opposite side of body
   b. Left hemisphere dominant for most people

STRESS AND HEALTH

- **STRESS - EMOTIONAL AND PHYSICAL RESPONSES TO STIMULI**

1. Caused by stimuli and the way those stimuli are perceived
2. Biological reaction
   a. Fight or flight - increase heart rate, breathing, tense muscles
   b. Increased activity in the sympathetic nervous system
   c. Adrenal glands secrete epinephrine (adrenalin) and norepinephrine
3. Coping with stress
   a. Reappraise situation
   b. Maintain control over the stressful situation

- **PSYCHOLOGY AND ILLNESS**

1. **Heart disease**
   a. **Type A** personalities - hard-working, competitive, increased incidence of heart disease
   b. **Type B** personalities - easy going
2. **Cancer**
   a. Exposure to carcinogens increases the risk
   b. Psychological factors influence functioning of immune system

- **HEALTH AND SOCIAL RELATIONSHIPS**

1. Friends - assisted coping
   a. Emotional, cognitive and tangible support
   b. Cultural differences in the value placed on friendships
2. Friends as stress producers
   a. Contagion effect - others can exaggerate stress
   b. Friend under stress can increase your stress level
   c. Burden of caring for others can increase stress

SENSATION AND PERCEPTION

- **SENSATION** - Awareness of physical changes
- **MEASURING SENSATION**
  1. Absolute thresholds - detection of signal 50 percent of time
  2. **Difference thresholds** (**j.n.d.** - *just noticeable difference*)
     a. Difference in sensation detectable 50 percent of time
     b. **Weber's Law** - change necessary for **j.n.d.** is a proportion of original stimulus
- **THE EYE**
  1. Light enters through the cornea
  2. Lens focuses light on the retina
  3. Retina - at the back of the eyeball
     a. **Rods** - respond to dim light
     b. **Cones** - respond to color
     c. **Fovea** - center of retina, contains only cones, site where vision is sharpest
- **THE EAR**
  1. **Outer ear** - collects sounds waves
  2. **Middle ear** - waves strike eardrum which passes them to three tiny bones which intensify the force of the vibrations
  3. **Inner ear** - contains receptor cells (hair cells) located within the cochlea which initiate nerve impulses which travel to the brain
- **TASTE**
  1. Four basic tastes - ***salty, sour, bitter and sweet*** - each associated with different receptors or taste buds
- **SMELL**
  1. Receptors in mucous membrane of nasal passage
- **SKIN SENSES**
  1. **Touch (pressure), warmth, cold and pain**
- **PERCEPTION** - organization and interpretation of sensations
  1. World seen as constant, although the sensations may change
  2. Needs, beliefs, emotions and expectations all influence perception

LANGUAGE, THINKING AND INTELLIGENCE

- **LANGUAGE** - Rule-governed system of symbols used to represent and communicate information
  1. Understanding language
     a. **Phonology** - knowledge of sounds
     b. **Semantics** - knowledge or word meanings
     c. **Syntax** - knowledge of grammatical structure
        i. **Deep structure** - meaning
        ii. **Surface structure** - organization of words
     d. **Psycholinguistics** - the study of the ability to produce and understand language
  2. Acquiring language
     a. Rules and strategies are innate
        i. Basic timing and sequence of language development is similar across cultures
        ii. Children learn the rules of their native language, (i.e., overgeneralization)
     b. Particular language acquired is based on experience
  3. Language and thought - language has an impact on how easily we process information
- **THINKING**
  1. Using concepts - apply past experiences to present thoughts
     a. Concept - a mental grouping of a set of objects or events on the basis of important common features
     b. Must be learned through definition or example
     c. Concepts aid in predicting and interpreting events and organizing experiences
  2. **Problem solving** - set of information used to achieve goal
     a. **Strategies**
        i. Define the problem

LANGUAGE, THINKING AND INTELLIGENCE *CONTINUED*

        ii. Use **algorithms** (systematic methods guaranteed to produce a solution) or
        iii. Use **heuristics** (a rule that may or may not produce a solution), (i.e., simplification, reasoning by analogy)
     b. **Insight** - sudden understanding of solution
- **INTELLIGENCE** - ***capacity to acquire and use knowledge***
  1. Measuring intelligence
     a. **Binet** - IQ tests - mental age (as determined by a test) divided by chronological age = IQ
     b. **Wechsler** - tests include verbal, mathematical and nonverbal thinking skills
     c. Average score is 100, scores describe a bell-shaped (normal) distribution
     d. I.Q. (**I**ntelligence **Q**uotient) is computed by dividing a person's "mental age" by their "chronological age" and multiplying by one hundred; yielding the formula: **IQ = (MA/CA) X 100**
  2. Uses of IQ tests
     a. As a predictor of school success
     b. Concerns about being "culture fair"
  3. Nature of intelligence - one ability or many?
  4. Influence of the environment
     a. **Hereditability** - studies over a forty-year span have revealed 50 – 80 % genetic component to IQ. Consequently, the general conclusion seems to be that heredity has a substantial effect on IQ scores, with at least half the observed variation in IQ scores attributable to genetic differences
     b. Experience determines point within genetic range
  5. Extremes in intelligence
     a. **Intellectually Challenged** - IQ below 70
        i. **Biologically based** - Downs syndrome, fetal alcohol syndrome
        ii. **Psychosocial** - disease, malnutrition, lack of intellectual stimulation
     b. **Intellectually gifted** - skills on one or more intellectual domains

MEMORY

Ability to retain and retrieve information

- **INFORMATION PROCESSING THEORY**
  1. Information must be encoded to be processed by brain
     a. **Storage** - retention of information
     b. **Retrieval** - accessing information
  2. Three memory systems
     a. **Sensory** - literal copy of information - held for 1-2 seconds
     b. **Short-term**
        i. Limited capacity (7 + or - 2 items)
        ii. Information held for about 30 seconds; then it is forgotten or further encoded and placed in long-term memory
     c. **Long-term**
        i. Unlimited capacity
        ii. Information stored and retrieved by category
  3. **Forgetting**
     a. In **sensory memory** - through decay
     b. In **short-term memory**
        i. Limited capacity subject to "filling up"
        ii. Can retain information through rehearsal
        (a) Maintenance (rote) rehearsal
        (b) Elaborative rehearsal - associating new with old information
     c. In **long-term memory**
        i. **Decay** - information fades if not used
        ii. **Forgetting**
        (a) **Interference** - similar items interfere
        (b) **Motivated** - conscious or unconscious "hiding" a memory
        (c) **Cue-dependent** - unable to gain access to the information
        (d) **Zeigarnik effect** - interrupted, or incomplete tasks seem to be better remembered than completed tasks
        (e) **Non-verbal memory** - pictures are remembered significantly better than words; motor memory seems to be impervious to decay

SOCIAL PSYCHOLOGY

- **ROLES - A social position governed by norms**
  1. **Norms** - conventions by which we live
  2. **Zimbardo's Prison Study**
     a. Students assigned to "guard" or "prisoner" roles
     b. Student behavior reflected their assigned roles
  3. **Milgram's Obedience Study**
     a. Participants thought they were part of an experiment in learning
     b. "Teacher" was instructed to shock "learner" for wrong answer
     c. Majority of "teachers" complied with the instructions to administer shock
- **SOCIAL COGNITION** - how the social environment influences thoughts, perception and belief
  1. **Attribution** - motivation to explain behavior
     a. **Situational** - caused by the environment
     b. **Dispositional** - caused by something within individual
     c. **Fundamental attribution error** - overestimate dispositional and underestimate situational causes
     d. **Self-serving bias** - use dispositional attributions for good behaviors and situational attributions to excuse our own behaviors
  2. **Stereotypes** - summary impressions when all members of a group share common traits
  3. **Attitude** - a relatively enduring opinion including both cognitive and emotional components
     a. Attitudes and behavior influence each other
     b. **Cognitive dissonance** - when an attitude and behavior conflict, we are motivated to make them consistent
  4. **Prejudice** - unjustified negative attitudes toward a group
- **CONFORMITY** - behavior that occurs as a result of real or imagined group pressure
- **OBEDIENCE** - following orders from an authority
- **INDIVIDUALS AND GROUPS**
  1. **Groupthink** - tendency for all group members to think alike and suppress dissent
  2. **Group Polarization** - tendency of a group to take a more extreme position than those of individual members
  3. **Responsibility**
     a. **Diffusion of responsibility** - avoidance
     b. **Social loafing** - individual slows down to let the group shoulder the load
     c. Bystander apathy will not occur when one
        i. **Perceives** the need to help
        ii. **Decides** to take responsibility
        iii. **Weighs** the costs of helping
        iv. **Knows** how to help
- **LOVE - (Sternberg)**
  1. Has three related components:
     a. **Intimacy**
     b. **Passion**
     c. **Commitment**
  2. Depending on the combination of these elements, produces different dimensions in a relationship:
     a. **Liking** - intimacy alone
     b. **Companionate Love** - intimacy and commitment
     c. **Empty Love** - commitment alone
     d. **Fatuous Love** - passion and commitment
     e. **Infatuation** - passion only
     f. **Romantic Love** - intimacy and passion
     g. **Consummate Love** - intimacy, passion, and commitment

DEVELOPMENT

- **DEFINITIONS**
  1. **Learning** - influence of experience (nurture)
  2. **Maturation** - unfolding of biological patterns (nature)
  3. **Critical Periods** - early development periods during which particular early experiences are essential
  4. **Stages** - organization of behaviors and thoughts during particular early periods of development - defined by relatively abrupt change
- **COGNITIVE DEVELOPMENT**
  1. **Piaget**
     a. **Assimilation** - fit new information into what is known
     b. **Accommodation** - change existing beliefs in response to new knowledge
     c. Stages of development
        i. **Sensory-motor stage (birth - 2)** - object permanence
        ii. **Preoperational stage (2-7)** - use of symbols and language; egocentric; lack the principles of conservation
        iii. **Concrete operational stage (7-11)** - understand conservation, identity, grounded in concrete experiences
        iv. **Formal operations stage (12-adult)** - abstract reasoning
  2. Language development - acquisition depends on biological readiness and experience
- **SOCIAL DEVELOPMENT**
  1. Attachment - emotional tie between infant and caretaker (**Harlow's** monkey studies)
  2. Sex typing - learning "masculine" or "feminine"
     a. Identification with the same sex parent
     b. Rewards and punishments for sex appropriate behavior
  3. **Erikson's stages**
     a. Trust Versus Mistrust: 0 – 2 years of age
     b. Autonomy Versus Doubt and Shame: 2- 3 years of age
     c. Initiative Versus Guilt: 3 – 6 years of age
     d. Industry Versus Inferiority: 6 – 11 years of age
- **MORAL DEVELOPMENT - Kohlberg Theory:**
  1. **Preconventional morality** - obey because ordered to or will be punished
  2. **Conventional morality** - based on trust, loyalty or understanding social order
  3. **Postconventional morality** - laws are situational and can be changed
- **CHRONOLOGICAL DEVELOPMENT**
  1. **Newborn Child**
     a. Reflexes - automatic behaviors, rooting, sucking, swallowing, startle, etc.
     b. Vision - nearsighted, interested in novelty
     c. Social skills
        i. Smile at 4-6 weeks in response to faces
        ii. Rhythmic "conversations"
  2. **Adolescence**
     a. **Biological development** - increased hormone production; sex organs mature; growth spurt
     b. **Intellectual development** - formal operational (abstract reasoning), independence, questioning
  3. **Aging**
     a. **Transition Theories** - unanticipated, anticipated, nonevent, chronic hassle
     b. **Major Milestones** - starting out, marriage or living alone, parenthood, empty nest, midlife crises, retirement, widowhood

PERSONALITY

Distinctive patterns of behavior, thoughts and emotions that characterize individual's patterns of adaptation

- **THE ORIGINS OF PERSONALITY**
  1. Biological and genetic influences
  2. Experience - cultural and unique
  3. Stability and change
     a. Genetic characteristics relatively stable through life
     b. Less active, hostile and impulsive with age
     c. Personality changes as a result of life experiences
- **FREUD**
  1. **Personality** consists of three parts
     a. **Id** - basic biological urges; unconscious
     b. **Ego** - gratifies urges within acceptable bounds; conscious
     c. **Superego** - values and ideals of society; conscience

PERSONALITY *CONTINUED*

  2. **Psychosexual** development
     a. **Oral** stage (**0-1**) - sucking, feeding, etc.
     b. **Anal** stage (**2-3**) - defecation
     c. **Phallic** stage (**3-5**) - sexual attraction to the opposite sex parent produces the Oedipus complex
     d. **Latency** period (**5-puberty**) - sexual feelings forgotten; child concentrates on skill development
     e. **Genital** stage - **adult** sexual relationships
  3. **Anxiety** - unjustified fears resolved by ego through use of defense mechanisms
     a. **Repression** - active exclusion of unconscious impulses from consciousness
     b. **Projection** - attribute to others our thoughts and feelings
     c. **Reaction formation** - behavior patterns opposite to our anxiety producing urges
     d. **Displacement** - redirects anxiety producing behaviors to a more acceptable target
     e. **Rationalization** - substitute "good" reasons for real reasons for behavior
  4. **Defense Mechanisms**
     a. **Denial** - the refusal to acknowledge an external source of anxiety
     b. **Fantasy** - utilizing imagination to satisfy desires that are, in reality, highly unlikely (e.g., sexually fantasizing about a celebrity)
     c. **Intellectualization** - the repression of the emotional component of an anxiety-provoking event; the event is treated in a purely analytical manner
     d. **Regression** - resorting to infantile behaviors as a method for avoiding anxiety and/or responsibility
     e. **Identification** - identifying with the anxiety-producing stimulus in an attempt to reduce one's own anxiety (opposite of projection)
     f. **Overcompensation** - an attempt to conceal perceived deficiencies in one area by excelling in another; e.g., a student with poor academic performance becomes an excellent athlete
     g. **Sublimation** - the re-channeling of sexual or aggressive impulses in a socially acceptable direction; e.g., an aggressive person becomes a professional boxer
- **HUMANISTIC THEORIES** - people are rational, capable of choice and desire to achieve personal growth
  1. **Carl Rogers** - self-concept directs behavior, conflict between real and ideal self
  2. **Abraham Maslow** - individual strives for self-actualization - fulfillment of potential
- **EXISTENTIAL PSYCHODYNAMICS**
  1. **Yalom** - primary drive of the individual is to derive meaning from the complexities of their life experiences; to understand a structure, rationale, or justification to the events they have experienced; failing this, life is seen as absurd and pointless, leading to despair, depression, and existential crises; the primary concerns of this approach to psychotherapy deal with confronting the issues of *death, freedom, existential isolation, and meaninglessness*
- **SOCIAL COGNITIVE THEORY** - how and under what situations thoughts and behaviors are learned
- **CONSISTENCY IN PERSONALITY**
  1. **Trait** - relatively enduring quality or characteristic
  2. **Cross-situational** - most central to self-concept
- **PERSONALITY ASSESSMENT**
  1. Assessment **methods** must be:
     a. **Reliable** - same results over time
     b. **Valid** - measure what it is supposed to measure
  2. **Interview**
     a. **Advantage** - tailored to individual's previous answers
     b. **Disadvantage** - low reliability
  3. **Observation**
     a. times particular behavior occurs
     b. Good reliability
  4. **Self-report**
     a. **MMPI** - to diagnose psychological disorders
     b. Ten primary scales measure personality dimensions
  5. **Projective techniques** - *individual provides an interpretation of ambiguous material*
     a. **Rorschach** inkblots
     b. **Thematic Apperception Test (TAT)**
     c. Concerns about reliability and validity since interpretations are subjective

MOTIVATION AND EMOTION

- **MOTIVATION** - need or desire to act a certain way to achieve a goal
  1. **Range** of motives
     a. **Physiological** - hunger, thirst, pain avoidance
     b. **Social** - learned
     c. **Maslow** - motives organized in a hierarchy of needs - physiological, safety, love and belonging, esteem, self-actualization
  2. **Motivational system** - set of motives and behaviors that operate in a particular life area
     a. **Hunger and eating**
        i. **Hunger signals** - stomach contractions, hypothalamus, environment
        ii. **Food preferences** - cultural, personal and biological origins
     b. **Sexual motivation** - hormones
     c. **Work**
        i. **Extrinsic motivation** - working for external reward
        ii. **Intrinsic motivation** - working for pleasure of activity itself
  3. **Maslow's hierarchy of motivations**
     a. In the hierarchy of needs, the needs at each level must be satisfied before going on to the next level
     b. The hierarchy of needs
        i. **Physiological needs** - food, water, sex, and shelter
        ii. **Safety needs** - security needs
        iii. **Belongingness and love needs** - acceptance and friendship
        iv. **Esteem needs** - self-esteem, and esteem from others
        v. **Self-actualization needs** - realizing one's potential as a creative, productive person
- **EMOTION**
  1. **Defining features of emotions** - subjective experience, physiological arousal, expressive behavior, changes in cognition
  2. **Inborn** - people from different cultural backgrounds can identify emotions
  3. **James-Lange Theory** - emotion is a result of a perception of bodily changes and behaviors
  4. **Cannon-Bard Theory** - emotion is a result of perception of a stimulus which causes both physiological changes and subjective feelings
  5. **Cognitive Labeling Theory** - emotion is a result of the interpretation of the causes of physiological arousal
  6. **Frustration-aggression hypothesis** - aggression results from blocking of efforts to achieve a goal

CONSCIOUSNESS

- **JAYNES' THEORY**
  1. Consciousness not only evolves neurobiologically, but is also formed by the individual's interactions with culture
  2. The foundation of consciousness is based in the physiology of the brain's left and right hemispheres; there are three fundamental forms of human awareness that are the outcome of this process:
     a. **Bicameral** - controlled by right hemisphere of brain, which dominates left-hemisphere activity; individual subordinates consciousness of self to control by a group, a higher power, or other individual
     b. **Modern** - the dominance of the right brain hemisphere over the left is weakened as civilization develops and humans become more autonomous and independent; as humans become more independent, individual consciousness emerges
     c. **Throwbacks to bicamerality** - the re-emergence of bicameral consciousness in modern life is manifested by episodes of schizophrenia, hypnosis and poetic and religious frenzy
- **SLEEP RHYTHMS**
  1. **REM** - rapid eye movements associated with dreaming

CONSCIOUSNESS *CONTINUED*

2. **Stages of brain waves**
   a. **Alpha Waves** - regular, high-amplitude, low frequency wave
   b. **Stage 1** - small, irregular brain waves, light sleep
   c. **Stage 2** - bursts of sleep spindles
   d. **Stage 3** - delta waves; deep sleep
   e. **Stage 4** - extremely deep sleep
   f. Entire cycle is 30-45 minutes and then reverses

- **WAKEFULNESS**

1. **Conscious** processes
2. **Subconscious** processes - can be brought into consciousness when necessary
3. **Nonconscious** processes - remain outside awareness but influence behavior

- **ALTERED STATES**

1. **Meditation** - eliminate distracting thoughts
2. **Psychoactive drugs** - influence perception, thinking or behavior
   a. **Stimulants** - speed up nervous system activity - cocaine, amphetamines
   b. **Depressants** - slow central nervous system activity - alcohol, tranquilizers
   c. **Opiates** - relieve pain and produce euphoria - opium, morphine, heroin
   d. **Psychedelic drugs** - alter consciousness - LSD, mescaline
3. **Hypnosis** - heightened state of suggestibility when subjects can sometimes control unconscious body functions
4. **Weil's Theory**
   a. Humans have an innate drive to experience states of non-ordinary consciousness
   b. Individuals and cultures experiment with ways to change their ordinary states of consciousness
   c. Altered states of consciousness are common; e.g., daydreaming, sleeping, etc
   d. Individuals often are unaware they are in the midst of an experience of non-ordinary consciousness; e.g., daydreams, or alcoholic 'black-out' episodes
   e. Altered states of consciousness form a continuum or spectrum ranging from normal, alert, waking consciousness to sensory deprivation, to coma
   f. Psychotropic and psychedelic drugs do not cause altered states of consciousness—they are merely a way to elicit such states
   g. Understanding the mechanisms of altered states of consciousness can be an avenue to greater understanding of the nervous system; furthermore, such knowledge may lead to the discovery of untapped human potential and a better understanding of ordinary waking consciousness

ABNORMAL BEHAVIOR

- **TYPES**

1. Statistical deviation
2. Violation of cultural standards
3. Maladaptive behavior
4. Emotional distress
5. Legal (impaired judgment and lack of self-control)

- **ANXIETY DISORDERS**

1. Generalized anxiety disorder - chronic anxiety
2. Phobia - fear of specific situation, activity or thing
3. Obsessive-compulsive disorder
   a. Obsessions - recurrent thoughts
   b. Compulsions - repetitive behaviors

- **MOOD DISORDERS - (depression & mania)**

1. Causes
   a. Biological (brain chemistry)
   b. Social (life situations)
   c. Attachment (disturbed relationships)
   d. Cognitive (maladaptive thoughts)

- **PERSONALITY DISORDERS**

1. Paranoid - excessive suspiciousness
2. Narcissistic - exaggerated sense of self-importance
3. Antisocial - lack of social emotions

- **DISSOCIATIVE DISORDERS - amnesia, multiple personality**
- **SOMOTOFORM DISORDERS - take the form of physical disorders**
- **PSYCHOTIC DISORDERS**

1. Schizophrenia - bizarre delusions, hallucinations, severe emotional problems, withdrawal
   a. Family dynamics - distorted patterns of communication
   b. Biological - brain disease(s) or abnormalities in neurotransmitters
   c. Stress - combination of heredity and stress
2. Organic brain disorders - i.e. diseases, brain injury

- **VIEWS ON THE REALITY OF MENTAL ILLNESS**

1. **Szasz's Objection** - the concept of "mental illness" is a socially constructed myth for the purpose of advancing certain social and political agenda; clinical psychology is an instrument of repression to enforce conformity and stigmatize non-conformists as "deviant" people with the label "mentally ill"
2. **Reznek's Definition** - something is a mental illness if, and only if, it is an abnormal* and involuntary process that does mental harm and should best be treated by medical means
   ***Note** - "abnormal" is used in the constructivist or normative sense, and not in the statistical or idealistic sense, as "normal" is a relative term determined by society

TREATMENT AND THERAPY

- **MEDICAL TREATMENTS**

1. **Antipsychotic drugs** (major tranquilizers) - schizophrenia
2. **Antidepressant drugs** (stimulants) - mood disorders
3. **Surgery** - to destroy brain areas believed responsible for emotional disorders
4. **Electroconvulsive therapy** - induces seizures used to treat major depression

- **PSYCHOTHERAPY**

1. **Psychodynamic** (insight) therapies - explore the unconscious dynamics of personality
   a. **Freud** -
      i. Understanding past produces insight
      ii. **Free association and transference**
   b. **Neo-Freudians** - use Freud's techniques, usually time limited
2. **Behavioral** therapies
   a. **Systematic desensitization** - exposure to a hierarchy of stimuli while relaxing to decrease fears
   b. **Aversive conditioning** - punishment for unwanted behavior

TREATMENT AND THERAPY *CONTINUED*

   c. **Implosion** - client required to imagine the anxiety-producing stimulus in its most vivid and extreme manifestation; client experiences full anxiety response without suffering any harm; consequently, the stimulus no longer elicits anxiety due to extinction of the response
   d. **Flooding** - same procedure and theory as implosion, but real or realistically depicted stimuli are used instead of imaginary ones
3. **Cognitive** therapy - to correct unrealistic thinking
4. **Humanistic** therapy
   a. Client-centered - **Carl Rogers**
      i. build self esteem
      ii. critical qualities of the therapist - warm, genuine and honest
   b. **Gestalt - Frederick Perls** - self-actualization
5. **Family and Group** therapies - theorize that problems develop in a social context and must be dealt with in that context

- **EVALUATING THERAPIES**

1. Therapies are less effective with serious disorders
2. Relationship between client and therapist is critical
3. Certain therapies are effective for certain specific problems

- **MEDICAL TREATMENTS**

1. **Advantages of Medical Model** - promotes a more humane understanding of patients; aids in the understanding of some organic mental disorders and further initiates research in brain function
2. **Disadvantages of Medical Model** - environmental variables are unduly minimized or neglected; diagnostic and treatment methods are questionable, thus fostering an institutionalization syndrome; this approach removes responsibility for recovery from the patient while promoting a dependence upon hospitals and chemicals

- **BEHAVIORISM**

1. Cognitive components to behavior (e.g., expectations, verbalization, imitation etc.) are unduly minimized or ignored
2. **Overly operationalistic** - physical correlates are closely identified with mental states (e.g., fear is identified with the physiological manifestations of anxiety); overlooks the possibility that the interpretation of observable physical symptoms can determine their reality; for instance, the physiological correlates of anxiety may be interpreted as fear, excitement, anger, or sexual arousal depending upon prior expectations, cultural values etc
3. Ignores the role played by intervening inferred cognitive variables

- **COGNITIVE BEHAVIORISM**

1. Difficult to avoid circular definitions in invoking the meaning of certain mental constructs
2. Difficult to determine what extent to allow decreasingly operationalizable mental entities
3. The role of psychosomatic variables may be overlooked or minimized
4. Some argue that the underlying cause of observable symptoms is ignored by behavioral therapies

   Note - Clinically, both behaviorism and cognitive behaviorism only seem effective in the treatment of very specific disorders; e.g., phobias, specific undesirable behaviors; cannot effectively be applied to amorphous problems such as undifferentiated existential depression

- **PSYCHOANALYSIS**

1. **Freud's** initial theory based only on case studies and anecdotal evidence, and a patient population which was very limited, atypical, and selective
2. Postulates entities that are by definition unobservable and cannot be operationalized for valid scientific evaluation
3. Psychoanalysis has been demonstrated (by **Eysenck**) to be ineffective in treating emotional disorders
4. In reaction to criticism and undermining evidence against their theory, Neo-Freudians have modified their theory with *post-hoc* hypotheses to the point that it is no longer scientifically testable even in principle

PSYCHOLOGY OF RELATIONSHIPS

STUDENTS' GUIDE TO RELATIONSHIP PROFILES - *NOT A SELF-HELP CHART*

INTRODUCTION

BASIS OF REFERENCE CHART

1. Intended to provide a basic understanding of fundamental concepts of psychology of interpersonal relationships, including a historical overview and current concepts regarding this topic.
2. Primary focus is on defining problems in relationships.

Not a Self-Help Chart.

PROPOSED DEFINITIONS

HISTORICAL PHILOSOPHICAL OVERVIEW

ARISTOPHANE'S MYTH

1. Humans were originally both male and female, sexually autonomous beings.
2. Zeus separated the male and female halves.

These now *incomplete creatures* were condemned to search the world for their other half.

3. Myth holds that people are incomplete and must search to find their ideal partner.

CHIVALRIC LOVE

1. Love that can never be consummated. Essential nature is a *perpetually unfulfilled yearning.*

   Love of someone from afar.
2. This type of "honorable" love can easily border on worship.

LOVE AS EROS

1. *Sexual,* or romantic love.
2. **Plato** called this love the "divine madness" due to the propensity of those who are romantically in love to have skewed and distorted perceptions of their beloved and of the world around them.

LOVE AS FRIENDSHIP

Aristotle distinguished three types of friendship:

1. **Friendship of Pleasure:** Some characteristics of the other affords pleasure, e.g. sense of humor, physical attractiveness, etc.
2. **Friendship of Utility:** Some common goal or shared activity motivates the friendship, e.g. camping, sports, etc.
3. **Friendship of the Good:** Love of another for themself.

LOVE AS AGAPE

1. **Religious:** Unconditional love of a superior for an inferior, most clearly manifested in God's love for the individual sinner who is utterly undeserving of this "grace."
2. **Secular:** Unconditional, or nearly unconditional love, of an independent for a dependent person, most clearly manifested in the love of a parent for a child.

LOVE AS COMPASSION

Buddhist notion of *Karuna.*

Defining characteristics of *Karuna* are compassion, affection, and nurturing.

LOVE AS "I-THOU"

Buber's theory

1. Mutually inclusive relationship where each partner fully experiences the other, not merely through empathy, but as an integration of consciousness; the relationship is not "I and the other," but it is a relationship of total reciprocity.
2. In an "I-Thou" relationship, one's whole being is integrated with the other and one holds nothing back.

LOVE AS SADOMASOCHISTIC ALTERNATION

Sartre's view:

1. *Process of sadomasochistic appropriation*, in which two persons in a love relationship seek to possess each other and yet wish to be simultaneously possessed by the other.
2. **Sartre's** view of sexual activity: We either focus on our own pleasure (a sadistic orientation) or the other's pleasure (a masochistic orientation) culminating in a situation where desire is doomed, for it bears within itself the cause of its own failure.

LOVE AS RESENTMENT AND SUPPRESSION

Nietzsche's theory of love:

1. Romantic love or "*amour-passion"* is a perversion and the artificial product of a decadent slave/morality.
2. Unadulterated sexual desire is legitimized by refining it in the mold of romantic interludes.

LOVE AS SUBJUGATION

1. Romantic love is a cultural invention created by men for the subjugation of women.
2. Love is a fictitious substitute that women have been deceived into accepting in lieu of power, prestige, wealth, education, or any empowering ideal to which women may aspire. Having love is somehow supposed to make any deficiency in their lives acceptable.

LOVE AS DUTY

1. **Kierkegaard's** theory is that love founded on inclination, or feelings, suffers from three deficiencies:
   a. It is subject to be easily transformed to hate, jealousy, or indifference in the light of changing circumstances.
   b. It is dependent upon the beloved's feelings and circumstances–for instance, whether they reciprocate to a like degree, their waning physical attractiveness due to aging, and so on.
   c. It can become disproportionate by overly idealizing the beloved to the point that the beloved is not seen as they really are, but as the lover wishes to see them.
2. Love based on a sense of duty, however, avoids these difficulties because it is based on more permanent and secure foundations than mere inclination–namely commitment and honor.

PSYCHOLOGICAL OVERVIEW

DEFINING CHARACTERISTICS OF ROMANTIC LOVE

1. **Sexual attraction:** May be for members of the same, or the opposite sex. Believed by some to constitute as much as 90% of the experience of "romantic love."
2. **Emotional involvement:** Not necessarily positive as one may say that they love but do not like their partner.
3. **Insecurity:** Tenuousness of the relationship where one feels they may be unable to keep the interest of the other.
4. **Possessiveness and jealousy:** Wanting to keep the beloved completely to oneself, and feeling rejected at even the slightest provocation.
5. **Obsessiveness:** One cannot stop thinking about the beloved and finds oneself utterly preoccupied and consumed by thoughts about that person.
6. **Dependency:** Unlike friendship, one is dependent on the relationship for a sense of well-being and balance. Any disruption to the integrity of the relationship may be experienced with great anxiety and distress.
7. **Passivity and helplessness:** Feeling of having lost control of emotions and behavior, thus the involuntary nature of the experience of *falling* in love.
8. **Ephemeral and transient:** The intense euphoria and elation of being in love seldom lasts more than three months. After that initial period sensibility and realism gradually return.
9. **Idealization:** The beloved is perceived in an unrealistic, idealized perspective.

LOVE AS ILLUSION

1. **Freud** and **Schopenhauer**
   a. Lover "over-values" the beloved, feeling that they two will finally achieve total contentment and happiness.
2. **Schopenhauer**
   a. Love is Nature's greatest deception, played on us in order to preserve the species.
   b. Once its purpose of procreation is achieved, we are often left bewildered, disappointed, and burdened with unexpected responsibilities for offspring.

THE FACADES OF LOVE

1. **Fromm's** theory
   a. Love is the most effective coping mechanism to counter the pain of one's separateness and existential isolation.
   b. Individuals make many false starts because they mistake common cases of misguided pseudo-love with rare genuine love.
2. Types of pseudo or misguided love:
   a. **Infantile:** Transference of feelings for a parent to a partner. Hence, one loves not the partner but certain attributes one has unknowingly superimposed upon the so-called "beloved."
   b. **Sterile:** Having grown up in an emotionally cold home, a person may adopt the same emotionally distant attitudes toward the partner while believing himself to be loving.
   c. **Imaginary:** Imagining oneself to be loving and caring, in order to cope with an emotionally impoverished life, when in reality one is cold and distant.
   d. **Eroticism:** Mistaking sexual pleasure for love.

e. **Superficiality:** One loves–not the person–but some attribute, e.g. prestige, status, etc.
f. **Symbiotic:** Deficient form of love in which two individuals become involved in a sadomasochistic cycle in order to assuage loneliness and isolation.
   i. Sadist seeks to overcome separateness by dominating and controlling.
   ii. Masochist seeks to overcome existential isolation and gain security by being used and dominated.
g. **Idolatrous:** A person with low self-esteem and lacking a firm sense of self-identity, idolizes anothers' love to the point of worship.
h. **Nostalgic:** Dwelling upon happy memories of courtship and honeymoon while ignoring bitter reality of loveless marriage, *or* deferring gratification and anticipating future romance in order to tolerate the drudgery and tedium of the present.
i. **Projective:** Each projects his own faults upon the other, thus ignoring their real problems and making genuine communication and love impossible.

LOVE AS PSYCHOPATHOLOGY

Freud's theory: All love is essentially an irrational aberration. Denies the existence of mature love and argues that all instances of falling in love are pathological and abnormal. These states are accompanied by distortions in reality, compulsiveness, transference and infantile regression.

LOVE AS EGO-COMPLETION

Theodore Reik theorized that love is the result of a *process of ego-completion.*

1. Love is a form of reaction formation, since people fall in love with those who possess the very qualities they are most lacking and most admire.
2. Love is a *process of compensation* whereby one's feelings of inadequacy are assuaged by supplanting those feelings with the admired qualities in the other.

LOVE AS ADDICTION

1. *Addiction is the process of engaging in an activity or using a substance to prioritize it so that it becomes an all–consuming compulsion stunting personal growth and normal maturation.*
2. Process of *falling out of love, being lovelorn, or having a broken heart* may be interpreted as a process of withdrawal, with symptoms very similar to the withdrawal experienced by a drug addict.

CONSUMMATE LOVE

Sternberg contends that *passion, intimacy, and commitment* comprise *consummate love.* Depending upon the combination of the presence or absence of these factors, seven distinct kinds of love may result:

1. **Liking**: Includes intimacy as in a close friendship.
2. **Infatuation:** Primarily intense passion and attraction.
3. **Empty Love:** Relationship based upon commitment and little else; e.g. staying together out of sheer convenience.
4. **Romantic Love:** Comprised of passion and intimacy, but may lack commitment.
5. **Fatuous Love:** Includes passion and commitment but no intimacy; e.g. partners stay together for sexual satisfaction only.
6. **Companionate Love:** Combination of intimacy and commitment; e.g. no longer having a passionate involvement but remaining emotionally close.
7. **Consummate Love:** Ideal combination of passion, intimacy and commitment.
8. Lasting relationship is often *a process* in which passion, abundantly present at the onset, is eventually diminished and replaced by intimacy and commitment, more enduring qualities, which then sustain the relationship.

RELATIONSHIPS: ACTUALIZED FUNCTIONAL

THE NON-ATTACHED ATTITUDE

CHARACTERISTICS SHARED IN MATURE AND HEALTHY RELATIONSHIPS: LYNGZEIDETSON'S CRITERIA

1. **Inner strength** and strong ego-integrity:
   a. Willingness to expose innermost self.
   b. Strong enough to be vulnerable.
2. Both **grow** and become better in and through the relationship.
3. Full **acceptance** of the other, without a need to manipulate and control, *after* deeming the other worthy and deserving of love.
4. Full **reciprocity** and **involvement** with the other.
5. **Nurturing**, protecting, and caring instead of patronizing, condescending, possessing or controlling
6. Each receives by **giving** to the other. Neither party is out to use or take advantage of the other.

TEST CASE

1. Willingness to let the other go if it *would be genuinely in their best interest.*
   a. Rare situation since it is to the mutual best interest of both partners to stay and grow old together.

FROMM'S CRITERIA FOR MATURE LOVE

PROCESS OF OVERCOMING INFANTILE EGOCENTRICITY

FROMM'S THEORY

In mature love each person preserves their integrity and individuality. The two become one and yet remain two.

TRANSFORMATIONAL

Develops from feelings of "being loved" into terms of "loving."

IMMATURE LOVE

1. Based upon **dependency** and egoism, and is thus passive.
2. **Infantile** because it follows the presumption that "I love because I am loved."
3. Giving is experienced as a depletion.

MATURE LOVE

1. Follows the principle "I am loved because I love."
2. Potent, giving and active, composed of a positive giving and not receiving. Love given is its own reward.
3. Giving makes one feel more alive and it is in giving that the mature lover finds joy.
4. Comprised of concern, responsivity, respect and knowledge.
5. Transcending self-concerns and empathizing with the other.

YALOM'S CRITERIA FOR NEED-FREE LOVE RELATIONSHIPS

OVERCOMING ISOLATION

Seeking to ameliorate our existential aloneness by entering into a relationship with another.

CHARACTERISTICS OF MATURE, HEALTHY, 'NEED-FREE' RELATIONSHIPS

1. **Suspend judgments** of self-centered egoism and relate *selflessly with one's whole being.*
   a. No ulterior motivation wherein one asks "What is in this for me?"
   b. No hidden agenda.
2. **Experience** and relate to **another** as completely as possible. Seeing another as an end and *not* as a means to an end.
3. **Nurturing:** Having genuine concern for the well being and growth of the other.
4. **Voluntary giving** process. Loving the other but not passively "falling for" the other.
5. Characteristic of **relationships in general**, not a discriminating, elusive, personal quality.
6. Love that results from **strength**, *not from a need to be loved in return, or wish to escape from loneliness, or a desire to feel complete, or to validate one's existence as a worthwhile human being.*
7. **Caring** for the other's concerns and well-being is **reciprocal.**
8. **Rewards** for caring are an **aftereffect**, not a motivating factor.

MASLOW'S CRITERIA FOR SELF-ACTUALIZED LOVE

HIERARCHY OF BASIC NEEDS

1. **Growth-oriented**
   a. Individuals are self-sufficient, not dependent upon surroundings to achieve feelings of self-worth.
   b. Their identity - who they are and what they stand for - is determined by internal precepts.
   c. Individuals do not relate to others as sources of validation or suppliers of love.
   d. Views others as unique and complex persons.
2. **Deficiency-oriented**
   a. Individuals who are deprived have failed to satisfy some of their needs.
   b. They are often needy and dependent.
   c. Governed by feelings of inadequacy.
   d. Views others in a utilitarian mode of what purpose and use the other may provide.
   e. Characteristics that are not relevant to satisfying some need are either ignored or viewed as a threat.

DISTINCTLY DIFFERENT KINDS OF LOVING

1. **Deficient–love**
   a. Selfish and based upon need.
   b. Characterized by possessiveness and need to control.
   c. Underlying hostility and anxiety characterized by jealousy, manipulation and obsessive guardedness.
2. **Actualized–love**
   a. Emanates from profound sense of security, autonomy and feeling of self-worth.

Maslow's Criteria (continued)

b. Involves admiration, nurturing and caring regard.
c. Characterized by *love for* another rather than desperate need of *love from* another.
d. Partner is cherished for themselves and not for what they can provide.
e. Each person has a concern for the others' well-being and is eager to help.
f. Relationship is characterized by *empathy for the other.*
g. Both members feel admiration and exaltation in the success and achievements of the other.
h. Instead of needing to be together, both people want to be together.

BUBER'S VIEW OF LOVE AS "I-THOU"

FUNDAMENTAL CONDITION

1. *Relatedness: Relationship with another* is primary human condition.

"I-IT" RELATEDNESS

1. Relationship is between a subject and object, lacking mutuality.
2. Attitude toward partner is objective and detached.
3. Involves intellectual and partial identification where one maintains separateness from the other.

"I-THOU" RELATEDNESS

1. Characterized by a profound sense of reciprocity.
2. The other is viewed with the same regard as oneself.
3. Individual exists in the context *of a betweenness with the other in an 'I-Thou' relationship.*
4. "I" is transformed from a disconnected, separated "I" to a fully integrated consciousness with the other.

LOVE AS "I-THOU"

1. *Both participants* lose themselves to the encounter.
2. One cannot live continuously in such a mode, for it is too all-consuming and intense.
3. Out of necessity, people usually live in an "I-It" mode of relatedness.
4. To be fully human one must relate to the other in an "I-Thou" mode, but cannot sustain the intensity.
5. Episodes of "I-Thou" occur as flashes of brilliance against the backdrop of ordinary existence.

MARGINALLY CO-DEPENDENT RELATIONSHIPS

HAPPINESS CONTINGENT ON PARTNER

1. Generally one person "has a problem" (e.g. alcoholism, drug-abuse, compulsive sexual philandering, or depression), and the other person is "out to save them."
2. Extreme instances can degenerate into outright dysfunctional or even toxic relationships.
3. Less severe instances can be viable and at least marginally functional.

NON-ACTUALIZED FUNCTIONAL RELATIONSHIPS

BASIS OF CLASS

DYNAMICS

1. Couple involved can remain together for a lifetime comparatively free of conflict.
2. One or both members of the couple fail to self-actualize fully in that they do not mature to their full emotional potential.

SYMBIOTIC RELATIONSHIP

PARENT-CHILD DEPENDENCY

1. Needy, *insecure person* involved with a *mature, autonomous person*
2. *Mature person* gains great personal satisfaction from caring for *needy person.*
3. *Needy person* feels great emotional relief and satisfaction in being nurtured and loved.

QUASI-SYMBIOTIC RELATIONSHIP

SELF-VALIDATION

1. Nurturing person is non-autonomous and in fact *needs* to be needed in order to validate their self-identity, feel complete, give their life purpose, etc.
   a. Compare to **Sartre's** notion of appropriating the will of another so as to justify one's otherwise superfluous existence.
   b. Compare to **Fromm's** notion of the facade of symbiotic love as pseudo love.

MISGUIDED RELATIONSHIPS

YALOM'S CRITERIA

DEFICIENT RELATIONSHIPS

1. Individuals involved may have actual symptoms of mild to severe emotional maladjustment.
2. *Misguided* in that the individual does not fully relate to the other but rather utilizes the other *as a means* to assuage their feelings of separateness and aloneness.

I. EXISTING IN THE EYES OF OTHERS

1. Attempt to validate and give credence to one's existence by having others recognize, approve of, or simply acknowledge one's presence.
2. Causes for failure:
   a. The other will eventually grow tired of being used to affirm the individual's existence.
   b. The other is unappreciated for themselves, but only in that aspect that serves the purpose of affirming the individual's existence.
   c. The other feels needed but not loved, and dissatisfied when the individual will take love and emotional support; but is unable to reciprocate.
   d. Being unable to love, individual misperceives situation as a problem of being unloved, when it is inability to affirm self that makes them feel this way.
   e. Due to a desperate need for continual affirmation, the individual finds any time alone to be unbearable. If forced into a solitary situation they will attempt to distract their attention by any means available: drugs, alcohol, busy-ness, fantasy and so on.

II. FUSION

Becoming one with, or absorbed into, another person or group of people.

III. SADISM

1. Sadists assuage their existential isolation by domination.
2. Masochists assuage isolation by being dominated.

IV. SEXUAL ADDICTION

By means of compulsive sexuality, the individual is distracted from feelings of existential isolation by relating to another as a mere non-conscious piece of equipment for personal, carnal gratification.

V. POSITIONING

1. Aware of one's existentially deprived state, one searches for a partner whose function will be to satisfy a specific need–the need to be elevated to a higher position on some personal level.
2. *The individual feels inferior in some respect, and uses the perceived superiority of the other to live vicariously at an elevated status.*

SOME MISGUIDED RELATIONSHIPS AND THEIR DYNAMICS

THE DANCE OF DOMINANCE

1. **VARIATION I**
   Two needy, insecure, and dependent individuals become involved in a vicious cycle wherein each seeks to gain the emotional upperhand and dominate the other in order to feel secure.
2. **VARIATION II**
   Two autonomous, independent people become involved wherein each keeps pulling away from the other in order to re-establish their ego-boundary.

DANCE OF THE DISCONNECTED

1. Partner *A* feels most comfortable in a relationship that is carefree with few or no commitments and demands.
2. Partner *B* feels emotionally detached, disconnected, and alienated.
3. *B* pulls away, causing *A* to exhibit feelings of need and vulnerability, which make *B* feel emotionally connected and closer to *A.*

THE ILLUSION OF LOVE REGAINED

1. Individual in the stronger position may escalate demands on the other partner to demonstrate love, commitment and so on.
2. The submissive member delusionally experiences love regained when the controlling member intensifies their dominance.

DYSFUNCTIONAL RELATIONSHIPS

NEUROTIC ATTACHMENT: LYNGZEIDETSON'S CRITERIA

1. Relationship is based upon fear, insecurity, and a desperate need to control, causing individual to display extreme possessiveness and jealousy.
2. One or both persons become *less in the relationship* due to a constant need to validate their self-esteem and affirm their value in the eyes of the other.
3. Fear of rejection, abandonment, or loss causes neurotically attached individual to preserve the relationship at all costs.
4. Individual interprets almost any effort by the other to be autonomous–even just needing space and time to themselves–as a threat or rejection.
5. Individual feels empty, incomplete, and "dead inside" without the presence of the other to mitigate their overwhelming loneliness.
6. Individual cannot tolerate change, wishing to maintain the *status quo.*

NEUROTIC DETACHMENT: LYNGZEIDETSON'S CRITERIA

1. The greater the need for intimacy and love, the more the individual will detach themselves.
2. Wanting the other to commit to them, they are not prepared to reciprocate in kind and wish to maintain their freedom due to predisposing factors.
   a. Overwhelming fear of rejection and abandonment, with the probable weariness of repeating a past negative experience.
   b. Pride and vanity usually rooted in an inferiority complex. Fear of risking possible rejection.
3. Evidence of *profound reaction formation* via declarations of autonomy, independence, and freedom, but experiencing severe separation anxiety if partner starts to withdraw.
4. *Rationalizations* to explain away need for intimacy and commitment.
5. Refusal to accept fault, blame, or responsibility for problems with the relationship.
6. Casting oneself in the role of the "helpless victim" and blaming the other for any problems with the relationship.

CASES OF HOPELESS LOVE:

DYSFUNCTIONAL

Emotional closure and full relatedness is not possible.

LOVE OF THE MISUNDERSTOOD

1. One partner is too immature to fully understand and appreciate the other's concerns, feelings, and thoughts.
2. Typically occurs if one is much older, wiser, more intelligent, or even of a different social or educational status.

THE SADDEST LOVE

1. Kierkegaard opines that the most noble love we may encounter is the love and reverence we feel for a deceased loved one.
2. Pure, unadulterated love characterized by unconditional respect, without reciprocity.

NEUROTIC ATTACHMENT: ADDICTION

THE ADDICTIVE PARADOX

Partners are oftentimes treated as disposable and replaceable commodities. Almost anyone halfway desirable will do as long as they provide love.

THE SENSES OF DUAL-ADDICTION

1. Dependency on the other to provide the love desparately needed for sustenance, and to allay feelings of being alone.
2. Addiction to *the process of falling in love*, craving the emotional highs and extremes of elation and euphoria experienced in falling in love.

THE REASSESSMENT PARADOX

1. Realistic and sensible individual will attempt a sober reassessment of the relationship once the initial euphoria of falling in love diminishes.
2. Addict cannot undergo normal *transition from being in love (which is a transient and intense experience) to loving (an enduring and less intense experience).*
3. Addict fails at reassessment and is perpetually dissatisfied with ordinariness of enduring love. They crave intensity and the highs of falling in love.

THE EMOTIONAL VACUITY OF ADDICTION

Sense of emptiness, aloneness, incompleteness must be incessantly assuaged, anesthetized, and distracted in an attempt *to achieve a sense of completion and wholeness, even if only temporarily.*

THE EXTREME PERVERSION OF ADDICTION

1. Being psychologically incapable of true empathy, understanding, concern, or sympathy *the other is depersonalized and used purely as a means to temporarily avoid one's own sense of worthlessness and psychic emptiness.*
2. Addict refuses to accept inevitability of becoming disillusioned with any partner. Insists there is a yet-to-be found perfect partner who will sustain intense feeling of being in love indefinitely.

TOXIC RELATIONSHIPS: pathological

SADISTIC ATTACHMENT

1. *Very weak, insecure person masks extreme vulnerability by attempting to control, manipulate, and dominate the other.*

SELF DEFEATING EXPECTATIONS

Feeling unworthy and undeserving of love, person continually sabotages relationships, driving their partner away only to conclude–in a self-fulfilling prophecy–that they were left because they are not worth being loved.

TOXIC ATTACHMENT

1. Result of abandonment or neglect as a child.
2. One partner becomes needy, dependent, and clinging, to the point that they emotionally smother and suffocate the other, who in abject desperation to regain their "space," is driven away.
3. The needy partner fears abandonment, engages in pre-emptive sabotage of the relationship in order to avoid getting too close.

SOME FUNDAMENTAL DILEMMAS

COMMITMENT VERSUS FREEDOM

FUNDAMENTAL TENSION

Need for security, stability, predictability and permanence in relationships, and an equally strong yearning for novelty, excitement, and change.

SEX WITH LOVE VERSUS SEX WITHOUT LOVE

LOVING SEXUAL RELATIONSHIP

1. **ADVANTAGES**
   Emotional satisfaction, security and expectation that the relationship will endure when sexual desire and passion diminish.
2. **DISADVANTAGES**
   Some may find emotional involvement to be inhibiting to sexual expression. Confusing lust with love can generate an endless amount of resentment and bitterness.

LOVELESS SEXUAL RELATIONSHIP

1. **ADVANTAGES**
   Feeling more free to express oneself sexually and experiment in this arrangement, gaining greater sexual satisfaction.
2. **DISADVANTAGES**
   Sex not founded on love has a tendency of quickly becoming stale, dull and boring.

EGO-INTEGRITY VERSUS EGO-MALLEABILITY

EMOTIONALLY INDEPENDENT

1. Applies mostly to mature individuals who have become emotionally self-sufficient and autonomous.
2. One may soon succumb to feelings of being overwhelmed by the presence of the other. May feel "invaded" or "violated" and experience difficulty tolerating the necessary compromises and inconveniences that any fully mature relationship requires.

ATTITUDES TOWARD MARRIAGE

THE CAUTIOUS ATTITUDE

Scientific approach, carefully weighing pros and cons, evaluating partner's positive and negative aspects, and making any concessions towards greater intimacy very gradually.

THE LEAP OF FAITH

1. Recognizing that one quickly reaches a point where no amount of evidence will ever be sufficient to absolutely guarantee the success of a lifelong union.
2. Willingness to make a total and unconditional commitment to do whatever is necessary to make the union last, predicated on the absolute conviction that it is right and good, and that the couple will prevail over any difficulties.
3. One chooses to believe that the union will last, and is willing to do anything to preserve it intact.

EMPATHY VERSUS SELF-CENTEREDNESS

Ability of the partners to *be empathetic to one another's needs and feelings,* for enduring success. Evaluating the other's behavior only from one's own selfish perspective is bound to generate negativity and discord.

DSM-IV classifications

PSYCHOLOGY: ABNORMAL

psychological perspective

MENTAL ILLNESS

CRITERIA & DEFINITIONS

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

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

THOMAS SZASZ'S OBJECTION

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

REZNEK'S DEFINITION OF MENTAL ILLNESS

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

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

MEDICAL MODEL

METHODOLOGY

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

CAUSAL FACTORS

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

BASIC TERMINOLOGY

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

CAUSE OF DISORDERS

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

CLASSIFICATION & DIAGNOSIS

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

ASSESSMENT TECHNIQUES

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

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

TREATMENTS

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

ADVANTAGES OF MEDICAL MODEL

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

DISADVANTAGES OF MEDICAL MODEL

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

PSYCHOLOGICAL PERSPECTIVE

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

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

GENERAL CAUSES OF ABNORMALITY

These merely predispose persons to abnormal behavior:

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

OVERVIEW OF PSYCHOLOGICAL SCHOOLS OF THOUGHT

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

PSYCHOANALYTIC PERSPECTIVE

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

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

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

A COMPENDIUM: DEFENSE MECHANISMS

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

THE BEHAVIORAL MODEL

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

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

PARADIGM OF BEHAVIORAL THERAPY

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

LEXICON OF BEHAVIORISTIC TERMINOLOGY

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

TREATMENT METHODOLOGY

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

DIAGNOSTIC CLASSIFICATION OF MENTAL ILLNESS

PROPOSED BIOLOGICAL CAUSES:

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

Causes may be:

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

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

CAUSAL ATTRIBUTIONS

Proposed causal explanations for neuroses include the following:

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

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

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

TREATMENT METHODOLOGY

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

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

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

DSM-IV CLASSIFICATIONS

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

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

DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE

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

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

OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

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

DELIRIUM, DEMENTIA, AMNESTIC & OTHER COGNITIVE DISORDERS

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

MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED

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

SUBSTANCE-RELATED DISORDERS

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

SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS

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

MOOD DISORDERS

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

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

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

ANXIETY DISORDERS

These disorders are frequently characterized by "panic attacks," discrete periods wherein the individual experiences fear, even terror, oftentimes concurrently with feelings of doom. Physiological correlates may include symptoms such as palpitation, shortness of breath, sweating, chest pain, feelings of suffocation, and a feeling of "losing control" and fear of "going crazy." Furthermore, such disorders oftentimes include elements of "agoraphobia," avoidance of, and anxiety about, places or situations, from which escape might be difficult or embarrassing.
- **Panic Disorder Without Agoraphobia:** Manifested by recurrent unexpected panic attacks, about which there is persistent concern. Panic disorder with agoraphobia would include agoraphobia as an additional element.
- **Agoraphobia Without History of Panic Disorder:** Indicated by the occurrence of agoraphobia and panic-like symptoms without a history of unexpected panic attacks.
- **Specific Phobia:** Essential feature includes clinically significant anxiety elicited by the presence of a feared object or situation, often accompanied by avoidance behavior.
- **Social Phobia:** Characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.
- **Obsessive-Compulsive Disorder:** Manifested by obsessions (causing marked anxiety and distress) and/or by compulsions (which serve to neutralize anxiety). The obsessions are frequently specific recurring thoughts, whereas compulsions are repetitious ritualistic behavior, which are performed.
- **Post-Traumatic Stress Disorder:** Manifested by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with trauma.
- **Acute Stress Disorder:** Indicted by symptoms similar to post-traumatic stress disorder, occurring in the immediate aftermath of an extremely traumatic event.
- **Generalized Anxiety Disorder:** Characterized by at least six months of persistent and excessive anxiety and worry.

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

SOMATOFORM DISORDERS

This category encompasses disorders characterized by the presence of observable physical symptoms that are indicative of a general medical condition, yet are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder. The symptoms must cause clinically significant distress or impairment in social, vocational, or other areas of functioning. Furthermore, the symptoms must be unintentional (not under voluntary control). Some subcategories include the following:
- **Conversion Disorder:** Indicated by unexplained symptoms or deficits affecting voluntary motor or sensory functions that suggest a neurological or other general medical condition. Psychological factors are believed to be involved with the symptoms or deficits.
- **Pain Disorder**: Characterized by pain as the predominant focus of clinical attention. Psychological factors are judged to play an important role in the onset, severity, exacerbation or maintenance of the pain.
- **Hypochondriasis:** The preoccupation with the fear of having, or the idea that one is afflicted with, a serious disease based upon the individual's misinterpretation of bodily symptoms or functions.
- **Body Dysmorphic Disorder:** The preoccupation with an exaggerated or imagined effect in physical appearance.

FACTITIOUS DISORDERS

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

DISSOCIATIVE DISORDERS

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

SEXUAL & GENDER IDENTITY DISORDERS

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

SEXUAL DYSFUNCTIONS

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

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

Sexual Arousal Disorders

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

Orgasmic Disorders

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

Sexual Pain Disorders

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

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

Paraphilias

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

GENDER IDENTITY DISORDERS

Two criteria must be satisfied for this diagnosis to apply:

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

EATING DISORDERS

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

SLEEP DISORDERS

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

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

IMPULSE-CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED

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

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

ADJUSTMENT DISORDERS

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

PERSONALITY DISORDERS

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

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

OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

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

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

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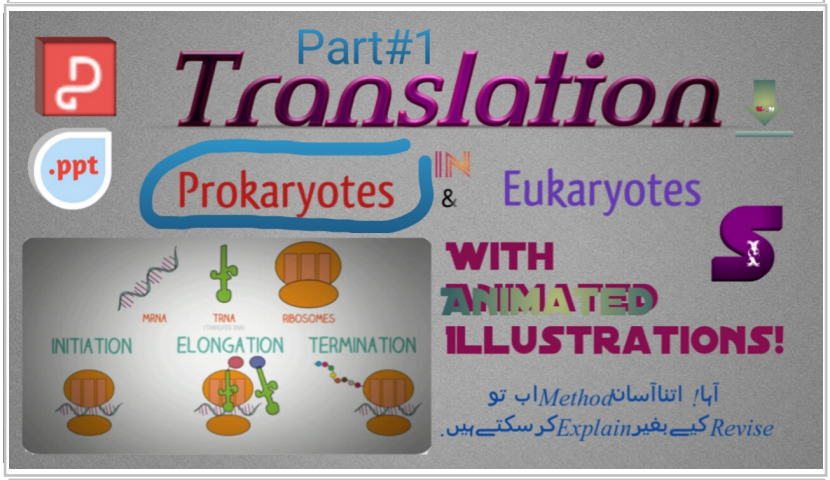

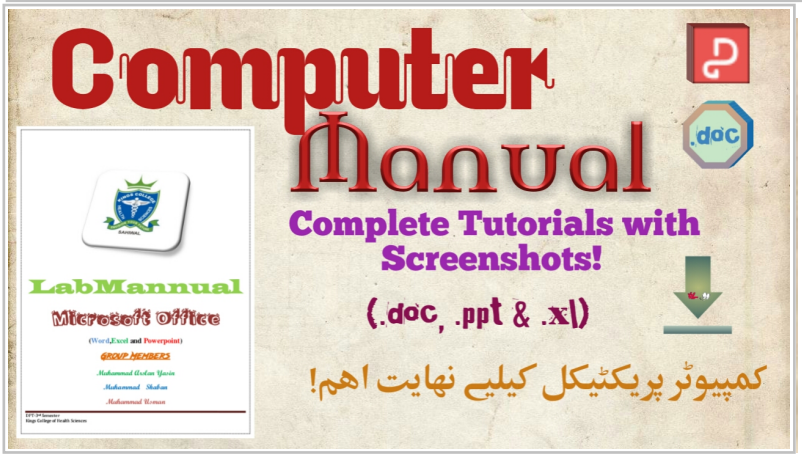

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