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Кафедра иностранных языков

Английский язык для клинических психологов

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What Is a Psychological Disorder?

A psychological disorder, also known as a mental disorder, is a pattern of behavioral or psychological symptoms that impact multiple life areas and/or create distress for the person experiencing these symptoms.

How are Psychological Disorders Diagnosed?

The classification and diagnosis is an important concern for both mental health providers and mental health clients. While there is no single, definitive definition of mental disorders, a number of different classification and diagnostic criteria have emerged. Clinicians utilize the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR), published by the American Psychiatric Association, to determine whether a set of symptoms or behaviors meets the criteria for diagnosis as a psychological disorder. The International Classification of Diseases (ICD-16), published by the World Health Organization, is also frequently used.

What Is the Purpose of Getting a Diagnosis?

While some people may avoid seeking a diagnosis out of fear of social stigma, getting a diagnosis is an essential part of finding an effective treatment plan. A diagnosis is not about applying a label to a problem, it is about discovering solutions, treatments and information related to the problem.

How Prevalent Are Psychological Disorders?

Relatively recent research has revealed that psychological disorders are far more prevalent than previously believed. According to the National Institute of Mental Health (NIMH), approximately 26 percent of American adults over the age of 18 suffer from some type of diagnosable mental disorder in a given year.

The 1994 National Comorbidity Survey (NCS) indicated that 30 percent of respondents had experienced symptoms of at least one psychological disorder in the previous year. The survey also indicated that nearly half of all adults experience some form of mental disorder at some point in their life.

What Are the Different Types of Mental Disorders?

The DSM-IV TR describes approximately 250 different psychological disorders, most of which fall under a category of similar or related disorders. Some of the prominent diagnostic categories include eating disorders, mood disorders, somatoform disorders, sleep disorders, anxiety disorders and personality disorders.

What Is the Diagnostic and Statistical Manual (DSM)?

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revision (DSM-IV-TR) is used by clinicians and psychiatrists to diagnose psychiatric illnesses. The DSM-IV-TR is published by the American Psychiatric Association and covers all categories of mental health disorders for both adults and children. The manual is non-theoretical and focused mostly on describing symptoms as well as statistics concerning which gender is most affected by the illness, the typical age of onset, the effects of treatment, and common treatment approaches.

The DSM-IV was originally published in 1994 and listed more than 250 mental disorders. An updated version, called the DSM-IV-TR, was published in 2000 and contains minor text revision in the descriptions of each disorder. Mental health providers use the manual to better understand a client's potential needs as well as a tool for assessment and diagnosis.

The DSM-IV TR is based on five different dimensions. This multi-axial approach allows clinicians and psychiatrists to make a more comprehensive evaluation of a client's level of functioning, because mental illnesses often impact many different life areas.

- **Axis I: Clinical Syndromes**
This axis describes clinical symptoms that cause significant impairment. Disorders are grouped into different categories, including adjustment disorders, anxiety disorders, and pervasive developmental disorders.
- **Axis II: Personality and Mental Retardation**
This axis describes long-term problems that are overlooked in the presence of Axis I disorders. Personality disorders cause significant problems in how a patient relates to the world and include antisocial personality disorder and histrionic personality disorder. Mental retardation is characterized by intellectual impairment and deficits in other areas such as self-care and interpersonal skills.
- **Axis III: Medical Conditions**
These include physical and medical conditions that may influence or worsen Axis I and Axis II disorders. Some examples may include HIV/AIDS and brain injuries.
- **Axis IV: Psychosocial and Environmental Problems**
Any social or environmental problems that may impact Axis I or Axis II disorders are accounted for in this assessment. These may include such things as unemployment, relocation, divorce, or the death of a loved one.
- **Axis V: Global Assessment of Functioning**
This axis allows the clinician to rate the client's overall level of functioning. Based on this assessment, clinicians can better understand how the other four axes are interacting and the effect on the individual's life.

While the DSM-IV-TR is an important tool, it is important to note that only those who have received specialized training and possess sufficient experience are qualified to diagnose and treat mental illnesses. Clinicians also use the DMS-IV to classify patients for billing purposes, since the government and many insurance carriers require a specific diagnosis in order to approve payment for treatment.

1. Say which of these statements are true or false

| | true | false |
|--|------|-------|
| 1 The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) was published by the World Health Organization | | + |
| 2 Psychological disorders are common | + | |
| 3 The aim of the diagnosis is just to apply a label to a problem | | + |
| 4 2000 mental disorders are described in the DSM-IV TR | | + |
| 5 Only doctors who have received specialized training and possess sufficient experience are qualified to diagnose and treat mental illnesses | + | |
| 6 The DSM IV TR describes mental health disorders only for adults | | + |
| 7 Personality disorders cause significant problems in how a patient relates to the world | + | |
| 8 Psychosocial problems include HIV, AIDS and brain injuries | | + |

Match the terms and the definitions

| | |
|---|--|
| histrionic personality disorder | a pattern of excessive emotions and attention-seeking, including an excessive need for approval, usually beginning in early adulthood |
| adjustment disorders | a short-term condition that occurs when a person is unable to cope with, or adjust to, a particular source of stress, such as a major life change, loss, or event |
| somatoform disorders | a group of disorders characterized by physical symptoms suggesting a medical disorder. |
| social stigma | the extreme disapproval of (or discontent with) a person or group on socially characteristic grounds that are perceived, and serve to distinguish them, from other members of a society. |
| Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) | A manual published by the American Psychiatric Association that provides a common language and standard criteria for the classification of mental disorders. |
| mental disorder | mental illness, arrested or incomplete development of mind, psychopathic disorder, or any other disorder or disability of the mind |
| insurance carrier | a company selling the insurance |
| survey | a critical, detailed, and formal inspection |
| comorbidity | the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases |

Use synonyms for the underlined words

1. Mental illnesses often influence on many different life areas.
2. Mental health providers use the manual to better understand a client's potential needs as well as a tool for evaluation and diagnosis.
3. Those who have sufficient experience are qualified to diagnose and treat mental illnesses.
4. The survey also indicated that nearly half of all adults suffer from some form of mental disorder at some point in their life.
5. Clinicians utilize the DSM-IV TR to find out whether a set of symptoms or behaviors meets the criteria for diagnosis as a psychological disorder.

List and Descriptions of the Categories of Psychological Disorders

The following list of psychological disorders includes the major categories of psychological disorders listed in the Diagnostic and Statistical Manual of Mental Disorders as well as several examples of each type of psychological disorder.

Adjustment Disorders

This classification of mental disorders is related to an identifiable source of stress that causes significant emotional and behavioral symptoms. The DSM-IV diagnostic criteria include:

- (1) Distress that is marked and excessive for what would be expected from the stressor and
- (2) Creates significant impairment in school, work or social environments.

In addition to these requirements, the symptoms must occur within three months of exposure to the stressor, the symptoms must not meet the criteria for an Axis I or Axis II disorder, the symptoms must not be related to bereavement and the symptoms must not last for longer than six months after exposure to the stressor.

Anxiety Disorders

Anxiety disorders are those that are characterized by excessive and abnormal fear, worry and anxiety. In one recent survey published in the Archives of General Psychology, it was estimated that as many as 18% of American adults suffer from at least one anxiety disorder.

Types of anxiety disorders include: Generalized anxiety disorder, Agoraphobia, Social anxiety disorder, Phobias, Panic disorder, Post-traumatic stress disorder, Separation anxiety

Cognitive Disorders

These psychological disorders are those that involve cognitive abilities such as memory, problem solving and perception. Some anxiety disorder, mood disorders and psychotic disorders are classified as cognitive disorders. Types of cognitive disorders include: Alzheimer's disease, Delirium, Dementia, Amnesia

Developmental Disorders

Developmental disorders, also referred to as childhood disorders, are those that are typically diagnosed during infancy, childhood or adolescence. These psychological disorders include: Mental retardation, Learning disabilities, Communication disorders, Autism, Attention-deficit hyperactivity disorder, Conduct disorder, Oppositional defiant disorder

Dissociative Disorders

Dissociative disorders are psychological disorders that involve a dissociation or interruption in aspects of consciousness, including identity and memory. Dissociative disorders include: Dissociative disorder (formerly known as multiple personality disorder, Dissociative fugue, Dissociative identity disorder, Depersonalization disorder

Eating Disorders

Eating disorders are characterized by obsessive concerns with weight and disruptive eating patterns that negatively impact physical and mental health. Types of eating disorders include: Anorexia nervosa, Bulimia nervosa, Rumination disorder

Factitious Disorders

These psychological disorders are those in which an individual acts as if he or she has an illness, often be deliberately faking or exaggerating symptoms or even self-inflicting damage to the body. Types of factitious disorders include: Munchausen syndrome, Munchausen syndrome by proxy, Ganser syndrome

Impulse-Control Disorders

Impulse-control disorders are those that involve an inability to control impulses, resulting in harm to oneself or others. Types of impulse-control disorders include: Kleptomania (stealing), Pyromania (fire-starting), Trichotillomania (hair-pulling), Pathological gambling, Intermittent explosive disorder, Dermatillomania (skin-picking)

Mental Disorders Due to a General Medical Condition

This type of psychological disorder is caused by an underlying medical condition. Medical conditions can cause psychological symptoms such as catatonia and personality changes. Examples of mental disorders due to a general medical condition include: Psychotic disorder due to epilepsy, Depression caused by diabetes, AIDS related psychosis, Personality changes due to brain damage

Mood Disorders

Mood disorder is a term given to a group of mental disorders that are all characterized by changes in mood. Examples of mood disorders include: Bipolar disorder, Major depressive disorder, Cyclothymic disorder

Personality Disorders

Personality disorders create a maladaptive pattern of thoughts, feelings, and behaviors that can cause serious detriments to relationships and other life areas. Types of personality disorders include: Antisocial personality disorder, Avoidant personality disorder, Borderline personality disorder, Dependent personality disorder, Histrionic personality disorder, Narcissistic personality disorder, Obsessive-compulsive personality disorder, Paranoid personality disorder, Schizoid personality disorder, Schizotypal personality disorder

Psychotic Disorders

Psychotic disorders are those that involve a loss of contact with reality. People experiencing psychotic disorders may experience hallucinations and often display disorganized thinking. Delusional beliefs are another common characteristic of this class of psychological disorders. Types of psychotic disorders include: Schizophrenia, Delusional disorder

Sexual and Gender Identity Disorders

Sexual disorders are those that impact sexual functioning, while gender identity disorders are those that involve a discontentment with the biological sex a person was born with. Examples of sexual disorders: Erectile dysfunction, Paraphilias

Sleep Disorders

Sleep disorders involve an interruption in sleep patterns. These disorders can have a negative impact on both physical and mental health. Examples of sleep disorders include: Narcolepsy, Sleep terror disorder, Sleepwalking disorder, Primary insomnia

Somatoform Disorders

Somatoform disorder is a class of psychological disorder that involves physical symptoms that do not have a physical cause. These symptoms usually mimic real diseases or injuries. It is important to note somatoform disorders differ from factitious disorders; people suffering from somatoform disorders are

not faking their symptoms. Conversion disorder, Somatization disorder, Hypochondriasis, Body dysmorphic disorder, Pain disorder

Substance Related Disorders

Substance-related disorders are those that involve the use and abuse of different substance, such as cocaine, methamphetamine, opiates and alcohol. These disorders can include dependence, abuse, psychosis, anxiety, intoxication, delirium and withdrawal that results from the use of various substances. Examples of substance-related psychological disorders include: Alcohol abuse, Caffeine-induced anxiety disorder, Cocaine withdrawal

1. Find the terms for these definitions:

1. an anxiety disorder characterized by anxiety in situations where the sufferer perceives certain environments as dangerous or uncomfortable, often due to the environment's vast openness or crowdedness.
2. a relatively rare form of child abuse that involves the exaggeration or fabrication of illnesses or symptoms by a primary caretaker
3. a severe condition that may develop after a person is exposed to one or more traumatic events, such as serious injury or the threat of death
4. a progressive disease that destroys memory and other important mental functions.
5. an eating disorder characterized by immoderate food restriction and irrational fear of gaining weight, as well as a distorted body self-perception.
6. a mental disorder characterized by at least two distinct and relatively enduring identities or dissociated personality states that alternately control a person's behavior, and is accompanied by memory impairment for important information not explained by ordinary forgetfulness.
7. a behavioral disorder characterized by extreme expressions of anger, often to the point of uncontrollable rage, that are disproportionate to the situation
8. a personality disorder in which the individual is described as being excessively preoccupied with issues of personal adequacy, power, prestige and vanity
9. a chronic neurological disorder caused by the brain's inability to regulate sleep-wake cycles normally
10. an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth, somatic complaints and rumination

2. Say which of these statements are true or false

| | true | false |
|---|------|-------|
| it was estimated that as many as 18% of American adults suffer from at least one eating disorder | | + |
| cognitive disorders are also referred to as childhood disorders | | + |
| factitious disorders are those in which an individual acts as if he or she has an illness, often be deliberately faking or exaggerating symptoms | + | |
| Sleep disorder can have a negative impact on both physical and mental health. | + | |
| people suffering from somatoform disorders are not faking their symptoms. | | + |
| Types of anxiety disorders include: Generalized anxiety disorder, Agoraphobia, Social anxiety disorder, Phobias, Panic disorder, Post-traumatic stress disorder, Autism, Attention-deficit hyperactivity disorder, Separation anxiety | + | |

Phobias

According to the American Psychiatric Association, a phobia is an irrational and excessive fear of an object or situation. In most cases, the phobia involves a sense of endangerment or a fear of harm. For example, those suffering from agoraphobia fear being trapped in an inescapable place or situation.

Symptoms of Phobias

Phobic symptoms can occur through exposure to the fear object or situation, or sometimes simply thinking about the feared object can lead to a response. Common symptoms associated with phobias include: Dizziness; Breathlessness; Nausea; A sense of unreality; Fear of dying

In some cases, these symptoms can escalate into a full-scale anxiety attack. As a consequence of these symptoms, some individuals begin to isolate themselves, leading to severe difficulties in daily life. In other cases, the individual may seek out medical care due to a constant concern with imagined illnesses or imminent death.

Types of Phobias

There are three types of phobias:

1. Social phobias—fear of social situations.
2. Agoraphobia—fear of being trapped in an inescapable place or situation.
3. Specific phobias—fear of a specific object (such as snakes).

There are four major types of specific phobias:

1. The natural environment—fear of lightning, water, storms, etc.
2. Animal—fear of snakes, rodents, spiders, etc.
3. Medical—fear of seeing blood, receiving injections, visiting a doctor, etc.
4. Situational—fear of bridges, leaving the home, driving, etc.

Prevalence of Phobias

Phobias are actually quite common, affecting more than 10% of the U.S. population. Phobias are the most common mental disorder in the United States, but far more women than men are affected by phobias. In many cases, people are able to recognize that their fear is irrational and therefore take steps to overcome their phobia. According to the Diagnostic and Statistical Manual of Mental Disorders, only about 10 percent of reported cases become life-long phobias.

Common Symptoms

Phobias can be divided into three types: specific phobia, social phobia and agoraphobia. Although the symptoms of each type will vary, there are some symptoms common to all phobias. These include:

Terror: A persistent and overwhelming fear of the object or situation.

Physical Symptoms: Dizziness, shaking, palpitations.

Obsessive Thoughts: Difficulty thinking about anything other than the fear.

Desire to Flee: An intense instinct to leave the situation.

Anticipatory Anxiety: Persistent worrying about upcoming events that involve the phobic object or situation.

Medical causes of phobia symptoms

Phobias can be tricky to diagnose, as some physical illnesses can cause symptoms that are very similar to those of a phobia. For example, an allergic reaction to medication can cause sweating, palpitations and other anxiety symptoms. The same symptoms could also be caused by an undiagnosed heart condition. Most of the time, physical illness causes more generalized symptoms of anxiety rather than those that are linked to a specified phobia. However, this is not always the case. Here are a few examples of times when the symptoms of physical illness and phobias may be closely linked.

Fear of Showing Symptoms of an Existing Illness

Many physical illnesses cause symptoms that may be viewed as abnormal or embarrassing. One such example is Parkinson's disease, which can cause tremors and other muscular symptoms.

It is natural for people suffering from such disorders to exhibit fear of their symptoms being noticed in public. If the fear becomes overwhelming and the sufferer limits his or her activities because of the fear (not the disease itself), then it may be diagnosed as a phobia.

Physical Illnesses That Cause Specific Phobias

A few physical illnesses can cause symptoms of specific phobias. Examples include:

- **Photophobia:** Aversion to light. Photophobia is a common symptom of several illnesses including meningitis and certain eye infections or injuries. If photophobia symptoms develop, it is important to rule out possible eye conditions.
 - **Phonophobia:** Fear of loud sounds. Phonophobia may be caused by hyperacusis, which is a physical condition that causes extreme sensitivity to sound.
 - **Osmophobia:** Aversion to odors. This phobia is often seen in migraine sufferers who have experienced odor-induced migraines.
 - **Hydrophobia:** Often confused with aquaphobia (fear of bodies of water), hydrophobia is a specific phobia of drinking water or other fluids. It is a late-stage symptom of rabies.
- Only a trained medical professional can distinguish phobias from physical illnesses. If you are experiencing the symptoms of a phobia, please make an appointment with your health care provider.

Treatments for Phobias

There are a number of treatment approaches for phobias. The effectiveness of a treatment depends on the individual and the type of phobia. These are just a few potential phobia treatments:

In **exposure treatments**, the patient is exposed to the fear object in order to help them overcome their fear. One type of exposure treatment is **flooding**, in which the patient is confronted by the fear object for an extended length of time without the opportunity to escape. The goal of this method is to help the individual face their fear and realize that the fear object will not harm them.

Another method often used in phobia treatment is **counter-conditioning**. In this method, the patient is taught a new response to the fear object. Rather than panic in the face of the feared object or situation, the client learns relaxation techniques to replace anxiety and fear. This new behavior is incompatible with the previous panicked response, so the phobic response gradually fades. Counter-conditioning is often used with patients who are unable to handle exposure treatments.

Match the terms and definitions

| | |
|----------------------|---|
| phobia | an abnormal intense and irrational fear of a given situation, organism, or object |
| To overcome | to surmount (obstacles, objections, etc.) |
| lifelong | lasting for or as if for a lifetime |
| irrational | inconsistent with reason or logic; illogical; absurd |
| agoraphobia | a pathological fear of being in public places, often resulting in the sufferer becoming housebound |
| tremor | an involuntary shudder or vibration, as from illness, fear, shock, etc |
| rabies | an acute infectious viral disease of the nervous system transmitted by the saliva of infected animals, esp dogs. It is characterized by excessive salivation, aversion to water, convulsions, and paralysis |
| palpitation | An abnormality of heartbeat characterized by simultaneous awareness of one's pulse and discomfort |
| dizziness | Felling faint or lightheaded, feeling weak and unsteady |
| Counter-conditioning | A type of therapy based on the principles of classical conditioning that attempts to replace bad or unpleasant emotional responses to a stimulus with more pleasant, adaptive responses |
| Flooding | a method of eliminating anxiety in a given situation, by exposing a person to the situation until the anxiety subsides |

Fill in the gaps with the appropriate words

(4) physical illnesses; (6) phobic symptoms; (1) counter-conditioning; (3) overcome; (2) exposure treatments; (5) life-long;

- In ..., the patient is taught a new response to the fear object.
- In, the patient is exposed to the fear object in order to help them overcome their fear.
- In many cases, people are able to recognize that their fear is irrational and therefore take steps to ... their phobia.
- A few can cause symptoms of specific phobias.
- According to the Diagnostic and Statistical Manual of Mental Disorders, only about 10 percent of reported cases become ... phobias.
- can occur through exposure to the fear object or situation, or sometimes simply thinking about the feared object can lead to a response.

Fill in the table

| symptom | disorder |
|---------|----------|
| | |

Agoraphobia (D), tremor (S), rabies (D), meningitis (D), nausea (S), dizziness (S), palpitation (S), breathlessness (S)

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) can be an extremely debilitating condition that can occur after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that can trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat.

Military troops who served in Vietnam and the Gulf Wars; rescue workers involved in the aftermath of disasters like the Oklahoma City bombing; survivors of accidents, and other crimes; immigrants fleeing violence in their countries; survivors of the 1994 California earthquake, the 1997 South Dakota floods, and hurricanes Hugo and Andrew; and people who witness traumatic events are among those at risk for developing PTSD. Families of victims can also develop the disorder.

Fortunately, through research supported by the National Institute of Mental Health (NIMH) and the Department of Veterans Affairs (VA), effective treatments have been developed to help people with PTSD. Research is also helping scientists better understand the condition and how it affects the brain and the rest of the body. NIMH is conducting a national education program on anxiety disorders, which include PTSD, panic disorder, obsessive-compulsive disorder, social phobia, and generalized anxiety disorder.

What Are the Symptoms of PTSD?

Many people with PTSD repeatedly re-experience the ordeal in the form of flashback episodes, memories, nightmares, or frightening thoughts, especially when they are exposed to events or objects reminiscent of the trauma. Anniversaries of the event can also trigger symptoms. People with PTSD also experience emotional numbness and sleep disturbances, depression, anxiety, and irritability or outbursts of anger. Feelings of intense guilt are also common. Most people with PTSD try to avoid any reminders or thoughts of the ordeal. PTSD is diagnosed when symptoms last more than 1 month.

How Common Is PTSD?

About 3.6 percent of U.S. adults ages 18 to 54 (5.2 million people) have PTSD during the course of a given year. About 30 percent of the men and women who have spent time in war zones experience PTSD. One million war veterans developed PTSD after serving in Vietnam. PTSD has also been detected among veterans of the Persian Gulf War, with some estimates running as high as 8 percent.

When Does PTSD First Occur?

PTSD can develop at any age, including in childhood. Symptoms typically begin within 3 months of a traumatic event, although occasionally they do not begin until years later. Once PTSD occurs, the severity and duration of the illness varies. Some people recover within 6 months, while others suffer much longer.

What Treatments Are Available for PTSD?

Research has demonstrated the effectiveness of cognitive-behavioral therapy, group therapy, and exposure therapy, in which the patient repeatedly relives the frightening experience under controlled conditions to help him or her work through the trauma. Studies have also shown that medications help ease associated symptoms of depression and anxiety and help promote sleep. Scientists are attempting to determine which treatments work best for which type of trauma.

Some studies show that debriefing people very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of 12,000 schoolchildren who lived through a hurricane in Hawaii found that those who got counseling early on were doing much better 2 years later than those who did not.

Do Other Illnesses Tend to Accompany PTSD?

Co-occurring depression, alcohol or other substance abuse, or another anxiety disorder are not uncommon. The likelihood of treatment success is increased when these other conditions are appropriately identified and treated as well.

Headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, or discomfort in other parts of the body are common. Often, doctors treat the symptoms without being aware that they stem from PTSD. NIMH, through its education program, is encouraging primary care providers to ask patients about experiences with violence, recent losses, and traumatic events, especially if symptoms

keep recurring. When PTSD is diagnosed, referral to a mental health professional who has had experience treating people with the disorder is recommended.

Who Is Most Likely to Develop PTSD?

People who have been abused as children or who have had other previous traumatic experiences are more likely to develop the disorder. Research is continuing to pinpoint other factors that may lead to PTSD. It used to be believed that people who tend to be emotionally numb after a trauma were showing a healthy response, but now some researchers suspect that people who experience this emotional distancing may be more prone to PTSD.

What Are Scientists Learning From Research?

NIMH and the VA sponsor a wide range of basic, clinical, and genetic studies of PTSD. In addition, NIMH has a special funding mechanism, called RAPID Grants, that allows researchers to immediately visit the scenes of disasters, such as plane crashes or floods and hurricanes, to study the acute effects of the event and the effectiveness of early intervention.

Studies in animals and humans have focused on pinpointing the specific brain areas and circuits involved in anxiety and fear, which underlie anxiety disorders such as PTSD. Fear, an emotion that evolved to deal with danger, causes an automatic, rapid protective response that occurs without the need for conscious thought. It has been found that the body's fear response is coordinated by a small structure deep inside the brain, called the amygdala.

The amygdala, although relatively small, is a very complicated structure, and recent research suggests that different anxiety disorders may be associated with abnormal activation of the amygdala. One aim of research is to use such basic knowledge to develop new therapies.

The following are also recent research findings:

- Animal studies show that the hippocampus - a part of the brain critical to emotion-laden memories - appears to be smaller in cases of PTSD. Brain imaging studies indicate similar findings in humans. Scientists are investigating whether this is related to short-term memory problems. Changes in the hippocampus are thought to be responsible for intrusive memories and flashbacks that occur in people with this disorder.
- People with PTSD tend to have abnormal levels of key hormones involved in response to stress. Some studies have shown that cortisol levels are lower than normal and epinephrine and norepinephrine are higher than normal.
- When people are in danger, they produce high levels of natural opiates, which can temporarily mask pain. Scientists have found that people with PTSD continue to produce those higher levels even after the danger has passed; this may lead to the blunted emotions associated with the condition.
- Research to understand the neurotransmitter system involved in memories of emotionally charged events may lead to discovery of drugs that, if given early, could block the development of PTSD symptoms.

Match the symptoms and their definition

| | |
|--------------------|---|
| Fear | is an emotion induced by a perceived threat which causes entities to quickly pull far away from it and usually hide |
| Breathlessness | is the subjective sensation of difficult or uncomfortable breathing. |
| Dizziness | is an impairment in spatial perception and stability |
| sweating | is the production of fluids secreted by the sweat glands in the skin of mammals |
| tremor | is a type of shaking movement. It is most often noticed in your hands and arms, but it may affect any body part |
| Obsessive thoughts | are unwelcome involuntary thoughts, images, or unpleasant ideas that may become obsessions, are upsetting or distressing, and can be difficult to manage or eliminate |
| Palpitation | is an abnormality of heartbeat that ranges from often unnoticed skipped beats or accelerated heart rate to very noticeable changes accompanied by dizziness or difficulty breathing |

Say if these statements are true or false

| | true | false |
|---|------|-------|
| 1. In exposure treatments the patient is taught a new response to the feat object. | | + |
| 2. Phonophobia is a fear of loud sounds. | + | |
| 3. Phobias affect over 10% of the US population. | + | |
| 4. It is easy to diagnose phobias and to distinguish them from physical illnesses | | + |
| 5. The effectiveness of a treatment depends on the individual and the type of phobia. | + | |
| 6. There are 3 types of phobias: specific phobia, social phobia and agoraphobia. | | + |
| 7. Symptoms of physical illness and phobias are not closely linked. | | + |

Fill in the gaps with an appropriate word or word combination

| |
|--|
| Trigger (3); exposure therapy (4); likelihood (5); war zones (1); severity (2); amygdala (6) |
|--|

- About 30% of men and women who have spent time in _____ experience PTSD
- Once PTSD occurs, the _____ and duration of the illness varies.
- Anniversaries of the event can also _____ symptoms
- In _____ the patients repeatedly relive the frightening experience under controlled conditions to help them work through the trauma.
- The _____ of treatment success is increased when these other conditions are appropriately identified and treated well.
- It has been found that the body's fear response is coordinated by a small structure deep inside the brain, called the _____.

Fill in the gaps with appropriate figures

- _____ schoolchildren lived through a hurricane in Hawaii
- _____ people have PTSD during the course of a given year in the US.
- _____ percent of people who have spent time in war zones experience PTSD.
- Symptoms begin within _____ months of a traumatic event.
- _____ veterans developed PTSD after serving in Vietnam.

What Is Alzheimer's Disease? What Causes Alzheimer's Disease?

Alzheimer's disease is a progressive neurologic disease of the brain leading to the irreversible loss of neurons and the loss of intellectual abilities, including memory and reasoning, which become severe enough to impede social or occupational functioning. Alzheimer's disease is also known as simply **Alzheimer's**, and **Senile Dementia of the Alzheimer Type (SDAT)** .

During the course of the disease plaques and tangles develop within the structure of the brain. This causes brain cells to die. Patients with Alzheimer's also have a deficiency in the levels of some vital brain chemicals which are involved with the transmission of messages in the brain - neurotransmitters.

Alzheimer's disease is the most common form of dementia. The disease gets worse as it develops - it is a progressive disease. There is no current cure for Alzheimer's, although there are ways of slowing down its advance and helping patients with some of the symptoms. Alzheimer's is also a terminal disease - it is incurable and causes death.

According the National Institute on Aging, there are estimated to be between 2.4 million and 4.5 million Americans who have Alzheimer's. There are approximately 417,000 people in the UK with Alzheimer's, according to the Alzheimer's Society.

Why the name Alzheimer's disease?

Aloysius Alzheimer was a German neuropathologist and psychiatrist. He is credited with identifying the first published case of "presenile dementia" in 1906, which Kraepelin later identified as Alzheimer's disease - naming it after his colleague.

In 1901, while he worked at the city mental asylum in Frankfurt am Main, Germany, Dr. Alzheimer had a 51 year old patient called Mrs. Auguste Deter. The patient had distinct behavioral symptoms which did not fit any existing diagnoses - she had rapidly failing memory, disorientation, confusion, had trouble expressing her thoughts, and was suspicious about her family members and the hospital staff. Her symptoms progressed relentlessly. Dr. Alzheimer wrote that she once said to him "I have lost myself."

Over the coming years Auguste Deter would take up more and more of Dr. Alzheimer's time, to the point of almost becoming an obsession for him. The lady died in 1906 and Dr. Alzheimer, who was working at Kraepelin's lab in Munich, had her patient records and brain sent there.

Along with two Italian doctors, Dr. Alzheimer performed an autopsy. The autopsy revealed that her brain had shrunken dramatically, but there was no evidence of atherosclerosis (thickening and hardening of the walls of the arteries). He used a silver staining technique he had learnt from ex-colleague Franz Nissl which identified amyloid plaques and neurofibrillary tangles in the brain - two hallmarks of the disease.

In November, 1906 Dr. Alzheimer gave the first lecture ever that presented the pathology and the clinical symptoms of presenile dementia together. Kraepelin started using the term Alzheimer's disease, which by 1911 was being used throughout Europe and by European doctors when diagnosing patients in the USA.

Fairly recently, Dr. Alzheimer's findings were reevaluated when his original microscope preparations on which he based his description of the disease were rediscovered in Munich.

A researcher from Prague, Oskar Fischer, and a contemporary of Dr. Alzheimer's, may have described the pathology of dementia in greater depth than did Alzheimer himself, say Czech scientists who have been digging through historical archives in Prague.

What are the symptoms of Alzheimer's disease?

- Doctors say Alzheimer's disease can sometimes be tricky to diagnose because each patient has unique signs and symptoms. Several of the signs and symptoms present in Alzheimer's disease also exist in other conditions and diseases.

Alzheimer's disease is classified into several stages. Some doctors use a 7-stage framework, while others may use a 4, 5 or 6-stage one.

A common framework includes 1. Pre-Dementia Stage. 2. Mild Alzheimer's Stage. 3. Moderate Alzheimer's Stage. 4. Severe Alzheimer's Stage. Most patients take from 8 to 10 years to progress through all stages. However, some may live for 20 years after neuron changes first occur.

Alzheimer's disease and life expectancy

The main reason Alzheimer's disease shortens people's life expectancy is not usually the disease itself, but complications that result from it. As patients become less able to look after themselves, any illnesses they develop, such as an infection, are more likely to rapidly get worse. Caregivers will find it harder and harder to identify complications because the patient becomes progressively less able to tell if he/she is unwell, uncomfortable, or in pain. Pneumonia and pressure ulcers are examples of common complications which may lead to death for people with severe Alzheimer's disease.

What are the causes or risk factors of Alzheimer's Disease?

Although a great deal of research has been done and is currently being done on the possible causes of Alzheimer's, experts are still not sure why the brain cells deteriorate. However, there are several factors which are known to be linked to a higher risk of developing the disease. These include:

- **Age**

After the age of 65 the risk of developing Alzheimer's doubles every five years. Although Alzheimer's is predominantly a disease that develops during old age, some younger people may also develop the condition. According to the Canadian Medical Association Journal the risk of developing Alzheimer's is as follows:

 - Ages 65-74, 1 in 100
 - Ages 75-84, 1 in 14
 - Age over 85, 1 in 4.
- **Family history**

People who have a close family member who developed Alzheimer's have a slightly higher risk of developing it themselves - just a slightly higher risk, not a significantly higher risk. Only about 7% of all cases are associated with genes that cause the early onset inherited familial form of the disease. Among those who do inherit the condition, it may start at an earlier age.
- **Down's syndrome**

People with Down's syndrome have an extra copy of chromosome 21, which contains a protein that exists in the brain of people with Alzheimer's. As people with Down's syndrome have a larger amount of this protein than others, their risk of developing the disease is greater.

How is Alzheimer's diagnosed?

- A doctor can diagnose most cases of Alzheimer's. However, nobody can be 100% sure until after death, when a microscopic examination of the brain detects plaques and tangles. There is no basic testing, such as a blood test, urine test, biopsy, or image scan for diagnosing Alzheimer's disease. A brain scan may help identify changes in the brain.

What is the treatment for Alzheimer's disease?

Alzheimer's is a terminal disease. This means it has no cure and will end in death. However, there are various medications which can help slow down the progression of the disease, and others that can improve the signs and symptoms, such as sleeplessness, wandering, depression, anxiety and agitation.

The doctor may prescribe the following medications to help slow down the disease:

Neurotransmitters - A neurotransmitter is a chemical that transmits neurologic information from one cell to another. Without neurotransmitters our nervous system, which includes the brain, would not work. We would be paralyzed, blind, with no thoughts, no movement - we would be dead.

Match the terms with their definitions

| | |
|------------------|---|
| irreversible | not able to be reversed; not able to be revoked or repealed; irrevocable |
| Terminal disease | terminating in death |
| reasoning | the act or process of drawing conclusions from facts, evidence, etc |
| neurotransmitter | a chemical by which a nerve cell communicates with another nerve cell or with a muscle |
| tangle | a confused or complicated mass of hairs, lines, fibres, etc., knotted or coiled together |
| plaque | any small abnormal patch on or within the body |
| life expectancy | the statistically determined average number of years of life remaining after a specified age for a given group of individuals |
| complication | a disease or disorder arising as a consequence of another disease |
| Pressure ulcer | a chronic ulcer of the skin and underlying tissues caused by prolonged pressure on the body surface of bedridden patients |
| agitation | a state of excitement, disturbance, or worry |

Say if these statements are true or false

| | true | false |
|---|------|-------|
| 1. During the course of the disease plaques and tangles develop within the structure of the brain. | + | |
| 2. Alzheimer's disease has nothing in common with dementia. | | + |
| 3. Alzheimer's is also a terminal disease - it is incurable | + | |
| 4. Pneumonia and pressure ulcers are examples of common complications which may lead to death for people with severe Alzheimer's disease. | + | |
| 5. Alzheimer's disease does not shorten people's life expectancy | | + |
| 6. After the age of 65 the risk of developing Alzheimer's doubles every two years. | | + |
| 7. Several of the signs and symptoms present in Alzheimer's disease also exist in other conditions and diseases | + | |

Fill in the gaps with the appropriate words

Deteriorate (1); progression (4); brain cells (7); complications (5.2); severe (6); plaques (3.1); inherited (2); life expectancy (5.1); tangles (3.2)

1. Although a great deal of research has been done and is currently being done on the possible causes of Alzheimer's, experts are still not sure why the brain cells
2. Only about 7% of all cases are associated with genes that cause the early onset ... familial form of the disease.
3. Nobody can be 100% sure until after death, when a microscopic examination of the brain detects ... and
4. There are various medications which can help slow down the ... of the disease, and others that can improve the signs and symptoms, such as sleeplessness, wandering, depression, anxiety and agitation.
5. The main reason Alzheimer's disease shortens people's is not usually the disease itself, but ... that result from it.
6. Pneumonia and pressure ulcers are examples of common complications which may lead to death for people with ... Alzheimer's disease.

7. During the course of the disease plaques and tangles develop within the structure of the brain which causes to die.

Dementia

The word **dementia** comes from the Latin de meaning "apart" and mens from the genitive mentis meaning "mind". Dementia is the progressive deterioration in cognitive function - the ability to process thought (intelligence).

Progressive means the symptoms will gradually get worse. The deterioration might be expected from normal aging and is due to damage or disease. Damage could be due to a stroke, while an example of a disease might be Alzheimer's.

Dementia is a set of signs and symptoms

Dementia is a non-specific syndrome in which affected areas of brain function may be affected, such as memory, language, problem solving and attention. Dementia, unlike Alzheimer's, is not a disease in itself. When dementia appears the higher mental functions of the patient are involved initially.

Eventually, in the later stages, the person may not know what day of the week, month or year it is, he may not know where he is, and might not be able to identify the people around him. Dementia is significantly more common among elderly people. However, it can affect adults of any age.

What are the symptoms of dementia?

- **Memory loss** - the patient may forget his way back home from the shops. He may forget names and places. He may find it hard to remember what happened earlier on during the day.
- **Moodiness** - the patient may become more and more moody as parts of the brain that control emotion become damaged. Moods may also be affected by fear and anxiety - the patient is frightened about what is happening to him.
- **Communicative difficulties** - the affected person finds it harder to talk, read and/or write.

As the dementia progresses, the patient's ability to carry out everyday tasks diminishes and he may not be able to look after himself.

Diseases that cause dementia

- **Alzheimer's disease** - This is by far the most common cause of dementia. The chemistry and structure of the brain of a person with Alzheimer's disease changes and his brain cells die prematurely.
- **Stroke** (Vascular problems) - this means problems with blood vessels (veins and arteries). Our brain needs a good supply of oxygen-rich blood. If this supply is undermined in any way our brain cells could die - causing symptoms of vascular dementia. Symptoms may appear suddenly, or gradually. A major stroke will cause symptoms to appear suddenly while a series of mini strokes will not.
- **Dementia with Lewy bodies** - spherical structures develop inside nerve cells. Brain cells are nerve cells; they form part of our nervous system. These spherical structures in the brain damage brain tissue. The patient's memory, concentration and ability to speak are affected. Dementia with Lewy bodies is sometimes mistaken for Parkinson's disease because the symptoms are fairly similar.
- **Fronto-temporal dementia** - this includes Pick's disease. The front part of the brain is damaged. The patient's behavior and personality are affected first, later his memory changes.
- **Other diseases** - progressive supranuclear palsy, Korsakoff's syndrome, Binswanger's disease, HIV and AIDS, and Creutzfeldt-Jakob disease (CJD). Dementia is also more common among patients who suffer from Parkinson's disease, Huntington's disease, Motor Neurone disease and Multiple Sclerosis. People who suffer from AIDS sometimes go on to develop cognitive impairment.

There are two main categories of dementia

According to most experts, there are two main categories of dementia - cortical and subcortical dementias.

- **Cortical Dementia** - The cerebral cortex is affected. This is the outer layer of the brain. The cerebral cortex is vital for cognitive processes, such as language and memory. Alzheimer's disease is a form of cortical dementia, as is CJD (Creutzfeldt-Jakob disease).
- **Subcortical Dementia** - A part of the brain beneath the cortex (deeper inside) becomes affected or damaged. Language and memory are not usually affected. A patient with subcortical dementia will usually experience changes in his personality, his thinking may slow down, and his attention span may

be shortened. Dementias which sometimes result from Parkinson's disease are subcortical dementias, as are those caused by AIDS and Huntington's disease.

A patient with multi-infarct dementia will have both the cortical and subcortical parts of the brain affected or damaged.

Diagnosis of dementia

Although there are some brief tests, a more reliable diagnosis needs to be carried out by a specialist, such as a geriatric internist, geriatric psychiatrist, neurologist, neuropsychologist or geropsychologist.

The following tests are commonly used:

- **AMTS** (Abbreviated Mental Test Score) A score lower than six out of ten suggests a need for further evaluation.
- **MMSE** (Mini Mental State Examination) A score lower than twenty-four out of thirty suggests a need for further evaluation)
- **3MS** (Modified Mini-Mental State Examination)
- **CASI** (Cognitive Abilities Screening Instrument)

It is important that the patient's score is interpreted in context with his socio-economic, educational and cultural background. The tester must also factor in the patient's present physical and mental state - does the patient suffer from depression, is he in great pain?

Poor physical performance in the very elderly - researchers from the University of California found that people aged at least 90 years who had poor physical performance tend to have a much higher risk of either having or soon developing dementia. They reported their findings in Archives of Neurology, October 2012 issue. They assessed a sample of over-90s for walking, standing up from a chair, standing and controlling balance, and gripping something.

What is the treatment for dementia?

In the majority of cases dementia is incurable. Researchers are making inroads into treatments that may slow down dementia's progress. Cholinesterase inhibitors are frequently administered during the early stages. Cognitive and behavioral therapies may also be useful. Several studies have found that music therapy helps patients with dementia. It is important to remember that the patient's caregiver also needs training and emotional support.

In the USA, Tacrine (Cognex), donepezil (Aricept), galantamine (Razadyne), and rivastigmine (Exelon) have been approved for the treatment of dementia caused by Alzheimer's disease - some physicians prescribe these drugs for vascular dementia as well. Selegiline, which is used for treating Parkinson's disease, has been found to slow down the progress of dementia.

In Canada, a country where two languages are spoken, English and French, researchers found that bilingual people who develop dementia do so four years later than monolingual people who develop dementia. The four year difference prevails even after factoring for such variables as cultural differences, education, employment, gender and immigration.

Anti-psychotics - health authorities around the world are becoming concerned about the over-prescribing of anti-psychotic medications for patients with dementia. UK health authorities reported in October 2012 that reducing the usage of anti-psychotics has been much more difficult than originally estimated. In the United Kingdom, up to 1,800 people with dementia die each year due to this type of medication.

How common is dementia?

- **United Kingdom** - According to a report by the Alzheimer's Society (UK), approximately 700,000 people in the United Kingdom have dementia, out of a total population of about 61 million. Your chances of having dementia are 1 in 100 during your late 60s, this rises to 6 in 100 in your late 70s, and 20 in 100 in your late 80s. As people live longer experts predict dementia will rise significantly. According to predictions, there will be 940,000 people with dementia in the United Kingdom by 2021.

- **Worldwide** - According to a study published in The Lancet, approximately 24.3 million people had dementia worldwide in 2005, with 4.6 million new cases every year. The number of people with dementia will double every two decades and reach 81.1 million by 2040. The rate of increase is expected to be faster in developing countries which have rapidly-growing life expectancies.

Match the terms with their definitions

| | |
|---------------------|---|
| cognition | the mental act or process by which knowledge is acquired, including perception, intuition, and reasoning |
| dementia | a state of serious emotional and mental deterioration, of organic or functional origin |
| geriatric | of or relating to geriatric medicine or to older people |
| To prevail | to be or appear as the most important feature; be prevalent |
| Lewy bodies | abnormal proteins that occur in the nerve cells of the cerebral cortex and the basal ganglia, causing Parkinson's disease and dementia |
| To undermine | to weaken gradually or insidiously |
| stroke | apoplexy; rupture of a blood vessel in the brain resulting in loss of consciousness, often followed by paralysis, or embolism or thrombosis affecting a cerebral vessel |
| multiple sclerosis | a chronic progressive disease of the central nervous system characterized by loss of some of the myelin sheath surrounding certain nerve fibres and resulting in speech and visual disorders, tremor, muscular incoordination, partial paralysis, etc |
| inhibitor | a substance that retards or stops a chemical reaction |
| Parkinson's disease | a progressive chronic disorder of the central nervous system characterized by impaired muscular coordination and tremor |

Fill in the gaps with the appropriate words from the box

Vital (1); elderly (8); geriatric internist (4); aging (3); moods (7); predict (5); prematurely (6); problem solving (2);

1. The cerebral cortex is ... for cognitive processes, such as language and memory.
2. Dementia is a non-specific syndrome in which affected areas of brain function may be affected, such as memory, language, and attention.
3. The deterioration might be expected from normal ... and is due to damage or disease.
4. Although there are some brief tests, a more reliable diagnosis needs to be carried out by a specialist, such as a
5. As people live longer experts ... dementia will rise significantly.
6. The chemistry and structure of the brain of a person with Alzheimer's disease changes and his brain cells die
7. ... may also be affected by fear and anxiety - the patient is frightened about what is happening to him.
8. Dementia is significantly more common among ... people.

Build word partnerships

Lewy(1) Geriatric(2) Vascular(3) Memory(4) Multiple(5) Cognitive(6) Major(7) Problem(8)

Loss(4) sclerosis(5) bodies(1) processes(6) solving(8) stroke(7) dementia(3) psychiatrist(2)

Sleep Disorders

According to the American Psychiatric Association, sleep disorders are major disturbances of normal sleep patterns that lead to distress and disrupt functioning during the day. Not only are sleep disorders extremely common, affecting virtually everyone at some point in their lives, but they can also lead to serious stress and other health consequences.

According to a major survey by the National Sleep Foundation, more than half of Americans reported experiencing at least one symptom of insomnia several times a week during the previous year.

Highlighting another major danger of sleep disorders, the survey also reported that 60 percent of respondents had driven while drowsy during the previous year.

Insomnia:

Insomnia is by far the most common sleep disorder, affecting nearly 60 percent of U.S. adults at least one night each week. Common symptoms of insomnia include difficulty getting to sleep and waking before it is time to get up. There are many factors that can contribute to insomnia including stress and underlying medical conditions. Typical treatments include sleeping pills and behavior therapy. Practicing good sleep habits can often be effective for treating mild cases of insomnia.

Sleep Apnea:

Sleep apnea is the second most common sleep disorder and affects approximately 20 million Americans. This disorder causes people to stop breathing abruptly while they are asleep. During this brief period, carbon dioxide builds up in the blood and the sleeper wakes suddenly to gasp for breath. The length of time that the sleeper stop breathing can vary from a few seconds to so long that the individuals skin actually turns blue from oxygen deprivation.

Sleepwalking & Night Terrors:

While insomnia and sleep apnea are more common in adults, other sleep disorders such as sleepwalking and night terrors are far more common in young children. Sleepwalking, also known as somnambulism, is characterized by periods of getting out of bed while asleep.

Night terrors are most frequently seen in very young children (between the ages of 2 and 6), but people of any age can be affected by this sleep disorder. Typical symptoms include excessive sweating, shaking and obvious fear.

What Is Narcolepsy?

Excessive Sleepiness May Be Due to Neurologic Condition

Narcolepsy is a neurologic condition that results in excessive daytime sleepiness and other symptoms due to a failure to regulate the states of sleep and wakefulness. This failure results in abrupt transitions from one state into the other. This may lead to sudden weakness while awake (called cataplexy) or even complete paralysis, as would normally occur to prevent a person from acting out her dreams.

Unfortunately, when this occurs at inappropriate times it may cause injury.

Additionally, people with narcolepsy may experience intense hallucinations while transitioning to sleep (called hypnagogic hallucinations) as the brain generates dreams while the narcoleptic remains awake.

Although only one in three people with narcolepsy will have all four symptoms, these four defining features are characteristic of the disorder. Cataplexy is not known to occur in any other disorder, so its presence is very helpful in identifying narcolepsy as the cause of the other symptoms.

How Common is Narcolepsy?

Narcolepsy was first described by the French physician Jean Gelineau in 1880. It is now thought to affect about 1 in 2,000 people. The symptoms of narcolepsy usually begin in the teens or early twenties, but it may rarely first occur in children or even the elderly. It affects men as commonly as women.

There may be some ethnic variation, as it is quite uncommon among Israeli Jews (with a prevalence of only 0.002%) and occurs relatively frequently among the Japanese (with a prevalence of 0.15%). A study of 18,000 people in five European countries found an estimated prevalence of 0.047%.

There may be a genetic component to the disorder as narcolepsy can be more commonly found among relatives of people with the disorder. However, the environment seems to have an important role as well (only 25 percent of identical twins will both have the disorder).

What Causes Narcolepsy?

Narcolepsy appears to occur because of a loss of the chemical hypocretin in an area of the brain called the hypothalamus. The nerve cells (or neurons) in the brain that rely on this chemical regulate sleep and alertness. Hypocretin is thought to promote wakefulness and maintain normal muscle tone, so it makes sense that its loss would lead to the sudden weakness seen in cataplexy.

It is thought that the body's immune system, which typically is responsible for fighting infection, may turn against the hypocretin-containing neurons. In narcoleptics, studies have shown that 85 to 95 percent of these neurons are lost. When these cells are damaged, there are frequent, inappropriate transitions between sleep and wakefulness.

Narcolepsy may also be caused by rare lesions within the brain that result because of tumors, strokes, or other insults.

Diagnosis and Treatment of Narcolepsy

If you believe you may be suffering from narcolepsy, it is important to speak with your doctor and a sleep specialist. After a careful evaluation and examination, you may need to undergo other testing to establish the diagnosis of narcolepsy. In general, these tests will include an overnight sleep study called a polysomnogram and a study the next day called a multiple sleep latency test (MSLT).

In addition, there may be laboratory tests (including a genetic test). If your sleep studies are negative but there is still a strong suspicion for narcolepsy, it may be important to test your cerebrospinal fluid for the chemicals orexin and hypocretin.

There is no cure for narcolepsy, but treatments may help to alleviate some of the symptoms. Excessive daytime sleepiness may be alleviated with stimulants such as Ritalin, Provigil, and Nuvigil. A medication called sodium oxybate can effectively treat the sleepiness as well as cataplexy.

If you have narcolepsy, it is best to review the treatment options with your physician to ensure that the appropriate medication is selected to manage your particular symptoms.

Match the terms with their definitions

| | |
|---------------|--|
| sleeping pill | a pill or tablet containing a sedative drug, such as a barbiturate, used to induce sleep |
| To disrupt | to interrupt the progress of smth |
| drowsy | heavy with sleepiness; sleepy |
| insomnia | chronic inability to fall asleep or to enjoy uninterrupted sleep |
| sleepwalking | a condition that is characterized by walking while asleep or in a hypnotic trance |
| night terrors | a condition in which a person, usually a child, suddenly starts from sleep in a state of extreme fear but cannot later remember the incident |
| hypothalamus | a neural control centre at the base of the brain, concerned with hunger, thirst, satiety, and other autonomic functions |
| narcolepsy | a rare condition characterized by sudden and uncontrollable episodes of deep sleep |
| sleeper | a person, animal, or thing that sleeps |
| sweating | the sensible elimination of fluid through the pores of the skin, which is visible as droplets on the skin |

Fill in the gaps in the sentences with the appropriate words from the box

| |
|--|
| Alertness (1); hypothalamus (5); alleviate (6); cataplexy (3); sleep disorder (4); neurons (7); lesions (2); |
|--|

1. The nerve cells (or neurons) in the brain that rely on this chemical regulate sleep and
2. Narcolepsy may also be caused by rare ... within the brain that result because of tumors and strokes.
3. Hypocretin is thought to promote wakefulness and maintain normal muscle tone, so it makes sense that its loss would lead to the sudden weakness seen in
4. Night terrors are most frequently seen in very young children (between the ages of 2 and 6), but people of any age can be affected by this
5. Narcolepsy appears to occur because of a loss of the chemical hypocretin in an area of the brain called the
6. There is no cure for narcolepsy, but treatments may help to ... some of the symptoms.
7. In narcoleptics, studies have shown that 85 to 95 percent of these ... are lost.

Say if these statements are true or false

| | true | false |
|--|------|-------|
| Narcolepsy was first described by the British physician Jean Gelineau in 1880. | | + |
| There may be a genetic component to the disorder as narcolepsy can be more commonly found among relatives of people with the disorder. | + | |
| Narcolepsy may also be caused by rare lesions within the brain that result because of tumors and strokes. | + | |
| Night terrors are never seen in very young children | | + |
| Typical treatments include exercises and reading | | + |
| Additionally, people with narcolepsy may experience intense hallucinations while transitioning to sleep | + | |
| Sleep apnea is the second most common sleep disorder and affects approximately 1 million Americans. | | + |

Dissociative Identity Disorder (Multiple Personality Disorder)

Dissociative identity disorder (previously known as multiple personality disorder) is an effect of severe trauma during early childhood, usually extreme, repetitive physical, sexual, or emotional abuse.

What Is Dissociative Identity Disorder?

Most of us have experienced mild dissociation, which is like daydreaming or getting lost in the moment while working on a project. However, dissociative identity disorder is a severe form of dissociation, a mental process, which produces a lack of connection in a person's thoughts, memories, feelings, actions, or sense of identity. Dissociative identity disorder is thought to stem from trauma experienced by the person with the disorder. The dissociative aspect is thought to be a coping mechanism -- the person literally dissociates himself from a situation or experience that's too violent, traumatic, or painful to assimilate with his conscious self.

What Are the Symptoms of Dissociative Identity Disorder?

Dissociative identity disorder is characterized by the presence of two or more distinct or split identities or personality states that continually have power over the person's behavior. With dissociative identity disorder, there's also an inability to recall key personal information that is too far-reaching to be explained as mere forgetfulness. With dissociative identity disorder, there are also highly distinct memory variations, which fluctuate with the person's split personality.

The "alters" or different identities have their own age, sex, or race. Each has his or her own postures, gestures, and distinct way of talking. Sometimes the alters are imaginary people; sometimes they are animals. As each personality reveals itself and controls the individuals' behavior and thoughts, it's called "switching." Switching can take seconds to minutes to days. When under hypnosis, the person's different "alters" or identities may be very responsive to the therapist's requests.

Along with the dissociation and multiple or split personalities, people with dissociative disorders may experience any of the following symptoms:

- Depression
- Mood swings
- Suicidal tendencies
- Sleep disorders (insomnia, night terrors, and sleep walking)
- Anxiety, panic attacks, and phobias (flashbacks, reactions to stimuli or "triggers")
- Alcohol and drug abuse
- Psychotic-like symptoms (including auditory and visual hallucinations)
- Eating disorders

Other symptoms of dissociative identity disorder may include headache, amnesia, trances, and "out of body experiences." Some people with dissociative disorders have a tendency toward self-persecution, self-sabotage, and even violence (both self-inflicted and outwardly directed). As an example, someone with dissociative identity disorder may find themselves doing things they wouldn't normally do such as speeding, reckless driving, or stealing money from their employer or friend, yet they feel they are being compelled to do it. Some describe this feeling as being a passenger in their body rather than the driver. In other words, they truly believe they have no choice.

What's the Difference Between Dissociative Identity Disorder and Schizophrenia?

Schizophrenia and dissociative identity disorder are often confused, but they are very different.

Schizophrenia is a severe mental illness involving chronic (or recurrent) psychosis, characterized mainly by hearing or seeing things that aren't real (hallucinations) and thinking or believing things with no basis in reality (delusions). People with schizophrenia do not have multiple personalities. Delusions are the most common psychotic symptom in schizophrenia; hallucinations, particularly hearing voices, are apparent in about half of people.

Suicide is a risk with both schizophrenia and dissociative identity disorder, although patients with multiple personalities have a history of suicide attempt more often than other psychiatric patients.

How Does Dissociation Change the Way a Person Experiences Life?

There are several main ways in which the psychological processes of dissociative identity disorder change the way a person experiences living, including the following:

- **Depersonalization.** This is a sense of being detached from one's body and is often referred to as an "out-of-body" experience.
- **Derealization.** This is the feeling that the world is not real or looking foggy or far away.
- **Amnesia.** This is the failure to recall significant personal information that is so extensive it cannot be blamed on ordinary forgetfulness. There can also be micro-amnesias where the discussion engaged in is not remembered, or the content of a meaningful conversation is forgotten from one second to the next.
- **Identity confusion or identity alteration.** Both of these involve a sense of confusion about who a person is. An example of identity confusion is when a person sometimes feels a thrill while engaged in an activity (such as reckless driving, DUI, alcohol or drug abuse) which at other times would be revolting. In addition to these apparent alterations, the person may experience distortions in time, place, and situation.

It is now acknowledged that these dissociated states are not fully-mature personalities, but rather they represent a disjointed sense of identity. With the amnesia typically associated with dissociative identity disorder, different identity states remember different aspects of autobiographical information. There is usually a host personality within the individual, who identifies with the person's real name. The host personality is usually unaware of the presence of other personalities.

What Roles Do the Different Personalities Play?

The distinct personalities may serve diverse roles in helping the individual cope with life's dilemmas. For instance, there's an average of two to four personalities present when the patient is initially diagnosed. Then there's an average of 13 to 15 personalities that can become known over the course of treatment. While unusual, there have been instances of dissociative identity disorder with more than 100 personalities. Environmental triggers or life events cause a sudden shift from one alter or personality to another.

Who Gets Dissociative Identity Disorder?

While the causes of dissociative identity disorder are still vague, research indicates that a combination of environmental and biological factors work together to cause it. As many as 98% to 99% of individuals who develop dissociative disorders have recognized personal histories of recurring, overpowering, and often life-threatening disturbances at a sensitive developmental stage of childhood (usually before age 9). Dissociation may also happen when there has been insistent neglect or emotional abuse, even when there has been no overt physical or sexual abuse. Findings show that in families where parents are frightening and unpredictable, the children may become dissociative.

How Is Dissociative Identity Disorder Diagnosed?

Making the diagnosis of dissociative identity disorder takes time. It's estimated that individuals with dissociative disorders have spent seven years in the mental health system prior to accurate diagnosis. This is common, because the list of symptoms that cause a person with a dissociative disorder to seek treatment is very similar to those of many other psychiatric diagnoses. In fact, many people who have dissociative disorders also have secondary diagnoses of depression, anxiety, or panic disorders.

The DSM-IV provides the following criteria to diagnose dissociative identity disorder:

1. Two or more distinct identities or personality states are present, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.
2. At least two of these identities or personality states recurrently take control of the person's behavior.
3. The person has an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
4. The disturbance is not due to the direct physiological effects of a substance (such as blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (such as complex partial seizures).

What's the Recommended Treatment Plan for Dissociative Identity Disorder?

While there's no "cure" for dissociative identity disorder, long-term treatment is very successful, if the patient stays committed. Effective treatment includes talk therapy or psychotherapy, medications, hypnotherapy, and adjunctive therapies such as art or movement therapy. Because often the symptoms of dissociative disorders occur with other disorders, such as anxiety and depression, dissociative disorder may be treated using the same drugs prescribed for those disorders. A person in treatment for a dissociative disorder might benefit from antidepressants or anti-anxiety medication.

Match the terms with their definitions

| | |
|-------------------|---|
| abuse | improper, incorrect, or excessive use; misuse; maltreatment of a person; injury |
| coping | The human behavioral process for dealing with demands, both internal and external, in situations that are perceived as threats. |
| Mood swing | An extreme or rapid change in mood |
| hallucination | the alleged perception of an object when no object is present, occurring under hypnosis, in some mental disorders, etc |
| split personality | a mental disorder in which an individual's personality appears to have become separated into two or more distinct personalities, each with its own complex organization |
| delusion | a belief held in the face of evidence to the contrary, that is resistant to all reason |
| recurrent | happening or tending to happen again or repeatedly |
| amnesia | a defect in memory, esp one resulting from pathological cause, such as brain damage or hysteria |
| antidepressant | any of a class of drugs used to alleviate depression |
| thrill | an abnormal slight tremor associated with a heart or vascular murmur, felt on palpation |

Say if these statements are true or false

| | true | false |
|--|------|-------|
| Dissociative identity disorder is characterized by the presence of two or more distinct or split identities or personality states that continually have power over the person's behavior. | + | |
| Schizophrenia and dissociative identity disorder are similar | | + |
| As many as 98% to 99% of individuals who develop dissociative disorders have recognized personal histories of recurring, overpowering, and often life-threatening disturbances at a sensitive developmental stage of childhood | + | |
| Nobody who has dissociative disorders also has secondary diagnoses of depression, anxiety, or panic disorders. | | + |
| When under hypnosis, the person's different "alters" or identities may be very responsive to the therapist's requests. | + | |
| Environmental triggers or life events cannot cause a sudden shift from one alter or personality to another. | | + |
| People with schizophrenia do not have multiple personalities. | + | |

Build word partnerships

Suicide (1), panic (2), drug (3), sleep (4), mood (5), multiple (6), visual (7), night (8)

Attack (2), swings (5), terrors (8), personality (6), walking (4), hallucinations (7), attempt (1), abuse (3)

Major depression

Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods.

True clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or longer.

Causes, incidence, and risk factors

The exact cause of depression is not known. Many researchers believe it is caused by chemical changes in the brain. This may be due to a problem with your genes, or triggered by certain stressful events. More likely, it's a combination of both.

Some types of depression run in families. But depression can also occur if you have no family history of the illness. Anyone can develop depression, even kids.

The following may play a role in depression: Alcohol or drug abuse; Certain medical conditions, including underactive thyroid, cancer, or long-term pain; Certain medications such as steroids; Sleeping problems; Stressful life events, such as: Breaking up with a boyfriend or girlfriend; Failing a class; Death or illness of someone close to you; Divorce; Childhood abuse or neglect; Job loss; Social isolation (common in the elderly)

Symptoms

Depression can change or distort the way you see yourself, your life, and those around you.

People who have depression usually see everything with a more negative attitude. They cannot imagine that any problem or situation can be solved in a positive way.

Symptoms of depression can include: Agitation, restlessness, and irritability; Becoming withdrawn or isolated; Difficulty concentrating; Dramatic change in appetite, often with weight gain or loss; Fatigue and lack of energy; Feelings of hopelessness and helplessness; Feelings of worthlessness, self-hate, and guilt; Loss of interest or pleasure in activities that were once enjoyed; Thoughts of death or suicide; Trouble sleeping or too much sleeping; Depression can appear as anger and discouragement, rather than feelings of sadness.

If depression is very severe, there may also be psychotic symptoms, such as hallucinations and delusions.

Signs and tests

Your health care provider will ask questions about your medical history and symptoms. Your answers and certain questionnaires can help your doctor diagnose depression and determine how severe it may be. Blood and urine tests may be done to rule out other medical conditions with symptoms similar to depression.

Treatment

In general, treatments for depression include: Medications called antidepressants; Talk therapy, called psychotherapy

If you have mild depression, you may only need one of these treatments. People with more severe depression usually need a combination of both treatments. It takes time to feel better, but there are usually day-to-day improvements.

If you are suicidal or extremely depressed and cannot function you may need to be treated in a psychiatric hospital.

MEDICATIONS FOR DEPRESSION

Drugs used to treat depression are called antidepressants. Common types of antidepressants include:

- Selective serotonin re-uptake inhibitors (SSRIs), including fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), citalopram (Celexa), and escitalopram (Lexapro).
- Serotonin norepinephrine reuptake inhibitors (SNRIs), including desvenlafaxine (Pristiq), venlafaxine (Effexor), and duloxetine (Cymbalta).

Other medicines used to treat depression include: Tricyclic antidepressants; Bupropion (Wellbutrin); Monoamine oxidase inhibitors

If you have delusions or hallucinations, your doctor may prescribe additional medications.

WARNING: Children, adolescents, and young adults should be watched more closely for suicidal behavior, especially during the first few months after starting medications.

If you do not feel better with antidepressants and talk therapy, you may have treatment-resistant depression. Your doctor will often prescribe higher (but still safe) doses of an antidepressant, or a combination of medications. Lithium (or other mood stabilizers) and thyroid hormone supplements also may be added to help the antidepressants work better.

St. John's wort is an herb sold without a prescription. It may help some people with mild depression.

However, it can change the way other medicines work in your body, including.

CHANGES IN MEDICATIONS

Sometimes, medications that you take for another health problem can cause or worsen depression. Talk to your doctor about all the medicines you take. Your doctor may recommend changing your dose or switching to another drug. Never stop taking your medications without first talking to your doctor.

TALK THERAPY

Talk therapy is counseling to talk about your feelings and thoughts, and help you learn how to deal with them.

Types of talk therapy include:

- Cognitive behavioral therapy teaches you how to fight off negative thoughts. You will learn how to become more aware of your symptoms and how to spot things that make your depression worse. You'll also be taught problem-solving skills.
- Psychotherapy can help you understand the issues that may be behind your thoughts and feelings.
- Joining a support group of people who are sharing problems like yours can also help. Ask your therapist or doctor for a recommendation.

OTHER TREATMENTS FOR DEPRESSION

- Electroconvulsive therapy (ECT) is the single most effective treatment for severe depression and it is generally safe. ECT may improve mood in people with severe depression or suicidal thoughts who don't get better with other treatments. It may also help treat depression in those who have psychotic symptoms.
- Transcranial magnetic stimulation (TMS) uses pulses of energy to stimulate nerve cells in the brain that are believed to affect mood. There is some research to suggest that it can help relieve depression.
- Light therapy may relieve depression symptoms in the winter time. However, it is usually not considered a first-line treatment.

Support Groups

You can often ease the stress of illness by joining a support group whose members share common experiences and problems.

Expectations (prognosis)

Some people with major depression may feel better after taking antidepressants for a few weeks.

However, many people need to take the medicine for 4 - 9 months to fully feel better and prevent the depression from returning.

People who have repeated episodes of depression may need quick and ongoing treatment to prevent more severe, long-term depression. Sometimes people will need to stay on medications for long periods of time.

Complications

People who are depressed are more likely to use alcohol or illegal substances.

Complications of depression also include: Increased risk of health problems; Suicide

Prevention

Do not drink alcohol or use illegal drugs. These substances can make depression worse and might lead to thoughts of suicide.

Take your medication exactly as your doctor instructed. Ask your doctor about the possible side effects and what you should do if you have any. Learn to recognize the early signs that your depression is getting worse.

The following tips might help you feel better: Get more exercise; Maintain good sleep habits; Seek out activities that bring you pleasure; Volunteer or get involved in group activities; Talk to someone you trust about how you are feeling; Try to be around people who are caring and positive

Match the terms with their definitions

| | |
|-------------------|--|
| Blue | melancholy state of mind; depression |
| Down in the dumps | depressed, moody, or unhappy |
| Depression | a mental disorder characterized by extreme gloom, feelings of inadequacy, and inability to concentrate |
| Trigger | to give rise (to); set off |
| Mood | a temporary state of mind or temper |
| Frustration | the prevention or hindering of a potentially satisfying activity |
| irritability | an excessive response to stimuli. It may be demonstrated in behavioral responses to both physiological and behavioral stimuli including environmental, situational, sociological, and emotional stimuli. |
| guilt | the fact or state of having done wrong or committed an offence |
| discouragement | a feeling of having lost hope or confidence |
| Talk therapy | an alternate name for the various forms of psychotherapy that emphasize the importance of the client or patient speaking to the therapist as the main means of expressing and resolving issues |

Match the beginning and the end of the phrase

| | |
|--|--|
| Talk therapy is counseling to talk about your feelings and thoughts, | that may be behind your thoughts and feelings |
| Cognitive behavioral therapy teaches you | how to fight off negative thoughts |
| Never stop taking your medications | without first talking to your doctor |
| Sometimes, medications that you take for another health problem | can cause or worsen depression |
| Electroconvulsive therapy may also help treat depression in those | who have psychotic symptoms. |
| Psychotherapy can help you understand the issues | and help you learn how to deal with them |
| Blood and urine tests may be done | to rule out other medical conditions with symptoms similar to depression |
| People with more severe depression usually | need a combination of both treatments |

Fill in the table

| Risk factors | symptoms | prevention |
|--------------|----------|------------|
| | | |

Fatigue and lack of energy(2); Alcohol or drug abuse(1); Feelings of worthlessness(2); Feelings of hopelessness(2); Sleeping problems(1); Social isolation(1); Certain medications(1); Maintain good sleep habits(3); Irritability(2); Becoming withdrawn(2); Dramatic change in appetite(2); Get more exercise (3); Difficulty concentrating(2);

What Is ADHD

- Attention Deficit Hyperactivity Disorder (ADHD) is a behavioral and developmental disorder.
- ADHD usually becomes apparent during the preschool and early school years.
- Children with ADHD have difficulty paying attention and controlling their behavior.
- Some estimates show that between 3 and 5 percent of children have ADHD, or approximately 2 million children in the United States.
- Based on these estimates, at least one child in a classroom of 25 to 30 children is likely to have ADHD.

History of ADHD

Dr. Heinrich Hoffman in 1845 first described ADHD in a children's book, *The Story of Fidgety Philip*, which contained an accurate description of a child with attention deficit hyperactivity disorder.

In 1902, Sir George F. Still provided the first clinical description of the disorder in a series of papers about a group of children who displayed impulsivity and behavior problems. According to Still, these symptoms were caused by a genetic dysfunction and not by poor parenting. Since that time, a wealth of research on the symptoms, causes and treatments for ADHD has been published.

There are three primary characteristics of ADHD:

1. **Inattention**
2. **Hyperactivity**
3. **Impulsivity**

The symptoms of ADHD usually appear in early childhood, but symptoms are often confused with other disorders or mistaken for normal childhood behaviors. In order for a child to receive appropriate intervention and treatment, it is important that a diagnosis is made by a well-qualified mental health professional.

Recognizing the Symptoms of ADHD

ADHD symptoms such as hyperactivity and impulsiveness tend to appear before inattentiveness. In many cases, symptoms only become apparent in specific situations. For example, a parent might not notice inattentive behavior because it does not cause major problems at home. However, inattentiveness will become more apparent when the child enters school and experiences academic difficulties due to inattentive behavior.

Hyperactivity and impulsivity draw greater notice because these symptoms lead to obvious behavioral problems and more disruptive behavior in school.

Most children display these behaviors at some point, but this behavior could be a sign of ADHD when hyperactivity, distractibility, poor concentration, or impulsivity negatively impact school performance, social functioning, or family life.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), there are three patterns of behavior that indicate ADHD:

1. **Predominantly hyperactive-impulsive type**, who do not exhibit significant inattention.
2. **Predominantly inattentive type**, who do not show significant hyperactive-impulsive behavior, occasionally referred to as ADD.
3. **Combined type**, who display both inattentive and hyperactive-impulsive symptoms.

Signs of Inattention in ADHD

Inattention is one of the aspects of ADHD that sometimes goes unnoticed. Symptoms of hyperactivity and impulsiveness are more obvious because they cause disruptions at home and school. Because inattentive behavior can lead to deficits in school, it is important to recognize these symptoms in order to obtain appropriate treatment.

Some inattentive behaviors that parents and teachers should look out for include:

- Failure to pay attention to details, often making careless mistakes on classwork.
- Difficulty paying attention to the task at hand or easily distracted by extraneous sights and sounds.
- Problems with organization and planning; may often lose items such as schoolwork, pens, books, or personal items.
- Skipping from one activity to the next without finishing previous tasks.

Identifying Inattention

Predominantly Inattentive ADHD can go unnoticed because children with this type of ADHD do not display behavior that is particularly disruptive. According to the National Institute of Mental Health, children with this type of ADHD rarely experience symptoms of impulsivity or hyperactivity. Often described as forgetful or sluggish, children experiencing symptoms of inattention need treatment just as much as those experiencing the more disrupting symptoms of hyperactivity and impulsivity.

How do you distinguish between normal childhood behavior and the symptoms of ADHD? According to the National Institute of Mental Health, children with ADHD may also experience some of the following symptoms of inattention:

Children who are inattentive have a hard time keeping their minds on any one thing and may get bored with a task after only a few minutes. If they are doing something they really enjoy, they have no trouble paying attention. But focusing deliberate, conscious attention to organizing and completing a task or learning something new is difficult.

Homework is particularly hard for these children. They will forget to write down an assignment, or leave it at school. They will forget to bring a book home, or bring the wrong one. The homework, if finally finished, is full of errors and erasures. Homework is often accompanied by frustration for both parent and child.

When children have problems at school or with their behavior, it is often suggested that they have attention deficit hyperactivity disorder and that they should have further testing or evaluation.

These evaluations often begin with parenting and teacher checklists to see if the child has enough symptoms of inattention, and/or hyperactivity and impulsivity to meet the criteria for having ADHD.

While this form can't diagnose a child with ADHD, it can be helpful to guide you to see if your child does need additional testing. When filling out this form, think about your child's behavior over at least the past six months.

Symptoms of Inattention*

Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

Has difficulty sustaining attention in tasks or play activities

Does not seem to listen when spoken to directly

Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace

Has difficulty organizing tasks and activities

Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as homework)

Loses things necessary for tasks or activities (toys, school assignments, pencils, books, or tools)

Is easily distracted by outside stimuli

Is forgetful in daily activities

Symptoms of Hyperactivity

Fidgets with hands or feet or squirms in seat

Leaves seat in classroom or in other situations in which remaining seated is expected

Runs about or climbs too much in situations in which it is inappropriate

Has difficulty playing quietly

Is 'on the go' or acts as if 'driven by a motor'

Talks too much

Symptoms of Impulsivity

Bursts out answers before questions have been completed

Has difficulty waiting his or her turn

Interrupts or intrudes on others (such as butting into conversations or games)

*Symptoms of inattention, hyperactivity and impulsivity are adapted from the DSM-IV diagnostic criteria for ADHD.

Match the terms with their definitions

| | |
|------------------------|--|
| developmental disorder | any condition, such as autism or dyslexia, that appears in childhood and is characterized by delay in the development of one or more psychological functions, such as language skill |
| parenting | the care and upbringing of a child |
| Disruptive behavior | Behaviors that hamper the ability of instructors to teach and students to learn |
| frustration | the prevention or hindering of a potentially satisfying activity |
| attention | the act of concentrating on any one of a set of objects or thoughts |
| on the go | active and energetic |
| fidget | a state of restlessness or unease, esp as expressed in continual motion |
| Impulsivity | Behavior without adequate thought, the tendency to act with less forethought than do most individuals of equal ability and knowledge, or a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions |
| To skip | to omit (intervening matter), as in passing from one part or subject to another |
| sluggish | lacking energy; inactive; slow-moving |

Fill in the gaps with the appropriate words

disruptive behavior (3); frustration (6); sluggish (4); inattentive behavior (1); skipping (7); bored (5); developmental (2)

1. Inattentiveness will become more apparent when the child enters school and experiences academic difficulties due to
2. Attention Deficit Hyperactivity Disorder (ADHD) is a behavioral and ... disorder.
3. Hyperactivity and impulsivity draw greater notice because these symptoms lead to obvious behavioral problems and more in school.
4. Often described as forgetful or ... , children experiencing symptoms of inattention need treatment just as much as those experiencing the more disrupting symptoms of hyperactivity and impulsivity.
5. Children who are inattentive have a hard time keeping their minds on any one thing and may get ... with a task after only a few minutes.
6. Homework is often accompanied by ... for both parent and child.
7. Some inattentive behaviors that parents and teachers should look out for include ... from one activity to the next without finishing previous tasks

Say if these statements are true or false

| | true | false |
|--|------|-------|
| Inattention is one of the aspects of ADHD that sometimes goes unnoticed | + | |
| Inattentive behavior does not lead to deficits in school | | + |
| There is one primary characteristic of ADHD: hyperactivity | | + |
| The evaluations often begin with parenting and teacher checklists to see if the child has enough symptoms of inattention, and/or hyperactivity | + | |
| The symptoms of ADHD usually appear in early adulthood | | + |
| Hyperactivity and impulsivity draw greater notice because these symptoms lead to obvious behavioral problems and more disruptive behavior in school. | + | |

Homework is easy for inattentive children.

+

What is bipolar disorder?

Bipolar disorder, also called manic depression, is a mental illness that is characterized by severe mood swings, repeated episodes of depression, and at least one episode of mania. Bipolar disorder is one kind of mood disorder that afflicts more than 1% of adults in the United States, up to as many as 4 million people. Here are some additional statistics about bipolar disorder:

- Bipolar disorder is the fifth leading cause of disability worldwide.
- The number of individuals with bipolar disorder who commit suicide is 60 times higher than that of the general population.
- People who have bipolar disorder are at a higher risk of also suffering from substance abuse and other mental health problems.
- Males may develop bipolar disorder earlier in life compared to females.
- Blacks are sometimes diagnosed more often with bipolar disorder compared to whites.

What is the history of bipolar disorder?

This disease was formally conceptualized by Emil Kraepelin more than 100 years ago, at which time he described it as manic-depressive insanity. However, mood problems that include depression alternating with symptoms that are now understood to be manic have been referenced in history as long ago as 200 A.D. At that time, this illness, like unipolar depression, was thought to be the result of bad blood, called black bile. In the 19th century, this illness was referred to by terms like biphasic illness, circular insanity, and dual-form insanity. Despite such unfortunate terminology for this disease, bipolar disorder is also known to be associated with significant achievement in some individuals. Many historical figures and current luminaries suffer from this disorder, whose creativity and accomplishments can therefore be an inspiration for current sufferers of bipolar disorder.

What are the types of bipolar disorder?

Bipolar disorder has a number of types, including bipolar type I and bipolar type II disorder. Depending on how rapidly the mood swings occur, the episodes of bipolar disorder can also be classified as mixed (mood disordered episodes that last less than the usual amount of time required for the diagnosis) or rapid cycling (four or more mood disordered episodes per year). About two-fifths of people with bipolar disorder have at least one period of rapid cycling over the course of their lifetime. For every type and duration of the illness, the sufferer experiences significant problems with his or her functioning at school, at work, or socially, may require hospitalization, or may have psychotic symptoms (for example, delusions or hallucinations). The diagnosis of bipolar I disorder requires that the individual has at least one manic episode but does not require a history of major depression. Bipolar II disorder is diagnosed if the person has experienced at least one episode of major depression and at least one episode of hypomania (a milder form of mania).

A mixed episode is defined as a period of time in which both the criteria to diagnose a major depressive episode and a manic episode are fully met, except for the duration requirements of each. The mood problem (manic alternating with depressive symptoms) takes place nearly every day for a total of at least a week.

What are bipolar disorder causes and risk factors?

One frequently asked question about bipolar disorder is if it is hereditary. As with most other mental disorders, bipolar disorder is not directly passed from one generation to another genetically. Rather, it is the result of a complex group of genetic, psychological, and environmental factors. Genetically, bipolar disorder and schizophrenia have much in common, in that the two disorders share a number of the same risk genes. However, both illnesses also have some genetic factors that are unique. Stress has been found to be a significant contributor to the development of most mental illnesses, including bipolar disorder.

What are bipolar disorder symptoms and signs in adults, teenagers, and children?

In order to qualify for the diagnosis of bipolar disorder, a person must experience at least one manic episode. Characteristics of manic episodes must last at least a week (unless it is a mixed episode) and include elevated, expansive, or irritable mood; racing thoughts; pressured speech (rapid, excessive speech); decreased need for sleep; grandiose beliefs (for example, feeling like one has super powers or

superlative talents or faults); tangential speech (repeatedly changing conversational topics to topics that are hardly related); increased goal directed activity; impulsivity and poor judgment.

Symptoms of the manic episode of early onset bipolar disorder tend to include outbursts of anger and rage, as well as irritability, as opposed to the expansive, excessively elevated mood seen in adults. The adolescent with bipolar disorder is more likely to exhibit depression and mixed episodes, with rapid changes in mood. Despite differences in the symptoms of bipolar disorder in teens and children compared to adults, many who are diagnosed with certain kinds of bipolar disorder before adulthood continue to have those symptoms as adults. Symptoms of bipolar disorder in women tend to include more depression and anxiety and a rapid cycling pattern compared to symptoms in men.

Although a major depressive episode is not required for the diagnosis of bipolar disorder, such episodes often alternate with manic episodes. In fact, depression occurs more often than mania in many people with bipolar disorder. Characteristics of depressive episodes include a number of the following symptoms: persistently depressed or irritable mood; decreased interest in previously pleasurable activities; change or problems in appetite, weight, or sleep; agitation or lack of activity; fatigue; feelings of worthlessness; trouble concentrating; thoughts of death or suicidal thoughts, plans or actions.

How is bipolar disorder diagnosed?

In asking questions about mental health symptoms, mental health professionals are often exploring if the individual suffers from depression and/or manic symptoms but also anxiety, substance abuse, hallucinations or delusions, as well as some personality and behavioral disorders. Health care professionals may provide the people they evaluate with a quiz or self-test as a screening tool for bipolar disorder and other mood disorders. Since some of the symptoms of bipolar disorder can also occur in other mental illnesses, the mental health screening is to determine if the individual suffers from bipolar disorder, an anxiety disorder like panic disorder, generalized anxiety disorder, or posttraumatic stress disorder (PTSD). The examiner also explores whether the person with bipolar disorder suffers from other mental illnesses like schizophrenia, schizoaffective disorder, and other psychotic disorders, or a substance abuse, personality, or behavior disorders like attention deficit hyperactivity disorder (ADHD). Any disorder that is associated with sudden changes in behavior, mood, or thinking, like a psychotic disorder, borderline personality disorder, or multiple personality disorder (MPD), may be particularly challenging to distinguish from bipolar disorder. In order to assess the person's current emotional state, health care professionals perform a mental status examination as well.

What illnesses coexist with bipolar disorder?

In addition to providing treatment that is appropriate to the diagnosis, determining the presence of mental illnesses that may co-occur (be co-morbid) with bipolar disorder is important in preventing bad outcomes. For example, people with bipolar disorder are at increased risk of committing suicide, particularly after engaging in previous episodes of cutting or other self-harm. Therefore, mental health care professionals will take care to examine for any warning signs that the person with bipolar disorder is thinking of harming himself or herself or others. Individuals who suffer from this illness, in addition to either alcohol or substance abuse problems or borderline personality disorder, are also at particular risk of committing suicide. People with bipolar disorder are at higher risk of having an anxiety disorder like panic disorder, phobias, generalized anxiety disorder, or obsessive compulsive disorder (OCD).

Psychotherapies

Talk therapy (psychotherapy) is an important part of helping individuals with bipolar disorder achieve the highest level of functioning possible by improving ways of coping with the illness. These interventions are therefore seen by some as being forms of occupational therapy for people with bipolar disorder. Psychotherapy may also engage people with bipolar disorder who prefer to receive treatment without medication. While medications can be quite helpful in alleviating and preventing overt symptoms, they do not address the many complex social and psychological issues that can play a major role in how the person with this disease functions at work, home, and in his or her relationships. Since about 60% of people with bipolar disorder take less than 30% of their medications as prescribed, any supports that can promote compliance with treatment and otherwise promote the health of individuals in this population are valuable.

Psychotherapies that have been found to be effective in treating bipolar disorder include family focused therapy, psycho-education, cognitive therapy, interpersonal therapy, and social rhythm therapy. Family focused therapy involves education of family members about the disorder and how to provide appropriate support (psycho-education) to their loved one. This intervention also includes communication-enhancement training, and teaching family members problem-solving skills training. Psycho-education involves teaching the person with bipolar disorder and their family members about the symptoms of full-blown depressive and manic symptoms, as well as warning signs (for example, change in sleep pattern or appetite, change in activity level or increased irritability) that the person is beginning to experience either mood episode. In cognitive behavioral therapy, the mental health professional works to help the person with bipolar disorder identify, challenge, and decrease negative thinking and otherwise dysfunctional belief systems. The goal of interpersonal therapy tends to be identifying and managing problems the sufferers of bipolar disorder may have in their relationships with others. Social rhythm therapy encourages stability of sleep-wake cycles, with the goal of preventing or alleviating the sleep disturbances often associated with this disorder.

1. Match the terms and definitions

| | |
|-----------------|--|
| Mood swings | an extreme or rapid change in mood |
| Mania | a mental disorder characterized by great excitement and occasionally violent behaviour |
| Depression | a mental disorder characterized by extreme gloom, feelings of inadequacy, and inability to concentrate |
| Hereditary | relating to, or denoting factors that can be transmitted genetically from one generation to another |
| afflict | to cause suffering or unhappiness to; distress greatly |
| Substance abuse | a patterned use of a substance (drug) in which the user consumes the substance in amounts or with methods which are harmful to themselves or others. |
| Black bile | one of the four bodily humours; melancholy |
| Episode | an incident, event, or series of events |

2. Say if these statements are true or false

| | true | false |
|--|------|-------|
| Stress does not influence on the development of mental disorders | | + |
| Symptoms of the manic episode of early onset bipolar disorder tend to include outbursts of anger and rage, as well as irritability | + | |
| In order to qualify for the diagnosis of bipolar disorder, a person must experience at least one manic episode. | + | |
| All people with bipolar disorder have at least one period of rapid cycling over the course of their lifetime. | | + |
| Bipolar disorder is one kind of eating disorder that afflicts more than 1% of adults in the United States | | + |
| Many famous people suffer from this disorder | + | |
| Genetically, bipolar disorder and schizophrenia have nothing in common | | + |

3. Fill in the gaps with appropriate words from the box

a screening tool (4); exhibit (5); bad outcomes (3.2); coping (6); severe mood swings (1); compliance (7); co-morbid (3.1); cycling (2)

- Bipolar disorder, also called manic depression, is a mental illness that is characterized by _____, repeated episodes of depression, and at least one episode of mania
- Depending on how rapidly the mood swings occur, the episodes of bipolar disorder can also be classified as mixed or rapid _____
- In addition to providing treatment that is appropriate to the diagnosis, determining the presence of mental illnesses that may be _____ with bipolar disorder is important in preventing _____
- Health care professionals may provide the people they evaluate with a quiz or self-test as _____ for bipolar disorder and other mood disorders
- The adolescent with bipolar disorder is more likely to _____ depression and mixed episodes, with rapid changes in mood.
- Talk therapy (psychotherapy) is an important part of helping individuals with bipolar disorder achieve the highest level of functioning possible by improving ways of _____ with the illness
- Since about 60% of people with bipolar disorder take less than 30% of their medications as prescribed, any supports that can promote _____ with treatment and otherwise promote the health of individuals in this population are valuable

What are learning disabilities?

Learning disability is a general term that describes specific kinds of learning problems. A learning disability can cause a person to have trouble learning and using certain skills. The skills most often affected are: reading, writing, listening, speaking, reasoning, and doing math.

Learning disabilities (LD) vary from person to person. One person with learning disabilities may not have the same kind of learning problems as another person with learning disabilities. One person may have trouble with reading and writing. Another person with learning disabilities may have problems with understanding math. Still another person may have trouble in each of these areas, as well as with understanding what people are saying.

Researchers think that learning disabilities are caused by differences in how a person's brain works and how it processes information. Children with learning disabilities are not "dumb" or "lazy." In fact, they usually have average or above average intelligence. Their brains just process information differently. The definition of "learning disability" just below comes from the Individuals with Disabilities Education Act (IDEA). The IDEA is the federal law that guides how schools provide special education and related services to children with disabilities.

There is no "cure" for learning disabilities. They are life-long. However, children with learning disabilities can be high achievers and can be taught ways to get around the learning disability. With the right help, children with learning disabilities can and do learn successfully.

IDEA's Definition of "Learning Disability"

Our nation's special education law, the Individuals with Disabilities Education Act, defines a specific learning disability as . . .

". . . a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia."

However, learning disabilities do not include, "...learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage." 34 Code of Federal Regulations §300.7(c)(10)

How common are learning disabilities?

Very common! As many as 1 out of every 5 people in the United States has a learning disability. Almost 3 million children (ages 6 through 21) have some form of a learning disability and receive special education in school. In fact, over half of all children who receive special education have a learning disability (Twenty-fourth Annual Report to Congress, U.S. Department of Education, 2002).

What about school and learning disabilities?

Learning disabilities tend to be diagnosed when children reach school age. This is because school focuses on the very things that may be difficult for the child - reading, writing, math, listening, speaking, reasoning. Teachers and parents notice that the child is not learning as expected. The school may ask to evaluate the child to see what is causing the problem. Parents can also ask for their child to be evaluated. With hard work and the proper help, children with learning disabilities can learn more easily and successfully. For school-aged children (including preschoolers), special education and related services are important sources of help. School staff work with the child's parents to develop an Individualized Education Program, or IEP. This document describes the child's unique needs. It also describes the special education services that will be provided to meet those needs. These services are provided at no cost to the child or family.

Supports or changes in the classroom (sometimes called accommodations) help most students with learning disabilities. Assistive technology can also help many students work around their learning disabilities. Assistive technology can range from "low-tech" equipment such as tape recorders to "high-tech" tools such as reading machines (which read books aloud) and voice recognition systems (which allow the student to "write" by talking to the computer).

It's important to remember that a child's learning disabilities may need help at home as well as in school.

Is there any treatment for learning disabilities?

The most common treatment for learning disabilities is special education. Specially trained educators may perform a diagnostic educational evaluation assessing the child's academic and intellectual potential and level of academic performance. Once the evaluation is complete, the basic approach is to teach learning skills by building on the child's abilities and strengths while correcting and compensating for disabilities and weaknesses. Other professionals such as speech and language therapists also may be involved. Some medications may be effective in helping the child learn by enhancing attention and concentration. Psychological therapies may also be used.

What Is Dyslexia?

As with other learning disabilities, dyslexia is a lifelong challenge that people are born with. This language processing disorder can hinder reading, writing, spelling, and sometimes even speaking. Dyslexia is not a sign of poor intelligence or laziness. It is also not the result of impaired vision. Children and adults with dyslexia simply have a neurological disorder that causes their brains to process and interpret information differently.

Dyslexia occurs among people of all economic and ethnic backgrounds. Often more than one member of a family has dyslexia. According to the National Institute of Child and Human Development, as many as 15 percent of Americans have major troubles with reading.

Much of what happens in a classroom is based on reading and writing. So it's important to identify dyslexia as early as possible. Using alternate learning methods, people with dyslexia can achieve success.

What Are the Effects of Dyslexia?

Dyslexia can affect people differently. This depends, in part, upon the severity of the learning disability and the success of alternate learning methods. Some with dyslexia can have trouble with reading and spelling, while others struggle to write, or to tell left from right. Some children show few signs of difficulty with early reading and writing. But later on, they may have trouble with complex language skills, such as grammar, reading comprehension, and more in-depth writing.

Dyslexia can also make it difficult for people to express themselves clearly. It can be hard for them to use vocabulary and to structure their thoughts during conversation. Others struggle to understand when people speak to them. This isn't due to hearing problems. Instead, it's from trouble processing verbal information. It becomes even harder with abstract thoughts and non-literal language, such as jokes and proverbs.

All of these effects can have a big impact on a person's self-image. Without help, children often get frustrated with learning. The stress of dealing with schoolwork often makes children with dyslexia lose the motivation to continue and overcome the hurdles they face.

What Are the Warning Signs?

The following are common signs of dyslexia in people of different ages. If you or someone you know displays these signs, it doesn't necessarily mean you have a learning disability. But if troubles continue over time, consider testing for dyslexia.

Young Children

School-Age Children

Teenagers & Adults

Trouble with:

Recognizing letters, matching letters to sounds, and blending sounds into speech

Pronouncing words, for example saying "mawn lower" instead of "lawn mower"

Learning and correctly using new vocabulary words

Learning the alphabet, numbers, and days of the week or similar common word sequences

Rhyming

Trouble with:

Mastering the rules of spelling

Remembering facts and numbers

Handwriting or with gripping a pencil

Learning and understanding new skills; instead, relying heavily on memorization

Reading and spelling, such as reversing letters (d,b) or moving letters around (left, felt)

Following a sequence of directions

Trouble with word problems in math

Trouble with:

Reading at the expected level

Understanding non-literal language, such as idioms, jokes, or proverbs

Reading aloud

Organizing and managing time

Trouble summarizing a story

Learning a foreign language

Memorizing

How Is Dyslexia Identified?

Trained professionals can identify dyslexia using a formal evaluation. This looks at a person's ability to understand and use spoken and written language. It looks at areas of strength and weakness in the skills that are needed for reading. It also takes into account many other factors. These include family history, intellect, educational background, and social environment.

Reading and writing are key skills for daily living. However, it is important to also emphasize other aspects of learning and expression. Like all people, those with dyslexia enjoy activities that tap into their strengths and interests. For example, people with dyslexia may be attracted to fields that do not emphasize language skills. Examples are design, art, architecture, engineering, and surgery.

Match the terms with their definitions

| | |
|----------------------|---|
| Learning disability | significant learning problems in an academic area |
| skill | special ability in a task, sport, etc., esp ability acquired by training |
| education | the act or process of acquiring knowledge, esp systematically during childhood and adolescence |
| intelligence | the capacity for understanding; ability to perceive and comprehend meaning |
| dyslexia | a developmental disorder which can cause learning difficulty in one or more of the areas of reading, writing, and numeracy |
| High achievers | those who achieve a goal; In school, they would be students who get high marks, good grades |
| aphasia | a disorder of the central nervous system characterized by partial or total loss of the ability to communicate, esp in speech or writing |
| Assistive Technology | assistive, adaptive, and rehabilitative devices for people with disabilities |
| mental retardation | the condition of having a low intelligence quotient (below 70) |
| reasoning | the act or process of drawing conclusions from facts, evidence, etc |

Put the verbs into the correct form

1. Researchers think that learning disabilities (to cause) by differences in how a person's brain works
2. Children with learning disabilities can (to teach) ways to get around the learning disability
3. IEP also describes the special education services that (to provide) to meet those needs.
4. Psychological therapies may also (to use).
5. Much of what happens in a classroom (to base) on reading and writing
6. Learning disabilities tend (to diagnose) when children reach school age.
7. Other professionals such as speech and language therapists also may (to involve).

Say which of these statements are true, false or not given

| | true | false | N/a |
|---|------|-------|-----|
| children with learning disabilities cannot be high achievers | | + | |
| Supports or changes in the classroom (sometimes called accommodations) help most students with learning disabilities. | + | | |
| The most common treatment for learning disabilities is special education | + | | |
| Children with learning disabilities are lazy. | | + | |
| Dyslexia occurs among people of all economic and ethnic backgrounds | + | | |
| Learning disabilities tend to be diagnosed in adulthood | | + | |
| a child's learning disabilities may need help at home as well as in school | | | + |
| Dyslexia can also make it difficult for people to express themselves clearly | + | | |
| Medication cannot be effective in helping children with LD | | + | |

What is Autism? What Causes Autism?

Autism is known as a complex developmental disability. Experts believe that Autism presents itself during the first three years of a person's life. The condition is the result of a neurological disorder that has an effect on normal brain function, affecting development of the person's communication and social interaction skills.

People with autism have issues with non-verbal communication, a wide range of social interactions, and activities that include an element of play and/or banter.

What is ASD?

ASD stands for **Autism Spectrum Disorder** and can sometimes be referred to as **Autistic Spectrum Disorder**. In this text Autism and ASD mean the same. ASDs are any developmental disabilities that have been caused by a brain abnormality. A person with an ASD typically has difficulty with social and communication skills.

A person with ASD will typically also prefer to stick to a set of behaviors and will resist any major (and many minor) changes to daily activities. Several relatives and friends of people with ASDs have commented that if the person knows a change is coming in advance, and has time to prepare for it; the resistance to the change is either gone completely or is much lower.

Autism is a wide-spectrum disorder

Autism (or ASD) is a wide-spectrum disorder. This means that no two people with autism will have exactly the same symptoms. As well as experiencing varying combinations of symptoms, some people will have mild symptoms while others will have severe ones. Below is a list of the most commonly found characteristics identified among people with an ASD.

Social skills

The way in which a person with an ASD interacts with another individual is quite different compared to how the rest of the population behaves. If the symptoms are not severe, the person with ASD may seem socially clumsy, sometimes offensive in his/her comments, or out of synch with everyone else. If the symptoms are more severe, the person may seem not to be interested in other people at all.

It is common for relatives, friends and people who interact with someone with an ASD to comment that the ASD sufferer makes very little eye contact. However, as health care professionals, teachers and others are improving their ability to detect signs of autism at an earlier age than before, eye contact among people with autism is improving. In many cases, if the symptoms are not severe, the person can be taught that eye contact is important for most people and he/she will remember to look people in the eye.

A person with autism may often miss the cues we give each other when we want to catch somebody's attention. The person with ASD might not know that somebody is trying to talk to them. They may also be very interested in talking to a particular person or group of people, but does not have the same skills as others to become fully involved. To put it more simply, they lack the necessary playing and talking skills.

Empathy - Understanding and being aware of the feelings of others

A person with autism will find it much harder to understand the feelings of other people. His/her ability to instinctively empathize with others is much weaker than other people's. However, if they are frequently reminded of this, the ability to take other people's feelings into account improves tremendously. In some cases - as a result of frequent practice - empathy does improve, and some of it becomes natural rather than intellectual. Even so, empathy never comes as naturally for a person with autism as it does to others.

Having a conversation with a person with autism may feel very much like a one-way trip. The person with ASD might give the impression that he is talking at people, rather than with or to them. He may love a theme, and talk about it a lot. However, there will be much less exchanging of ideas, thoughts, and feelings than there might be in a conversation with a person who does not have autism.

Almost everybody on this planet prefers to talk about himself/herself more than other people; it is human nature. The person with autism will usually do so even more.

Physical contact

A number of children with an ASD do not like cuddling or being touched like other children do. It is wrong to say that all children with autism are like that. Many will hug a relative - usually the mother, father, grandmother, grandfather, teacher, and or sibling(s) - and enjoy it greatly. Often it is a question of practice and anticipating that physical contact is going to happen. For example, if a child suddenly tickles another child's feet, he will most likely giggle and become excited and happy. If that child were to tickle the feet of a child with autism, without that child anticipating the contact, the result might be completely different.

Loud noises, some smells, and lights

A person with autism usually finds sudden loud noises unpleasant and quite shocking. The same can happen with some smells and sudden changes in the intensity of lighting and ambient temperature. Many believe it is not so much the actual noise, smell or light, but rather the surprise, and not being able to prepare for it - similar to the response to surprising physical contact. If the person with autism knows something is going to happen, he can cope with it much better. Even knowing that something 'might' happen, and being reminded of it, helps a lot.

Speech

The higher the severity of the autism, the more affected are a person's speaking skills. Many children with an ASD do not speak at all. People with autism will often repeat words or phrases they hear - an event called echolalia.

The speech of a person with ASD may sound much more formal, compared to other people's speech. Teenagers with Asperger's Syndrome can sometimes sound like young professors. Their intonation may sound flat.

Repetitive behaviors

A person with autism likes predictability. Routine is his/her best friend. Going through the motions again and again is very much part of his/her life. To others, these repetitive behaviors may seem like bizarre rites. The repetitive behavior could be a simple hop-skip-jump from one end of the room to the other, repeated again and again for one, five, or ten minutes - or even longer. Another could be drawing the same picture again and again, page after page.

People without autism are much more adaptable to changes in procedure. A child without autism may be quite happy to first have a bath, then brush his teeth, and then put on his pajamas before going to bed - even though he usually brushes his teeth first. For a child with autism this change, bath first and then teeth, could completely put him/her out, and they may become very upset. Some people believe that helping a child with autism learn how to cope better with change is a good thing, however, forcing them to accept change like others do could adversely affect their quality of life.

A child with autism develops differently

While a child without autism will develop in many areas at a relatively harmonious rate, this may not be the case for a child with autism. His/her cognitive skills may develop fast, while their social and language skills trail behind. On the other hand, his/her language skills may develop rapidly while their motor skills don't. They may not be able to catch a ball as well as the other children, but could have a much larger vocabulary. Nonetheless, the social skills of a person with autism will not develop at the same pace as other people's.

Learning may be unpredictable

How quickly a child with autism learns things can be unpredictable. They may learn something much faster than other children, such as how to read long words, only to forget them completely later on. They may learn how to do something the hard way before they learn how to do it the easy way.

Physical tics and stimming

It is not uncommon for people with autism to have tics. These are usually physical movements that can be jerky. Some tics can be quite complicated and can go on for a very long time. A number of people with autism are able to control when they happen, others are not. People with ASD who do have tics often say that they have to be expressed, otherwise the urge does not stop. For many, going through the tics is enjoyable, and they have a preferred spot where they do them - usually somewhere private and

spacious. When parents first see these tics, especially the convoluted ones, they may experience shock and worry.

Obsessions

People with autism often have obsessions.

The benefits of early intervention for kids with an ASD

Children with an ASD who received early intervention tend to have better brain function, communication skills and overall social behavior compared to ASD children with no early intervention, researchers from the Yale School of Medicine reported in the Journal of Autism and Developmental Disorder (November 2012 issue).

They added that the brains of kids with autism appear to respond well to “pivotal response treatment” if it is provided early on. The program, which requires parental involvement as well as “play” situations, was created specifically for children with autism.

The new technique incorporates learning and development factors which are easy to use with very young children.

Researchers closing in on gene mutations linked to autism

A mutation in the gene that encodes a protein, SynGAP1, severely disrupts how the developing brain circuits organize themselves during a human’s first years of life.

Researchers from The Scripps Research Institute reported in the journal Cell (November 2012 issue) that they are discovering how genetic mutations can be responsible for the behavioral and cognitive problems found in people with an ASD.

SynGAP1 is estimated to cause disabilities in about 1 million people around the world. It is known to be directly involved in raising autism risk.

The authors explained that genetic mutations that cause ASDs generally affect synapses. A significant proportion of children with severe behavioral and intellectual impairments are believed to carry singly mutations in key neurodevelopmental genes.

Head researcher, Prof. Gavin Rumbaugh, said "In this study, we did something no one else had done before. Using an animal model, we looked at a mutation known to cause intellectual disability and showed for the first time a causative link between abnormal synapse maturation during brain development and life-long cognitive disruptions commonly seen in adults with a neurodevelopmental disorder. There are a few genes that can't be altered without affecting normal cognitive abilities.

SynGAP1 is one of the most important genes in cognition - so far, every time a mutation that disrupts the function of SynGAP1 has been found, that individual's brain simply could not develop correctly. It regulates the development of synaptic function like no other gene I've seen."

Flu and persistent fever during pregnancy raise autism risk

If a pregnant woman gets the flu or has a fever that persists for more than one week, there is a greater chance that her offspring will be diagnosed with an ASD by the age of three, researchers from the University of Aarhus, Denmark, reported in the journal Pediatrics (November, 12th, 2012 issue).

The scientists examined data on 96,736 children in Denmark from 1997 to 2003. They found that non-flu respiratory infections, urinary tract infections, genital infections, colds and sinus infections during pregnancy were not associated with a higher risk of autism for the baby.

However, the following illnesses and circumstances did increase the risk of the child later on being diagnosed with an ASD:

- **Influenza during pregnancy** - doubles autism risk for the child
- **Persistent fever during pregnancy** - that lasted for at least one week triples autism risk for the child
- **Antibiotic usage during pregnancy** - slightly raises autism risk for the child

Head researcher, Hjordis Osk Atladottir, MD, PhD, emphasized that autism risk for pregnant mothers who catch the flu or those with a persistent fever should not be alarmed - 98% of those who did become ill in their study went on to give birth to “healthy” babies who never developed an ASD.

1. Match the terms with their definitions

| | |
|-------------------------|--|
| Communication skills | skills in interpersonal processing, listening, observing, speaking, questioning, analyzing, gestures, and evaluating enables collaboration and cooperation |
| brain abnormalities | any atypical feature in brain functioning, structure or biochemical levels |
| echolalia | the tendency to repeat mechanically words just spoken by another person: can occur in cases of brain damage, mental retardation, and schizophrenia |
| cue | a signal or reminder to do something; the part of any sensory pattern that is identified as the signal for a response |
| offensive | unpleasant or disgusting, as to the senses; causing anger or annoyance; insulting |
| neurological disorder | any disorder of the body nervous system. |
| Nonverbal communication | the process of communication through sending and receiving wordless (mostly visual) cues between people. |
| Stimming | carrying out a repetitive body movement, such as hand flapping. |
| clumsy | lacking in skill or physical coordination |

2. Say which of these statements are true or false

| | true | false |
|--|------|-------|
| A child with autism will develop in many areas at a relatively harmonious rate | | + |
| All people with autism have exactly the same symptoms | | + |
| A person with an ASD typically has difficulty with social and communication skills. | + | |
| A person with autism will find it much harder to understand the feelings of other people | + | |
| ASD sufferer makes very good eye contact. | | + |
| if a child suddenly tickles another child's feet with autism, he will most likely giggle and become excited and happy. | | + |
| A person with and ASD will easily accept any major (and many minor) changes to daily activities. | | + |
| A person with autism likes predictability. | + | |
| A person with autism usually finds sudden loud noises unpleasant and quite shocking. | + | |
| ASDs are any developmental disabilities that have been caused by a brain abnormality. | + | |

3. Fill in the gaps with –ing forms

Improving (3) playing (4) experiencing (1) exchanging (6) talking (5) following (7) varying (2)

As well as (1)... (2).... combinations of symptoms, some people will have mild symptoms while others will have severe ones.

As health care professionals, teachers and others are (3).... their ability to detect signs of autism at an earlier age than before, eye contact among people with autism is improving.

ASD sufferers lack the necessary (4).... and (5).... skills.

There will be much less (6).... of ideas, thoughts, and feelings than there might be in a conversation with a person who does not have autism.

The (7).... illnesses and circumstances did increase the risk of the child later on being diagnosed with an ASD

Mental retardation

Mental retardation (MR) is a generalized disorder appearing before adulthood, characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors. It has historically been defined as an Intelligence Quotient score under 70. Once focused almost entirely on cognition, the definition now includes both a component relating to mental functioning and one relating to individuals' functional skills in their environment. As a result, a person with a below-average intelligence quotient may not be considered mentally retarded. **Syndromic mental retardation** is intellectual deficits associated with other medical and behavioral signs and symptoms. Non-syndromic mental retardation refers to intellectual deficits that appear without other abnormalities.

Signs and symptoms

The signs and symptoms of mental retardation are all behavioral. Most people with mental retardation do not look like they have any type of intellectual disability, especially if the disability is caused by environmental factors such as malnutrition or lead poisoning. The so-called "typical appearance" ascribed to people with mental retardation is only present in a minority of cases, all of which involve syndromic mental retardation.

Children with mental retardation may learn to sit up, to crawl, or to walk later than other children, or they may learn to talk later. Both adults and children with mental retardation may also exhibit some or all of the following characteristics:

- Delays in oral language development
- Deficits in memory skills
- Difficulty learning social rules
- Difficulty with problem solving skills
- Delays in the development of adaptive behaviors such as self-help or self-care skills
- Lack of social inhibitors

Children with mental retardation learn more slowly than a typical child. Children may take longer to learn language, develop social skills, and take care of their personal needs, such as dressing or eating. Learning will take them longer, require more repetition, and skills may need to be adapted to their learning level. Nevertheless, virtually every child is able to learn, develop and become a participating member of the community.

In early childhood, mild mental retardation (IQ 50–69, a cognitive ability about half to two-thirds of standard) may not be obvious, and may not be identified until children begin school. Even when poor academic performance is recognized, it may take expert assessment to distinguish mild mental retardation from learning disability or emotional/behavioral disorders. People with mild MR are capable of learning reading and mathematics skills to approximately the level of a typical child aged 9 to 12. They can learn self-care and practical skills, such as cooking or using the local mass transit system. As individuals with mild mental retardation reach adulthood, many learn to live independently and maintain gainful employment.

Moderate mental retardation (IQ 35–49) is nearly always apparent within the first years of life. Speech delays are particularly common signs of moderate MR. People with moderate mental retardation need considerable supports in school, at home, and in the community in order to participate fully. While their academic potential is limited, they can learn simple health and safety skills and to participate in simple activities. As adults they may live with their parents, in a supportive group home, or even semi-independently with significant supportive services to help them, for example, manage their finances. As adults, they may work in a sheltered workshop.

A person with severe or profound mental retardation will need more intensive support and supervision his or her entire life. They may learn some activities of daily living. Some will require full-time care by an attendant.

Diagnosis

According to the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), three criteria must be met for a diagnosis of mental retardation: an IQ below 70, significant

limitations in two or more areas of adaptive behavior (as measured by an adaptive behavior rating scale, i.e. communication, self-help skills, interpersonal skills, and more), and evidence that the limitations became apparent before the age of 18.

It is formally diagnosed by professional assessment of intelligence and adaptive behavior.

IQ below 70

The first English-language IQ test, the Terman-Binet, was adapted from an instrument used to measure potential to achieve developed by Binet in France. Terman translated the test and employed it as a means to measure intellectual capacity based on oral language, vocabulary, numerical reasoning, memory, motor speed and analysis skills. The mean score on the currently available IQ tests is 100, with a standard deviation of 15 (WAIS/WISC-IV) or 16 (Stanford-Binet). Sub-average intelligence is generally considered to be present when an individual scores two standard deviations below the test mean. Factors other than cognitive ability (depression, anxiety, etc.) can contribute to low IQ scores; it is important for the evaluator to rule them out prior to concluding that measured IQ is "significantly below average". Since the diagnosis is not based on IQ scores alone, but must also take into consideration a person's adaptive functioning, the diagnosis is not made rigidly. It encompasses intellectual scores, adaptive functioning scores from an adaptive behavior rating scale based on descriptions of known abilities provided by someone familiar with the person, and also the observations of the assessment examiner who is able to find out directly from the person what he or she can understand, communicate, and such like. This enables diagnosis to avoid the pitfall of the Flynn Effect which is a consequence of a periodic re-calibration of average IQ (usually upwards) affecting the absolute values of the standard deviation causing some people to fall into a different IQ range as-if overnight.

Significant limitations in two or more areas of adaptive behavior

Adaptive behavior, or adaptive functioning, refers to the skills needed to live independently (or at the minimally acceptable level for age). To assess adaptive behavior, professionals compare the functional abilities of a child to those of other children of similar age. To measure adaptive behavior, professionals use structured interviews, with which they systematically elicit information about persons' functioning in the community from people who know them well. There are many adaptive behavior scales, and accurate assessment of the quality of someone's adaptive behavior requires clinical judgment as well. Certain skills are important to adaptive behavior, such as:

- Daily living skills, such as getting dressed, using the bathroom, and feeding oneself
- Communication skills, such as understanding what is said and being able to answer
- Social skills with peers, family members, spouses, adults, and others

Evidence that the limitations became apparent in childhood

This third condition is used to distinguish mental retardation from dementing conditions such as Alzheimer's disease or due to traumatic injuries with attendant brain damage.

Mental Deficiency: Gene Mutations That Affect Learning, Memory In Children Identified

Feb. 6, 2009 — Mental deficiency is the most frequently occurring, yet least understood handicap in children. Even a mild form can lead to social isolation, bullying and require assistance with simple tasks. The most common variety, non-syndromic mental deficiency (NSMD), is defined as affecting an otherwise normal looking child.

With few physical clues in affected children to point researchers towards candidates to study, progress in identifying genetic causes of NSMD has been very slow. Yet that is beginning to change.

Jacques L. Michaud, a geneticist at the Sainte-Justine University Hospital Research Center and the Centre of Excellence in Neuromics of the Université de Montréal, has led a multidisciplinary team which has identified mutations in a novel gene in children with NSMD. Their study is published in today's issue of the New England Journal of Medicine and includes collaborators from McGill University in Canada, the National Institute of Mental Health and the Nathan S Kline Institute in the U.S. and the Université Paris Descartes in France.

"NSMD is a disorder that has many causes," says Dr. Michaud. "By linking this gene to one kind of NSMD, we better understand the causes and we can work towards a way of identifying and treating this incapacitating condition".

The identified mutations affect the function of SYNGAP1, a gene that codes for a protein involved in the development and function of the connections between brain cells, also called synapses. The disruption of this gene has been shown to impair memory and learning in mice.

A new approach

Dr. Michaud's research team hypothesized that new mutations that arise in children - while not present in their parents - may represent a common cause of mental deficiency. "Several observations indicate that new mutations are a frequent cause of neurodevelopmental disorders, but their identification has been difficult because it requires the study of a large fraction of genes, which represents a challenging task," says Dr. Fadi F. Hamdan, first author of the study.

In order to identify these new mutations, the team took advantage of the platform developed by the Synapse to Diseases consortium, based in Montreal, to study 500 synaptic genes in a group of children with unexplained mental deficiency. The team found that three percent of their subjects had new deleterious mutations in the SYNGAP1 gene.

"This discovery illustrates the power of novel technologies that allow researchers to study hundreds of genes in large groups of individuals, and provides validation for the use of such an approach for the exploration of neurodevelopmental disorders," says Dr. Guy A. Rouleau, Director of Sainte-Justine Research Center and Head of the Synapse to Diseases consortium.

Impact of the discovery

Children with mutations in SYNGAP1 show strikingly similar forms of NSMD, with delays in their language and mental development and, in some cases, a mild form of epilepsy. Now that these SYNGAP1 mutations have been linked to NSMD, diagnostic tests can be offered to children with NSMD, and adapted strategies of learning can be developed. Moreover, because of the wealth of knowledge about the function of SYNGAP1, it may also be possible to design targeted pharmacological therapies that would aim at improving cognition and associated complications such as epilepsy.

Match the terms with their definitions

| | |
|-----------------------------------|---|
| cognition | the mental act or process by which knowledge is acquired, including perception, intuition, and reasoning |
| intelligence quotient | a measure of the intelligence of an individual derived from results obtained from specially designed tests. The quotient is traditionally derived by dividing an individual's mental age by his chronological age and multiplying the result by 100 |
| Self care | actions and attitudes which contribute to the maintenance of well-being and personal health and promote human development. |
| malnutrition | lack of adequate nutrition resulting from insufficient food, unbalanced diet, or defective assimilation |
| Interpersonal skills | the life skills we use every day to communicate and interact with other people, both individually and in groups |
| Adaptive behavior | a type of behavior that is used to adjust to another type of behavior or situation. |
| sheltered workshop | an organization or environment that employs people with disabilities separately from others. |
| handicap | any physical disability or disadvantage resulting from physical, mental, or social impairment or abnormality |
| Flynn effect | the substantial and long-sustained increase in both fluid and crystallized intelligence test scores measured in many parts of the world from roughly 1930 to the present day |
| syndromic intellectual disability | intellectual deficits which are associated with other medical and behavioral signs and symptoms |

Fill in the gaps with the words from the box

Participate (3); reach (5); distinguish (1); learn (4); appear (7); measure (2); rule out (6);

1. Even when poor academic performance is recognized, it may take expert assessment to mild mental retardation from learning disability or emotional/behavioral disorders.
2. The first English-language IQ test, the Terman-Binet, was adapted from an instrument used to potential to achieve developed by Binet in France.
3. People with moderate mental retardation need considerable supports in school, at home, and in the community in order to fully.
4. Children with mental retardation may ... to sit up, to crawl, or to walk later than other children, or they may learn to talk later.
5. As individuals with mild mental retardation ... adulthood, many learn to live independently and maintain gainful employment.
6. Factors other than cognitive ability (depression, anxiety, etc.) can contribute to low IQ scores; it is important for the evaluator to ... them prior to concluding that measured IQ is "significantly below average".
7. Non-syndromic mental retardation refers to intellectual deficits that ... without other abnormalities.

Build word partnerships

Mental (1); speech (2); problem solving (3); intelligence (4); learning (5); sheltered (6); cognitive (7); adaptive (8)

Behavior (8); retardation (1); ability (7); quotient (4); skills (3); workshop (6); delays (2);

disability (5)

Munchausen by Proxy Syndrome: A Deadly Disorder

Introduction

When asked what Munchausen by Proxy Syndrome is, most people will draw a blank. They are unaware of this form of abuse that claims the life of nine percent of children that fall victim to it. This paper will discuss the definition of Munchausen by Proxy Syndrome (MBPS), the origin of its name, the symptoms associated with it, the dynamic relationship between the sufferer of the disorder and the physicians caring for the sufferer's child, the causes of this syndrome, and the suggested treatment for it. MBPS is extremely difficult to diagnose, which is why many children die before doctors realize what was actually happening to them. Treatment for this disorder is limited, as well as knowledge and understanding of its causes. For this reason, it is extremely important to raise awareness of Munchausen by Proxy Syndrome and to work towards ensuring that no more children fall victim to illness and death at the hands of their own parents.

Munchausen by Proxy Syndrome Defined

Munchausen by Proxy Syndrome, also called Factitious Disorder by Proxy, is a psychological disorder characterized by a pattern of behavior in which someone, usually a mother, induces physical ailments upon another person, usually her child ("Munchausen by Proxy Syndrome," n.d., p. 1). The mother attempts to gain attention and recognition for herself by putting on the public façade of dedicated and loving mother. However, when alone with her child she will subject them to abuse, both physical and emotional, as she tries to deliberately make them sick. The website "Munchausen by Proxy Survivors Network," offers an extended definition for the disorder:

Children who fall victim to a parent suffering from Munchausen by Proxy Syndrome quite often require extensive emergency medical care, and undergo several unnecessary procedures such as painful surgeries and physical testing. Parents with Munchausen by Proxy Syndrome do not typically appear psychotic and, based on incidents caught on film, are calm and collected when inflicting harm on their children. Victims of Munchausen by Proxy Syndrome range greatly in age. The youngest case known was of a mother intentionally harming her fetus. The older cases involve people inducing illness in adults (Schreier & Libow, 1993, p. 6). With such a wide array of possibilities it is often too late for the victim before the disorder can be diagnosed.

The Origin of the Name

Munchausen Syndrome, a disorder where people fabricate illness in themselves, and Munchausen by Proxy Syndrome were named after an 18th-century German dignitary named Baron von Munchausen. Baron von Munchausen was known for telling "outlandish stories," ("Munchausen by Proxy Syndrome," n.d., p. 1). The name was first used in 1951 by Dr. Richard Asher to describe self-induced illness. It is told that Asher came upon the name Baron Hieronymus Karl Friedrich Freiherr von Munchausen in fictional accounts of his stories published in 1785 (Schreier & Libow, 1993, p.6-7). Because of the correlation between Baron von Munchausen's fictional stories and the exaggerated and made up symptoms of a person with this disorder, the terms Munchausen Syndrome or Munchausen by Proxy Syndrome were adopted as clinical terms describing the two main factitious disorders.

Symptoms of Munchausen by Proxy Syndrome

Munchausen by Proxy Syndrome is quite possibly one of the most difficult disorders to diagnose. For this reason, an unfortunate nine percent of victims to this abuse die (Feldman, 1998, p. 1). Indicators that a parent may be suffering from Munchausen by Proxy Syndrome include but are not limited to a discrepancy between the child's medical records and what actually seems logical to have happened, the child exhibiting symptoms that do not respond to treatment as they were expected to, an illness that only appears or becomes more grave in the presence of the parent, symptoms that disappear in the absence of the perpetrating parent, sickness that resumes once the caretaker is informed that the child is recovering, or similar symptoms found in siblings or family members of the victim (Lasher, 2004, p.1). The induced illness can range anywhere from diabetes to diarrhea. The possibilities are endless, as individuals with this disorder do not conform to feigning any particular illness. Because of the seemingly infinite sicknesses people with Munchausen by Proxy Syndrome have to choose from, it is impossible for doctors

to single out Munchausen Syndrome based solely on the ailment of the patient. This makes it particularly important for medical personnel to recognize the behavioral patterns that individuals with Munchausen by Proxy Syndrome display. A single child suffering from many different illnesses in a short span of time is usually an early indicator that something is not right. Unusual responses to treatment are also factors that can indicate a problem (Schreier & Libow, 1993, p. 15). It is common for victims of this syndrome to exhibit genuine symptoms of illness along with the exaggeration and fabrication of other symptoms. This furthers the difficulty in diagnosing Munchausen by Proxy Syndrome because it makes it difficult for physicians to distinguish the real ailments from the ones which were made up. Another sign that is common among parents with Factitious by Proxy Disorder is their “righteous indignation” when confronted by a doctor about their fictitious accounts of the child’s medical history, or of inducing symptoms in their child. Often the parent will threaten to file a malpractice lawsuit, or may even cause the child to become deathly ill to prove to physicians that she was right about the child’s poor health (Schreier & Libow, 1993, p. 40)

Dynamics of the Mother-Physician Relationship

When a mother (or caregiver) suffers from Munchausen by Proxy Syndrome, she is in a constant effort to mask the life endangering child abuse she commits behind closed doors. Schreier and Libow call this process “mother imposturing.” They define it as a clinical condition that is “a form of relating (here, to a physician) in which lying is the essential mode of interaction,” (1993, p. 84-85). The mother attempts to portray an outward image of perfection. She shows compassion and devotion to her child by giving up much or all of her time to constantly take them to the hospital (Feldman, 1998, p. 1). Though the abuse on the child is the most prevalent aspect of Munchausen by Proxy Syndrome, the real focus of the disorder is on the relationship between the doctor and the parent. When the pediatrician withholds some attention from the mother and her ill child, the symptoms further escalate, as the mother tries harder to gain the attention of the doctor. It is clear that the mother thrives off of any sympathy or attention given to her, especially by a physician.

Causes of Munchausen by Proxy Syndrome

There are various theories regarding the cause of Munchausen Syndrome. Dowdell and Foster theorize that a mother may feel that a sick child can bring her closer to her spouse. It is more likely, however, that mothers suffering from this disorder “have had an emotionally deprived childhood with a high probability of a history of physical abuse,” (n.d., p. 1). The women are most likely depressed and insecure, and channel their personal inadequacies into abusive behavior, which in turn produces gratifying attention for themselves. The environment of a hospital also gives the mother a chance to rid herself of parental responsibility while medical personnel tend to her child. It is common for mothers with this disorder to wander the hospital and speak with other parents. Their sick child helps them establish a common bond with other mothers in the hospital and thus makes the mother feel as if she fits in. According to Schreier and Libow, “longed-for but absent” fathers appear quite often in clinical data (1993, p. 98). If a mother realizes an increasing detachment from the family in the father of her child, she may resort to hurting her child in order to restore cohesiveness in the family. An absent spouse also leaves the mother plenty of time alone with her child to inflict injuries and sickness that she otherwise may not be able to inflict in the presence of her husband.

Treatment of Munchausen by Proxy Syndrome

Knowledge of how to treat Munchausen by Proxy Syndrome is limited. Feldman relays about mothers with MBPS that “virtually all have personality disorders that lead them to behave in odd and even destructive ways, especially when they feel under stress,” (1998, p. 1). It is even more important, then, for these mothers to undergo extensive psychotherapy. In most cases, the mother is fully aware of her behavior but reluctant to openly acknowledge it. She is unaware of the its cause and feels she has no control over her own actions. “The therapist’s task was described as ‘uncover[ing] and interpret[ing] these fantasies and behaviors to the patient’,” (Schreier & Libow, 1993, p. 153). Parents suffering from Munchausen by Proxy Syndrome are highly unlikely to voluntarily attend psychotherapy. It is important for the court system to mandate visits for the sufferer, or the problem will not be assessed and treated. Unfortunately, “very little encouraging data is available on successful therapeutic work with MBPS mothers,” (Schreier & Libow, 1993, p. 162).

Conclusion

Munchausen by Proxy Syndrome is extremely difficult to characterize and diagnose. It manifests in so many different forms that it often goes undetected. It is often difficult for physicians to believe that a mother would intentionally hurt or even kill her own offspring, as it is a mother's job to protect and ensure that her children are protected from all harm. Symptoms of this disorder are often near impossible to distinguish, however, with raised awareness among doctors and nurses, it can be spotted and treated before a child is put in life-threatening jeopardy. There is not nearly enough research on the syndrome to completely understand or pinpoint why some parents suffer from it. It is crucial that in the future some measures for prevention of Munchausen by Proxy syndrome, and more effective ways of treating it are developed.

Match the terms with their definitions

| | |
|---------------|---|
| To inflict | to impose (something unwelcome, such as pain, oneself, etc.); to cause to suffer; afflict (with) |
| ailment | a slight but often persistent illness |
| pattern | a representative sample |
| victim | a person or thing that suffers harm, death, etc., from another or from some adverse act, circumstance, etc |
| factitious | artificial rather than natural; not genuine; sham |
| deliberate | carefully thought out in advance; planned; studied; intentional |
| To undergo | to experience, endure, or sustain |
| To thrive | 1) to grow strongly and vigorously 2) to do well; prosper |
| To perpetrate | to perform or be responsible for (a deception, crime, etc.) |
| compassion | a feeling of distress and pity for the suffering or misfortune of another, often including the desire to alleviate it |

Fill in the gaps with the words from the box

| |
|--|
| Awareness (1.1); physical ailments (5); discrepancy (6); inflicting harm (2); victim (1.2); age (4); attention (3) |
|--|

1. It is extremely important to raise ... of Munchausen by Proxy Syndrome and to work towards ensuring that no more children fall ... to illness and death at the hands of their own parents.
2. Parents with Munchausen by Proxy Syndrome do not typically appear psychotic and, based on incidents caught on film, are calm and collected when ... on their children.
3. It is clear that the mother thrives off of any sympathy or ... given to her, especially by a physician.
4. Victims of Munchausen by Proxy Syndrome range greatly in ...
5. Munchausen by Proxy Syndrome is a psychological disorder characterized by a pattern of behavior in which someone, usually a mother, induces ... upon another person, usually her child
6. Indicators that a parent may be suffering from Munchausen by Proxy Syndrome include but are not limited to a ... between the child's medical records and what actually seems logical to have happened

Say if these statements are true or false

| | true | false |
|---|------|-------|
| Parents suffering from Munchausen by Proxy Syndrome are highly likely to voluntarily attend psychotherapy. | | + |
| A single child suffering from many different illnesses in a short span of time is usually an early indicator that something is not right. | + | |
| It is not common for victims of this syndrome to exhibit genuine symptoms of illness along with the exaggeration and fabrication of other symptoms. | | + |
| Children who fall victim to a parent suffering from Munchausen by Proxy Syndrome quite often require extensive emergency medical care | + | |
| Munchausen by Proxy Syndrome is easy to characterize and diagnose | | + |
| Often the parent will threaten to file a malpractice lawsuit, or may even cause the child to become deathly ill to prove to physicians that she was right about the child's poor health | + | |

Understanding Alcohol Use Disorders and Their Treatment

For many people, drinking alcohol is nothing more than a pleasant way to relax. People with alcohol use disorders, however, drink to excess, endangering both themselves and others. This question-and-answer fact sheet explains alcohol problems and how psychologists can help people recover.

When does drinking become a problem?

For most adults, moderate alcohol use -- no more than two drinks a day for men and one for women and older people -- is relatively harmless. (A "drink" means 1.5 ounces of spirits, 5 ounces of wine, or 12 ounces of beer, all of which contain 0.5 ounces of alcohol.)

Moderate use, however, lies at one end of a range that moves through alcohol abuse to alcohol dependence:

- **Alcohol abuse** is a drinking pattern that results in significant and recurrent adverse consequences. Alcohol abusers may fail to fulfill major school, work, or family obligations. They may have drinking-related legal problems, such as repeated arrests for driving while intoxicated. They may have relationship problems related to their drinking.
- People with **alcoholism** -- technically known as alcohol dependence -- have lost reliable control of their alcohol use. It doesn't matter what kind of alcohol someone drinks or even how much: Alcohol-dependent people are often unable to stop drinking once they start. Alcohol dependence is characterized by tolerance (the need to drink more to achieve the same "high") and withdrawal symptoms if drinking is suddenly stopped. Withdrawal symptoms may include nausea, sweating, restlessness, irritability, tremors, hallucinations, and convulsions.

Although severe alcohol problems get the most public attention, even mild to moderate problems cause substantial damage to individuals, their families, and the community.

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), 1 in 12 American adults is an alcohol abuser or alcoholic. And, says NIAAA, young adults aged 18 to 29 are the most likely to have alcohol problems. For example, a government survey revealed that almost 8 percent of young people aged 12 to 17 and almost 41 percent of young adults aged 18 to 25 indulge in binge drinking -- downing five or more drinks on the same occasion at least once during the past month.

What causes alcohol-related disorders?

Problem drinking has multiple causes, with genetic, physiological, psychological, and social factors all playing a role. Not every individual is equally affected by each cause. For some alcohol abusers, psychological traits such as impulsiveness, low self-esteem, and a need for approval prompt inappropriate drinking. Some individuals drink to cope with or "medicate" emotional problems. Social and environmental factors such as peer pressure and the easy availability of alcohol can play key roles. Poverty and physical or sexual abuse also increase the odds of developing alcohol dependence. Genetic factors make some people especially vulnerable to alcohol dependence. Yet a family history of alcohol problems doesn't mean that children will automatically grow up to have the same problems. Nor does the absence of family drinking problems necessarily protect children from developing these problems.

Once people begin drinking excessively, the problem can perpetuate itself. Heavy drinking can cause physiological changes that make more drinking the only way to avoid discomfort. Individuals with alcohol dependence may drink partly to reduce or avoid withdrawal symptoms.

How do alcohol use disorders affect people?

While some research suggests that small amounts of alcohol may have beneficial cardiovascular effects, there is widespread agreement that heavier drinking can lead to health problems.

Short-term effects include memory loss, hangovers, and blackouts. Long-term problems associated with heavy drinking include stomach ailments, heart problems, cancer, brain damage, serious memory loss, and liver cirrhosis. Heavy drinkers also markedly increase their chances of dying from automobile accidents, homicide, and suicide. Although men are much more likely than women to develop alcoholism, women's health suffers more, even at lower levels of consumption.

Drinking problems also have a very negative impact on mental health. Alcohol abuse and alcoholism can worsen existing conditions such as depression or induce new problems such as serious memory loss, depression, or anxiety.

Alcohol problems don't just hurt the drinker. Spouses and children of heavy drinkers may face family violence; children may suffer physical and sexual abuse and neglect and develop psychological problems. Women who drink during pregnancy run a serious risk of damaging their fetuses. Relatives, friends, and strangers can be injured or killed in alcohol-related accidents and assaults.

When should someone seek help?

Individuals often hide their drinking or deny they have a problem. How can you tell if you or someone you know is in trouble? Signs of a possible problem include having friends or relatives express concern, being annoyed when people criticize your drinking, feeling guilty about your drinking and thinking that you should cut down but finding yourself unable to do so, or needing a morning drink to steady your nerves or relieve a hangover.

Some people with drinking problems work hard to resolve them. With the support of family members or friends, these individuals are often able to recover on their own. However, those with alcohol dependence usually can't stop drinking through willpower alone. Many need outside help. They may need medically supervised detoxification to avoid potentially life-threatening withdrawal symptoms, such as seizures. Once people are stabilized, they may need help resolving psychological issues associated with problem drinking.

There are several approaches available for treating alcohol problems. No one approach is best for all individuals.

How can a psychologist help?

Psychologists who are trained and experienced in treating alcohol problems can be helpful in many ways. Before the drinker seeks assistance, a psychologist can guide the family or others in helping to increase the drinker's motivation to change.

A psychologist can begin with the drinker by assessing the types and degrees of problems the drinker has experienced. The results of the assessment can offer initial guidance to the drinker about what treatment to seek and help motivate the problem drinker to get treatment. Individuals with drinking problems improve their chances of recovery by seeking help early.

Using one or more of several types of psychological therapies, psychologists can help people address psychological issues involved in their problem drinking. A number of these therapies, including cognitive-behavioral coping skills treatment and motivational enhancement therapy, were developed by psychologists.

These therapies can help people boost their motivation to stop drinking, identify circumstances that trigger drinking, learn new methods to cope with high-risk drinking situations, and develop social support systems within their own communities.

All three of these therapies have demonstrated their effectiveness. One analysis of cognitive-behavioral approaches, for instance, found that 58 percent of patients receiving cognitive-behavioral treatment fared better than those in comparison groups. In another study, motivational interventions reduced how often and how much adolescents drank following alcohol-related emergency room treatment. And an intervention called Making Alcoholics Anonymous Easier significantly increased participants' odds of abstaining from alcohol. Many individuals with alcohol problems suffer from other mental health conditions, such as severe anxiety and depression, at the same time. Psychologists can also diagnose and treat these "co-occurring" psychological conditions. Further, a psychologist may play an important role in coordinating the services a drinker in treatment receives from various health professionals.

Psychologists can also provide marital, family, and group therapies, which often are helpful for repairing interpersonal relationships and for resolving problem drinking over the long term. Family relationships influence drinking behavior, and these relationships often change during an individual's recovery. The psychologist can help the drinker and significant others navigate these complex transitions, help families understand problem drinking and learn how to support family members in recovery, and refer family members to self-help groups.

Because a person may experience one or more relapses and return to problem drinking, it can be crucial to have a trusted psychologist or other health professional with whom that person can discuss and learn from these events. If the drinker is unable to resolve alcohol problems fully, a psychologist can help with reducing alcohol use and minimizing problems.

Psychologists can also provide referrals to self-help groups. Even after formal treatment ends, many people seek additional support through continued involvement in such groups.

Alcohol-related disorders severely impair functioning and health. But the prospects for successful long-term problem resolution are good for people who seek help from appropriate sources.

Match the terms with their definitions

| | |
|-----------------|--|
| alcoholism | a condition in which dependence on alcohol harms a person's health, social functioning, or family life |
| withdrawal | the period a drug addict (alcohol abuser) goes through following abrupt termination in the use of narcotics (alcohol), usually characterized by physical and mental symptoms |
| alcohol | a colourless flammable liquid, the active principle of intoxicating drinks, produced by the fermentation of sugars, esp glucose, and used as a solvent and in the manufacture of organic chemicals |
| assault | a violent attack, either physical or verbal |
| willpower | the ability to control oneself and determine one's actions |
| Self-help group | groups of people who provide mutual support for each other |
| abstain | restrain oneself from doing or enjoying something |
| hangover | the delayed aftereffects of drinking too much alcohol in a relatively short period of time, characterized by headache and sometimes nausea and dizziness |
| blackout | a momentary loss of consciousness, vision, or memory |

Say if these statements are true or false

| | true | false |
|---|------|-------|
| Genetic factors do not make people vulnerable to alcohol dependence | | + |
| Heavy drinking can cause physiological changes that make more drinking the only way to avoid discomfort | + | |
| Social and environmental factors such as peer pressure and the easy availability of alcohol do not play key roles. | | + |
| Alcohol abuse is a drinking pattern that never results in significant and recurrent adverse consequences | | + |
| A family history of alcohol problems means that children will automatically grow up to have the same problems. | | + |
| Withdrawal symptoms may include nausea, sweating, restlessness, irritability, tremors, hallucinations, and convulsions. | + | |
| Once people begin drinking excessively, the problem can perpetuate itself. | + | |

Build word partnerships

| | |
|---------|------------|
| peer | pressure |
| Self | esteem |
| alcohol | dependence |

| | |
|------------|-----------|
| coping | skills |
| withdrawal | Symptoms |
| alcohol | abuse |
| relieve | hangover |
| Liver | cirrhosis |