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25 Other Conditions that May be a Focus of Clinical Attention

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Other Conditions that May be a Focus of Clinical Attention In the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5), in a section called Other Conditions That May Be a Focus of Clinical Attention, there is a list of conditions that are not mental disorders but that have led to contact with the mental health care system. In some instances, one of these conditions will be noted during the course of a psychiatric evaluation (e.g., divorce), although no mental disorder has been found. In other instances, the diagnostic evaluation reveals no mental disorder, but a need is seen to note the primary reason for contact with the mental health care system (e.g., homelessness). In some cases, a mental disorder may eventually be found, but the focus of attention or treatment is on a condition that is not caused by a mental disorder. For example, a patient with an anxiety disorder may receive treatment for a marital problem that is unrelated to the anxiety disorder itself. Table 25-1 lists the many conditions that may be a focus of clinical attention or that may influence the diagnosis, treatment, or course of a mental disorder that is contained in DSM-5. The list of conditions that make up this category cover the entire life cycle from infancy through childhood, adolescence, adulthood, and old age. The list of conditions covers almost every conceivable life circumstance from divorce to problems related to being in military service. In one sense, they represent the vicissitudes of life or, as Shakespeare has Hamlet state, “the slings and arrows of outrageous fortune.” Each of these conditions or circumstances is capable of having a profound input on a particular mental illness or on the human experience in general. Table 25-1 Conditions That May Be a Focus of Clinical Attention

The conditions discussed in this chapter include the following: (1) malingering, (2) bereavement, (3) occupational problems, (4) adult antisocial behavior, (5) religious or spiritual problem, (6)

acculturation problem, (7) phase of life problem, (8) noncompliance with treatment for a mental disorder, and (9) relational problems. Problems related to the maltreatment and abuse of children is covered in Section 31.19c, and problems related to the physical and sexual abuse of adults is covered in Chapter 26. MALINGERING Malingering is the deliberate falsification of physical or psychological symptoms in an attempt to achieve a secondary gain such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, malingering may represent adaptive behavior—for example, as mentioned below, feigning illness while a captive of the enemy during wartime.

Malingering should be strongly suspected if any combination of the following is noted: (1) medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination or is incarcerated), (2) evident discrepancy between the individual's claimed stress or disability and the objective findings, (3) lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen, and (4) the presence of antisocial personality disorder. Epidemiology A 1 percent prevalence of malingering has been estimated among mental health patients in civilian clinical practice, with the estimate rising to 5 percent in the military. In a litigious context, during interviews of criminal defendants, the estimated prevalence of malingering is much higher—between 10 and 20 percent. Approximately 50 percent of children presenting with conduct disorders are described as having serious lying-related issues. Although no familial or genetic patterns have been reported and no clear sex bias or age at onset has been delineated, malingering does appear to be highly prevalent in certain military, prison, and litigious populations and, in Western society, in men from youth through middle age. Associated disorders include conduct disorder and anxiety disorders in children and antisocial, borderline, and narcissistic personality disorders in adults. Etiology Although no biological factors have been found to be causally related to malingering, its frequent association with antisocial personality disorder raises the possibility that hypoarousability may be an underlying metabolic factor. Still, no predisposing genetic, neurophysiological, neurochemical, or neuroendocrinological forces are presently known. Diagnosis and Clinical Features Avoidance of Criminal Responsibility, Trial, and Punishment. Criminals may pretend to be incompetent to avoid standing trial; they may feign insanity at the time of perpetration of the crime, malinger symptoms to receive a less harsh penalty, or attempt to act too incapacitated (incompetent) to be executed. Avoidance of Military Service or of Particularly Hazardous Duties. Persons may malinger to avoid conscription into the armed forces and, after being conscripted, they may feign illness to escape from particularly onerous or hazardous duties. Financial Gain. Modern malingerers may seek financial gain in the form of undeserved disability insurance, veterans' benefits, workers' compensation, or tort

damages for purported psychological injury. Avoidance of Work, Social Responsibility, and Social Consequences. Individuals may malinger to escape from unpleasant vocational or social circumstances or to avoid the social and litigation-related consequences of vocational or social improprieties. An owner of a previously successful photographic equipment supplier declared bankruptcy in a way that the government maintained was illegal. Subsequently, the government indicted the defendant on various counts of fraud. The defendant's counsel maintained that the defendant was too depressed to cooperate with him and that, because of that depression, he experienced memory loss that made it impossible to understand what had occurred and therefore impossible to provide a meaningful defense. The government's forensic psychiatrist evaluated the defendant to ascertain the nature of his depression and to determine whether it was causing

cognitive problems. When asked early in his evaluation when his birthday was, he responded, “Oh, what does it matter? It was in the 40s or 50s.” Similarly, when queried about where he was born, he said, “Some place in Hungary.” Even when pressed for more specifics, he refused to elaborate. Yet, at many points later in his evaluation, he responded with complete, often detailed, information about transactions not related to those for which he had been indicted. It was the impression of the evaluator that the defendant was malingering in a gross and inconsistent fashion, incompatible with the kinds of decreases in cognitive skills that occasionally attend major depression. (Adapted from case of Mark J. Mills, J.D., M.D., and Mark S. Lipian, M.D., Ph.D.) Facilitation of Transfer from Prison to Hospital. Prisoners may malinger (fake bad) with the goal of obtaining a transfer to a psychiatric hospital from which they may hope to escape or in which they expect to do “easier time.” The prison context may also give rise to dissimulation (faking good), however; the prospect of an indeterminate number of days on a mental health ward may prompt an inmate with true psychiatric symptoms to make every effort to conceal them. Admission to a Hospital. In this era of deinstitutionalization and homelessness, individuals may malinger in an effort to gain admission to a psychiatric hospital. Such institutions may be seen as providing free room and board, a safe haven from the police, or refuge from rival gang members or disgruntled drug cronies who have made street life even more unbearable and hazardous than it usually is. A robust, neatly attired man presented to the psychiatric emergency department in the early-morning hours. He stated that “the voices” were worse and that he wished to

be readmitted to the hospital. When the psychiatrist challenged him, observing that he had just been discharged that afternoon, that he routinely left the hospital in the morning and demanded rehospitalization at night, and that, despite multiple hospitalizations, his reported history of hallucinations had been increasingly doubted, the man became belligerent. When the psychiatrist still refused to admit him, the patient grabbed the psychiatrist’s clothes, threatening him but inflicting no harm. The psychiatrist asked the hospital police to escort him off the grounds. The patient was told he could seek readmission to his regular ward during the day. Subsequent contact with the patient’s ward revealed that their diagnoses were substance abuse and homelessness; his apparent schizophrenia appeared never to have been an actual issue in his treatment. (Courtesy of Mark J. Mills, J.D., M.D., and Mark S. Lipian, M.D., Ph.D.) Drug Seeking. Malingerers may feign illness in an effort to obtain favored medications, either for personal use or, in a prison setting, as currency to barter for cigarettes, protection, or other inmate-provided favors. The plaintiff, a woman in her late 20s, was injured while dancing at a club. Although her claim initially appeared bona fide, subsequent investigation cast doubt on the mechanism of injury that she claimed—namely, that a misplaced electrical cord under a carpet caused her to slip. This was true, she claimed, even though she had to been dancing in a particularly jerky manner that could have easily caused problems without tripping. Subsequently, she sought medical and surgical treatment for torn cartilage in her injured knee. Even though the initial surgery went well, she kept reinjuring the knee with various “slips.” As a result, she requested narcotic analgesics. A careful medical record review revealed that she was obtaining such medications from multiple practitioners and that she had apparently forged at least one prescription. In reviewing the case before binding arbitration, it was the opinion of the orthopedic and psychiatric consultants that, although the initial injury and reported pain were real, the plaintiff consciously elaborated her injuries to obtain the desired narcotic analgesics. (Courtesy of Mark J. Mills, J.D., M.D., and Mark S. Lipian, M.D., Ph.D.) Child Custody. Minimizing difficulties or faking good for the sake of obtaining child custody can occur when one party accurately accuses the other of being an unfit parent because of

psychological conditions. The accused party may feel compelled to minimize symptoms or to portray him- or herself in a positive light to reduce chances of being deemed unfit and losing custody.

Differential Diagnosis Malingering must be differentiated from the actual physical or psychiatric illness suspected of being feigned. Furthermore, the possibility of partial malingering, which is an exaggeration of existing symptoms, must be entertained. Also, the possibility exists of unintentional, dynamically driven misattribution of genuine symptoms (e.g., of depression) to an incorrect environmental cause (e.g., to sexual harassment rather than to narcissistic injury). It should also be remembered that a real psychiatric disorder and malingering are not mutually exclusive. Factitious disorder is distinguished from malingering by motivation (sick role vs. tangible pain), whereas the somatoform disorders involve no conscious volition. In conversion disorder, as in malingering, objective signs cannot account for subjective experience, and differentiation between the two disorders can be difficult. Table 25-2 lists some variables that may aid in distinguishing between these two conditions. Table 25-2 Factors Aiding in the Differentiation between Malingering and Conversion Disorder Course and Prognosis Malingering persists as long as the malingerer believes it will likely produce the desired rewards. In the absence of concurrent diagnoses, after the rewards have been attained, the feigned symptoms disappear. In some structured settings, such as the military or prison units, ignoring the malingered behavior may result in its disappearance, particularly if an expectation of continued productive performance, despite complaints, is made clear. In children, malingering is most likely associated with a predisposing anxiety or conduct disorder; proper attention to this developing problem may alleviate the child’s propensity to malinger. Treatment The appropriate stance for the psychiatrist is clinical neutrality. If malingering is suspected, a careful differential investigation should ensue. If, at the conclusion of the

diagnostic evaluation, malingering seems most likely, the patient should be tactfully but firmly confronted with the apparent outcome. The reasons underlying the ruse need to be elicited, however, and alternative pathways to the desired outcome explored. Coexisting psychiatric disorders should be thoroughly assessed. Only if the patient is utterly unwilling to interact with the physician under any terms other than manipulation should the therapeutic (or evaluative) interaction be abandoned. BEREAVEMENT Normal bereavement begins immediately after or within a few months of the loss of a loved one. Typical signs and symptoms include feelings of sadness, preoccupation with thoughts about the deceased, tearfulness, irritability, insomnia, and difficulties concentrating and carrying out daily activities. On the basis of the cultural group, bereavement is limited to a varying time, usually 6 months, but it can be longer. Normal bereavement, however, can lead to a full depressive disorder that requires treatment. Some grieving individuals present with symptoms characteristic of a major depressive episode such as depressed mood, insomnia, anorexia, and weight loss. The duration of grief and bereavement vary considerably among different cultural groups and with the same cultural group. The diagnosis of depressive disorder is generally not given unless the symptoms are still present 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a “normal” grief reaction may be helpful in differentiating bereavement from depression. These include (1) guilt about things other than actions taken or not taken by the survivor at the time of the death, (2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person, (3) morbid preoccupation with worthlessness, (4) marked psychomotor retardation, (5) prolonged and marked functional impairment, and (6) hallucinatory experiences

other than thinking that he or she hears the voice of or transiently sees the image of the deceased person. OCCUPATIONAL PROBLEMS Occupational problems often arise during stressful changes in work, namely, at initial entry into the workforce or when making job changes within the same organization to a higher position because of good performance or to a parallel position because of corporate need. Distress occurs particularly if these changes are not sought and no preparatory training has taken place, as well as during layoffs and at retirement, especially if retirement is mandatory and the person is unprepared for this event. Work distress can result if initially agreed-to conditions change to work overload or lack of challenge and opportunity to experience work satisfaction, if an individual feels unable to fulfill conflicting expectations or feels that work conditions prevent accomplishing assignments because of lack of legitimate power, or if an individual believes he or she works in a hierarchy with harsh and unreasonable superiors.

Work Choices and Changes Young adults without role models or guidance from families, mentors, or others in their communities too often underestimate their lifetime potential abilities to learn a trade or earn a college or postgraduate degree. In addition, women and members of minority groups often feel less prepared to accept work challenges, fear rejection, and do not apply for jobs for which they are qualified. On the other hand, men, in fields in which they are underrepresented, often and confidently move up the career ladder faster (glass elevator). As part of initial interviews for evaluation of occupational problems, patients should be encouraged to consider their heretofore unrecognized, unadmitted talents; long-held, yet unexpressed, dreams and goals regarding work; actual successes in work and school; and motivation to risk learning what they would find satisfying. Minorities and those in low-paying and low-skilled jobs too often have less job security. Business and institutional reorganization and consequent downsizing, factory closings, and moves affect many, often leaving these workers feeling hopeless and helpless about future employment, on welfare, angry, and depressed. With ongoing and often sudden downsizing of corporations and businesses, men and women continue to struggle with unexpected job loss and premature retirement even when finances are not an issue. In addition, men, in particular, define themselves by their work roles, and thus experience more occupational distress from these changes. Women may adjust faster to retirement, but they often have less financial security than men do (white women earn approximately 80 cents on the dollar, and African American and Hispanic women earn even less for comparable work); women have generally been in lower status work positions, find themselves widowed more often than men, and are more likely to be caring for children, grandchildren, and elderly relatives. Women represent more of the single working parent group and the working poor. Stress and the Workplace More than 30 percent of workers report that they are under stress at work. Workplace distress is implicated in at least 15 percent of occupational disability claims. Expected distress follows recognized and uncontrollable work changes—downsizing; mergers and acquisitions; work overload; and chronic physical strains, including work noise, temperature, bodily injuries, and strain from performing computer work. According to one study, the top ten most stressful jobs in 1998 were (1) president of the United States, (2) firefighter, (3) senior corporate executive, (4) race car driver, (5) taxi driver, (6) surgeon, (7) astronaut, (8) police officer, (9) football player, and (10) air traffic controller. People who work under deadlines, such as bus drivers, are subject to hypertension. Work frustration can also arise from an individual worker’s unrecognized (and therefore unresolved) psychodynamic issues, such as working appropriately with superiors and not relating to one’s supervisor as a parent figure. Other developmental issues include unresolved problems with competition, assertiveness, envy, fear of success, and inability to communicate verbally in a constructive

manner. After the September 11, 2001, World Trade Center tragedy, a 32-year-old, married

male firefighter, who had been away on vacation that day with his wife and children, began to exhibit changed behaviors at home and at work. At home, he appeared not to listen to his two children and, instead, focused his attention on television sporting events. At work, he also appeared to be more focused on cooking the same dinners for his peers and watching television than on interacting verbally with his remaining peers and the new chief. In the course of several months, a chaplain visited the station several times and talked to the firefighters about survivor guilt and the 9/11 tragedy, and the firefighter began to return somewhat to his former healthier behaviors. (Courtesy of Leah J. Dickstein, M.D.) Often, work conflicts reflect similar conflicts in the worker's personal life, and referral for treatment, unless there is insight, is in order. Some studies have found that massage therapy, meditation, and yoga at intervals during the work day relieve stress when used on a regular basis. Approaches using cognitive therapy have also helped people reduce work pressure. Suicide Risk Some occupations—health professionals, financial service workers, and police, the first and latter groups because of easier access to lethal drugs and weapons—both attract persons with a high suicide risk and involve increased chronic distress that may lead to higher suicide rates. Career and Job Problems of Women Most women work outside the home out of necessity to support themselves or their dependents (whether children or adults) or as part of a working couple. With the divorce rate remaining at the 50 percent level, many women find themselves economically poorer after a divorce than when married, although divorced men usually find their economic status improved. Despite more than four decades of increasing knowledge about and concern for women's status in the workplace, unique gender issues, bias, and lack of accommodation to their unique needs at certain life stages (i.e., pregnancy and postpartum, major responsibility for young healthy and ill children) continue. Yet, women were the largest group establishing new small businesses in the 1990s. Many have left large corporations where they were not valued for their efforts because of their gender. Women experience problems when they are the sole woman in a man's field. Despite increasing recognition of the need for men in relationships with women to assume home and family responsibilities, fewer than 25 percent of men do so equitably. Women of childbearing and child-rearing ages continue to find themselves in conflict with job expectations, opportunities, and personal responsibilities. High-quality, on-site, dependent-care facilities with extended hours are rare and often out of range financially. Major unresolved work issues that are unique to women at certain life stages include flextime and paid and unpaid dependent leave options. Beyond dependent care issues, women in the workforce continue to

experience distress after chronic and repeated sexual harassment, despite its illegality and media attention. Increasingly, more women have travel responsibilities, work long hours, work shifts beyond daylight hours, and experience personal workplace violence. Among dual-career families and partners, the woman is more likely to move when the man chooses to move for a work opportunity than vice versa. Consequently, a woman's career is interrupted more often. Less reluctance is seen, however, to have the two members of a relationship work for the same organization than previously, albeit usually in different departments. Work distress may also stem from continuous miscommunication, especially that based on gender. Working Teenagers With unemployment increasing, many teenagers work part time while attending high school. Consequently, stress can arise because of less parent–teenager interaction and constructive parental control issues about teens' use of earnings, time spent away from home, and consequent behaviors both in and outside the home. When both parents or a single parent, as well as the

teenager, work outside the home, often on different schedules, parent–teen verbal communication must be proactive, clear, and ongoing. Working within the Home Although most women with children of all ages must work outside the home, at times they may be home full time or part time or may work at home. When their husbands or partners work full time outside the home, problems may develop from each one's perceived expectations of the other. Women who care for children and their home exclusively may be seen by their partners as not only economically dependent and inferior but also not as competent and not understanding of the man's stressors and needs. Ongoing respectful listening and verbal communication must be encouraged. People in organizations are increasingly taking work home as their work expectations increase. This work-at-home experience can and does interfere with personal lives and satisfaction, which can then have further repercussions at work. Chronic Illness As general and other medical and psychiatric treatments for chronic diseases improve, employers have been increasingly concerned about accommodating patients with acquired immunodeficiency syndrome (AIDS), diabetes mellitus, and other disorders. The issue of mandatory testing for AIDS and substance abuse (alcohol and other illegal substances) continues to be of concern. Employee assistance programs offering education about general and mental health topics have proved timely and cost effective. Domestic Violence Although occurring in the home, signs and symptoms that interfere with work often trigger identification of those who experience domestic violence. Trained professionals must question all employees experiencing work distress about domestic violence and, when indicated, refer individuals for assistance, which includes safety in the workplace.

Job Loss Regardless of the reason for job loss, most people experience distress, at least temporarily, including symptoms of normal grief, loss of self-esteem, anger, and reactive depressive and anxiety symptoms, as well as somatic symptoms and possibly the onset of or increase in substance abuse or domestic violence. Timely education, support programs, and vocational guidance should be instituted and access to treatment made available if indicated. Vocational Rehabilitation Rehabilitation is often necessary for those traumatized by stresses in the workplace, those who had to take a leave of absence because of medical or psychiatric reasons, and those who have been fired. Individual or group counseling enables persons to improve personal relationships, raise self-esteem, or learn new work skills. Patients with schizophrenia may benefit from sheltered workshops in which they perform work that is geared to their level of function. Some patients with schizophrenia or autism do well in tasks that are repetitive or require obsessive concern with details. ADULT ANTISOCIAL BEHAVIOR Characterized by activities that are illegal, immoral, or both, antisocial behavior usually begins in childhood and often persists throughout life. The term antisocial behavior somewhat confusingly applies both to persons' actions that are not due to a mental disorder and to actions by those who never received a neuropsychiatric workup to determine the presence or absence of a mental disorder. As Dorothy Lewis noted, the term can apply to behavior by normal persons who "struggle to make a dishonest living." Epidemiology Depending on the criteria and the sampling, estimates of the prevalence of adult antisocial behavior range from 5 to 15 percent of the population. Within prison populations, investigators report prevalence figures between 20 and 80 percent. Men account for more adult antisocial behavior than do women. Etiology Antisocial behaviors in adulthood are characteristic of a variety of persons, ranging from those with no demonstrable psychopathology to those who are severely impaired and have psychotic disorders, cognitive disorders, and retardation, among other conditions. A comprehensive neuropsychiatric assessment of antisocial adults is indicated and may reveal potentially treatable psychiatric and neurological impairments that can easily be overlooked.

Only in the absence of mental disorders can patients be categorized as displaying adult antisocial behavior. Adult antisocial behavior

may be influenced by genetic and social factors. Genetic Factors. Data supporting the genetic transmission of antisocial behavior are based on studies that found a 60 percent concordance rate in monozygotic twins and about a 30 percent concordance rate in dizygotic twins. Adoption studies show a high rate of antisocial behavior in the biological relatives of adoptees identified with antisocial behavior and a high incidence of antisocial behavior in the adopted-away offspring of those with antisocial behavior. The prenatal and perinatal periods of those who subsequently display antisocial behavior often are associated with low birth weight, mental retardation, and prenatal exposure to alcohol and other drugs of abuse. Social Factors. Studies have shown that in neighborhoods in which families with low socioeconomic status (SES) predominate, the sons of unskilled workers are more likely to commit more offenses and more serious criminal offenses than do the sons of middle-class and skilled workers, at least during adolescence and early adulthood. These data are not as clear for women, but the findings are generally similar in studies from many countries. Areas of family training differ by SES group. Middle-SES parents use love-oriented techniques in discipline. They withdraw affection rather than impose physical punishment as is done in low-SES groups. Negative parental attitudes toward aggressive behavior, attempts to curb aggressive behavior, and the ability to communicate parental values are more characteristic of middle- and high-SES groups than of low ones. Adult antisocial behavior is associated with the use and abuse of alcohol and other substances and with the easy availability of handguns. Diagnosis and Clinical Features. The diagnosis of adult antisocial behavior is one of exclusion. Substance dependence in such behavior often makes it difficult to separate the antisocial behavior related primarily to substance dependence from disordered behaviors that occurred either before substance use or during episodes unrelated to substance dependence. During the manic phases of bipolar I disorder, certain aspects of behavior, such as wanderlust, sexual promiscuity, and financial difficulties, can be similar to adult antisocial behavior. Patients with schizophrenia may have episodes of adult antisocial behavior, but the symptom picture is usually clear, especially regarding thought disorder, delusions, and hallucinations on the mental status examination. Neurological conditions can be associated with adult antisocial behavior, and electroencephalograms (EEGs), computed tomography (CT) scans, magnetic resonance imaging (MRI), and complete neurological examinations are indicated. Temporal lobe epilepsy should be considered in the differential diagnosis. When a clear-cut diagnosis of temporal lobe epilepsy or encephalitis can be made, the disorder may be considered to contribute to the adult antisocial behavior. Abnormal EEG findings are prevalent among violent offenders: An estimated 50 percent of aggressive criminals have abnormal EEG findings. Persons with adult antisocial behavior have difficulties in work, marriage, and money

matters and conflicts with various authorities. The symptoms of adult antisocial behavior are summarized in Table 25-3. (Antisocial personality disorder is discussed in Chapter 22.) Table 25-3 Symptoms of Adult Antisocial Behavior Treatment In general, therapists are pessimistic about treating adult antisocial behavior. They have little hope of changing a pattern that has been present almost continuously throughout a person’s life. Psychotherapy has not been effective, and no major breakthroughs with biological treatments, including medications, have occurred. Therapists show more enthusiasm for the use of therapeutic communities and other forms of group treatment, although the data provide little basis for optimism. Many adult criminals who are

incarcerated in institutional settings have shown some response to group therapy approaches. The history of violence, criminality, and antisocial behavior has shown that such behaviors seem to decrease after age 40 years. Recidivism in criminals, which can reach 90 percent in some studies, also decreases in middle age. Prevention. Because antisocial behavior often begins during childhood, the major focus must be on delinquency prevention. Any measures that improve the physical and mental health of socioeconomically disadvantaged children and their families are likely to reduce delinquency and violent crime. Often, recurrently violent persons have sustained many insults to the central nervous system (CNS) prenatally and throughout

childhood and adolescence. Consequently, programs must be developed to educate parents about the dangers to their children of CNS injury from maltreatment, including the effects of psychoactive substances on the brains of growing fetuses. Public education about the releasing effect of alcohol on violent behaviors (as well as its contribution to vehicular homicide) may also reduce crime. In a Surgeon General's Report on Violence and Public Health, the Committee on the Prevention of Assault and Homicide emphasized the importance of discouraging corporal punishment in the home, forbidding it in the schools, and even abolishing capital punishment by the state, saying that all are models and sanctions for violence. Since that time, capital punishment has been instituted in states that did not have it, such as New York. No evidence indicates that capital punishment reduces crime in states that have it. Opponents of capital punishment see it as "vengeance," not punishment. Although persons disagree about the contribution of violence in the media to violent crime, the propaganda potential of the media is universally recognized. The extent to which the media, such as television, can be used to transmit positive social values has not yet been realized. The guidelines issued by the television industry to indicate the amount of sex and violence in programs is an attempt to deal with the issue; however, program content that espouses traditional societal values would be beneficial. The most successful preventive measures within the field of medicine have come from community-wide public health programs (e.g., campaigns against smoking) and from programs that detect individual vulnerabilities (e.g., individual monitoring of blood pressure). Studies of adult antisocial behavior reveal the contribution of broad cultural factors and constellations of individual biopsychosocial vulnerabilities. Prevention programs must recognize and address both kinds of factors. RELIGIOUS OR SPIRITUAL PROBLEM A religious or spiritual problem can bring the person to the psychiatrist under one of several circumstances. For example, a person may begin to question his or her faith and choose not to discuss the problem with a spiritual advisor. Or a person may wish to convert to a new faith in order to marry or to create harmony in a marriage in which husband and wife are of different faiths. Psychiatrists must enable and assist patients to distinguish religious thought or experience from psychopathology and, if this is a problem, encourage patients to work through the issues independently or with assistance. Religious imagery may be recognized in mental illness when persons state they believe they have been commanded by God to take a dangerous or grandiose action. Religious experience may factor into a person's life in unexpected ways as in the following case. A midcareer male surgeon who was very successful but long overcommitted to his private practice and his academic responsibilities revealed to his often-neglected wife that, at age 9 years, he was approached by his religious leader to get close physically and ultimately engaged in sexual acts over several years. Believing it was his fault, he never told anyone and decided never to have children. After telling his wife about the experience, they engaged in family therapy to work through the stresses the confession produced in their marriage.

Cults Recently, cults have appeared to be less popular and less attractive to naïve late adolescents and young adults seeking assistance in discovering who they are as they struggle to develop more mature relationships with their parents. Cults are led by charismatic leaders, often out of control themselves, with inappropriate and often unethical values but purporting to offer acceptance and guidance to troubled followers. Cult members are strongly controlled and forced to dissolve allegiance to family and others to serve the cult leader's directives and personal needs. These young members often come from educated families who then seek professional help in persuading their children to leave the cult and enter deprogramming therapy to restore personal psychological stability to the former cult members. Deprogramming and adjustment back into family, society, and an independent life are time intensive and long term with resultant posttraumatic stress disorder (PTSD), which must be recognized and treated. ACCULTURATION PROBLEM Acculturation is the process whereby a person from one culture undergoes a change in manner, customs, and dress among others to adapt to a different culture. It leads to assimilation in which the person has identified with the new culture, usually without conflict or ambivalence. In some cases, however, major cultural change can evoke severe distress, termed culture shock. This condition arises when individuals suddenly find themselves in a new culture in which they feel completely alien. They may also feel conflict over which lifestyles to maintain, change, or adopt. Children and young adult immigrants often adapt more easily than do middle-aged and elderly immigrants. Younger immigrants often learn the new language more easily and continue to mature in the new culture, but those who are more senior, having had more stability and unchanging routines in their former culture, struggle more to adapt. Culture shock from immigration clearly differs from the restless and continuous moving of psychiatric patients secondary to their illness. Culture shock can occur within a person's own country with geographic, school, and work changes, such as joining the military, experiencing school busing, moving across country, or moving to a vastly different neighborhood or from a rural area to a metropolis. Reactive symptoms, which are understandable, include anxiety, depression, isolation, fear, and a sense of loss of identity as the person adjusts. If the person is part of a family or group making this transition and the move is positive and planned, stress can be lower. Furthermore, if selected cultural mores can be safely maintained as persons integrate into the new culture, stress is also minimized. Constant geographic moves because of chosen work opportunities or necessity involve a large proportion of workers in the United States. Joining activities in the new community and actively trying to meet neighbors and coworkers can lessen the culture shock.

An 18-year-old, first-year female college student offered an academic scholarship by a small Southern college with a major in her field of interest realized on her return home to the Midwest for winter break that she felt like a misfit among her dorm peers. They were friendly yet generally kept their distance from her after class. At home, she discussed her experiences with high school friends, who replied that they had heard about such cultural dissonance from peers at their Midwestern colleges. The student returned to college feeling that it was not her fault or imagination and slowly began to reach out more assertively to her peers so they could get to know her beyond stereotypical beliefs and so she could do the same. Brainwashing. First practiced by the Chinese Communists on American prisoners during the Korean War, brainwashing is the deliberate creation of culture shock. Individuals are isolated, intimidated, and made to feel different and out of place to break their spirits and destroy their coping skills. When a person appears mentally weak and helpless, the aggressors impose new ideas on them that they would never have accepted in their normal state. As with those involved in cults, on release and return to their homes, brainwashed

individuals with PTSD require deprogramming treatment, including reeducation and ongoing supportive psychotherapy, both on an individual and group basis. Treatment is usually long term to rebuild healthy self-esteem and coping skills. (See also Section 27.4: Disaster Psychiatry.) Prisoners of War and Torture Victims. Prisoners who survive war or torture experiences do so because of personal inner strengths developed in their earlier lives, beginning within their emotionally strong and caring families; if they come from troubled families, they are more likely to commit suicide during imprisonment and torture. Prisoners must constantly cope with ongoing anxiety, fear, isolation from known lives, and complete loss of all control over their lives. Those who appear to cope best believe they must survive for a reason (e.g., to tell others what they experienced or to find and return to loved ones). Prisoners who cope best describe living simultaneously on two levels—coping in the here and now to survive the situation while maintaining constant mental connections to their past values and experiences and those important to them. Beyond the surviving prisoner's personal difficulties, including PTSD disorder, if and when his or her survival behavior continues, his or her family may be affected by the surviving prisoner's inordinate fear of police and strangers, overprotection and overburdening of children to replace those significant others lost, lack of sharing of the past, continued isolation from current communities, or inappropriate expressed anger. Thus, another generation (i.e., children of survivors) can be affected in their personal development and psychological functioning and may require psychiatric evaluation and treatment. (See also Chapter 11, Trauma and Stressor-Related Disorder, for further discussion of these topics).

A 75-year-old, Catholic, female survivor of the Pawiak prison in Warsaw, Poland, and then of a concentration camp after her capture as a member of the underground in World War II stated that she had wanted to become a painter. In camp, she carved the Madonna and Child on her toothbrush and sent it home to her mother. She made other clandestine carvings for several women in her barracks to send home to their families, which pleased everyone. After the war, she became a well-known sculptress with exhibits throughout Europe. Many of her art pieces taught people about suffering and respect for others who are of different religions and cultures. PHASE OF LIFE PROBLEM Phase of life problems may occur at any point along the life cycle: the first day of school as a child, the divorce of a parent during adolescence, starting college as a young adult, marriage, having children, illness, caring for aged parents, and many others. Although, on some level, adults recognize that life events will intrude on expected plans in the course of a lifetime, unexpected, multiple, major negative occurrences, especially if they are chronic, overwhelm a person's ability to recover and function constructively. Common phase of life problems include relationship changes, such as a changed significant personal relationship or its loss, job crises, and parenthood. Because of sex role socialization and consequent cultural expectations, whereas men appear externally better able to handle these phases of life problems, women, people with lower SES, and minority group members appear more vulnerable to negative experiences, perhaps because they feel less empowered psychologically. Major life changes precipitate distress in the form of anxiety and depressive symptoms, an inability to express reactive emotions directly, and often difficulties in coping with ongoing or changed life responsibilities. Individuals with positive attitudes, strong family and personal relationships, and mature defense mechanisms and coping styles, including basic trust in self and others, good verbal communication skills, a capacity for creative and positive thinking, and the ability to be flexible, reliable, and energetic, appear to be best able to cope with phase of life problems. Furthermore, a capacity for sublimation; adequate financial and work status; solid values; and healthy, feasible goals can enable people to face,

accept, and deal realistically with expected and unexpected life problems and changes. NONCOMPLIANCE WITH TREATMENT Compliance is the degree to which a patient carries out the recommendations of the treating physician. It is fostered when the doctor–patient relationship is a positive one, but even in those circumstances, the patient may be reluctant to comply with a physician's advice. In psychiatry, a major concern is medication noncompliance, which may result from discomforting side effects, expense, personal value judgments, and denial of illness, among many others. This category should be used only when the problem is sufficiently severe to warrant independent clinical attention. RELATIONAL PROBLEMS

An adult's psychological health and sense of well-being depend to a significant degree on the quality of his or her important relationships—that is, on patterns of interaction with a partner and children, parents and siblings, and friends and colleagues. Problems in the interaction between any of these significant others can lead to clinical symptoms and impaired functioning among one or more members of the relational unit. Relational problems may be a focus of clinical attention (1) when a relational unit is distressed and dysfunctional or threatened with dissolution and (2) when the relational problems precede, accompany, or follow other psychiatric or medical disorders. Indeed, other medical or psychiatric symptoms can be influenced by the relational context of the patient. Conversely, the functioning of a relational unit is affected by a member's general and other medical or psychiatric illness. Relational disorders require a different clinical approach than other disorders. Instead of focusing primarily on the link between symptoms, signs, and the workings of the individual mind, the clinician must also focus on interactions between the individuals involved and how these interactions are related to the general and other medical or psychiatric symptoms in a meaningful way. Definition Relational problems are patterns of interaction between members of a relational unit that are associated with significantly impaired functioning in one or more individual members. Thus one may have parent–child problems, sibling-related problems, or other dyad or triad impairments. At times the entire unit such as the family itself, may be dysfunctional. Epidemiology No reliable figures are available on the prevalence of relational problems. They can be assumed to be ubiquitous; however, most relational problems resolve without professional intervention. The nature, frequency, and effects of the problem on those involved are elements that must be considered before a diagnosis of relational problem is made. For example, divorce, which occurs in just under 50 percent of marriages, is a problem between partners that is resolved through the legal remedy of divorce and need not be diagnosed as a relational problem. If the persons cannot resolve their disputation and continue to live together in a sadomasochistic or pathologically depressed relationship with unhappiness and abuse, then they should be so labeled. Relationship problems between involved persons that cannot be resolved by friends, family, or clergy require professional intervention by psychiatrists, clinical psychologists, social workers, and other mental health professionals. Relational Problem Related to a Mental Disorder or General Medical Condition When a family member is ill either from a psychiatric or medical illness, there are reverberations throughout the family unit. Studies indicate that whereas satisfying

relationships may have a health-protective influence, relationship distress tends to be associated with an increased incidence of illness. The influence of relational systems on health has been explained through psychophysiological mechanisms that link the intense emotions generated in human attachment systems to vascular reactivity and immune processes. Thus, stress-related psychological or physical symptoms can be an expression of family dysfunction. Adults must often

assume responsibility for caring for aging parents while they are still caring for their own children, and this dual obligation can create stress. When adults take care of their parents, both parties must adapt to a reversal of their former roles, and the caretakers not only face the potential loss of their parents but also must cope with evidence of their own mortality. Some caretakers abuse their aging parents, a problem that is now receiving attention. Abuse is most likely to occur when the caretaking offspring have substance abuse problems, are under economic stress, and have no relief from their caretaking duties or when the parent is bedridden or has a chronic illness requiring constant nursing attention. More women are abused than men, and most abuse occurs in persons older than age 75 years. The development of a chronic illness in a family member stresses the family system and requires adaptation by both the sick person and the other family members. The person who has become sick must frequently face a loss of autonomy, an increased sense of vulnerability, and sometimes a taxing medical regimen. The other family members must experience the loss of the person as he or she was before the illness, and they usually have substantial caretaking responsibility—for example, in debilitating neurological diseases, including dementia of the Alzheimer's type, and in diseases such as AIDS and cancer. In these cases, the whole family must deal with the stress of prospective death as well as the current illness. Some families use the anger engendered by such situations to create support organizations, increase public awareness of the disease, and rally around the sick member. But chronic illness frequently produces depression in family members and can cause them to withdraw from or attack one another. The burden of caring for ill family members falls disproportionately on the women in a family—mothers, daughters, and daughters-in-law. Chronic emotional illness also requires major adaptations by families. For instance, family members may react with chaos or fear to the psychotic productions of a family member with schizophrenia. The regression, exaggerated emotions, frequent hospitalizations, and economic and social dependence of a person with schizophrenia can stress the family system. Family members may react with hostile feelings (referred to as expressed emotion) that are associated with a poor prognosis for the person who is sick. Similarly, a family member with bipolar I disorder can disrupt a family, particularly during manic episodes. Family devastation can occur when illness (1) suddenly strikes a previously healthy person, (2) occurs earlier than expected in the life cycle (some impairment of physical capacities is expected in old age, although many older persons are healthy), (3) affects the economic stability of the family, and (4) when little can be done to improve or ease the condition of the sick family member. Parent–Child Relational Problem

Parents differ widely in sensing the needs of their infants. Some quickly note their child's moods and needs; others are slow to respond. Parental responsiveness interacts with the children's temperament to affect the quality of the attachment between child and parent. The diagnosis of parent–child relational problem applies when the focus of clinical attention is a pattern of interaction between parent and child that is associated with clinically significant impairment in individual or family functioning or with clinically significant symptoms. Examples include impaired communication, overprotection, and inadequate discipline. Research on parenting skills has isolated two major dimensions: (1) a permissive– restrictive dimension and (2) a warm and accepting versus a cold and hostile dimension. A typology that separates parents on these dimensions distinguishes among authoritarian (restrictive and cold), permissive (minimally restrictive and accepting), and authoritative (restrictive as needed but also warm and accepting) parenting styles. Children of authoritarian parents tend to be withdrawn or conflicted; those of permissive parents are likely to be more aggressive, impulsive, and low achievers; and children of

authoritative parents seem to function at the highest level, socially and cognitively. Yet, switching from an authoritarian to a permissive mode may create a negative reinforcement pattern. Difficulties in many situations stress the usual parent–child interaction. Substantial evidence indicates that marital discord leads to problems in children, from depression and withdrawal to conduct disorder and poor performance at school. This negative effect may be partly mediated through triangulation of the parent–child relationships, which is a process in which conflicted parents attempt to win the sympathy and support of their child, who is recruited by one parent as an ally in the struggle with the partner. Divorces and remarriages stress the parent–child relationship and may create painful loyalty conflicts. Stepparents often find it difficult to assume a parental role and may resent the special relationship that exists between their new marital partner and the children from that partner's previous marriages. The resentment of a stepparent by a stepchild and the favoring of a natural child are usual reactions in a new family's initial phases of adjustment. When a second child is born, both familial stress and happiness may result, although happiness is the dominant emotion in most families. The birth of a child can also be troublesome when parents had adopted a child in the belief that they were infertile. Single-parent families usually consist of a mother and children, and their relationship is often affected by financial and emotional problems. Other situations that can produce a parent–child problem are the development of fatal, disabling, or chronic illness, such as leukemia, epilepsy, sickle-cell anemia, or spinal cord injury, in either the parent or child. The birth of a child with congenital defects, such as cerebral palsy, blindness, or deafness, may also produce parent–child problems. These situations, which are not rare, challenge the emotional resources of those involved. Parents and the child must face present and potential loss and must adjust their day-to-day lives physically, economically, and emotionally. These situations can strain the healthiest families and produce parent–child problems not only with the sick person but also with the unaffected family members. In a family with a severely sick child, parents may resent, prefer, or neglect the other children because the ill child requires so much time and attention. Parents with children who have emotional disorders face particular problems, depending on the child's illness. In families with a child with schizophrenia, family treatment is beneficial and improves the social adjustment of the patient. Similarly,

family therapy is useful when a child has a mood disorder. In families with a substanceabusing child or adolescent, family involvement is crucial to help control the drugseeking behavior and to allow family members to verbalize the feelings of frustration and anger that are invariably present. Normal developmental crises can also be related to parent–child problems. For instance, adolescence is a time of frequent conflict as the adolescent resists rules and demands increasing autonomy and at the same time elicits protective control by displaying immature and dangerous behavior. The parents of sons ages 18, 15, and 11 years presented with distress about the behavior of their middle child. The family had been cohesive with satisfactory relationships among all members until 6 months before this consultation. At that time, the 15-year-old son began seeing a girl from a comparatively unsupervised household. Frequent arguments had developed between parents and son regarding going out on school nights, curfews, and neglect of schoolwork. The son's combativeness and lowered academic achievement upset his parents a great deal. They had not experienced similar conflicts with their oldest child. The adolescent, however, maintained a good relationship with his siblings and friends, did not have behavior problems at school, continued to participate on the school basketball team, and was not a substance user. Day Care Centers. Quality of care during the first 3 years of life is crucial to neuropsychological development. The

National Institute of Child Health and Human Development does not consider day care harmful to children, especially when the caregivers and day care teachers provide consistent, empathetic, nurturing care. Not all day care centers can meet that level of care, however, especially those located in poor urban areas. Children receiving less than optimal caring exhibit decreased intellectual and verbal skills that indicate delayed neurocognitive development. They may also become irritable, anxious, or depressed, which interferes with the parent–child bonding experience, and they are less assertive and less effectively toilet trained by the age of 5 years. Currently, more than 55 percent of women are in the workforce, many of whom have no choice but to place their children in day care centers. Close to 50 percent of entering medical students are women; few medical centers, however, make adequate provisions for on-site day care centers for their students or staff. Similarly, corporations need to provide on-site, high-quality care for the children of their employees. Not only will that approach benefit the children, but also corporate economic benefits will accrue as a result of reduced absenteeism, increased productivity, and happier working mothers. Such programs have the added benefit of decreasing stresses on marriages. Partner Relational Problem

Partner relational problem are characterized by negative communication (e.g., criticisms), distorted communication (e.g., unrealistic expectations), or noncommunication (e.g., withdrawal) associated with clinically significant impairment in individual or family functioning or symptoms in one or both partners. When persons have partner relational problems, psychiatrists must assess whether a patient’s distress arises from the relationship or from a mental disorder. Mental disorders are more common in single persons—those who never married or who are widowed, separated, or divorced—than among married persons. Clinicians should evaluate developmental, sexual, and occupational and relationship histories, for purposes of diagnosis. (Couples therapy is discussed in Chapter 28, Section 28.4.) Marriage demands a sustained level of adaptation from both partners. In a troubled marriage, a therapist can encourage the partners to explore areas such as the extent of communication between the partners, their ways of solving disputes, their attitudes toward child bearing and child rearing, their relationships with their in-laws, their attitudes toward social life, their handling of finances, and their sexual interaction. The birth of a child, an abortion or miscarriage, economic stresses, moves to new areas, episodes of illness, major career changes, and any situations that involve a significant change in marital roles can precipitate stressful periods in a relationship. Illness in a child exerts the greatest strain on a marriage, and marriages in which a child has died through illness or accident more often than not end in divorce. Complaints of lifelong anorgasmia or impotence by marital partners usually indicate intrapsychic problems, although sexual dissatisfaction is involved in many cases of marital maladjustment. Adjustment to marital roles can be a problem when partners are from different backgrounds and have grown up with different value systems. For example, members of low SES groups perceive a wife as making most of the decisions in the family, and they accept physical punishment as a way to discipline children. Middle-class persons perceive family decision-making processes as shared, with the husband often being the final arbiter, and they prefer to discipline children verbally. Problems involving conflicts in values, adjustment to new roles, and poor communication are handled most effectively when therapist and partners examine the couple’s relationship, as in marital therapy. Epidemiological surveys show that unhappy marriages are a risk factor for major depressive disorder. Marital discord also affects physical health. For example, in a study of women age 30 to 65 years with coronary artery disease, marital stress worsened the prognosis 2.9 times for recurrent coronary events. Marital conflict was also associated with a 46 percent higher relative

death risk among female patients having hemodialysis and with elevations in serum epinephrine, norepinephrine, and corticotrophin levels in both men and women. In one study, high levels of hostile marital behavior were associated with slower healing of wounds, lower production of proinflammatory cytokines, and higher cytokine production in peripheral blood. Overall, women show greater psychological and physiological responsiveness to conflict than men. Physician Marriages. Physicians have a higher risk of divorce than other occupational groups. The incidence of divorce among physicians is about 25 to 30 percent. Specialty choice influenced divorce. The highest rate of divorce occurred in psychiatrists (50 percent) followed by surgeons (33 percent) and internists, pediatricians, and pathologists (31 percent). The average age at first marriage was 26

years among all groups. It is not clear why physicians are at high risk for divorce. Factors implicated include the stresses of dealing with dying patients, making life-and-death decisions, working long hours, and the constant risk of malpractice litigation. Such stressors may predispose physicians to a variety of emotional ills, with the most common being depression and substance abuse, including alcoholism. Such persons generally cannot deal with the complex interactions required to maintain successful long-term relationships of any kind, and marriage requires the most interpersonal skills of all. Sibling Relational Problem Sibling relationships tend to be characterized by competition, comparison, and cooperation. Intense sibling rivalry can occur with the birth of a child and can persist as the children grow up, compete for parental approval, and measure their accomplishments against one another. Alliances between siblings are equally common. Siblings may learn to protect one another against parental control or aggression. In households with three children, one pair tends to become closely involved with one another, leaving the extra child in the position of outsider. Relational problems can arise when siblings are not treated equally; for instance, when one child is being idealized while another is cast in the role of the family scapegoat. Differences in gender roles and expectations expressed by the parents can underlie sibling rivalry. Parent–child relationships also are dependent on personality interactions. A child’s resentment directed at a parental figure or a child’s own disavowed dark emotions can be projected onto a sibling and can fuel an intense hate relationship. A child’s general, other medical or psychiatric condition always stresses the sibling relationships. Parental concern and attention to the sick child can elicit envy in the siblings. In addition, chronic disability can leave the sick child feeling devalued and rejected by siblings, and the latter may develop a sense of superiority and may feel embarrassed about having a disabled sister or brother. Twin relationships have become an area of increasing study. Preliminary data show that twins are more likely to be cooperative than competitive. Whether or not identical twins should be dressed differently during their toddler years in an effort to ensure a separate identity is open to question as is the issue of whether or not they should be in separate classrooms when they begin school. Other Relational Problems People, across the life cycle, may become involved in relational problems with leaders and others in their communities at large. In such relationships, conflicts are common and can bring about stress-related symptoms. Many relational problems of children occur in the school setting and involve peers. Impaired peer relationships can be the chief complaint in attention-deficit or conduct disorders, as well as in depressive and other psychiatric disorders of childhood, adolescence, and adulthood. Racial, ethnic, and religious prejudices and ignorance cause problems in interpersonal relationships. In the workplace and in communities at large, sexual harassment is often a combination of inappropriate sexual interactions; inappropriate displays of abuse of power and dominance; and expressions of negative gender stereotypes, primarily

toward women and gay men, although it is also geared toward children and adolescents of both sexes. REFERENCES Barzilai-Pesach V, Sheiner EK, Sheiner E, Potashnik G, Shoham-Vardi I. The effect of women’s occupational psychologic stress on outcome of fertility treatments. J Occup Environ Med. 2006;48(1):56–62. Bhugra D. Migration and depression. Acta Psychiatr Scand Suppl. 2003;418:67–72. Bogduk N. Diagnostic blocks: A truth serum for malingering. Clin J Pain. 2004;20(6):409–414. Bosco SM, Harvey D. Effects of terror attacks on employment plans and anxiety levels of college students. College Student J. 2003;37:438–446. Campagna AF. Sexual abuse of males: The SAM model of theory and practice. J Am Acad Child Adolesc Psychiatry. 2005;44(10):1064–1065. Costigan CL, Cox MJ, Cauce AM. Work–parenting linkage among dual earner couples at the transition to parenthood. J Fam Psychol. 2003;17:397–408. Dagan E, Gil S. BRCA1/2 mutation carriers: Psychological distress and ways of coping. J Psychol Oncol. 2004;22(3):93–106. Guriel J, Fremouw W. Assessing malingered posttraumatic disorder: A critical review. Clin Psychol Rev. 2003;23(7):881– 904. Johnston D. What makes a difference to patients? Int Rev Psychiatry. 2013; 25(3):319–328. Langan J, Mercer SW, Smith DJ. Multimorbidity and mental health: Can psychiatry rise to the challenge? Br J Psychiatry. 2013;202(6):391–393. Larrabee GJ. Detection of malingering using atypical performance patterns on standard neuropsychological tests. Clin Neuropsychol. 2003;17(3):410–425. Mason AM, Cardell R, Armstrong M. Malingering psychosis: guidelines for assessment and management. Perspect Psychiatr Care . 2014;50(1):51–57. Mills MJ, Lipian MS. Malingering. In: Sadock BJ, Sadock VA, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 8th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins. 2005:2247. Ninivaggi FJ. Malingering. In: Sadock BJ, Sadock VA, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 9th ed. Vol. 2. Baltimore: Lippincott Williams & Wilkins; 2009:2479. O’Bryant SE, Hilsabeck RC, Fisher JM, McCaffrey RJ. Utility of the trail making test in the assessment of malingering in a sample of mild traumatic brain injury litigants. Clin Neuropsychol. 2003;17(1):69–74. Stansfeld S, Pike C, McManus S, et al. Occupations, work characteristics and common mental disorder. Psychol Med. 2013;43(5):961–973. Zierold KM, Anderson H. The relationship between work permits, injury, and safety training among working teenagers. Am J Ind Med. 2006;49(5):360–366.

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