

Exam 3 Study Guide

Ch. 12 Gender Dysphoria (used to be gender identity disorder)

- o **Gender Identity** - Our sense of ourselves as being either male or female; Gender identity almost always reflects physical anatomy
- o Relatively new label in DSM V; brought controversy; disorder = negative connotation; good = taking serious, bad = negative
- o **Gender Dysphoria**: sense of discomfort with one's anatomical sex; sense of self is mismatched with anatomical; transsexualism; not psychotic; rare in comparison to most of the other disorders; male to female transsexuals are more common than female to male
- o **Josie** - boy to girl - anxiety at age 9 because worried about puberty - too young to decide (effects life-long - infertile if get sex change/hormone therapy) blockers are reversible
- o **Pro of label**: people like having DSM give medical label; allows them to get treatment
- o **Con of label**: including it in DSM implicitly calls it an illness; on medical record and stigma
- o **Symptoms** - convinced their anatomy does not match; aware of feelings in early childhood; wear clothing and adopt sex-role behavior of other gender; intensity varies; more intense during adolescence when secondary sex characteristics develop (more difficult to pass); preoccupied with surgery; not always homosexual
- o **Different from transvestic disorder**: form of paraphilia (dress to receive sexual arousal)
- o **Comorbidities** - depression, anxiety
- o **causes/risk factors** - very little is known; genetic: symptoms of gender identity during childhood are at least moderately heritable; neurobiological factors: exposure to high levels of sex hormones in utero; Social and psychological: reinforcement of cross gender behaviors; psuedohermaphrodite (male but not right hormones to have penis)
- o **treatment options** - psychotherapy 1) change identity to match anatomy; can be more harmful 2) change anatomy to match identity; sex reassignment surgery - results generally positive and decrease anxiety and depression
- o **sex roles** - what you do; masculine or feminine

Ch. 16 Psychological Disorders of Childhood

- **Developmental Psychopathology** - emphasizes importance of developmental norms (age-graded averages) to understanding influences on abnormal behavior; look at duration, severity, and context

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- **Considerations of what constitutes *abnormal*** - need to understand typical behavior to define atypical; only concerned if behavior deviates from developmental norms; presence of abnormality may change over time
- **Terms: Internalizing Disorders versus Externalizing Disorders** - **externalizing** creates difficulties for the child's external world; failure to control their behavior according to expectations of parents, peers, teachers, or legal authorities;
- **Internalizing** - psychological problems that primarily affect the child's internal world, for example excessive anxiety or sadness;

- **Internalizing Disorders: general symptoms**
- Fears and Anxiety - Children often have trouble identifying their anxiety, but they are more aware of their fears
- Somatic symptoms are common
- Depressive Symptoms - Less common in young children
- More irritability
- Comorbid with both externalizing problems and anxiety
- Troubled peer relationships

- **Childhood anxiety disorders with a focus on separation anxiety, social phobia, school refusal,**
- **Separation anxiety**
- Persistent and excessive worry about safety of caregiver and self
- Refusal to be alone
- **School Phobia (School Refusal)**
- Severe and pervasive reluctance to go to attend school
- Somatic symptoms often present
- May be related to:
- Specific aspect of school environment (e.g., academic failure)
- **Social phobia**
- When children are afraid of social situations in which they have to interact with people
- **Selective Mutism** - inability to speak and communicate effectively
- **Other Neurodevelopmental Disorders** - Specific Learning Disorder (learning disability, students who perform substantially below their ability in a specific area of learning) - Tic Disorders (tourettes - rare characterized by repeated motor and verbal tics)- Developmental Coordination Disorder (slowness and inaccuracy of performance of motor skills)
- **Trauma- and Stressor-Related Disorders** - Reactive attachment disorder (withdrawn behavior among very young children around adult caregivers, observed following neglect,

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fail to seek comfort)- Disinhibited social engagement disorder (reaction to neglect, indiscriminant toward caregivers, willing to go off with anyone)

- **Elimination Disorders** - Encopresis (inappropriately controlled defecation) and enuresis (inappropriately controlled urination) age 5, 5% 5 year olds wet bed; encopresis less common 1%
- **Prevalence of Internalizing disorders**
- 32% of youth; 35% young women 19% young men depression by 19
- **Course of Internalizing disorders**
- Depends on the disorder – specific fears usually short lived; depression/anxiety usually more permanent
- **Causes of Internalizing disorders: biological, psychological, social/family systems**
- **Biological factors**
- Few behavioral genetic studies have been conducted
- Evidence of heritability
- **Social factors**
- Focus on attachments (refer back to attachment styles)
- Early adversity
- Family Conflict
- Bi-directionality
- Depressed parent
- **Psychological Factors**
- Rumination, repeatedly focusing on distress
- Poor form of emotion regulation
- Foreshadows future depression in early adolescence
- “Caretaking” children
- Unable to make parents happy
- Feel guilty and responsible.
- **Course and Outcome**
- Some but not all, problems persist over time – childhood depression predicts 6x increase in risk for suicide among young adults
- **Treatment for Internalizing disorders**
- **Children are NOT little adults...Family Involvement is often essential!!!**
- **Anxiety Disorders**