Schizoaffective disorder is a chronic, recurrent disorder with a prevalence slightly lower than that of schizophrenia. It is characterized by episodes of nonmood psychosis and mood episodes (i.e., manic or depressed) with psychotic features. Its diagnosis therefore cannot be based on the patient's clinical findings at any one point in time but requires knowledge of the overall course. The outcomes of schizoaffective disorder are heterogeneous but on average are intermediate between schizophrenia and mood disorders. Treatment is symptomatic, using antipsychotic, mood stabilizing, and antidepressant medications to target specific psychotic and mood symptoms.

Delusional disorder is characterized by delusions in the absence of thought process disorder, prominent hallucinations, or the negative symptoms of schizophrenia. The delusions may be potentially plausible (i.e., not bizarre). Delusional disorder has a lifetime prevalence of approximately 0.2%. It often is only partially responsive to antipsychotic medications, but patients' functioning may be largely unimpaired if they are able with the aid of antipsychotics and psychotherapy to avoid acting on their delusions. The pathogeneses of the nonschizophrenic primary psychotic disorders remain largely unknown.

SOMATIC SYMPTOM DISORDER AND RELATED DISORDERS

Formerly called *somatoform disorders*, these conditions include somatic symptoms and associated thoughts, feelings, or behaviors that are distressing and disabling. Prominent types include somatic symptom disorder (i.e., excessive thoughts, feelings, or behaviors associated with one or more somatic symptoms), illness anxiety disorder (i.e., illness preoccupation and health-related behaviors disproportionate to somatic symptoms), conversion (i.e., functional neurologic symptom) disorder (i.e., neurologic somatoform symptoms incompatible with recognized neurologic or general medical conditions), and psychological factors affecting physical conditions. Factitious disorder (i.e., Munchausen's syndrome) is a mental disorder in which patients consciously produce stigmata of disease (e.g., simulated or artificially induced fever or hypoglycemia) for the unconscious gain of assuming the sick role.

Although identifiable physical disease is insufficient to fully explain the patient's presentation, in all these conditions other than factitious disorder, the patient's distress and dysfunction are *not* consciously produced and are just as distressing to patients as would be similar symptoms produced by other medical conditions. Malingering is the conscious feigning of illness for conscious gain and therefore is not a mental disorder.

PERSONALITY DISORDERS

Personality is defined as the repertoire of enduring patterns of inner mental experience and behavior, including affect and impulse regulation, defense and coping mechanisms, and interpersonal relatedness. Personality traits must be distinguished from time-limited states. For example, a patient who exhibits dependent features solely while acutely depressed does not have a dependent personality.

A personality disorder is diagnosed when personality traits lead to pervasive (if variable) subjective distress or dysfunction in a broad range of situations. The major personality disorders are listed in Table 109-3. Personality and personality disorders are the result of complex interactions among genetic, environmental, and developmental factors. Approaches to patients with personality disorders depend on the specific type, but in most clinical circumstances other than long-term psychotherapy, the realistic goal is not to alter fundamental personality structure but to help the patient maximize use of personality strengths (e.g., optimal defense mechanisms) while minimizing the harmful effects of emotional dysregulation, unhelpful defenses, and destructive behaviors.

Although not the mainstay of most treatments for personality disorders, pharmacotherapy can be useful in selected patients (e.g., antipsychotics to target escalating paranoia in paranoid personality disorder, mood stabilizers or antidepressants to target emotional dysregulation in borderline personality disorder). Patients with personality disorders are also prone to mood, anxiety, eating, addictive, and other treatable psychiatric disorders.

PROSPECTUS FOR THE FUTURE

Advances in neuroscience will lead to better pharmacologic or other somatic therapies. One example, deep brain stimulation, is being studied for severe refractory mood and anxiety disorders. In the future, regimens tailored for each individual may be based on genomic or proteomic profiles. These same advances may help identify patients for whom evidence-based psychotherapies or other psychosocial interventions are most likely to be effective. Identification of more specific and powerful risk markers may lead to the development of preventive interventions for at-risk individuals or groups. The current U.S. health care system, however, provides barriers that often prevent implementation of mental health treatments, although this may change in light of recent incentives to improve the health of populations.

SUGGESTED READINGS

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