KARNATAKA STATE OPEN UNIVERSITY

MUKTHAGANGOTHRI, MYSURU

DEPARTMENT OF STUDIES AND RESEARCH IN PSYCHOLOGY

M.Sc PSYCHOLOGY

THIRD SEMESTER

COURSE-11 PSYCHOLOGICAL DISORDERS

BLOCK - III : MOOD AND SCHIZOPHRENIC DISORDERS

BLOCK - IV : AGING AND PERSONALITY DISORDERS

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COURSE-11 PSYCHOLOGICAL DISORDERS

INTRODUCTION

Dear Students,

This course Psychological Disorders deals with the mental disorders. It is very important for the students of Psychology to have a clear understanding about the distinguishing between the normal and abnormal behaviour, the normality and abnormality, the abnormal behaviours which may lead to the Psychological disorders. Psychological disorders or mental illnesses are the conditions which affects the individual's thinking, feeling and acting that is it affects the thoughts, emotions and the behaviour of an individual making the individual unable to function in the expected level of behaviour. This course gives a detailed understanding of the various Psychological disorders, its causes, symptoms, consequences, types and treatment processes.

The first block gives an introduction to psychological disorders, the concepts of normal, abnormal behavior, the historical development of psychopathology, the various concepts which are important to understand psychological disorders. It explains the major models of psychopathology and the way they understand psychological disorder's causes and treatment. There are different types of mental disorders, those disorders are being classified on the basis of the classification given by DSM and ICD, these classification and categorizing mental disorders, is being discussed here. The diagnosis is an important step in the identification of mental disorders. The methods used in the clinical assessment, the various tools of psychological assessment like case history, clinical interview, mental status examination, behavioural and cognitive assessment and the psychological tests being utilized for identification and diagnosis of psychological disorders are being discussed in detail.

The second block deals with the anxiety and stress related disorders which are very commonly found. The basic concepts like fear, stress, tension, conflicts, their consequences, the generalized anxiety, disorders, panic disorders, phobias, post traumatic stress disorders, obsessive compulsive disorders, its causes, treatments are being discussed.

The third block deals with mood and schizophrenic disorders, mania, depression, unipolar disorder, bipolar disorders, schizophrenia, delusional disorders, the causes, symptoms, types, treatment of all these disorders are being discussed in detail.

The fourth block deals with aging and personality disorders, there are a number of psychological problems which occur during the old age like delirium, dementia, Alzheimer's disease, the causes, types and symptoms are explained in detail. There are different types of personality disorders, the classification, types its cause, symptoms are dealt. There are different types of organic mental disorders, its causes, types and its diagnosis is explained. Certain disorders are very specific in childhood, it may be related with anxiety, learning, beahvioural disorders, eating disorders, mood disorders and many more. All these disorders related with childhood and adolescents are being discussed in detail.

A detailed study of this course gives a thorough knowledge in understanding the psychological disorders, its identification, treatment processes. It also helps the students of Psychology to be able to identify, distinguish the normal and abnormal behaviour. A thorough understanding of this course makes you capable in understanding the importance of mental health.

Wishing you All the Best,

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BLOCK-1 INTRODUCTION TO PSYCHOLOGICAL DISORDERS

UNIT-1: INTRODUCTION TO PSYCHOLOGICAL DISORDERS

STRUCTURE

1.1 OBJECTIVES

After going through this unit, you will be able to explain

- origin of psychopathology,
- Normality and abnormality
- the ancient treatments to abnormal behavior.
- The historical development of three models Supernatural, Biological, and Psychological.

1.2 INTRODUCTION

Psychopathology or abnormal Psychology is the scientific study of troublesome feelings, thoughts and behaviours associated with mental disorders. This branch of Psychology is specially designed to evaluate, understand, predict, and prevent mental disorders and also to help those who are in distress.

Psychopathology is a term used for the study of mental illness or mental distress, or the manifestation of behaviours and experiences which may be indicative of mental illness or psychological impairment. It is the branch of Psychology which focuses mainly on understanding the abnormal behaviour, its identification, diagnoses and the treatment of an individual who is suffering from this abnormality. Abnormal Psychology provides the knowledge to the practioners to detect, assess and treat abnormal patterns of functioning.

Psychopathology is the study of mental illness. Many different professions are involved in studying mental illness or distress. Among them the most important ones are psychiatrists and Clinical Psychologists. They are involved in clinical treatment of mental illness, research into the origin, development and manifestations of such states, and often, both. Many professionals do study psychopathology. For example, a neuroscientist focuses on brain changes related to mental illness. A psychopathologist, is the one who has specialized in studying this area.

Psychiatrists are interested in descriptive psychopathology, it is the branch which aims at describing the symptoms and syndromes of mental illness. This is both for the diagnosis of individual patients (to see whether the patient's experience fits any pre-existing classification), or for the creation of diagnostic systems (such as the Diagnostic and Statistical Manual of Mental

Disorders) which define exactly which signs and symptoms should make up a diagnosis, and how experiences and behaviours should be grouped in particular diagnoses (e.g. clinical depression, schizophrenia).

1.3 MEANING AND DEFINITIONS OF PSYCHOLOGICAL DISORDERS

Psychological disorder or abnormal behaviour is a psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected. On the surface, these criteria may seem obvious, but they were not easily arrived at, and it is worth a moment to explore what they mean. You will see, importantly, that no one criterion has yet been developed that fully defines abnormality.

MENTAL ILLNESS OR MENTAL DISORDERS

The individuals who experience mental illnesses or who are suffering from mental disorders do not feel that they are having an alternative way of acting. The important characteristics of the individual suffering from mental disorders are the lack of control over one's experience. It can also be described as a loss of freedom or an inability to consider alternative ways of thinking, feeling, and acting. Some individuals show this loss mainly in terms of emotional experiences, they show loss in cognitive processes.

A mental disorder is a group of emotional (feelings), cognitive(thinking) or behavioural symptoms that cause distress or significant problems.

Mental illness not only affects the individual's interpersonal relationships with others but also their relationship with themselves, their intrapersonal relationship. For ex: when people suffering from schizophrenia or depression talk to themselves, they often think negative thoughts about who they are, and what will happen in the future. The experience of mental disorder results in personal distress.

In psychopathology, four important components are considered.

1. Loss of freedom or ability to consider alternatives,
2. A loss of honest personal contact
3. A loss of one's connection with oneself and ability to live in a productive manner

4. Personal distress.

Mental disorders result in loss of productivity, lost personal enjoyment, and even potentially even premature death.

DIMENSIONS UNDERLYING MENTAL DISORDERS

There was quite a discussion on what should be considered as abnormal behaviour. The experts in abnormal Psychology view that abnormality is in emotions, thoughts or behaviours as a matter of degree, not of kind. That is, emotions, thoughts and behaviours associated with mental disorders are present to some degree in all the individuals. Abnormal behaviour cannot be told as present or absent but they do exist in a continuum in everyone to some or the other degree. To decide whether behaviour is different or deviant from the norm is a matter of degree. To judge whether a behaviour is maladaptive or not is also a matter of degree. The most important thing to be remembered is that we all experience anxiety, sadness, stress, anger in our daily life, it is the degree on the continuum from extremely low to extremely high levels. The concept and the idea that emotions, thoughts and behaviours exist on a continuum in varying degrees is a very important aspect to be remembered while assessing an individual to find out if he or she is normal or abnormal. A mental health professional assesses an individual based on the three dimensions that is emotions, thoughts and behaviour.

1.4 CONCEPTS OF NORMALITY AND ABNORMALITY

Abnormal psychology studies the behaviour and experiences of abnormal people. It provides preventive and curative measures for the treatment of abnormal behaviour or disorders.

Normality: The term Normal seems to be derived from the word ‘Norma’ which means a carpenter’s square or rule a norm therefore becomes a rule, pattern or standard. The term ‘abnormal’ with its prefix ‘ab’ (away from) thus came to signify the deviance or variation from the normal. Anything not normal must, therefore be abnormal.

Abnormality: It is difficult to label normal and abnormal behaviour, hence certain criteria are used to understand and distinguish the normal and abnormal behaviour. The patterns in Psychological abnormality can be understood based upon the four D’s i.e.,

Deviant- different, extreme, unusual, perhaps even bizarre. Behaviours are considered abnormal when thoughts, emotions, behaviours violate a society's ideas about proper functioning. Each society establishes norms- explicit and implicit rules for proper conduct. Behaviours that violate legal norms are called criminal. Behaviour, thoughts and emotions that violate norms of Psychological functioning are called abnormal.

Distress – It is unpleasant and upsetting to the person, the behaviour, ideas, or emotions which usually cause distress to the individual.

Dysfunctional- Interfering with the person's ability to conduct daily activities in a constructive way. Abnormal behaviour interferes with the daily functioning. It upsets, distracts, or confuses people that they cannot care for themselves properly, participate in ordinary social interactions, or work productively.

Dangerous-The ultimate in psychological dysfunctioning is behaviour that becomes dangerous to oneself or others. The individuals whose behaviour is consistently careless, hostile or confused may be placing themselves or those around them at risk.

Abnormality criteria:

The individual's behavior is away from normal or deviates from society norms or norm violation. Society sets norms and rules of living which tells us what is 'right' and 'wrong' to do and when and where and with whom. Consider for example, the way of eating our food that is our food habits, the way the individual dresses, celebration of festivals, rituals etc. The ability to maintain one's mental health. An ability to cope up with the situations and solve problems.

1.5 SCOPE OF ABNORMAL PSYCHOLOGY

Abnormal Psychology studies two types of behaviours. Adaptive and maladaptive behaviour.

Adaptive behaviours are those behaviours which are well suited to the nature of people, their lifestyles and their surroundings, and in the way how they communicate with other people, which helps them in understanding others.

By understanding the behaviours which are **maladaptive** it can be found out that what behaviours are creating problems, it also suggests what behaviours the individual is vulnerable to and cannot cope up with the environmental stress which inturn is leading the individual to have problems in functioning in their daily life with their emotions, mental thinking, physical activities and their communication.

Abnormal Psychology is that branch of Psychology which studies the abnormality of an individual's behaviour. Abnormal Psychology is the theoretical branch which provides the information and knowledge about the understanding of abnormality. Clinical Psychology is the applied field of Psychology which assess, understands and treats the Psychological conditions, the Psychological problems, disorders in clinical practice.

TREATMENT

Once it is found that an individual is suffering from any mental disorder or illness treatment has to be given. The Clinical Psychologists first distinguish the normal and abnormal behavior. Treatment or therapy is a procedure which is designed to change the abnormal behavior in an individual. According to the Clinical Psychologist Jerome Frank all forms of Psychotherapy have three essential features. They are:

1. A sufferer who seeks relief from the healer.
2. A trained, socially accepted healer, whose expertise is accepted by the sufferer and his or her social group.
3. A series of contacts between the healer and the sufferer, through which the healer, often with the aid of the group, tries to produce certain changes in the sufferer's emotional state, attitudes and behavior.

Some clinicians view abnormality as an illness and so consider therapy a procedure that helps cure the illness. Certain other clinicians view abnormality as a problem in living and the therapists as a teacher of more functional behavior and thought. Whatever be the differences in the way they view, but ultimate goal of a psychologist is to help the individuals who are unable to adjust to their environment to help them make necessary changes for their adjustment and for those individuals who are suffering from psychological illness to help them overcome those illness and to lead a better adjusted and a normal life.

1.6 HISTORICAL DEVELOPMENT OF PSYCHOPATHOLOGY

Tracing back to the history, humans have tried to explain the abnormal and problematic behaviour. Humans have always thought that certain agents outside our bodies and environment influence our behaviour, thinking, and emotions. These agents, which might be divinities, demons, spirits or other phenomena such as magnetic fields or the moon or the stars are the driving forces behind the supernatural model. In the ancient Greece, the mind has often been called the soul or the psyche and considered separate from the body. They have believed that the mind can influence the body and in turn, the body can influence the mind, most philosophers looked for causes of abnormal behaviour in one or the other.

Various models have been developed to explain this abnormal behavior. The aim of these models is to give an explanation to these behaviours. This split gave rise to two traditions of thought about abnormal behaviour, it can be understood as the biological model and the psychological model. These three models 1) supernatural, 2) biological 3) psychological, tries to provide an explanation to the abnormal behavior

1.6.1 SUPERNATURAL TRADITIONS

Most historians believed that the prehistoric societies regarded the abnormal behavior as the work of evil spirits. These early societies explained that the evil spirits possessed the humans and make them behave in this manner. In these societies they believed that human body and mind as a battlefield between the external forces of good and evil. The abnormal behavior was typically viewed as the victory of evil spirits, and the cure for such behavior was to force the demons from the victim's body.

Barbara Tuchman, a noted historian, chronicled the second half of the 14^{th} century, a particularly difficult time for humanity, in A Distant Mirror (1978). She very ably captures the conflicting tides of opinion on the origins and treatment of insanity during that bleak and tumultuous period.

The people who were showing the abnormal behavior were seen as they were possessed by the supernatural powers. Usually it was considered as an angry God or an evil spirit. The treatment used for these possessions were **trephination** and **exorcism. Trephination** means a

stone instrument, or trephine was used to cut away a circular section of the skull. They used this as an operation which was performed as a treatment for severe abnormal behavior. It may be hallucinations- in which the individual hears to sounds which is not there, or sees something which does not exist. It was also used in melancholia, which was characterized by extreme sadness and immobility. **Exorcism** was often used in these societies for the treatment of abnormality. Exorcism was the idea to coax the evil spirits to leave or to make the person's body an uncomfortable place in which to live. A shaman, a priest used to recite prayers, plead with the evil spirits, insult them, perform magic, make loud noises, or they used to make the individual drink bitter potions. If these techniques failed the shamans used to perform the extreme form of exorcism, such as whipping or starving the person. Apart from these some more severe measures like starving or flogging were also used. In this supernatural tradition as it was also called as demonological method the abnormal behavior were considered to be caused by demons, spirits or the influence of planets.

At the same time it was also seen that a few so called creative "therapies" decided that hanging people over a pit full of poisonous snakes might scare the evil spirits right out of their bodies (to say nothing of terrifying the people themselves). Strangely, this approach sometimes worked, that is, the most disturbed, oddly behaving individuals would suddenly come to their senses and experience relief from their symptoms, if only temporarily. Naturally, this was reinforcing to the therapist and so, snake pits were built in many institutions. Many other treatments based on the hypothesized therapeutic element of shock were developed including dunkings in ice-cold water.

During the same time it was also found the enlightened view that insanity was a natural phenomenon, caused by mental or emotional stress and that it was curable. Mental depression and anxiety were recognized as illnesses, although symptoms such as despair and lethargy were often identified by the church with the sin of acedia, or sloth. Common treatments were rest, sleep and a healthy and happy environment. Other treatments included baths, ointments, and various options. During the 14^{th} centuries, the insane, along with the physically deformed or disabled were often moved from house to house in medieval villages, as neighbors took turns caring for them. We now know that this medieval practice of keeping people who have psychological disturbances in their own community is beneficial.

GREEK AND ROMAN VIEWS AND TREATMENT

Around 500 B.C to A.D 500 in Greek and Roman civilizations, the philosophers and physicians identified a number of mental disorders. The development of medicine among Egyptians and Greeks helped to replace the ancient supernatural theories with the natural ones. The new natural theories reject supernatural forces and instead of that they look at the things that can be observed i.e., the things that can be observed, known and measured as potential causes of the occurring events.

The most important one was the melancholia, a condition where the individual is filled with sadness, mania, a state where the individual is in a state of euphoria and frenzied activity, dementia a general intellectual decline, hysteria the presence of a physical ailment with no apparent physical cause, delusions, bluntly false beliefs, and hallucinations the experience of imagined sights or sounds as if they were real.

1.6.2 BIOLOGICAL TRADITIONS

Hippocrates (460-377 B.C) a Greek physician known as the father of the modern medicine rejected the demons and evil spirits as causes of abnormal behavior. According to Hippocrates, he believed that the brain was the central organ of the body and that abnormal behavior resulted from the brain disorders or dysfunctions. He also recommended that psychological disorders could be treated like any other disease. He believed that the psychological disorders might be caused by brain pathology or head trauma and it could be influenced by heredity (genetics). He also recommended certain treatments for the abnormal behavior that would restore functioning, including special diets, rest, abstinence from alcohol, regular exercise. Hippocrates also recognized the importance of psychological and interpersonal contributions to psychopathology, such as, sometimes the negative effects of family stress; in some occasions, he removed patients from their families.

The Roman physician Galen later adopted the ideas of Hippocrates and his associates and developed them further, creating a powerful and influential school of thought within the biological tradition that extended well into the 19th century.

The very important and interesting influential legacies of the Hippocratic-Galenic approach are the humoral theory of disorders. Hippocrates assumed that normal brain functioning is related to four bodily fluids of humors; blood, black bile, yellow bile and phlegm. Blood comes from the heart, black bile from the spleen, phlegm from the brain and choler or yellow bile from the liver. Physicians believed that disease results from too much or too little of one of the humors; for example too much black bile was thought to cause melancholia (depression). In fact, the term melancholer, which means black bile, is still used today in its derivative form melancholy to refer to aspects of depression. The humoral theory was, perhaps the first example of associating psychological disorders with chemical imbalance, an approach that is widespread today.

The four humors were related to the Greek's conception of the four basic qualities: heat, dryness, moisture and cold. Each humor was associated with one of these qualities. Terms derived from the four humors are still sometimes applied to personality traits. For example, sanguine (red, like blood) describes someone who is ruddy in complexions, presumably from copious blood flowing through the body and cheerful and optimistic, though insomnia and delirium were thought to be caused by excessive blood in the brain. Melancholic, of course, refers to a depressive personality (depression was thought to be caused by black bile flooding the brain). A phlegmatic personality (from the humor phlegm) indicates apathy and sluggishness, but can also mean being calm under stress. A choleric person (from the yellow bile or choler) is hot tempered). Excesses of one or more humors were treated by regulating the environment to increase or decrease heat, dryness, moisture or cold, depending on which humor was out of balance. In addition to rest, good nutrition and exercise, two treatments were developed. In one, bleeding or bloodletting, a carefully measured amount of blood was removed from the body, often with leeches. The other was the induction of vomiting; indeed in a well-known treatise on depression published in 1621, Anatomy of Melancholy, Burton recommended eating tobacco and a half-boiled cabbage to induce vomiting.

Hippocrates also coined the word hysteria to describe a concept he learned about from the Egyptians, who had identified what we now call the somatoform disorders. In these disorders the physical symptoms appear to be the result of an organic pathology for which no organic cause can be found, such as paralysis and some kinds of blindness.

The Development of Biological treatments

The biological origin of psychological disorders led, ultimately to greatly increased understanding of biological contributions to psychopathology and to the development of new treatments. In the 1930s, the physical interventions of electric shock and brain surgery were often used. Their effects, and the effects of new drugs, were discovered quite by accident. For example, insulin was occasionally given to stimulate appetite in psychotic patients who were not eating, but it also seemed to calm them down. In 1927, a Viennese physician, Manfred Sakel, began using higher and higher dosages, until, finally patients convulsed and became temporarily comatose. Some actually recovered their mental health, much to the surprise of everybody, and the recovery was attributed to the convulsions. The procedure became known as insulin shock therapy, but it was abandoned because it was too dangerous, often resulting in prolonged coma or even death. Other methods of producing convulsions had to be found.

In the 1920s, Joseph von Meduna observed that schizophrenia was very rarely found in epileptics (which ultimately did not prove to be true). Some of his followers concluded that induced brain seizures might cure schizophrenia. Following suggestions on the possible benefits of applying electric shock directly to the brain – notably, by two Italian physicians, Cerletti and Bini, in 1938 – a surgeon in London treated a depressed patient by sending six small shocks directly through his brain, producing convulsions. The patient recovered. Though greatly modified, shock treatment is still with us today. The controversial modern uses of electroconvulsive therapy (ECT) are interesting that even now we have very little knowledge of how it works.

During the 1950s, the first effective drugs for severe psychotic disorders were developed in a systematic way. Prior to that time, a number of medicinal substances, including opium (derived from poppies), had been used as sedatives, along with countless herbs and folk remedies. With the discovery of Rauwolfia serpentine (later renamed reserpine) and another class of drugs called neuroleptics (major tranquilizers), for the first time hallucinatory and delusional though processes could be diminished; these drugs also controlled agitation and aggressiveness. Other discoveries included benzodiazepines (minor tranquilizers) which seemed to reduce anxiety. By the 1970s, the benzodiazepines (known by such brand name as Valium and Librium) were among the most widely prescribed drugs in the world. As drawbacks and

side effects of tranquilizers became apparent, along with their limited effectiveness, prescriptions decreased somewhat.

Throughout the centuries, as Alexander and Selesnick (1966) point out, "The general pattern of drug therapy for mental illness has been one of initial enthusiasm followed by disappointment. For example, bromides, a class of sedating drugs were used at the end of the 19th and the beginning of the 20th century to treat anxiety and other psychological disorders. By the 1920s, they were reported as being effective for many serious psychological and emotional symptoms. By 1928, one of every five prescriptions in the United States was for bromides. When their side effects, including various undesirable physical symptoms, became widely known, and experience began to show that their overall effectiveness was relatively modest, bromides largely disappeared from the scene.

Neuroleptics have also been used less as attention has focused on their many side effects, such as tremors and shaking. However, the positive effects of these drugs on some patients, psychotic symptoms of hallucinations, delusions and agitation revitalized both the search for biological contributions to psychological disorders and the search for new and more powerful drugs was done.

Consequences of the Biological Tradition

In the late 19th century, John P. Grey and his colleagues, ironically, reduced or eliminated interest in treating mental patients because they though mental disorders were due to some as yet undiscovered brain pathology and were therefore incurable. Emil Kraepelin was the dominant and one of the founding fathers of modern psychiatry. He was extremely influential in advocating the major ideas of the biological tradition, but he was little involved in treatment, reflecting the belief that disorders were due to brain pathology. His lasting contribution was in the area of diagnosis and classification. Kraepelin was one of the first to distinguish among various psychological disorders seeing that each may have a different age of onset and time course, with somewhat different clusters of presenting symptoms and probably a different cause.

By the end of the 1800s, a scientific approach to psychological disorders and their classification had begun with the search for biological causes. Further, treatment was based on

humane principles. There were many drawbacks, the most important one was being that active intervention and treatment were all but eliminated in some settings, despite the fact that some very effective approaches were available.

MASS HYSTERIA

During the last half of the middle ages in Europe a new and peculiar practice came into vogue. In Europe whole groups of people were simultaneously compelled to run in the streets, singing, dancing, screaming, shouting, rave and jump around as they wish. This behavior or practice was known as Saint Vitus's dance and **tarantism.** This is now called as Mass Hysteria. Mass hysteria may have served the purpose in the sense, emotions are contagious, if someone nearby becomes very frightened or very sad, chances are that for the moment you will also feel fear or sadness. When this kind of experience escalates into full-blown panic, whole communities are affected. People are also very suggestible when they are in states of high emotion. Therefore, if one person identifies a "cause" of the problem, others will probably assume that their own reactions have the same source. This shared response is sometimes referred to as mob psychology.

The Moon, the Stars and human mind

Paracelsus, a Swiss physician who lived from 1493 to 1541, rejected notions of possession by the devil, suggesting instead that the movements of the moon and stars had profound effects on people's psychological functioning. This influential theory inspired the word lunatic, which is derived from the Latin word for moon, luna. When someone mentions that they behaved in a crazy way usually people tease them by saying may be because it is full moonday or it is no moonday.

The belief that heavenly bodies affect human behaviour still exists, although there is no scientific evidence to support it. People still do believe that their behaviours are affected by the position of moon and the stars.

1.6.3 THE PSYCHOLOGICAL TRADITIONS

It is a long leap from evil spirits to brain pathology as causes of psychological disorders. In the intervening centuries, where was the body of thought that put psychological development,

both normal and abnormal in an interpersonal and social context. In fact, this approach has a long and distinguished tradition. Plato, for example thought that the two causes of maladaptive behaviour are the social and cultural influences in one's life and the learning that takes place in that environment. If something was wrong in the environment, such as abusive parents, one's impulses and emotions would overcome reason. The best treatment was to reeducate the individual through rational discussion so that the power of reason would predominate. This was very much a precursor to modern psychosocial approaches, which focus not only on psychological factors, but on social and cultural ones as well. Other well-known early philosophers, including Aristotle, also emphasized the influence of the social environment and early learning on later psychopathology. These philosophers wrote about the importance of fantasies, dreams, and cognitions and thus anticipated to some extent, late developments to psychoanalytic thought and cognitive science. They also advocated humane and responsible care for the psychologically disturbed.

Moral therapy

During the 1st half of the 18th century, a strong psychosocial approach to mental disorders called moral therapy became influential. The term moral really meant "emotional" or "psychological" rather than a code of conduct. Its basic tenets included treating institutionalized patients as normally as possible in a setting that encouraged and reinforced normal social interaction, thus providing them with many opportunities for appropriate social and interpersonal contact. Relationships were carefully nurtured. Individual attention clearly emphasized positive consequences for appropriate interactions and behaviour; the staff made a point of modeling this behaviour.

The principles of moral therapy date back to Plato and beyond. But moral therapy as a system originated with the well-known French psychiatrist Philippe Pinel.

After William Tuke followed Pinel's lead in England, Benjamin Rush, often considered the founder of American psychiatry, introduced moral therapy in his early work at Pennsylvania Hospital. It then became the treatment of choice in the leading hospitals. Asylums had appeared in the 16th century, but they were more like prisons than hospitals. It was the rise of moral therapy in Europe and the United States that made institutions habitable and even therapeutic.

Asylum Reform and the Decline of Moral Therapy

During the early part of the renaissance with the changes in cultural and scientific activity the demonological views of abnormality came to a decline. The German physician Johann Weyer (1515-1588), the first physician to specialize in mental illness, believed that the mind was as susceptible to sickness as the body. He is considered as the founder of the modern study of psychopathology. The care of mentally ill people came to improve in this period. Shrines were developed to take care of these mentally ill people. The best out of these shrines were in Gheel in Belgium. It continued to take care of these people. It demonstrated that people with psychological disorder can respond to loving care and respectful treatment. Later these community hospitals were converted into hospitals and they were converted into **asylums. Asylums** were the institutions whose primary purpose was to care for people with mental illness.

A reason for the decline of moral therapy has an unlikely source. The great crusader Dorethea Dix campaigned endlessly for reform in the treatment of the insane. A school teacher who had worked in various institutions, she had firsthand knowledge of the deplorable conditions imposed on the insane, and she made it her life's work to inform the American public and their leaders of these abuses. Her work became known as the mental hygiene movement.

In addition to improving the standards of care, Dix worked hard to make sure that everyone who needed care received it, including the homeless. Through her efforts, humane treatment became more widely available in American institutions. As her career drew to a close, she was rightly acknowledged as a hero of the 19^{th} century.

Unfortunately, an unforeseen consequence of Dix's heroic efforts was a substantial increase in the number of mental patients. This influx led to a rapid transition from moral therapy to custodial care because hospitals were inadequately staffed. Dix reformed the asylums and single-handedly inspired the construction of numerous new institutions here and abroad. But even her tireless efforts and advocacy could not ensure sufficient staffing to allow the individual attention necessary to moral therapy.

A final blow to the practice of moral therapy, mentioned earlier was the decision in the middle of the 19th century that mental illness is caused by brain pathology and therefore is incurable.

Several factors were responsible for the decline of moral treatment. As the mental hospitals multiplied, severe money and staffing shortages developed, recovery rates declined, and overcrowding in hospitals became a major problem. Another major factor for its decline was the assumption behind moral treatment that all the patients could be cured if treated with humanity and dignity. For few it was sufficient, but for certain patients it was not enough and they remained mentally ill and even died like that. These factors and many other contributing factors lead to the decline of moral treatment.

1.7 SUMMARY

Abnormal behaviour is generally considered when it is deviant, distressful, dysfunctional and dangerous. Therapy is a systematic process of helping people overcome their psychological difficulties. The rise of awareness about the mental illness, the way individuals were being treated centuries back, the changes in thinking and the growth of scientific knowledge brought about a slow but progressive change in the way the mental illness was viewed and the way the people suffering from these illnesses were being treated. A detailed history of these are being discussed in this unit.

1.8 KEY WORDS

Psychopathology
Psychological disorder
Psychological dysfunction
Distress or Impairment
Mass hysteria
Melancholia
Phlegmatic

1.9 CHECK YOUR PROGRESS

1. What is psychopathology? Explain the normality and abnormality.
2. Explain the meaning and definitions of Psychological Disorders.
3. Discuss the scope of Abnormal Psychology.
4. Explain the history of supernatural tradition in psychopathology.
5. Explain the history of biological tradition in psychopathology.
6. Explain the history of psychological tradition in psychopathology.

1.10 ANSWERS TO CHECK YOUR PROGRESS

1. 1.3
2. 1.4
3. 1.5
4. 1.6.1
5. 1.6.2
6. 1.6.3

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UNIT - 2: MODELS OF PSYCHOPATHOLOGY

STRUCTURE

2.1 OBJECTIVES

After going through this unit, you will be able to explain:

- models of psychopathology
- Psychoanalytical model
- Behaviouristic model
- Cognitive model
- Humanistic model
- Behavioural or Neuroscience model

2.2 INTRODUCTION

In the previous unit we have understood about the Concept of Psychopathology, mental illness, the criteria for deciding the abnormal behaviour. In the present unit we have mainly focused completely upon the various perspectives of understanding the abnormal behaviour and the psychopathology behind these. We have looked at numerous factors that are associated with the etiology of various psychological disorders. We need to see if there is a way to organize many factors into an overarching model of psychopathology. Without such a unifying model, a comprehensive understanding of psychopathology will continue to elude us. Each model has its own view to explain the psychological disorders those are psycho analytical Behaviouristic, cognitive, humanistic and existential and neuroscience perspectives.

Psychoanalytic perspective initially proposed by Freud that emphasizes the importance of the unconscious and the early childhood experiences as the key to understanding behavior and thought. Behavioral perspective emphasizes the role of environment in shaping behavior. Cognitive perspective emphasizes the role of mental processes that underlie behavior. Humanistic perspective emphasizes the importance of individual's subjective experience as a key to understanding behaviour. Neuroscience a field combines the work of psychologists, biologists, biochemists, medical researcher, and others in the study of the structure and function of the nervous system.

Perspectives or models are the systematic ways of viewing and explaining what we see in the world. Models are the ways of looking at things. Models help the mental health professionals

and influence them in their way of looking, thinking, assessing and treating mental disorders. Many mental health professionals integrate these models to study and explain mental disorders.

2.3 PSYCHOANALYTIC MODEL

The psychoanalytical model is the oldest and most famous of the modern Psychological models. This model believes that a person's behaviour, whether normal or abnormal, is determined largely by underlying forces of which he or she is not consciously aware. These internal forces are described as dynamic that is they interact with one another and their interaction gives rise to the behaviour, thoughts and emotions. Abnormal symptoms are viewed as the result of conflicts between these forces.

Freud (1856-1939) developed this psychoanalytic model over a period of five decades of observing and writing. The major principles of his model were based on the clinical study of individual patients – Mostly Neurotic – who were undergoing treatment for their problems. Freud developed the theory of Psychoanalysis to explain both the normal and abnormal functioning as well as a method in treating which he called as Psychoanalytical model or Psychoanalysis.

THE BEGINNINGS OF PSYCHOANALYSIS

Freud worked in collaboration with Joseph Breuer a physician, he had introduced an interesting innovation in the use of hypnosis on his neurotic patients, chiefly women. In the process of hypnosis the patients used to speak freely about whatever was there in their mind. But when they came to complete conscious they were not aware of what they had spoken, at the same time they felt they were relieved and feeling better. As this method helped the individual to release their emotions and feel better this method was called as "Cathartic method". This led to the understanding and discovery of the unconscious part of the mind.

PRINCIPLES OF PSYCHOANALYSIS MODEL

According to Freud there are three central forces which shape the behavior of an individual and also the personality. They are Id, ego and superego.

Id: Id denotes the instinctual needs, drives and impulses. Id is based on pleasure principle. Id demands for immediate gratification of its wishes and desires. Id is completely selfish in nature.

Ego: Ego is based on reality principle. It mediates between the id and the external reality of the world. The basic purpose of ego is to fulfill the demands of id but in reference with the reality. It uses the principle of reason and the use of intellectual resources to deal with Id and the external realities of the world. By utilizing the knowledge we have the ego uses the reasoning capacity and guides us to know when we can and cannot express the id impulses.

Superego: The superego grows from the ego. Superego is based on the morality principle. As we grow we learn from our parents that many of our id impulses are unacceptable, hence we then consciously adopt or introject our parents values. We learn to judge ourselves through their values. When we uphold those values we feel good, when we go against them we feel guilty. Through this we develop conscience. The superego strives to compel the ego to inhibit desires that are considered wrong and immoral.

These three parts of the personality are in some degree in conflict with one another. A healthy personality is the one in which an effective working relationship, an acceptable compromise, has been formed between these three forces. According to Freud, if Id, ego and superego are in conflict with one another and there is no harmony then it will lead to the signs of dysfunction in the individual.

Anxiety

Defence mechanisms and the unconscious. The concept of anxiety is prominent in the psychoanalytic model Freud distinguished among three types of anxiety, or psychic pain, that people can suffer

(a) **Reality anxiety**: It is the anxiety which arises from dangers or threats in the external world.

(b) **Neurotic anxiety** – caused by impulses threatening to break through ego controls, resulting in behaviour that will be punished in some way.

(c) **Moral anxiety**: arising from a real or contemplated action in conflict with the individual's super ego or moral values and arousing feeling of guilt.

DEFENSE MECHANISMS

The ego experiences anxiety when the id urges it to seek impulsive gratification or when the superego imposes shame and guilt. Anxiety is a painful emotion, it is a warning of impending danger as well as a painful experience, so it forces the individual to take corrective actions often the ego can cope up with the anxiety by rational measures. The ego develops certain basic strategies which are called as defense mechanisms. These defense mechanisms help the individual to protect one's ego from being hurt by providing certain ways to explain the behavior. There are a number of defense mechanisms used by the individual in different context based upon the situation. A list of these is mentioned below:

1. Repression
2. Denial
3. Regression
4. Projection
5. Fantasy
6. Rationalization
7. Reaction formation
8. Displacement
9. Intellectualization
10. Undoing
11. Overcompensation
12. Sublimation

These defense mechanisms alleviate the painful anxiety, but they do so by distorting reality instead of dealing directly with the problem.

Another important concept in the psychoanalytic model is that of the **unconscious.** Freud thought that the conscious represents a relatively small area of the mind while the unconscious part is the much larger portion. In the depths of the unconscious are the hurtful memories, forbidden desires and other experiences that have been pushed out of the conscious.

Psychosexual stages of Development

Freud viewed personality development as a succession of stages. He proposes that at each stage of the development, from infancy to maturity, new events and pressures challenge individuals and require adjustments to their id, ego and superego. If the adjustments are successful, they lead to personal growth. If they are not successful, the individual become fixated at that stage of development. The stages of development are as follows:

(a) **Oral stage**: During the first two years of life, the mouth is the principal erogenous zone, the infant's greatest source of gratification is assumed to be sucking.

(b) **Anal Stage**: From age to age 3, the membranes of the anal region presumably provide the major source of pleasurable simulation.

(c) **Phallic stage**: From age 3 to age 5 or 6, self-manipulation of the genitals provides the major source of pleasurable sensation.

(d) **Latency stage**: In the years from 6 to 12 sexual motivations presumably recede in importance as the child becomes preoccupied with developing skills and other activities.

(e) **Genital Stage**: After puberty, the deepest feelings of pleasure presumably come from heterosexual relations.

Impact on the views of Psychopathology

According to the psychoanalytic model, people are dominated by instinctual biological drives, as well as by unconscious desires in a constructive libidinal side in each individual, there are also the darker forces of aggression leading forward destruction and death. And although the ego toward rationality; the counterpaces of intra psychic conflict, defense mechanisms, and the unconscious all tend toward a high degree of irrationality and maladaptive behaviour. In addition, behaviour is further determined through past learning, especially from early experiences. Thus the psychoanalytic model presents a negativistic and deterministic view of human behaviour and minimizes rationality and freedom for self-determination.

2.4 BEHAVIOURISTIC MODEL

Behavioural perspective developed in the 20th century. Behavioural theorists believe that our actions are determined largely by our experiences in life. Behavioural perspectives focus on

the environmental stimuli and behavioural responses. This model concentrates on behaviours, the response an organism makes to its environment. According to behavioural model all our behaviours are learnt behaviours. Many behaviours help people to cope with daily challenges and to lead a happy life, at the same time abnormal behaviours can also be learnt.

Behaviorism

Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I will guarantee to take any one at random and train him to become any type of specialist I might suggest – doctor, lawyer, merchant-chief and yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations and the race of his ancestors.- John B. Watson.

Johns Hopkins University Psychologist John B. Watson sound argued that environmental influences – not spirits, demons or intrapsychic forces – shape our behavior. Behaviorists focus on two basic types of learning: classical conditioning and operant conditioning.

Classical Conditioning

Classical Conditioning was discovered by chance. The Russian psychologist Ivan Pavlov was exploring the biological pathways of dog's salivary glands, but the animals fouled up his results by salivating apparently arbitrarily. Pavlov noted the animals were in fact salivating not arbitrarily, but in response to his assistants coming into the lab or to the accidental changing of metal on metal. So Pavlov undertook a clever experimental program to show the dogs salivated to these events because the events were associated with feeding.

When you put meat on a dog's tongue, the dog salivates. Salivation in response to meat is a reflex – a simple kind of unlearned behaviour. People also have many reflexes, such as blinking the eye in response to a puff of air and jerking the knee in response to a tap beneath. A change in the environment like putting meat on a dog's tongue or tapping beneath the knee is referred to as a stimulus. A reflex is one type of response to a stimulus. Reflexes are not learned, but they can be conditioned to, or associated with, various stimuli.

In this classic demonstration, meat is an **unconditioned stimulus**(US). Salivation in response to meat is termed as **unconditioned response** (UR)."Unconditioned" means unlearned. Originally, the bell is a **neutral** or meaningless stimulus. But after being associated repeatedly

with the US (meat), the bell becomes a learned or **conditioned stimulus** (CS). The bell is then capable of eliciting salivation. Salivation in response to the bell is termed a learned, or **conditioned response** (CR).

Conditioning of Fears

As any behavior can be learned through conditioning whether good or bad, it was found that the way we learn from association of two different stimulus evoking same kind of response, it was also found that in a similar manner fears can also be learned. Conditioning of fears is a simple form of associative learning wherein an individual learns to associate the presence of a neutral stimulus, with the presence of a motivationally significant stimulus.

John Watson and Rosalie Rayner, his future wife, showed that fears can be conditioned by showing "Little Albert", an 11 month-old boy .a laboratory rat and then banging steel bars together behind his head. Before conditioning, Albert reached out to play with the rat. After numerous pairing of the rat and the clanging, however, Albert cried when the rat was brought in and tried to avoid it. Through classical conditioning we come to associate stimuli, so a response elicited by one is then elicited by the other. With little Albert, jarring clanging was associated with a rat, so the rodent came to evoke the fear elicited by the noise. Fear conditioning is not always so reliable, however. Attempts to replicate the Little Albert experiment have not always been successful.

Operant Conditioning

Operant conditioning is a process of learning in which behaviour that leads to satisfying consequences is likely to be repeated. It is also called as respondent conditioning because here in this form the organism learns to give responses to the learned behaviour for the behaviour's effect. It operates upon, or it manipulates the environment to produce certain effects.

In operant conditioning the organisms learns or acquires a particular skill when reinforcement is provided for it. According to the behavioural approach reinforces play a very important role in the acquisition of a skill.

REINFORCERS

Reinforces are those things which make an activity or a behaviour to be repeated when presented after a particular behaviour. There are different types of reinforces.

Positive reinforces are those which when presented helps and boosts the frequency of the behaviour. For ex: food, money, social approval, praise, compliment etc.

Negative reinforces are those which when they are not presented increases the behaviour. For ex: the negative emotions like fear, anger, pain, social disapproval. We usually learn to do things which help us to remove these things.

REWARDS

Rewards are the positive reinforces. Rewarding a desirable behavior will help in making that particular behaviour to get established in the individual. To reward a behaviour it is essential that the individual need to be observed carefully and attention need to be paid on the good behaviour and it need to be rewarded immediately. Rewarding works better than punishing. Rewarding works very well with young children. It is also applied to correct the misbehaviour of a child.

PUNISHMENT

Punishment is usually used to correct the behaviour and also to create the awareness in an individual that the behaviour is not expected and it should not occur again. Punishment usually reduces the frequency and suppresses the behaviour but it does not completely remove the unwanted behaviour. Punishment may be physical or psychological. Punishment may suppress the behaviour but it does not eliminate the behaviour. The moment the punishment is withdrawn the undesirable behaviour may occur again. Punishment makes the individual to avoid the situation itself rather than correcting oneself. For ex: a child being punished in the class may start missing the class to avoid the punishment. Punishment generates anger, hostility, hatredness, rather than being a constructive learning experience.

2.5 COGNITIVE MODEL

In the early 1960s the two most influential Cognitive Psychologists Albert Ellis and Aaron Beck proposed a theory based on the cognitive processes that the cognitive processes are

the center of an individual's behaviour, thought, and emotions. If we understand these , we can best understand the abnormal functioning by looking to cognition. The cognitive model describes how people's thoughts and perceptions influence their behaviour. Distress can distort people's perceptions, and that in turn, can lead to unhealthy emotions and behaviours. Cognitive perspectives explain that our emotions and behaviour are influenced by how we experience and think about our present and past experiences. All our actions and experiences are actively interpreted. This processing and the interpretation are being influenced by the cognitive schemas and the beliefs the individual has and the expectations which are being represented by a network of accumulated knowledge. People interpret events they experience, and these interpretations affect their moods and behaviour.

According to the cognitive theorists we do reproduce and create the world our minds as we try to understand the world around us. If we are effective we will be creating accurate cognitions about the surrounding world and our experiences which are useful for us. If not we may be creating an ineffective, meaningless, painful, distorted images which will lead to psychological worries. Abnormal functioning can result from several kinds of cognitive problems. Many individuals make their own assumptions and create, adopt attitudes which are disturbing and inaccurate in its nature.

Another very important source for abnormal functioning is the illogical thinking. Some individuals keep on thinking illogical thoughts and they arrive at self-defeating conclusions. Aaron Beck's cognitive theory holds that mental disorder may result if one has negative views of oneself, and the other people in the world and negative views about the future.

According to the cognitive therapists individuals can overcome their problems or psychological disorders by developing a new, more functional way of thinking. Aaron Beck put forwards his theory and develops a new approach called cognitive therapy. In this therapy the therapist helps the clients recognize their negative thoughts, biased interpretation, false thinking, faulty thoughts and errors in logic that dominate their logic. Therapists help the clients to challenge their dysfunctional thoughts and try out new ways of their thinking in their daily life.

Rational Emotive Behaviour Therapy

Albert Ellis developed a new theory called as Rational emotive behavior therapy based on the cognitive perspective. This therapy focuses on the people's way of processing

information, which may be faulty and irrational in its expectation. The irrational expectations people have about themselves and the surrounding world creates a large amount of stress and frustration which troubles the individual's peace of mind creating psychological tension. This in turn will lead to the maladjustment and abnormal functioning of an individual behavior.

According to Ellis people make their life miserable by what they think about the events they experience and what they say to themselves about the events, this self-talk when it is not based upon the understanding of the situation completely and being reality based rather if it is affected with one's emotional thoughts it may affect the way the reality is perceived. In actuality the events in it do not lead to anxiety, depression or they do not disturb our behavior, but the misinterpretation of those events does lead to those.

Ellis proposes an "A-B-C approach" to explain the causes of misery.

A- Activating events

B- Beliefs

C- Consequences

Activating Events – Beliefs – Consequences

The apprehension about the future and feelings of disappointment are perfectly normal when people face losses. However, the adoption of irrational beliefs can lead people to *catastrophize* the magnitude of losses and contribute to profound distress and depression. When the emotional responses are intensified and feelings of helplessness are felt, such beliefs impair coping ability. Such beliefs also lower self-efficacy expectations and distract people from trying to solve their problems.

Rational-emotive therapists help the clients to overcome these irrational beliefs and substitute them with more rational ones. A list of irrational beliefs is given below:

1. You must have love and approval nearly all the time from people who are important to you.

2. You must be completely competent in all your endeavours. Or you must have real expertise or talent in something important.

3. Life must go the way you want it to go. Things are awful when you don't get your first choices.

4. Other people should treat everyone fairly. When people are unfair or unethical, they are horrible and rotten and should be punished or avoided.

5. People and things should turn out better than they do. It's awful and terrible when quick solutions to life's hassles are not forthcoming.

6. Your past is a strong influence on your behaviour and must continue to affect you and determine your behaviour.

7. You can find happiness by inertia, inactivity or passivity.

It is natural that an individual expects to be accepted by others, but it is an irrational assumption that everybody should like us and also that we cannot survive if we are not liked by all.

Ellis highlights the importance of childhood experiences which are involved in the origins of irrational beliefs, according to Ellis the way to be happy is to recognize and modify our irrational beliefs and have a realistic expectation.

Aaron Beck

Psychiatrist Aaron Beck focuses on the cognitive distortions which contribute to emotional difficulties. He encourages therapy clients to see the irrationality of their thought patterns. Cognitive errors or distortions – such as minimization and pessimism – can occur so quickly and routinely that they are difficult for the person to detect. Beck's approach to therapy, called cognitive therapy helps clients identify and correct these cognitive errors.

Aaron Beck shows the importance of four basic types of cognitive errors which are the reasons for emotional distress. They are:

1. **Selective abstraction**: People may selectively abstract the parts of their experiences that reflect upon their flaws and ignore evidence of their competencies.

2. **Overgeneralization**: People may overgeneralize from a few isolated experiences. For example, they may see their futures as hopeless because they were laid off or believe they will never marry because they were rejected by someone.

3. **Magnification**: People may blow out of proportion or magnify the importance of unfortunate events. Students may catastrophize a bad test grade by jumping to the conclusion that they will flunk out of college and their lives will be ruined.

4. **Absolutist thinking**: Absolutist thinking is seeing the world in black and white terms, rather than in shades of gray. Absolutist thinkers may assume that any grade less than a perfect "A", or a work evaluation less than a rave is a total failure.

2.6 HUMANISTIC MODEL

Humanistic perspective is that perspective where the Psychologists belonging to this perspective emphasizes the human growth, choice and responsibility. Humanistic model of Psychology was developed in the 1950s and it is also called as the third force in Psychology. The main assumption about the humanistic model is that people are naturally good and strive for personal growth and fulfilment. They believe that we seek to be creative and meaningful in our lives and when we are thwarted in this goal, we become alienated from others and possibly develop a mental disorder. This model also gives the assumption that humans have choices and are responsible for their own fates. Hence, a person with a mental disorder may enhance his recovery by taking greater responsibility for his actions.

Humanistic psychologists adopt a phenomenological approach has an assumption that one's behaviour is determined by perceptions of herself or himself. They believe that a subjective human experience includes individual awareness of how we behave in the context of our environment and other people. To understand an individual completely we need to understand and see the world from his viewpoint and not as we see it. Everybody has a different view of the world that affects our behaviour.

ABRAHAM MASLOW

Abraham Maslow (1908-1970) believed that humans have basic and higher order needs they strive to satisfy during their lifetime. American psychologist Abraham Maslow argued that people also have powerful growth-oriented needs for self-actualization, to become whatever they are capable of being. Because of their uniqueness, people must follow their own paths of self-actualization. People can only actualize themselves if they set out on their own and take risks. The self-actualized person experiences life in the present in the here and now.

The Hierarchy of Need

Maslow's hierarchy of needs includes the following:

1. Biological needs: Physical survival needs, water, food, sleep, warmth, elimination, rest, avoidance of pain, sex and so on.

2. Safety needs: Physical safety, economic security, adequate clothing and housing, protection from crime and financial hardship, freedom from threats.

3. Love and belongingness needs: Love and acceptance through the formation of friendships and intimate relationships.

4. Esteem needs: Competence, achievement, approval, recognition, status and prestige.

5. Self-actualization: The development of our unique potentials and personal growth. Also at the highest level are needs for cognitive understanding (novelty, exploration and pursuit of knowledge) and aesthetic experience (music, art and poetry).

Self-actualized people are thought to be moral beings, they understand reality and can view things objectively. According to Maslow healthy people are motivated towards to the attainment of self-actualization they become more mature in accepting others, solving problems, seeking autonomy and developing deep seated feelings of compassion and empathy to others.

CARL ROGERS

Carl Rogers (1902-1987) a leading proponent of the humanistic model of Psychology. Rogers believed that humans strive for self- actualization and the frustration toward this goal could lead to mental problems such as depression. Rogers's views are termed self-theory because he believed that self is the executive or controller of personality. The sense of self is inborn, or innate that is sense of ourselves is separate human beings having our own characteristics, values and ways of relating to others. The self is the center of experience. The self provides the experience of being human in the world. It is the continuing sense of who we are our sense of how and why we react to the environment, and how we decide to act upon the environment. Rogers believed choices are conscious and based on personal values.

Rogers believed people have unique ways of seeing themselves and the world – unique frames of reference. We define ourselves in different ways and judge ourselves according to

different sets of values. Rogers assumed we all develop a need for self-regard or self-esteem, and our self-esteem is wrapped up in how we live up to our ideals.

Unconditional Positive Regard: It refers to an environment in which a person is fully accepted as they are and allowed to pursue their own desires and goals. Parents help children develop self-esteem and actualize themselves when they show them unconditional positive regard – accept them as having intrinsic merit regardless of their behaviour at the particular moment in time.

In Rogers's view, the pathway to self-actualization involves a process of self-discovery and self-awareness, of getting in touch with our true feelings, accepting them as our own, and acting in ways that genuinely reflect them. These are the goals of Rogers's method of psychotherapy called person-centered therapy.

2.7 BIOLOGICAL OR NEUROSCIENCE MODEL

The biological model assumes that the mental states, emotions, behaviours arise from brain function and other physical processes. Biological theorists view abnormal behaviour as an illness brought by malfunctioning parts of the organism. They say that the malfunctioning is in the brain as the cause of the abnormal behaviour, focusing particularly on problems in brain anatomy or brain chemistry.

Biological factors clearly play a role in many psychological disorders ranging from depression to schizophrenia. To lay a framework for discussing biological factors in abnormal behaviour, we first need to describe some key biological structures and processes beginning with the nervous system.

The Nervous System

Every neuron has a cell body, or soma, dendrites and an axon. The cell body contains the nucleus of the cell. The cell body metabolizes oxygen to carry out the work of the cell. Short fibers called dendrites project from the cell body to receive messages from the adjoining neurons. Each neuron has a single axon that projects trunk like from the cell body. They can extend as long as several feet if they are conveying messages between the toes and the spinal cord. Axons terminate in small branching structures that are aptly termed terminals. Neurons

convey messages in one direction, from the dendrites or cell body along the axon to the axon terminals. The messages are then conveyed from terminal knobs to other neurons, muscles or glands.

Neurons transmit messages to other neurons by means of chemical substances called neurotransmitters. Neuro-transmitters induce chemical changes in receiving neurons. These changes cause axons to conduct the messages in electrical form.

The junction between a transmitting neuron and a receiving neuron is termed a synapse. A transmitting neuron is termed pre synaptic. A receiving neuron is said to be postsynaptic. A synapse consists of an axon terminal from a transmitting neuron, a dendrite of a receiving neuron and a small fluid-filled gap between the two that is called the synaptic cleft. The message does not jump the synaptic cleft like a spark.

Each kind of neurotransmitter has a distinctive chemical structure. Excesses or deficiencies or neurotransmitters have been linked to various kinds of mental health problems. Alzheimer 's disease, which involves the progressive loss of memory and cognitive functioning, is associated with reductions in the levels in the brain of the neurotransmitter acetylcholine. Irregularities involving the neurotransmitter dopamine appear to be involved in schizophrenia. People with schizophrenia may use more of the dopamine that is available in their brains than do nonschizophrenics. The result may be hallucinations, incoherent speech and delusional thinking. Antipsychotic drugs used to treat schizophrenia apparently work by locking some dopamine out of its receptor sites.

Norepinephrine is manufactured mostly by neurons in the brain stem. It is chemically akin to the hormone epinephrine (also known as adrenaline). Norepinephrine acts as a neuro transmitter and a hormone. Like epinephrine, norepinephrine accelerates the heart rate and other body processes. Norepinephrine is involved in learning and memory, eating and general emotional arousal. Excesses and deficiencies of norepinephrine have been connected with mood disorders and eating disorders. Serotonin, another neuro-transmitter may be linked to various psychological disorders, including anxiety disorders, mood disorders and eating disorders. Although neurotransmitters are believed to play a role in various psychological disorders, precise casual relationships have not been determined.

Many kinds of abnormal behaviour patterns are connected with chemical imbalances in the level of neurotransmitters in the brain. Researchers, however, have not yet unearthed the precise causal relationships. Important areas in the frontal part of the brain, or forebrain, are the thalamus, hypothalamus, limbic system, basal ganglia and cerebrum. The thalamus relays sensory information to the cortex as from the eyes to the visual areas of the cortex. The thalamus is also involved in sleep and attention, in coordination with other structures like the RAS.

The hypothalamus is a tiny structure located between the thalamus and the pituitary gland. The hypothalamus is vital in regulating body temperature, concentration of fluids, storage of nutrients and motivation and emotion. By implanting electrodes in parts of the hypothalamus of animals and observing the effects when a current is switched on, researchers have found that the hypothalamus is involved in a range of motivational drives and behaviours including hunger, thirst, sex, parenting behaviours and aggression.

The peripheral nervous system connects the brain to the outer world. Without the peripheral nervous system, people could not perceive the world or act on it. The two main divisions of the peripheral nervous system are the somatic nervous system and the autonomic nervous system.

The somatic nervous system transmits messages about sights, sounds and smells, temperature, body position and so on, to the brain. Messages from the brain and spinal cord to the somatic nervous system regulate intentional body movements, like raising an alarm, winking or walking; breathing; and subtle movements that maintain posture and balance.

Psychologists are particularly interested in the autonomic nervous system (ANS) because its activities are linked to emotional response. Autonomic means “automatic”. The ANS regulates the glands and involuntary activities like heart rate, breathing, digestion and dilation of the pupils of the eyes, even when we are in sleep.

The ANS has two branches or subdivisions, the sympathetic and the parasympathetic. These branches have mostly opposing effects. Many organs and the glands are served by both branches of the ANS. The sympathetic division is most involved in processes that draw body energy from stored reserves, which helps prepare the person to fend off threats or dangers. The parasympathetic division is most active during processes that replenish energy reserves like

digestion. When we are afraid or anxious, the sympathetic branch of the ANS accelerates the heart rate. When we relax, the parasympathetic branch decelerates the heart rate. The parasympathetic branch incites digestion, but the sympathetic branch constrains digestive activity. Because the sympathetic branch dominates when we are fearful or anxious, fear or anxiety can cause indigestion by interfering with digestion of consumed food.

Parts of the cerebral cortex not involved in sensation or motor function are called association areas. These areas make possible such higher mental functions as learning thought, memory, and language. In many ways, the hemispheres duplicate each other's functions, but they are not fully equal. For most people, the left hemisphere contains language functions and is dominant.

The Endocrine System

The body has two kinds of glands: glands that carry the secretions to specific locations by means of ducts and ductless glands that pour their secretions directly into the bloodstream. Saliva, tears and sweat reach their destinations by way of a system of ducts. Psychologists are particularly interested in the chemicals secreted by ductless glands because of their behavioral effects. The ductless glands make up the endocrine system and they secrete chemical called hormones.

A range of factors contribute to biological dysfunctioning, from head injuries to poor nutrition, vascular diseases, which may affect the flow of blood to the brain.

2.8 SUMMARY

This unit has dealt with the major models of psychopathology in understanding the abnormal behaviour of an individual. Models are used to understand and treat abnormal behaviour. The biological model looks at the processes of human functioning to explain abnormal behaviour, it points out the anatomical or biochemical problems in the brain and body. Psychodynamic theorists believe that an individual's behaviour, whether normal or abnormal, is determined by underlying psychological forces. Behavioural model focuses on behaviour and proposes that all behaviouris learnt behaviours. Cognitive model understands human thought to understand human behaviour. Humanistic model focuses on the human need to successfully

confront philosophical issues such as self-awareness, values, meaning and choice in order to be satisfied in life.

2.9 KEY WORDS

Psychoanalysis

Id

Ego

Super Ego

Anxiety

Psychosexual Development

Behaviouristic Model (Learning Perspectives)

Classical-Conditioning

Conditioning of Fears

Extinction and Spontaneous Recovery

Operant Conditioning

Types of Reinforcers

Punishment

Rewarding

Cognitive

Humanistic model

Existential model

Hierarchy of Needs

Neuroscience

Autonomic Nervous System

Neuro Transmitter

Endocrine System

2.10 CHECK YOUR PROGRESS

1. Explain the psychoanalytical model of psychopathology.
2. Explain the Behaviouristic model of psychopathology.

3. Explain the cognitive model of psychopathology.
4. Explain the humanistic model of psychopathology.
5. Explain the biological model of psychopathology.

2.9 ANSWERS TO CHECK YOUR PROGRESS

1. 2.3
2. 2.4
3. 2.5
4. 2.6
5. 2.7

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UNIT – 3 : CLASSIFICATION OF MENTAL DISORDER

STRUCTURE

3.1 OBJECTIVES

Diagnosis is a critical aspect of the field of abnormal psychology. It is essential for professionals to be able to communicate accurately with one another about the types of cases they are treating or studying. Furthermore, to find the causes or best treatments for disorders, it must be classified correctly.

3.2 INTRODUCTION

By the end of the nineteenth century medicine had progressed far beyond its practice during the middle ages. People recognized that different illnesses required different treatments. Diagnostic procedures were improved, diseases classified and applicable remedies administered. New diagnostic procedures came into practice in the field of medicine, investigators of abnormal behaviour also sought to develop classification schemes. Advances in various other branches of sciences, such as botany and chemistry, physics had followed the development of classification systems. In the same manner there came a necessity for a classification of mental illness.

3.3 CLASSIFICATION SYSTEMS

The requirement of classification of mental illness led to a new development in the field of Psychology. During the nineteenth and twentieth century, there was an inconsistency in the classification of abnormal behaviour. In the United Kingdom in 1882, the statistical Committee of the Royal Medico-Psychological Association produced a classification scheme. Even though it was revised several times, however, it was never adopted by its members. In Paris, in 1889, the Congress of Mental Science adopted a single classification system, but it was never widely used. In the United States the Association of Medical Superintendents of American Institutions for Insane, a forerunner of the American Psychiatric Association, adopted a somewhat revised version of the British system in 1886. Then in 1913, the group accepted a new classification, which incorporated some of Emil Kraepelin's ideas. Again consistency was lacking.

3.4 DEVELOPMENT OF THE WHO AND DSM SYSTEMS

The principle behind diagnosis was very clear. That is when certain symptoms regularly occurred together a cluster of symptoms is called as a syndrome. It follows a particular course. These symptoms make up a particular mental disorder. In 1939 the World Health

Organization (WHO) added mental disorders to the International List of Causes of Death. In 1848, the list was expanded to become the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD) a comprehensive listing of all diseases including a classification of abnormal behaviour. Although this nomenclature was unanimously adopted at a WHO conference, the mental disorders section was not widely accepted. Even through American psychiatrists had played a prominent role in the WHO efforts, the American Psychiatrist Association published its own Diagnostic and Statistical Manual (DSM) in 1952.

In 1969, the WHO published a new classification system, which was more widely accepted. A second version of the American Psychiatric Association's DSM, DSM-II (1968) was similar to the WHO system, and in the United Kingdom a glossary of definitions was produced to accompany it. The WHO classifications were simply a listing of diagnostic categories; the actual behaviour or symptoms that were the bases for the diagnoses were not specified. DSM-II and the British Glossary of Mental Disorders provided some of this crucial information but did not specify the same symptoms for a given disorder. Thus actual diagnostic practices still varied widely. In 1980, the American Psychiatric Association published an extensively revised diagnostic manual, DSM-III. A somewhat revised version, DSM-III-R appeared in 1987.

In 1988, the American Psychiatrist Association appointed a task force, chaired by psychiatrist Allen Frances, to begin work on DSM-IV. Working groups, which included many psychologists were established to review sections of DSM-III-R, prepare literature reviews, analyze previously collected data, and collect new data if needed. An important change in the process for this edition of the DSM was the adoption of a conservative approach to making changes in the diagnostic criteria – the reasons for changes in diagnoses would be explicitly stated and clearly supported by date. In previous versions of the DSM, the reasons for diagnostic changes had not always been explicit.

I DSM-IV

DSM-IV was published in 1994.

II The Diagnostic System of the American Psychiatric Association (DSM-IV-TR)

Several major innovations distinguish the third edition and subsequent versions of the DSM. Perhaps the most sweeping change is the use of multiaxial classification, whereby each individual is rated on five separate dimensions or axes.

3.5 FIVE DIMENSIONS OF CLASSIFICATION

The five axes of DSM-IV-TR are :

Axis-I : All diagnostic categories except personality disorders and mental retardation.

Axis-II : Personality disorders and mental retardation.

Axis-III : General medical conditions

Axis-IV: Psychosocial and environmental problems.

Axis-V : Current level of functioning.

Axis I includes all diagnostic categories except the personality disorders and mental retardation, which make up Axis-II. Thus Axes I and II comprise the classification of abnormal behaviour. Axes I and II are separated to ensure that the presence of long-term disturbances is not overlooked. Most people consult a mental health professional for an Axis I condition, such as depression or an anxiety disorder. But prior to the onset of their Axis I condition, they may have had an Axis II condition, such as dependent personality disorder. The separation of Axes I and II is meant to encourage clinicians to be attentive to this possibility. The presence of an Axis II disorder along with an Axis I disorder generally means that the person's problems will be more difficult to treat.

Although the remaining three axes are not needed to make the actual diagnosis, their inclusion in the DSM indicates that factors other than a person's symptoms should be considered in an assessment so that the person's overall life situation can be better understood. On Axis III the clinician indicates any general medical conditions believed to be relevant to the mental disorder in question. For example, the existence of a heart condition in a person who was also diagnosed with depression would have important implications for treatment; some antidepressant drugs could worsen the heart condition. Axis IV codes psychosocial and environmental problems that the person has been experiencing and that may be contributing to the disorder. These include occupational problems, economic problems, interpersonal difficulties with family

problems and a variety of problems in other life areas, which may influence psychological functioning. Finally, on Axis V, the clinician indicates the person's current level of adaptive functioning. Life areas considered are social relationships, occupational functioning and use of leisure time. Ratings of current functioning are supposed to give information about the need for treatment.

In 1883 Emil Kraepelin developed the first modern classification system for abnormal behaviour. They laid the foundation for the Psychological part of International Classification of Diseases (ICD) the classification which is now used by World Health Organization.

The DSM like ICD has been changed over time. It was first published in1952, it underwent major revisions in 1968, 1980, 1987, and 1994. DSM-IV published in 1994 is slightly revised in 2000. The most widely used classification.

3.6 MULTI-AXIAL CLASSIFICATION: DSM-IV-TR I.C.D-10

Multi-axial Classification: DSM-IV-TR

1. Disorders usually first diagnosed in infancy, childhood, or adolescence
2. Delirium, dementia, and amnestic and other cognitive disorders
3. Mental disorders due to a general medical condition not elsewhere classified
4. Substance-related disorders:
5. Schizophrenia and other psychotic disorders
6. Anxiety disorders
7. Somatoform
8. Factitious disorders
9. Dissociative disorders
10. Sexual and gender identity disorder
11. Eating disorders
12. Sleep disorders
13. Impulse-control disorders not elsewhere classified
14. Adjustment disorders
15. Personality disorders
16. Additional codes

DSM-IV -TR

The diagnostic process uses five dimensions called 'axes' to ascertain symptoms and overall functioning of the individual. These axes are as follows

AXIS I - Particular Clinical Syndromes

Disorders usually first diagnosed in infancy, childhood or adolescence, delirium, dementia, Amnestic and other cognitive disorders, Substance-related disorders, Schizophrenia and other Psychotic disorders, Mood disorders, Anxiety disorders, Somatoform Disorders, Factitious disorder, Dissociative Disorders, Sexual and gender Identity Disorders, Eating disorders, sleep disorders, Impulse Control Disorders Not Elsewhere classified, Adjustment disorders.

AXIS II - Permanent Problems (Personality Disorders, Mental Retardation)

AXIS III - General Medical Conditions

On Axis III the clinician indicates any general medical conditions believed to be relevant to the mental disorder in question. For example, the existence of a heart condition in a person who was also diagnosed with depression would have important implications for treatment; some antidepressant drugs could worsen the heart condition.

AXIS IV - Psychosocial/Environmental Problems

Problems with primary support group. Problems related to the social environment. Educational problem, Occupational problem, Housing problem, Economic problem, Problems with access to health care services. Problems related to interaction with the legal system/crime. Other psychosocial and environmental problems.

AXIS V - Global Assessment of Functioning

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health/illness. Do not include impairment in functioning due to physical (or environmental) limitations.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 4TH EDITION, TEXT REVISION, also known as DSM-IV-TR, is a manual published by the American Psychiatric Association (APA) that includes all currently recognized mental health disorders. The coding system utilized by the DSM-IV is designed to correspond with codes from the International Classification of Diseases, commonly referred to as the ICD. Since early versions of the DSM did not correspond with ICD codes and updates of the publications for the ICD and the DSM are not simultaneous, some distinctions in the coding systems may still be present. For this reason, it is recommended that users of these manuals consult the appropriate reference when accessing diagnostic codes.

- NOS = Not Otherwise Specified.

3.7 MULTI-AXIAL CLASSIFICATION: DSM-IV-TR

Axis 1

1. Disorders usually first diagnosed in infancy, childhood, or adolescence

Learning disorders: Reading disorder Mathematics disorder Disorder of written expression Learning disorder NOS

Motor skills disorders: Developmental Coordination Disorder

Communication disorders: Expressive language disorder Mixed receptive-expressive language disorder Phonological disorder Stuttering Communication disorder NOS

Pervasive developmental disorders Autistic disorder Rett's Disorder Childhood Disintegrative Disorder Asperger's Disorder Pervasive Developmental Disorder NOS

Attention-deficit and disruptive behavior disorders Attention-Deficit Hyperactivity Disorder Combined subtype Predominantly hyperactive-impulsive subtype Predominantly inattentive subtype Attention-Deficit Hyperactivity Disorder NOS

Conduct disorder Childhood onset Adolescent onset Unspecified onset Oppositional Defiant Disorder Disruptive Behavior Disorder NOS

Feeding and eating disorders of infancy or early childhood Pica Rumination disorder Feeding disorder of infancy or early childhood

Tic disorders Tourette's Disorder Chronic motor or vocal tic disorder

Transient tic disorder Tic disorder NOS

Elimination disorders Encopresis Encopresis, with constipation and overflow incontinence Encopresis, without constipation and overflow incontinence Enuresis (not due to a general medical condition)

Other disorders of infancy, childhood, or adolescence Separation anxiety disorder Selective mutism Reactive attachment disorder of infancy or early childhood Stereotypic movement disorder Disorder of infancy, childhood, or adolescence NOS

2. Delirium, dementia, and amnestic and other cognitive disorders

Delirium due to... [indicate the general medical condition] Delirium NOS

Dementia: Dementia due to Creutzfeldt-Jakob Disease

Dementia due to head trauma Dementia due to HIV disease Dementia due to Huntington's disease Dementia due to Parkinson's disease Dementia due to Pick's disease Dementia due to... [indicate other general medical condition] Dementia NOS

Dementia of the Alzheimer's Type, with early onset Uncomplicated With delirium With delusions With depressed mood

Vascular dementia With delirium With delusions With depressed mood

Amnestic disorders Amnestic disorder due to...[indicate the general medical condition] Amnestic disorder NOS

Other cognitive disorders :Cognitive disorder NOS

3. Mental disorders due to a general medical condition not elsewhere classified

Catatonic disorder due to... [indicate the general medical condition] 1 Personality change due to... [indicate the general medical condition] (Subtypes: Labile, Disinherited, Aggressive, Apathetic, Paranoid, Other, Combined, Unspecified) Mental disorder NOS due to... [indicate the general medical condition]

4. Substance-related disorders

Alcohol-related disorders

Alcohol : Abuse Dependence Induced anxiety disorder Induced mood disorder Induced persisting amnestic disorder Induced persisting dementia Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations

Induced sexual dysfunction : Induced sleep disorder Intoxication Intoxication delirium Related disorder NOS Withdrawal Withdrawal delirium

Amphetamine (or amphetamine-like) related disorders (or amphetamine-like) Abuse Dependence -Induced anxiety disorder -Induced mood disorder -Induced psychotic disorder, with delusions -Induced psychotic disorder, with hallucinations -Induced sexual dysfunction -Induced sleep disorder

Intoxication : Intoxication delirium -Related disorder NOS Withdrawal

Caffeine-related disorders Caffeine -Induced anxiety disorder -Induced sleep disorder Intoxication -Related disorder NOS

Cannabis-related disorders Cannabis Abuse Dependence Induced anxiety isorder Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations Intoxication Intoxication delirium Related disorder NOS

Cocaine-related disorders: Cocaine Abuse Dependence Induced anxiety disorder Induced mood disorder Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations Induced sexual dysfunction Induced sleep disorder Intoxication Intoxication delirium Related disorder NOS Withdrawal

Hallucinogen-related disorders: Hallucinogen Abuse Dependence Induced anxiety disorder-Induced mood disorder - Induced psychotic disorder, with delusions - Induced psychotic disorder, with hallucinations Intoxication Intoxication delirium Persisting perception disorder Related disorder NOS

Inhalant-related disorders: Inhalant Abuse Dependence Induced anxiety disorder Induced mood disorder Induced persisting dementia Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations Intoxication Intoxication delirium Related disorder NOS

Nicotine-related disorders: Nicotine Dependence -Related disorder NOS Withdrawal

Opioid-related disorders: Opioid Abuse Dependence Induced mood disorder Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations Induced sexual dysfunction Induced sleep disorder Intoxication Intoxication delirium Related disorder NOS Withdrawal

Phencyclidine (or phencyclidine-like)-related disorders Phencyclidine (or phencyclidine-like) Abuse Dependence Induced anxiety disorder Induced mood disorder Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations Intoxication :Intoxication delirium -Related disorder NOS

Sedative-, hypnotic-, or anxiolytic-related disorders: Sedative, hypnotic, or anxiolytic Abuse Dependence Induced anxiety disorder Induced mood disorder Induced persisting amnestic disorder Induced persisting dementia Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations Induced sexual dysfunction Induced sleep disorder Intoxication Intoxication delirium Related disorder NOS Withdrawal Withdrawal delirium.

Polysubstance -related disorder Polysubstance dependence: Other (or unknown) substance-related disorder Other (or unknown) substance Abuse Dependence Induced anxiety disorder Induced delirium Induced mood disorder Induced persisting amnestic disorder Induced persisting dementia Induced psychotic disorder, with delusions Induced psychotic disorder, with hallucinations Induced sexual dysfunction Induced sleep disorder Intoxication Related disorder NOS Withdrawal.

5. Schizophrenia and other psychotic disorders

Schizophrenia Catatonic type Disorganized type Paranoid type Residual type Undifferentiated type Schizophreniform disorder Schizoaffective disorder Delusional disorder Brief psychotic disorder Shared psychotic disorder Psychotic disorder due to... [indicate the general medical condition] With delusions With hallucinations Psychotic disorder NOS Mood disorders

Depressive disorders Dysthymic disorder Major depressive disorder Major depressive disorder, recurrent In full remission In partial remission Mild Moderate Severe without psychotic features

Severe with psychotic features Unspecified Major depressive disorder, single episode In full remission In partial remission Mild Moderate Severe without psychotic features Severe with psychotic features Unspecified Depressive disorder NOS

Bipolar disorders Bipolar disorders Bipolar disorder NOS Bipolar I disorder, most recent episode depressed In full remission In partial remission Mild Moderate Severe without psychotic features Severe with psychotic features Unspecified Bipolar disorder I, most recent episode hypomanic Bipolar disorder I, most recent episode manic In full remission In partial remission Mild Moderate Severe without psychotic features Severe with psychotic features Unspecified Bipolar disorder I, most recent episode mixed In full remission In partial remission Mild Moderate Severe without psychotic features Severe with psychotic features Unspecified Bipolar I disorder, most recent episode unspecified Bipolar I disorder, single manic episode In full remission In partial remission Mild Moderate Severe without psychotic features Severe with psychotic features Unspecified Bipolar II disorder Cyclothymic disorder Mood disorder Mood disorder due to... [indicate the general medical condition] Mood disorder NOS

6. Anxiety disorders

Generalized anxiety disorder Panic disorder With agoraphobia Without agoraphobia Agoraphobia without history of panic disorder Specific phobia Social phobia Obsessive-compulsive disorder Posttraumatic stress disorder Acute stress disorder Anxiety disorder Anxiety disorder due to... [indicate the general medical condition] Anxiety disorder NOS

7. Somatoform disorders

Somatization disorder Undifferentiated somatoform disorder Conversion disorder Pain disorder Associated with both psychological factors and a general medical condition Associated with psychological factors Hypochondriasis Body dysmorphic disorder Somatoform disorder NOS

8. Factitious disorders

Factitious disorder With combined psychological and physical signs and symptoms With predominantly physical signs and symptoms With predominantly psychological signs and symptoms Factitious disorder NOS

9. Dissociative disorders

Depersonalization disorder Dissociative amnesia Dissociative fugue Dissociative identity disorder Dissociative disorder NOS

10. Sexual and gender identity disorder

Sexual dysfunctions Female hypoactive sexual desire disorder due to... [indicate the general medical condition] Male hypoactive sexual desire disorder due to... [indicate the general medical condition] Hypoactive sexual desire disorder Sexual aversion disorder Female sexual arousal disorder Male erectile disorder Male erectile disorder due to... [indicate the general medical condition] Female orgasmic disorder Male orgasmic disorder Premature ejaculation Dyspareunia (not due to a general medical condition) Female dyspareunia due to... [indicate the general medical condition] Male dyspareunia due to... [indicate the general medical condition] Vaginismus (not due to a general medical condition) Other female sexual dysfunction due to... [indicate the general medical condition] Other male sexual dysfunction due to... [indicate the general medical condition] Sexual Abuse Sexual abuse of adult Sexual abuse of adult (if focus of attention is on victim) Sexual abuse of child Sexual abuse of child (if focus of attention is on victim) Sexual disorder NOS Sexual dysfunction NOS.

Paraphilias Exhibitionism Fetishism Frotteurism Pedophilia Sexual masochism Sexual sadism Transvestic fetishism Voyeurism Paraphilia NOS Gender identity disorders

Gender identity disorder In adolescents or adults In children Gender identity disorder NOS

11. Eating disorders

Anorexia nervosa Bulimia nervosa Eating disorder not otherwise specified (EDNOS)

12. Sleep disorders

Primary sleep disorders Primary hypersomnia Primary insomnia
Narcolepsy Breathing-related sleep disorder Circadian rhythm sleep disorder Dyssomnia NOS
Parasomnias Nightmare disorder Sleep terror disorder Sleepwalking disorder Parasomnia NOS

Other sleep disorders Sleep disorder Sleep disorder due to... [indicate the general medical condition] Hypersomnia type Insomnia type Mixed type Parasomnia type Insomnia related to... [indicate the Axis I or Axis II disorder] Hypersomnia related to... [indicate the Axis I or Axis II disorder].

13. Impulse-control disorders not elsewhere classified

Intermittent explosive disorder Kleptomania Pyromania Pathological gambling Trichotillomania Impulse-control disorder NOS.

14. Adjustment disorders

Adjustment disorders Unspecified With anxiety With depressed mood With disturbance of conduct With mixed anxiety and depressed mood With mixed disturbance of emotions and conduct

Axis II

Mental retardation: Mild mental retardation Moderate mental retardation Severe mental retardation Profound mental retardation Mental retardation, severity unspecified

15. Personality disorders

Cluster A (odd or eccentric) Paranoid personality disorder Schizoid personality disorder Schizotypal personality disorder

Cluster B (dramatic, emotional, or erratic) Antisocial personality disorder Borderline personality disorder Histrionic personality disorder Narcissistic personality disorder

Cluster C (anxious or fearful) Avoidant personality disorder Dependent personality disorder Obsessive-compulsive personality disorder NOS Personality disorder NOS

16. Additional codes

Academic problem Acculturation problem Adverse effects of medication NOS Age-related cognitive decline Antisocial behavior Adult antisocial behavior Child or adolescent antisocial behavior Bereavement Borderline intellectual functioning Identity problem

Medication-induced Movement disorder Movement disorder NOS Postural tremor Neglect of child, Neglect of child (if focus of attention is on victim) Neuroleptic-induced Acute akathisia Acute dystonia Parkinsonism Tardive dyskinesia Neuroleptic malignant syndrome No diagnosis on Axis II No diagnosis or condition on Axis I Noncompliance with treatment Occupational problem Parent-child relational problem Partner relational problem Phase of life problem Physical abuse Physical abuse of adult Physical abuse of adult (if focus of attention is on victim) Physical abuse of child Physical abuse of child (if focus of attention is on victim) Psychological factors affecting medical condition Relational problem Relational problem NOS Relational problem related to a mental disorder or general medical condition Religious or spiritual problem Sibling relational problem Unspecified mental disorder (nonpsychotic) Diagnosis deferred on Axis II Diagnosis or condition deferred on Axis I Malingering

3.8 ICD CLASSIFICATION

The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease.

The International Classification of Diseases is published by the World Health Organization. The ICD is a core classification of the WHO Family of International Classifications (WHO-FIC).

An important alternative to the mental disorders section of the ICD is the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the primary diagnostic system for psychiatric and psychological disorders within the United States and some other countries, and is used as an adjunct diagnostic system in other countries.

ICD-10

Work on ICD-10 began in 1983 and was completed in 1992.Adoption was relatively swift in most of the world, but not in the United States. Since 1988, the USA had required ICD-

9-CM codes for Medicare and Medicaid claims, and most of the rest of the American medical industry followed suit.

On 1 January 1999 the ICD-10 (without clinical extensions) was adopted for reporting mortality, but ICD-9-CM was still used for morbidity. Meanwhile, NCHS received permission from the WHO to create a clinical modification of the ICD-10, and has produced drafts of the following two systems:

ICD-10-CM, for diagnosis codes, is intended to replace volumes 1 and 2. A draft was completed in 2003.

ICD-10-PCS, for procedure codes, is intended to replace volume 3. A final draft was completed in 2000.

However, neither of these systems is currently in place. There is not yet an anticipated implementation date to phase out the use of ICD-9-CM. There will be a two year implementation window once the final notice to implement has been published in the Federal Register. A detailed timeline is provided here.

The ICD-10's chapter five has been influenced by APA's DSM-IV and there is a great deal of concordance between the two. WHO maintains free access to the ICD-10 Below are the main categories of disorders:

1. Organic, including symptomatic, mental disorders
2. Mental and behavioural disorders due to psychoactive substance use
3. Schizophrenia, schizotypal and delusional disorders
4. Mood [affective] disorders
5. Neurotic, stress-related and somatoform disorders
6. Behavioural syndromes associated with physiological disturbances and physical factors
7. Disorders of adult personality and behaviour
8. Mental retardation
9. Disorders of psychological development
10. Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

11. Unspecified mental disorder

ICD-11

The first draft of the ICD-11 system is expected in 2010, with publication following by 2014 and in 2015+ implementation will take place. WHO has announced that it will apply principles for the first time to revise the ICD. The ICD revision process is open to all comers willing to register, back their suggestions with evidence from medical literature and participate in online debate over proposed changes. More detailed information ôn the revision process and access to the revision platform is available at the WHO website.

3.9 SUMMARY

Diagnosis is a critical aspect of the field of abnormal psychology. DSM-IV lists approximately 400 disorders. Clinicians must evaluate a client's condition on five axes, or categories of information. Classification system makes it possible for clinicians to communicate effectively with one another and facilitates the search for causes and treatments for the various psychopathologies. A novel feature of the DSM is its multi-axial organization; every time a diagnosis is made the clinician must describe the patient's condition according to each of five axes or dimensions. Axes I and II make up the mental disorders per se; Axis III lists any physical disorders believed to bear on the mental disorder in question; Axis IV is used to indicate the psychosocial and environmental problems that the person has been experiencing; and Axis V rates the person's current level of adaptive functioning. A multi-axial diagnosis is believed to provide a more multidimensional and useful descriptions of the patient's mental disorder. Several general and specific issues must be considered when evaluating the classification of abnormality. An important one is whether the categorical approach of the DSM, as opposed to a dimensional classification system, is best for the field. Because recent versions of the DSM are far more concrete and description than was DSM-II, diagnoses based on these versions are more reliable, that is, diagnosticians do agree upon the way the diagnose a particular case based on these classification.

3.10 KEY WORDS

DSM

WHO

ICD

DSM-IV-TR

Multiaxial classification

Delirium

Dementia

Amnestic

Cognitive disorders

Mental disorders

Substance-related disorders

Schizophrenia

Anxiety

Disorders Somatoform

Factitious disorders

Dissociative disorders

Sexual and gender identity disorder

Eating disorders

Sleep disorders

Impulse-control disorders

Adjustment disorders

Personality disorders

3.11 CHECK YOUR PROGRESS

1. Explain the classification system of mental disorders.
2. Explain the development of the WHO and DSM systems.
3. Explain the five dimensions of classification.
4. Explain the multi-axial classification of DSM-IV-TR.
5. Explain the International Classification of Diseases (ICD).

3.12 ANSWERS TO CHECK YOUR PROGRESS

1. 3.3
2. 3.4
3. 3.5
4. 3.6
5. 3.7

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UNIT: 4 METHODS OF ASSESSMENT AND DIAGNOSIS

STRUCTURE

4.1 OBJECTIVES

After going through this unit, you will be able to explain:

- Clinical Assessment
- Characteristics of Assessment tools
- Psychological Assessment
- Case History
- Clinical Interview
- Mental Status Examination
- Behavioural and Cognitive Assessment
- Psychological Tests

4.2 INTRODUCTION

In the previous units we have already discussed about the basic knowledge and information about the various psychological disorders, the concepts of normality and abnormality, the meaning and definitions of psychopathology, psychological illness and other basic concepts which are very important to understand psychopathology. We have also discussed about the models of psychopathology and the different perspectives of understanding psychopathology and the method of treatment adopted in those models. Further knowledge about the ICD and DSM classification is also given. With this knowledge moving further it is the first and foremost duty and responsibility of a Psychologist to identify the Psychological problems by which the client is suffering. Before starting any kind of treatment, it is important to identify, diagnose the psychological problems. To serve this purpose Psychology adopts various forms of assessing. The assessment, psychological testing used in the clinical setting, case history taking, clinical assessment is being discussed in detail in this unit.

4.3 CLINICAL ASSESSMENT

Assessment is the first step. Assessment is the process of gathering the information about a person so that clinical decision can be taken about the individual about his symptoms. A variety of symptoms may be presented when an individual is brought to a clinician or a psychologist to get necessary help. The psychologist may assume something as soon as he listens

to the symptoms provided by the person or his family member. But an actual understanding of a psychological problem cannot be done on just the list of symptoms presented. Psychology provides a range of psychological testing and assessment to be conducted to assess an individual whether it is for understanding the normality or abnormality, and the severity of abnormality. These methods help the psychologist to understand and judge the person accurately. The task of the clinical assessment is to gather data necessary to rule out the possible causes of the symptoms. The process of clinical assessment and diagnosis is most important for the study of psychopathology and ultimately to the treatment of psychological disorders.

Clinical assessment is the systematic evaluation and measurement of psychological, biological and social factors in an individual presenting with a possible psychological disorder. **Diagnosis** is the process of determining whether the particular problem affecting the individual meets all the criteria for a psychological disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth edition or DSM-IV-TR. In the psychological assessment the Psychologist begins by collecting a lot of information about the individual regarding various aspects of the behaviour so that a diagnosis about the illness can be made. Once the Psychologist gets a preliminary sense of the overall functioning of the person, then he narrows down the focus by ruling out problems in some areas and trying to focus upon only selected area which is in need of, that is the most important and the relevant one.

Clinical assessment involves defining and classifying mental disorders. It involves evaluating the person's strengths and weaknesses and understanding the problem, to develop a treatment plan. This includes providing a diagnosis for the person. Clinical assessment is used to determine how and why a person is behaving abnormally and how that person may be helped. It also helps the clinician to evaluate people's progress after they have been in treatment and also to decide whether the treatment should be continued or is it to be changed.

Clinicians following different perspectives of Psychology do follow different types of assessment. Psychodynamic clinicians use methods which assess a client's personality and probes the unconscious conflicts he or she may be experiencing. This type of assessment is called personality assessment. Behavioural and Cognitive clinicians use assessment methods that reveal specific dysfunctional behaviours and cognitions. This type of assessment is called

behavioural assessment, it provides functional analysis of the person's behaviour. An analysis of how the behaviour are learned and reinforced.

4.4 CHARACTERISTICS OF ASSESSMENT TOOLS

Assessment tools should have certain common characteristics so that it can be completely reliable and accurate in its assessment of an individual. Clinicians must follow the same procedures when they are doing a particular technique of assessment. There are three important characteristics which determine the value of Psychological Assessment they are reliability, validity and standardization.

Reliability means the consistency of assessment measures. Reliability refers to consistency of scores. A good assessment should always yield the same results in the same situation. Reliability is the degree to which a measurement is consistent. One way psychologists improve their reliability is by carefully designing their assessment devices and then conducting research on them to ensure that two or more raters will get the same answers (called interrater reliability). **Test retest reliability** is the extent to which a person provides similar answers to the same test items across time. An assessment tool shows that it has high reliability when the same test is given in two different time settings over a gap period and still it yields the same results. This is called test-retest reliability. **Interrater reliability** is the extent to which two raters or observers agree about their ratings or judgements of a person's behaviour. Internal consistency reliability refers to whether items on a test appear to be measuring the same thing.

Validity means the accurate measure of what it is supposed to measure. Validity is whether something measures what it is designed to measure. The accuracy of a test's or study results that are the extent to which the test or study actually measures or shows what it claims. **Predictive validity** is a tool's ability to predict future characteristics or behaviour. **Concurrent validity** is the degree to which the measure gathered from one tool agrees with measures gathered from other assessment techniques**. Construct validity** refers to whether test or interview results relate to other measure or behaviours in a logical, theoretical expected manner.

Standardization is the process by which a certain set of standards or norms is determined for a technique in order to make its use consistent across different measurements. To standardize a technique is to set up common steps to be followed whenever it is administered. At

the same time, all clinicians must standardize the way they interpret the results of an assessment toll in order to understand the particular score means the standards might apply to the procedures of testing scoring and evaluating data. For example, the assessment might be given to a large numbers of people who differ on important factors such as age, race, gender, socio-economic status and diagnosis; their scores would then be used as a standard or norm, for comparison purposes.

Any assessment technique must meet the criteria of requirements of standardization, reliability and validity. An assessment technique should always be interpretable, consistent and accurate. Reliability, validity and standardization are important to all forms of psychological assessment.

4.5 PSYCHOLOGICAL ASSESSMENT

Psychological assessment techniques are designed to determine cognitive, emotional, personality and behavioral factors in psychopathological functioning. Psychological assessment is the process of testing which uses a combination of techniques to arrive at a conclusion or hypotheses about an individual about his behaviour, personality and capabilities. This is also referred as Psychological testing. Psychological assessment should always be done by a licensed Psychologist, Clinical Psychologist. Psychologist is the only professional who is expertly trained to perform and interpret the Psychological tests.

Psychological assessment instruments and procedures are widely used in research purposes in Psychology, education, and many other professions. Psychological assessment is mainly used in the clinical setting for the identification, diagnosis, assessment of psychological illness or psychological disorders. It is used as the first step for the treatment purposes. In this unit we are going to discuss the main types of assessment which are mainly used in the clinical setting for evaluation.

4.6 CASE HISTORY

A case study or case history taking is a descriptive research approach. Case study method helps to obtain an in depth information about a person or a group. Case study tends to use

qualitative data, such as interviews, it may also use questionnaires. Case studies use techniques such as personal interviews, direct observation, psychometric tests and other records to gather information. This method helps to explore the cause of the underlying principles. They provide extensive information about the individual. A detailed history of a particular case (an individual or a group is considered as a case in the study) is very much important in understanding the present condition and the past situations which has led to the development of the psychological problem.

There is a prescribed format through which case history taking has to be done. It covers the major areas, some specific areas, specific questions which need to be considered in a clinical case study.

The format has to cover these below mentioned information in detail.

I. Present status

A. Adaptations (major tasks in life like work, school, family)level of functioning in these areas.

B. Symptomatic behaviours

C. Motivation for Clinical care and preconceptions about mental health

D. Appearance and behaviour in clinic

II. The manifest personality

A. Biological features (whether the patient is healthy, appearance)

B. Temperament

C. Manifest personality traits

D. Interpersonal behaviour

III. Personality dynamics and structure

A. Motives and affects

B. Moral principles, social values and attitudes.

C. Ego functions and identity

1) Ego strength
2) Defenses and coping mechanism
3) Thought organization, cognitive controls and styles.
4) Intelligence, abilities, competencies
5) Identity and self-concept

IV. Social determinants and current life situations.

A. Group memberships and roles.

B. Family

C. Education and work.

D. Social ecology

V. Major stresses and coping potential

VI. Personality development

VII. Formation of the case

a) Synthetic interpretation of the personality

b) Overall diagnostic impression

c) Specific dysfunctions

VIII. Recommendations and predictions

A. Desired outcomes

B. Possible intervention

1) Environmental and social

2) Psychotherapy

3) Other therapeutic interventions.

C. Course of future life

The qualitative research methods are used by the Clinical Psychologists. The case study method helps in understanding human mind and behaviour in general. In case study the information is collected from various sources that are from the parents, siblings, family members, peers, teachers, and other relevant persons in the life of that individual. The medical history, family history, develop mental history, are all taken into considerations. The current status of the individual psychological functioning is done within the context. The information like the fears, interest, aspirations, goals the individual had about himself is also collected. Case study method uses psychological tests and questionnaires, interviews and the life experiences.

4.7 CLINICAL INTERVIEW

A **Clinical interview** is a face to face encounter between the clinician and the client. Clinical interview is used by Psychologists, Psychiatrists and other mental health professionals. In a clinical interview the interviewer gathers information on current and past behavior, attitudes

and emotions, as well as a detailed history of the individual's life in general and of the presenting problem. Clinicians determine when the specific problem first started and identify other events (e.g life stress, trauma, physical illness) that might have occurred about the same time.

Clinical interview is used to collect the detailed information about the person's problems and feelings, life style and relationships and also other personal history. In the clinical interview it may also be asked to the client about the expectations he has about the therapy and the motives behind seeking this treatment. In clinical interview not only the already decided information is being collected by the clinician but also special attention is given to whatever topics the clinician consider most important. Different theorists focus on different aspects of information during the interview. Psychodynamic theorists in their interviews with the client try to learn about the person's needs and memories of the past events and relationships. Behavioural interviewers try to pinpoint the precise nature of the abnormal responses, including information about the stimuli that trigger such responses, including information about the person's self-evaluation, self-concept and values. The biological theorists look for the signs of biochemical or brain dysfunction. The sociocultural interviewers ask about the family, social and cultural environments.

Most clinicians gather at least some information on the patient's current and past interpersonal and social history, including family makeup (e.g. marital status, number of children, college student currently living with parents), and on the individual's upbringing. Information on sexual development, religious attitudes (current and past), relevant cultural concerns (such as stress induced by discrimination) and educational history are also routinely collected. When a whole lot of information is collected it is necessary to organize the information obtained during an interview to serve this purpose many clinicians use a mental status exam.

Interviews may be conducted in two different forms based upon the requirement of the clinician and the amount of information needed for the diagnosis. **Structured interview** a type of an interview where the clinicians asks predetermined questions. The number of questions, its order everything is decided before the actual interview. Here the clinician has already decided what information he needs to collect and goes according to this plan. A structured format ensures that clinicians will be able to cover the most important issues in the interview.

Unstructured interview is a type of interview where the clinician has complete liberty to ask any number of questions in any given order. The clinician asks open ended questions, which helps the clinician to probe into those answers which he may feel is most relevant about the information he needs to collect. This helps the clinician to explore relevant topics which need to be focused.

4.8 MENTAL STATUS EXAMINATION

The mental status examination is a set of questions and observations that systematically evaluate the client's awareness, orientation with regard to time and place, attention span, memory, judgement and insight thought content and processes, mood, and appearance. It involves the systematic observation of somebody's behavior. This type of observation occurs when any one person interacts with another.

Mental status examination is done to obtain in depth information about a person's emotional state (affect and mood), intellectual and perceptual functioning (attention, concentration, memory, intelligence, and judgement) style and content of thought processes and speech, level of insight into mental status and personality problems, and psychomotor activity, the person's general appearance, attitude and insight into his or her condition. Through the various amount of information collected through mental status examination clinicians organize their observations of other people in a way that gives them sufficient information to determine whether a psychological disorder might be present. Mental status exams can be very structured and detailed, they are performed relatively quickly by experienced clinicians in the course of interviewing or observing a patient. The mental status examination covers five categories; appearance and behaviour, thought processes, mood and affect, intellectual functioning and sensorium.

1. **Appearance and behavior**: The clinician notes the overt physical behaviours such as the individual's dress, general appearance, posture and facial expression, motor behaviour etc.

2. **Thought process**: When clinicians listen to a patient talk, they are getting a good idea of that person's thought processes. They look for several things here. For example, the rate or flow of speech, whether the person talk really fast or really slow, the continuity of speech, or

ideas presented with no apparent connection, the content of speech, whether evidence of any delusions are present.

3. **Mood and affect**: Determining mood and affect is an important part of the mental status exam. "Mood" is the predominant feeling state of the individual. The variations in the mood, is there any signs of depression? Is it too much in the intensity? The way the individual shows affect is also seen, "Affect" is the feeling which is accompanied with what we say at a given point of time. Normally any individual shows an appropriate affect that is to laugh when listening to a joke, becoming sad for something which is not liked by the individual is common. This particular behaviour is noted by the clinician whether it is appropriate or not.

4. **Intellectual functioning**: Clinicians or Psychologists do have a capability to assess roughly the individual's intellectual functioning just by talking to them. They observe whether the individual has a good vocabulary, can they use abstractions, metaphors, they also observe the memory capabilities of the individual.

5. **Sensorium**: Sensorium means the general awareness about the surroundings. Orientation about time, day and place, about themselves is seen.

4.9 BEHAVIORAL AND COGNITIVE ASSESSMENT

Behavioral and Cognitive assessment involves **SORC** that is **S** for **stimuli**, the environmental situations which led for the development of the problem. **O** means **organism** that is both physiological and psychological factors. **R** means overt **responses.** The problematic behaviour its frequency, intensity and form are all noted. **C** means **consequent variables**. The events that reinforce the behaviour being observed.

The information necessary for a behavioral or cognitive assessment is gathered by several methods, including direct observation of behavior in real life as well as in contrived settings, interviews and self-report measures and various other methods of cognitive assessment.

Direct Observation

In direct observation method the observation is done on the individual without his awareness that he is being observed.

Self-observation

In self-observation method the behavior therapists and researchers asks the individuals to observe their own behavior and to keep a track of various categories of response. This approach is called self-monitoring. **Self-monitoring** has been used to collect a wide variety of data of interest to both clinicians and researchers, including moods, stressful experiences, coping behaviors and thoughts.

4.10 PSYCHOLOGICAL TESTS

Psychological test are standardized procedures designed to measure a person's performance on a particular task or to assess his or her personality. Psychological tests are used to assess a wide variety of mental abilities and attributes, including achievement and ability, personality and neurological functioning.

Psycho diagnosis

Psychodiagnosis is the process of examining a person from a psychological viewpoint to determine the nature and the extent of a mental or behavioural disorder. The psychodiagnostician observes interviews and tests the patients to determine the presence or absence of certain psychological and physical symptoms. The patient's symptoms are then compared with the standard descriptions of abnormal behaviour to determine which category of disorder the patient is suffering from.

Psychological tests structures the process of assessment. The same test is administered to many people at different times and the responses collected are analyzed to indicate how certain kinds of people tend to respond. A brief introduction towards the categories of Psychological tests is given below:

Personality Inventories

Personality Inventories are those in which the person is asked to complete a self-report questionnaire indicating whether statements assessing habitual tendencies apply to him or her. The major ones are Minnesota Multiphasic Personality Inventory (MMPI), Eyesenck personality

inventory(EPI), Bell's Adjustment Inventory (BAI), Cattell's Clinical Analysis Questionnaires(CAQ), Cattell's 16 Personality Factor(16PF) etc.

Projective Personality Tests

A **Projective test** is a psychological assessment device in which a vague stimulus is given and the subject gives his responses based upon how he perceives the stimulus. A set of standard stimuli-inkblots or drawings-ambiguous enough to allow variation in responses is presented to the individual. The assumption is that because the stimulus materials are unstructured, the patient's responses will be determined primarily by unconscious processes and will reveal his or her true attitudes, motivations and modes of behaviour. Projective tests are mainly used by Psychodynamic Clinicians to help assess the unconscious drives and conflicts. The major Projective techniques are Rorschach Ink Blot Test, Thematic Apperception Test, Sentence Completion Test, Word Association Test etc.

Intelligence Tests

Alfred Binet, a French psychologist and his associate Theodre Simon produced an intelligence test consisting of series of tasks requiring people to use various verbal and nonverbal skills. The general score derived from this and subsequent intelligence tests are termed as intelligent quotient (IQ). An intelligence test, often referred as an IQ test, is a standardized means of assessing a person's current mental ability. Individually administered tests such as the Wechsler Adult Intelligence Scale (WAIS), the Wechsler Intelligence Scale for Children (WISC) and the Stanford-Binet are all based on the assumption that a detailed sample of an individual's current intellectual functioning can predict how well he or she will perform in school. Intelligence tests are also used with achievement tests, to diagnose learning disabilities and to identify areas of strengths and weaknesses for academic planning, it is used to determine whether a person is mentally retarded, it is used to identify intellectually gifted children so that appropriate instruction can be provided them in school, as part of neuropsychological evaluations, for example, periodically testing a person believed to be suffering from a degenerative dementia so that deterioration of mental ability can be followed over time.

4.11 SUMMARY

This unit has dealt with the clinical assessment, the tools used in clinical assessment, psychological testing, psychological tests and its importance in assessment in clinical setting. Clinical assessment falls into three categories: clinical interview, tests, and observations. The clinical interview provides the clinician an opportunity to interact and assess the client using structured or unstructured interview. Different types of clinical assessment like mental status examination, case history taking, interviews, psychological testing are all discussed in this unit.

4.12 KEY WORDS

Reliability
Validity
Psychological assessment
Clinical interviews
Direct observation
Self-observation
Cognitive assessment
Psychological tests
Personality inventories
Intelligence tests
Rorschach Inkblot Test
Thematic Apperception Test (TAT)
Wechsler Adult Intelligence Scale (WAIS)
Wechsler Intelligence Scale for Children (WISC)

4.13 CHECK YOUR PROGRESS

1. What is assessment? Explain Reliability, Validity, and Standardization.
2. Explain the Characteristics of Assessment tools.
3. Define Psychological Assessment.
4. Explain Case History method.
5. How is Clinical Interview conducted?
6. Describe Mental Status Examination.

7. Explain Behavioural and Cognitive Assessment.
8. Explain the importance of Psychological Tests in clinical assessment.

4.14 ANSWERS TO CHECK YOUR PROGRESS

1. 4.3
2. 4.4
3. 4.5
4. 4.6
5. 4.7
6. 4.8
7. 4.9
8. 4.10

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BLOCK-2 ANXIETY AND STRESS RELATED DISORDERS

UNIT-5 GENERALIZED ANXIETY DISORDER (GAD)

STRUCTURE

5.1 OBJECTIVES

After going through this unit, you will be able to explain

- Differences among anxiety, fear, worry, phobia and panic attack
- Meaning of generalized anxiety disorder
- Symptoms of generalized anxiety disorder
- Prevalence of generalized anxiety disorder
- Causes and treatments of generalized anxiety disorder.

5.2 INTRODUCTION

Everyone has feelings of anxiety at some point in their life -for example, it may be worried and anxious about sitting an exam, or having a job interview or medical test. Some people find it hard to control their anxiety. Their feelings of anxiety are more constant and can often affect their daily lives. Anxiety is a negative mood state characterized by bodily symptoms of physical tension and by apprehension about the future. It is different from fear, worry, phobia and panic. Anxiety is classified into three types .They are normal anxiety, neurotic anxiety and moral anxiety.

Generalized anxiety disorder (GAD)is characterized by chronic excessive worry about a number of events or activities. This state was originally described as free-floating anxiety because it was not anchored to a specific object or situation as with specific or social phobias.
GAD generally begins in childhood or adolescence. GAD was found to be most common in the group over 45 years of age, and least common in the youngest group aged 15 to 24.

There are several reasons for GAD .These reasons and treatments are explained under socio-cultural, psychodynamic, humanistic, existential, cognitive and biological perspectives.

5.3 DIFFERENCES AMONG ANXIETY, FEAR, WORRY, PHOBIA AND PANIC ATTACK

Anxiety is a common negative emotion, found in all disorders; whether it is minor or major and either at the initial stage or at some stage.

Anxiety: It is a fear from within but the cause is not known. It is a defused, vague, very unpleasant feeling of fear and apprehension. Person with anxiety worries a lot about an unknown danger. It resembles fear, worry, phobia, and panic.

Fear: It has a definite cause, visible or audible. Fear is an emotional response to a specific stimulus. It prepares the person internally and externally, either to fight or flight, at the sight of danger. Ex: sudden loud sound or sight of a snake.

Worry: It is an imaginary fear about something which may or not happen. Ex: A good friend may give up friendship. It may be failure in the examination etc.

Phobia: It is an intense, irrational fear, unproportioned to the stimulus. Ex: Intense fear of water, darkness, rat, cockroach etc.

Panic attack: It is a rapidly rising surge of intense anxiety that occurs suddenly, either with or without clear cues, in an unpredictable manner. The person experiencing panic often will have phobic fears that the stimuli evoke.

Anxiety is classified into three types

1. Normal anxiety: Normal anxiety occurs when we are confronted with a new situation with which we are not familiar, but it disappears after facing it, and need no treatment.

2. Neurotic anxiety: In Neurotic anxiety the person experiences intense anxiety which makes him completely nervous and all his activities. - Physical, physiological, and mental activities paralyse.

3. Moral anxiety: In Moral anxiety the person who is honest and sincere whose super ego is strong experience anxiety when he tells a lie or cheats knowingly or unknowingly. When he feels guilty of not having told the truth to the person whom he loves and respects. Symptoms like nervousness, tension, feeling tired, dizziness, etc.

5.4 MEANING OF GENERALIZED ANXIETY DISORDER

Generalized anxiety disorder (GAD) is characterized by chronic excessive worry about a number of events or activities. This state was originally described as free-floating anxiety because it was not anchored to a specific object or situation as with specific or social phobias.

DSM-IV criteria specify that the worry must occur more days than not for at least six months and that it must be experienced as difficult to control. The subjective experience of excessive worry must also be accompanied by at least three of the following six symptoms: (1) restlessness or feelings of being keyed up or on edge, (2) a sense of being easily fatigued, (3) difficulty concentrating or mind going blank, (4) irritability, (5) muscle tension, and (6) sleep disturbance.

People with GAD worry about many things in their lives. Ex: worry about their performance on the job, about how their relationships are going, and about their own health. The focus of their worries may shift frequently, and they tend to worry about many different things, instead of just focusing on one issue of concern. Their worry is accompanied by many of the physiological symptoms of anxiety, including muscle tension; sleep disturbances, and a chronic sense of restlessness.

Generalized anxiety is called generalized because it is not focused on any one specific threat; instead it attaches itself to various threats, real and imagined. Sufferers of GAD worry more or less continuously, about multiple issues and sometimes gastrointestinal upset due to over activity of the autonomic nervous system.

5.5 SYMPTOMS OF GENERALIZED ANXIETY DISORDER

In GAD Symptoms may be experienced individually or in combination.

A) Worry and Apprehension feelings about the future: The individuals with GAD worries about the future hold for him or for people close to him.

B) Hyper vigilance: The individuals with GAD constantly scan the environment for danger but cannot specify the danger. This hyper vigilance causes difficulty to sleep.

C) Motor tension: The individuals with GAD cannot relax are tensed and have strained facial expression.

D) Autonomic reactivity: With anxiety patients sympathetic and parasympathetic nervous system seem to work overtime. So there is a combination of sweating, dizziness, racing of heart, hot and cold spells, stomach upset, lightheadedness, cold and clammy hands, frequent urination or defecation, lump in the throat and high pulse rate and respiration.

E) The person finds it difficult to control the worry.

F) Sleep disturbance

G) The anxiety causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5.6. PREVELENCE OF GENERALIZED ANXIETY DISORDER

Approximately 4-5% of the population meets criteria for GAD during a given 6 months period. This is still quite a large number, making GAD one of the most common anxiety disorders. Rates are highest among women, middle-aged people, people living alone, and of low income. GAD usually begins in childhood or adolescence. Once established, it tends to be a chronic disorder, up to 80 % of people diagnosed with GAD report having been worried or anxious all their lives. In the large and morbidity study, GAD was found to be most common in the group over 45 years of age, and least common in the youngest group aged 15 to 24.

5.7. CAUSES AND TREATMENTS OF GENERALIZED ANXIETY DISORDER

GAD is caused by a variety of factors. There are different approaches to explain and treat such as socio cultural, psychodynamic, humanistic, existential, cognitive, and biological.

5.7.1 SOCIO- CULTURAL PERSPECTIVE

Overpopulation is the main social cause of GAD. Every population needs food, water, shelter and protection. As the population increases many problems arise when the population is less, the land to grow food, will be vast air and water are abundant. With the growth of the population these natural resources become insufficient and scarce. As the increase in population need for more food, water and job arise. More jobs increased number of hands. These things cause lot of competition, which is unhealthy. Survival has become more difficult. Naturally people resort to unhealthy habits, unlawful acts, and poor values of life. All these things lead to stress and GAD. Innumerable industries, travelling by road, accidents, robbery, dacoity, etc are increasing, life is become insecure, and all these factors invariably puts the individuals into the stressful situations resulting in GAD. Poverty and race is also one of the main sources of GAD. Marriage, divorce, death of a love done, pressures to excel in school, difficulties at work and so on. Some might be physical, such as an injury or illness. One of the most powerful forms of societal stress is poverty. People without financial means are likely to have less equality, less

power, and greater vulnerability; to live in run-down communities with high crime rates; to have fewer educational and job opportunities; and to run a greater risk for health problems.

5.7.2 PSYCHODYNAMIC PERSPECTIVE

Freud (1917) developed the first psychological theory of generalized anxiety. He distinguished among three kinds of anxiety: realistic, neurotic, and moral. **Realistic anxiety** occurs when we face a real danger or threat, such as an oncoming tornado. **Neurotic anxiety** occurs when we are repeatedly prevented from expressing our id impulses, it causes anxiety. **Moral anxiety** occurs when we have been punished for expressing our id impulses, and we come to associate those impulses with punishment, causing anxiety. Generalized anxiety occurs when our defense mechanisms can no longer contain either the id impulses or the neurotic or moral anxiety that arises from these impulses. More recent psychodynamic theories attribute generalized anxiety to poor upbringing, which results in fragile and conflicted images of the self and others. Children whose parents were not sufficiently warm and nurturing and many have been overly strict or critical, may develop images of the self as vulnerable and images of others as hostile. As adults, their lives are filled with frantic attempts to overcome or hide their vulnerability, but stressors often overwhelm their coping capacities, causing frequent bouts of anxiety.

Psychodynamic Therapies

Psychodynamic therapists use the same general techniques to treat all psychological problems-Free association and the therapist's interpretations of transference, resistance, and dreams. Freudian psychodynamic therapists use these methods to help clients with generalized anxiety disorder become less afraid of their id impulses and more successful in controlling them. Other psychodynamic therapists particularly object relations therapists, use them to help anxious patients identify and settle the childhood relationship problems that continue to produce anxiety in adulthood. Controlled studies have typically found psychodynamic treatments to be of only modest help to persons with generalized anxiety disorder. An exception to this trend is short-term psychodynamic therapy which has in some cases significantly reduced the levels of anxiety, worry, and social difficulty of Patients with this disorder.

5.7.3 HUMANISTIC PERSPECTIVE

Humanistic theorists propose that generalized anxiety disorder, like other psychological disorders, arises when people stop looking at themselves honestly and acceptingly. Repeated denials of their true thoughts, emotions, and behaviour make these people extremely anxious and unable to fulfil their potential as human beings. The humanistic view of why people develop this disorder is best illustrated by Carl Rogers's explanation. Rogers believed that children who fail to receive unconditional positive regard from others may become overly critical of them and develop harsh self-standards, what Rogers called conditions on worth. They try to meet these standards by repeatedly distorting and denying their true thoughts and experiences. Despite such efforts, however, threatening self-judgments keep breaking through and causing them intense anxiety. This onslaught of anxiety sets the stage for generalized anxiety disorder or some other form of psychological dysfunctioning.

Practitioners of Rogers's treatment approach, **client-centered therapy,** try to show unconditional positive regard for their clients and to empathize with them. The therapists hope that an atmosphere of genuine acceptance and caring will help clients feel secure enough to recognize their true needs, thoughts, and emotions. When clients eventually are honest and comfortable with themselves, their anxiety or other symptoms will subside. In the following quote, Rogers describes the progress made by a client with anxiety and related symptoms:

In spite of such optimistic case reports, controlled studies have failed to offer strong support for this approach. Although research does suggest that client-centered therapy is usually more helpful to anxious clients than no treatment, the approach is only sometimes superior to placebo therapy. In addition, researchers have found, at best, only limited support for Rogers's explanation of generalized anxiety disorder and other forms of abnormal behaviour. Nor have other humanistic theories and treatment received much research support.

5.7.4 EXISTENTIAL PERSPECTIVE

According to existentialists that existential anxiety is a universal human fear. We experience existential anxiety because we know that life is finite and we fear death ,that is waiting .we know every living being and more so man will have death. We also know that our

personal existence lack meaning and know that our actions and choices hurt others. According to existentialists we confront existential anxiety by taking responsibility for our actions and decisions .we want to make our living meaningful and appreciate our own uniqueness and try to shrink from confrontation. Then we are caught up this change, confusion and strain of modern civilization that we are leading inauthentic lives. This helps as to deny our fear. We avoid taking responsibility and conform much to guidelines of the society. Such a life style fails to reduce personal existential anxiety .Then gradually it erupts in the form of generalized and other form of anxiety disorders. Existential the rapists use a variety of techniques. They help anxious patients, to take more responsibility and to live more meaningful life.

5.7.5 COGNITIVE PERSPECTIVE

Cognitive theories of GAD suggest that the cognitions of people with GAD are focused on threat, at both the conscious and non conscious levels. At the conscious level, people with GAD have a number of maladaptive assumptions that set them up for anxiety, such as -I must be loved or approved of by everyone, it's always best to expect the worst, People with GAD believe that worrying can prevent bad events from happening. These beliefs are often superstitions, but people with GAD also believe that worrying motivates them and facilitates their problem solving, yet people with GAD seldom get around to problem solving. Indeed, they actively avoid visual images of what they worry about, perhaps as a way of avoiding the negative emotion associated with those images. Their maladaptive assumptions lead people with GAD to responds to situations with automatic thoughts, which directly stir up anxiety, cause them to be hyper vigilant, and lead them to overreact to situations.

Cognitive Therapies

Two kinds of cognitive approaches are used in cases of generalized anxiety disorder. In one, based on the pioneering work of Ellis and Beck, therapists help clients change the maladaptive assumptions that characterize their disorder. In the other, new-wave cognitive therapists help clients to understand the special role that worrying may play in the disorder and to change their views about and reactions to worrying.

Changing Maladaptive Assumptions

In Ellis's technique of rational-emotive therapy, therapists point out the irrational assumptions held by clients, suggest more appropriate assumptions, and assign homework that gives the individuals practice at challenging old assumptions and applying new ones. Studies do suggest that his approach and similar cognitive approaches bring at least modest relief to persons suffering from generalized anxiety. Ellis's approach is illustrated in the discussion between him and an anxious client who fears failure and disapproval at work, especially over a testing procedure that she has developed for her company: Beck's similar but more systematic approach, called, simply, cognitive therapy, is an adaptation of his influential and very effective treatment for depression. Researchers have found that, like Ellis's rational emotive therapy, it often helps reduce generalized anxiety to more tolerable levels.

Focusing on Worrying

Alternatively, some of today's new-wave cognitive therapists specifically guide clients with generalized anxiety disorder to recognize and change their dysfunctional use of worrying. They begin by educating the clients about the role of worrying in their disorder and have them observe their bodily arousal and cognitive responses across various life situations. In turn, the clients come to appreciate the triggers of their worrying, their misconceptions about worrying, and their misguided efforts to control and predict their emotions and their lives by worrying. As their insights grow, clients are expected to see the world as less threatening, tryout and adopt more constructive ways of dealing with arousal, and worry less about the fact that they worry so much. Research has begun to indicate that a concentrated focus on worrying is indeed a helpful addition to the traditional cognitive treatment for generalized anxiety disorder. Treating individuals with generalized anxiety disorder by helping them to recognize their inclination to worry is similar to another cognitive approach that has gained popularity in recent years. The approach, mindfulness-based cognitive therapy, was developed by the Psychologist Steven Hayes and his colleagues as part of their broader treatment approach called acceptance and commitment. In mindfulness-based cognitive therapy, therapists help clients to become aware of their streams of thoughts, including their worries, as they are occurring and to accept such thinking as mere events of the mind. By accepting their thoughts rather than trying to eliminate them, the clients are expected to be less upset and affected by them. Mindfulness-based cognitive

therapy has also been applied to a range of other psychological problems such as depression, posttraumatic stress disorder, personality disorders, and substance abuse, often with promising results .This cognitive approach borrows heavily from a form of meditation called mindfulness meditation, which teaches individuals to pay attention to the thoughts and feelings that flow through their minds during meditation and to accept such thoughts in a nonjudgmental way.

5.7.6 BIOLOGICAL PERSPECTIVE

Biological theorists believe that generalized anxiety disorder is caused chiefly by biological factors. For years this claim was supported primarily by family pedigree studies, in which researchers determine how many and which relatives of a person with a disorder have the same disorder. If biological tendencies toward generalized anxiety disorder are inherited, people who are biologically related should have similar probabilities of developing this disorder. Studies have in fact found that biological relatives of persons with generalized anxiety disorder are more likely than nonrelatives to have the disorder also. Approximately 15 %of the relatives of people with the disorder display it themselves-much more than the6 % lifetime prevalence rate found in the general population. And the closer the relative (an identical twin, for example, as opposed to a fraternal twin or other sibling),the greater the likelihood that he or she will also have the disorder. Of course, investigators cannot have full confidence in biological interpretations of such findings. Because relatives are likely to share aspects of the same environment, their shared disorders may reflect similarities in environment and upbringing rather than similarities in biological makeup. And, indeed, the closer the relatives, the more similar their environmental experiences are likely to be. Because identical twins are more physically alike than fraternal twins, they may even experience more similarities in their upbringing.

Recently brain researchers have offered more evidences that GAD is related to biochemical dysfunctioning in the brain. From the studies it is found that diazepam (valium) alprazor an (xanas) and chlordiaxepoxide (Librium) provide relief from anxiety. Newly developed radioactive technique to pinpoint the exact areas in the brain that are affected by benzodiazepines.

Biological Treatments

The leading biological approach to treating generalized anxiety disorder is drug therapy. Other biological interventions are relaxation training, which teaches people to relax the muscles throughout their bodies, and biofeedback, which trains clients to control underlying biological processes voluntarily.

Antianxiety Drug Therapy: In the late 1950s a group of drugs called benzodiazepines was marketed as **sedative-hypnotic** drugs-drugs that calm people in low doses and help them fall asleep in higher doses. These new antianxiety drugs seemed less addictive than previous sedative-hypnotic medications, such as barbiturates, and they appeared to produce less tiredness. Thus, they were quickly embraced by both doctors and patients. Specific neuron sites in the brain that receive benzodiazepines and that these same receptor sites ordinarily receive the neurotransmitter GABA. Apparently, when benzodiazepines bind to these neuron receptor sites, particularly those receptors known as GABA-A receptors, they increase the ability of GABA to bind to them as well, and so improve GABA 's ability to stop neuron firing and reduce anxiety. Certain kinds of antidepressant drugs seem to reduce the symptoms of generalized anxiety disorder-namely those that operate by increasing the activity of the neurotransmitter serotonin. Like GABA, serotonin is a neurotransmitter that carries messages between neurons. However, serotonin acts at different neurons and brain areas than GABA. Based partly on this finding, some researchers believe that generalized anxiety may also be the result of low serotonin activity, and, in fact, a number of today's clinicians are more inclined to prescribe the serotonin-enhancing antidepressants to treat generalized anxiety disorder than the GABA-enhancing benzodiazepines.

Relaxation Training

A nonchemical biological technique generally used to treat generalized anxiety disorder is relaxation training. The notion behind this approach is that physical relaxation will lead to a state of psychological relaxation. In one version, therapists teach clients to identify individual muscle groups, tense them, release the tension, and ultimately relax the whole body. With continued practice, they can bring on a state of deep muscle relaxation at will, reducing their state of anxiety. Research indicates that relaxation training is more effective than no treatment or placebo treatment in cases of generalized anxiety disorder. Other techniques that are known to

relax people, such as meditation, often seem to be equally effective. Relaxation training is of greatest help to people with generalized anxiety disorder when it is combined with cognitive Therapy or with biofeedback.

Bio-Feedback

In biofeedback, therapists use electrical signals from the body to train people to control physiological processes such as heart rate or muscle tension. Clients are connected to a monitor that gives them continuous information about their bodily activities. By attending to the therapist's instructions and the signals from the monitor, they may gradually learn to control even seemingly involuntary physiological processes.

The most widely applied method of biofeedback for the treatment of anxiety uses adevice called an electromyography (EMG), which provides feedback about the level of muscular tension in the body. Electrodes are attached to the client's muscles-usually the forehead muscles-where they detect the minute electrical activity that accompanies muscle tension The device then converts electric potentials coming from the muscles into an image, such as lines on a screen, or into a tone whose pitch changes along with changes in muscle tension. Thus clients "see" or "hear" when their muscles are becoming more or less tense. Through repeated trial and error, the individuals become skilled at voluntarily reducing muscle tension and, theoretically, at reducing tension and anxiety in everyday stressful situations.

5.8 SUMMARY

Anxiety is a common negative emotion, found in all disorders; whether it is minor or major and either at the initial stage or at some stage. Generalized anxiety disorder (GAD)is characterized by chronic excessive worry about a number of events or activities. This state was originally described as free-floating anxiety because it was not anchored to a specific object or situation as with specific or social phobias. GAD Symptoms may be experienced individually or in combination with Worry and Apprehension feelings about the future, hyper vigilance, motor tension, autonomic activity, sleep disturbance etc.

GAD is caused by a variety of factors. There are different approaches to explain and treat such as socio cultural, psychodynamic, humanistic, existential, cognitive, and biological.

5.9 KEY WORDS

Generalized anxiety disorders

Socio- Cultural

Psychodynamic

Humanistic

Existential

Cognitive

Biological

Relaxation training

Bio-feedback

5.10 CHECK YOUR PROGRESS

1. What is anxiety? How it is different from fear, worry and phobia?
2. What is generalized anxiety disorder? Explain the symptoms of generalized anxiety disorder.
3. Explain the causes and treatments of generalized anxiety disorder.

5.11 ANSWERS TO CHECK YOUR PROGRESS

1) 5.3 2) 5.4 & 5.5 3) 5.7

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UNIT-6 : PANIC DISORDER AND PHOBIC DISORDER

STRUCTURE

6.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning of Panic disorder
- Symptoms of Panic disorder
- Prevalence of Panic disorder
- Causes and treatments of Panic disorder
- Meaning of Phobic disorder
- Symptoms of Phobic disorder
- Prevalence of Phobic disorder
- Causes and treatments of Phobic disorder

6.2 INTRODUCTION

Everyone experiences feelings of panic at certain times during their lifetime. It is a perfectly natural response, particularly when we are in a stressful or dangerous situation. Panic disorder is a complex mental health condition that involves feelings of anxiety and apprehension. The panic disorder is a sudden, overwhelming, and apparently senseless terror. Panic disorder may attack with no warning at any time and any stage. Panic attack denotes "an abrupt surge of intense anxiety rising to a peak without obvious cues and is spontaneous and unpredictable". The person in panic, experiences phobic fear that stimulus evokes. A panic attack is a sudden attack of intense apprehension, terror, and feelings of impending doom, accompanied by at least four other symptoms. Physical symptoms can include laboured breathing, heart palpitations, nausea, upset stomach, chest pain, dizziness, light-headedness, sweating, and feelings of choking and smothering, chills, hot flashes, and trembling.

A number of factors may be involved in the causes of panic disorders. Stressful life events and major life transitions, such as long-term unemployment, loss of a loved one can trigger panic disorders. Drug therapy and cognitive therapies are generally used for panic disorder.

Phobia is a form of fear, different from normal fear, in the sense it is "intense, unproportionate, persistent and unreasonable fear of particular object, activity, or situation. It is unreasonable. In the sense, normally there is no need for fear of a situation. Ex: intense fear of

deep water, darkness. Phobic reason is terribly afraid of the situation. Mainly there are three types of phobias. They are specific phobias, social phobia and agoraphobia. Simple extinction, desensitization, flooding, aversion therapy, Modeling or vicarious conditioning is the several treatments for phobic disorder.

6.3 MEANING OF PANIC DISORDER

The panic disorder is a sudden, overwhelming, and apparently senseless terror. Panic disorder may attack with no warning at any time and any stage. Panic attack denotes "an abrupt surge of intense anxiety rising to a peak without obvious cues and is spontaneous and unpredictable". The person in panic, experiences phobic fear that stimulus evokes. Stressful events like new job, marriage, sudden termination from service, unexpected failure in the examination etc. trigger panic attack.

A panic attack is a sudden attack of intense apprehension, terror, and feelings of impending doom, accompanied by at least four other symptoms. Physical symptoms can include labored breathing, heart palpitations, nausea, upset stomach, chest pain, dizziness, light-headedness, sweating, and feelings of choking and smothering, chills, hot flashes, and trembling. When panic attacks occur unexpectedly, they are called uncued attacks. When panic attacks are clearly triggered by specific situations, such as seeing a snake, they are referred to as cued panic attacks. People who only have cued attacks most likely suffer from a phobia.

In DSM-IV-TR, there are two types of panic disorder: with agoraphobia and without agoraphobia. Agoraphobia is defined by anxiety about situations in which it would be embarrassing or difficult to escape if panic symptoms occurred. Often, the person fears public places where it would be embarrassing to experience a panic attack. Commonly feared situations include driving, bridges, crowds, and crowded places such as grocery stores, malls, and temples. Many people with agoraphobia are unable to leave their house, and even those who can leave their home do so only with great distress. Agoraphobia can also be diagnosed in the absence of panic disorder. In such a case, the person's fears still focus on developing panic-like symptoms (e.g., dizziness) in a place from which it would be hard to escape.

6.4 SYMPTOMS OF PANIC DISORDER

Panic attacks, are short but intense periods in which individual experiences many symptoms of anxiety. Heart palpitations, trembling, feeling of choking, dizziness, intense dread, and so on. Panic attacks may occur in the absence of any environmental triggers on in some people panic attacks are situationally predisposed. The person is more likely to have them in certain situation but does not always have them when in those situations. In all cases, however, the panic attack is a terrifying experience, causing a person intense fear or discomfort the physiological symptoms of anxiety, the feeling of losing control, going crazy, or dying when panic attacks become a common occurrence. When the panic attacks are usually not provoked by any particular situation, and when a person begins to worry about having attacks and changes behaviours as a result of this worry, a diagnosis of panic disorder is made. Some people with panic disorder have many attacks in a short period of time. Less frequently, people who have panic disorder often fear that they have life - threatening illnesses. E.g., thyroid disorders, or with a cardiac disorder called mitral value prelate. Between 1.5 and 4 % of people will develop panic disorder at some time in their lives. Most people who develop panic disorder usually do so sometime between late adolescence and their midthirties. Many people with panic disorder also suffer from chronic generalized anxiety, depression, and alcohol abuse.

Clinical features of panic attack are:-

1. Shortness of breath

2. Trembling, shaking or sweating

3. Dizziness, unsteadiness, or fainting

4. Palpitations or racing of heart rate

5. Choking nausea or stomach pain

6. Numbness', or tingling, flushing or chills

7. Chest pain or discomfort

8. A sense of "strangeness" of being detected by oneself or one's surroundings

9. Fear of going crazy, lacking control, and dying.

Panic disorder affects women more than men. Younger group will have more attack than the elderly. This disorder develops between late adolescence and midthirties some will have this attack not severe.

These panic attacks ranges from a few second, to many hours' even days. They also differ in severity and in the degree of incapacitation. After experiencing unpredictable and recurrent panic attack, people become fearful of a place where help is not available or escape is very difficult.

6.5. PREVELENCE OF PANIC DISORDER

Panic Disorder is fairly common. Approximately 2.7% of the population meet criteria for Panic Disorder during a given 1-year period and 4.7% met them at some point during their lives, two-thirds of them women. Panic disorder usually occurs in early adult life-from midteens through about 40 years of age. The median age of onset is between 20 and 24 (Kessler, Berglund, et al., 2005). Most initial unexpected panic attacks begin at or after puberty. In general, the prevalence of PD or comorbid panic disorder and agoraphobia decreases among the elderly, from 5.7% at ages 30-44 to 2.0% or less after age 60(Kessler, Berglund, et al., 2005).Most (75% or more) of those who suffer from agoraphobia are women (Barlow, 2002; Myers et al., 1984; Thorpe & Burns, 1983).The higher the severity of agoraphobic avoidance, the greater the proportion of women.

6.6. CAUSES AND TREATMENTS OF PANIC DISORDER

A number of factors may be involved in the causes of panic disorders. Stressful life events and major life transitions, such as long-term unemployment, loss of a loved one can trigger panic disorders.

6.6.1 BIOLOGICAL EXPLANATION AND TREATMENT

The biology of Panic disorder is application of antidepressent drugs. This alters the activity of nor epinephrine. If antidepressant drugs alter nor epinephrine activity and eliminate panic attack, then panic disorder is caused by abnormal nor epinephrine activity. Nor epinephrine

activity may be irregular in people who experiences panic attack. It is round form the research that the locus cerulean in brain area is rich in neuron, that use nor epinephrine when electrically stimulated in monkeys; they displayed panic like reaction .This suggests that panic reactions may be related to changes in nor epinephrine activity in the locus cerulean us. In another study panic was induced in human beings by administering chemicals known to the activity of nor epinephrine.

Genetic Factors: There is also evidence that panic disorder tends to run in families. Many studies have shown that first-degree relatives of panic clients are more likely to experience panic disorder than are relatives of controls and monozygotic twins are somewhat more likely to be concordant for the diagnosis than are dizygotic twins.

Drug Therapies

Antidepressant drugs give relief from panic disorder. These Antidepressant drugs help to neither restore appropriate nor epinephrine activity in people with panic disorder. Recentlyalphazolam (xanax) is found to be more effective in the treatment of panic disorder. A combination of antidepressant drugs and behavioural exposure treatment is more effective than either treatment alone.

6.6.2 COGNITIVE EXPLANATION AND THERAPY

Cognitive theorists have come to recognize that biological factors are only part of the Cause of panic attacks. In their view, full panic reactions are experienced only by people who further misinterpret the physiological events that are occurring within their bodies.

Cognitive theorists believed that panic-prone people are highly sensitive to certain bodily sensations, and they misinterpret them as indicative an imminent catastrophe. They do not understand the probable cause of sensations. Panic-prone people are worried about losing control, fear very much, lose all their perspective and rapidly deteriorate in to panic. They expect that their dangerous sensation may occur at any time and so they set themselves for future misinterpretations and panic attack. Panic-prone people have high degree of sensitivity. They are preoccupied with their bodily sensation and lose their ability to assess them logically and interpret them as potential harmful. Studies found that subjects who scores high on anxiety

sensitivity, found that people who develop panic attack five times more than others with in 3 years. Such people tend to misinterpret many kinds of sensations and seem to over breathe in stressful situations. This abnormal breathing makes to think they are in danger or even dying so they become panic. Other physical sensations trigger misinterpretation with the panic -prone individual, it includes euphoric excitement, fullness in the abdomen, acute anger and sudden tearing in the eyes.

Cognitive Therapies

Cognitive therapists try to correct people's misinterpretations of their body sensations. The first step is to educate clients about the general nature of panic attacks, the actual causes of bodily sensations, and the tendency of clients to misinterpret their sensations. The next step is to teach clients to apply more accurate interpretations during stressful situations, thus short-circuiting the panic sequence at an early point. Therapists may also teach clients to cope better with anxiety-for example, by applying relaxation and breathing techniques-and to distract themselves from their sensations, perhaps by striking up a conversation with someone.

Cognitive therapists may also use biological challenge procedures (called interceptive exposure when applied in therapy) to induce panic sensations, so that clients can apply their new skills under watchful supervision. Individuals whose attacks are typically triggered by a rapid heart rate, for example, may be told to jump up and down for several minutes or to run up a flight of stairs. They can then practice interpreting the resulting sensations appropriately and not dwelling on them.

6.7. MEANING OF PHOBIC DISORDER

As part of normal life, many of us may feel uncomfortable or fearful at times about certain objects or situations. If such experiences become feared and disrupt life to the point where we are unable to enter social situations or to carry out our work and everyday activities, this may be due to an anxiety disorder called a phobia.

Phobia is a Greek word means “Fear”. It is form of fear, different from normal fear, in the sense it is “intense, un proportionate, persistent and unreasonable fear of particular object, activity, or situation. It is unreasonable. In the sense, normally there is no need for fear of a

situation. Ex: intense fear of deep water, darkness. Phobic person is terribly afraid of the situation.

Phobic fears are different from common fears. For ex: normal fear of snake is different from snakephobia. Person with phobic disorder experience, much distress, which interferes dramatically with their personal, social and occupational functioning.

6.8. SYMPTOMS OF PHOBIC DISORDER

Some common symptoms of Phobic Disorders:

- Physical signs, such as restlessness, trouble falling or staying asleep, headaches, trembling, twitching, muscle tension, or sweating, often accompany these psychological symptoms.

- Persistent concern about having additional attacks
- Patients with specific phobia display anxiety as soon as they confront the phobic stimulus.
- Individuals with specific phobia avoid the phobic stimulus or endure it with deep distress and anxiety.
- Many people experience specific phobias, intense, irrational fears of certain things or situations--dogs, closed-in places, heights, escalators, tunnels, highway driving, water, flying, and injuries involving blood are a few of the more common ones.
- To diagnose specific phobia in a patient who is under 18 years of age, the duration of the disorder needs to be at least six months.
- These are accompanied by physical manifestations such as sweating, dry mouth, hot flashes or chills, muscle tension, dizziness, palpitations, trembling, or restlessness.

6.9. PREVALENCE OF PHOBIC DISORDER

Mild phobias are very common, particularly in childhood, although most of these fears disappear by the age of six. People can also develop phobias when going through a particularly stressful period of their lives. Depending upon the research study, approximately 5% of adults develop agoraphobia, although a smaller number around 1% of the population experience severe

distress and significant limitation of their daily activities. Agoraphobia usually starts when a person is in their late 20s and is more common in women than men. Around 1 to 2% of men and women develop social phobia, which is often linked to low self-esteem and fear of criticism.

6.10. TYPES OF PHOBIAS

DSM-IV presents 3 main types of phobias

1. Specific phobias

2. Social phobias

3. Agoraphobia

1. SPECIFIC PHOBIAS

A specific phobia is an irrational fear of specific object or situation that severely interferes with the individual's ability to function.

According to DSM-IV diagnostic criteria for specific phobias are

1. Marked and persistent fear that is unreasonable cued, by the presence or anticipation of specific object or situation ex: fear of heights, animals, blood, flying by aeroplane etc.

2. Exposure of the phobic stimulus provokes an immediate anxiety response.

3. The person is aware that the fear is excessive and unreasonable.

4. The phobic situation is avoided or is endured with intense anxiety,

5. The feared situation interferes significantly with the people's normal routine.

6. The duration is at least 6 months.

Some of the Common specific Phobias are

Acrophobia -fear of heights

Apiphobia-fear of bees

Aquaphobia-fear of water

Cynophobia - fear of dogs

Gynophobia - fear of women

Iatrophobia – fear of doctors

Monophobia: fear of being alone

Mysophobia-fear of dirt, germs

Necrophobia- fear of death

Nyctophobia - fear of darkness

Ophidiphobia- fear of snakes

Pyrophobia - fear of fire

Sociophobia-fear of social situations

Theophobia-fear of God

Xenophobia - fear of strangers

Zoophobia-fear of animals

Specific phobias can develop at any time in life. Some animal phobias begin during child hood and disappear on their own, before adulthood. Some of the phobias which continue to adult hood become stubborn. They usually reduce only after treatment.

2. SOCIAL PHOBIAS

Social Phobia is a fear of a social or performance situations, such as attending a party or speaking in public. People with social phobia fear that they will behave in an unacceptable or embarrassing way that will lead others to judge them negatively.

Social phobias cannot be highly incapacitating .a person is unable to react with others or speak in public, may fail to perform important scholastic or professional responsibilities. Ex: a

person who can eat in public place may reject dinner invitation and other social engagement. People with these phobias keep their fears secret. Their social reluctance is misinterpreted as snobbery, disinterest or stubbornness.

Those social phobias are more common than agoraphobia. More frequently, women than men experience this phobia. This disorder often begins in late child hood or adolescence and likely to persist for years .the intensity of this may fluctuate for years.

3. AGORAPHOBIA

This is a fear of an actual or anticipated situation, such as using public transportation, being in open or enclosed spaces, standing in line or being in a crowd, or being outside the home alone. The anxiety is caused by fearing no easy means of escape or help if intense anxiety develops.

People with this phobia avoid entering crowded street or stores, driving through tunnels or Bridges, travelling on public transportation and using elevators. They will go out of the house only in the company of close relatives and friends.

In many cases the intensity of agoraphobia fluctuates. In severe cases the person becomes virtual prisoner at his house. Their social life dwindles and cannot hold a job. Sometimes he becomes depressed as a result of severe limitations. Most people who have agoraphobia develop it after having one or more panic attacks, causing them to fear another attack and avoid the place where it occurred. For some people, agoraphobia may be so severe that they're unable to leave home.

6.11. CAUSES AND TREATMENTS OF PHOBIC DISORDER

Phobia is usually caused in the early childhood. Different psychologists gives different explanation based upon the approaches they follow. The causes and the treatment based on these approaches are being explained as follows

6.11.1 PSYCHODYNAMIC EXPLANATION AND TREATMENT

Freud believed that phobias result when people make excessive use of defense mechanisms such as repression and displacement to control the under lying anxiety. They try to push their anxiety producing impulses deeper into unconscious (repression) and transfer their

fears to neutral (unconcerned) stimulus (displacement).these stimuli are easier to cope up with and control. The objects of fear are often related to threatening impulses, the phobic person is not aware of the relationship.

If the original repressed traumatic experience is recalled with the aid of free association or dream analysis, and makes the patient to understand and reeducate or adjusted, phobia disappears. This technique was criticized on the ground it is time consuming and free association.

6.11.2 BEHAVIORAL EXPLANATION AND TREATMENT

Behaviorists like Watson, Betrov, Skinner, Woolmen etc believed that people with phobia, first learn to fear certain objects, situations, or events, through conditioning. Once the fears are acquired, the individuals keep avoiding the dreaded object, or situation. This avoidance makes the phobia to become more intense.

Behaviorist proposed **1).Classical conditioning** which is a way of acquiring fear of objects or situations that are not dangerous by themselves. If two events occur close together time, become closely associated in the mind of the person, then he starts reacting similarly to both of them. If one event triggers fear the other also triggers fear.

2. Modeling through observation and imitation or by observing others who are afraid of some objects or events the observer also develops fear of the same objects or events. The process of acquiring fear reactions through modeling in this way is called as vicarious conditioning.
According to behaviorists the specific learned fear may further blossom into generalized anxiety. If a person experiences series of upsetting events and each event produces fear, these stimuli generalize .That person builds up a large number of fears and develop a generalized anxiety disorder.

Behavioral Treatments

1. **Simple extinction:** Learnt behavior tends to become weak and disappears with the lapse of time if it is not reinforced. So maladaptive behavior which is learned, can be

eliminated by removing the reinforcement from it. The removal of reinforcement must be abrupt and complete to be effective.

2. **Desensitization:** The maladjusted behavior, which is reinforced by avoidance of the concerned stimulus or situation, can be eliminated by gradually exposing the patient to the situation, making him to understand the absurdity of it and adapt to it negatively.
3. **Flooding:** Exposing the patient to massive flood or implosion of anxiety with repeated exposure in a safe setting where no harm is forthcoming. This stimulus loses it power to elicit anxiety and the neurotic aoidance behavior is extinguished.
4. **Aversion therapy:** This method involves the modification of undesirable behavior by punishment. For ex: is allocation treatment. The punishment may be electric shock or nausea producing drug. Shock is to be administered in association with sight, smell and taste of alcohol every time. This causes aversion towards alcohol. This therapy is used in the treatment of a wide range of maladaptive behavior like smoking drug dependence, sexual deviation like fetishism and homosexuality.
5. **Modeling or vicarious conditioning:** This technique is used to treat specific phobias. Here the therapist confronts the feared object or a situation, in the presence of the fearful patient, observing the therapists acts as a model who demonstrates that the clients fear is groundless. After several sessions client by himself approaches the object or situation which was causing fear.

6.12. SUMMARY

The panic disorder is a sudden, overwhelming, and apparently senseless terror. Panic disorder may attack with no warning at any time and any stage. Panic attack denotes “an abrupt surge of intense anxiety rising to a peak without obvious cues and is spontaneous and unpredictable”. The person in panic, experiences phobic fear that stimulus evokes. A number of factors may be involved in the causes of panic disorders. Stressful life events and major life transitions, such as long-term unemployment, loss of a loved one can trigger panic disorders. Drug therapy and cognitive therapies are generally used for panic disorder.

Phobia is a form of fear, different from normal fear, in the sense it is “intense, unproportionate, persistent and unreasonable fear of particular object, activity, or situation. It is

unreasonable. In the sense, normally there is no need for fear of a situation. Ex: intense fear of deep water, darkness. Phobic person is terribly afraid of the situation. Mainly there are three types of phobias. They are specific phobias, social phobia and agoraphobia. Simple extinction, desensitization, flooding, aversion therapy, Modeling or vicarious conditioning are the several treatments for phobic disorder.

6.13. KEY WORDS

Panic attack	Simple extinction
Social phobia	Desensitization
Agoraphobia	Flooding
Pyrophobia	Aversion therapy
Modeling	Vicarious conditioning

6.14. CHECK YOUR PROGRESS

1) Define Panic disorder. Explain the symptoms of Panic disorder.
2) Explain the Clinical features of panic attack.
3) Describe the causes and treatments of Panic disorder.
4) What is phobia? Explain the symptoms of Phobic disorder.
5) Explain the types of phobias.
6) Write a note on agoraphobia.
7) Describe the causes and treatments of Phobic disorder.

6.15. ANSWERS TO CHECK YOUR PROGRESS

1) 6.3 & 6.4 2)6.4 3)6.6 4) 6.7 & 6.8 5)6.10 6)6.10 7) 6.11

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UNIT- 7 POST- TRAUMATIC STRESS DISORDER (PTSD)

STRUCTURE

7.1 OBJECTIVES

After going through this unit you will be able to

- Meaning of Post-Traumatic Stress disorder
- Symptoms of Post-Traumatic Stress disorder
- Causes of Post-Traumatic Stress disorder
- Treatment of Post-Traumatic Stress disorder

7.2 INTRODUCTION

Sometimes, after particularly traumatic experiences, an individual can experience Post Traumatic Stress Disorder, or PTSD. PTSD is an anxiety disorder which occurs after a person experiences a severe trauma. PTSD most often occurs after a terrifying event where physical harm occurred or was threatened. These events can include assaults, rape, accidents, military combat, fires, or other disasters. PTSD symptoms include re-experiencing symptoms of the traumatic event, aviodant symptoms, symptoms of increased arousal, reduced responsiveness**.**

7.3 MEANING OF POST TRAUMATIC STRESS DISORDER

Trauma is a severe psychological and physiological stress resulting in injury or wound. PTSD is an anxiety disorder which occurs after a person experiences a severe trauma. It is a set of symptom including hyper vigilance, re-experiencing of the trauma, emotional numbing experienced by trauma survivors. People who experience severe and long lasting traumas, who have lower levels of social support, who experience socially stigmatizing traumas, who were already depressed or anxious before the trauma, or who have maladaptive coping styles may be at increased risk for PTSD.

The traumatic experiences may be after war, combat, floods, earthquake, sudden death of spouse, divorce, rape, plane crash, sudden loss of lucrative job, or car accident etc.

7.4 SYMPTOMS OF POST - TRAUMATIC STRESS DISORDER

Anxiety linked symptoms begin within four weeks after the traumatic event, and lasts for less than a month. This is known as acute stress disorder. If the symptoms continue longer than a month, it is known as post-traumatic stress disorder. These two anxiety disorders are identical and will have the following symptoms.

1. **Re-experiencing symptoms of the traumatic event:** These symptoms may include the following:

- intrusive memories of the traumatic event
- acting or feeling as if the traumatic event is reoccurring recurrent,
- distressing dreams about the traumatic event
- mental and physical discomfort when reminded of the traumatic event (e.g. on the anniversary of the traumatic event)

2. Avoidant symptoms: In which the person tries to avoid anything associated with the traumatic event. These symptoms may also include a "numbing" effect, where the person's general response to people and events is deadened. Avoidant symptoms include the following:

- avoiding thoughts or feelings, people or situations (anything that could stir up memories) associated with the traumatic event
- not being able to recall an important aspect of the traumatic event
- reduced interest or participation in significant activities
- feeling disconnected from others
- showing a limited range of emotion

3. Symptoms of increased arousal: It may be similar to symptoms of anxiety or panic attacks. Increased arousal symptoms include the following:

- difficulty concentrating
- exaggerated watchfulness and wariness
- irritability or outbursts of anger
- difficulty falling or staying asleep
- being easily startled

4. Reduced responsiveness: Reduced responsiveness is prominent in acute stress disorder. It may further include dissociation or emotional separation, dazedness, loss of memory, derealisation or depersonalizations.

An acute or post-traumatic stress disorder can occur at any age, even in childhood and can impair one's personal, family, social, or occupational functioning. Survey report shows about

0.5% of total population experiences one of these disorders in any given year. At least 1.3% will suffer from this in their life time.

7.5 CAUSES OF POST TRAUMATIC STRESS DISORDER

There are several factors seem to play important roles in causes of post-traumatic stress disorder.

1. Childhood events: Some of the events occurred in childhood develop acute and post-traumatic stress disorder. Those experiences are poverty, parental separation, or divorce before the child is 10 years old. This family suffers from mental disorders, or has experienced assault, abuse, catastrophe at an early age when exposed to traumatic experiences develop stress disorders.

2. Personality profiles: People with certain personality profiles are more likely to develop these disorders. For example the rape victims who had psychological problems before if they are raped or if they were struggling with stressful life situations and war veterans who had poor relationships before they went in to combat will have greater risk of developing lingering stress reactions after their traumatic experiences. Similarly people who have suffered aversive events beyond their limit develop more severe stress symptoms after criminal assaults, than others.

3. Support systems: People, whose support systems are weak after a traumatic event, are likely to develop an extended disorder. Rape victims who feel loved, cared for, accepted by group of friends or relatives, and treated with dignity and respect by gents of criminal justice system are more likely to recover successfully from their sexual assaults. On the other hand people with weak social support develop post-traumatic stress disorder.

7.6 TREATMENT OF POST-TRAUMATIC STRESS DISORDER

Recent identification of acute or post-traumatic stress disorder as specific category number of treatments have emerged, but they vary from trauma to trauma (1) They try to help survivor to reduce or overcome their lingering symptoms. (2)Gain perspective on their traumatic experiences, (3) Return to constructive living.

1. Medical Therapy:

a).The therapists have used a combination of technique to alleviate the post traumatic symptoms of veterans. They used anxiety drugs to reduce tension, hyper alertness and exaggerated startle responses the veterans were experiencing.

b).In addition they used antidepressant medicines to reduce nightmare, flashbacks, intrusive recollection and feeling of depression.

2. Behavioral exposure technique: In this technique therapists used flooding along with relaxation training to overcome frightening combat flashback and night mare. Here the therapist and the client single out combat scenes that the veteran experiencing frequently. The therapist helps the client to imagine one of these traumatic scenes in great detail and urges him to retain the images until his anxiety subsides. Thus after each flooding exercises the therapist switches on to positive imagery and leads him to relaxation exercise. By this treatment the veteran's flashbacks and nightmares diminish.

3. Stress management: The methods of stress management helps to develop skills to overcome stressful issues.

4. Crisis Intervention Therapy: A brief problem-focused counseling approach referred to as crisis intervention may aid a victim of a traumatic event in readjusting to life after the stressful situation has ended. In brief crisis-oriented therapy with people in a crisis situation, the disaster victim is provided emotional support and is encouraged to talk about their experiences during the crisis**.**

5. Social-Cultural Help: Community level interventions help the people with PTSD caused by natural disasters, etc.

7.7 SUMMARY

Post-Traumatic Stress Disorder is an anxiety disorder which occurs after a person experiences a severe trauma. PTSD most often occurs after a terrifying event where physical harm occurred or was threatened. These events can include assaults, rape, accidents, military combat, fires, or other disasters. PTSD symptoms includes Re-experiencing symptoms the

traumatic event, Avoidant symptoms, Symptoms of increased arousal, reduced responsiveness**.** Childhood events, Personality profiles, lack of Support systems are the major causes for Post-Traumatic Stress Disorder. Medical Therapy, Behavioral exposure technique, Stress management, Crisis Intervention Therapy, Social-Cultural Help are the major treatment for Post-Traumatic Stress Disorder.

7.8 KEY WORDS

Trauma
Stress disorder
Post-traumatic stress disorder
Combat
Avoidant symptoms
Stress management
Social-Cultural

7.9 CHECK YOUR PROGRESS

1. What is Post Traumatic Stress Disorder? Explain the symptoms of Post Traumatic Stress Disorder.
2. Explain the Causes of Post-Traumatic Stress Disorder.
3. Explain the treatments of Post-Traumatic Stress Disorder.

7.10 ANSWERS TO CHECK YOUR PROGRESS

1) 7.3 & 7.4 2) 7.5 3) 7.6

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UNIT: 8 - OBSESSIVE-COMPULSIVE DISORDERS

STRUCTURE

8.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning of Obsession.
- Meaning of Compulsion.
- Characteristics of patients having Obsessive-Compulsive disorders.
- Causes and treatments of Obsessive-Compulsive disorders.

8.2 INTRODUCTION

Obsessive-Compulsive disorder (OCD) is one of the anxiety disorders, **where a person has obsessive thoughts and compulsive activity.** The individual who suffers from OCD becomes trapped in a pattern of repetitive thoughts and behaviours that are senseless and distressing.

Obsessions are unwelcome thoughts, images, urges or doubts that repeatedly appear in the mind. These obsessive thoughts persistently occurred and distract our attention. The obsessions are often frightening or seem so horrible that can't be shared with others. It interrupts other thoughts and makes the individual feel very anxious.

Compulsions are repetitive behaviours that a person with OCD feels the urge to do in response to an obsessive thought. Obsessions and compulsions are interrelated. Ego dystonic, ambivalence, Insight, Guilt are the major characteristics of patients having obsessive-compulsive disorders. There are several reasons for OCD .These reasons and treatments are explained under socio- psychodynamic, behavioral, cognitive and biological perspectives.

8.3 MEANING OF OBSESSION

Obsessions are unwelcome thoughts, images, urges or doubts that repeatedly appear in the mind. These obsessive thoughts persistently occurred and distract our attention. The obsessions are often frightening or seem so horrible that can't be shared with others. It interrupts other thoughts and makes the individual feel very anxious.

Common obsessive thoughts in obsessive-compulsive disorder (OCD) include:

- Fear of being contaminated by germs or dirt or contaminating others.

- Fear of causing harm to him or others.
- Excessive focus on religious or moral ideas.
- Intrusive sexually explicit or violent thoughts and images.
- Fear of losing or not having things.
- Order and symmetry: the idea that everything must line up “just right.”
- Superstitions; excessive attention to something considered lucky or unlucky.

8.4 MEANING OF COMPULSION

Compulsions are repetitive thoughts or images inside a person which does not remain merely as thoughts of images alone. They may express into some silly or unwanted action. It is an irresistible impulse to perform a certain act repetitively though it is unpleasant and undesirable. If the action is resisted, tension goes on building up till it becomes unbearable, and ends with the action. Soon after the work is over, tension is released, but after some time the urge to do it again builds up. Thus the urge or tension repeatedly continues till the individual is totally tired. Compulsions are constant, continual, and irresistible inclinations to engage in meaningless motor actions. Though the compulsive behavior is technically under voluntary control, the person is compelled to do it with no choice. They believe something terrible will happen if they do not yield to compulsion. These people know that their behavior is excessive and unreasonable but helpless.

Common compulsions include:

- Excessive washing and cleaning e.g. having to wash the hands very frequently in order to feel clean.
- Repetitive checking and rechecking,
- Touching every light switch in the house every time the individual leaves or enters the house.
- Counting or repeating words (usually silently)
- Redoing, such as opening and closing, erasing and rewriting
- Hoarding use less items
- Biting finger nails

- Fiddling with buttons
- Praying (continuous or excessive)
- Symmetry (movements or objects need to match or be ordered in a certain way).

Both obsession and compulsions occupy the total attention and effort of the patient. As a result of this the work efficiency and personal adjustment is seriously impaired. Both these abnormalities appear and persist when the patient is awake and not when he is sleeping. The frequency is greater when he is unoccupied, than when he is engaged in some tasks.

Personality of the compulsive patient is introvert, sensitive, over-conscientious and orderly. They are precise and perfect in their actions. They impose regimentation on others also. They are devoid of humour and are unfriendly.

Relationship between obsession and compulsion

Though some people with an obsessive compulsive disorder experience only obsessions or only compulsions, but most of them experience both. Their compulsive acts are often a response to their obsessive thoughts. In some cases compulsions seem to serve to control their obsessions, by diverting their attention to some other compulsive acts particularly to cleaning and checking compulsions. They do not usually lead to acts of violence, immorality and the like.

8.5 CHARACTERSTICS OF PATIENTS HAVING OBSESSIVE-COMPULSIVE DISORDERS

The following are some important characteristics of patients having obsessive-compulsive disorders:

1. Ego-dystonic: This refers to the characteristic feeling in obsessive compulsive patients that their symptoms are incompatible or unacceptable to their own ego. They feel that their symptoms are alien or not their own although they recognize that they are their own thoughts, feelings images.

2. Ambivalence: This refers to a state of psychic incompatibility in obsessive-compulsive patients of being pulled on one side towards the compulsive act and an inner desire on other side to get away from it at the same time. There is a case of young man who stumbled upon a stone while walking along a road. His immediate thought was what would happened if in

his place his fiancée happened to trip on the same piece of stone. He was at once prompted to pick the stone and carry it to other side of the street. After a few minutes, it occurred to him that his act of shifting the stone was farfetched and silly. He returned to replace the stone back to the original place once again.

3. Insight: This refers to capacity of the obsessive-compulsive patient to recognize his own symptoms and yet being unable to do anything to overcome them.

4. Guilt: This refers to the strong feeling in obsessive-compulsive patient that s/he has committed some offence or something wrong. They may or may not be aware of the source of their feelings of guilt.

8.6. CAUSES AND TREATMENTS OF OBSESSIVE-COMPULSIVE DISORDERS

The psychodynamic ,behavioural, cognitive and biological perspectives gives different reasons for the causes of obsessive compulsive disorders. Their perspectives about the causes and treatment of obsessive compulsive disorder is being discussed here:

8.6.1 THE PSYCHODYNAMIC PERSPECTIVE

According to Sigmund Freud and his followers this disorder is due to exaggerated use of Psychological defense mechanisms like isolation, undoing and reaction formation.

1. Isolation: In this mechanism people unconsciously isolate and discuss undesirable and unwanted thoughts, experiencing them as foreign intrusions.

2. Undoing: Undoing is a type of ego defense mechanism in which a person unconsciously attempts to atone for an unacceptable desire or act by another act. This undoing is very essential to maintain ethical human relations and to maintain self-esteem. This is most valuable ego defense mechanism. If undoing is beyond certain limits it becomes a major symptoms of depressive psychosis and involutional melancholia wherein demands some punishment.

3. Reaction formation: Reaction formation is a method of controlling socially acceptable or undesirable urges, by denying their existence and to develop diametrically opposite traits that disguises and checks more basic motives. Reaction formation helps to maintain socially approved behavior and to avoid self-devaluating behavior. This mechanism is self-

deceptive in nature and hence not subjected to conscious control. It often results in exaggerated and rigid belief that it will lead to excessive harness in dealing with lapses of others. If it is beyond certain limits it complicates the adjustive reactions.

Psychodynamic therapy: When treating patients with obsessive-compulsive disorder, psychodynamic therapists try to help the individuals uncover and overcome their underlying conflicts and defences, using the customary techniques of free association and therapist interpretation. Free association and interpretation may inadvertently play in to the tendency of obsessive-compulsive person to ruminate and over interpret.

8.6.2 THE BEHAVIORAL PERSPECTIVE:

Behaviourists have focused on explaining and treating compulsions rather than obsessions. They propose that people happen upon their compulsions quite randomly. In a fearful situation, they happen just coincidentally to wash their hands, say, or dress a certain way. When the threat lifts, they link the improvement to that particular action. After repeated accidental associations, they believe that the action is bringing them good luck or actually changing the situation, and so they perform the same actions again and again in similar situations. The act becomes a key method of avoiding or reducing anxiety.

Behaviour therapy: Exposure and response prevention therapy is used for obsessive-compulsive disorder in which clients are exposed to anxiety-arousing thoughts or situations and then prevented from performing their compulsive acts.

8.6.3 THE COGNITIVE PERSPECTIVE:

Cognitive theorists explain the obsessive-compulsive disorder caused by repetitive, unwanted, and intrusive thoughts. Such as thoughts of harming others or being contaminated by germs. Those who develop this disorder, believe themselves responsible for having such terrible thoughts and worry that the thoughts will lead to harmful acts or consequences. These people find intrusive thoughts so repulsive and stressful that they try to eliminate or avoid by neutralizing. i e thinking or behaving in ways calculated to put the matters right internally and to make amends for unacceptable thoughts. They may use neutralizing techniques, requesting

special reassurance from others, thinking good thoughts, cleaning their hands or checking for possible sources of danger.

Studies have found that people, who have obsessive-compulsive disorder experience intrusive thoughts more often than other people, resort to more elaborate neutralizing strategies, and experience reductions in anxiety after using neutralizing techniques.

Cognitive therapies:

Cognitive therapists focus treatment on the cognitive processes that help produce and maintain obsessive thoughts and compulsive acts. Initially, they provide psycho education, teaching clients about their misinterpretations of unwanted thoughts, excessive sense of responsibility, and neutralizing acts.

Habituation training: In this training therapist tries to evoke the patients obsessive thoughts again and again. This intensified exposure to thoughts will reduce the threatening meaning of that thought which is causing anxiety and so trigger fewer new obsessive thoughts or compulsive acts.

Covert-response prevention: In this therapy the clients are taught to prevent or distract themselves from carrying out any other obsessive thoughts or compulsive actions which may emerge during habituation training. During repeated sessions the patient's obsession and compulsions are expected to decrease.

8.6.4 BIOLOGICAL PERSPECTIVE

Biological reasons for obsessive-compulsive disorder are as follows

1. Abnormal low activity of neurotransmitter serotonin.
2. Abnormal functioning in key areas of the brain.
3. Serotonin like GABA and norepinephrine is a brain chemical that carries messages from one neuron to another neuron. It is implicated in obsessive – compulsive disorder. Clinicians found that administration of antidepressant drugs like clomicpramine and fluoxecative reduce Obsessive -Compulsive symptoms. These drugs seem to increase serotonin activity and reduce

Obsessive – Compulsive symptoms. The antidepressant drugs alleviate Obsessive – Compulsive disorder by increasing serotonin activity.

Heightened functioning in orbital region and the caud nuclei in the brain is also another reason for obsessive – compulsive disorder.

Biological therapies: Antidepressant drugs which arises serotonin activity particularly clomipramine. It is very useful to treat Obsessive -Compulsive disorder but it does not totally disappear rather reduces it. It reappears if the medications discontinued. Exposure and response prevention treatment is another biological therapy for Obsessive-Compulsive disorder.

8.7 SUMMARY

Obsessions are unwelcome thoughts, images, urges or doubts that repeatedly appear in the mind. These obsessive thoughts persistently occurred and distract our attention. **Compulsions** are repetitive behaviours that a person with OCD feels the urge to do in response to an obsessive thought. Obsessions and compulsions are interrelated. Ego-dystonic, ambivalence, Insight, Guilt are the major Characteristics of patients having obsessive-compulsive disorders. There are different approaches to explain and treat such as psychodynamic, behavioral, cognitive, and biological.

8.8 KEY WORDS

Obsession	Undoing
Compulsion	Reaction formation
Ego-dystonic	Serotonin
Ambivalence	Antidepressant drugs
Guilt	Norepinephrine
Insight	Habituation training
Covert-response	Neurotransmitter

8.9 CHECK YOUR PROGRESS

1. What are Obsessions and compulsions? How they are related?
2. Explain the Characteristics of patients having obsessive-compulsive disorders.

3. Describe the Causes and treatments of obsessive-compulsive disorders.

8.10 ANSWER TO CHECK YOUR PROGRESS

1) 8.3 & 8.4 2)8.5 3)8.6

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BLOCK-3 : MOOD AND SCHIZOPHRENIC DISORDERS

UNIT: 9 MANIC AND DEPRESSIVE DISORDER

STRUCTURE

9.1 OBJECTIVES

After going through this unit, you will be able to explain

- Mood disorders
- Manic disorders
- DSM-IV diagnostic criteria for Mania
- Depressive disorder
- Major depressive disorder
- DSM-IV –TR Diagnostic criteria for major depressive disorder
- Dysthmic disorder
- DSM-IV Features of Dysthmic disorder
- Causes of Manic and Depressive disorders

9.2 INTRODUCTION

This unit deals with the various effects of emotional state which when prolonged in an individual sometimes may lead to abnormal states and later to disorders. The prolonged emotional state referred as mood and the disorders caused due to mood are called as mood disorders. This unit deals with manic disorders, depressive disorders, dysthmicdis orders, its features and its causes.

9.3 MOOD DISORDERS

Mood refers to a prolonged emotional state, it covers the aspects of a person's thought and behavior. In normal situation an individual experiences different mood at different situations. In certain situations, some individuals do experience an intense and prolonged mood which may be harmful, even life-threatening actions. These can be considered as disorders.

People with mood disorders experience prolonged periods of extreme depression or elation, often unrelated to their circumstances, that disrupt their everyday functioning.

Mood disorders are disturbances in mood or prolonged emotional state. The individuals seem stuck either in one end or the other in an emotional spectrum- either consistently excited and euphoric or consistently sad.

According to DSM-IV –TR a mood disorder is a serious, persistent disturbance in a person's emotions that causes psychological discomfort, impairs the ability to function, or both.

Mood disorders are a category of mental disorders in which significant and chronic disruption in mood is the predominant symptom, causing impaired cognitive, behavioural and physical functioning.

In mood disorders, emotions violate the criteria of normal moods. In quality, intensity and duration, a person's emotional state does not seem to reflect what's going on in his or her life. A person may feel a pervasive sadness despite the best of circumstances. Or a person may be extremely energetic and overconfident with no apparent justification. These mood changes persist much longer than the normal fluctuations in moods that we all experience.

9.4 MANIC DISORDERS

People sometimes experience an intense state of happiness called euphoria. Euphoria is a wonderful feeling many people sense immediately after hearing a good news or after a pleasurable event. Euphoria is usually short-term feeling that fades as a person becomes accustomed to whatever the experience they had. Euphoria is not generally harmful as long as it is temporary.

Euphoria can be lingering or ongoing for some people. People with chronic euphoria often have constant feelings of being "on the go" thoughts "racing" through their head, a sense of pleasure to keep talking and chronic loss of sleep. They are also distracted and make poor personal decisions. They may also have a sense of grandiosity or a belief that they are especially powerful or talented when it is actually not true. These symptoms can be so severe that they lead to extreme irritability and self-destructive or even suicidal behavior. These symptoms refer to mania, it is the far end of the happiness and euphoria continuum.

The symptoms of less severe manic disorder are:

- Intense euphoria for a longer period.
- Feelings of agitation and inflated self-esteem.
- Intense, racing thoughts that lead to distractibility and difficulty concentrating.
- Less need for sleep, pressure to talk continuously, working for hours on end.

The symptoms of more severe manic disorder are:

- Extreme euphoria for very long periods, such as months.
- Sense of grandiosity about oneself, such as the belief that one is a great playwright.
- Racing thoughts almost nonstop that lead to complete inability to concentrate or speak to others coherently.
- Engaging in pleasurable activities that lead to damage, going for races, spending all of one's money.

In manic disorder a person feels highly euphoric or irritable. The individual may have a sense of grandiosity, or a feeling that he can do something unlikely or impossible. Ex: individual may feel he can fly. The individual may pursue pleasurable activities to such an extent that the activities become self-destructive. A person with manic disorder may go for shopping spree, pour money into foolish investments or joy ride in a car at high speeds. Severe problems in functioning at work, can also result from extreme distractibility. They speak very rapidly, as if their mind is generating so many thoughts, they cannot express them quickly enough. This is flight of ideas.

9.5 DSM-IV DIAGNOSTIC CRITERIA FOR MANIA

A. A distinct period of abnormality and persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three(or more) of the following symptoms have persisted (four if the mood is only irritable) and have been persistent to a significant degree:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (eg: feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. Increase in goal-directed activity (either socially, at work or school or sexually) or psychomotor agitation.

7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg engaging in unrestrained buying sprees, sexual indiscretions or foolish business investments).

C. The symptoms do not meet criteria for a mixed episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance(eg, a drug of abuse, a medication, or other treatment) or a general medical condition(eg, hyperthyroidism).

9.6 DEPRESSIVE DISORDER

Depressive disorders affect an individual emotionally, behaviourally, cognitively and physically.

Sadness is a natural reaction to unfortunate events that happen in life. Sadness will be usually mild and temporary for small failures, and certain small unhappy events. When any incident occurs, which is very unfortunate to the near and dear ones and big failures occurs to an individual sadness can be more intense and it may last for a longer period. This sadness generally lingers but eventually fades off. The individual copes with the stressor more effectively. This is a normal and natural phenomenon. But for certain individuals in certain situations, sadness lingers for a long time, occurs for little reason, or is so intense that interacting with others is difficult. The sadness often prevents a person from functioning effectively. A person may have trouble eating, sleeping, or concentrating, will feel responsible for things beyond his control, and feels extremely fatigued. Sadness or a sense of hopelessness can become so intense that harming oneself or committing suicide seems like the only way to stop the pain. These symptoms refers to depression, which is at the far end of the sadness continuum.

There are two main types in depressive disorders. They are major depression and dysthymia.

9.7 MAJOR DEPRESSIVE DISORDER

Major depressive disorder involves a longer period during which a person experiences multiple major depressive episode. Major depressive disorder may be mild, moderate or severe and may occur with or without psychotic features. The symptoms of major depressive disorder are it involves a period of time, typically at least 2 weeks but usually longer, where the individual experience sad or empty moods most of the day, nearly every day. The sadness is usually very intense, to the point that the individual finds trouble functioning in his daily life. The individual loses pleasure in doing things they used to enjoy, withdraws from those activities, no longer gets much pleasure from them. It may also involve severe changes in appetite, weight and sleep. The individuals fail to eat, loses interest in eating. The consequence is loss in weight, this they do to compensate for their sadness. They find it difficult to sleep, wakes up early each morning. Consequently, they have a heavy feeling of fatigue and loss of energy that leads to oversleeping. Such hypersomnia may also be a way to escape painful life events or extreme feelings of sadness. Lack of physical energy, they feel worthless and guilty about many things, including life events beyond their control. They blame themselves, find it difficult to concentrate, make decisions, the serious symptom of major depressive disorder is thoughts of ideas about death or suicide, an actual suicide attempt.

The symptom of major depressive disorder can be understood in the following manner:

Emotional symptoms:

- Feelings of sadness, hopelessness, helplessness, guilt, emptiness or worthlessness and inadequacy.
- Feeling emotionally disconnected from others.
- Turning away from other people.

Behavioral symptoms

- Dejected facial expression.
- Makes less eye contact; eyes downcast.
- Smiles less often.
- Slowed movements, speech and gestures.

- Tearfulness or spontaneous episodes of crying spells with no apparent reason.
- Loss of interest or pleasure in usual activities, including sex.
- Withdrawn from social activities.

Cognitive symptoms

- Difficulty thinking, concentrating and remembering.
- Global negativity and pessimism.
- Suicidal thoughts or preoccupation with death.

Physical symptoms

- Changes in appetite resulting in significant weight loss or gain.
- Insomnia, early morning awakening or oversleeping.
- Vague but chronic aches and pains.
- Diminished sexual interest.
- Loss of physical and mental energy.
- Global feelings of anxiety.
- Restlessness, fidgety activity.

9.8 DSM-IV –TR DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSIVE DISORDER

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
    1. Depressed mood most of the day, nearly every day, as indicated by either subjective report(eg, feels sad or empty)or observation made by others (eg, appears tearful).
       Note: In children and adolescents, can be irritable mood.
    2. Markedly diminished interest in pleasure in all, or almost all activates most of the day, nearly everyday (as indicated by either subjective account or observation made by others).

3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day.

   Note: In children, consider to make expected weight gains.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly everyday (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Thoughts of death (not just a fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hypothyroidism).

9.9 DYSTHMIC DISORDER

Dysthymic disorder is chronic, low-grade depression. It's characterized by many of the symptoms of depression, but the symptoms are less intense. Usually, dysthymic disorder develops in response to some stressful event or trauma. The negative mood persists indefinitely. Although the person functions adequately, he has a chronic case of "the blues" that can continue for years. A mixture of symptoms is seen often involving appetite and sleep changes, fatigue, low self-esteem, trouble concentrating or making decisions and feeling hopelessness.

9.10 DSM-IV-TR-TR FEATURES OF DYSTHMIC DISORDER

All of the following symptoms are present:

- Depressed mood for most of the day, more days than at least 2 years.
- No presence of manic, mixed or hypomanic episode nor of cyclothymia.
- Symptoms are not due to a substance or medical condition.
- Symptoms cause significant distress or impairment in social, occupational or other areas of functioning.
- During the 2-year period of the symptoms listed above, the person has never been without these symptoms for more than 2 months at a time.

The disorder does not occur during a chronic psychotic disorder.

Presence of two or more of the following:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Trouble concentrating or difficulty making decisions
- Feelings of hopelessness

9.11 CAUSES OF MANIC AND DEPRESSIVE DISORDERS

The major factors that cause mood disorders are being discussed:

Biological risk factors: Biological risk factors in people with mood disorders includes genetics, brain features, neurochemical and hormonal features and deficiencies.

Genetics: Researches have shown that depression run in families. First degree relative of people with depression have depression themselves 15 to 25 percent of time, which is a much higher incidence than in the general population or controls. Children of depressed parents are four times more likely to have mood disorders than the children of non depressed parents. Twin studies also suggest that mood disorders have a genetic basis.

Brain features: People with mood disorders may have differences in brain areas affected by genetic predispositions. People with mood disorders often display reduced activity and size changes in the prefrontal and other cortical areas of the brain. This reduced activity relates to decreased serotonin levels.

Neurochemical features: Mood disorders like depression involves certain neurotransmitters, especially serotonin, norepinephrine and dopamine. These neurotransmitters closely link to limbic and other key brain systems that influence motivation level and emotional state. People with depression have lower than normal levels of these neurotransmitters, especially serotonin. Low serotonin level may predispose a person for a mood disorder. People with low serotonin plus low norepinephrine and dopamine may experience depression.

Hormonal changes: Hormonal changes may also cause mood disorders. People with severe depression and cognitive deficits such as memory problems often have increased cortical levels. Increased cortical, as well as disruption of the hypothalamic- pituitary – adrenocortical axis, relates to anxiety disorders. Hence people with mood and anxiety disorders show similar symptoms as agitation or restlessness. People with underactive thyroid conditions often experience symptoms of depression.

Sleep deficiencies: People with mood disorders often experience disruptions in their normal sleep-wake cycle. People with depression often have insomnia or hypersomnia and usually feel tired during the day.

Environmental risk factors: Environmental risk factors include stressful events and cognitive, interpersonal and family factors.

Stressful life events: All individuals do experience negative life events that cause us to struggle, but they "bounce back" with the help of others. The individuals who are predisposed to depression, for them stressful life events seem more frequent, painful and difficult to cope with.

Cognitive factors: An environmental risk factor related to mood disorder is negative thought patterns or cognitive distortions. According to Aaron Beck people with depression develop overly distorted, pessimistic views of themselves, the world around them and their future. People with depression experience a negative life event, assume the event will last a long time and

believe the event will affect most areas of their life. Hopelessness results from internal attributions because the person could excessively blame himself for a negative life event and develop low self-esteem. Hopelessness develops because a person believes that no matter what he does, his efforts will not lead to change. This sense of learned helplessness might relate to excessive depending on others.

Interpersonal factors: Depression may also be caused due to interpersonal difficulties such as social skill deficits, communication problems, relationship or marital conflict. People with depression see themselves as socially ineffective with others.

9.12 SUMMARY

To sum up with, this unit has given a detailed understanding about the mood disorders, manic disorders the DSM-IV diagnostic criteria for diagnosing the disorder, mania, depressive disorder, major depressive disorder, dysthmic disorder its features, the causes of manic and depressive disorders and the various factors associated in its causes. By going through this unit, you will be able to clearly understand the symptoms, classification and diagnosing these disorders.

9.13 KEYWORDS

Mood disorders

Manic disorder

Depressive disorder

Major depressive disorder

Dysthmic disorder

9.14 CHECK YOUR PROGRESS

1. Define mood disorders.
2. Describe manic disorders.
3. Explain the diagnostic criteria for mania.
4. What are depressive disorders?
5. Describe dysthmic disorder and its features.

9.15 ANSWERS TO CHECK YOUR PROGRESS

1. 9.3
2. 9.4
3. 9.5
4. 9.6
5. 9.9 & 9.10

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UNIT- 10: UNIPOLAR AND BIPOLAR DISORDERS

STRUCTURE

10.1 OBJECTIVES

After going through this unit, you will be able to explain

- Unipolar disorders
- Bipolar disorders
- Bipolar- I disorder
- Bipolar-II disorder
- Cyclothymic disorder
- Causes of unipolar and bipolar disorders

10.2 INTRODUCTION

An individual experiences various life situation which keeps changing his emotions and its after effects called mood. Normally, the after effects of emotions i.e, mood subside after sometime. They change with changing situations. Sometimes mood continue to be in the same state creating an imbalance in the behaviour leading to mood disorders. This unit deals with different mood disorders. The unipolar mood disorder, bipolar mood disorder and the other types. Its causes are also being discussed in detail.

10.3 UNIPOLAR DISORDERS

When an individual experience only depression, the disorder is called unipolar depression. Major depression and dysthmia are called unipolar disorders, because they are characterized by mood changes in only one direction-downward from normal. When an individual experiences only depression i.e., major depressive disorder then it is called unipolar disorder.

The clinical features of depressive disorder are:

MILD DEPRESSIVEDISORDER

In mild depressive disorder a mixture of anxiety and depression is found. The symptoms may not be sufficiently severe to meet diagnostic criteria for depressive disorder. The frequent symptoms are:

- Anxiety and worrying thoughts
- Sadness and depressive thoughts
- Irritability
- Poor concentration
- Insomnia
- Fatigue
- Lack of energy or enjoyment
- Somatic symptoms, including abdominal discomfort, indigestion, flatulence, poor appetite, palpitations, pericardial discomfort, concerns about heart disease, headache, pain in the neck, back and shoulders.
- Excessive concern about bodily functions.

MODERATE DEPRESSIVEDISORDER

In moderate depressive disorder the symptoms are

- Low mood
- Lack of enjoyment
- Reduced energy
- Pessimistic thinking
- Sad appearance
- Psychomotor retardation
- Feelings of restlessness
- Inability to relax
- Sadness, anxiety and irritability, lack of interest, lack of enjoyment
- Poor concentration
- Subjective poor memory

Depressive thinking

- Pessimistic and guilty thoughts
- Ideas of personal failure
- Hopelessness
- Suicidal ideas
- Self-blame
- Hypochondrial ideas

Biological symptoms

- Early wakening and other
- Sleep disturbance
- Weight loss
- Reduced appetite

Other symptoms

- Obsession symptoms
- Depersonalization, etc.

SEVERE DEPRESSIVEDISORDER

In severe depressive disorder all the symptoms described under moderate depressive disorder occur with greater intensity. There are additional symptoms namely

- Delusions
- Hallucinations
- Delusions of worthlessness, guilt, ill health, poverty, nihilism, persecution.
- Hallucinations of auditory and rarely visual
- Perceptual disturbances
- Suicidal ideas

SEASONAL AFFECTIVEDISORDER (SAD)

Some individuals develop depressive disorder only in certain months every year. This type is called seasonal affective disorder. It is related to the seasons ex; the length of daylight. The symptoms are hypersomnia, increased appetite and the other symptoms found in mild depressive disorder.

10.4 BIPOLAR DISORDERS

Bipolar disorders are also called manic depression characterized by days or weeks of mania alternating with longer periods of major depression. Bipolar disorder is a disorder in which an individual experiences an episode of mania and alternating depression episode. Bipolar disorder, depression (which is usually dominant state) alternates with periods of mania, a state of highly excited mood and behavior that is quite the opposite of depression. Bipolar disorders are characterized by mood swings in both directions, downward in depressive episodes and upward in manic episodes. Such episodes may last from a few days to several months and periods of normal mood is euphoric and cognitions are grandiose. The person sees no limits to what he or she can accomplish and fails to consider negative consequences that may ensue if grandiose plans are acted upon.

10.5 BIPOLAR- I DISORDER

Bipolar –I –disorder refers to one or more manic or mixed episodes in an individual. It is called as manic-depression and mania. Bipolar-I-disorder may involve just a single manic episode, people with bipolar I disorder often have a major depressive episode that lasts weeks or months, followed by an interval of normal mood. This period of normal mood should last at least 2 months but this period may be shorter. The individual then enters a manic or mixed episode. Individuals with bipolar disorder experience rapid crying, which means they frequently switch from depression to mania and back again with little or no period of normal mood. At least four cycles occur per year in these cases.

Mania occurs as part of bipolar disorder in which there may also be episodes of depression. When manic symptoms occur without significant psychosocial impairment, the syndrome is called hypomania.

Clinical features of mania

The symptoms of mania are

- Elation or irritability
- Increased activity
- Self-important ideas
- Elevated mood appears as elation, euphoria, cheerfulness, undue optimism, infectious gaiety.
- Sometimes elation is interrupted by sudden, brief episodes of depression.

Appearance

- Patients select brightly coloured and ill-assorted clothes
- They may appear untidy and disheveled.

Behaviour

- Over reactive
- Distractible
- Socially inappropriate behavior
- Reduced sleep
- Increased appetite
- Increased libido

Thinking and speech

- Flight of ideas
- Expansive ideas
- Grandiose ideas
- Hallucinations

The periods of hypomania, mild mania or moderate mania may be present.

Manic and depressive symptoms occur together, as a mixed mood state. Ex an overactive and over talkative patient may have profound depressive thoughts including suicidal ideas.

In alternating mood states mania and depression follow one another in a sequence of rapid changes. Thus, a manic patient may be intensely depressed for a few hours and then quickly become manic. Occasionally, states of mania and depression follow one another regularly with intervals of a few weeks or months between them. The disorder is called rapid cycling when four or more episodes of mood disorder (depressive, manic or mixed) occur within 9 to 12 months period.

10.6 BIPOLAR-II DISORDER

Some individuals experience a hypomanic episode. A hypomanic episode comprises the same symptom as a manic episode but may not cause severe impairment in daily functioning. Unlike "bursts of energy" hypomanic episodes last at least 4 days. Hypomanic episodes often occur within the context of bipolar II disorder.

DSM-IV-TR features of hypomania episode

All of the following symptoms are present:

During this mood disturbance, three or more of the following symptoms are persistent and present to a significant degree (four if the mood is only irritable).

- Inflated self-esteem or grandiosity
- Decreased need for sleep, such as feeling rested after only 3 hours of sleep
- More talkative than usual or pressure to keep talking
- Subjective experience that one's thoughts are racing, or flight of ideas.
- Distractibility
- Increase in goal-directed activity (socially, work, school, sexually) or psychomotor agitation.
- Excessive involvement in pleasurable activities that have a high potential for painful consequences.
- Persistently elevated, expansive, or irritable mood that lasts at least 4 days and is clearly different from the usual non depressed mood.

The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when symptoms are not present.

The disturbance in mood and change in functioning are observable by others.

The episode is not severe enough to cause significant impairment in social or occupational functioning or to cause the person to be hospitalized and no psychotic features are present.

Symptoms are not due to a substance or medical condition.

Bipolar II disorder comprises of hypomania that alternates with episode of major depression. Full blown manic or mixed episodes are not seen as they are in bipolar I disorder. Hypomanic episodes could worsen and become manic episodes, bipolar II to may become bipolar I disorder. For a diagnosis of bipolar II disorder to be made, the condition must not be caused by themselves may not cause significant impairment in functioning, but hypomanic episodes with major depressive episodes (bipolar II disorder) do significantly interfere with daily functioning.

10.7 CYCLOTHYMIC DISORDER

Cyclothymic disorder or cyclothymia refers to symptoms of hypomania and depression that fluctuate over at least a 2-year period. Individuals with cyclothymia do not have full blown episodes of depression, mania or hypomania. Instead, general symptoms of hypomania and depression cycle back and forth with intermediate periods of normal mood. A diagnosis of cyclothymic disorder requires that these symptoms not be absent for more than 2 months. Cyclothymic disorder must not be caused by a medical condition or substance but must significantly interfere with daily functioning.

DSM-IV –TR features of Cyclothymic disorder

All of the following symptoms are present:

- For at least 2 years, the presence of numerous periods of hypomanic symptoms and numerous periods of depressive symptoms that do not meet criteria for a major depressive episode.
- No major depressive, manic or mixed episode has been present during the first 2 years of the disturbance.

- Symptoms are not due to a substance or medical condition.
- During this 2-year period, the person has not been without the symptoms listed above for more than 2 months at a time.
- The above symptoms are not better accounted for by a psychotic disorder.
- Symptoms cause significant distress or impairment in social, occupational or other areas of functioning.

10.8 CAUSES OF UNIPOLAR AND BIPOLAR DISORDERS

Biological risk factors in individuals with bipolar disorders include genetics, brain features, neurochemical and hormonal features and sleep deficiencies.

Genetics: Bipolar disorders run in families. Studies of bipolar disorder indicate identical twins share the disorder about 40 to 70 percent of the time. Here debility for bipolar disorders is about 80 percent.

Brain features: Increased activity of areas like white matter, basal ganglia and pons which are involved in regulation of attention, motor behavior, memory and emotions are found in people with bipolar disorder. Heightened activity in these areas helps explain restlessness, movement, goal directed activity in people with bipolar disorder.

Neurochemical features: People with bipolar disorder have reduced levels of serotonin but higher than normal levels of norepinephrine. Rapid cycling in bipolar disorder relates to a less active thyroid.

Sleep deficiencies: Individuals with bipolar disorder may have disrupted REM and slow-wave sleep, and some sleep deprivation may trigger manic episode and especially rapid cycling.

Environmental risk factors:

Stressful life events: Stressful life events may also trigger bipolar disorder.

Cognitive factors, interpersonal factors and other factors may also lead to bipolar disorders.

10.9 SUMMARY

This unit has dealt with the various mood disorders, unipolar disorder, the mild depressive disorder, moderate depressive disorder, severe depressive disorder, bipolar disorders where an individual's mood disorder moves from mania to depression, the cause of it, the factors affecting these disorders are all discussed in detail in this unit.

10.10 KEYWORDS

Unipolar disorder

Bipolar disorder

Mania

Depression

Cyclothymic disorder

10.11 CHECK YOUR PROGRESS

1. Distinguish between unipolar and bipolar disorder.

2. Explain bipolar-I disorder.

3. Describe cyclothymic disorder.

10.12 ANSWERS TO CHECK YOUR PROGRESS

1. 10.3 & 10.4

2. 10.5

3. 10.7

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UNIT- 11: SCHIZOPHRENIA

STRUCTURE

11.1 OBJECTIVES

After going through this unit you will be able to explain

- Schizophrenia
- Positive symptoms
- Negative Symptoms
- DSM-IV Diagnostic criteria for schizophrenia
- Subtypes of schizophrenia
- Causes of schizophrenia

11.2 INTRODUCTION

Schizophrenia is a severe psychological disorder characterized by impaired social, emotional, cognitive and perceptual functioning. It is a class of disorders involving severe distortions of reality. Delusions and hallucinations are the major symptoms of schizophrenia. Schizophrenia has different subtypes like paranoid schizophrenia, disorganized schizophrenia, catatonic schizophrenia, undifferentiated schizophrenia. This unit deals with the schizophrenia, its symptoms, causes and its types.

11.3 SCHIZOPHRENIA

The term schizophrenia was first used by the Swiss Psychiatrist Eugen Bleurer in the year 1911. The term comes from the Greek words ‘schizo’ which means “split” and ‘premium’ which means “mind”, so it literally means “split mind”. Bleurer believed, that schizophrenia entails a split among such mental processes as attention, perception, emotion, motivation and thought, such that these processes operate in relative isolation from one another, leading to bizarre and disorganized thoughts and actions. The term ‘schizophrenia’ i.e., “split mind” has often led people to confuse schizophrenia with dissociative identity disorders (split personality). But multiple personalities are not what Bleurer had in mind when he coined this term. Bleurer intended to suggest that certain physiological functions, such as thought, language and emotion, which are joined together in normal people, are somehow apart or disconnected in schizophrenia.

Schizophrenia refers to a class of disorders involving severe distortions of reality. Thinking, perception, emotion might deteriorate; there may be a withdrawal from social

interactions and there might be displays of bizarre behavior. The characteristic symptoms of schizophrenia can be described in terms of two broad categories; positive and negative symptoms. Positive symptoms of schizophrenia represent excessive or overt symptoms, negative symptoms of schizophrenia represent deficit or covert symptoms.

11.4 POSITIVE SYMPTOMS

Positive symptoms of schizophrenia include delusions and hallucinations as well as disorganized speech and behavior.

Delusions: Delusion is a positive symptom of schizophrenia. Delusion is an irrational belief involving a misinterpretation of life experiences. Delusions are false beliefs, firmly held, unshakeable beliefs with no basis in reality. Most commonly, they believe that they are being controlled by someone else, that they are being persecuted by others, or that they are being broadcast so that others are able to know what they are thinking. Delusions can be in several forms, including persecutory, control, grandiose, referential and somatic.

Persecutory delusion: Persecutory delusions are the type of delusions which are most common in people with schizophrenia. These delusions represent irrational beliefs that one is being harmed or harassed in some way. A person with a persecutory delusion may believe secret governmental officials are following him and about to do something dire. Persecutory delusions may intersect with control delusions, in which a person may believe others are deliberately

- Placing thoughts in their mind without permission (thought insertion)
- Transmitting his thoughts so everyone can know them (thought broadcasting)
- Stealing their thoughts and creating memory loss (thought withdrawal)

Grandiose delusions: Grandiose delusions represents irrational beliefs that one is an especially powerful or important person, when actually this is not so. A person with grandiose delusion may truly but wrongly believe he is a top government official, a chief minister or even prime minister.

Referential delusions: Referential delusions are irrational beliefs that events in everyday life have something special to do with one self. A person watching T V may feel that the story coming in T V is his real-life aspect.

Somatic delusions: Somatic delusions represent irrational beliefs that one's physical body is affected, usually in a negative way and often by an outside source. A person may believe an inability to sleep is caused by excessive microwave radiation outside the house.

Hallucinations: Hallucinations are sensory experiences a person believes to be true, when actually they are not. The most common hallucination in schizophrenia is auditory, in which a person may hear voices that repeat their thoughts, comment on their appearance, behavior, argue or command them to do something. The voices may be recognizable and comforting to the person, or it may be the person's own voice. Hallucinations can also be visual or tactile, a person when sees images or visions not seen by others or feels bizarre sensation on their skin. Hallucinations can be olfactory where they feel that they can smell strange smells.

Disorganized speech:

Disorganized speech is seen in schizophrenia. Speech patterns can be so disorganized that a person cannot maintain a regular conversation. Verbalizations may be disconnected, jumbled, interrupted, forgotten in midsentence or mixed in their phrasing (loose association). Ex: a person may say "store I go to the have to" instead of "I have to go to the store". A person may also simply make up words that do not make sense to anyone(neologism), repeat the same words over and over, say words together because they rhyme (clang association) or not speak at all (alogia). Some individuals with schizophrenia speak quite clearly, stop without warning, and then talk about a completely different topic. This phenomenon, known as tangentiality, requires the listener to constantly steer the speaker back to the original topic of conversation.

Catatonic behavior

People with schizophrenia are disorganized not only in their speech but also in their behavior. A person may be unable to care for oneself and not engage in appropriate hygiene, dress, or even eating. The person may be highly agitated, show inappropriate affect or emotions in a given situation. May laugh during a sad story. Such behavior is often unpredictable and frightening to others.

Catatonic behavior is the unusual motor symptoms. A person with schizophrenia may not react to environmental events such as when someone wishes hello or may seem completely

unaware of his surroundings. A person's body part, such as an arm, can be moved to a different posture and that posture is maintained for long periods. This is called as waxy flexibility or catalepsy. Other people with schizophrenia may

- Show wild or uncontrolled motor activity (catatonic excitability)
- Repeat other's words (echolia)or actions(echopraxia)
- Adopt a rigid posture that is difficult to change.

11.5 NEGATIVE SYMPTOMS

Negative symptoms of schizophrenia refer to pathological deficits in behavior, or showing too little of a certain behavior. The common negative symptoms in schizophrenia include

Flat affect: Flat affect or showing very little emotion in even in situations that seem to demand much emotion. A person often speaks in monotone and show few changes in her facial expression.

Alogia: Speaking very little to other people and appearing withdrawn. The language is often very basic and brief.

Avolition: An inability or unwillingness to engage in goal directed activities such as caring for oneself, working or speaking to others. The individual appears depressed.

Anhedonia: Lack of pleasure or interest in life activities. Lack of insight or poor awareness of one's mental condition is also a negative symptom of schizophrenia.

Symptoms of schizophrenia interfere significantly with one's ability to function on an everyday basis.

11.6 DSM-IV DIAGNOSTIC CRITERIA FOR SCHIZOPHRENIA

A. **Characteristic symptoms**: two (or more) of the following, each present for a significant portion of the time during a 1-month period (or less if successfully treated):
    1. Delusions

2. Hallucinations
3. Disorganized speech (eg, frequent derailment or incoherence)
4. Grossly disorganized
5. Negative symptoms i.e., affective flattening, alogia or avolition.

Note: Only one criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. **Social/ Occupational dysfunction**: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset (or when the onset is childhood or adolescence, failure to achieve expected level of interpersonal, academic or occupational achievement).
C. **Duration**: Continuous signs of the disturbance persist at least 6 months. This 6 month period must include at least 1 month of symptoms (or less if successfully treated) that meet criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in criterion A present in an attenuated form (eg, odd beliefs, unusual perceptual experiences).
D. **Schizoaffective and mood disorder exclusion**: Schizoaffective disorder and mood disorder with psychotic features have been ruled out because either (i) no major depressive episode, manic episode or mixed episode has occurred concurrently with the active phase symptoms or (ii) if mood episodes have occurred during active phase symptoms, their total duration has been relative to the duration of the active and residual periods.
E. **Substance/general medical condition exclusion**; the disturbance is not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition.

F. **Relationship to a pervasive developmental disorder**: If there is a history of autistic disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

11.7 SUBTYPES OF SCHIZOPHRENIA

Schizophrenia is divided into subtypes based upon the predominant clinical features.

1. **Paranoid schizophrenia**: It is the most common form of schizophrenia. Paranoid schizophrenia primarily involves persecutory or grandiose delusions and auditory hallucinations but few problems putting thoughts together. Strange thoughts occur, communication is largely undisturbed.
2. **Disorganized schizophrenia**: It primarily involves fragmented, incoherent, odd and inappropriate speech, behavior and emotions. The words will be jumbled up, and conveys little meaning. Social interactions do become disturbed.
3. **Catatonic schizophrenia**: It primarily involves abnormal motor symptoms, such as immobility, odd movements and excessive activity. People in a catatonic state may be at risk for harming themselves or others because of their bizarre movements and they must be supervised.
4. **Undifferentiated schizophrenia**: It involves a mixture of symptoms that do not clearly match the other subtypes. The main key features of schizophrenia are present.
5. **Residual schizophrenia**: It primarily involves negative symptoms of schizophrenia, usually after a person experiences and has been treated for full blown symptoms such as delusions and hallucinations. The individual acts oddly and seem withdrawn for long periods without major positive symptoms.

11.8 CAUSES OF SCHIZOPHRENIA

Biological factors

Genetics: Schizophrenia has a strong genetic basis. Schizophrenia is present in less than 1 percent of the general population. Children of people with schizophrenia are about 12 times

likely than the general population to develop schizophrenia. Twin studies indicate schizophrenia has a genetic component.

Brain features: Individual with schizophrenia have certain brain features that may help produce the disorder. The key feature is enlarged ventricles or spaces or gaps in the brain. One possibility is that enlarged ventricles mean a general failure in normal brain development or disruption in pathways from one area of the brain to the next. An important disruption may involve neural connections between areas of the brain that influence cognition and language. People with schizophrenia often have problems in auditory processing and language, these problems are due to differences in temporal lobe areas. The medial temporal lobe, amygadala and hippocampus, is smaller in people with schizophrenia. These areas are primarily responsible for verbal and spatial memory processing and emotion, which are problematic in individuals with schizophrenia. Reductions in total brain size and gray matter, which affect the size of different brain lobes and thus cognition. Enlarged ventricles and reduced brain size in certain areas such as the frontal lobe may help explain the negative symptoms of schizophrenia. Differences in other areas such as the temporal lobe may explain positive symptoms of schizophrenia.

Neurochemical features: The most prominent theories of schizophrenia are that symptoms are caused by an excess of certain neurotransmitters in the brain, especially dopamine. Excess levels of dopamine, from methamphetamine intoxication can lead to motor problems and psychotic symptoms. Changes in dopamine and key areas of the brain may interact to help produce symptoms of schizophrenia. Neurotransmitters like serotonin, interact with dopamine and deficits in key brain areas to help produce symptoms of schizophrenia.

Cognitive deficits: Brain changes and other biological factors explain why people with schizophrenia have several cognitive deficits. The main cognitive deficits are memory, attention, learning, languages and executive functions such as problem solving and decision making abilities. Difficulty in processing information may lead to sensory overload and this explains the positive symptoms of psychotic disorders like hallucinations and delusions. Negative symptoms may be the result of withdrawal from this sensory overload.

Environmental factors

Prenatal complications:

The individuals with schizophrenia, especially early onset schizophrenia, tend to have had more complications that is involved in psychotic disorders is hypoxic ischemia, or low blood flow and oxygen to the brain. This can lead to enlarged ventricles.

Adverse life events and substance abuse

Maternal stress during the prenatal period may lead to important brain changes and later mental disorders, including schizophrenia. Later environmental factors like adverse life events and substance abuse may cause psychotic disorders. People with schizophrenia experience stressful life events in weeks and months before the onset of psychotic symptoms. Drugs can lead to psychotic symptoms. Substance abuse among people with schizophrenia symptoms is common. Traumatic life events and substance abuse often occur together in individuals with schizophrenia.

Various other cultural and evolutionary factors may also lead to schizophrenia.

11.9 SUMMARY

Schizophrenia is a common mental disorder. It is mainly marked by social isolation, withdrawal, impairment in functioning, disturbances in thinking, delusions, disturbances of perception, disturbances in emotions, attention and concentration, and the overall behaviour. Hallucinations and delusions are present, the various symptoms are discussed in detail.

11.10 KEYWORDS

Schizophrenia
Delusions
Hallucinations
Catatonic stupor
Waxy flexibility

11.11 CHECK YOUR PROGRESS

1. Define Schizophrenia.

2. Explain the positive and negative symptoms of schizophrenia.

3. Explain the subtypes of schizophrenia.

4. Describe the causes of schizophrenia.

11.12 ANSWERS TO CHECK YOUR PROGRESS

1. 11.3

2. 11.4 &11.5

3. 11.7

4. 11.8

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UNIT-12: DELUSIONAL DISORDERS

STRUCTURE

12.1 OBJECTIVES

After going through this unit, you will be able to explain

- Delusional disorders
- Symptoms of delusional disorders
- DSM-IV Criteria for delusional disorders
- Types of delusional disorders

12.2 INTRODUCTION

Delusional disorders are common psychotic disorders. The individuals will have delusions but no other symptoms of schizophrenia. There are five types of delusional disorders. This unit deals with delusional disorders, its causes and the types of delusional disorders.

12.3 DELUSIONAL DISORDERS

Delusional disorder is a chronic and unshakeable delusional system, developing in a person. The individual will have no psychotic symptoms except for one or more delusions. The delusions in these disorders are not considered bizarre as they are in schizophrenia. The person's belief theoretically could be true but are not. Individuals with delusional disorder can often work and maintain a reasonable social life. They do not experience significant impairments in daily functioning but may be quite distressed.

A delusion is a belief that is held with strong conviction despite the evidence disproving it that is stronger than any evidence supporting it. It is distinct from erroneous belief caused by incomplete information or misunderstanding deficit memory or incorrect perception. Delusions are associated with a variety of mental and neurological disorders, but are of diagnostic importance in the psychotic disorders.

12.4 SYMPTOMS OF DELUSIONAL DISORDERS

Delusions are generally categorized in 4 groups**. Bizarre**-Bizarre delusions are strange and implausible**, non-bizarre**- non bizarre delusions are possible but unlikely, **mood congruent**-mood congruent delusions are false beliefs that are consistent with the patient's mood if disordered. **Mood neutral-** mood neutral delusions are not related to the patient's mood.

Delusions are present in a variety, but the most common one's include delusions of control, mind reading, thought insertion, reference, persecution, grandeur, self-accusation, jealousy, romance or sexual involvement, somatic change or disease or death. Somatic delusions are associated with mood disorders and organic dementias, grandiose and persecutory delusions are often cardinal symptoms of schizophrenia and related disorders. The individuals tend to be oversensitive and humorless, secretive, suspicious.

DSM-IV uses delusional disorders to describe a disorder with persistent, non-bizarre delusions that is not due to any other disorder. It is synonymous with the widely used term paranoid psychosis and it includes the non-specific term of paranoid states.

12.5 CAUSES OF DELUSIONAL DISORDERS

Delusional disorders may be caused by a number of factors, the major causes which are being identified are as follows:

Genetic: Delusional disorders are more common in the individuals of those who have one or the other family member suffering from this. One of the factors is, it may be caused due to hereditary factors.

Biological: The biological causes like imbalance in the chemical secretions in the brain, that is the neurotransmitters, is also seen as one of the causes for the delusional disorder. An imbalance in the neurotransmitters may interfere with the transmission of messages, leading to symptoms. The abnormal brain regions that control perception and thinking is also one of the causes for the delusional disorder.

Addictions: The delusional disorders may be caused due to various addictions, like alcoholism, drug abuse.

12.6 DSM-IV CRITERIA FOR DELUSIONAL DISORDERS

A. Non-bizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance or deceived by spouse or lover or having a disease) of at least 1 month's duration.

B. Criterion A for schizophrenia has never been met

   Note: Tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional theme.

C. Apart from the impact of the delusion(s) or its ramifications functioning is not markedly impaired and behavior is not obviously odd or bizarre.

D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relatively to the duration of the delusional periods.

E. The disturbance is not due to the direct physiological effects of a substance (eg a drug of abuse, a medication) or a general medical condition.

12.7 TYPES OF DELUSIONAL DISORDERS

Delusional disorders can be classified as following:

1. Pathological jealousy
2. Erotomania
3. Somatic delusional disorder
4. Grandiose delusional disorder
5. Persecutory delusional disorder

1. Pathological jealousy

The individual will have an abnormal belief that the sexual partner is unfaithful. This condition is called pathological jealousy, because the belief, may be a overvalue idea or a delusion, which is held on inadequate grounds and is unaffected by rational argument. Jealousy is not classified as pathological because of strong feelings of jealousy or a violent response to a lover's infidelity, the condition is classified as pathological when the jealousy is based on unsound reasoning. This jealousy is also called as sexual jealousy, erotic jealousy, morbid jealousy, psychotic jealousy and Othello syndrome.

The symptoms are an abnormal belief in the partner's infidelity, it may be accompanied with other abnormal beliefs, ex: the partner is plotting against the patient. The mood is variable and includes misery, apprehension, irritability and anger. There is an intensive seeking for evidence of the partner's infidelity, ex: searching diaries and correspondence. The patient may follow the

partner or hire a detective to follow and find out where they go, with whom they talk etc. The jealous person cross-questions the partner incessantly. This may lead to dangerous assault or murder. The partner getting fed up with the suspicion may even make a false confession.

2. **Erotomania or erotic delusions**

Erotic delusions can occur in any psychotic disorder. But it is predominant and persistent symptom in a form of delusional disorder called erotomania. In erotomania, the patient, usually a single woman, believes that an exalted person is in love with her. The supposed lover is usually inaccessible, as he is already married, or a famous star, actor, or a public figure. The infatuated women believe that it is the supposed lover who first fell in love with her and that he is more in love than she is. She derives satisfaction and pride from this belief. She is convinced that the supposed lover cannot be a happy or complete person without her. The patient believes that the supposed lover is unable to reveal his love for various unexplained reasons, and that he has difficulties in approaching her, has indirect conversations with her, and has to behave in a paradoxical and contradictory way.

3. Somatic delusional disorder

Individuals with somatic delusional disorder believe that they suffer from a physical illness or deformity. It involves monosymptomatic hypochondrial psychosis, where there is a single delusional belief. Somatic delusional disorder needs to be distinguished from the hypochondriacal delusions that occur in severe depression and schizophrenia. The symptoms of somatic delusional disorder are excessive concern and irrational ideas about bodily functioning, which may include worries regarding infestation with parasites or insects, imagined physical deformity, or a conviction that one is emitting a foul stench when there is no problematic odour. There is a mistaken belief about one's body, such as having some serious medical disease.

4. Grandiose delusional disorder

The patient has a mistaken belief that one is as especially powerful, famous or knowledgeable person. The individual beliefs that one's importance and uniqueness and keeps telling it to others. The individual believes that one has a distinguished role, has some remarkable connections with important persons or enjoys some extraordinary powers or abilities.

5. Persecutory delusional disorder

In persecutory delusional disorder the individual believes that another person is aimed to harm them. The individual believes that somebody is following and they are planning to kill them, everyone is looked at suspicion.

12.8 SUMMARY

Delusional disorders are systematized delusions. They may have hallucinations but these hallucinations are not prominent. Delusional disorder patients exhibit behavioural characteristics. There are several types of delusional disorders, the main ones are discussed here.

12.9 KEYWORDS

Delusions
Delusion of grandeur
Delusion of persecution
Delusion of jealousy
Pathological jealousy
Erotomania
Hypochondrial delusions
Somatic delusion
Paranoia
Mixed delusions

12.10 CHECK YOUR PROGRESS

1. Define delusions disorders.
2. Explain the symptoms of delusional disorder.
3. Explain the DSM-IV criteria of delusional disorders.
4. Describe the different types of delusional disorders.

12.11 ANSWERS TO CHECK YOUR PROGRESS

1.12.3
2. 12.4

3. 12.5
4. 12.6

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BLOCK - 4 : AGING AND PERSONALITY DISORDERS

UNIT-13 DELIRIUM, DEMENTIA AND ALZEMIER'S DISEASE

STRUCTURE

13.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of delirium
- Signs and symptoms of delirium
- Causes of delirium
- Dementia
- Signs and symptoms of dementia
- Causes of dementia
- Types of dementia
- Alzheimer disease
- Clinical picture of Alzheimer disease
- Signs and symptoms of Alzheimer disease

13.2 INTRODUCTION

Delirium is a nonspecific syndrome characterized by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behavior, emotion and sleep-wake cycle. Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. Alzheimer's disease is a primary degenerative cerebral disease of unknown etiology, with characteristic neuropathological and neurochemical features. The clinical criterion includes decline in memory and other cognitive functions, deficits in two or more areas of cognition and progressive worsening over time.

13.3 MEANING AND DEFINITION OF DELIRIUM

Delirium is used to describe a syndrome of impairment of consciousness accompanied by abnormalities of perception and effect. In DSM IV, Delirium has been defined as 'a transient disorder of cognition (perception, thinking and memory) and attention (alteration in the level of awareness and consciousness), accompanied by disturbances of the sleep wake cycle and

psychomotor behavior. A fluctuating clinical picture with worsening of symptoms at night, is often seen and is highly characteristic of Delirium.

In Delirium cognitive functions are impaired, accompanied by deterioration in emotional control, social behavior or motivation and the consciousness is not clouded. This syndrome shows up in Alzheimer's disease, in cerebrovascular disease and other conditions affecting the brain.

The research study rates of incidence and prevalence of Delirium are affected by the age of population under study and the setting of the study. In the 65 years of age and above, the rate of prevalence ranges from 30 to 50%. Among medical / surgical inpatients, it ranges between 5 and 15%. About 15 to 20% of the medical / surgical inpatients referred for psychiatric consultation receive a diagnosis of Delirium.

13.4 SIGNS & SYMPTOMS OF DELIRIUM

To diagnose Delirium, the following symptoms, mild or severe should be present in the following areas,

1. **Disturbances of Consciousness and Attention** i.e., reduced awareness of what is going on in the environment along with reduced ability to focus, sustain or shift attention.
2. **Global Cognitive Disturbances**, i.e., Perceptual disturbances, cognitive deficits, illusions and hallucinations – most often visual; impairment of thinking and comprehension; along with incoherence in speech and impairment in recent memory and general disorientation.
3. **Psycho-motor disturbances**, i.e., hypo – or hyperactivity and unpredictable shifts from one to other.
4. **Sleep disturbances**, i.e., insomnia, total sleep loss, disturbing dreams / nightmares, daytime drowsiness.
5. **Emotional disturbances**, i.e., anxiety, fear, irritability, euphoria, apathy and depression.
6. Evidence that the condition is caused by the direct physiological consequences of a medical condition or interaction, which can be attributed to a psychoactive substance, e.g., Alcohol.

13.5 CAUSES OF DELIRIUM

- **Primary Cerebral Disease** – Degenerative diseases like multiple sclerosis, dementia; Primary & Secondary Neoplasm, subdural hematoma; CNS infections like Meningitis, Encephalitis, HIV associated CNS infections; Cerebral Thrombosis & Head Injury.
- **Systemic Diseases** – Systemic diseases like metabolic encephalopathies, cerebrovascular complications and infections; other issues like Heat stroke, and hypothermia.
- **Intoxication** – abuse of drugs like LSD's, Aminophylline, Opiates, Sedative Hypnotics, Anticonvulsants and Antiarrhythmic. Alcohol and its types. Industrial poisons like carbon monoxide, heavy metals and other organic solvents.
- **Withdrawal** – withdrawal from abuse of drugs like Barbiturates, benzodiapines and alcohol.

Delirium – To diagnose Delirium, attention must be paid to the onset, course and duration of the illness. An examination must include testing of all cognitive functions like attention, memory, orientation, abstract thinking along with speed and dynamics of thought.

Delirium, is one of the most commonly encountered organic mental disorders in clinical practice of Mental Health. Delirium is a nonspecific syndrome characterized by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behavior, emotion and sleep-wake cycle. Epidemiologically speaking, in the 65 years of age and above category, the rate of prevalence ranges from 30 to 50%. The causal factors are disturbances of Consciousness and Attention, Global Cognitive Disturbances, Psycho-motor disturbances, Sleep disturbances, Emotional disturbances, and others. The treatment of Delirium consists of two aspects, i.e., identifying the underlying medical cause and treating it and general psychosocial supportive treatment.

Diagnosing Delirium, the following symptoms, should be observed for Decline in both memory and thinking, Memory Impairment, Cognitive Impairment Information Processing, Personality changes and Emotional Impairment. The causes are of Dementia are Degenerative causes, Vascular causes, Intracranial space occupying lesions, Metabolic disorders, Endocrine Disorders, Others like Head Injury, Epilepsy. In the early phase of treatment, especially in cases of reversible.

13.6 DEMENTIA

Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment.

Dementia is an acquired global impairment of intellect, memory and personality, but without impairment of consciousness. The Royal College of Physicians of London defines Dementia as 'the global impairment of higher cortical function including memory, the capacity to solve the problems of day to day living, the performance of learned perceptual – motor skills, the correct use of social skills and control of emotional responses, in the absence of clouding of consciousness. The condition is often irreversible and progressive'.

The essential feature of brain deterioration in Dementia is a gradual loss of intellectual abilities, which can interfere, in the activities-of-daily-living in an individual's life. Other changes like loss of self-control, motor and language problems, decline in ability to exercise good judgment and personality changes also occur.

The prevalence rate of Dementia as reported by majority of research studies are that this disorder increases with age and is between 3 to 5%. The rate of prevalence begins at 0.1% under the age of 60 years to 15 to 20% by the age of 80 years. It is reported that severe dementia is present in about 7% of the population aged 80 years or older.

13.7 SIGNS AND SYMPTOMS OF DEMENTIA

To diagnose Dementia, the following symptoms, mild or severe should be present in the following areas for at least 6 months

1. There is appreciable evidence of a **decline in both memory and thinking**, which is sufficient to impair activities-of-daily-living in an individual's life.
2. **Memory Impairment** - The memory disturbances affect all the processes of memory, i.e., registration, storage and retrieval of new information; further, previously learnt material may also be lost.

3. **Cognitive Impairment -** Impairment is observed in thinking, reasoning, and a reduction in the flow of ideas.
4. **Information Processing -** The process of incoming information is impaired, in that the individual finds it increasingly difficult to attend to more than one stimulus, such as conversing with several people and to shift from topic to other.
5. **Personality changes**, usually a decreased drive and enthusiasm with the patient showing a lack of interest in day-to-day activities. Easy fatigability sets in. There is anxiety, depression, self-centered and withdrawn behavior with lack of concern and feeling for others.
6. **Emotional Impairment** – Inability to perform complex tasks occasionally leads to violent emotional upheavals, referred to 'catastrophic reaction'.

Just like its predecessor, Delirium like Dementia is a product of widespread cerebral pathology and is etiologically numerous. The base for development of Dementia is widespread cerebral dysfunction or damage. Psychosocial factors and other premorbid personality, intelligence, education, social support network have limited influence on degree of severity of dementia. The causes are listed below,

13.8 CAUSES OF DEMENTIA

- **Degenerative causes** – senile dementia, Alzeheimer's disease, Pick's disease, Huntington's disease, Parkinson's disease, Wilson's disease, and Multiple Sclerosis.
- **Vascular causes** – Vascular dementia, Carotid artery occlusive disease, Arterio-venous malformation and Binswanger's disease.
- **Intracranial space occupying lesions** – Neoplasms, Chronic subdural hematoma, Tuberculoma, Chronic Abscess & Colloid Cyst.
- **Metabolic disorders** – Hepatic, Renal and Pulmonary failure, Porphyria and Paget's disease.
- **Endocrine Disorders** – Myxedema, Addison's disease, Hypoparathyroidism, Hyperparathyroidism & Cushing's Syndrome.
- Others like Head Injury, Epilepsy.

The clinical diagnosis of Dementia is arrived at by the information obtained from a detailed longitudinal history and a mental status examination, supplemented by a thorough physical examination. In history, one should look for intellectual decline, memory deficits and personality changes, especially in those above 50 years of age with past and family history of psychiatric illness must be taken into account. A mental status examination must be carried out to confirm the presence of cognitive dysfunction. Similarly, patient's general appearance and non-verbal behavior must be noted.

Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. The essential feature of brain deterioration in Dementia is a gradual loss of intellectual abilities, which can interfere, in the activities-of-daily-living in an individual's life. Other changes like loss of self-control, motor and language problems, decline in ability to exercise good judgment and personality changes also occur. The prevalence rate of Dementia as reported by majority of research studies the rate of prevalence begins at 0.1% under the age of 60 years to 15 to 20% by the age of 80 years.

Dementia, emphasis should be on identifying underlying medical causes and prompt treatment, along with psychosocial management and Institutionalization.

13.9 TYPES OF DEMENTIA

Vascular Dementia formerly known as atherosclerotic dementia, is the second most common amongst dementing disorders in both presenium and senium. The original term arteriosclerosis's of peripheral vessels like retinal vessels is a poor indicator of a similar generalized state. Earlier, Vascular Dementia was also known as Multi infract Dementia, as was emphasized by the fact that progress of this disease depends on the accumulation of the deficits results from multiple infracts and hence Multi infract Dementia. However, it is now very well recognized that progressive cognitive decline can ensue after a single stroke, hence, the term Vascular dementia is preferred. Vascular dementia is distinguishable from Alzheimer's by its history of onset, clinical features and subsequent course.

Signs and Symptoms of vascular dementia

Typically, there is a history of transient ischemic attacks with brief impairment of consciousness and visual loss. The dementia may also follow a succession of acute cerebrovascular accidents or less commonly a single major stroke. Certain impairments of memory and thinking then become visible. Usually in later life, i.e., 60's and 70's the onset can be abrupt, following an ischemic episode. The dementia is result of infraction of the brain due to vascular diseases, including hypertensive cerebrovascular disease. The infracts are small, but cumulative in their effect.

Occasionally the onset may be gradual when emotional and personality changes dominate the picture; usually judgment and personality are preserved largely than in Alzheimer's disease. Depression is more commonly associated with cortical and sub cortical infractions.

Fluctuation in cognitive impairment, probably related to episodes of clouding of consciousness, is a highly characteristic feature. Generally, after an episode of stroke, there is recovery but each subsequent episode of similar accidents leave in its wake increasing cognitive impairment, which progresses on to dementia. Characteristically, the disease progresses in a step-ladder like fashion. Emotional changes in the form of emotional incontinence, pathological laughing and crying are very common.

In Vascular dementia many physiological issues are observed, such as, the presence of single or small multiple cortical infracts strategically located infract can give rise to dementia. Small vessel disease, wherein infracts occur in the territories of small penetrating vessels to various parts of the brain. Thus, vascular dementia may be the end result of multiple pathogenic mechanisms. Patients who suffer from hypertension, diabetes mellitus or cardiac disease and smokers are at a greater risk to develop vascular dementia.

13.10 ALZHEIMER'S DISEASE

Dementia in Alzheimer's Type sets in after the age of 65 years and above, is known as Senile Dementia. Since the most common etiological factor has been Alzheimer's disease, this disorder has been designated as 'Senile Dementia of the Alzheimer's type' (SDAT).

Alzheimer's disease is a primary degenerative cerebral disease of unknown etiology, with characteristic neuropathological and neurochemical features. The clinical symptoms includes decline in memory and other cognitive functions, deficits in two or more areas of cognition and progressive worsening over time. These are supported by progressive deterioration in cortical skills (such as language, motor performance and perception), alteration in behavior and impaired activities of daily living and family history of similar disorder. The major issue is decline in the intellectual functioning over a period.

13.11 CLINICAL PICTURE OF ALZHEIMERS DISEASE

The clinical picture is characterized by 3 stages.

The first stage: dominated by forgetfulness, difficulty in completing tasks of activities-of-daily-living and spatial disorientation. This stage lasts for about 2 to 3 years. It is accompanied with, the changes in memory, disturbances in mood, anxiety and depression.

The second stage: the 'confessional state' comprises of profound changes in cognitive abilities and personality. Personality changes are characterized by reversal of premorbid personality patterns and / or the emergence asocial traits. Psychotic symptoms in the form of delusions and hallucinations are also noticed.

The third stage: the 'dementia phase', neurological dysfunctions are prominent and florid. Seizures may be present in about 75% of the cases, towards the terminal stages, the patients are usually apathetic, doubly incontinent and bedridden.

Alzheimer's disease, mainly consists of early memory difficulties, emotional changes such as a spontaneity, purposeless hyperactivity; dysphasia, agnosia and early spatial disorientation.

Neurochemicals one of the keys to Alzheimer's disease may be a certain type of brain cell, the cholinergic cell, that is involved in memory and learning. These cells release an important chemical messenger called acetylcholine. Acetylcholine is a key player in brain activity. When it is released by the cholinergic cell, it stimulates neighboring cells and causes them to release other chemical and these chemicals in turn influence still other cells. Alzheimer's disease evidently throws all these process into disarray.

There is substantial neuronal cell loss in Alzheimer's patients; these losses are generalized but more emphatic in frontal, temporal and parietal areas of the brain. They affect predominantly the large neurons, amounting to a reduction of 40 to 60%.

13.12 SIGNS AND SYMPTOMS OF ALZHEIMERS DISEASE

1. Presence of a dementia
2. Insidious onset with slow deterioration. While the onset usually seems difficult to pinpoint in time, realization by others that the defects exist may come suddenly. An apparent plateau may occur in the progression.
3. Absence of clinical evidence or finding from special investigations suggest that the mental state may be due to other systemic or brain disease which can induce dementia (e.g., hypothyroidism, hypercalcemia and others).
4. Absence of a sudden, apoplectic onset or conditions such as sensory loss, visual field defects and in coordination occurring early in the illness.

The clinical criterion includes decline in memory and other cognitive functions, deficits in two or more areas of cognition and progressive worsening over time, progressive deterioration in cortical skills (such as language, motor performance and perception), alteration in behavior and impaired activities of daily living and family history of similar disorder.

The clinical picture is dominated by forgetfulness, difficulty in completing tasks of activities-of-daily-living and spatial disorientation, the 'confessional state' comprises of profound changes in cognitive abilities and personality, the 'dementia phase', neurological dysfunctions are prominent and florid.

There is neuronal cell loss in Alzheimer's patients; these losses are in frontal, temporal and parietal areas of the brain. Evidence indicates that Alzheimer's disease is a hereditary disease governed by genes that cause damage to the patient's brain later in life. Research studies have linked the disease to abnormalities on chromosomes.

13.13 SUMMARY

Delirium is a nonspecific syndrome characterized by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behavior, emotion and

sleep-wake cycle Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. The essential feature of brain deterioration in Dementia is a gradual loss of intellectual abilities, which can interfere, in the activities-of-daily-living in an individual's life. Alzheimer's disease is a primary degenerative cerebral disease of unknown etiology, with characteristic neuropathological and neurochemical features. The clinical symptoms include decline in memory and other cognitive functions.

13.14 KEYWORDS

Delirium

Dementia

Alzheimer disease

Cognitive functions

Attention

Perception

Psychomotor ability

13.15 CHECK YOUR PROGRESS

1. Describe the signs and symptoms of delirium.
2. Define Dementia and explain the Signs and symptoms of dementia
3. Explain the different types of dementia.
4. Explain Alzheimer disease.

13.16 ANSWERS TO CHECK YOUR PROGRESS

1. 13.4
2. 13.6 &13.7
3. 13.9
4. 13.10

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UNIT-14: PERSONALITY DISORDERS

STRUCTURE

14.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of personality disorder
- Classification of personality disorder
- General characteristics of personality disorders
- Paranoid personality disorder
- Schizoid personality disorder
- Schizotypal personality disorder
- Antisocial personality disorder
- Narcissistic personality disorder
- Histrionic personality disorder
- Borderline personality disorder
- Avoidant personality disorder
- Dependent personality disorder
- Obsessive-Compulsive personality disorder

14.2 INTRODUCTION

Personality disorders are a heterogeneous group of disorders regarded as enduring, inflexible patterns of inner experience and behavior that deviate from cultural expectations and cause distress or impairment (Davison, G.C. & Neale, J.M., 1996). Personality disorders derive from a trait approach to personality. This unit deals with the personality disorders, its types, the clinical picture, signs and symptoms of various personality disorders.

14.3 MEANING AND DEFINITION OF PERSONALITY DISORDER

Personality traits are enduring patterns of perceiving, relating to and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute personality disorder. Both personal and social aspects are needed to account fully for the symptoms of personality disorder.

It refers to severe disturbance in the characterlogical constitution and behavioral tendencies of the individual, involving several areas of personality and associated with considerable personal and social disruption. Psychological tests and collecting the detail history data from the informants are essential in the diagnosis and management of the disorder.

14.4 CLASSIFICATION OF PERSONALITY DISORDERS

DSM-IV divides the personality disorders into three groups or clusters. Cluster A is called the "odd" or "eccentric" cluster. This category includes paranoid, schizoid, and schizotypal personality disorders. Cluster B is the "dramatic", "emotional" or "erratic", cluster: it consists of antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster C is the "anxious", or "fearful", cluster: it includes avoidant, dependant, and obsessive- compulsive personality disorders.

ICD- 10

According to ICD-10 personality disorders are described as severe disturbance of personality and behavior that are pronounced deviations, from normal cultural patterns.

The diagnostic guidelines include disturbance of long standing duration in several areas of functioning; pervasive and maladaptive behavior; onset in childhood or adolescence; continuation in adulthood: considerable personality distress: and usually, but not always, significant problems in the work and social behavior.

ICD – 10 also allows for the possibility of criteria developed to describe personality disorders in different cultures.

According to ICD-10 there are 10 specific personality disorders namely,

1. Paranoid personality disorder
2. Schizoid personality disorder
3. Dissocial personality disorder
4. Emotionally unstable personality disorder
5. Histrionic personality disorder
6. Narcissistic personality disorder
7. Anxious (Avoidance) personality disorder
8. Dependent personality disorder

9. Mixed and Other specific personality disorders
    a. Mixed personality disorder *
    b. Troublesome personality changes *

    * No attempt was made for sets of criteria for these disorders

10. ICD -10 also give the provision for *Enduring personality changes, not attributable to brain damage and diseases*

a. Enduring personality changes after psychiatric illness

b. *Enduring personality change, unspecified*

14.5 GENERAL DIAGNOSTIC CRITERIA OF PERSONALITY DISORDERS

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual culture. This pattern is manifested in two or more of the following areas.

1. Cognition (ways of perceiving and interpreting self, other people and events)

2. Affectivity (the range, intensity, liability and appropriateness of emotional response)

3. Interpersonal functioning

4. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequences of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (Drug abuse, medication) or a general medical condition (Head injury).

14.6 PARANOID PERSONALITY DISORDER

Definition: This is personality disorder in which a pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent and begins by early adulthood and is present in a variety of contexts.

Characteristics and Diagnosis

According to DSM IV following criteria are considered for the diagnosis of this disorder.

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts', as indicated by four or more of the following:

1. Suspects, without sufficient basis, that others are exploiting, harming or deceiving him or her.

2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.

3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.

4. Reads hidden demeaning or threatening meanings into benign remarks or events.

5. Persistently bears grudges – is unforgiving of insults, injuries or slights.

6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.

7. Has recurrent suspiciousness, without justification, regarding fidelity of spouse or sexual partner.

B. Does not occur exclusively during the course of schizophrenia, mood disorder with psychotic features and is not due to the direct physiological effects of a general medical condition.

This disorder first may be apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language and idiosyncratic fantasy. These children may appear to be odd or eccentric and attract teasing. Relatives of probands with chronic schizophrenia and specific familial relationship with delusional disorder of persecutory type are prone to this type of disorder.

Evidence for biological contributions to paranoid personality disorder is limited. Psychological contributions to this disorder are even less certain. Cultural factors also have implicated in paranoid personality disorder.

14.7 SCHIZOID PERSONALITY DISORDER

The essential feature of this disorder is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings. This pattern begins by early adulthood and is present in a variety of contexts. This type of disorder is uncommon in clinical setting.

Characteristics and diagnosis

A. A pervasive pattern of detachment from social relationships and restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts as indicated by four (or more) of the following.

1. Neither desires nor enjoys close relationships, including being part of a family.
2. Almost always chooses solitary activities
3. Has little if any, interest in having sexual experiences with another person.
4. Takes pleasure in few if any activities
5. Lacks close friends or confidants' others than first degree relatives.
6. Appears indifferent to the praise or criticisms of others.
7. Shows emotional coldness, detachment, or flattened affectivity.

B. Does not occur exclusively during the course of schizophrenia, mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder and is not due to the direct physiological effects of a general medical condition.

Research shows that early problems with interpersonal relationships to produce the social deficits that define schizoid personality disorders. This disorder is first apparent in childhood and adolescence with solitariness, poor peer relationships, and underachievement in school which mark these children or adolescents as different and make them subject to teasing. In the families of relatives of individuals with schizophrenia/schizotypal personality disorders can cause this disorder.

14.8 SCHIZOTYPAL PERSONALITY DISORDER

A pervasive pattern of social and interpersonal deficits marked by acute discomfort with and reduced capacity for close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior. This pattern begins by early adulthood and is present in a variety of contexts.

Characteristics and diagnosis

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with and reduced capacity for close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts as indicated by five (or more) of the following:

1. Ideas of reference (excluding delusions of reference)

2. Odd beliefs or magical thinking that influences behavior and is inconsistent with sub cultural norms. (Superstitiousness, belief in clairvoyance, telepathy, or sixth sense: in children and adolescents, bizarre fantasies or preoccupations)

3. Unusual perceptual experiences, including bodily illusions.

4. Odd thinking and speech (E.g. vague, circumstantial, metaphorical, overelaborate, or stereotyped)

5. Suspiciousness or paranoid ideation

6. Inappropriate or constricted affect

7. Behavior or appearance that is odd, eccentric, or peculiar.

8. Lack of close friends or confidents other than the first-degree relatives

9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

B. Does not occur exclusively during the course of schizophrenia, mood disorder with psychotic features, another psychotic Disorder, or a pervasive developmental disorder.

First apparent in childhood and adolescence with solitariness, poor peer relationships, and underachievement in school which mark these children or adolescents as different and make them subject to teasing. Schizotypal personality disorder is viewed by some to be one phenotype of a schizophrenia genotype.

14.9 ANTISOCIAL PERSONALITY DISORDER

Antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern is also called as psychopathy, sociopathy, dissocial personality disorder. The deceit and manipulation are central features of this disorder.

Characteristics and Diagnosis:

According to DSM-IV, following features or criteria should be met while diagnosing this condition.

A. There is a pervasive pattern of disregard for, and violation of, the rights of others occurring since the age of 15 years, as indicated by three (or more) of the following;

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.

2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning other for personal profit or pleasure.

3. Impulsivity or failure to plan ahead.

4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.

5. Reckless disregard for safety of self or others.

6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.

7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least 18 years

C. There is evidence of conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.

The factors such as genetic influences, gene- environment interaction, neurobiological influences, psychosocial and social dimensions, developmental influences all tried to explain the psychopathology of this personality disorders.

Conduct disorders (before the age of 10) and accompanying attention deficit-hyperactivity disorder increase the likely hood of developing antisocial personality disorder in adult life. Conduct disorder is more likely to develop into antisocial personality disorder when there is erratic parenting, neglect, or inconsistent parental discipline.

14.10 NARCISSISTIC PERSONALITY DISORDER

The Pervasive sense of grandiosity (in fantasy or in behavior), need for admiration, lack of empathy, and intense envy beginning by early adulthood are the hallmarks of this disorder.

Characteristics/diagnosis

If the above defined symptoms manifest in a variety of contexts as indicated by five (or more) of the following:

1. Grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

2. Preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love.

3. Believes that he or she is special and unique and can only be understood by or should associate with other special or high status people or institutions.

4. Requires excessive admiration.

5. Has a sense of entitlement, i.e. unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

6. Interpersonally exploitative, i.e. takes advantages of others to achieve his or her expectations.

7. Lacks empathy, is unwilling to recognize or identify with the feelings and needs of others

8. Often envious of others or believes that others are envious of him or her.

9. Shows arrogance, haughty behaviors or attitudes.

The risk to develop this disorder is high in the offspring of narcissistic parents who gives an unrealistic sense of grandiosity. Most narcissistic persons are realistically talented, beautiful, or highly intelligent as these features serve as nucleus around which the sense of specialness if further organized.

14.11 HISTRIONIC PERSONALITY DISORDER

This disorder is marked by Pervasive and excessive self-dramatization, excessive emotionality, and attention seeking symptoms.

Characteristics & Diagnosis

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Uncomfortable in situations in which he or she is not the center of attention.

2. Interaction with others is often characterized by inappropriate sexually seductive or Provocative behavior.

3. Displays rapidly shifting and shallow expression of emotions

4. Consistently uses physical appearances to draw attention to self

5. Has a style of speech that is excessively impressionistic and lacking in detail

6. Shows self-dramatization, theatricality, and exaggerated expression of emotion

7. Suggestible, easily influenced by others or circumstances

8. Considers relationship to be more intimate than they actually are.

This disorder tends to run in families. A genetic link between histrionic and antisocial personality disorders and alcohol use disorders has been suggested. Many individuals may display histrionic personality traits. If these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress they constitute this disorder.

14.12 BORDERLINE PERSONALITY DISORDER

Pervasive and excessive instability of affects, self-image, and interpersonal relationships as well as marked impulsivity are the marks of this disorder.

Characteristics and diagnosis

According to DSM IV following criteria should be fulfilled for the diagnosis of this disorder.

A. A Pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance; markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (E.g. spending, sex, Substance abuse, reckless driving, binge eating)
5. Recurrent suicidal behavior, gestures, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g. intense episodic Dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress related paranoid ideation or severe dissociative symptoms

Early traumatic experiences may be a cause of this disorder. Childhood trauma, vulnerable temperament and series of triggering events are responsible to this disorder. A combination of early traumatic events and certain biological vulnerabilities (in the emotional domain) are the primary cause of this disorder. Physical and sexual abuse, neglect, hostile conflict, early parental loss or separation, familial aggregation is the commonly seen factor in this disorder.

14.13 AVOIDANT PERSONALITY DISORDER

This disorder is characterized by pervasive and excessive hypersensitivity to negative evaluation, social inhibition, and feelings of inadequacy.

Characteristics/diagnosis

A. A pervasive pattern of social inhibition, feelings of social inadequacy, and hypersensitivity to negative evaluation beginning by early adulthood and present in a variety of contexts as indicated by four (or more) following:

1. Avoids occupational activities that involve significant interpersonal contact, because of fear of criticism, disapproval, or rejection.

2. Unwilling to get involved with people unless certain of being liked.

3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.

4. Preoccupied with being criticized or rejected in social situations

5. Inhibited in new interpersonal situations because of feelings of inadequacy

6. Views self as socially inept, personally unappealing, or inferior to others

7. Unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Frequently beginning in childhood with shyness and fear of strangers and new situations, disfiguring illness and shyness in childhood predispose children to avoidant personality disorder.

The avoidance behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Individuals who go on to develop Avoidant Personality disorder may become increasingly shy and avoidant during adolescence and early childhood, especially when the social relationship becomes important.

14.14 DEPENDANT PERSONALITY DISORDER

A pervasive, excessive, need to be taken care of, leading to clinging behavior, submissiveness, fear of separation, and interpersonal dependency are the main features of this disorder

Characteristics/diagnosis

The defined characteristics are beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Difficulty in making every day decisions without an excessive amount of advice and reassurance from others.

2. Needs others to assume responsibility for most major areas of his or her life.

3. Has difficulty in expressing disagreement with others because of fear of loss of support or approval. (Do not include realistic fear of retribution)

4. Difficulty in initiating projects or doing things on his or her own (because of a lack of self confidence in judgment or abilities rather than a lack of motivation or energy)

5. Goes to excessive lengths to obtain nurturance and support from others to the point of volunteering to do things that are unpleasant.

6. Feels uncomfortable or helpless when alone because of exaggerated fear of being unable to care for himself or herself

7. Urgently seeks another relationship as a source of care and support when a close relationship ends.

8. Unrealistically preoccupied with fears of being left to take care of himself or herself.

Chronic physical illness or separation anxiety disorder may predispose for this disorder whose familial pattern and genetics are unknown. Low socioeconomic status and poor family and marital functioning are other risk factors.

14.15 OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

Pervasive preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency are the main characteristics of this disorder.

Characteristics/diagnosis

The defined characteristics are beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.

2. Shows perfectionism that interferes with task completion, (e.g. unable to complete a project because his or her own overly strict standards are not met)

3. Excessively devoted to the work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).

4. Over consciousness, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).

5. Unable to discard worn-out or worthless objects even when they have no sentimental values.

6. Reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.

7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.

8. Shows rigidity and stubbornness.

Obsessions and compulsions have been repeatedly linked to high central serotonergic function. The hypothesis that obsessions and compulsions represent psychological and behavioral mechanisms against anxiety is supported by the finding that this disorder generally associated with anxiety.

14.16 SUMMARY

This unit has given you a detailed understanding about the various personality disorders. The criteria for deciding it to be a disorder. Personality disorders are enduring patterns of perceiving, relating to and thinking about oneself and the environment around oneself. It is a maladaptive behaviour which affects the individual himself and the people around him.

14.17 KEYWORDS

Personality disorder
Paranoid personality disorder
Schizoid personality disorder
Schizotypal personality disorder
Antisocial personality disorder
Narcissistic personality disorder
Histrionic personality disorder
Borderline personality disorder
Avoidant personality disorder
Dependent personality disorder
Obsessive-Compulsive personality disorder

14.18 CHECK YOUR PROGRESS

1. Define personality disorder. Name the types.
2. Discuss paranoid and schizoid personality disorder.
3. Describe Obsessive –Compulsive disorder.

14.19 ANSWERS TO CHECK YOUR PROGRESS

1. 14.3 & 14.4
2. 14.6 & 14.7
3. 14.15

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UNIT- 15: ORGANIC MENTAL DISORDERS

STRUCTURE

15.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of organic mental disorders
- Causes of organic mental disorders
- Symptoms of organic mental disorders
- Types of organic mental disorders
- Neurological syndromes

15.2 INTRODUCTION

Organic mental disorder is also known as organic brain syndrome or chronic organic brain syndrome. Organic mental disorders are result from brain dysfunction caused by organic pathology inside or outside the brain. Organic mental disorder is a form of decreased mental function due to a medical or physical disease, rather than a psychiatric illness. It is a dysfunction of the brain that may be permanent or temporary.

15.3 MEANING AND DEFINITION OF ORGANIC MENTALDISORDERS

Organic mental disorders are disturbances that may be caused by injury or disease affecting brain tissues as well as by chemical or hormonal abnormalities. Exposure to toxic materials, neurological impairment, or abnormal changes associated with aging can also cause these disorders.

Organic brain syndrome can be divided into two major subgroups. 1. Acute (delirium or acute confusional state) and 2. Chronic (dementia) and a third one encephalopathy (subacute organic brain syndrome) denotes a gray zone between delirium and dementia, in the beginning course it may fluctuate, but it is often persistent and progressive. The damage to brain functioning can be not only to organic (physical) injury (a severe blow to the head, stroke, chemical and toxic exposures, organic brain disease, substance abuse, etc) and also to non-organic means such as severe deprivation, abuse, neglect and severe psychological trauma.

The most common organic mental disorders are delirium, dementia, Alzehiemer’s disease and amnesia.

Organic mental disorder or organic brain syndrome is not a disease, rather, it is a term used to refer to any of the conditions caused due to the gradual decrease in the functioning of the brain. Organic mental disorders can be temporary and acute(delirium) or permanent and chronic(dementia).

15.4 CAUSES OF ORGANIC MENTAL DISORDERS

Organic mental disorders are disturbances that may be caused by injury or disease affecting brain tissues as well as by chemical or hormonal abnormalities. It may be caused due to toxic materials, neurological impairment, or abnormal changes associated with aging can also cause these disorders. Other factors like alcohol or metabolic disorders such as liver, kidney or thyroid disease, vitamin deficiencies, concussions, blood clots, bleeding in or around the brain from trauma may also lead to organic brain syndrome. Low oxygen in the blood, high amount of carbon dioxide in the body, strokes, brain infections, and heart infections can lead to an organic mental disorder. There are various factors that can lead to organic mental disorder:

1. **Physical or medical conditions**
    a) Brain injury due to trauma, bleeding within the brain, bleeding into the space around the brain, blood clot inside the skull causing pressure on brain, concussion.
    b) Breathing conditions: Low oxygen in the body, high carbon dioxide levels in the body.
    c) Cardiovascular conditions: Stroke, dementia due to many strokes, heart infections, transient ischemic attack (TIA).
    d) Degenerative disorders: Alzheimer’s disease, dementia, Huntington disease, multiple sclerosis, Parkinson’s disease.
    e) Organic amnesic syndrome: A syndrome that causes prominent impairment of recent and remote memory while immediate recall is preserved. The ability to learn new things slows down.
    f) Delirium: An acute but temporary organic cerebral syndrome that affects consciousness, attention, perception, thinking, memory, behaviour and sleep-wake schedule.

g) Personality and behavioural disorders due to brain disease, damage or dysfunction.

15.5 SYMPTOMS OF ORGANIC MENTAL DISORDERS

The symptoms of organic mental disorders include confusion, memory loss, agitation, irritability, change in behaviour and impaired brain function, cognitive ability or memory. The individual with organic mental disorder may have difficulty in concentrating for a long period of time. They may get confused during their routine work, inability to manage relationships, collaborate and communicate with others. The symptoms depend on the part of the brain that is affected and the condition that caused this disorder. The common symptoms are:

- Memory loss: The individual may lose the ability to identify and recognize people, family and friends.
- Confusion: Individual may be confused about where they are what they are doing.
- Difficulty in understanding.
- Anxiety and fear.
- Inability to focus or concentrate.
- Short term memory loss.
- Difficulty in performing routine tasks.
- Difficulty in controlling voluntary muscle movements.
- Visual disturbance
- Poor judgement
- Coordination problems.
- Extreme rage or paranoid ideas.

15.6 TYPES OF ORGANIC MENTAL DISORDERS

The most common types of organic mental disorders are:

1) Delirium
2) Dementia

3) Amnestic syndromes

1. **Delirium**: Delirium is an acute generalized impairment of brain function in which the most important feature is impairment of consciousness. It is an acute onset of neuropsychiatric disorder characterized by confusion, incoherent thought and speech, hallucinations and delusions.

2. **Dementia**: Dementia is characterized by a gradual loss of brain function and a decline in cognitive or intellectual functioning. The individual with dementia have symptoms similar to those of delirium, i.e., confusion, problems with mood, speech and thought as well as changes in personality and disorientation.
   (Delirium and Dementia are already discussed in detail in unit-13 please refer for detailed explanation).

3. **Amnestic syndromes**: Amnesia is loss of memory and amnestic syndromes or amnestic disorders are those in which memory is specifically and persistently affected. Amnestic disorder is defined as a specific impairment of episodic memory, manifesting as inability to learn new information (anterograde amnesia) and to recall past events (retrograde amnesia) accompanied by significant impairment in social or occupational functioning with evidence of a general medical condition. Amnesia is characterized by partial or total loss of memory which is not part of delirium or dementia. Long term memory is usually not as affected as short term memory. Amnesia can be caused by shock, psychological disturbance, brain injury or illness. It can be temporary or permanent depending on the cause.

Clinical features of amnestic syndromes

The cardinal feature is a profound deficit of episodic memory. Disorientation of time, loss of autobiographical information, severe anterograde amnesia for verbal and visual material, lack of insight into the amnesia is found. Events are recalled immediately after they occur, but forgotten a few minute later. New learning is grossly defective. Cognitive functions are relatively intact, although some emotional blunting and inertia are often observed. Gaps in memory are often filled by confabulation. That is, the patient may give a vivid and detailed account of recent

activities, that, on checking, turn out to be inaccurate. It is as if the individual cannot distinguish between true memories and the products of his imagination or recollection of events from times other than those he is trying to recall.

4. **Korsakov syndrome**: The common cause of amnestic syndrome is Korsakov syndrome, named after the Russian neuropsychiatrist. The alternative term Wernicke-Korsakov syndrome was proposed by Victor.et al, because the syndrome often follows an acute neurological syndrome called Wernicke's encephalopathy. It comprises of delirium, truncal ataxia, papillary abnormalities, opthalmophegia, nystagmus and a peripheral neuropathy. Korsakov is usually caused by thiamine deficiency, secondary to alcohol abuse; it occasionally results from hyperemesis gravidarum and severe malnutrition.

15.7 NEUROLOGICAL SYNDROMES

A variety of primary neorulogical conditions may also cause cognitive decline and other neuropsychiatric symptoms. The common and important ones are discussed below:

NORMAL –PRESSURE HYDROCEPHALUS

In normal-pressure hydrocephalus (NPH) there is dilation of the ventricles in the absence of a mechanical block within the ventricular system. Instead, there is obstruction in the subarachnoid space. At lumbar puncture, the CSF pressure measurement is usually high normal, representing the fact there is little rise in intracranial pressure. The characteristic features are a triad of gait ataxia, dementia and urinary incontinence. Gait disturbance is due to the ventricular dilatation stretching the corona radiation holding the motor fibres which innervate the lower limbs. It presents similarly to Parkinsonism, but without the other typical features. The dementia is progressive, with worsening memory, inattention, apathy and fatigue.

CEREBROVASCULAR DISEASE

Many people after surviving from stroke, return to fully independent life. Some may suffer from psychological as well as physical problems. The psychological changes are more significant, preventing a return to normal life. A wide range of psychiatric symptoms occur after a stroke.

- **Cognitive deficits**: Stroke can cause dementia as well as specific deficits of higher cortical functions, such as dysphasia and dyspraxia.
- **Personality changes**: Irritability, apathy or liability of mood may occur after a cerebrovascular activity.
- **Depression**: It is a partly a psychological reaction caused due to the effect of stroke. It can contribute to the intellectual impairment.
- **Mood**: Liability of mood is frequent.
- **Psychosis**: Psychosis is also found in some rare cases in after stroke.

CEREBRAL TUMOURS

Cerebral tumours cause psychological symptoms at some stage. Fast growing tumours cause a delirium, if there is raised intracranial pressure, slow growing tumours are more likely to present with dementia or occasionally depressive symptoms.

15.8 SUMMARY

This unit has given you an overview of the organic mental disorders. The delirium, dementia, amnestic syndromes their symptoms , causes are being discussed in this unit. By understanding these you will be able to differentiate the organic mental disorders from other mental disorders.

15.9 KEYWORDS

Delirium
Dementia
Amnestic syndromes
Korsakov syndrome
Cerebrovascular disease
Depression

15.10 CHECK YOUR PROGRESS

1. Define organic mental disorders.

2. Explain the causes of organic mental disorders.

3. Discuss the symptoms of organic mental disorders.

4. Explain different types of organic mental disorders.

15.11 ANSWERS TO CHECK YOUR PROGRESS

1. 15.3

2. 15.4

3. 15.5

4. 15.6

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UNIT-16: DISORDERS OF CHILDHOOD AND ADOLESCENCE

STRUCTURE

16.1 OBJECTIVES

After going through this unit, you will be able to explain

- Problems faced by children and adolescents
- Types of problems in childhood and adolescents
- Childhood anxiety disorders
- Childhood depression
- Disruptive behaviour disorder
- Attention deficit hyperactive disorder
- Elimination disorders
- Autism
- Mental retardation
- Stress related disorder
- Mood disorders
- Learning disabilities
- Obsessive-compulsive disorder

16.2 INTRODUCTION

People always believe that childhood is a period of enjoyment and fun. Children always are carefree and enjoy the most. They do not have any sort of worries and stress, they are free from all kinds of responsibilities. In actuality children also do face lots of stress, worry for their own reasons and sometimes also suffer from loneliness, anxiety, fear, frustration, jealousy, anger, threat and lots of other things, these are only different in their form and the cause, reasons, consequences compared to adults. This unit deals with the psychological problems faced by the children and the adolescents. Its forms, symptoms and their consequences.

16.3 PROBLEMS FACED BY CHILDREN AND ADOLESCENTS

Children coming from various backgrounds and different societies throughout the world irrespective of their culture, society, socio-economic status do face certain common psychological problems. Childhood is a sensitive age and the minds of children are usually

tender, soft can be easily hurt also. The various day to day events may create some amount of stress when the necessary guidance and help is not provided by the parents and the other elders in handling these situations. Timely help and guidance help the children to learn even the most difficult things in life. But sometimes a lack of these leads to various problems in children, added to these there may be biological, hereditary predispositions which may also worsen the problems.

According to Eric Erickson (1963) each and every individual pass through the eight stages of psychosocial development and successful passing from one stage to the next stage leads to successful completion of that stage as well as preparation for the next stage whereas a failure to accomplish the desired expectation in each stage leads to psychological problems which will be carried to the next stages as well. Hence, childhood problems may lead to problems in adolescence or sometimes the individual may start finding various problems specifically related with adolescence.

ADOLESCENTS PROBLEMS

Adolescence can be a difficult stage. There are lots of physical, psychological, sexual, social, emotional changes occurring at this stage. As this is a stage of transition the individual faces lots of doubts about oneself, the changes occurring within one physical makeup, body image change, the social expectations of behaviour at this age, academic pressures etc leads to a state of anxiety, confusion and sometimes may lead to depression also.

16.4 TYPES OF PROBLEMS IN CHILDHOOD AND ADOLESCENCE

The major disorders found among children and adolescents are as follows:

1. Childhood anxiety disorders
2. Childhood depression
3. Disruptive behaviour disorder
4. Attention deficit hyperactive disorder
5. Elimination disorders
6. Autism
7. Mental retardation

16.5 CHILDHOOD ANXIETY DISORDERS

Anxiety disorders are characterized by fear, worry or dread that impairs the ability to function normally and it is disproportionate to the circumstances. Anxiety may result in physical symptoms. Anxiety disorders often emerge during childhood and adolescence. Anxiety disorders in adolescents include agoraphobia, generalized anxiety disorder, separation anxiety disorder, social anxiety disorder and specific phobias. The common anxiety disorders experienced by children and adolescents are specific phobias, social phobias, generalized anxiety disorders, obsessive compulsive disorder. There is one specific disorder only experienced by children that is separation anxiety disorder.

Separation anxiety disorder: Children with this disorder feel extreme anxiety, often panic, whenever they are separated by their parents or home. They have problem travelling away from their home, they often refuse to visit their friend's house, attend camps sometimes even going to school becomes a problem. They cannot stay alone at home, they always try to cling to their parents, it is partly done in a fear of being left alone, they quarrel with their parents if they leave them, they cry, plead, their parents not to leave them. The children may fear that they will get lost when separated from their parents or that their parents will meet in an accident or illness. (APA, 2000). In many cases it is triggered by a stressful event, such as death of a parent, or a pet, moving away from home, change of school in early age, etc. The symptoms last for four weeks usually much longer but may wane of as they move into adolescence.

16.6 CHILDHOOD DEPRESSION

Children like adults may develop depression, the symptoms of childhood depression may be that the child's activity level seems to be lowered, below the expected level of a child, it may start showing a lack of interest in toys which are available for its play, the child may not be interested in play for more than few minutes, the child may show signs which reveals that it is not happy at home or at school, the child may not have friends, may not be good at playing games, the child may not be happy within oneself, apart from these symptoms usually the children suffering from depression may show symptoms which may include physical discomfort, for example: stomachache, headache, etc, irritability, social withdrawal,(APA,2000). According to the theorists the factors like, loss, learned helplessness, negative cognitions, and low serotonin

or norepinephrine activity. It is also found that the childhood depression seems to be triggered by a negative life event, major change, rejection, or ongoing abuse.

16.7 DISRUPTIVE BEHAVIOUR DISORDER

Disruptive behaviour disorder is also called as conduct disorder. Conduct disorder is a recurrent or persistent pattern of behaviour that violates the rights of others or violates major age-appropriate societal norms or rules. Children often break rules or misbehave in certain situations, but if this becomes a pattern and consistently the child is disobeying and misbehaving, displaying extreme hostility and defiance, loses its temper, feel great anger and resentment, often ignore the order given by the elders, try to annoy people, blame others for its own mistakes and problems, then it is considered as conduct disorder. Further, some of the symptoms mentioned here are also seen in these children, i.e., they violate the basic rights of others, often show aggressiveness, may physically assault others, treat people and animals cruelly, destroy others property, skip school, run away from home, steal, threaten others, harm others, commit crimes such as shoplifting, forgery, breaking into buildings and cars. Conduct disorder usually begins at the age of 7 and 15 years, children with mild conduct disorder may improve with time, but severe cases frequently continue into adulthood also.

16.8 ATTENTION DEFICIT HYPERACTIVE DISORDER

ADHD is a syndrome of inattention, hyperactivity and impulsivity. ADHD is considered as a neuro developmental disorder. It impairs development of personal, social, academic and occupational functioning. It involves difficulties with acquisition, retention or application of specific skills or sets of information.

Attention deficit hyperactivity disorder is often referred to as hyperactivity. ADHD is one of the most common childhood disorders and continue through adolescence and adulthood. In DSM-IV, the symptoms of ADHD are categorized into three clusters. They are referred to as subtypes:1. Inattentive 2. Hyperactive /impulsive 3. Combined. ADHD is characterized by the following symptoms:

1. **Overactivity**: They show excessive restlessness, excessive or exaggerated muscular activity, they cannot sit in one place for a long time, show difficulty in engaging in play activities quietly, often run haphazardly, climb excessively in inappropriate situations.
2. **Inattention:** They have difficulty in sustaining attention in tasks and play activities. Shift from one activity to another without completing any activity, they dislike tasks which require high attention and concentration.
3. **Impulsivity:** They show reckless and impulsive behaviour, they are prone to accidents, they cannot wait for their turn in games, they do things impulsively.
4. **Distractibility:** They are highly distractible, fail to give close attention to details and they make silly mistakes, they do not follow the instructions given to them.
5. **Low frustration tolerance:** They are unable to manage oneself in stressful situations, show inappropriate behaviour in some situations.
6. **Developmental delays:** They show developmental delays especially motor and language development.
7. **Social disinhibition:** They often talk excessively, their talks are immature, socially disinhibited. Find difficulty in making friends.

They also show learning difficulties, cognitive misattributions, and they also show some other behavioral problems.

16.9 ELIMINATION DISORDERS

The children suffering from the elimination disorders repeatedly urinate or pass feces in their clothes, in bed or on the floor. Usually they already have reached an age at which they are expected to control these bodily functions, and these symptoms are not caused due to any physical illness.

There are two types of elimination disorders. They are 1. Enuresis 2. Encopresis

1. Enuresis: It is the repeated involuntary bedwetting or wetting of one's clothes. Usually it occurs during night, but sometimes it may also occur in the day time. According to the psychodynamic theorists, it is a symptom of broader anxiety and underlying conflicts.

2. Encopresis: It is the repeatedly defecating into one's clothing, this is less common compared to enuresis. It usually occurs at night when the child is sleeping. This may occur due to stress, constipation or improper toilet training.

16.10 AUTISM

Autism or autistic disorder is a long term disorder marked by extreme unresponsiveness to others, poor communication skills, and highly repetitive and rigid behaviour. The symptoms appear early in life i.e., before the age of 3 years. The symptoms include the individual's lack of responsiveness, including extreme aloofness, lack of interest in other people, there is language and communication problems occurring in these children, they fail to speak or develop language skills, they speak with peculiarities, they show echolalia-the exact echoing of phrases spoken by others. They repeat the words spoken by others, in the same accent without understanding them. They have limited imaginative play, very repetitive, and rigid behaviour. They become upset with minor changes of objects, persons, or routine, they resist any efforts to change their repetitive behaviour. They show temper tantrums, they are strongly attached to particular objects like plastic lids, rubber bands, buttons, water, etc. Their motor movements are unusual, they are sometimes over stimulated by the sights and sounds and try to block them out.

Individuals with autism avoid eye contact, show few facial expressions and bodily gestures, they fail to make friendship, they do not share their emotions.

16.11 MENTAL RETARDATION

According to DSM-IV, the individual who is displaying general intellectual functioning which is well below the average, in combination with poor adaptive behaviour is termed to be mentally retarded. (APA,2000).

The clinical description of mental retardation is as follows: sub-average general intellectual functioning, physical abnormalities, neurological abnormalities, delayed developmental milestones, poor communication skills, impaired social interaction, lack of self-help, behavioural problems, psychological problems.

Mental retardation may be classified on the basis of various criteria,

DSM-IV describes four levels of mental retardation: mild-IQ 50-70, moderate-IQ35-49, severe-IQ 20-34, and profound-IQ below 20.

Mild mental retardation: 85% of all the people with mental retardation fall into this category. They are sometimes called as "educable retarded" because they can be trained and they can also benefit from schooling, they can support themselves as adults. Mild mental retardation is not recognized until the child enters the school and is assessed there.

Moderate mental retardation: Approximately 10 percent of the mentally retarded are moderate mental retarded. These individuals can be trained to take care of themselves and they can be vocationally trained also. They can work in unskilled or semi-skilled jobs, with some supervision.

Severe mental retardation: Approximately 4percent of the mentally retarded are severe mentally retarded. They usually require careful supervision, they can be profited very little from vocational training, they can perform only basic and structured tasks with some guidance.

Profound mental retardation: Approximately about 1 percent of mentally retarded fall under this category. With training they may improve in the basic skills like walking, some talking, and feeding themselves. They need a structured environment, a very keen supervision and a large amount of help.

16.12 STRESS RELATED DISORDERS

Acute stress disorder(ASD) and posttraumatic stress disorder (PTSD) are reactions to traumatic events. The reactions involve intrusive thoughts or dreams, avoidance of reminders of the event and negative effects on mood, cognition, arousal and reactivity. Traumatic events commonly associated with these disorders include assaults, sexual assaults, accidents, dog attacks and injuries. Domestic violence is the most common cause of PTSD. Children, if they witness a traumatic event happening to others or learn that has occurred to a close family member, develop a stress disorder.

16.13 MOOD DISORDERS

Mood disorders are characterized by sadness or irritability that is severe or persistent enough to interfere with functioning or cause considerable distress. Depressive disorders in children and adolescents include:

- Disruptive mood dysregulation disorder
- Major depressive disorder
- Persistent depressive disorder(dysthmia)

16.14 LEARNING DISABILITES

Learning disabilities refers to inadequate development in a specific area of academic, language, speech and motor skills that is not due to mental retardation, autism, demonstrable physical disorder, or deficient educational opportunities. Children with these disorders are usually of average or above average intelligence but have difficulty learning specific skills like arithmetic, reading, writing , motor skills, etc.

Learning disorders are not due to sensory problems like visual or hearing impairments. There are a wide variety of symptoms present in the learning disabled individuals the main one are being discussed here:

Motor difficulties: refers to the problems in movement and coordination in either fine motor skills like writing, cutting, drawing or gross motor skills like running, jumping, balancing oneself. It also includes the eye-hand coordination, like holding pencil, buttoning a shirt, tying shoe lace, etc.

Language difficulties: The child may find difficulty in understanding language, to produce spoken language. There may be problems in verbal learning skills, ability to recall, fluency in speech, directions, etc.

Behavioural problems: Behavioural and emotional problems are high in these children. They show social maladjustment, immaturity, inadequacy in their behaviour.

Learning disability involves many areas of perception, they include:

- Visual-perceiving differences, filling in missing spaces.
- Auditory –auditory discrimination, auditory closure, figure ground.
- Visual and auditory memory
- Auditory association
- Spatial perception
- Temporal perception- time perception

The most common types of learning disabilities are:

Dyslexia: refers to learning problems in reading and spelling, some individuals see the letters in reverse.

Dysgraphia: A disorder of written expression, such as writing very slowly.

Dyscalculia: refers to problems learning mathematics, understanding time, using money.

Dysnomia: A disorder of naming or recalling objects.

Dysphasia: A disorder of comprehending or expressing words in proper sequence, such as failing to understand what others say or trouble speaking logically to others.

Dyspraxia: A disorder of fine motor movements, such as holding a pencil, buttoning a shirt, tying shoe lace.

Dyslalia: A disorder of articulation or trouble saying words clearly and understandably.

16.15 OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder is characterized by obsessions, compulsions or both. Obsessions are irresistible, persistent ideas, images or impulses to do something. Compulsions are pathologic urges to act on an impulse, which, if resisted, result in excessive anxiety and distress. Obsessions and compulsions cause great distress and interfere with academic and social functioning.

16.16 TREATMENT

Psychodynamic, behavioural, cognitive, family and group therapies separately or in combination, is used to treat anxiety disorders in children and adolescence, often it will be successful. Usually play therapy is used for diagnoising and treating a wide variety of psychological problems in children. Play therapy is the most important one in diagnosing and also certain many of the psychological problems and certain childhood disorders.

16.17 SUMMARY

To sum up with this unit has dealt in detail about the various problems faced by the children and the effects of those in the growing minds which lead to psychological problems. The various psychological and emotional problem of childhood and adolescence. Its treatment is being disused in detail.

16.18 KEYWORDS

Attention deficit hyperactivity disorder

Hyperactivity

Impulsive

Learning disability

Dyslexia

Dyscalculia

Dysgraphia

Dyspraxia

Autism

Mental retardation

Conduct disorder

16.19 CHECK YOUR PROGRESS

1. Explain the types of problems faced by children.
2. Discuss Learning disability and obsessive Compulsive disorder.
3. Explain ADHD.
4. Discuss stress related disorder.

16.20 ANSWERS TO CHECK YOUR PROGRESS

1. 16.4
2. 16.14 & 16.15
3. 16.8
4. 16.12

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