UNIT 1 NORMAL HUMAN EXPERIENCE

Structure

1.0 INTRODUCTION

Psychopathology is the scientific study of abnormal behaviour. In the field of mental health, clinicians are concerned with disturbed behaviour, its severity and duration amongst patients, and look for indications of diagnosis, treatment and follow up. At one extreme are the greatly and visibly disturbed people, once called insane, mad or lunatic, and now called the psychotic. At the other end are the unhappy people, unable to cope effectively with life demands, limited in their ability to love, work or find meaning in their lives, either over long periods or in brief, stress-related episodes. Against standards of mental health or normality these are all described as forms of mental disorder or psychopathology. But what defines psychological normality and abnormality? In this unit we will deal with this issue.

This unit introduces a number of issues that are important to abnormal psychology. It starts by defining what is meant by normality and abnormality. Next we will describe the phenomena of psychopathology in terms of levels of dysfunctions. Lastly we will study the history of psychopathology.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define normality;
- Elucidate the concept of normality;
- Describe the criteria for abnormality; and
- Analyse the growth of the history of psychopathology.

1.2 THE CONCEPT OF NORMALITY

Concept of normality is difficult to explain as over a period of time this concept has been changing. Traditionally it was conceptualised as the person's adjustment to his environment. But now it is termed as 'adaptability'. The concept of normality focuses more on positive attributes such as individuality, creativity and self-fulfilment. But most of us are unable to explore or realise our potentials to the maximum and lead routine lives. Yet, we would not be considered abnormal and maladjusted.

There is no clear consensus as to how normality is defined and which particular types of disordered behaviour can be considered abnormal. Normality and abnormality are viewed on a continuum with the characteristics and attributes present in greater degree in normal people than in abnormal people.

Offer and Sabshin (1966) had surveyed the many meanings of normality which have arisen in psychology, psychiatry, sociology and anthropology. Based on their analysis normality is viewed as Health (meaning 'not sick'), as an Ideal state, as Average, as Socially acceptable and as Process (change over time).

Following are some of the norms used to define normality:

Psychological normality has most often been defined either as an average, an ideal, or a level of adjustment. Normality as an average is a statistical definition that identifies the typical or most common behaviours among a group of people as being normal for that group. Have not we heard at time people saying to a person behaving differently, that "why can't you be like others?" This 'others' behaviour is the normal and those who differ from this are brought back into the main stream.

Identifying some large middle percentage of a group of persons as showing normal behaviour has the benefit of providing a precise criterion for deciding whom to consider abnormal, namely those who fall outside this middle range. Attention to typical patterns of behaviour also promotes cultural sensitivity and helps clinicians avoid seeing psychopathology where none exists.

Cultural sensitivity in this regard consists of recognising that 'normal' for a person depends in part on the attitudes and behaviour patterns that are valued in the groups to which the person belongs. Being aware of normality in terms of customs, traditions, and expectations, an abnormal behaviour in a person may be even considered normal (for instance possession syndrome) in that person's sociocultural context. Such behaviours in another culture may be considered abnormal and may require treatment.

Thus the cultural sensitivity to a great extent helps clinicians and psychologists not to attribute psychopathology where it is not considered pathological but part of a cultural behaviour. Psychological disturbance from seemingly strange characteristics may be common in a subculture but others may not be familiar with it because they are not part of that culture.

i) State of perfection as normality

Another way to define normality is to refer to a state of perfection that people aspire to but seldom attain. This "nobody is perfect" assumes that all people

struggle with psychological limitations of one kind or another that prevent them from being as happy and successful as they would like to be.

Regarding normality as an ideal way of being avoids statistical decisions that label unusually intelligent, happy, or productive people as abnormal. Further this approach calls attention to the potential for people to become more than what they are, the ideal perspective on normality encourages striving toward self improvement and the active pursuit of greater happiness and success.

On the other hand by implying that almost everyone is disturbed to some extent, normality as an ideal is a difficult concept to apply.

ii) **Level of adjustment as normality**

Level of adjustment as a criterion for normality refers to whether people can cope reasonably well with their experiences in life, particularly with respect to being able to establish enjoyable interpersonal relationships and work constructively toward self fulfilling goals. When normality is defined in these terms, abnormality becomes a state of mind or way of acting that prevents people from dealing adequately with the social and occupational demands of daily life.

iii) **Reality testing as normality**

Normal persons are able to perceive, interpret and react to what is going on in the world around them in a realistic manner. They appraise themselves in a realistic manner, neither overestimate nor underestimate themselves. They do not misunderstand what others say and do and are able to analyse situations critically.

iv) **Behaviour control as normality**

Normal persons feel in control and are confident in themselves regarding controlling and directing their behaviour. They are able to control their aggressive and sexual impulses. Whenever there is a problem with conforming to social norms, it is usually a well thought out and voluntary decision and not due to uncontrollable impulses.

v) **Self worth as normality**

Normal individuals are able to appreciate their own self worth and feel accepted by society. They are comfortable in their social relationships and are able to accept and listen to differences of opinion and if they are convinced ready to change their own views also.

vi) **Self awareness as normality**

Even if normal persons do not fully understand their feelings and behaviour yet they do have some awareness of their feelings and motives. Important motives and feelings may be suppressed or hidden from oneself and normal persons would be aware of their feelings and emotions and know the motivation behind their behaviour.

vii) **Social relationships as normality**

Normal individuals are able to form and maintain close, long term and healthy relationships with other people. They do not manipulate or use relationships to their own advantage and are also sensitive to the needs and feelings of others.

They are able to reciprocate and provide comfort and affection to people close to them.

viii) **Effective functioning**

Normal people are enthusiastic about life and use their skills and abilities in productive and creative manner. They are able to meet demands of daily life without any need for external force or pressure.

1.3 CONCEPTS OF ABNORMALITY

If we define normality by the above said perspectives, then the opposite of these should mean abnormality. However such statement could be only partly true. Absence of these certainly leads to maladjustment with self and society and also to certain psychological problems.

1.3.1 Statistical Infrequency

Under this definition, a person's trait, thinking or behaviour is classified as abnormal if it is rare or statistically unusual. With this definition it is necessary to be clear about how rare a trait or behaviour needs to be before we class it as abnormal.

For instance one may say that an individual who has an IQ below or above the average level of IQ in society is abnormal (Figure 1.1 below normal distribution).

However this definition obviously has limitations, it fails to recognise the desirability of the particular behaviour. Going back to the example, someone who has an IQ level above average would not necessarily be seen as abnormal. Rather they would be highly regarded for their intelligence.

This definition also implies that the presence of abnormal behaviour in people should be rare or statistically unusual, which not the case. Instead, any specific abnormal behaviour may be unusual, but it is not unusual for people to exhibit some form of abnormal behaviour at some point in their lives.

The major limitation of this approach is that it fails to distinguish between desirable and undesirable behaviour.

Statistically speaking, many very gifted individuals could be classified as 'abnormal' using this definition. The use of the term abnormal in this context would not be appropriate.

Many rare behaviours or characteristics (e.g. left handedness) have no bearing on normality or abnormality. Some characteristics are regarded as abnormal even though they are quite frequent. Depression may affect 27% of elderly people (NIMH, 2001). This would make it common but that does not mean it is not a problem.

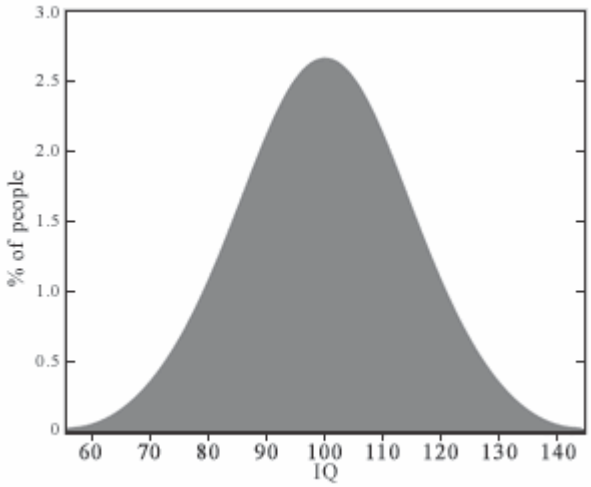

Fig.1.1: Normal distribution of IQ

1.3.2 Violation of Social Norms

Under this, a person's thinking or behaviour is classified as abnormal if it violates the (unwritten) rules about what is expected or acceptable behaviour in a particular social group. Their behaviour may be confusing to others or make others feel threatened or uncomfortable.

Social behaviour varies markedly when different cultures are compared. A visitation by dead in many Asian cultures is considered normal but other societies mark it as abnormal.

In another example, it is common in Southern Europe to stand much closer to strangers than in India or even U.K.

Voice pitch and volume, touching, direction of gaze and acceptable subjects of discussion have all been found to vary among cultures.

With this definition, it is necessary to consider the degree to which a norm is violated, the importance of that norm and the value attached by the social group to different sorts of violation. For example is the violation rude, eccentric, abnormal or criminal?

The major limitation is that social norms change over time. Behaviour that was once seen as abnormal may, given time, become acceptable and vice versa.

For example drunk driving was once considered acceptable but now seen as unacceptable whereas homosexuality was once considered a psychological disorder but now is considered acceptable.

Decade ago, most Indians would have been intolerant of women dressing in minimum with bare arms and legs; they now tend to see this as a changing life style rather than an abnormality.

So, the definition of abnormality needs to be more comprehensive than mere social noncompliance.

1.3.3 Maladaptive Behaviour

Maladaptive behaviours may be thought of as those that cause difficulties, or are counterproductive, for the individual or for others. The repetitive hand washing in obsessive compulsive disorder could be regarded as maladaptive, particularly if it leads to sores or other skin damage. The self-starvation of a patient with severe anorexia nervosa, which sometimes leads to death, would be a second example. Yet would we consider the self-destructive behaviour of a cigarette smoker evidence of mental illness? Clearly, no. as it is not an abnormality.

1.3.4 Personal Distress

Many patients with mental illness experience pronounced personal suffering. For example, patients with severe depression often describe feelings of anguish in addition to misery. Others express their distress in terms of physical complaints and may even visit their doctor believing that they are physically unwell. However, the subjective experience of the patient is not always a reliable indicator of illness, as some do not themselves acknowledge that they are ill. For example, patients with mania often say they feel ecstatic and euphoric, and in the early stages of schizophrenia the individual may be indifferent to or unaware of their deteriorating mental state.

1.3.5 Failure to Function Adequately

Under this definition, a person is considered abnormal if they are unable to cope with the demands of everyday life. They may be unable to perform routine activities of daily living e.g. self-care, hold down a job, interact meaningfully with others, make themselves understood etc. Rosenhan & Seligman (1989) suggest the following characteristics that define failure to function adequately:

- Suffering
- Maladaptiveness (danger to self)
- Vividness and unconventionality (stands out)
- Unpredictability and loss of control
- Irrationality/incomprehensibility
- Causes observer discomfort
- Violated moral/social standards

One limitation of this definition is that apparently abnormal behaviour may actually be helpful, functional and adaptive for the individual. For example, a person who has obsessive compulsive disorder of hand washing may find that the behaviour makes him happy and better able to cope with his day.

Self Assessment Questions

1) Discuss the concept of abnormality.

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2) What is meant by statistical frequency.

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3) What are the various criteria for abnormality.

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1.4 OTHER MODELS OF ABNORMALITY

More complex models of abnormality in the context of mental health consider abnormal behaviour to be a sign of a mental health problem when

- It is the result of distorted psychological processes.
- It causes or is the result of distress and/or is dysfunctional.
- It is an out-of-the-ordinary response to particular circumstances.

Another criterion is that the individual may place them self in danger as a result of a distorted view of the world, although this is relatively infrequent even among those who may be thought of as having a mental health problem. These criteria can be summarised according to Comer as the 'four Ds':

- Deviance (from the norm)
- Distress
- Dysfunctional
- Dangerous.

Self Assessment Questions

1) Write how will you decide when any behaviour, such as social drinking or even shopping or Internet use, crosses the line from "normal" to "abnormal"?

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2) Is there a set of your own personal criteria you use in all cases? How does your criterion differ from the criteria specified in the unit?

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3) What are the various other models of abnormality?

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4) Why cultural diversity has to be considered while dealing with pathology?

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5) Describe the various criteria used for abnormality and normality.

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1.5 HISTORY OF PSYCHOPATHOLOGY

Descriptions of abnormal behaviour can be found amongst the historical records of the first civilisations and it is certain that the early Indians, Egyptians, Chinese, Greeks, etc., were familiar with the features of disturbed behaviour that we may, today, identify as mental illness.

Also for much of recorded history such people have found themselves marginalised, shunned or ridiculed, with their symptoms variously attributed to the processes of demonic possession, divine punishment, planetary influence or witchcraft.

More than 2,000 years ago, the Greek philosophers Hippocrates and Plato argued that mental illnesses had more commonplace causes. For instance Hippocrates considered physiological dysfunction as the cause for mental illness. On the other hand, Plato considered psychological conflict as the cause for mental disorders. Charaka and Susruta, physician and surgeon par excellence from India, who lived in 100 AD and 500 AD respectively, emphasised the importance of emotions in the causation of mental illness.

For them peace and happiness were the outcome of positive mental health. They too had put forth the theory of humoral disequilibrium brought about by one's improper lifestyle as the cause of illness.

Records for the next 1,500 years (of west) are very sketchy, although we know that this period of European history (known as the Dark and Middle Ages) was marked by a decline in rational scientific thinking and a return to religious superstition.

The weak position of mentally ill individuals was illustrated in 1484, when the Pope issued a decree reminding his emissaries that sudden loss of reason, amongst other signs, should be regarded as one of the features of demonic possession, for which the appropriate action was burning at the stake.

But outside Europe the story was not as bleak. In Arabia and parts of Asia there was a revival of scientific interest. An asylum for the mentally ill was built in Baghdad in 705 AD, providing humane treatment for its inmates. History records that in Arabia and Asia mentally ill patients received a much more humane and kind treatment than in Christian lands. The Muslim belief as stated by Prophet that the insane were loved by God, underlay this sentiment.

In India the spread of Buddhism and Jainism and Hindu medicine, which advocated humane treatment for the mentally ill, went a long way in making humane treatment available to the sick. In spite of these few bright sparks the period between 500 and 1000 AD was an age of mental and intellectual stagnation.

The idea that mentally deranged people might actually be ill first began to reappear at the time of major population shifts from rural to urban dwelling. As cities got larger, municipal authorities gave themselves powers to incarcerate people who appeared to be mentally unwell.

Initially, specific provision for the mentally unwell was restricted to a handful of institutions. For example, the Priory of Saint Mary of Bethlehem, founded in 1243, developed a facility for housing a small number of people with mental illness, which somewhat later was handed over to the City of London as an institution specifically for this purpose. Its name became corrupted and came to be known as Bedlam. It developed a degree of notoriety as a sort of tourist attraction, which people could visit to observe the behaviour of the inmates, both male and female. (Astonishingly, this practice continued well into the 1800s.)

Moral Treatment

The French Revolution in the late 1700s brought about a marked change in the methods of dealing with mentally ill people. The French physician Philippe Pinel was shocked to see the conditions under which the inmates of asylums were expected to live and, in the spirit of revolution, called for their unchaining. Pinel,

with his enlightened approach, known as moral treatment, attracted the attention of other like-minded individuals and gradually a change in attitude towards how best to manage mentally ill people spread through Western Europe.

For example, William Tuke, a Quaker, persuaded others from his religious group to fund the building of a mental hospital, The York Retreat, was founded in 1796. Here, patients received care and treatments similar to those advocated by Pinel.

Dorothea Dix (1802–1887), a Boston schoolteacher, travelled across the country decrying the deplorable conditions in the jails and almshouses where mentally disturbed people were placed. As a result of her efforts, 32 mental hospitals devoted to treating people with psychological disorders were established throughout the United States.

Institutional care of the mentally ill in India dates back to very old times which were supported by contemporary rulers as shown by the Edicts of Asoka (BC 250) and others. A special hospital exclusively for the mentally ill patients was established at Dhar, near Mandu in Madya Pradesh in the 15th century AD by Mohammed Khilji. This was the first asylum in the country. This asylum provided treatment according to the Ayurvedic and Unani systems of medicine.

Ironically, the success of moral treatment also contributed to its downfall in the latter stages of the nineteenth century, as it became apparent that mental illness was much more common than had previously been thought. (Tuke's Retreat could accommodate only thirty patients.)

As more people were recognised to be suffering from mental illness, major building programmes were instigated both in Europe and the United States, leading to the rapid growth in the number of state-run asylums for the mentally ill. Over a relatively short period in Victorian England, several hundred hospitals were built to accommodate many thousands of patients. The standards of care that prevailed in York could not be extended to these new hospitals and moral treatment fell out of favour.

The Modern Era: Brain or Mind

Despite the inevitable deterioration in provision for mentally ill people, by the end of the century there was renewed interest in science and in the principle of somatogenesis which had first been described by Hippocrates 2,000 years earlier. It was against this background that the discipline of psychiatry began to emerge and the work of Kraepelin and Bleuler came to prominence. At that time, melancholia, mania and phrenitis, first described by Hippocrates, were identified as mental disorders, and this list was expanded to include paranoia, catatonia and hebephrenia, among many others.

Kraepelin's best known contribution to psychopathology was his proposal that mental illnesses can be divided into two broad syndromes: dementia praecox and manic-depressive psychosis. He reached this conclusion on the basis of detailed recording, over long periods of time, of the features (the signs and symptoms) of illness displayed by his patients. Although Bleuler disagreed with Kraepelin on matters of detail, he too adopted precise methods and his fascination with the nature and causes of psychiatric symptoms was hallmark of his work.

Between them, Kraepelin and Bleuler shaped the direction that psychiatry has subsequently taken and their contributions are still much in evidence today. Kraepelin and Bleuler were convinced that mental illnesses had physical origins (the somatogenic approach). However, others believed that there were psychological (psychogenic) explanations of mental illness.

These ideas had originally been discussed by Plato and they began to receive increasing attention once again. Mesmer (1734–1815) is often credited with initiating the renewed interest in psychogenesis, having 'invented' a form of hypnosis that came to be known as 'mesmerism'. In the late nineteenth century there was an explosion of interest in the role of psychological mechanisms in illness.

Charcot, a prominent neurologist, demonstrated that symptoms characteristic of nerve damage could arise for psychological reasons and could be influenced by hypnotic suggestion. His colleague Breuer began using hypnosis as a treatment and it became apparent to him that, if he talked with his clients about their symptoms while they were under hypnosis, this often resulted in greater relief from symptoms.

Breuer's technique became known as catharsis and was for a time adopted by another Viennese neurologist, Freud, who saw it as a potentially powerful means of exploring the unconscious mind.

The Twentieth Century and Science

Our brief review has brought us to the beginning of the twentieth century. By this time most of the main ideas that have continued to dominate and shape the direction of modern psychopathology had already surfaced. During the past one hundred years, the pendulum has continued to swing between somatogenic and psychogenic explanations of disorder. Initially, the camps divided geographically, with the Europeans favouring somatogenesis, while practitioners in the United States preferred psychogenic explanations of mental illness.

The divide has, to some extent, fallen along occupational lines, with medically trained psychiatrists resorting to somatogenic approaches and psychologists, not surprisingly, tending to rely upon psychogenic explanations.

One of the main strengths of psychopathology over the past century has been a willingness on the part of practitioners to rely on empirical evidence gathered through scientific research. This approach has, for example, led to the demise of unsupportable procedures such as insulin coma therapy (an early treatment for schizophrenia).

On the other hand, it has established the advantages of equally controversial procedures such as electro-convulsive therapy (ECT). Not all scientific discoveries have favoured somatogenic approaches. For example, the value of biofeedback training to help control anxiety and the adoption of a procedure known as cognitive therapy in the treatment of depression, both tend to support psychogenic arguments.

Gradually, research in psychopathology has made people aware that neither a strictly somatogenic or psychogenic approach can fully explain how mental illnesses arise. Indeed, evidence suggests that most occur as a result of a

combination of factors, and a causal model known as the stress-diathesis model (Goldman 1992) has evolved to occupy this centre ground.

In simple terms, this model implies that mental illness is a reaction to life experiences in individuals who are vulnerable or predisposed in some way to that mental illness. One sort of predisposition may be genetic, but others may involve early brain damage or even early experience. The causative factors will inevitably vary, ranging from the effects of major and sudden life events such as bereavement or unemployment, to the minor but more enduring tensions of family life.

Self Assessment Questions

1) Trace the history of psychopathology in the medieval period.

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2) Trace the history of how mental illness was considered during the 17th and 18th centuries?

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3) What are the developments that took place during the 20th century regarding mental illness?

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Short questions

i) Write the names of the different perspectives in defining normality as offered by Offer and Sabshin?

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ii) Write the names of the different criteria as offered by Comer to determine that behaviour is abnormal?

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iii) How do views about abnormal behaviour vary across cultures?

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iv) How have views about abnormal behaviour changed over time?

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1.6 LET US SUM UP

The study of psychopathology is the search for the reasons people behave, think, and feel in unexpected, sometimes bizarre, and self-defeating ways. A person can be called normal if he is not sick, if he is average, if he confirms to social norms, or if he approximates an ideally mature, healthy or fully functioning personality. In addition to this he should be able to interpret correctly what is going around him, has control over his behaviour, is aware of his feelings and emotions, be able to establish close interpersonal relationships and finally lead a productive life. In evaluating whether behaviour is abnormal, psychologists consider several different characteristics: statistical infrequency, violation of societal norms, personal distress, behavioural dysfunction and failure to function adequately. Each characteristic tells something about what can be considered abnormal, but none by itself provides a fully satisfactory definition.

The debate about whether mental illnesses have somatogenic or psychogenic origins has dominated the history of psychopathology and can be traced back to the ideas of Hippocrates and Plato. Only recently have people begun to realise that mental disorders probably arise as a result of the combination of factors, rather than being due to single causes. Currently, integrated models of causation, like the stress-diathesis model, find the widest acceptance in psychopathology.

1.7 UNIT END QUESTIONS

1) Describe in detail the different norms used by mental health professions in defining normal behaviour?

2) Describe in detail the different criterion and models used by mental health professions in defining abnormal behaviour?

3) Write how has the treatment of people with mental disorders changed over time?

1.8 GLOSSARY

Incarceration : Incarceration is the detention of a person in jail, typically as punishment for a crime. People are most commonly incarcerated upon suspicion or conviction of committing a crime, and different jurisdictions have differing laws governing the function of incarceration within a larger system of justice. Incarceration serves four essential purposes with regard to criminals:

1) to punish criminals for committing crimes
2) to isolate criminals to prevent them from committing more crimes
3) to deter others from committing crimes
4) to rehabilitate criminals

Incarceration rates, when measured by the United Nations, are considered distinct and separate from the imprisonment of political prisoners and others not charged with a specific crime. Historically, the frequency of imprisonment, its duration, and severity have varied considerably. There has also been much debate about the motives for incarceration, its effectiveness and fairness, as well as debate regarding the related questions about the nature and etiology of criminal behaviour.

Psychopathology : This is the study of the causes, processes, and manifestations of mental disorders. It is the behavioural manifestation of any mental disorder.

Somatogenic : Arising from physiological causes. That is thbe mental disorder arises from physiological causes rather than being psychogenic in origin; “somatogenic theories of schizophrenia” . Here there is involvement of the body as distinguished from the mind or spirit.

Maladjustment : *Psychol* a failure to meet the demands of society, such as coping with problems and social relationships: usually reflected in emotional instability. It is a faulty or bad adjustment.

1.9 SUGGESTED READINGS

Carson, R. C., Butcher, J. N., & Mineka, S. 2003. *Abnormal Psychology and Modern Life*. Pearson Education: New Delhi.

Comer, R.J. 2010. *Abnormal Psychology*, 7th edition. Worth Publishers. New York.

Davison, G.C., Neale, J.M., Kring, A.M. *Abnormal Psychology*, 9th edition. Wiley & Sons:USA.

Sharma, R., 2006. *Abnormal Psychology*. Atlantic Publishers & Distributors: New Delhi.

UNIT 2 INTRODUCTION TO DSM IV AND DIAGNOSTIC CLASSIFICATION

Structure

2.0 INTRODUCTION

In the last unit, we had studied the meaning of normality and various alternative views of normality, concept of mental health, mental illness and the phenomena of psychopathology.

In this unit, we will describe how to classify mental disorders and teach you the classification in terms of the Diagnostic and statistical manual of mental disorders (DSM) which is a part of American Psychiatric Association. We will first discuss the concept of classification, its purpose, historical background and types of classification and then describe the major classification systems in use. Next, the unit would describe the DSM-IV classification in detail, its features and the multiaxial approach and we will also describe the major diagnostic categories and the symptoms and factors relevant to particular disorders. Lastly, we would evaluate the DSM classification and also discuss its major advantages and disadvantages.

2.1 OBJECTIVES

After studying this unit, you will be able to:

- Understand the purpose of classification;

- Know the major classificatory systems used in abnormal psychology;
- Describe in detail DSM-IV and its multiaxial classification system, including its major diagnostic categories; and
- Analyse the advantages and disadvantages of the modern classification system.

2.2 CLASSIFICATION IN PSYCHOPATHOLOGY

The structure of our language is based on classification. Every common noun such as tree, chair, and cat indicates category of "things". It is a natural human tendency to identify and categorise a wide range of observable phenomena and experiences with an aim to increase their understanding and their predictability. Classification is an attempt to bring order out of a mass of chaotic information. It is a process by which complex phenomenon are organised into categories, classes or ranks so as to bring together those things that most resemble each other, and to separate those that differ. This basic human tendency to categorise things is reflected in defining the illnesses as well.

2.2.1 Purpose of Classification

There are three major purposes of classification, viz., (i) facilitate comprehension (ii) enable communication (iii) help in prediction. Let us take each of these and explain.

i) To facilitate *Comprehension:* In psychopathology, comprehension means understanding the nature, causes and course of an illness and factors influencing them. By knowing the common characteristics of a particular group, details of its individual members are easily understood.

ii) To enable *communication:* Classification aids effective communication. The system provides a language with which health professionals in different parts of the world can communicate with each other. It serves as shorthand for describing the objects contained in them. Diagnosis conveys a lot of information in one or two words about the clinical picture with which a particular patient presents. For example, a diagnosis of recurrent depressive disorder would indicate that the patient has had at least two episodes of depression, each lasted for a minimum of 2 weeks and the episodes were separated by several months of normal mood state and the patient would have symptoms such as low mood, loss of interest and enjoyment, reduced energy and activity with disturbed sleep and appetite.

iii) Helps in *prediction*: Diagnosis helps to predict the prognosis. Many psychological disorders are associated with distinctive course and outcome. For example, the bipolar disorder is usually episodic and has good outcome while the personality disorders have poor outcome.

Apart from these general purposes, classification also serves specific purposes such as educational, clinical, administrative, legal, research, etc. Research helps in generation of hypothesis and prediction of outcome.

2.2.2 Types of Classification

Diseases may be classified in different ways, depending on the purpose they serve. They may be classified based on (i) etiology (causes), (ii) course and (iii) outcome and also (iv) based on symptoms.

Any classification of psychological disorders, like medical illnesses, should ideally be based on etiology. But, for a large majority of psychological disorders, no distinct cause is known at present, although there are many probabilities for each of them.

Hence, the only rational way to classify at present is syndrome based. A syndrome is defined as a group of symptoms and signs that often occur together, and which describes a recognisable clinical condition. This approach of classifying psychological disorders on the basis of their clinical signs and symptoms is very similar to the historical approach to classifying medical illnesses, when etiology of a majority of medical illnesses was still not known.

2.2.3 Historical Perspective

The earliest records on recognition and classification of mental disorders were found in references to them in Egypt and India as early as BC 3000. By BC 1500 India had its own classification of mental illness as seen in *ayurveda* (meaning the science of life), where spoiling of humors (vital bodily fluids or *pith*) and demonic possessions were responsible for different types of mental illnesses. A thousand years later Hippocrates (BC 460-337) described six types of mental disorders. He classified abnormal behaviours according to his theory of humors which states that illness occurs due to imbalance of humors in the body. Influenced by Hippocrates the Greek physician Galen developed the system further and this remained in use till the 18th century. In the early years of the 19th century, Philippe Pinel adopted a descriptive system of classification in which he divided the mental disorders into five groups: mania without delirium, mania with delirium, melancholia, dementia and idiocy.

The present day classification used in most of the countries is rooted in a system compiled by Emile Kraepelin (1855-1926). The table of contents of his *textbook of psychiatry* formed the basis for the modern classification. He observed that patients whose symptoms had a similar course suffered from the same disease. Long term observation of patients in mental hospitals helped him to differentiate illnesses depending on their course and outcome. By the end of the 19th century an outline of the present day classification had been laid down.

2.3 CLASSIFICATION SYSTEMS

At present, there are two major classification systems in use worldwide, namely ICD-10 (1992) and DSM-IV-TR (2000).

ICD-10 (The International Classification of Diseases, 10th Revision, 1992): is WHO's classification for all diseases and related health problems and not only mental disorders. Chapter 'F' classifies mental disorders as *Mental and Behavioural Disorders (MBDs)* and codes them on an alphanumeric system from F00 to F99.

DSM-IV-TR (The Diagnostic and Statistical Manual of mental Disorders, IV Edition, Text Revision, 2000): is the APA's (American Psychiatric Association's) classification of mental disorders. DSM-IV-TR is a text revision of the DSM-IV published in 1994. The latest version of theses classifications resemble each other in most of the details but differ in others. All the categories used in DSM-IV are seen in ICD-10 but all categories of ICD-10 are not seen in the other.

DSM is primarily formulated for use in a single country (United States). ICD, on the other hand is designed for international use and with variations in the official classification in Europe and several countries. In India ICD-10 is the official diagnostic system. Differences between the two classifications can be seen in the table below.

The next editions of ICD (ICD-11) and DSM (DSM-V) are likely to be available in the year 2011.

Table: ICD-10 and DSM-IV: Comparison

	ICD-10		DSM-IV
1.	International classification	1.	National classification
2.	Available in several versions	2.	Single version
3.	Available in different languages	3.	English language only
4.	Alphanumerical coding	4.	Numerical coding
5.	10 major categories of disorders	5.	17 major categories
6.	Single axis for chapter V (F)	6.	Multiaxial classification

Self Assessment Questions

1) Write, in five lines, the contribution of Kraeplin towards classification?

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2) Write, in four lines, the main purposes of classification?

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3) Write, in five lines, about the major classification systems widely used?

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2.4 THE DSM-IV

The 6th revision of the International Statistical Classification of Diseases was widely criticised and failed to gain acceptance except in very few countries. As an alternative to ICD-10 the American Psychiatric Association (APA) published a Diagnostic Manual in 1952 called *The Diagnostic and Statistical Manual*. This provided description for the categories of mental disorders which were listed.

In 1965 the second edition of DSM (DSM-II) was published which did not differ much from DSM-I. However it contained a glossary with definitions of the various disorders which the ICD-8 (published at the same time), lacked.

A third revision in an improved form was published in 1980 which was revised again and brought out as DSM-IIIR in 1987.

DSM-IV was published in 1994 and is complementary to ICD-10 and the latest version is a text revision called DSM-IV-TR published in 2000.

2.4.1 Features of DSM-IV

DSM-IV comprises of 17 major categories and over 300 specific disorders. The major categories included in DSM IV are as given in the box below.

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) Mood disorders
7) Anxiety disorders
8) Somatoform disorders
9) Factitious disorders
10) Dissociative disorders
11) Sexual and gender identity disorders
12) Eating disorders
13) Sleep disorders
14) Impulse-control disorders not elsewhere classified
15) Adjustment disorders
16) Personality disorders (Axis II)

Like ICD-10 the above is also a descriptive classification and is not etiologic. Specific diagnostic categories are provided for each mental disorder along with other details of the disorder like epidemiology details, course of illness, differential diagnosis, decision trees, etc. An important and distinct feature is the scope for multiaxial evaluation. The classification has five axes and the patient is simultaneously evaluated along several variables.

While Axis I provides information about clinical disorders, axis II provides information about personality disorders and mental retardation. Axis III provides information about any medical conditions that are presen, while Axis IV describes psychosocial and environmental factors affecting the person. Axis V is a rating scale called the Global Assessment of Functioning.(GAF)

The GAF goes from 0 to 100 and provides a way to summarise in a single number just how well the person is functioning overall. (These axes are dealt with in detail in the subsequent section)

In the DSM-IV, abnormal behaviour patterns are categorised according to the features they share. For example, abnormal behaviour patterns chiefly characterised by anxiety, such as panic disorder or generalised anxiety disorder, are classified as anxiety disorders. Behaviours chiefly characterised by disruptions in mood are categorised as mood disorders.

2.4.2 The DSM-IV Axes

Today, practitioners make use of a multiaxial classification system designed to summarise the diverse information relevant to an individual case rather than to provide a single label. Instead of merely assigning a case to a category (such as schizophrenia), clinicians using a multiaxial system can describe an individual in terms of a set of clinically important factors, or axes. DSM-IV provides information about the context in which abnormal behaviour occurs as well as a description of the behaviour. The axes of DSM-IV provide information about the biological, psychological, and social aspects of a person's condition.

The system contains the following axes:

Axis I: *Main clinical problem or disorder*

This axis includes a wide range of clinical syndromes, including anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, adjustment disorders, and disorders usually first diagnosed during infancy, childhood, or adolescence (except for mental retardation, which is coded on Axis II).

Axis II: Personality disorders and Mental Retardation

Personality disorders are enduring and rigid patterns of maladaptive behaviour that typically impair relationships with others and social functioning. These include antisocial, paranoid, narcissistic, and borderline personality disorders. Mental retardation, which is also coded on Axis II, involves pervasive intellectual impairment. People may be given either Axis I or Axis II diagnoses or a combination of the two when both apply. For example, a person may receive a diagnosis of an anxiety disorder (Axis I) and a second diagnosis of a personality disorder (Axis II).

Axis III: General Medical Conditions

All medical conditions and diseases that may be important to the understanding or treatment of an individual's mental disorders are coded on Axis III. For example, if hypothyroidism were a direct cause of an individual's mood disorder (such as major depression), it would be coded under Axis III. Medical conditions that affect the understanding or treatment of a mental disorder (but that are not direct causes of the disorder) are also listed on Axis III. For instance, the presence of a heart condition may determine whether a particular course of drug therapy should be used with a depressed person.

Axis IV: Psychosocial and Environmental Problems

The psychosocial and environmental problems that affect the diagnosis, treatment, or outcome of a mental disorder are placed on Axis IV. These include job loss, marital separation or divorce, homelessness or inadequate housing, lack of social support, the death or loss of a friend, or exposure to war or other disasters. Some positive life events, such as a job promotion, may also be listed on Axis IV, but only when they create problems for the individual, such as difficulties adapting to a new job.

Axis V: Global Assessment of Functioning (Level of functioning)

The clinician rates the client's current level of psychological, social, and occupational functioning using a scale similar to that shown in Table 1.2.4. The clinician may also indicate the highest level of functioning achieved for at least a few months during the preceding year. The level of current functioning indicates the current need for treatment or intensity of care. The level of highest functioning is suggestive of the level of functioning that might be restored.

An example of how this is recorded is given in the box below.

As an example, results of a DSM-IV multiaxial evaluation are recorded as:	
Axis I Major depressive disorders, single episode in partial remission	
Axis II	Borderline personality disorder
Axis III	Diabetes mellitus – type 1/insulin dependent
Axis IV	Social Isolation
Axis V	GAF 40

2.4.3 The Major Diagnostic Categories

Most research and treatment in psychopathology is targeted toward the Axis I and Axis II disorders. We now provide a brief overview of several of these disorders.

Disorders Usually First Diagnosed in Infancy, Childhood, and Adolescence

The DSM-IV lists ten major categories of childhood disorder, all of which, except mental retardation, are coded on Axis I. These disorders are grouped together primarily due to their time of onset rather than by their shared symptoms. In general, they reflect problems with development and maturation. These include disruptive behaviour, conduct disorder, Attention-deficit hyperactivity disorders, learning disorders, etc.

Delirium, dementia, amnesia, etc.

These disorders usually take us to the other end of the age-scale, and encompass serious and often irreversible impairments of cognition and mental function. They include Alzheimer's disease and Huntington's disease.

Substance-related disorders

Ingestion of one or more of a variety of substances (LSD, alcohol, etc.) is deemed to have brought about the change in mental functioning. They include alcohol use disorder, cocaine use disorder, etc.

Schizophrenia and other psychotic disorders

Marked to a greater or lesser extent by the presence of delusions (false beliefs), hallucinations (false perceptions) and disordered thinking. The individual's behaviour signals loss of contact with reality, either intermittently or indefinitely.

Mood disorders

As the name implies, the primary disturbance for this set of disorders is to mood (or affect). It encompasses various degrees of depression, mania, bipolar disorder (otherwise known as manic-depressive illness) and seasonal affective disorder.

Anxiety disorders

DSM identifies ten different types, including phobias, obsessive-compulsive disorder and post-traumatic stress disorder.

Somatoform and dissociative disorders

In the former, the individual repeatedly complains of physical symptoms which have no basis in reality. In the latter, there are sudden inexplicable changes to memory or consciousness (again, in the absence of any physical causes).

Sexua- and gender identity disorders

Sexual dysfunction disorders. The paraphilias, fetishism, pedophilia and sadomasochism are amongst those listed.

Eating and sleeping disorders

The former identifies anorexia and bulimia; the latter encompasses a range of sleep disorders including insomnia, narcolepsy and sleep apnea.

Factitious disorder

This rare diagnosis applies to people who deliberately induce physical or psychological symptoms apparently in order to gain attention.

Adjustment disorders

This refers to the development of an emotional or behavioural disorder, clearly related to some major life stressor, not meeting any other Axis 1 diagnosis.

Impulse control disorders

The name is self-defining. This controversial diagnostic category includes kleptomania, pyromania and even pathological gambling.

There are only two groups of Axis II disorders:

i) *Mental retardation*

People with this disorder display significantly sub average intellectual functioning and poor adaptive functioning by 18 years of age.

ii) *Personality disorders*

People with these disorders display a very rigid maladaptive pattern of inner experience and outward behaviour that has continued for many years. People with antisocial personality disorder, for example, persistently disregard and violate the rights of others. People with dependent personality disorder are persistently dependent on others, clinging, obedient, and very afraid of separation.

2.4.4 Problem of Labeling

A problem that occurs any time we categorise people is Labelling. Something in human nature causes us to use a label, even one as superficial as skin colour, to characterise the totality of an individual ("He's brown….. He's different from me"). We see the same phenomenon among psychological disorders ("He's a schizo"). The very act of classifying people can lead to unintended results for example many socio-cultural theorists believe that diagnostic labels can become self fulfilling prophecies.

When people are diagnosed as mentally disturbed, they may be viewed and reacted to correspondingly. If others see them as deficient and expect them to take on a sick role, they may begin to consider themselves sick as well and act that way. Furthermore, our society attaches a stigma to abnormality. People labelled mentally ill may find it difficult to get a job, especially a position of responsibility, or to be able to participate in social relationships. Once a label has been applied, it may stick for a long time.

Because of these problems, some clinicians would like to do away with diagnoses. Others disagree. They believe we must simply work to increase what is known about psychological disorders and improve diagnostic techniques (Cunningham, 2000). They hold that classification and diagnosis are critical to understanding and treating people in distress.

Self Assessment Questions

1) What is the importance of DSM IV?

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2) What is the difference between ICD 10 and DSM IV?

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3) What is the multiaxial system of diagnosis?

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4) Discuss the major diagnostic categories.

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2.5 EVALUATING THE DSM SYSTEM

To be useful, a diagnostic system such as the DSM must demonstrate reliability and validity. The DSM can be considered reliable, or consistent, if

i) different evaluators using the system are likely to arrive at the same diagnoses when they evaluate the same cases.

ii) if diagnostic judgments correspond with observed behaviour. For example, people diagnosed with social phobia should show abnormal levels of anxiety in social situations.

iii) Another form of validity is predictive validity, or ability to predict the course the disorder is likely to follow or its response to treatment. For example, people diagnosed with bipolar disorder typically respond to the drug lithium.

iv) Likewise, persons diagnosed with specific phobias (such as fear of heights) tend to be highly responsive to behavioural techniques for reducing fears.

Overall, evidence supports the reliability and validity of many DSM categories, including many anxiety and mood disorders, as well as alcohol and drug dependence disorders (Grant et al., 2006; Hasin et al., 2006).

Yet questions about validity persist for some diagnostic classes, such as Axis II personality disorders, as well as Axis V, Global Assessment of Functioning (Moos, McCoy, & Moos, 2000; Widiger & Simonsen, 2005). Overall, it is fair to say that the validity of the DSM remains a subject of ongoing debate and study.

Many observers have argued that the DSM should become more sensitive to cultural and ethnic diversity. The behaviours included as diagnostic criteria in the DSM are determined by consensus of mostly U.S. trained psychiatrists, psychologists, and social workers.

Had the American Psychiatric Association asked Asian trained or Latin American trained professionals to develop their diagnostic manual, for example, there might have been some different diagnostic criteria or even different diagnostic categories.

In fairness to the DSM, however, the latest edition does place greater emphasis than did earlier editions on weighing cultural factors when assessing abnormal behaviour. It recognises that clinicians unfamiliar with an individual's cultural background may incorrectly classify that individual's behaviour as abnormal when it in fact falls within the normal spectrum in his or her culture. The same behaviour might be deemed normal in one culture but abnormal in another.

The DSM-IV-TR specifies that in order to make a diagnosis of a mental disorder, the behaviour in question must not merely represent a culturally expectable and sanctioned response to a particular event, even though it may seem odd in the light of the examiner's own cultural standards.

The DSM-IV-TR also recognises that abnormal behaviours may take different forms in different cultures and that some abnormal behaviour patterns are culturally specific.

All things considered, the current edition of the DSM, the DSM-IV-TR, is widely recognised as an improvement over previous editions, even though questions remain about the reliability and validity of certain diagnostic categories and about the specific criteria used to reach certain diagnoses.

Self Assessment Questions

1) Evaluate the DSM IV.

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2) How does cultural factors play a role in diagnosis of a mental disorder?

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3) Please list some of the behaviours which are considered appropriate and normal in your culture but might be seen as abnormal in different cultures?

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2.6 ADVANTAGES AND DISADVANTAGES OF THE DSM SYSTEM

The major advantage of the DSM may be its designation of specific diagnostic criteria. The DSM permits the clinician to readily match a client's complaints and associated features with specific standards to see which diagnosis best fits the case. For example, auditory hallucinations ("hearing voices") and delusions (fixed, but false beliefs, such as thinking that other people are devils) are characteristic symptoms of schizophrenia.

The multiaxial system gives a comprehensive picture of clients by integrating information concerning abnormal behaviours, medical conditions that affect abnormal behaviours, psychosocial and environmental problems that may be stressful to the individual, and level of functioning.

The possibility of multiple diagnoses is taken care of by making the clinicians to consider presenting current problems (in Axis I) along with the relatively long-standing personality problems (in Axis II) that may contribute to them.

Criticisms are also levelled against the DSM system. Critics challenge the utility of certain conditions, like particular symptoms with particular syndromes or specific diagnostic criteria, such as the requirement that major depression be present for 2 weeks, be met before a diagnosis is reached (Faraone et al., 2006; Zimmerman et al., 2006).

Others challenge the reliance on the medical model. In the DSM system, problem behaviours are viewed as symptoms of underlying mental disorders in much the same way that physical symptoms are signs of underlying physical disorders. The very use of the term diagnosis presumes the medical model is an appropriate basis for classifying abnormal behaviours.

But some clinicians feel that behaviour, abnormal or otherwise, is too complex and meaningful to be treated as merely symptomatic. They assert that the medical model focuses too much on what may happen within the individual and not enough on external influences on behaviour, such as social factors (socio-economic, socio-cultural, and ethnic) and physical environmental factors.

Another concern is that the medical model focuses on categorising psychological (or mental) disorders rather than describing people's behavioural strengths and

weaknesses. Similarly, many investigators question whether the diagnostic model should retain its categorical structure (a disorder is either present or not).

Critics also complain that the DSM system might stigmatize people by labelling them with psychiatric diagnoses. Our society is strongly biased against people who are labelled as mentally ill. They are often shunned by others, including even family members, and subjected to discrimination.

The DSM system, despite its critics, has become part and parcel of the everyday practice of most U.S. mental health professionals. It may be the one reference manual found on the bookshelves of nearly all professionals. Perhaps the DSM is best considered a work in progress, not a final product.

Self Assessment Questions

1) Do we really need an authoritative diagnostic manual? Why or why not?

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2) How can we fix the problems of negative, derogatory connotations of diagnoses of mental disorders in our society?

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3) What are the advantages and disadvantages of the DSM system?

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4) What is the DSM? Use four lines for your answer.

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5) Why DSM is considered a multiaxial system? Use five lines for your answer

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6) What are the major strengths and weaknesses of the DSM?

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2.7 LET US SUM UP

Classification is necessary in all branches of knowledge. In the area of personality and abnormal behaviour, classification is based on assessment of what clients say and how they behave. It also takes account of events they have experienced in the present as well as their past histories. In abnormal psychology the classification of a person is referred to as a diagnosis. The diagnosis places the person's disorder within an existing system or grouping of disorders.

The classification is a descriptive one in which different types of disorders are described in detail. On the one hand, a descriptive classification system is valuable for communication concerning treatment, in research, and for statistical purposes. On the other hand, classification may result in labelling that creates stigmatization. In classifying individuals, it is important to characterise their problems within the context of their stresses as well as of their vulnerabilities, resiliency and coping abilities.

A multiaxial diagnostic system is designed, not to provide a simple label, but to summarise information about several aspects of the person's history and behaviour. Since 1980, the diagnostic system used for most purposes in the United States, the Diagnostic and Statistical Manual of Mental Disorders (DSM), has used a multiaxial system. DSM-IV has five axes: Axis I, the primary diagnosis; Axis II, personality disorders and mental retardation; Axis III, relevant physical conditions; Axis IV, recent stresses; Axis V, a global assessment of psychosocial functioning, currently and in the past year.

Axis I includes groupings for developmental disorders, serious cognitive disorders, substance-related disorders, sleep disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, dissociative disorders, sexual disorders, factitious disorders, impulse control

disorders not classified elsewhere, eating disorders, adjustment disorders and psychological factors that affect a physical condition. Axis II includes personality disorders and mental retardation.

The DSM approach is to use highly specific, descriptive diagnostic criteria for each category. This approach increases the reliability of diagnosis among clinicians. DSM-IV is more comprehensive and includes many more disorders and subdivisions of different disorders than previous editions. But more research is needed to know whether these additional classifications are justified. Overall, the changes in DSM-III, DSM-III-R, DSM-IV and DSM-IV R have added clarity to the diagnostic process.

2.8 UNIT END QUESTIONS

1) Write about the meaning, purpose and history of classification of mental disorders?

2) Write about the major differences between ICD-10 and DSM-IV?

3) Write in brief about the major diagnostic categories present in DSM-IV?

4) Critically evaluate the DSM system?

2.9 GLOSSARY

Syndrome : A cluster of symptoms that usually occur together.

Classification System : A list of disorders, along with descriptions of symptoms and guidelines for making appropriate diagnoses.

Diagnosis : The process of attempting to determine the identity of a possible disease or disorder and to the opinion reached by this process.

Course : 'usual' pattern that disease takes.

Prognosis : Medical term to describe the likely outcome of an illness.

Onset : Beginning or time when the signs or symptoms first appear.

Reliability : In psychological assessment, the consistency of a measure or diagnostic instrument or system.

Validity : The degree to which a test or diagnostic system measures the traits or constructs it purports to measure.

2.10 SUGGESTED READINGS

Bennett , Paul 2005. *Abnormal and Clinical Psychology: An Introductory Textbook*, 2nd Edn. Open University Press, McGraw-Hill Education: England.

Carson, R. C., Butcher, J. N., & Mineka, S. 2002. *Abnormal Psychology and Modern Life*. Allyn & Bacon: New York.

Mangal, S.K. 2006. *Abnormal Psychology.* Sterling Publishers: New Delhi.

Sarason, I.G., Sarason, B.R.2005. *Abnormal Psychology: The Problem of Maladaptive Behaviour.* Prentice-Hall of India: New Delhi.

UNIT 3 ETIOLOGY OF PSYCHOPATHOLOGY

Structure

3.0 INTRODUCTION

In unit 2, we learned several aspects of the classification of mental disorders, the DSM-IV and its major features and as well as its advantages and disadvantages. In this unit we will try to understand the different causes of abnormal behaviour.

In this unit we will explore the causal factors and as well as study the viewpoints which speak of the development and maintenance of abnormal behaviour. It is important to have an understanding of these causes in prevention and treatment of abnormal and maladaptive behaviour. For this purpose, we will examine

contemporary approaches to understanding abnormal behaviour from the biological, psychological and socio-cultural perspectives. Many scholars today believe that abnormal behaviour patterns are complex phenomena that are best understood by taking into account the different perspectives, rather than stressing any one causal factor. For this reason current view of abnormal behaviour tends to integrate several viewpoints. At the end of this unit we will describe the current approach — the integrative perspective for explaining the etiology of psychopathology.

3.1 OBJECTIVES

After studying this unit, you will be able to:

- Explain the causes of Abnormal Behaviour;
- Describe the biological factors contributing to abnormal behaviour;
- Explain the psychological factors causing abnormal behaviour;
- Analyse the Socio-Cultural Factors contributing to abnormal behaviour; and
- Describe the integrative models explaining abnormality.

3.2 ETIOLOGY OF ABNORMAL BEHAVIOUR

Knowledge of the causes of psychological disorders is important for two main reasons. First, in everyday clinical work it helps the psychologist to understand possible causes of an individual patient's psychological disorder. Second, it adds to the general understanding of mental disorders, which may contribute to advances in diagnosis, treatment, or prognosis. In this unit we will only deal with the first of these—the assessment of the causes of disorders.

When trying to understand the causes or etiology of abnormal behaviour there are really no clear cut answers as we have for understanding physical illnesses. Various viewpoints or models of the causes of abnormal behaviour have emerged because no single approach could satisfactorily explain all abnormal behaviours. Each approach focuses on important aspects of behaviour, although they fall short of explaining the entire behaviour. Behaviour, whether normal or abnormal, is determined by a multitude of factors. These factors can be grouped under three categories, viz., biological, psychological and socio cultural. These factors alone or in most cases jointly influence and give rise to the behaviour, that is normal or abnormal. Biological model include causal factors from the fields of genetics and neuroscience. Psychological model includes factors from psychodynamic, behavioural and cognitive processes. Social influences contribute in a variety of ways to psychopathology.

Irrespective of whichever viewpoint one follows, one should have an understanding of some important terms that are used in psychopathology to have clear understanding of the different types of causes and the role they play in the etiology of maladaptive and abnormal behaviour.

A *necessary cause* is a condition that must be there for a disorder to occur. For example, general paresis, a degenerative brain disorder cannot develop unless a person had syphilis. A necessary cause is not always sufficient to cause a disorder and therefore other factors may also be required.

A *sufficient cause* is a condition that guarantees the occurrence of a disorder. For example, one theory says that hopelessness is a sufficient cause of depression (Abramson et al 1995). According to this theory if you are hopeless enough about your future then you will become depressed.

A *contributory cause* is one that increases the probability of developing a disorder. For example, parental rejection could increase the probability that the child may have problems in handling close relationships later.

When there are multiple causes it is useful to group them into predisposing, precipitating, and perpetuating factors.

Predisposing factors determine the vulnerability to other causes that act close to the time of the illness. Many predisposing factors act early in life, for example, genetic endowment, the environment *in utero,* trauma at birth, and social and psychological factors in infancy and childhood.

Precipitating factors are events that occur shortly before the onset of a disorder and appear to have induced it. They may be physical, psychological, or social. Physical precipitating factors include diseases such as cerebral tumour, traumatic brain injury that is caused by accidents, and the effects of drugs taken for treatment or used illegally.

As for psychological causes, there are many as for example a psychological cause can be bereavement, losing a very near and dear person. This causes depression. While moving home is a social cause, some causes may act in more than one way; for example, a head injury may induce a psychological disorder through physical changes in the brain and through psychological effects.

Perpetuating factors (or maintaining factors) prolong a disorder after it has begun. Sometimes a feature of a disorder makes itself perpetuating (e.g. some ways of thinking commonly prolong anxiety disorders). Social factors are also important (e.g. overprotective attitudes of parents or care givers or relatives). Awareness of perpetuating factors is particularly important in planning treatment because they may be modifiable even when little can be done about predisposing and precipitating factors.

3.3 BIOLOGICAL FACTORS

The biological viewpoint focuses on mental disorders as diseases whose primary symptoms are behavioural or cognitive although their causes are biological or physiological as against the physical illnesses where the cause and symptoms are purely physical. According to this view, mental disorders are seen as disorders of the central nervous system and thus are sometimes inherited or caused by some medical factors like injuries or physical diseases. Psychological or environmental factors are not considered to cause these disorders. We will discuss 'five' of the most important categories of biological factors that seem to be responsible for maladaptive behaviour. These are given below:

- Neurotransmitter and Hormonal imbalances in the brain,
- Genetics,
- Constitutional liabilities,

- Brain structure,
- Physical deprivation or disruption.

3.3.1 Neurotransmitter and Hormonal Imbalances in the Brain

Neurotransmitter Imbalances

The 100 billion neurons in the central nervous system (CNS) communicate by chemical messengers called neurotransmitters. When these neurotransmitters become imbalanced they give rise to many psychological problems. Biological approaches to treatment focus mainly on medications that rectify neurotransmitter imbalances.

Neurotransmitters (e.g., serotonin, dopamine, nor epinephrine, GABA) are released into the synaptic cleft*. They regulate level of mood, anxiety, and cognitive functioning.

Factors affecting neurotransmitter imbalance include:

1) Excessive production and release of the neurotransmitter substance into the synapses, causing an excess in levels of that neurotransmitter.

2) Dysfunctions in the normal processes by which neurotransmitters are deactivated after they are released into the synapse. This deactivation is done in two ways. They are either deactivated by enzymes present in the synapse or reabsorbed or sucked back into the presynaptic axon button, a process called re-uptake. Dysfunctions can occur when the enzymes in the synapse are deficient or there is slowing of the process of re-uptake.

3) Problems in the receptors in the postsynaptic neuron, which may either be abnormally sensitive or insensitive.

Different disorders are thought to occur from different patterns of neurotransmitter imbalances. Different types of drugs that are used to treat various disorders are believed to work by correcting these imbalances. For example, the antidepressant drug Prozac slows down the re-uptake process of the neurotransmitter serotonin. Dopamine has been implicated in schizophrenia and GABA has been strongly implicated in anxiety.

3.3.2 Hormonal Imbalance

Hormones are chemicals messengers secreted by the endocrine glands (e.g., pituitary). They play a role in the functioning of the nervous system and in the regulation of behaviour (e.g., during adolescence, changes in the hypothalamic-pituitary-adrenal axis are involved in the increase in cortisol, a stress-related hormone). Malfunction of this system has been said to be responsible for various forms of psychopathology. Hormonal influences are also responsible for the differences in behaviour between men and women.

3.3.3 Genetics

Genes play an important role in determining risks for both psychotic and non psychotic disorders. For example, the lifetime risk of schizophrenia is 1%, but for the offspring of an affected person it becomes 10% and in bipolar disorder is 20%.

For many years, twin studies served as the most direct way of determining whether or not a disorder has a genetic basis. In the classic twin study design, the similarity of monozygotic ('identical') twins and disygotic ('fraternal') twins are compared. Because monozygotic twins share all of their genes and disygotic twins share only half their genes, greater similarity among monozygotic twins than among disygotic twins implies a genetic component.

Another genetically informative design that has been used in psychopathology research is the adoption design. In this design, the prevalence of psychopathology in adopted children is examined as a result of psychopathology in their biological parents and in their adoptive parents. If there is a significant association between psychopathology in the adopted individuals and their biological parents, a genetic influence is suggested; if there is a significant association between psychopathology in the adopted individuals and their adoptive parents, a family environment influence is suggested.

For most major mental disorders (e.g., schizophrenia, the major mood disorders, anxiety disorders, alcohol-use disorders), twin and/or adoption studies have demonstrated significant genetic effects. However, these studies also demonstrate equally, if not more, important environmental effects. However, psychologists often assume that 'environment' means the family or psychosocial environment and this is not necessarily the case. Factors such as the prenatal environment and viral infections are all part of the 'environment' in genetic terms.

Recent years have witnessed a revolution in molecular genetics. As a result, we are no longer primarily interested in conducting twin or adoption studies to determine whether or not a disorder has a genetic component. Today, and increasingly in the future, we are more concerned with the discovery of the specific genes that are inherited and how they act to produce mental disorders.

Using several different techniques to analyse DNA (the molecular basis of genes), researchers are now in a position to correlate the presence of specific genes with specific mental disorders. The task is complicated because existing research suggests that most mental disorders are caused by multiple genes (polygenic), making it very difficult to discover each individual gene that is associated with a disorder.

Finally, there are so many genes that the thousands of analyses undertaken in a single study can sometimes lead to false positive findings. Thus replication of positive findings is crucial. Despite these problems, it seems highly likely that in the next decade many genes associated with mental disorders will be identified.

3.3.4 Constitutional Liabilities

The term 'constitutional' is used to describe any characteristic that is either innate or acquired early in life often at prenatal stage and in such strength that it is functionally similar to a genetic characteristic. Physical handicaps and temperament are some of the traits included in this category.

Embryonic abnormalities or environmental conditions operating before or after birth may result in physical defects. The most common birth difficulty associated with learning disabilities and behavioural and emotional disorders is low birth weight. Prenatal conditions that can lead to premature birth and low birth weights

include nutritional deficiencies, disease, and exposure to radiation, drugs, severe emotional stress or mother's excessive use of alcohol or tobacco. Socio-economic status is also related to foetal and birth difficulties.

The temperament of an infant or young child has profound effects on a variety of important developmental processes (Rothbart & Ahadi, 1994). For example, a child with fearful temperament would become conditioned to 'fear situations' in which fear is provoked. Later the child may learn to avoid entering these feared situations and evidence suggests that they might be likely to learn to fear social situations.

A child with a low threshold or low tolerance for distress may also learn to regulate distress by keeping the level of stimulation low, whereas a child with a high need for stimulation may do things to increase stimulation. Given these effects on various developmental processes, it can be said that temperament might also cause various forms of psychopathology in later life. For example, children who are fearful in many situations might be at risk for developing anxiety disorders later in childhood or in adulthood.

3.3.5 Brain Structure

Knowledge about brain structure has increased with the advances in computed tomography (CT) scanning and magnetic resonance imaging (MRI). This has lead to many notable observations. For instance, neuroimaging in some patients with schizophrenia shows dilated cerebral ventricles and reduced frontal lobe density. This evidence indicates that schizophrenia may be neurodevelopmental in origin. Exposure to adverse conditions which can affect brain development (in utero or in early life) may lead to changes in the frontal lobes that increase the risk of schizophrenia. Neuroimaging also helps us to distinguish between different types of dementia. Also, some older people experiencing severe depression for the first time might have underlying cerebro-vascular disease.

3.3.6 Physical Deprivation or Disruption

The most basic human requirements are those of food, water, oxygen, sleep and elimination of wastes. Insufficient rest, inadequate diet or working too hard when ill, can all interfere with a person's ability to cope and might predispose him or her to a variety of problems. Experimental studies of volunteers who have gone without sleep for 72 to 98 hours show psychological problems like disorientation for time and place and feelings of depersonalisation. Prolonged food deprivation also affects psychological health. Severe malnutrition in children not only impairs physical development and lowers resistance to disease but it also stunts brain growth, results in lowered intelligence and increases risk for disorders like attention-deficit disorder.

Healthy mental development depends on a child's receiving adequate stimulation from the environment. In addition to the psychological problems which can result by too little stimulation, the physical development of the brain is also affected by an unstimulating environment.

Many animal studies have demonstrated that under conditions of special stimulation, such as enriched and complex environments in which many different activities can be engaged in, the animals were provided varying stimulation. It

was found that there were positive changes in brain chemistry and structural changes in many parts of the brain (Diamond, 1988; Nelson & Blum, 1997). On the other hand sensory overload can also impair adult functioning.

> Critical thinking.....
>
> Some severe psychiatric conditions such as Huntington's disease in which the individual develops increasing muscular spasticity and mental deterioration leading to death in middle age can be predicted by genetic testing. It cannot be prevented, but those who have the gene for the condition may choose not to have children and pass the gene on to them. Would you want to know as a young person whether you carry the gene?

3.4 PSYCHOLOGICAL FACTORS

Personality 'traits' are usually defined as those aspects of how one person relates to others, reacts to interpersonal stimuli and evaluates themselves over time. For all this, a person may laugh, cry, be angry, be thoughtful and act unkindly at different times. This does not mean that their 'personality' is constantly changing – it is the overall balance of thinking, feeling and behaviour that is important, not how they react in any specific situation.

A key factor is flexibility. More 'mature' personalities have a wider range of responses to cope with different circumstances. Those with a more limited range may manage in predictable situations but not in more challenging ones. For example, obsessional people may cope well with a highly predictable office job but do poorly in a management type position where tasks are less clearly defined.

There are several causes of how personality develops. Most are based on close, long term clinical observations and offer important insights into how people think and feel.

3.4.1 Psychodynamics and the Parent-Child Relationship

Freud emphasised the role of the early parent–child relationship in the development of mental illness. According to Freud, to the extent that the child did not successfully negotiate the psychosexual stages, mental illness would develop.

But Freud did not focus on what actually occurred in the parent–child relationship (e.g. whether parents were actually poor caretakers). Instead, his focus was on the unconscious internal desires and motivations of the child (e.g. sexual and aggressive impulses) and how the child negotiated them as s/he progressed through the early relationship with the child's parents. For example, if an adult male found himself unable to deal with authority figures, this might be interpreted as unresolved aggressive impulses towards his father. Whether his father behaved as a harsh authority figure or not would be considered less relevant. So, according to Freud, mental illness is due to intra-psychic (i.e. within the mind) conflict. This means a person may have very little insight into the 'true' causes of their symptoms, as these are thought to be occurring at an unconscious level of processing.

Many of Freud's ideas have gone unsupported by research, but a number of them have proven to be fairly accurate. For example, there is ample evidence that people experience and process things at an unconscious level (Westen, 1998) and that early interpersonal experiences affect later outcomes. In fact, this latter hypothesis became central to contemporary psychodynamic models of abnormal behaviour.

Contemporary psychodynamic models (e.g., Kohut, 1977; Kernberg, 1976; Mitchell, 1988) also suggest that the early parent child relationship is the original source of mental illness, and that what goes on in the mind of the child (and the adult) is important. But these models differ from Freud's in that they focus more on interpersonal relationships than on intra-psychic conflict. These later models suggest that the early relationship between the child and the primary caregiver is crucial to the development of the self-concept, concepts of others, and the quality of relationships throughout life. The idea is that this early caregiver and child relationship is internalised by children, so that they learn about themselves and others from the manner in which the caregiver treats them. According to this framework, the nature of this internalised relationship and its resulting impact on the sense of self and the sense of others is what can create vulnerability to psychological problems. Table below presents the different stages of evelopment according to Psychoanalytical approach and the associated problems thereof that can develop if the concerned stage of development is not passed through without difficulty. If there had been conflicts and the child could not pass through the stage without difficulties, certain problems can arise which are given below in the table.

Table: Some adult personality characteristics associated with a failure to progress through Freud's development stages

Stage	Associated Problems that may develop
Oral	Depression, narcissism, dependence
Anal	Obstinacy, obsessive-compulsive disorder, sadomasochism
Phallic	Gender identity problems, antisocial personality
Latent	Inadequate or excessive self-control
Genital	Identity diffusion

3.4.2 Attachment and Security

The attachment model of psychopathology, developed by Bowlby (1969; 1973; 1980) resembles the contemporary psychodynamic models in that it also emphasises the early parent child relationship and how the resulting models of self and others guide development. However rather than being interested in people's perceptions of their early experience, Bowlby was interested in the actual characteristics of the relationship. He relied on observational studies of parents and children to build his theory, rather than on retrospective reports of adults. The theory therefore has a strong empirical foundation.

Attachment theory suggests that when parental behaviour fails to make children feel safe, secure, and able to turn to and trust the parent in times of need, then children will be unable to regulate their emotions and needs adaptively and will develop negative, 'insecure' views of themselves and others. This would put

children at risk for developing psychological disorders. Research supports this hypothesis, as 'insecure' children and adults who show more psychopathology than 'secure' children and adults (see Dozier, Stovall & Albus, 1999; Greenberg, 1999).

3.4.3 Learned Behaviour

Behavioural models suggest that all behaviours, abnormal included, is a product of learning, that is mainly learning by association. For example, according to the classical conditioning model of learning (e.g. Pavlov, 1928), if a person experiences chest pain which results in anxiety while shopping in a departmental store, he may develop a fear of departmental stores and begin to avoid them because he associates them with anxiety. There is nothing inherently frightening about departmental stores, but this person fears them because of the association that he has formed with his earlier anxiety about having a possible heart attack.

To cite another example which instead of classical conditioning approach uses the operant model of learning (e.g. Skinner, 1953). Let us say a young normal weight woman begins to lose weight and her friends and family praise her for doing so, she may continue to lose weight, even if it means starving herself. Her restricted eating behaviour will continue because she now associates a reduction in her diet with the praise and acceptance of others.

There is a third type of learning, called as the observational learning. This does not rely on personal experiences to establish associations. In observational learning (modelling), behaviour is learned simply by watching someone else do something and observing what happens to them (Bandura, 1969). For example, a young boy may learn to be aggressive after watching his peers act aggressively.

Each of these learning models was built on a solid foundation of empirical research, and there is a great deal of evidence that each of the three learning processes plays an important role in abnormal behaviour.

Behavioural work with animals first led to the idea that repeated unpleasant experiences, over which an individual has no control, might induce a state of *learned helplessness.* Seligman (1974) subjected dogs to inescapable electric shocks: at first they ran around in a distressed way, but then they seemed to give up and passively accept the painful stimulation. Seligman was impressed by the apparent similarity between their behaviour and the symptoms of depression. Translating this work to the human situation would imply that some people learn to expect that, no matter what they do, their efforts seem to end in failure. It is this sense of helplessness and lack of control that leads to depression.

3.4.4 Distorted Thinking

Cognitive models of abnormal behaviour focus on the way people think about themselves, others and the world (e.g. Beck et al., 1979). Distorted cognitive processes – such as selectively attending to some information and ignoring other information, exaggerating negative feelings, expecting the worst, or making inaccurate attributions about events have been shown to play an important role in various types of psychological disorders.

For example, suppose a woman has a bad day at work. If she says to herself, 'Oh well, tomorrow will be better', she will probably feel fine. But if she says to

herself, 'Oh, I'm just a horrible person with no future' (i.e. if she exaggerates her negative feelings), she may become depressed. Or suppose a young man loses at a game of carroms. If he thinks, 'I sure had bad luck with the carroms today', he will feel fine. But if he thinks, 'my rotten friends purposely cheated me!' he may become hostile and aggressive.

3.4.5 Family Theories

Some psychologists have suggested that psychosis is a way of thinking and behaving acquired in childhood, usually as a result of the attitudes, communication and behaviour of parents. Fromm-Reichmann (1948) coined the term *schizophrenogenic mother,* to describe a parent who was cold, domineering and manipulative, and who had a marked tendency to induce conflict in others around her. According to Fromm-Reichmann, this combination of characteristics made these mothers unable to show normal affection to their children. She considered that this deficiency in mothering caused the child to develop a lifelong distrust and resentfulness towards others and thereby to go on to develop schizophrenia.

Bateson *et al.* (1956) argued that schizophrenia develops as a result of repeated exposure to a process called the *double-bind.* This term means communications that are inherently contradictory or conflicting, and which put the child in a 'no win' situation. For example, a child would be in a double-bind if he were told by his parents to go outside and play outside in a muddy garden, but also that he must not get his clothing dirty. The child would have no opportunity to please his parents, as all of the actions open to him would be likely to lead to parental disapproval. But there is little, if any, scientific support that shows mothers of patients to be aloof, cold or rejecting, or that people with schizophrenia were repeatedly exposed to double-binds as children.

Lidz *et al.* (1958) suggested that abnormalities in the relationships between the parents of mentally ill patients were primarily responsible for their developing psychological problems. They coined the terms *skew* and *schism* to describe such relationships. *Skew* describes a marriage where one partner is dominant and the other submissive, while *schism* describes the relationship in which parents are emotionally distant from one another. He proposed that, over a period of time, these dysfunctional patterns of interaction would be psychologically harmful to the child, leading ultimately to their developing psychopathology.

According to Laing, abnormalities in relationships within the family, together with abnormal communication between parent and child, undermine the child's sense of self.

Outright parental abuse (physical, sexual or both) of children has also been associated with many negative effects on the development of children. Abused children often have tendency to be overly aggressive both verbally and physically and some even respond with anger and aggression to friendly overtures from classmates. Researchers have also found that maltreated children have difficulties in linguistic development and might also develop depression and anxiety.

3.5 SOCIO-CULTURAL FACTORS

In contrast to the psychological and biological perspectives proposed by psychologists and psychiatrists, sociologists have long emphasised the influence

of various socio-cultural factors on mental disorder. These factors are discussed below.

3.5.1 Social-Economic Status

Social class is one of the most important causal factors in mental illness. This has been clearly and consistently demonstrated by studies related to mental disorder. It was found that those from the lower economic classes are more likely than those from other classes to be mentally ill. Although mental illness among the low socio-economic classes is more likely to be reported to the authorities, surveys on random samples of the population have consistently found a greater percentage of lower class people suffering from psychological symptoms.

There are two conflicting explanations of this. One, called social causation, suggest that lower economic class people are more prone to mental disorder because they are more likely to experience social stress (e.g. unemployment, separation), to suffer from psychic frailty, infectious diseases, neurological impairments, and to lack good medical treatment, coping ability and social support. Through an accumulation of these problems, and the stresses that result, low social status becomes a cause of mental illness.

The other explanation emphasises social selection or drift. This suggests that mentally ill people from higher social classes often drift downward into the lower class areas, (due to job loss, unemployment) helping to increase the rate of mental illness in such neighbourhoods. This explanation suggests that being lower economic class is a result of mental illness among formerly higher status individuals. Both explanations may be true to some extent.

3.5.2 Gender

The next social factor associated with mental illness is gender. There are conflicting findings as to which gender is more likely to become mentally ill. In most studies women are found to have a higher rate of mental disorder, but some others find men to be more predominant or no difference between the sexes.

These conflicting findings, however, refer to mental illness most generally. Studies on specific types of disorders, however, do indicate gender differences. These usually show that women predominate in depression and anxiety disorders, while men more commonly have antisocial personalities, paranoia, drug and alcohol abuse disorders. Most sociologists' attribute this difference to differences in gender roles.

The female role is relatively restrictive and oppressive, likely to confine the woman to her inner self, such that she tends to keep her frustration and anger to herself rather than aggressively pour it out on others. Hence women are more likely to fall victim to depression and anxiety. Men, on the other hand, have a more liberated role, and they are encouraged to be bold, assertive and aggressive in social relations. If frustrated and angry, they are more likely to take it out on others — behaving as antisocial and paranoid individuals.

3.5.3 Age

Another social factor that has been associated with mental disorder is age. Studies conducted before the 1980's suggested that older persons were more likely to

suffer from mental disorders. This was attributed to societal neglect of the elderly eventually resulting in institutionalisation, where the neglect can continue. Yet, more recent studies in the 1980's and 1990s show that the elderly are the least likely among all age groups to become mentally ill.

The increasing prevalence of depression among younger people can be attributed to changes in modern society, that is an increase in social stresses coupled with a decrease in social resources for dealing with them. Most of these stresses come from family problems (e.g. divorce, child abuse, or parental indifference). The difficulty in coping comes largely from the loss of the extended family and close-knit village-like community in modern society. Research has shown, for example, that lack of parental love and affection, divorce, and other factors can significantly contribute to the development of depression, anxiety, or other types of mental disorder.

3.5.4 Race and Ethnicity

A third social factor in mental disorders is race and ethnicity. Like gender, these have not been consistently found to be related to mental illness in general. While many studies have shown higher rates of psychological stress among minorities, the standard explanation has been that these groups experience more social stresses stemming from discrimination, poverty and cultural conflict.

On the other hand, there are studies showing no significant difference in psychological problems between minorities and whites in U.S. An explanation for this finding could be: minority group identification, group solidarity, or social networks which protect them against these social stresses, for example people from India who have settled in west tend to form social groups, clubs or cultural societies. The same explanation has been offered to account for the lower rate of mental illness among British minorities.

More consistent data are available on the relationship between race or ethnicity and specific forms of mental disorder. In the U.S., Puerto Ricans and African Americans are more likely than Irish or Jewish Americans to have sociopathic inclinations or paranoid tendencies. Jewish Americans, in contrast, tend more to manifest depressive disorders. In addition, Americans of Korean ancestry, have more depressive symptoms than whites.

3.5.5 Urban Environment

An important social factor implicated in mental illness is the urban environment itself. Community surveys indicate higher rates of mental disorders in urban areas, particularly the inner city, than in rural areas, including the suburbs and small towns. It is argued that the urban environment produces a lot of mental problems because it generates an abundance of physical and social stresses (e.g. traffic congestion, noise, population density, tenuous social relations, loneliness and lack of social support). Some community studies also reveal a link between urban living and specific psychological problems (e.g. neurotic and personality disorders).

In contrast, more serious psychotic conditions are more prevalent among rural and small town residents. This could be explained by the argument that rural and small-town residents find their lives too restrictive, and they are not able to express

frustration and anger in the presence of others — who may easily find out who the troublemakers are. By suppressing their frustration, they may get deeper and deeper into themselves until they become psychotic. In contrast, urban dwellers can get away from family and friends, are freer to express frustration in the midst of strangers, and tend more to tolerate unconventional behaviour. If they persist in doing so, urbanites may become neurotics, who, unlike psychotics, retain their grip on conventional reality. Otherwise, they may develop an antisocial psychopathic personality, which is essentially an "acting out" disorder.

3.5.6 Social Networks

Having caring and close relationships strongly protects against most non psychotic forms of mental illness. Supportive social networks, particularly family, are crucial in times of crisis. Such networks extend beyond family and close friends, and in many communities include religious groups. People with psychological illness tend to have more impaired social networks than their peers.

3.5.7 Migration

Immigrants are not a homogenous group. Economic immigrants (those who chose to migrate in search of a better life) often have better than average mental health. In contrast, refugees from war and persecution have often suffered experiences that affect their mental health adversely.

Sometimes first generation immigrants appear to have lower rates of mental illness because of low rates of recognition. By contrast, the second generation may have higher rates, partly due to conflict between the cultural norms of the host society and the expectations of their parents. There may also be an effect of time on presentation. One study of southern European women immigrants found that they developed depression about fifteen years after arrival.

It was suggested that while initially they were busy helping their husbands and children to settle (i.e. their children became fluent in English and their husbands became established in their jobs) the women became increasingly isolated and eventually lost their meaningful role.

Thinking about . . .

Most strategies for reducing the burden of mental health disorders have focused on treatment once they have developed. The importance of social and cultural factors points to another way of addressing the issue: to reduce the social, economic and cultural factors that may contribute to poor mental health. This could be done in a number of ways – anti-bullying campaigns in schools, providing cheap or free crèches so that young single mothers can access recreational facilities or have a break from child care, ensuring economic security for people in old age – that on the surface have little to do with mental health, but may actually have a significant impact on it

So, if you are given free rein, how would you change the society in which we live to maximize the mental health of the general population?

3.6 INTEGRATIVE MODELS

The models of abnormal behaviour described above are quite different from one another, and each is more or less well suited to particular disorders. As most disorders are quite complex, no single model can provide a full explanation of their onset and course over time. Instead, each model can help us to understand a different aspect of each disorder. This is where integrative models are useful.

You may have noticed that only some of the models above explicitly focus on childhood factors that may contribute to the development of abnormal behaviour, whereas the others only do so at an implicit level. For example, behavioural models suggest that abnormal behaviour is the product of 'earlier' learning experiences, but they don't elaborate on exactly what those experiences are. By contrast, *developmental psychopathology* provides a more rigorous framework for understanding how psychopathology develops from childhood to adulthood. It is also likely that mental illness results only when particular combinations of factors are present. This notion is at the heart of the *diathesis–stress model*.

3.6.1 The Diathesis–Stress Model

Research in psychopathology has made people aware that neither a strictly biological or psychological approach can fully explain how mental illnesses arise. Evidence also suggests that most occur as a result of a combination of factors, and a causal model known as the *stress-diathesis model* (Goldman 1992) has evolved. In simple terms, this model implies that mental illness is a reaction to life experiences in individuals who are vulnerable (a diathesis) or predisposed in some way to that mental illness. One sort of predisposition may be genetic, but others may involve early brain damage or even early experience. The causative factors (stress) will vary, ranging from the effects of major and sudden life events such as bereavement or unemployment, to the minor but more enduring tensions of family life. This approach can also be called as biopsychosocial approach.

Diatheses and stressors can be defined broadly. For example, a genetic or biological predisposition to mental illness might be the diathesis, and a troubled parent–child relationship could be the stressor; or a dysfunctional pattern of thinking about the world can be the diathesis, and a major life event the stressor.

3.6.2 Developmental Psychopathology

According to this model, psychopathology is best understood using a lifespan development approach. It considers how the negotiation and attainment of earlier developmental tasks affects people's capacities to manage later tasks (e.g. Cicchetti, Rogosch & Toth, 1994).

In other words, people may travel down one of many paths, their success or failure at various junctures along the way determines the subsequent path that they follow. So, earlier deficits in functioning may leave us unprepared to successfully negotiate subsequent related situations, putting us at even greater risk for psychopathology. For example, a young girl who is harshly and chronically criticized by her parents may develop low self-esteem and the expectation that people will not like her, which puts her at risk of becoming depressed.

She may then have difficulty making friends in school because she is afraid of rejection. She may feel lonely and undesirable, her withdrawal leading to actual rejection by her peers, continuing her risk for depression. But if this young girl has a teacher who treats her with warmth and care and helps her learn how to make friends, her risk for depression might be reduced.

This is because she is acquiring important skills that have the potential to change the course of her subsequent development.

Self Assessment Questions

Exercise: 1

Multiple choices

1) ..... theorists believe that severe problems in the relationships between children and their caregivers may lead to abnormal development and psychological difficulties.

   a) Ego, b) Self, c) Behaviour, d) Object relations

2) ..... are chemicals released into the bloodstream.

   a) Genes, b) Synapses, c) Neurotransmitters, d) Hormones.

3) Behavioural therapists base their explanations and treatments of mental abnormality on principles of

   a) Relationships, b) ego development, c) dream analysis, d) learning

4) Which is an inaccurate statement about the role of genes in abnormal behaviour?

   a) Genes probably play a part in mood disorders.

   b) Researchers are able to identify some specific genes that cause some major mental disorders.

   c) Researchers have not been able to identify any specific genes that cause most mental disorders.

   d) In most cases, many genes combine to help produce dysfunctional behaviour.

5) A researcher who examines the physiological responses associated with a psychological disorder is interested in which perspective?

   a) Social, b) behavioural, c) biological, d) developmental

6) Much of our development and most of our behaviour, personality and IQ are influenced by many genes, each contributing only a portion of the overall effect. This type of influence is known as:

   a) Integrative, b) polygenic, c) reciprocal, d) recessive

7) Which model states that individuals inherit tendencies to express certain traits or behaviours, which may then be activated under conditions of stress?

   a) Developmental, b) stress management, c) diathesis-stress,
   d) non genomic inheritance

8) Reuptake occurs when

   a) A neurotransmitter is drawn back into the nerve cell from the synaptic cleft

b) Individuals with mental illness are moved against their will into mental institutions.

c) A person experiences the same type of mental illness multiple times.

d) Nerve impulses travel from the sense organs to specific areas of the brain.

9) In the diathesis-stress model, "diathesis" refers to

a) An inherited tendency or condition that makes a person susceptible to developing a disorder.

b) The conditions in the environment that can trigger a disorder depending upon how severe the stressors are

c) An inherited disorder

d) The inheritance of multiple disorders

10) People who have many social contacts and live their lives continually interacting with others

a) Often suffer from psychological disorders such as dependency

b) Have not been found to differ on any health outcome

c) Live longer and healthier lives

d) Develop more infections and have poorer overall health.

3.7 LET US SUM UP

The causes of abnormal behaviour are complex and fascinating. We can say that psychological disorders are caused by nature (biology) and by nurture (psychosocial) and we would be both right and wrong.

To identify the causes of various psychological disorders, we must consider the interaction of all relevant dimensions i.e. genetic contributions, the role of the nervous system, behavioural and cognitive processes, emotional influences, social and interpersonal influences, and developmental factors. Thus, we have arrived at a multidimensional integrative approach to the causes of psychological disorders.

The field of neuroscience promises much as we try to understand psychopathology. Within the nervous system, levels of neurotransmitter and neuroendocrine activity interact in very complex ways to modulate and regulate emotions and behaviour and contribute to psychological disorders. Critical to our understanding of psychopathology are the levels of neurotransmitter and hormones. Imbalances in their levels could lead various types of psychological problems.

The genetic influence on much of our development and most of our behaviour, personality and even our IQ is polygenic i.e. influenced by many genes. This is assumed to be same for abnormal behaviour as well, although research is beginning to identify specific small groups of genes that relate to some of the major psychological disorders.

The psychodynamic, behavioural and cognitive models provide a valuable perspective on how the parent-child relationship, type of learning and the way we process information affect the adaptation each of us experience throughout

life. Social and interpersonal influences profoundly affect both psychological disorders and biology.

In considering an integrative approach to psychopathology it is important to understand the various paths to a particular outcome not just the results. In the diathesis-stress model, individuals are assumed to inherit certain vulnerabilities that make them susceptible to a disorder when the right kind of stressor comes along. Psychopathology should also be understood in terms of the life span developmental approach.

3.8 UNIT END QUESTIONS

1) What are the biological underpinnings of abnormal behaviour?

2) What are the major psychological factors of abnormal behaviour?

3) What is the basic idea underlying the socio-cultural perspective on abnormal behaviour?

4) What is the diathesis-stress model?

3.9 GLOSSARY

Perspective : **A** view

Prognosis : Is a medical term to describe the likely outcome of an illness.

Degenerative disease : is a disease in which the function or structure of the affected tissues or organs and will progressively deteriorate over time.

Implicated : Connected or involved with.

Neurotransmitters : Chemical substances that transmit messages from one neuron to another.

Hormone : Chemical messenger produced by the endocrine glands.

Neuron : Individual nerve cell, responsible for transmitting information.

Synapse : The junction between one neuron and another through which nerve impulses pass.

Synaptic cleft : The small gap between the axon of one and the dendrites of the receiving or postsynaptic neuron.

Axon : Nerve cell branches that transmit outgoing electrochemical impulses to other neurons.

Dendrite : Branched part of a cell that serves as receptor for nerve impulses from the axons of other cells and transmit them to cell body.

Central nervous system : The brain and spinal cord.

Defence mechanisms : The reality-distorting strategies used by the ego to shield the self from awareness of anxiety-provoking materials.

Classical conditioning : A form of learning in which a response to one stimulus can be made to occur to another stimulus by pairing or associating the two stimuli.

Operant conditioning : A form of learning in which behaviour is acquired and Strengthened when it is reinforced.

Diathesis : A vulnerability or predisposition to a particular disorder.

Depersonalisation : Feelings of unreality or loss of personal identity.

3.10 SUGGESTED READINGS

Carson, R. C., Butcher, J. N., & Mineka, S. *Abnormal Psychology and Modern Life*, 11TH edition. Pearson Education:New Delhi

Davison, G.C., Neale, J.M., Kring, A.M. *Abnormal Psychology*, 9th edition. Wiley & Sons:USA.

Sarason, I.G., Sarason, B.R. 1998. *Abnormal Psychology: The Problem of Maladaptive Behaviour.* Prentice-Hall of India: New Delhi.

UNIT 4 ASSESSMENT OF PSYCHOPATHOLOGY, INTERVIEW AND TESTING

Structure

4.0 INTRODUCTION

From the last units we have now a fairly good idea about what abnormal behaviour is and what are the different causes of this behaviour. Clinical practitioners apply this general information in their work. To help a particular client overcome his or her problems, a psychologist must have the fullest possible understanding of that person and know the circumstances under which the problems arose. Only after thoroughly examining the person can the therapist effectively apply relevant information. When faced with a new client clinicians use the procedures of assessment and diagnosis to gather individual information about a client. Then they would be in a position to apply treatment.

Let us consider in this unit the various ways of assessing abnormal behaviour. We will first begin by trying to understand the concept of assessment and the basic requirements for methods of assessment—that they be standardised, reliable and valid. Then we would be discussing in detail the types of assessment methods like clinical interviews and psychological tests.

4.1 OBJECTIVES

After studying this unit, you will be able to:

- Define assessment;
- Indicate the basic requirements of assessment measures;
- Elucidate the methods of assessment;
- Define the Psychological Tests to be administered;
- Elucidate the Neuropsychological Assessment;
- Analyse the Clinical Observations; and
- Explain the Socio-cultural and Ethnic factors in Assessment.

4.2 CONCEPT OF ASSESSMENT

Assessment is simply the process of gathering relevant information in an effort to reach a conclusion. It goes on in every aspect of life. We make assessments when we decide what product to buy, what subject and which college to choose or which candidate to vote for. College admissions officers, who have to select the "best" of the students applying to their college, depend on academic records, recommendations, entrance test scores, interviews, and application forms to help them decide. Employers, who have to predict which applicants, are most likely to be effective workers, collect information from résumés, interviews, references, and perhaps on the job observations. This type of assessment is used for the daily and routine activities, in order to choose the best which is reliable, long lasting and effective. In contrast, the clinical assessment is done with a specific target.

Clinical assessment is used to determine how and why a person is behaving abnormally and how that person may be helped. It also helps clinicians to evaluate people's progress after they have been in treatment for a while and decide whether the treatment should be changed.

There are hundreds of clinical assessment techniques and tools that have been developed. These techniques fall into three categories: clinical interviews, tests, and observations. To be useful, these tools must be standardised and have clear reliability and validity.

4.3 BASIC REQUIREMENTS OF ASSESSMENT MEASURES

In explaining the criteria of a good psychological test or any assessment, tools have to be objective, standardised, reliable, and valid and should have norms. This criterion could be followed here because crucial decisions are made on the

basis of assessment. For example, recommendations for specific treatment techniques may vary according to our assessment of the problems client exhibits. Therefore, methods of assessment must be standardised, reliable and valid.

To *standardise* a measure the technique used is to have common steps to be followed whenever it is administered. Similarly, clinicians must standardise the way they interpret the results of an assessment tool in order to be able to understand what a particular score means. They may standardise the scores of a test, for example, by first administering it to a group of subjects whose performance will then serve as a common standard, or norm, against which later individual scores can be measured. The group that initially takes the test is called the *standardisation sample.* This sample must be typical or representative of the larger population the test is intended for. For example, If a social support test meant for the public at large were standardised on a group living on ship, for example, the resulting "norm" might turn out to be misleading.

The *reliability* of a method of assessment refers to its consistency. A measure of height would be unreliable if people looked taller or shorter at every measurement. A reliable measure of abnormal behaviour must also yield the same results on different occasions. Also, different people should be able to use the measure and agree on the result. For example, two teachers may be asked to use a behavioural rating scale to evaluate a child's aggressiveness, hyperactivity, and sociability. The scale would have good reliability if both teachers rated the same children in similar ways.

Assessment techniques must also be *valid*; that is, instruments used in assessment must measure what they intend to measure. Suppose a measure of depression actually turned out to be measuring anxiety. Using such a measure may lead an examiner to a wrong diagnosis.

4.4 METHODS OF ASSESSMENT

Psychologists use different methods of assessment to arrive at diagnoses, including interviews, psychological testing, self-report questionnaires, behavioural measures, and physiological measures. A careful assessment provides a wealth of information about client's personality and cognitive functioning. This information helps clinicians develop a broader understanding of their clients' problems and helps to recommend appropriate forms of treatment. In most cases, the formal assessment involves one or more clinical interviews with the client, leading to a diagnostic impression and a treatment plan.

In some cases, more formal psychological testing might be needed to probe the client's psychological problems relating to intellectual, personality, and neuropsychological functioning. The various methods of assessment are discussed below.

4.4.1 The Clinical Interview

The clinical interview is the most widely used means of assessment. The interview is usually the client's first face-to-face contact with a clinician. Clinicians often begin by asking clients to describe the presenting complaint in their own words, saying something like, "Can you describe to me the problems you've been having

lately?" (Therapists should learn not to ask, "What brings you here?" to avoid receiving answers such as, "A car," "A bus," or "My parents.").

The clinician will then usually probe different aspects of the presenting complaint, such as behavioural abnormalities and feelings of discomfort, the circumstances regarding the onset of the problem, history of past episodes, and how the problem affects the client's daily functioning. The clinician may explore possible precipitating events, such as changes in life circumstances, social relationships, employment, or schooling. The interviewer encourages the client to describe the problem in her or his own words in order to understand it from the client's viewpoint.

4.4.2 Format of Clinical Interview

Although the format may vary, most interviews cover these topics:

i) **Identifying data:** Information regarding the client's socio-demographic characteristics like address and telephone number, marital status, age, gender, racial/ethnic information, religion, employment, family composition, and so on.

ii) **Description of the presenting problem(s):** How does the client perceive the problem? What troubling behaviours, thoughts, or feelings are reported? How do they affect the client's functioning? When did they begin?

iii) **Psychosocial history:** Information describing the client's developmental history like educational, social, and occupational history; early family relationships.

iv) **Medical/psychiatric history:** History of medical and psychiatric treatment and hospitalisations: Is the present problem a recurrent episode of a previous problem? How was the problem handled in the past? Was treatment successful? Why or why not?

v) **Medical problems/medication:** Description of present medical problems and present treatment, including medication. The clinician is alert to ways in which medical problems may affect the presenting psychological problem. For example, drugs for certain medical conditions can affect people's moods and general levels of arousal.

The interviewer should be attentive to the client's nonverbal as well as verbal behaviour, forming judgments about the appropriateness of the client's attire and grooming, apparent mood, and ability to focus attention. Clinicians should also judge the clarity or soundness of clients' thought and perceptual processes and level of orientation, or awareness of themselves and their surroundings (who they are, where they are, and what the present date is). These clinical judgments form an important part of the initial assessment of the client's mental state.

4.4.3 Types of Clinical Interviews

There are three general types of clinical interviews. The unstructured, semi-structured and structured interviews:

In an unstructured interview, the clinician adopts his or her own style of questioning rather than following a standard format. The major advantage of the

unstructured interview is its spontaneity and conversational style. Because the interviewer is not bound to follow any specific set of questions, there is an active give-and-take with the client. The major disadvantage is the lack of standardisation. Also, the conversational flow of the interview may fail to touch on important clinical information needed to form diagnostic information, such as suicidal tendencies.

In a semi-structured interview, the clinician follows a general outline of questions designed to gather essential information but is free to ask the questions in any particular order and to branch off into other directions to follow up on important information.

In a structured interview, the interview follows a preset series of questions in a particular order. For example the mental status exam, in which a set of questions and observations are used to systematically evaluate the client's awareness, orientation with regard to time and place, attention span, memory, judgment and insight, thought content and processes, mood, and appearance. Structured interviews (also called *standardised interviews*) provide the highest level of reliability and consistency in reaching diagnostic judgments, which is why they are used frequently in research settings.

4.4.4 Limitations of Clinical Interviews

Although interviews often produce valuable information about people, there are limits to what they can accomplish. One problem is that they sometimes lack validity, or accuracy. Individuals may intentionally mislead in order to present themselves in a positive light or to avoid discussing embarrassing topics. Or people may be unable to give an accurate report in their interview. Individuals who suffer from depression, for example, take a pessimistic view of themselves and may describe themselves as poor workers or inadequate parents when that isn't the case at all.

Clinicians too may make mistakes in judgments that slant the information they gather. They usually rely too heavily on first impressions, for example, and give too much weight to unfavourable information about a client (Meehl, 1996, 1960). Interviewer biases, including gender, race, and age biases, may also influence the interviewers' interpretations of what a client says (Plante, 1999). Interviews, particularly unstructured ones, may also lack reliability. People respond differently to different interviewers, providing less information to a distant interviewer than to a warm and supportive one. Similarly, a clinician's race, sex, age, and appearance may influence a client's responses (Paurohit, Dowd, & Cottingham, 1982). Because different clinicians can obtain different answers and draw different conclusions, even when they ask the same questions of the same person, some researchers believe that interviewing should be discarded as a tool of clinical assessment.

4.5 PSYCHOLOGICAL TESTS

A psychological test is a structured method of assessment used to evaluate reasonably stable traits, such as intelligence and personality. Tests are usually standardised on large numbers of subjects and provide norms that compare clients' scores with the average. By comparing test results from samples of people who

are free of psychological disorders with those of people who have psychological disorders, we may gain some insights into the types of response patterns that are indicative of abnormal behaviour. Although we tend to think of medical tests as a "gold standard" of testing, a recent analysis showed that many psychological tests were on par with many medical tests in their ability to predict variables, such as underlying conditions or future outcomes (Daw, 2001; Meyer et al., 2001).

Psychological testing is done primarily with four objectives:

1) To screen for certain traits or behaviours like psychoticism, extroversion, neuroticism, poor coping resources etc. Emotionally unstable individuals are more prone to develop emotional or behavioural disorders. Psychological tests are used for screening individuals who are at risk for developing these disorders.

2) To assess psychopathology and to help in making a diagnosis.

3) To elicit factors which are causative as well as maintaining maladaptive disorders.

4) To plan rehabilitation programme for patients with psychological or neurological disorders, handicaps and head injury patients.

Here we will examine major kinds of psychological tests: Intelligence tests, Personality inventories, projective tests, neuropsychological, and psycho-physiological tests.

4.5.1 Intelligence Tests

The assessment of abnormal behaviour often includes an evaluation of intelligence. Formal intelligence tests are used to help diagnose mental retardation. They evaluate the intellectual impairment that may be caused by other disorders, such as organic mental disorders caused by damage to the brain. They also provide a profile of the client's intellectual strengths and weaknesses to help develop a treatment plan suited to the client's competencies. The general score derived from intelligence tests is termed an *intelligence quotient*, or IQ, so called because initially it represented the ratio of a person's "mental" age to his or her chronological" age, multiplied by 100.

There are now more than 100 intelligence tests available. The most widely used are *Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children,* and *Stanford-Binet Intelligence Scale.* Some of the tests are

Wechsler's intelligence scales are the most widely used intelligence tests. Different versions are used for different age groups. The Wechsler scales group questions into subtests or subscales, with each subscale measuring a different intellectual ability. The Wechsler scales are thus designed to offer insight into a person's relative strengths and weaknesses, and not simply yield an overall score. Wechsler's scales include both *verbal* and *performance* subtests to compute verbal and performance IQs. Verbal subtests generally require knowledge of verbal concepts; performance subtests rely more on spatial relations skills.

The Malin's Intelligence Scale for Indian Children (MISIC) is an Indian adaptation of the Wechsler's Intelligence Scale for Children (WISC). The MISIC test is used for children aged 6–15 years and consists of a questionnaire in Hindi/English.

Like the original scale these tests also have two groups called verbal and performance which have different subtests. Malin's adaptation omits one subtest called the picture arrangement of the performance scale as it proved to be too culturally biased. Based on the answers given by the patient the 'raw scores' are calculated. The norms for different age groups, derived from an Indian population are available along with the questionnaire. These norms give the weighted scores for the corresponding raw scores in individuals of different age groups. Verbal, performance and full scale IQ can be derived from the scale.

Bhatia's Battery of performance test of intelligence, devised by Dr. C.M.Bhatia in India, measures performance intelligence. The test consists of five sub-tests that are loaded that are loaded with the general factor (G) and a specific factor (S). The sub-tests are Kohs block design test, Alexander's pass along test, Pattern drawing test, immediate memory test and picture construction test.

Standard Progressive Matrices (SPM) was developed by Raven and has three forms. Besides standard progressive matrices the other two are coloured and advanced progressive matrices. The test has five sets of matrices with 12 patterns in each set. This test is considered culture fair test as familiarity with any specific language is not needed. Intelligence is expressed in terms of percentile ranks in this test (see figure below).

Intelligence tests are among the most carefully produced of all clinical tests. Because they have been standardised on large groups of subjects, clinicians have a good idea how each individual's score compares with the performance of the population at large. These tests have also shown very high reliability: people who repeat the same IQ test years later receive approximately the same score. Finally, the major IQ tests appear to have fairly high validity: for example children's IQ scores often correlate with their performance in school.

Intelligence tests also have some key shortcomings. Factors that have nothing to do with intelligence, such as low motivation and high anxiety, can greatly influence a performance. In addition, IQ tests may contain cultural biases in their language or tasks that place people of one background at an advantage over those of another.

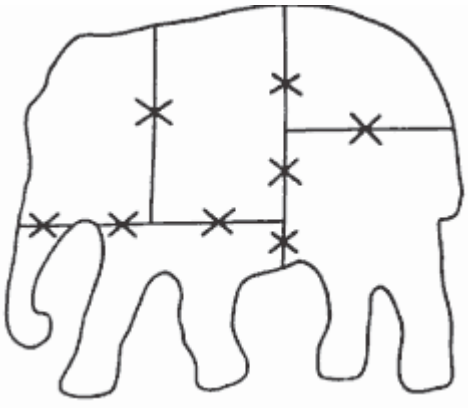
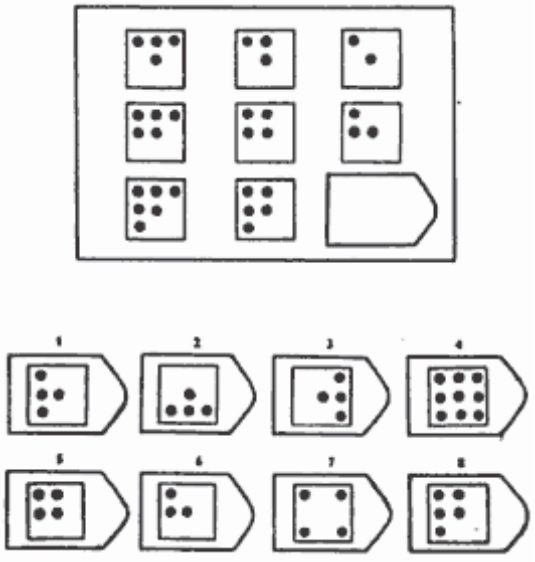


Fig. Object Assembly test in MISIC



Standard Progressive Matrices

4.5.2 Personality Inventories

Personality inventories are also called Objective tests. We consider these tests objective because they limit the range of possible responses and so can be scored objectively. They are also considered objective because they were developed based on empirical evidence supporting their validity. Personality inventory asks subjects a wide range of questions about their behaviour, beliefs, and feelings. In a typical personality inventory, individuals indicate whether or not each of a long list of statements applies to them. Psychologists then use the responses to draw conclusions about the person's personality and psychological functioning. By far the most widely used personality inventory is the *Minnesota Multiphasic Personality Inventory* (*MMPI*). Some of the tests are:

Minnesota Multiphasic Personality Inventory (MMPI): The MMPI contains more than 500 true-false statements that assess interests, habits, family relationships, physical (somatic) complaints, attitudes, beliefs, and behaviours characteristic of psychological disorders. It is widely used as a test of personality as well as to assist clinicians in diagnosing abnormal behaviour patterns. The items in the MMPI make up 10 clinical scales:

1) **Hypochondriasis (HS):** Items showing abnormal concern with bodily functions ("I have chest pains several times a week").

2) **Depression (D):** Items showing extreme pessimism and hopelessness ("I often feel hopeless about the future").

3) **Conversion hysteria (CH):** Items suggesting that the person may use physical or mental symptoms as a way of unconsciously avoiding conflicts and responsibilities ("My heart frequently pounds so hard I can feel it").

4) **Psychopathic deviate (PD):** Items showing a repeated and gross disregard for social customs and an emotional shallowness ("My activities and interests are often criticized by others").

5) **Masculinity femininity (MF):** Items that are thought to distinguish male and female respondents ("I like to arrange flowers").

6) **Paranoia (Pa)** Items that show abnormal suspiciousness and delusions of grandeur or persecution ("There are evil people trying to influence my mind").

7) **Psychasthenia (Pt)** Items that show obsessions, compulsions, abnormal fears, and guilt and indecisiveness ("I save nearly everything I buy, even after I have no use for it").

8) **Schizophrenia (Sc)** Items that show bizarre or unusual thoughts or behaviour, including extreme withdrawal, delusions, or hallucinations ("Things around me do not seem real").

9) **Hypomania (Ma)** Items that show emotional excitement, over activity, and flight of ideas ("At times I feel very 'high' or very 'low' for no apparent reason").

10) **Social Introversion (Si)** These items asssess a person's tendency to withdraw from social contacts and responsibilities. (("I am easily embarrassed").

Scores for each scale can range from 0 to 120. When people score above 70, their functioning on that scale is considered deviant. When the scores are connected on a graph, a pattern called the *profile* takes shape, indicating the person's general personality and underlying emotional needs. In addition to such clinical measures, questions have been built into the MMPI to detect whether respondents are lying, defensive, or careless in their answers.

Eysenck's Personality Questionnaire (EPQ): This questionnaire measures only three dimensions of personality namely, introversion-extroversion, neuroticism, psychoticism and has a lie score which provides validity to the scores. This questionnaire consists of 86 items and has been commonly used in research studies in India.

The MMPI and other personality inventories have several advantages over projective tests. Because they are paper-and-pencil tests, they do not take much time to administer, and they are objectively scored. Most of them are standardised, so one person's scores can be compared to those of many others. They often show greater test retest reliability than projective tests. For example, people who take the MMPI a second time after a period of less than two weeks receive approximately the same scores. Personality inventories also appear to have greater validity, or accuracy, than projective tests. However, they cannot be considered highly valid. When clinicians have used these tests alone, they have not been able to judge a person's personality accurately.

One problem is that the personality traits that the tests seek to measure cannot be examined directly. How can we fully know a person's character, emotions, and needs from self-report alone? Another problem is the frequent failure of the tests to allow for cultural differences in people's responses. Responses indicative of a psychological disorder in one culture may be normal responses in another (Butcher, 2000; Dana, 2000). Despite their limited validity, personality inventories continue to be popular. Research indicates that they can help clinicians learn about people's personal styles and disorders as long as they are used in combination with interviews or other assessment tools.

4.5.3 Rating Scales

To measure psychopathology objective rating scales can be used. Rating scales enable the observer to indicate not only the presence or absence of a trait or behaviour but also its prominence. The rating scales are generally of two types: self rating scales and observer rating scales. Beck's Depression rating scale and Hamilton rating scales are commonly used to measure depression. Anxiety can be measured on State and Trait Anxiety Scale and Hamilton Anxiety scale.

Brief psychiatric rating scale (BPRS) is one of the most widely used rating scale for recording observations in clinical practice and in research. The BPRS provides a structured format for rating clinical symptoms such as somatic concern, anxiety, emotional withdrawal, hostility, guilt feelings, suspiciousness and unusual thought patterns. It contains 18 scales that are scored from ratings made by clinician following an interview with the patient.

4.5.4 Projective Tests

The word *projective* is used because these personality tests derive from the psychodynamic belief that people impose, or "project," their own psychological

needs, drives, and motives, much of which lie in the unconscious, onto their interpretations of ambiguous stimuli. A projective test, unlike an objective test, offers no clear, specified response options. Clients are presented with ambiguous stimuli, such as inkblots, and asked to respond to them.

The psychodynamic model holds that potentially disturbing impulses and wishes, often of a sexual or aggressive nature, are often hidden from consciousness by our defence mechanisms. Indirect methods of assessment, however, such as projective tests, may offer clues to unconscious processes. More behaviourally oriented critics say that the results of projective tests are based more on clinicians' subjective interpretations of test responses than on empirical evidence.

Many projective tests have been developed, including tests based on how people fill in missing words to complete sentence fragments or how they draw human figures and other objects. The two most prominent projective techniques are the Rorschach Inkblot Test and the Thematic Apperception Test (TAT).

4.5.5 The Rorschach Test

The Rorschach test was developed by a Swiss psychiatrist, Hermann Rorschach (1884–1922). He had experimented with the use of ink-blots in his clinical practice. He noted that people saw different things in the same blot, and he believed their "percepts" reflected their personalities as well as the stimulus cues provided by the blot. He had selected 10 ink blots and published them in 1921 for use in assessment. Five of the inkblots are black and white, and the other five have colour. Each inkblot is printed on a separate card, which is handed to subjects in sequence. Subjects are asked to tell the examiner what the blot might be or what it reminds them of. Then, they are asked to explain what features of the blot (its colour, form, or texture) they used to form their perceptions.

Clinicians who use the Rorschach form their interpretations based on the content and the form of the responses. For example, they may infer that people who use the entire blot in their responses show an ability to integrate events in meaningful ways. Those who focus on minor details of the blots may have obsessive–compulsive tendencies, whereas clients who respond to the negative (white) spaces may see things in their own idiosyncratic ways, suggesting underlying negativism or stubbornness. A response consistent with the form or contours of the blot is suggestive of adequate reality testing. People who see movement in the blots may be revealing intelligence and creativity. Content analysis sheds light on underlying conflicts. For example, adult clients who see animals but no people may have problems relating to people. Clients who appear confused about whether or not percept of people are male or female may, according to psychodynamic theory, be in conflict over their own gender identity.

4.5.6 The Thematic Apperception Test (TAT)

The Thematic Apperception Test (TAT) was developed by psychologist Henry Murray (1943) at Harvard University in the 1930s. *Apperception* is a French word that can be translated as "interpreting (new ideas or impressions) on the basis of existing ideas (cognitive structures) and past experience." The TAT consists of a series of cards, each depicting an ambiguous scene It is assumed that clients' responses to the cards will reflect their experiences and outlooks on life—and, perhaps, shed light on their deep-seated needs and conflicts.

Subjects are asked to describe what is happening in each scene, what led up to it, what the characters are thinking and feeling, and what will happen next. Psychodynamic theorists believe that people will identify with the protagonists in their stories and project underlying psychological needs and conflicts into their responses. More superficially, the stories suggest how clients might interpret or behave in similar situations in their own lives. TAT results may also suggest clients' attitudes toward others, particularly family members.

The Indian adaptation of this test is also available which had been developed by Uma Choudary.

Fig.: An inkblot used in Rorschach

Fig. A picture used in TAT

4.5.7 Sentence Completion Test

The sentence-completion test, first developed in the 1920s (Payne, 1928), asks people to complete a series of unfinished sentences, such as "I wish _____" or "My father _____." The test is considered a good springboard for discussion and a quick and easy way to pinpoint topics to explore in treatment.

4.5.8 Drawings

On the assumption that a drawing tells us something about its creator, clinicians often ask clients to draw human figures and talk about them. Evaluations of these drawings are based on the details and shape of the drawing, solidity of the pencil line, location of the drawing on the paper, size of the figures, features of the figures, use of background, and comments made by the subject during the drawing task. In the *Draw-a-Person* (*DAP*) *Test*, the most popular of the drawing tests, subjects are first told to draw "a person," and then are instructed to draw another person of the opposite sex.

Until the 1950s, projective tests were the most common technique for assessing personality. In recent years, however, clinicians and researchers have relied on them largely to gain "supplementary" insights. One reason for this shift is that practitioners who follow the newer models have less use for the tests than psychodynamic clinicians do. Even more important, the tests have rarely demonstrated much reliability or validity (Wood et al., 2002; Meyer, 2001).

4.6 NEUROPSYCHOLOGICAL ASSESSMENT

Neuropsychological assessment involves the use of tests to help determine whether psychological problems reflect underlying neurological impairment or brain damage. When neurological impairment is suspected, a neurological evaluation may be requested from a neurologist—a medical doctor who specialises in disorders of the nervous system.

A clinical neuropsychologist may also be consulted to administer neuropsychological assessment techniques, such as behavioural observation and psychological testing, to reveal signs of possible brain damage. Neuropsychological testing may be used together with brain-imaging techniques such as the MRI and CT to shed light on relationships between brain function and underlying abnormalities. The results of neuropsychological testing may not only suggest whether patients suffer from brain damage but also point to the parts of the brain that may be affected.

The Bender Visual Motor Gestalt Test

One of the first neuropsychological tests to be developed and still one of the most widely used neuropsychological tests is the Bender Visual Motor Gestalt Test, now in a second edition, the Bender-Gestalt II. "The Bender" consists of geometric figures that illustrate various Gestalt principles of perception. The client is asked to copy geometric designs, and signs of possible brain damage include rotation of the figures, distortions in shape, and incorrect sizing of the figures in relation to one another. The examiner then asks the client to reproduce the designs from memory, because neurological damage can impair memory functioning. Although the Bender remains a convenient and economical means of uncovering possible organic impairment, more sophisticated test batteries have been developed for this purpose, including the widely used Halstead-Reitan Neuropsychological Battery and Luria-Nebraska Battery.

The Halstead-Reitan Neuropsychological Battery

Psychologist Ralph Reitan developed the battery by adapting tests used by his mentor, Ward Halstead, an experimental psychologist, to study brain–behaviour relationships among organically impaired individuals. The battery contains tests that measure perceptual, intellectual, and motor skills and performance. A battery of tests permits the psychologist to observe patterns of results, and various patterns of performance deficits would suggest certain kinds of brain defects, such as those occurring following head trauma.

PGI Memory Scale

This scale has been standardised by Pershad for Indian population. It is used on both literate and illiterate, adults and older persons. It has 10 subtests, namely - remote memory, recent memory, mental balance, attention and concentration, delayed recall, immediate recall, verbal retention for similar pairs, verbal retention for dissimilar pairs, verbal retention and recognition (See Figure). This test has objective scoring and norms according to age and sex.

Memory Questionnaires

For assessment of working memory simple assessment questionnaires can also be used. The content of these questionnaires is related to historical facts, important

life events, memory of specific situations on the basis of repeated experience with everyday memory tasks. Generally immediate, recent and remote memory is assessed.

Fig.: Recognition tests in PGI Memory Scale

4.7 CLINICAL OBSEVATIONS

In addition to interviewing and testing people, clinicians may systematically observe their behaviour. In one technique, called naturalistic observation, clinicians observe clients in their everyday environments. In another, analogue observation, they observe them in an artificial setting, such as a clinic or laboratory. Another technique is self-monitoring wherein clients are instructed to observe themselves.

4.7.1 Naturalistic and Analogue Observations

Naturalistic clinical observations usually take place in homes, schools, institutions such as hospitals and prisons, or community settings. Most of them focus on parent-child, sibling-child, or teacher-student interactions and on fearful, aggressive, or disruptive behaviour.

Often such observations are made by *participant observers*, key persons in the client's environment, and reported to the clinician. When naturalistic observations are not practical, clinicians may resort to analogue observations, often aided by special equipment such as a videotape recorder or one-way mirror. Analogue observations have often focused on children interacting with their parents, married couples attempting to settle a disagreement, speech-anxious people giving a speech, and fearful people approaching an object they find frightening.

Although much can be learned from actually witnessing behaviour, clinical observations have certain disadvantages. For one thing, they are not always reliable. It is possible for various clinicians who observe the same person to

focus on different aspects of behaviour, assess the person differently, and arrive at different conclusions.

Another possible problem is *observer bias*—the observer's judgments may be influenced by information and expectations he or she already has about the person.

A client's *reactivity* may also limit the validity of clinical observations; that is, his or her behaviour may be affected by the very presence of the observer. If clients are aware that someone is watching them, for example, they may change their usual behaviour, perhaps in the hope of creating a good impression.

Finally, clinical observations may lack *cross-situational*, or *external, validity.* A child who behaves aggressively in school is not necessarily aggressive at home or with friends after school. Because behaviour is often specific to particular situations, observations in one setting cannot always be applied to other settings (Haynes, 2001; Simpson & Halpin, 1986).

4.7.2 Self-Monitoring

Training clients to record or monitor the problem behaviour in their daily lives is another method of relating problem behaviour to the settings in which it occurs. In self-monitoring, clients take up the responsibility for assessing the problem behaviour in the settings in which it naturally occurs.

Behaviours that can be easily counted, such as food intake, cigarette smoking, nail biting, hair pulling, study periods, or social activities, are well suited for self-monitoring. Self-monitoring can produce highly accurate measurement, because the behaviour is recorded as it occurs, not reconstructed from memory.

There are various devices for keeping track of the targeted behaviour. A behavioural diary or log is an easy way to record calories ingested or cigarettes smoked. Such logs can be organised in columns and rows to track the frequency of occurrence of the problem behaviour and the situations in which it occurs (time, setting, feeling state, etc.). In reviewing an eating diary with the clinician, a client can identify problematic eating patterns, such as eating when feeling bored or in response to TV food commercials, and devise better ways of handling these cues.

Behavioural diaries can also help clients increase desirable but low-frequency behaviours, such as assertive behaviour and dating behaviour. Unassertive clients might track occasions that seem to warrant an assertive response and jot down their actual responses to each occasion. Clients and clinicians then review the log to highlight problematic situations and rehearse assertive responses.

Self-monitoring also has its disadvantages. Some clients are unreliable and do not keep accurate records. They become forgetful or sloppy, or they underreport undesirable behaviours, such as overeating or smoking, because of embarrassment or fear of criticism.

4.8 SOCIO-CULTURAL AND ETHNIC FACTORS IN ASSESSMENT

Researchers and clinicians must keep socio-cultural and ethnic factors in mind when assessing personality traits and psychological disorders. When testing people

from other cultures, careful translations are essential to capture the meanings of the original items. However, assessment techniques that are reliable and valid within one culture may not be so in another, even when they are translated accurately (Bolton, 2001; Cheung et al., 2003).

For example, the Chinese version of the Beck Depression Inventory (BDI), a widely used inventory of depression in the United States, has shown good validity in distinguishing people with depression from people without depression (Chan, 1991 Yeung et al., 2002).

However, other investigators found that Chinese people in both Hong Kong and the People's Republic of China showed high levels of disturbed behaviour when tested with a Chinese version of the MMPI (Cheung, Song, & Butcher, 1991). When a more careful analysis was done it suggested that their test responses reflected cultural differences rather than greater psychopathology (Cheung, 1991; Cheung & Ho, 1997).

In other words, researchers need to disentangle psychopathology from socio-cultural factors. Translations of assessment instruments should not only translate words, but also provide instructions that encourage examiners to address the importance of cultural beliefs, norms, and values, so diagnosticians and interviewers will consider the client's background when making assessments of abnormal behaviour patterns.

Self Assessment Questions

1) What are the basic requirements of assessment measures?

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2) What is a clinical interview?

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3) What are psychological tests?

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4) What is a neuropsychological assessment?

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5) Why is it important to take cultural or ethnic factors into account in psychological assessment?

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4.9 LET US SUM UP

People's psychological problems, which are no less complex than people themselves, are assessed in many ways. Clients are asked to explain their problems as best they can. Psychologists can draw on batteries of tests that assess intelligence, personality, and neuropsychological integrity. Many psychologists prefer to observe people's behaviour directly. Modern technology has provided several means of studying the structure and function of the brain. The methods of assessment clinicians select reflect the problems of their clients, their theoretical orientations, and their mastery of specialised technologies.

4.10 UNIT END QUESTIONS

1) What are the three major types of clinical interviews?

2) What are the major types of psychological tests?

3) What are some of the methods used in behaviour observation?

4.11 GLOSSARY

Assessment : The process of collecting and interpreting relevant information about a client or subject.

Reliability : A measure of the consistency of test or research results.

Validity : The accuracy of a test's or study's results; that is, the extent to which the test or study actually measures or shows what it claims.

Mental Status Examination : A set of interview questions and observations designed to reveal the degree and nature of a client's abnormal functioning

Battery : A series of tests, each of which produces a different kind of data

4.12 SUGGESTED READINGS AND REFERENCES

Carson, R. C., Butcher, J. N., & Mineka, S. *Abnormal Psychology and Modern Life*, 11TH edition. Pearson Education:New Delhi

Davison, G.C., Neale, J.M., Kring, A.M. *Abnormal Psychology*, 9th edition. Wiley & Sons:USA.

Sarason, I.G., Sarason, B.R. 1998. *Abnormal Psychology: The Problem of Maladaptive Behaviour.* Prentice-Hall of India: New Delhi.

References

Barlow, D.H., & Durand, V.M. 2007. *Abnormal Psychology: An Integrative Approach.* Thomson Learning Inc., New Delhi.

Bennett, Paul. 2005. *Abnormal and Clinical Psychology: An Introductory Textbook*, 2nd Ed. Open University Press, McGraw-Hill Education: England.

Carson, R. C., Butcher, J. N., & Mineka, S. 2003. *Abnormal psychology and modern life*. Pearson Education: New Delhi.

Constantino, M. J., & Spofford, C.M. 2008 Encyclopedia *of Counseling*. Sage Publications. (http://www.sage-ereference.com/counseling/Article_n182.html).

Halgin, R.P., & Whitbourne, S.K. 1997. *Abnormal Psychology: The Human Experience of Psychological Disorders*. Brown & Benchmark Publishers: London.

Hecker, J.E., & Thorpe, G.L. 2005. *Introduction to Clinical Psychology: Science, Practice, and Ethics.* Pearson Education: New Delhi.

Kenneth, S., & Trull, T. 2007. *The International Handbook of Psychology*. SAGE Publications. <http://www.sage-ereference.com/hdbk_intlpsych/Article_n21.html>.

Korchin, S.J. 2004. *Modern Clinical Psychology: principles of intervention in the clinic and community*. CBS Publishers: New Delhi.

Mangal, S.K. 2006. *Abnormal Psychology.* Sterling publishers: New Delhi.

Pichot, P. 2003. *Encyclopedia of Psychological Assessment.* Sage Publications. (http://www.sage-ereference.com/psychassessment/Article_n71.html).

Sarason, I.G., & Sarason, B.R.2005. *Abnormal Psychology: The problem of maladaptive behaviour.* Prentice-Hall of India: New Delhi.

Sharma, R., 2006. *Abnormal Psychology*. Atlantic Publishers & Distributors: New Delhi.

UNIT 1 CHILD AND ADOLESCENT DISORDER

Structure

1.0 INTRODUCTION

Although it is sometimes assumed that childhood and adolescence are times of carefree bliss, as many as 20% of children and adolescents have one or more diagnosable mental disorders. Most of these disorders may be viewed as exaggerations or distortions of normal behaviours and emotions.

Like adults, children and adolescents vary in temperament. Some are shy and reticent; others are socially exuberant. Some are methodical and cautious, and others are impulsive and careless. Whether a child is behaving like a typical

child or has a disorder is determined by the presence of impairment and the degree of distress related to the symptoms. For example, a 12-yr-old girl may be frightened by the prospect of delivering a class report in front of her class. This fear would be viewed as social phobia only if her fears were severe enough to cause significant impairments and distress.

The mental disorders that children can develop are commonly divided into two groups: disruptive or externalising behaviour disorders (e.g., attention-deficit hyperactivity disorder, conduct problems) and emotional or internalising behaviour disorders (e.g., anxiety, depression). In this unit we would focus on types of internalising and externalising disorders in children. We will also discuss in depth the etiology and treatment involved in these disorders.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- Define emotional and behavioural disorders;
- Describe the different types of the emotional and behavioural disorders that are most likely to arise in childhood and adolescence;
- Explain the etiology (causes) of these disorders; and
- Describe the different types of treatment for these disorders.

1.2 CLASSIFICATION OF CHILDHOOD DISORDERS

An important perspective within which to understand children's mental disorders is developmental. By its nature, children's behaviour fluctuates over time. One of the biggest challenges for parents and psychologists is to distinguish between normal developmental changes and the emergence of a disorder (atypical changes). Development is also an important consideration in determining whether early signs of a disorder will emerge as a full-blown disorder, develop into a different disorder, or resolve into healthy functioning.

To classify abnormal behaviour in children, psychologists must first consider what is normal for a particular age. The diagnosis for a child who lies on the floor kicking and screaming when he or she does not get his or her way must take into account whether the child is two years old or seven. The field of developmental psychopathology studies disorders of childhood within the context of normal life-span development, helping us to identify behaviours that are appropriate at one stage but are considered disturbed at another.

Childhood disorders are often categorised into two broad groups, called externalising and internalising disorders. Externalising disorders are characterised by more outward- directed behaviours, such as aggressiveness, noncompliance, over activity, and impulsiveness, and include disorders such as ADHD, conduct disorder (CD), and oppositional defiant disorder (ODD). Internalising disorders are characterised by more inward-focused experiences and behaviours such as depression, social withdrawal, and anxiety, and include childhood anxiety and mood disorders. Children and adolescents may exhibit symptoms from both domains. Externalising behaviours are consistently found more often among boys and internalising behaviours more often among girls, at least in adolescence, across cultures.

1.3 ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Attention Deficit Hyperactivity Disorder (ADHD) belongs to the group of externalising disorders of childhood. The term hyperactive is familiar to most people, especially parents and teachers. The child who is constantly in motion, tapping fingers, jiggling legs, poking others for no apparent reason, talking out of turn, and fidgeting is often called hyperactive. These children also have difficulty concentrating on the task at hand for an appropriate period of time.

To distinguish the normal range of hyperactive behaviours from a diagnosable ADHD, the behaviours should be extreme for a particular developmental period, persistent across different situations, and linked to significant impairments in functioning. The ADHD diagnosis should not be applied to youngsters who are rambunctious, active, or slightly distractible, children are often so in the early school years. To use the label simply because a child is livelier and more difficult to control than a parent or teacher would indicate a misuse of the term. The diagnosis of ADHD is reserved for truly extreme and persistent cases.

Children with ADHD seem to have particular difficulty controlling their activity in situations that call for sitting still, such as in the classroom or at mealtimes. When required to be quiet, they appear unable to stop moving or talking. They are disorganised, erratic, tactless, obstinate, and bossy. Their activities and movements seem haphazard. They quickly wear out their shoes and clothing, smash their toys, and exhaust their families and teachers. Many children with ADHD have difficulty getting along with peers and establishing friendship, perhaps because their behaviour is often aggressive and generally annoying and intrusive to others. Although these children are usually friendly and talkative, they often miss subtle social cues, such as noticing when playmates are tiring of their constant jiggling. They also frequently misinterpret the wishes and intentions of their peers and make inadvertent social mistakes, such as reacting aggressively because they assume that a neutral action by a peer was meant to be aggressive.

DSM-IV-TR includes three subcategories of ADHD:

i) Predominantly inattentive type: Children whose problems are primarily those of poor attention.

ii) Predominantly Hyperactive-Impulsive type: Children whose difficulties result primarily from hyperactive-impulsive behaviour.

iii) Combined type: Children who have both sets of problems.

The combined type comprises the majority of ADHD children. The prevalence of ADHD has been difficult to establish because of varied definitions of the disorder over time and differences in the populations sampled. The consensus is that about 3 to 7 percent of school-age children worldwide currently have ADHD (DSM-IV-TR, 2000). Evidence indicates that ADHD is more common in boys than in girls, but exact figures depend on whether the sample is taken from clinic referrals or from the general population. Boys are more likely to be referred to clinics because of a higher likelihood of aggressive and antisocial behaviour.

At one time it was thought that ADHD simply went away by adolescence. However this belief has been contradicted by numerous longitudinal studies (e.g., Barkley et al., 1990; Biederman et al., 1996; Claude & Firestone, 1995; Weiss & Hechtman, 1993). Although they do show reduced severity of symptoms in adolescence, 65 to 80 percent of children with ADHD still meet criteria for the disorder in adolescence and in adulthood. In addition to the fidgety, distractible, impulsive behaviours, adolescents with ADHD are far more likely to drop out of high school and develop antisocial behaviour than their peers. In adulthood, although most are employed and financially independent, these individuals generally reach only a lower socioe-conomic level and change jobs more frequently than would normally be expected.

Case Example

Rohit is not doing well in school. His teacher is convinced that he is just not trying. He doesn't listen and he rarely completes work in class time. When work is done, Rohit often misses important details. What is turned in is often incomplete. Furthermore, he is constantly losing pencils and paper, and his book is a mess. Rohit has many symptoms of ADHD, inattentive type.

1.3.1 Etiology of ADHD

The cause of ADHD in children has been much debated. It still remains unclear to what extent the disorder results from environmental or biological factors and recent research point to both genetic and social environmental factors. Many researchers believe that biological factors such as genetic inheritance will turn out to be important precursors to the development of ADHD. But firm conclusions about any biological or psychological basis for ADHD must await further research.

1.3.2 Biological Causes

i) *Genetic Factors*

Research suggests that a genetic predisposition toward ADHD may play an important role. When parents have ADHD, half of their children are likely to have the disorder. Adoption studies and numerous large-scale twin studies indicate a genetic component to ADHD, with monozygotic concordance rates as high as.70 to .80.

Exactly what is inherited is as yet unknown, but recent studies suggest that brain function and structure differ in children with and without ADHD. Studies have documented that the frontal lobes of children with ADHD are under responsive to stimulation and cerebral blood flow is reduced (Sieg et al;, 1995). Moreover, parts of the brains (frontal lobes, caudate nucleus, globus pallidus) of ADHD

children are smaller than those of normal children. Evidence shows poorer performance of children with ADHD on neuropsychological tests of frontal-lobe functioning (such as inhibiting behavioural responses), which provides further support for the theory that a basic deficit in this part of the brain may be related to the disorder.

ii) *Perinatal and Prenatal Factors*

Other biological risk factors for ADHD include a number of perinatal and prenatal complications. Low birth weight, for example is considered to be a specific predictor of the development of ADHD. Other complications associated with childbirth such as delayed birth cry are also predictive of ADHD symptoms.

iii) *Environmental Toxins*

Although evidence suggests that lead poisoning may be associated to a small degree with symptoms of hyperactivity and attention problems, most children with lead poisoning do not develop ADHD, and most children with ADHD do not show elevated levels of lead in the blood.

Nicotine (especially maternal smoking) is an environmental toxin that plays an important part in the development of ADHD. Milberger et al. (1996) reported that 22 percent of mothers of children with ADHD reported smoking a pack of cigarettes per day during pregnancy, compared with 8 percent of mothers whose children did not develop ADHD. Animal studies indicate that chronic exposure to nicotine increases dopamine release in the brain and causes hyperactivity. On the basis of these data, Milberger and his associates hypothesise that maternal smoking can affect the dopaminergic system of the developing foetus, resulting in behavioural disinhibition and ADHD.

Can excessive early TV viewing be linked to ADHD?

Researchers have found that television exposure at ages 1 to 3 years is associated with attention problems at age 7. In fact, they found that each hour of daily viewing increased the risk of ADHD by almost 10% at age 7. As a result, the authors suggest limiting exposure to television viewing in the formative years of brain development (Christakis, Zimmerman, DiGiuseppe, & Mc-Carty, 2004).

1.3.3 Psychological Causes

Bruno Bettelhmeim (1973), a child psychoanalyst, had proposed a diathesis-stress theory of ADHD, suggesting that hyperactivity develops when a predisposition to the disorder is coupled with authoritarian upbringing by parents. If a child with a disposition toward over activity and moodiness is stressed by a parent who is impatient and resentful, the child may be unable to cope up with the parent's demands for obedience. As the parent becomes more and more negative and disapproving, the parent-child relationship ends up in a battleground. When such a disruptive and disobedient pattern gets established, the child will not be able to handle the demands of school, and his or her behaviour will often be in conflict with the rules of the classroom.

Learning may also be responsible in causing ADHD as well. Hyperactivity could be reinforced by the attention it elicits, thereby increasing in frequency or intensity. Hyperactivity may also be modelled on the behaviour of parents and siblings.

However, such theories have not been supported by research. Neurological and genetic factors have far greater support than psychological factors in the etiology of ADHD.

1.3.4 Treatment of ADHD

ADHD is typically treated with medication and behavioural methods based on operant conditioning.

Medications

Stimulant medications (like methylphenidate, or Ritalin) have been prescribed for ADHD since the early 1960s. The prescription of these medications is sometimes continued into adolescence and adulthood as accumulating evidence suggests that the symptoms of ADHD do not usually disappear with the passage of time.

The drugs used to treat ADHD reduce disruptive behaviour and improve ability to concentrate. Numerous controlled studies comparing stimulants with placebos in double blind designs have shown short term improvements in concentration, goal-directed activity, classroom behaviour, and social interactions with parents, teachers, and peers and reductions in aggressiveness and impulsivity in about 75 percent of ADHD children (Spencer et al., 1996; Swanson et al., 1995).

Despite the promising findings on the efficacy of stimulant medications for ADHD, other research indicates that these drugs may not improve academic achievement over the long haul. Further, stimulant medications have side effects. In addition to transient loss of appetite and sleep problems a risky side effect of the widespread prescription of stimulants has emerged. Newsweek magazine reported in the mid-1990s that children had begun to use Ritalin and other stimulants obtained from their siblings or friends as recreational drugs. Its use has also spread among high school and college students not suffering from ADHD as they find that snorting it like cocaine helps them focus better on their schoolwork and ward off fatigue. While these misuses of Ritalin are indeed troubling, it is nonetheless effective in the treatment of ADHD and should be considered a critical component of treatment programs.

Psychological Treatment

Other than medications, the most promising treatments of ADHD children involve parent training and changes in classroom management based on operant-conditioning principles. These programs have demonstrated at least short-term success in improving both social and academic behaviour. In this treatment, children's behaviour is monitored at home and in school, and they are reinforced for behaving appropriately, for example, for remaining in their seats and working on assignments. Point systems and star charts are typical components of these programs. Youngsters earn points and younger children earn stars for behaving in certain ways; the children can then spend their earnings for rewards. The focus of these operant programs is on improving academic work, completing household tasks, or learning specific social skills, rather than on reducing signs of hyperactivity, such as running around and jiggling.

School interventions for children with ADHD include training teachers to understand the unique needs of these children and to apply operant techniques in

the classroom, peer tutoring in academic skills, and having teachers provide daily reports to parents about in-school behaviour, which is followed up with rewards and consequences at home. Research has demonstrated that certain classroom structures can have a favourable impact on children with ADHD. For example, in the ideal classroom environment teachers modify the presentation format and materials used for tasks, keep assignments brief and provide immediate feedback regarding accuracy, have an enthusiastic and task-focused style, provide breaks for physical exercise, use computer-assisted drill programs, and schedule academic work during the morning hours. Such environmental changes are designed to accommodate the limitations imposed by this disorder rather than to change the disorder itself.

1.4 CONDUCT DISORDER AND OPPOSITIONAL DEFIANT DISORDER

This group of externalising disorders involves a child's or an adolescent's relationship to social norms and rules of conduct. In both oppositional defiant disorder and conduct disorder, aggressive or antisocial behaviour is the focus. These disorders are closely linked. However, it is important to distinguish between persistent antisocial acts such as setting fires, where the rights of others are violated and the less serious pranks often carried out by normal children and adolescents. Also, oppositional defiant disorder and conduct disorder involve misdeeds that may or may not be against the law; *juvenile delinquency* is the legal term used to refer to violations of the law committed by minors.

1.4.1 Conduct Disorder(CD)

The DSM-IV-TR definition of conduct disorder focuses on behaviours that violate the basic rights of others and major societal norms. Nearly all such behaviour is also illegal. The types of behaviour considered typical of conduct disorder include aggression and cruelty toward people or animals, damaging property, lying, and stealing. Conduct disorder denotes a frequency and severity of acts that go beyond the mischief and pranks common among children and adolescents. Often the behaviour is marked by callousness, viciousness, and lack of remorse, making conduct disorder precursor for adult antisocial personality disorder.

1.4.2 Oppositional Defiant Disorder (ODD)

A related but less well understood externalising category in the DSM is oppositional defiant disorder (ODD). Oppositional defiant disorder is diagnosed if a child does not meet the criteria for conduct disorder, especially, if extreme physical aggressiveness is not met, but exhibits behaviours such as losing his or her temper, arguing with adults, repeatedly refusing to comply with requests from adults, deliberately doing things to annoy others, and being angry, spiteful, touchy, or vindictive. The DSM also mentions that such children, most of them boys, seldom see their conflicts with others as their fault; they justify their oppositional behaviour by claiming that unreasonable demands are being placed on them. In everyday talk these children are simply referred to as spoiled brats.

Population-based studies indicate that conduct disorder is fairly common. A review of epidemiological studies reveals prevalence rates ranging from 4 to 16 percent for boys and 1.2 to 9 percent for girls.

Many children with conduct disorder display other problems as well. There is a high degree of co morbidity between conduct disorder and ADHD. This is true for boys, much less is known about comorbid conduct disorder and ADHD among girls. Substance abuse also commonly co occurs with conduct problems. Anxiety and depression, generally viewed as internalising problems, and these are common among children with conduct disorder.

Important Distinction

While ODD is associated with overt and non destructive behaviours, CD is linked with overt and covert behaviours which can be destructive and violate the rights of others.

1.4.3 Etiology of Conduct Disorder

Different causes have been put forward for the etiology of conduct disorder, including biological, Psychological (learning and cognitive) and sociological factors.

Biological Factors

The evidence for genetic influences in conduct disorder is mixed, although heritability may well play a part. For example, a study of over 3,000 twin pairs indicated only modest genetic influence on childhood antisocial behaviour; family environment influences were found to be more significant (Lyons et al., 1995). However, a study of 2,600 twin pairs in Australia found a substantial genetic influence and almost no family environment influences for childhood symptoms of conduct disorder (Slutske et al., 1997). The authors of the latter study point out that the differences in the samples may have accounted for the different findings.

Evidence from twin studies indicates that aggressive behaviour (e.g., cruelty to animals, fighting, destroying property) is clearly heritable, whereas other delinquent behaviours (e.g., stealing, running away, truancy) may not be. Other evidence suggests that the period when antisocial and aggressive behaviour problems begin is related to heritability. For example, aggressive and antisocial behaviour that begins in childhood is more heritable than similar behaviours that begin in adolescence. What might be heritable in conduct disorder are temperamental characteristics that interact with other biological difficulties (e.g., neuropsychological deficits) as well as with a whole set of environmental factors (e.g., parenting, school performance, peer influences) to cause conduct disorder.

Neurological investigations have found less frontal lobe activity in the brains of youth with conduct disorder (Moffit & Henry, 1989). Neuropsychological deficits have been implicated in the childhood profiles of children with conduct disorder. These deficits include poor verbal skills, difficulty with executive functioning (the ability to anticipate, plan, use self-control, and problem solve), and problems with memory. In addition, children who develop conduct disorder at an earlier age have been shown to have an IQ score of one standard deviation below age-matched peers without conduct disorder, and this IQ deficit is apparently not due to lower socioeconomic status, race or school failure.

Psychological Factors

An important part of normal child development is the growth of moral awareness, the acquisition of a sense of what is right and wrong and the ability, even desire,

to abide by rules and norms. Most people refrain from hurting others not only because it is illegal but because it would make them feel guilty to do otherwise. Children with conduct disorder often seem to be deficient in this moral awareness, lacking remorse for their wrongdoing and viewing antisocial acts as exciting and rewarding, as central to their very self-concept.

According to learning theorists children can learn aggressiveness from parents who behave aggressively. Indeed, children who are physically abused by parents are likely to be aggressive when they grow up. Children may also imitate aggressive acts seen from other sources, such as on television. Since aggression is an effective, albeit unpleasant, means of achieving goals, it is likely to be reinforced. Thus, once imitated, aggressive acts will probably be maintained.

In addition, parenting characteristics such as harsh and inconsistent discipline and lack of monitoring are consistently associated with antisocial behaviour in children. Perhaps children who do not experience negative consequences for early signs of misbehaviour later develop more serious conduct problems. A social cognitive perspective on aggressive behaviour comes from the work of Kenneth Dodge and his associates. In one of his early studies, Dodge found that the cognitive processes of aggressive children had a particular attribution bias; these youngsters interpreted ambiguous acts, such as being bumped in line, as evidence of hostile intent. Such perceptions lead these children to retaliate aggressively for actions that may not have been intended as provocative. Subsequently, their peers, remembering these aggressive behaviours, tend to be aggressive more often against them, further angering the already aggressive children and continuing a cycle of rejection and aggression. Dodge has constructed a social-information processing theory of child behaviour that focuses on how children process information about their world and how these cognitions markedly affect their behaviour (Crick & Dodge, 1996).

Peer Influences

Investigations of how peers influence aggressive and antisocial behaviour in children have focused on two broad areas: Acceptance or rejection by peers and affiliation with deviant peers.

Being rejected by peers has been shown to be causally related to aggressive behaviour, particular in combination with ADHD. Studies have shown that being rejected by peers can predict later aggressive behaviour, even after controlling for prior levels of aggressive behaviour. Associating with other delinquent peers also increases the likelihood of delinquent behaviour (Patterson & Capaldi, 1991). But it is not confirmed whether delinquent children choose to associate with like-minded peers, thus continuing on their path of antisocial behaviour, or if simply being around delinquent peers can influence the beginnings of antisocial behaviour.

Sociological Factors

Social class and urban living are related to the incidence of delinquency. High unemployment, poor educational facilities, disrupted family life, and a subculture that finds delinquency acceptable have all been found to be contributing factors. The combination of early antisocial behaviour in the child and socio-economic disadvantage in the family predicts early criminal arrests.

1.4.4 Treatments and Outcomes

The management of conduct disorder is one of the most important challenges to society. We will discuss some of the psychological methods aimed at the individuals and their families.

As mentioned earlier, conduct disorder is the precursor to psychopathy. And like psychopaths, young people who commit violent and antisocial acts with little remorse or emotional involvement are highly difficult to reach. Incarceration, release, and recidivism is usually the pattern. One of society's most pressing problems is how to deal with people whose social conscience appears to be grossly underdeveloped. Simply jailing juvenile delinquents will not reduce crime. A longitudinal study demonstrated that punitive discipline, such as juvenile incarceration, leads to lower job stability and more adult crime. Thus, harsh discipline, whether imposed by the state or by the parents, appears to contribute in a major way to further delinquency and criminal activity in adulthood.

Family Interventions

Some of the most promising approaches to treating conduct disorder involve intervening with the parents or families of the child with conduct disorder. Gerald Patterson and his colleagues have developed a behavioural program of parental management training (PMT), in which parents are taught to modify their responses to their children so that pro social rather than antisocial behaviour is consistently rewarded. Parents are taught to use techniques such as positive reinforcement when the child exhibits positive behaviours and time-out and loss of privileges for aggressive or antisocial behaviours.

Multisystemic Treatment

A promising treatment for serious juvenile offenders is Henggeler's multisystemic treatment (MST). MST involves delivering intensive and comprehensive therapy services in the community, targeting the adolescent, the family, the school, and in some cases the peer group. The intervention views the conduct problem as influenced by multiple contexts within the family and between the family and other social systems.

The strategies used by MST therapists are varied, incorporating behavioural, cognitive, family-systems, and case-management techniques. The therapy's uniqueness and effectiveness lies in emphasising individual and family strengths, identifying the context for the conduct problems, using present-focused and action-oriented interventions, and using interventions that require daily or weekly efforts by family members. Treatment is provided in "ecologically valid" settings, such as the home, school, or local recreational centre, to maximise generalisation of therapeutic changes.

Cognitive Approaches

Although the above mentioned interventions with parents and families are a critical component of success, such treatments are expensive and time-consuming. Some families may not even be able or willing to become involved in it. Thus it is important to know about other research which indicates that individual cognitive therapy can improve children and their behaviour even without the involvement of the family. For example, teaching children cognitive skills to control their anger shows real potential in helping them reduce their aggressive behaviour. In

anger-control training, aggressive children are taught self-control in anger provoking situations. They learn to withstand verbal attacks without responding aggressively by using distracting techniques such as humming a tune, saying calming things to themselves, or turning away. The children then apply these self-control methods while a peer provokes and insults them.

Another strategy involves focusing on the deficient moral development of children with conduct disorder. Teaching moral-reasoning skills to groups of adolescents with behaviour problems in school has achieved some degree of success. This success is heartening, but other research cautions that behavioural changes produced by altering cognitive patterns may yield only short-term gains—improvements that maybe lost when the youngsters return to their familiar, "bad" neighbourhoods. Environmental contingencies—the communities in which people live –need to be considered when dealing with the complexities of aggression.

Self Assessment Questions

Multiple Choices

1) What percentage of the school-aged population can be expected to have ADHD?
   a) 20%–25%
   b) 12%–15%
   c) 1%–2%
   d) 3%–7%
2) Which of the following is a likely consequence of having the hyperactive/impulsive type of ADHD as a teenager?
   a) increased risk of car accidents as teenagers
   b) increased risk of drop out before graduation
   c) increased risk of having conduct problems
   d) all of the above
3) Parents report that children who are diagnosed with ADHD demonstrated all of the following in early childhood except:
   a) excessive sleep
   b) difficult temperament
   c) irritability
   d) establishing secure attachments with caregivers
4) Sam hits Joey because he thinks that Joey is going to hit him. Joey is shocked because he just turned around to look at the clock on the wall behind Sam. Sam's behaviour is likely the result of:
   a) relational aggression
   b) hostile attribution bias
   c) instrumental aggression
   d) bullying

5) Neurological investigations have found ..... in aggressive youth.

a) increased frontal lobe activity

b) high levels of DBH

c) decreased frontal lobe activity

d) low levels of hormone testosterone

1.5 ANXIETY DISORDERS OF CHILDHOOD AND ADOLESCENCE

Anxiety disorders are characterised by fear, worry, or dread that greatly impairs the ability to function normally and that is disproportionate to the circumstances at hand. Anxiety may also result in physical symptoms.

Some anxiety is a normal aspect of development, as in the following cases:

- Most toddlers become fearful when separated from their mother, especially in unfamiliar surroundings.
- Fears of the dark, monsters, bugs, and spiders are common in 3 to 4 year olds.
- Shy children may initially react to new situations with fear or withdrawal.
- Fears of injury and death are more common among older children.
- Older children and adolescents often become anxious when giving a book report or talking in front of their classmates.

Such difficulties should not be viewed as evidence of a disorder. However, if manifestations of anxiety become so exaggerated that they greatly impair functioning or cause severe distress, an anxiety disorder should be considered. At some point during childhood, about 10 to 15% of children experience an anxiety disorder (e.g., social phobia, separation anxiety disorder, specific phobia, panic disorder, acute and posttraumatic stress disorders), making these one of the most common disorders of childhood. Although most unrealistic childhood fears dissipate over time, it is also true that most of the adults suffering from anxiety can trace their problems back to their childhood.

The seriousness of childhood anxiety problems should therefore not be underestimated. Not only do they suffer, as adults do, from being anxious they also lose out on mastering developmental tasks at various stages of their lives. For example, a child who is painfully shy and who finds interacting with peers intolerable is also unlikely to learn how to interact with other people. This deficit will persist as the child grows into adolescence and later as an adult would lead to social retardation. The most common types of anxiety disorders which children usually suffer are mentioned below.

1.5.1 School Phobia

Social phobia, sometimes called school refusal, has serious academic and social consequences for the child and can be extremely disabling. Two types of school phobia have been identified. They are:

- Separation anxiety
- Phobia or fear of school

1.5.2 Separation Anxiety

This is one of the most common types of anxiety disorder. In this disorder, children worry constantly that some harm will befall their parents or themselves when they are away from their parents and when at home they shadow one or both of their parents. Although school refusal is the most common symptom of children with separation anxiety disorder (75%), only one third of all children who refuse to attend school do so because they have separation anxiety disorder.

Since the starting of school is usually the first circumstance that requires lengthy and frequent separation of children from their parents, separation anxiety is often a main cause of school phobia. One study found that 75 percent of children who have school refusal caused by separation anxiety have mothers who also avoided school during childhood. It has been hypothesised that the child's reluctance to go to school stems from some problem in the mother-child relationship. Perhaps the mother communicates her own separation anxieties and unwittingly reinforces the child's dependent and avoidant behaviour.

1.5.3 Fear of School

The second major type of school refusal is that associated with a true phobia of school i.e. either a fear specifically related to school or a more general social phobia. Children with this type of phobia generally begin refusing to go to school later in life and have more severe and pervasive avoidance of school. Their fear is more likely to be related to specific aspects of school environment, such as worries about academic failure or discomfort with peers.

Psychologists agree that if it is not treated, school phobia in childhood can have long-term negative consequences as the person grows into adolescence and adulthood. The child with a school phobia can grow up to be a seriously dependent and fearful person.

1.5.4 Social Phobia

Most classrooms have at least one or two children who are extremely quiet and shy. Often these children will play only with family members or familiar peers, avoiding strangers both young and old. Their shyness may prevent them from acquiring social skills and participating in a variety of activities enjoyed by most of their age mates, for they avoid playgrounds and games played by neighbourhood children. Although some children who are shy may simply be slow to warm up, withdrawn children never do, even after prolonged exposure to new people.

Extremely shy children may refuse to speak at all in unfamiliar social circumstances; this condition is called *selective mutism*. In crowded rooms they cling and whisper to their parents, hide behind the furniture, cower in corners, and may even have tantrums. At home they ask their parents endless questions about situations that worry them. Withdrawn children usually have warm and satisfying relationships with family members and family friends, and they show a desire for affection and acceptance.

Theories of etiology of social phobia in children are generally similar to theories of social phobia in adults. Research has shown that children with anxiety disorders overestimate the danger in many situations and underestimate their ability to cope with them. The anxiety created by these cognitions then interferes with social interaction, causing the child to avoid social situations and thus does not get much practice at social skills. Another reason could be that withdrawn children may simply not have the social know how that facilitates interaction with same age children. The finding that isolated children make fewer attempts to make friends and are less imaginative in their play may indicate a deficiency in social skills. Finally, isolated children may have become so because they have in the past spent most of their time with adults; these children interact more freely with adults than with other children.

1.6 ACUTE AND POSTTRAUMATIC STRESS DISORDERS (PTSD)

Acute stress disorder (ASD) is a brief period (about 1 month) of intrusive recollections (e.g., flashbacks and nightmares), dissociation, avoidance, and anxiety occurring within 1 month of a traumatic incident.

Posttraumatic stress disorder (PTSD) causes recurring, intrusive recollections of an overwhelming traumatic incident that persist more than one month, as well as emotional numbing and hyper arousal.

Because vulnerability and temperament are different, not all children who are exposed to a severe traumatic event develop a stress disorder. Traumatic events commonly associated with these disorders include assaults, sexual assaults, abuse, car accidents, dog attacks, and injuries (especially burns). In young children, domestic violence is the most common cause of post traumatic stress disorder.

Acute stress disorder (ASD) and post traumatic stress disorder (PTSD) are closely related and are distinguished primarily by duration of symptoms. ASD is diagnosed within 1 month of the traumatic event, and PTSD is diagnosed only after 1 month has passed and symptoms have persisted. In a few cases, onset of PTSD symptoms may be delayed months or even years after the traumatic event.

Emotional numbing and hyper arousal are common. Emotional numbing includes the following symptoms such as general lack of interest, social withdrawal, a subjective sense of feeling numb, a foreshortened expectation of the future (e.g., thinking "I will not live to see 20)". Hyper arousal symptoms include jitteriness, exaggerated startle response, difficulty relaxing, and disrupted sleep sometimes with frequent nightmares. Typically, children with acute stress disorder are in a daze and may seem dissociated from everyday surroundings.

Children with posttraumatic stress disorder have intrusive recollections that cause them to re-experience the traumatic event. The most dramatic kind of recollection is a flashback. Flashbacks may be spontaneous but are most commonly triggered by something associated with the original trauma. For example, the sight of a dog may trigger a flashback in children who experienced a dog attack. During a flashback, children may be in a terrified state and unaware of their current surroundings while desperately searching for a way to hide or escape; they may temporarily lose touch with reality and believe they are in grave danger. Some

children have nightmares. When children re-experience the event in other ways (e.g., in thoughts, mental images, or recollections), they remain aware of current surroundings, although they may still be greatly distressed.

Diagnosis is based on a history of severely frightening and horrifying trauma followed by re-experiencing, emotional numbing, and hyper-arousal. These symptoms must be severe enough to cause impairment or distress.

Prognosis for children with acute stress disorder is much better than for those with posttraumatic stress disorder, but both benefit from early treatment. Severity of the trauma, physical injuries, and the underlying resiliency of children and family members affect the final outcome.

Information

Parents who are overprotective or who are anxious themselves may act to shield the child from perceived threat and thereby reduce the child's opportunity to develop adequate coping skills while reinforcing the child's avoidance tendencies. At least one study has demonstrated that children who were anxiously attached as infants were twice as likely to develop an anxiety disorder in adolescence compared to peers who were securely attached.

1.7 TREATMENT OF ANXIETY DISORDERS

The anxiety disorders of childhood may continue into adolescence and young adulthood, leading first to maladaptive avoidance behaviour and later to increasingly idiosyncratic thinking and behaviour or an inability to "fit in" with a peer group. Typically, however, this is not the case. As effected children grow and have wider interactions in school and in activities with peers, they often benefit from experiences such as making friends and succeeding at given tasks. Teachers who are aware of the needs of overanxious, shy, and withdrawn children are often able to ensure that they will have successful experiences that help alleviate anxiety.

1.7.1 Medications

Psychopharmacological treatment of anxiety disorders in children and adolescents is becoming more common today. Birmaher et al., (2003) evaluated the efficacy of using fluoxetine in the treatment of a variety of anxiety based disorders and found the medication useful. However, the cautious use of medication is advisable as this might lead to dependence. Medications such as SSRIs often help in PTSD to reduce emotional numbing and re-experiencing of symptoms but are less effective for hyper arousal.

1.7.2 Psychological Treatment

Behaviour therapy procedures have proved to be useful with anxious children. Such procedures include assertiveness training to provide help with mastering essential competencies, and desensitisation to reduce anxious behaviour. Kendall and his colleagues have reported the successful use of manual-based cognitive behavioural treatment (well-defined procedures using positive reinforcement to enhance coping strategies to deal with fears) for children with anxiety disorders. Behavioural treatment approaches such as desensitisation must be explicitly

tailored to a child's particular problem, and in vivo methods (using real-life situations graded in terms of the anxiety they arouse) tend to be more effective than having the child "imagine" situations.

1.8 CHILDHOOD DEPRESSION

Despite reports of childhood depression dating as far back as the 1930s, there was early scepticism whether children were capable of experiencing depression. In the 1960s it was thought that depression in children manifested as delinquent behaviours whereas the 1970's ushered in the belief that children could experience depressed feelings, but only on a temporary basis (e.g., adjustment reaction). Today, it is recognised that children can experience the entire gamut of depressed feelings from depressed mood to depressed syndromes to depressive disorders; although there is controversy whether children and adolescents express the same symptoms as adults, and how to best categorise, assess, and treat the disorder in children and youth.

Currently, childhood depression is classified according to essentially the same DSM diagnostic criteria as are used for adults (American Psychiatric Association, DSM-IV-TR, 2000). However, recent research on the neurobiological correlates and treatment responses of children, adolescents, and adults has shown clear differences in hormonal levels and in the response to treatment. One modification used for diagnosing depression in children is that irritability is often found as a major symptom and can be substituted for depressed mood. Childhood depression includes behaviours such as withdrawal, crying, avoidance of eye contact, physical complaints, poor appetite, and even aggressive behaviour and in some cases suicide.

Depression in children and adolescents occurs with high frequency. The point prevalence (the rate at the time of the assessment) of major depressive disorder has been estimated to be between 0.4 and 2.5 percent for children and between 4.0 and 8.3 percent for adolescents. The lifetime prevalence for major depressive disorders in adolescents is between 15 and 20 percent. Before adolescence, rates of depression are somewhat higher in boys, but depression occurs at about twice the rate for adolescent girls as for adolescent boys.

1.8.1 Etiology of Childhood Depression

As with adults, evidence suggests that biological and psychological factors (learning) play a role in the development of depression in children.

Biological Factors

There appears to be an association between parental depression and mood problems in children. According to a study, children of parents with major depression were more impaired, received more psychological treatment, and had more psychological diagnoses than children of parents with no psychological disorders (Kramer, Warner, et. al. 1998). A controlled study of family history and onset of depression found that children from mood-disordered families had significantly higher rates of depression than those from non disordered families. The suicide attempt rate has also been shown to be higher for children of depressed parents (7.8 percent) than for the offspring of control parents (Weissman et. al. 1992). All these correlations suggest a potential genetic component to childhood depression, but in each case, learning could also be the causal factor.

Other biological factors might also make children vulnerable to depression. These factors include biological changes in the neonate as a result of alcohol intake by the mother during pregnancy. One recent study reported that prenatal exposure to alcohol is related to depression in children. Intense or persistent sensitisation of the central nervous system in response to severe stress might also induce hyper reactivity and alteration of the neurotransmitter system, leaving children vulnerable to later depression.

Psychological Factors

Learning of maladaptive behaviours appears to be important in childhood depressive disorders. A number of studies have indicated that children's exposure to early traumatic events can increase their risk for the development of depression. Children who have experienced past stressful events are susceptible to states of depression that make them vulnerable to suicidal thinking under stress. Children who are exposed to negative parental behaviour or negative emotional states may develop depressed mood themselves. For example, childhood depression has been found to be more common in divorced families.

One important area of research is focusing on the role of the mother-child interaction in the transmission of depressed mood. Specifically, investigators have been evaluating the possibility that mothers who are depressed transfer their low mood to their infants through their interactions with them. Depression among mothers is not uncommon and can result from several sources. Some women become depressed during pregnancy or following the delivery of their child, in part because of exhaustion and hormonal changes that can affect mood. Several investigators have reported that marital problems, delivery complications, and difficulties with the infant are also associated with depression in mothers. Although most of the studies have implicated the mother- child relationship in development of the disorder, depression in fathers has also been related to depression in children.

Another important line of research in childhood depression involves the cognitive behavioural perspective. Considerable evidence has shown that depressive symptoms are positively correlated with the tendency to attribute positive events to external, specific, and unstable causes and negative events to internal, global, and stable causes; wth fatalistic thinking; and with feelings of helplessness. For example, the child may respond to peer rejection or teasing by concluding that he or she has some internal flaw. Hinshaw (1994) considers the tendency to develop distorted mental representations an important cause of depression. In addition, children who show symptoms of depression tend to underestimate their self competence over time (Cole et al. 1998).

BOX: Characteristics Associated With Depression in Children and Adolescents

Characteristics and signs that may be associated with child and adolescent depression:

- Repeated complaints of vague physical symptoms (e.g., headaches, stomachaches, leg pains, feeling tired, weary, dizzy, feeling sick to the stomach); not feeling well.
- Frequent school absences without medical support; poor school performance.

- Extreme vulnerability to criticism; overly sensitive.
- Reckless and impulsive behaviour; heightened risk taking.
- Loss of interest in social contact; withdrawal from playing with friends.
- Frequent complaints of boredom.
- Irritable outbursts, angry provocations; hostility towards others.
- Unexplained crying; easily upset.
- Talk of running away from home.
- Substance or alcohol abuse.
- Repeated comments that no one cares about them; or no one loves them.
- Difficulty with relationships.

Source: Adapted from the NIMH Fact Sheet (2000) on depression.

1.8.2 Treatment of Depression

The view that childhood and adolescent depression is like adult depression has prompted researchers to treat children displaying mood disorders – particularly adolescents who are viewed as suicidal with medications that have worked with adults. Research on the effectiveness of antidepressant medications with children is both limited and contradictory at best, and some studies have found them to be only moderately helpful. Some present studies using fluoxetine (Prozac) with depressed adolescents have shown the drug to be more effective than a placebo, and recent studies have shown fluoxetine to be effective in the treatment of depression along with cognitive behavioural therapy although complete remission of symptoms was seldom obtained.

Antidepressant medications may have some undesirable side effects (nausea, headaches, nervousness, insomnia, and even seizures) in children and adolescents. Attention is also being given to the increased risk of suicidal ideation and behaviour in children and adolescents who are taking SSRIs for their depression. However, the use of antidepressant medication for depressed adolescents has increased from three to fivefold over the past 10 years.

An important aspect of psychological treatment with children is providing a supportive emotional environment in which they can learn more adaptive coping strategies and effective emotional expression. Older children and adolescents can often benefit from a positive therapeutic relationship in which they can discuss their feelings openly. Younger children and those with less developed verbal skills can benefit from play therapy. Controlled studies of psychological treatment with depressed adolescents have shown significantly reduced symptoms with cognitive behavioural therapy (Brent, Holder, et. al. 1997) derived from Beck's cognitive behavioural approach. But over the past few years, the predominant approach for treating depression in children and adolescents has been the combined use of medication and psychotherapy.

Self Assessment Questions

Multiple choices

1) All of the following have been found to increase the risk for childhood depression, *except*:

a) family conflict

b) increased attentional control

c) harsh parenting style

d) peer rejection

2) Children and youth who were raised by depressed mothers exhibit all of the following *except*:

a) increased risk for developing insecure attachments

b) increased risk for depression themselves

c) increased emotional regulation

d) responses to having a mother who is less emotionally available

3) Anil's mother is concerned because Anil is very fearful of monsters and is afraid of the dark. You explain to Anil's mother that at Anil's age this is a common fear. How old is Anil?

a) 7 years old

b) 9 years old

c) 6 years old

d) 4 years old.

4) Which of the following is not a common type of phobia?

a) fear of books

b) fear of heights

c) fear of thunder

d) fear of flying

5) Which of the following is FALSE regarding separation anxiety disorder and school refusal?

a) 75% of children with separation anxiety disorder demonstrate school refusal

b) only 10% of children who refuse to attend school have separation anxiety disorder

c) school refusal can occur for many reasons, including school bullying

d) highly structured behavioural methods are the best intervention for school refusal

1.9 LET US SUM UP

Mental health problems in children are relatively common. This is defined as a disturbance in the areas of relationship, feelings, behaviour or development. These disturbances must be of sufficient severity as to require professional intervention. Many developmental, emotional and behavioural problems are short-lived. For instance, fears in small children, temper tantrums in toddlers and periods of defiance in adolescence are common; they may cause worry for a period without ever needing any professional intervention. However, if a child is doing something that is outside the range you would expect for his or her age and circumstances

and is either causing or experiencing distress (in the children themselves and all those who care for them), then there is a problem which merits attention. Similarly, if what he or she is doing is getting in the way of living a reasonable life, there is a problem.

Childhood disorders are often organised in two broad categories, called externalising and internalising disorders. Externalising disorders are characterised by behaviours, such as aggressiveness, noncompliance, over activity, and impulsiveness, and include the DSM IVTR categories of ADHD, conduct disorder (CD), and oppositional defiant disorder (ODD). Internalising disorders are characterised by more inward-focused experiences and behaviours such as depression, social withdrawal, and anxiety, and include childhood anxiety and mood disorders.

Attention Deficit Hyperactivity Disorder is one of the more common behaviour problems of childhood. In this disorder, the child shows impulsive, overactive behaviour that interferes with his or her ability to accomplish tasks. The major approaches to treating hyperactive children have been medication and behaviour therapy. Using medications with children is somewhat controversial. Behaviour therapy, particularly cognitive behavioural methods, has shown a great deal of promise in modifying the behaviour of hyperactive children.

In conduct disorder, a child engages in persistent aggressive or antisocial acts. The possible causes of conduct disorder or delinquent behaviour include biological factors, personal pathology, family patterns, and peer relationships.

Children who suffer from anxiety or depressive disorders typically do not cause trouble for others through their aggressive conduct. Rather, they are fearful shy, withdrawn, and insecure and have difficulty adapting to outside demands. The anxiety disorders may be characterised by extreme anxiety, withdrawal, or avoidance behaviour. A likely cause is early family relationships that generate anxiety and prevent the child from developing more adaptive coping skills.

1.10 UNIT END QUESTIONS

1) Describe ADHD and its sub categories?
2) Discuss the etiology and treatment for ADHD?
3) Discuss the difference between conduct disorder and oppositional defiant disorder?
4) Describe the causal factors implicated in conduct disorder and treatment of conduct disorder?
5) Describe in detail the anxiety disorders in children and adolescents?
6) Discuss the etiology and treatment for depression in children and adolescents?

1.11 GLOSSARY

Disinhibition	**:**	A lack of restraint
Incarceration	**:**	Detention of a person in jail
Recidivism	**:**	The chronic tendency toward repetition of criminal or anti social behaviour patterns or state of returning habitually to crime.

1.12 SUGGESTED READINGS

Bennett , Paul 2005. *Abnormal and Clinical Psychology: An Introductory Textbook*, 2nd Edn. Open University Press, McGraw-Hill Education: England.

Barlow, D.H., & Durand, V.M. 2007. *Abnormal Psychology: An Integrative Approach.* Thomson Learning Inc., New Delhi.

Carson, R. C., Butcher, J. N., Mineka, S., Hooley, J.M. 2007. *Abnormal Psychology.* Pearson Education: New Delhi.

Sarason, I.G., & Sarason, B.R.2005. *Abnormal Psychology: The Problem of Maladaptive Behaviour.* Prentice-Hall of India: New Delhi.

Sharma, R., 2006. *Abnormal Psychology*. Atlantic Publishers & Distributors: New Delhi.

1.13 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) d, 2) d, 3) a, 4) b, 5) c

Self Assessment Questions 2

1) b, 2) c, 3) d, 4) a, 5) b

UNIT 2 LEARNING DISABILITIES

Structure

2.0 INTRODUCTION

Academic achievement is highly valued in our society. It often causes parents to invest a great deal of time and emotional energy to ensure their children's academic success, it can also be very upsetting when a child with no obvious intellectual deficits does not achieve as expected. A learning disability is a neurological disorder. In simple terms, it results from a difference in the way a person's brain is "wired." People with learning disabilities are as smart as or smarter than their peers, but they have difficulty reading, writing, spelling, reasoning, recalling and/or organising information if left to figure things out by themselves or if taught in conventional ways. This unit will focus on building an in depth understanding of learning disabilities. We will describe the different types of learning disabilities classified in DSM-IV-TR. The causes and the different types of problems and issues associated with learning disabilities would be discussed. We will also focus on diagnosis and intervention for learning disabilities.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Define learning disabilities;
- Describe the characteristics of learning disabilities;
- Explain the causes and types of learning disabilities;
- Analyse the various problems and issues related to learning disabilities; and
- Explain the process of diagnosis and intervention in learning disabilities.

2.2 LEARNING DISABILITIES

> "He has the ability, if he just tried harder, he could do it. He chooses not to do the work."
>
> "If she would just pay attention, she would get it."
>
> "After I give the instructions, he sits there and stares at his paper. He is not motivated."

Children with a learning disability cannot try harder, pay closer attention, or improve motivation on their own; they need help to learn how to do those things. Learning disabilities signify inadequate development in a specific area of academic, language, speech, or motor skills. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning.

A learning disability is a type of neurological disorder that affects the brain's ability to receive, process, store, and respond to information. Learning disabilities can affect a child's ability in the areas of listening, speaking, reading, writing, and mathematics.

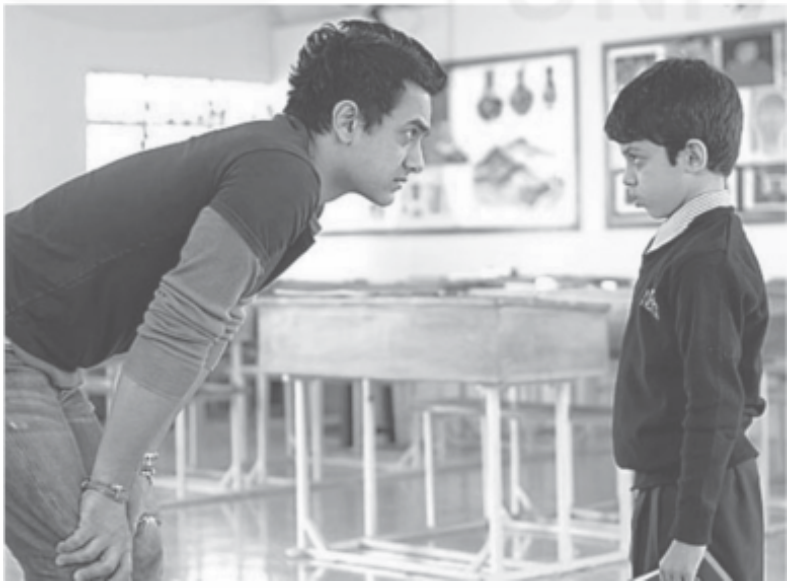


Fig. 2.1: Movie "Taare Zamein Par" dealt with issue of Learning disability

Children with learning disabilities are usually of average or above average intelligence but have difficulty acquiring the basic academic skills that are essential

for success at school and work, and for coping with life in general. These children show a distinct gap between the level of achievement that is expected and what is actually being achieved. These disorders are not primarily due to hearing and/ or vision problems, mental retardation, autism, cultural or linguistic differences, and lack of motivation or ineffective teaching.

Learning disabilities can be lifelong conditions that in some cases affect many parts of a person's life. In some people, many overlapping learning disabilities may be apparent. Other people may have a single, isolated learning problem that has little impact on other areas of their lives.

2.3 TYPES OF LEARNING DISABILITIES

"Learning disability" is not a diagnosis in the same sense as "chickenpox" or "Flu". Chickenpox and Flu imply a single, known cause with a predictable set of symptoms. Rather, Learning disability is a broad term that covers a range of possible causes, symptoms, treatments, and outcomes. Partly because learning disabilities can show up in so many forms, it is difficult to diagnose or to pinpoint the causes. And no one knows of a pill or remedy that will cure them.

Not all learning problems are necessarily learning disabilities. Many children are simply slower in developing certain skills. Because children show natural differences in their rate of development, sometimes what seems to be a learning disability may simply be a delay in maturation. To be diagnosed as a learning disability, specific criteria must be met. The term learning disabilities is not used by DSM-IV-TR but is used by most health professionals to group together three disorders that do appear in the DSM. Learning disabilities can be divided into three broad categories:

- Learning disorders
- Communication disorders
- Motor Skills disorders

Any of these disorders may apply to a child who fails to develop to the degree expected by his or her intellectual level in a specific academic, language or motor skill area. Each of these categories includes a number of more specific disorders. Table below presents the details.

Table: Specific Types of Learning Disabilities

Type of Learning	Primary Area Affected	Description of Difficulties
Dyscalculia	Mathematics	Problems understanding and using math concepts and symbols, recalling math facts and understanding concepts such as time and money. At its most basic level, problems may exist in simple counting due to problems with one to one correspondence. Student may not be able to count by 3s or 5s. Math word problems are difficult because the

		student does not have a sense of what information is relevant and what is irrelevant to solving the problem.
Dysgraphia	Written Expression	Handwriting can be illegible due to poor letter formation and poor letter spacing. Academic problems may include spelling and excessive time required to execute written notes and assignments. Often experience difficulty organising information and in starting written assignments.
Dyslexia	Reading, Spelling	Problems in recalling letter sequences ("gril" for "girl"), sound to symbol association (recall the sound that goes with the letter b), and word forms (was vs. saw). Student may mix up letters within words and words within sentences while reading. Letter reversals (b and d), inversions (p and d) are common, and can also extend to numbers (9 for 6). Often there are problems with directionality and spatial orientation (left and right).
Dyspraxia	Tasks requiring fine motor skills	May demonstrate a specific disorder in the area of motor skill development. May experience problems planning and completing fine motor tasks. Approximately 2% of the general population is afflicted and about 70% are male. Simple tasks such as buttoning a shirt or more complex tasks such as using scissors to cut straight lines or brushing teeth may be a challenge.
Nonverbal Learning Disability	Mathematics and Spatial Awareness	Impaired functioning evident in non language areas, such as mathematics, visual/spatial organisation and motor coordination. Social skills are also impaired due to problems with interpreting subtle social cues.

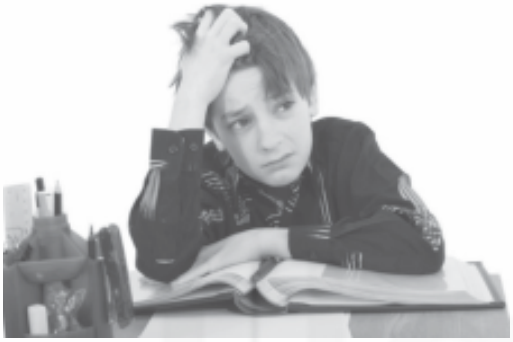
Let us take learning disorders and deal with it.

2.3.1 Learning Disorders

Students with learning disorders are often years behind their classmates in developing reading, writing, or arithmetic skills. DSM-IV-TR divides learning disorders into three categories:

- Reading disorder
- Disorder of written expression
- Mathematics disorder

None of these diagnoses is appropriate if the disability can be accounted for by a sensory deficit, such as a visual or auditory problem.



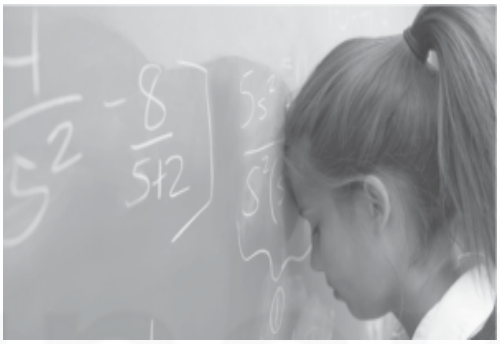


Fig.2.2

Children with learning disorders find classroom a frustrating place when they are unable to understand what they are reading or to follow directions.

Self Assessment Questions

1) Define Learning disability.

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2) What are the types of learning disabilities?

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3) What are the subtypes of learning disabilities?

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2.3.2 Reading Disorder

This type of disorder, also known as *dyslexia*, is quite widespread. In fact, reading disabilities affect 5 to 10 percent of school-age children. Children with reading disorder have significant difficulty with word recognition, reading comprehension and written spelling. When reading out loud they omit, add, or distort the pronunciation of words to an extent which is unusual for their age. In adulthood, problems with reading, comprehension, and written spelling persist. But presence of this disorder does not prevent the person from great achievements. For example, Tom Cruise, well-known actor, has dyslexia.

Scientists have found that a significant number of people with dyslexia share an inability to distinguish or separate the sounds in spoken words. A child with dyslexia, for example, might have problem in identifying the word "bat" by sounding out the individual letters, b-a-t. Other children with dyslexia may have trouble with rhyming games, such as rhyming "cat" with "bat." These skills are fundamental to learning to read. Fortunately, remedial reading specialists have developed techniques that can help many children with dyslexia acquire these skills.

However, there is more to reading than recognising words. If the brain is unable to form images or relate new ideas to those stored in memory, the reader can't understand or remember the new concepts. So other types of reading disabilities can appear in the higher grades when the focus of reading shifts from word identification to comprehension.

Remember

There is a common misperception that all people with dyslexia see words backwards (e.g., was for saw). However, only about 30% of persons with dyslexia have trouble with reversing letters and numbers.

2.3.3 Disorder of Written Expression

This disorder involves impairment in the ability to compose the written word i.e. spelling errors, errors in grammar or punctuation, or very poor handwriting which is serious enough to interfere significantly with academic achievement or activities of daily living that require writing skills.

Writing involves several brain areas and functions. The brain networks for vocabulary, grammar, hand movement, and memory must all be in good working order. So a developmental writing disorder may result from problems in any of these areas. For example, a child, who is unable to distinguish the sequence of sounds in a word, has problems with spelling. A child with a writing disability might be unable to compose complete, grammatical sentences.

2.3.4 Mathematics Disorder

Children with mathematics disorder may have difficulty rapidly and accurately recalling arithmetic facts, counting objects correctly and quickly, or aligning numbers in columns.

If you doubt that arithmetic is a complex process, think of the steps you take to solve this simple problem: 25 divided by 3 equals?

Arithmetic involves recognising numbers and symbols, memorising facts such as the multiplication table, aligning numbers, and understanding abstract concepts like place value and fractions. Any of these may be difficult for children with arithmetic disorder. Problems with numbers or basic concepts are likely to show up early. Disabilities that appear in the later grades are more often tied to problems in reasoning.

Many aspects of speaking, listening, reading, writing, and arithmetic overlap and build on the same brain capabilities. So it's not surprising that people can be diagnosed as having more than one area of learning disability. For example, the ability to understand language underlies learning to speak. Therefore, any disorder that hinders the ability to understand language will also interfere with the development of speech, which in turn hinders learning to read and write. A single gap in the brain's operation can disrupt many types of activity.

2.3.5 Communication Disorders

Speech and language problems are often the earliest indicators of a learning disability. People with developmental speech and language disorders have difficulty producing speech sounds, using spoken language to communicate, or understanding what other people say. Depending on the problem, the specific diagnosis may be:

- Expressive Language disorder
- Mixed Receptive-Expressive Language disorder
- Phonological disorder
- Stuttering

2.3.6 Expressive Language Disorder

In expressive language disorder, the child has difficulty expressing himself or herself in speech. The child might look eager to communicate but would have difficulty finding the right words. For example, he may be unable to come up with the word *bus* when pointing to a bus on the road. By age four, such child would be able to speak only in short phrases. Old words are easily forgotten when new ones are learned and also the use of grammatical structures would be below his age level.

Remember

According to the *DSM*, expressive language disorders may occur in communication regardless of whether the communication is oral or sign language.

2.3.7 Mixed Receptive Expressive Language Disorder

In addition to having expressive language problems, as mentioned above, children in this category also experience receptive language difficulties (understanding words, sentences, or types of words, e.g., spatial, quantity, and so forth). Some people have trouble understanding certain aspects of speech. It's as if their brains are set to a different frequency and the reception is poor. For example, a toddler who doesn't respond to his name, a preschooler who hands you a bell when you asked for a ball, or a worker who consistently can't follow simple directions. Their hearing is fine, but they can't make sense of certain sounds, words, or

sentences they hear. They may even seem inattentive. Because using and understanding speech are strongly related, many people with receptive language problem also have an expressive language disability.

Of course, in preschoolers, some misuse of sounds, words, or grammar is a normal part of learning to speak. It's only when these problems persist that there is any cause for concern.

2.3.8 Phonological Disorder

Children with phonological disorder are able to comprehend and use a substantial vocabulary but their speech is not clear. Children with this disorder have trouble controlling their rate of speech. Or they may lag behind playmates in learning to make speech sounds. For example, a child at age 6 might still say "wabbit" instead of "rabbit" and "thwim" for "swim." They have not learned articulation of the later-acquired speech sounds, such as *r, sh, th, f, z, l,* and *ch.* Developmental articulation disorders are common. They appear in at least 10 percent of children younger than age 8. Fortunately, articulation disorders can often be outgrown or successfully treated with speech therapy.

Stuttering

This involves disturbance in verbal fluency that is characterised by one or more of the following speech patterns:

- Frequent repetitions or prolongations of sounds (e.g., "C-c-c-c-can I go?").
- Long pauses between words.
- Substituting easy words for those that are difficult to pronounce.
- Repeating whole words (e.g., saying "go-go-go-go" instead of just one "go").
- Sometimes bodily twitching and eye blinking accompany the verbal difficulties.

Stuttering can interfere with academic, social and occupational functioning and can prevent a capable person from reaching his potential. It is worse when the person gets nervous or anxious. This usually shows up at around age five and almost always before the age of ten and is found three times more in males than females. Recovery can be spontaneous.

2.3.9 Motor Skills Disorder

Motor skills disorder, also known as developmental coordination disorder, involves impairment in the development of motor coordination that is not explainable by mental retardation or a known physical disorder such as cerebral palsy. Children having this disorder would have difficulty tying shoe laces and buttoning shirts and, when older, with playing ball, printing or handwriting. This diagnosis is made only if the impairment interferes significantly with academic achievement or with activities of daily living.

Self Assessment Questions

1) What is reading disorder? Give examples.

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2) What is meant by disorders of writing expressions?

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3) Define communication disorder and present the characteristics.

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4) What is phonological disorder?

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5) Describe the motor skills disorder.

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2.4 CAUSES OF LEARNING DISABILITIES

One of the first questions parents ask when they learn their child has a learning disorder is *"Why? What went wrong?"*

Mental health professionals stress that since no one knows what causes learning disabilities, it doesn't help parents to look backward to search for possible reasons. There are too many possibilities to pin down the cause of the disability with certainty. It is far more important for the family to move forward in finding ways to get help.

Scientists, however, do need to study causes in an effort to identify ways to prevent learning disabilities. Once, scientists thought that all learning disabilities were caused by a single neurological problem. But research has helped us see

that the causes are more diverse and complex. New evidence seems to show that most learning disabilities do not stem from a single, specific area of the brain, but from difficulties in bringing together information from various brain regions.

Today, a leading theory is that learning disabilities stem from subtle disturbances in brain structures and functions. Some scientists believe that, in many cases, the disturbance begins before birth.

2.4.1 Errors in Foetal Brain Development

Throughout pregnancy, the foetal brain develops from a few all-purpose cells into a complex organ made of billions of specialised, interconnected nerve cells called neurons. During this evolution, things can go wrong that may alter how the neurons form or interconnect.

In the early stages of pregnancy, the brain stem forms. It controls basic life functions such as breathing and digestion. Later, a deep ridge divides the cerebrum—the thinking part of the brain—into two halves, a right and left hemisphere. Finally, the areas involved with processing sight, sound, and other senses develop, as well as the areas associated with attention, thinking, and emotion. As new cells form, they move into place to create various brain structures. Nerve cells rapidly grow to form networks with other parts of the brain. These networks are what allow information to be shared among various regions of the brain.

Throughout pregnancy, this brain development is vulnerable to disruptions. If the disruption occurs early, the foetus may die, or the infant may be born with widespread disabilities and possibly mental retardation. If the disruption occurs later, when the cells are becoming specialised and moving into place, it may leave errors in the cell makeup, location, or connections. Some scientists believe that these errors may later show up as learning disorders.

2.4.2 Other Factors That Affect Brain Development

Through experiments with animals, scientists are trying to determine what disrupts brain development. By studying the normal processes of brain development, scientists can better understand what can go wrong. Some of these studies are examining how genes, substance abuse, pregnancy problems, and toxins may affect the developing brain.

Genetic Factors

The fact that learning disabilities tend to run in families indicates that there may be a genetic link. For example, children who lack some of the skills needed for reading, such as hearing the separate sounds of words, are likely to have a parent with a related problem. However, a parent's learning disability may take a slightly different form in the child. A parent who has a writing disorder may have a child with an expressive language disorder. For this reason, it seems unlikely that specific learning disorders are inherited directly. Possibly, what is inherited is a subtle brain dysfunction that can in turn lead to a learning disability.

There is also an alternative explanation for why learning disability might seem to run in families. Some learning difficulties may actually stem from the family environment. For example, parents who have expressive language disorders might

talk less to their children or the language they use may be distorted. In such cases, the child lacks a good model for acquiring language and therefore, may seem to be learning disabled.

Tobacco, Alcohol, and Other Drug Use

Many drugs taken by the mother pass directly to the foetus. Research shows that a mother's use of cigarettes, alcohol, or other drugs during pregnancy may have damaging effects on the unborn child. Therefore, to prevent potential harm to developing babies, efforts are being made by governments all over the world to make people aware of the possible dangers of smoking, drinking, and using drugs.

Scientists have found that mothers who smoke during pregnancy may be more likely to bear smaller babies. This is a concern because small newborns, usually those weighing less than 5 pounds (or less than 2.5 kg), tend to be at risk for a variety of problems, including learning disorders.

Alcohol is also dangerous to the foetus' developing brain. It appears that alcohol may distort the developing neurons. Heavy alcohol use during pregnancy has been linked to foetal alcohol syndrome, a condition that can lead to low birth weight, intellectual impairment, hyperactivity, and certain physical defects. Any alcohol use during pregnancy, however, may influence the child's development and lead to problems with learning, attention, memory, or problem solving. Because scientists have not yet identified "safe" levels, alcohol should not be used by women who are pregnant or who may soon become pregnant.

Drugs such as cocaine-especially in its smoke able form known as *crack*-seem to affect the normal development of brain receptors. These brain cell parts help to transmit incoming signals from our skin, eyes, and ears, and help regulate our physical response to the environment. Because children with certain learning disabilities have difficulty understanding speech sounds or letters, some researchers believe that learning disabilities, as well as ADHD, may be related to faulty receptors. Current research points to drug abuse as a possible cause of receptor damage.

2.4.3 Problems During Pregnancy and Delivery

Other possible causes of learning disabilities involve complications during pregnancy. In some cases, the mother's immune system reacts to the foetus and attacks it as if it were an infection. This type of disruption seems to cause newly formed brain cells to settle in the wrong part of the brain. Or during delivery, the umbilical cord may become twisted around the neck and temporarily cut off oxygen to the foetus. This, too, can impair brain functions and lead to Learning disability.

2.4.4 Toxins in the Child's Environment

New brain cells and neural networks continue to be produced for a year or so after the child is born. These cells are vulnerable to certain disruptions, also.

Researchers are looking into environmental toxins that may lead to learning disabilities, possibly by disrupting childhood brain development or brain processes. Cadmium and lead, both prevalent in the environment, are becoming a leading focus of neurological research. Cadmium, used in making some steel

products, can get into the soil, then into the foods we eat. Lead was once common in paint and gasoline, and is still present in some water pipes. A study of animals sponsored by the National Institutes of Health showed a connection between exposure to lead and learning difficulties. In the study, rats exposed to lead experienced changes in their brainwaves, slowing their ability to learn. The learning problems lasted for weeks, long after the rats were no longer exposed to lead.

In addition, there is growing evidence that learning problems may develop in children with cancer who had been treated with chemotherapy or radiation at an early age. This seems particularly true of children with brain tumours who received radiation to the skull.

Self Assessment Questions

1) What are the causes of learning disabilities?

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2) What are the factors that affect brain development that lead to learning disabilities?

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3) Describe the problems during pregnancy and delivery that would affect braing development.

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4) How does toxin in the child's environment affect the child's learning ?

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2.5 LEARNING DISABILITIES: RELATED PROBLEMS AND ISSUES

2.5.1 Social, Emotional and Behavioural Difficulties

When students have learning difficulties, sometimes secondary issues emerge. Students can get anxious about school work or become depressed. Behaviours can develop that are coping strategies to deal with frustration. While these behaviours are not seen by others as effective, they may indeed serve an important function to the student:

Work avoidance: avoids embarrassment – "it is better to not do work than to do it and get a poor grade – it is better to be seen as forgetful than stupid".

Denial of problems: "if I ignore the problem I feel better now".

Acting out in class: "if I am silly in class my peers may value me. If I get kicked out of class I won't have to read aloud. It is better to be seen as bad than stupid".

Drugs and Alcohol: "these help me feel better and hanging out with kids involved with similar activities. It is at least a group that wants me".

Social and emotional skills are an area where a parent can have a huge impact. For all children, but especially those with learning disabilities, social and emotional skills are the most consistent indicators of success, outweighing everything else, including academic factors. Academic challenges may lead to low self–esteem, withdrawal and behaviour problems, but these things can be countered by creating a strong support system for the child and helping them learn to express themselves, deal with frustration and work through challenges. Focus should be on their growth as a person, and not just on academic achievements which will help them learn good emotional habits and the right tools for lifelong success.

2.5.2 Other Disorders that Make Learning Difficult

Difficulty in school doesn't always stem from a learning disability. Anxiety, depression, stressful events, emotional trauma, and other conditions affecting concentration make learning more of a challenge.

ADHD – Attention Deficit Hyperactivity Disorder (ADHD), while not considered a learning disability, can certainly disrupt learning. Children with ADHD often have problems with sitting still, staying focused, following instructions, staying organised, and completing homework.

Autism – Difficulty mastering certain academic skills can stem from Pervasive Developmental Disorders such as autism and Asperger's syndrome. Children with an autism spectrum disorder may have trouble making friends, reading body language, communicating, and making eye contact.

2.6 DIAGNOSIS OF LEARNING DISABILITY

Learning disability is defined as a significant gap between a person's intelligence and the skills the person has achieved at each age. This means that a severely retarded 10-year-old who speaks like a 6-year-old probably doesn't have a

language or speech disability. He has mastered language up to the limits of his intelligence. On the other hand, a fifth grader with an IQ of 100 who can't write a simple sentence probably does have learning disability.

Learning disorders may be informally identified by observing significant delays in the child's skill development. A 2-year delay in the primary grades is usually considered significant. So learning disabilities aren't usually suspected unless there is more than a 2-year delay. Actual diagnosis of learning disabilities, however, is made using standardised tests that compare the child's level of ability to what is considered normal development for a person of that age and intelligence.

Factors that affect test outcomes include the child's actual abilities, the reliability of the test instrument, and his ability to understand the directions, questions, and pay attention during the testing session. Learning disabilities are diagnosed in different ways.

Vision and hearing are always tested to rule out sensory impairment and assure that the person can see and hear clearly.

Academic skills disorders, reading, math, and writing are evaluated using standardised tests. (e.g., Specific learning disability (SLD) battery)

Intelligence testing is completed by a psychologist.

Pronunciation, vocabulary, and grammar are compared to the developmental abilities of same-age peers to diagnose speech and language disorders.

Medical doctors check for ear infections or throat and vocal cords problems.

Once all other possible factors that might have caused the learning problems are eliminated, diagnosis of a learning disability might be made.

Important Distinction

As part of the differential diagnoses, the *DSM–IV–TR* (APA, 2000) notes that a key defining feature in making a differential diagnosis between mental retardation and a learning disorder is that in mental retardation, academic achievement is low, but commensurate with expected IQ. However, in those with a learning disorder, academic achievement is substantially below measured intelligence.

2.7 INTERVENTION FOR LEARNING DISABILITIES

Although obtaining a diagnosis is important, even more important is getting the right help. Because learning disabilities can affect the child and family in so many ways, help may be needed on a variety of fronts: educational, medical, emotional, and practical.

In most ways, children with learning disabilities are no different from children without these disabilities. At school, they eat together and share sports, games, and after-school activities. But since children with learning disabilities do have specific learning needs, schools should provide special programs. Schools should typically provide special education programs either in a separate all-day classroom or as a special education class that the student attends for several hours each

week. Parents can also hire trained tutors to work with their child after school. If the problems are severe, parents can also choose to place their child in a special school for the learning disabled.

Special education teachers identify the types of tasks the child can do and the senses that function well. By using the senses that are intact and bypassing the disabilities, many children can develop needed skills. These strengths offer alternative ways the child *can* learn. After assessing the child's strengths and weaknesses, the special education teacher designs an Individualised Educational Program (IEP). The IEP outlines the specific skills the child needs to develop as well as appropriate learning activities that build on the child's strengths. Many effective learning activities engage several skills and senses. For example, in learning to spell and recognise words, a student may be asked to see, say, write, and spell each new word. The student may also write the words in sand, which engages the sense of touch. Many experts believe that the more senses children use in learning a skill, the more likely they are to retain it.

Researchers are also investigating nonstandard teaching methods. Some create artificial learning conditions that may help the brain receive information in nonstandard ways. For example, in some language disorders, the brain seems abnormally slow to process verbal information. Scientists are testing whether computers that talk can help teach children to process spoken sounds more quickly. The computer starts slowly, pronouncing one sound at a time. As the child gets better at recognising the sounds and hearing them as words, the sounds are gradually speeded up to a normal rate of speech.

The effects of learning disabilities can ripple outward from the disabled child or adult to family, friends, and peers at school or work. Children with learning disabilities often absorb what others thoughtlessly say about them. They may define themselves in light of their disabilities, as "behind," "slow," or "different."

Specially designed computer games may help

Fig. 2.3: Children improve their language skills

Sometimes they don't know how they're different, but they know how awful they feel. Their tension or shame can lead them to act out in various ways-from withdrawal to belligerence. They may stop trying to learn and achieve and eventually drop out of school. Or they may become isolated and depressed.

Children with learning disabilities and attention disorders may have trouble making friends with peers. Some children with delays may be more comfortable with younger children who play at their level. Social problems may also be a product of their disability. Some people with learning disabilities seem unable to interpret tone of voice or facial expressions. Misunderstanding the situation, they act inappropriately, turning people away.

Without professional help, the situation can spiral out of control. The more that children or teenagers fail, the more they may act out their frustration and damage their self-esteem. The more they act out, the more trouble and punishment it brings, further lowering their self-esteem. Having a child with a learning disability may also be an emotional burden for the family. Parents often sweep through a range of emotions: denial, guilt, blame, frustration, anger, and despair. Brothers and sisters may be annoyed or embarrassed by their sibling, or jealous of all the attention the child with learning disability gets.

Counselling can be very helpful to people with LD and their families. Counselling can help affected children, teenagers, and adults develop greater self-control and a more positive attitude toward their own abilities. Talking with a counsellor or psychologist also allows family members to air their feelings as well as get support and reassurance.

Science Talks

In one study, researchers found that Kindergarten children differed in their ability to answer the question: "Which number is bigger—4 or 3?" Despite controlling for student ability to count and produce simple calculations, students with higher socio-economic status (SES) answered the question correctly 96% of the time compared to only 18% accuracy for children from lower SES backgrounds. The researchers suggest that number sense development may be linked to informal learning in some home environments and that early intervention (pre-K or K) may be beneficial in allowing some students to catch up.

Many parents find that joining a support group also makes a difference. Support groups can be a source of information, practical suggestions, and mutual understanding. Self-help books written by educators and mental health professionals can also be helpful.

Behaviour modification also seems to help many children with learning disability. In behaviour modification, children receive immediate, tangible rewards when they act appropriately. Receiving an immediate reward can help children learn to control their own actions, both at home and in class. A school or private counsellor can explain behaviour modification and help parents and teachers set up appropriate rewards for the child.

Parents and teachers can help by structuring tasks and environments for the child in ways that allow the child to succeed. They can find ways to help children build on their strengths and work around their disabilities. For a teenager with a language problem, it may mean providing pictures and diagrams for performing a task. A counsellor or school psychologist can help identify practical solutions that make it easier for the child and family to cope day by day.

Every child needs to grow up feeling competent and loved. When children have learning disabilities, parents may need to work harder at developing their children's self-esteem and relationship-building skills. But self-esteem and good relationships are as worth developing as any academic skill.

Self Assessment Questions

Multiple Choices:

1) ..... signify inadequate development in a specific area of academic, language, speech, or motor skills that is not due to mental retardation, autism, or deficient educational opportunities.
   a) Psychological difficulties
   b) Developmental disabilities
   c) Learning disabilities
   d) Physical disabilities
2) There are several categories of communication disorders including all of the following EXCEPT .....
   a) expressive language disorder
   b) receptive speech disability
   c) phonological disorder
   d) Stuttering
3) Children with ..... disorder have difficulty recalling arithmetic facts, counting objects correctly and aligning numbers in columns.
   a) Reading
   b) Mathematics
   c) Communication
   d) Motor skills
4) Disorder of written expression is often associated with
   a) Reading disorder
   b) Mixed expressive-receptive language disorder
   c) Developmental coordination disorder
   d) Mathematics disorder
5) Manifestations of developmental coordination disorder include:
   a) Delays in reaching motor milestones such as sitting and crawling
   b) Avoidance of participation in sports activities with peers
   c) Messy or illegible writing
   d) All of the above
6) Children with expressive language disorder are distinguishable from children with pervasive developmental disorders in that they___
   a) Appropriately use gestures to communicate
   b) Readily form meaningful and warm social relationships
   c) Show significant frustration with the inability to communicate verbally
   d) All of the above

7) What is dyslexia?
   a) Any impairment of language processing
   b) Specific problems with reading
   c) Inability to retrieve difficult vocabulary words, on command
   d) A group of symptoms including stuttering and letter-reversal

8) A specific learning disability involves problems with motor skills is referred to as:
   a) dysgraphia
   b) dyscalculia
   c) dyspraxia
   d) dystonia

9) Treatment for learning, communication, and motor skills disorders a ..... approach designed by teachers, school psychologists, specialised therapists, and parents.
   a) Systemic
   b) Multidisciplinary
   c) CBT
   d) None

10) The special education teacher designs an _____ program which outlines the specific skills the child needs to develop as well as appropriate learning activities that build on the child's strengths.
   a) Individualised Educational Program (IEP)
   b) Computer
   c) Training
   d) Academic

2.8 LET US SUM UP

Learning disabilities involve delay or deficit in some area of functioning including academic, language, speech, or motor skills that is not due to mental retardation, autism, a 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 or reading. These disorders can interfere with the child's ability to make progress in school and in social situations and, for adults, can interfere with occupational success and social adjustment. These disorders are usually identified within the school system rather than through mental health clinics.

Neurological impairments are thought to be at the root of these disorders. There is mounting evidence that the learning disabilities have genetic and other biological components as causal factors. Treatment for learning, communication, and motor skills disorders occurs in the schools and involves a multi disciplinary approach designed by teachers, school psychologists, specialised therapists, and

parents. One of the most important focus of treatment is to build on the child's strengths so he or she can feel a sense of self-esteem and accomplishment.

2.9 UNIT END QUESTIONS

1) What is learning disability? Define the seven learning disabilities in the three groups?
2) What are the different causes of learning disabilities?
3) Mention the types of problems and issues associated with learning disabilities?
4) Write about the ways in which learning disabilities are diagnosed?
5) Describe the types of approaches to learning disabilities?

2.10 GLOSSARY

Accounted : Explained by

Communication disorders : Problems in transmitting or conveying information, including stuttering and expressive language disorder.

Reading disorder : Reading performance significantly below age norms.

Receptive language : Communicated material that is understood.

Stuttering : Disturbance in the fluency and time patterning of speech (e.g., sound and syllable repetitions or prolongations).

2.11 SUGGESTED READINGS

Barlow, D.H., & Durand, V.M. 2007. *Abnormal Psychology: An Integrative Approach.* Thomson Learning Inc., New Delhi.

Davison, G.C., Neale, J.M., Kring, A.M. *Abnormal Psychology,* 9th edition. Wiley & Sons:USA.

Wilmshurst, Linda. 2008. *Abnormal Child Psychology: A Developmental Perspective*. Taylor & Francis Group: New York.

2.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions

1) (c), 2) (b), 3) (b), 4) (a), 5) (d), 6) (d), 7) (b), 8) (c), 9) (b), 10) (a)

UNIT 3 MENTAL RETARDATION

Structure

3.0 INTRODUCTION

Mental retardation is a developmental disability characterised by inadequate adaptation to societal demands. This disability is typically diagnosed in early childhood, when a discrepancy is recognised between a child's level of intellectual and adaptive functioning and that of children of the same chronological age. In this unit we would be studying mental retardation, the criteria used to define mental retardation. We discuss the various causal factors of mental retardation and lastly we describe in detail the prevention and intervention approaches.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Define Mental Retardation;
- Describe the different levels of mental retardation;
- Explain the etiology of mental retardation; and
- Elucidate the measures of prevention and treatment of mental retardation.

3.2 MENTAL RETARDATION

The American Association on Mental Retardation (AAMR) has served as the premier authority on matters of definition and classification for mental retardation since 1876. The *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association (APA), incorporated the AAMR definition beginning in 1968.

AAMR (2002) defines mental retardation as a "*state of functioning beginning in childhood that is characterised by limitations in intellectual and adaptive skills"*.

3.2.1 Criteria to Diagnose Mental Retardation

The DSM-IV TR definition has three criteria that must be met for a diagnosis of mental retardation:

- Significantly subnormal intellectual functioning,
- Impairments in adaptive functioning, and
- Onset before 18 years of age.

3.2.2 Intelligence-Test Scores

The first component of the DSM definition requires a judgement of intelligence. According to the *DSM*, subnormal intellectual functioning is an IQ of approximately 70 or less obtained on a standardised and well recognised instrument that has been developed specifically to assess intelligence (e.g., Wechsler Intelligence Scale for Children, Stanford-Binet, etc.). Approximately 3 percent of the population falls into the criterion of "significant sub average general intellectual functioning."

The determination of IQ should be based on tests administered by a competent, well trained professional. While Interpreting scores the clinician must take into account cultural, linguistic and sensory or motor limitation that may affect performance. For example, when testing a child with cerebral palsy who has limited use of his or her hands, the examiner might select IQ tests that require verbal responses or simple gesture responses, rather than the traditional intellectual tests, which include a nonverbal or performance component requiring complex and rapid motor movements. Similarly, a child who speaks Hindi at home and English at school cannot be tested in a valid way using only English-language measures (American Association of Mental Retardation [AAMR], 1992).

3.2.3 Adaptive Functioning

Adaptive functioning refers to mastering childhood skills such as toileting and dressing; understanding the concepts of time and money; being able to use tools, to shop, and to travel by public transportation; and becoming socially responsive. An adolescent, for example, is expected to be able to apply academic skills, reasoning, and judgement to daily living and to participate in group activities. An adult is expected to be self-supporting and to assume social responsibilities.

Several tests have been constructed to assess adaptive behaviour. Best known are the Adaptive Behaviour Scale, or ABS and the Vineland Adaptive behaviour Scales (Sparrow, Ballo, & Cicchetti , 1984). One main problem with many assessments of adaptive behaviour is that they fail to consider the environment

to which the person must adapt. A person who lives in a small rural community where everyone is acquainted may not need skills as complex as those needed by someone who lives in New Delhi. Youngsters who are competent working at farm chores, walking to school, and shopping at the local store may, when transported to a city, be considered deficient in adaptive behaviour if they are not able to ride the metro or take the subway to school or buy groceries at a store where English is spoken. By the same token, city children may find themselves at a loss with some of the activities expected of the youngsters living on a farm. An effective and valid assessment of adaptive behaviour should therefore consider the interaction between the child and the surroundings in which he or she must function.

3.2.4 Age of Onset

The final definition criterion is that mental retardation should manifest before age eighteen, so that any deficits in intelligence and adaptive behaviour from injury and illness occurring later in the life is not classified as mental retardation. Children with severe impairments are often diagnosed during infancy. Most Children considered mentally retarded, however, are not identified until they enter school. These children have no obvious physiological, neurological, or physical manifestations, and their problems become apparent only when they are unable to keep up with their peers in school.

3.3 CLASSIFICATION OF MENTAL RETARDATION

The most consistent feature of mental retardation is that the person learns very slowly. Other areas of difficulty are attention, short-term memory, planning, and language. DSM-IV-TR describes four levels of severity of mental retardation based on IQ levels as the criteria in distinguishing ranges of impairment. But IQ ranges are not the sole basis of diagnosis; deficiencies in adaptive behaviour are also a criterion of mental retardation. For example, if a person's IQ falls in the mildly retarded range but shows no deficits in adaptive functioning then he would not be considered mentally retarded. In fact the IQ criterion should be applied after deficits in adaptive functioning have been identified. The following is a brief summary of characteristics of people at each level of mental retardation.

3.3.1 Mild Mental Retardation

Mild mental retardation (IQ range, 50-55 to 70) represents approximately 85 percent of persons with mental retardation. In general, children with mild mental retardation are not identified until after first or second grade, when academic demands increase. By late adolescence, they often acquire academic skills at approximately a sixth grade level. Specific causes for the mental retardation are often unidentified in this group. As adults they are likely to be able to maintain themselves in unskilled jobs or in sheltered workshops, although they may need help with social and financial problems. Many adults with mild mental retardation can live independently with appropriate support and raise their own families.

3.3.2 Moderate Mental Retardation

Moderate mental retardation (IQ range, 35-40 to 50-55) represents about 10 percent of persons with mental retardation. Most children with moderate mental retardation acquire language and can communicate adequately during early

childhood. They are challenged academically and often are not able to achieve academically above a second to third grade level. During adolescence, socialisation difficulties often set these persons apart, and a great deal of social and vocational support is beneficial. Brain damage and other pathologies are frequent. People with moderate mental retardation may have physical defects and neurological dysfunctions that hinder fine motor skills, such as grasping and colouring within lines, and gross motor skills, such as running and climbing. As adults, persons with moderate mental retardation may be able to perform semiskilled work under appropriate supervision.

3.3.3 Severe Mental Retardation

Severe mental retardation (IQ range, 20-25 to 35-40) comprises about 4 percent of individuals with mental retardation. They typically demonstrate basic motor and communication deficits during infancy. Many also show signs of neurological dysfunction and have an increased risk for brain seizure disorder, or epilepsy. In school, they may be able to string together only two or three words when speaking. Individuals in this category usually require careful supervision, profit somewhat from vocational training, and can perform only basic work tasks in structured and sheltered settings. Their understanding of communication is usually better than their speech. In adulthood, persons with severe mental retardation may adapt well to supervised living situations, such as group homes, and may be able to perform work-related tasks under supervision.

3.3.4 Profound Mental Retardation

Profound mental retardation (IQ range below 20-25) constitutes approximately 1 to 2 percent of persons with mental retardation. Most individuals with profound mental retardation have identifiable causes for their condition. This level of retardation is very noticeable at birth or early infancy. With training, people with profound mental retardation may learn or improve basic skills such as walking, some talking, and feeding themselves. They need a very structured environment, with close supervision and considerable help, including a one-to-one relationship with a caregiver, in order to develop to the fullest.

Severe and profound levels of mental retardation often appear as part of larger syndromes that include severe physical handicaps. The physical problems are often even more limiting than the individual's low intellectual functioning and in some cases can be fatal.

The four ranges of MR, according to the *DSM-IV-TR* (APA, 2000) are:

- Mild MR: 50–55 to approximately 70 IQ
- Moderate MR: 35–40 to 50–55
- Severe MR: 20–25 to 35–40
- Profound MR: Below IQ of 20–25

3.4 PREVALENCE OF MENTAL RETARDATION

The prevalence of mental retardation at any one time is estimated to range from 1 percent to 3 percent of the population. The incidence of mental retardation is difficult to calculate because mild mental retardation sometimes goes unrecognised until middle childhood. In some cases, even when intellectual

function is limited, good adaptive skills are not challenged until late childhood or early adolescence, and the diagnosis is not made until that time. The highest incidence is in school-age children, with the peak at ages 10 to 14 years. Mental retardation is about 1.5 times more common among men than among women. In older persons, prevalence is lower; those with severe or profound mental retardation have high mortality rates because of the complications of associated physical disorders.

Remember

Terman's idea of the intelligence quotient (IQ) allows for comparing the mental functioning of children of different ages. The formula is to divide mental age by chronological age (multiply by 100). For example, Sham is 8 years old (chronologically), but he functions like a 6 year old. His IQ would be $6/8 \times 100 = 75$.

3.5 ETIOLOGY OF MENTAL RETARDATION

In only about 25 percent of population with mental retardation the primary cause has been identified. The specific causes that are identified are typically biological. The causes include:

3.5.1 Genetic Conditions and Chromosomal Abnormalities

Sometimes MR is caused by genetic defects that can be inherited from parents, or result from chromosomal abnormalities when genes combine, or other genetic reasons. Examples of genetic conditions are *Down syndrome, Fragile X syndrome,* and *phenylketonuria (PKU).*

Down syndrome

Down syndrome (or Mongolism) is a chromosomal abnormality involving chromosome 21 (trisomy or extra chromosome 21). There are variations within the disorder and not all features are present in every one with Down syndrome. Some of the more classic features include, short stature, short broad hands and feet, round face, almond-shaped eyes (oblique eye fissures), flat facial features (protruding tongue), and low muscle tone. Language and motor skills are the most impaired in children with Down syndrome. Speech problems are common, as are health problems, especially with the heart. The cardinal feature of Down syndrome is a limitation in intellectual functioning. The average score for an individual with Down syndrome is approximately an IQ of 50. Mental age in individuals with Down syndrome is typically 8 years of age or lower. There is increased risk for having a child with Down syndrome with increases in maternal and paternal age. Although normally approximately 1 in 800 births will be a Down syndrome infant, the risk for women over 45 years of age is 1 in 25 births.

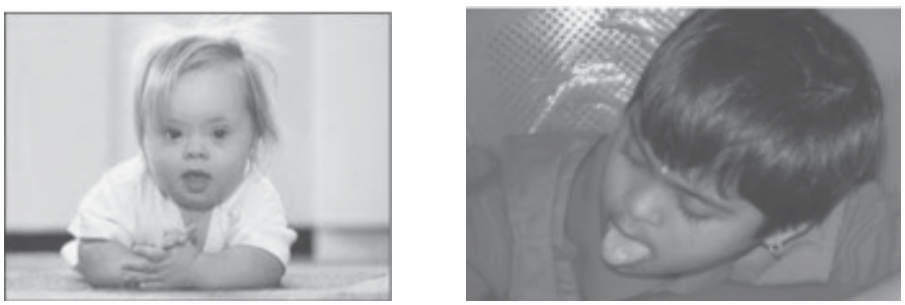

Fig.3.1: Children with Down syndrome

Fragile X syndrome

This is the most common inherited cause after Down syndrome of mental retardation, in which the X chromosome breaks into two. The symptoms of Fragile X include intellectual deficits, and possible physical characteristics (longer ears, faces, and jaws). There may also be challenging behaviours (fearfulness, anxiety) and males may tend to be inattentive or aggressive, while females may appear withdrawn and shy. Language problems are also often evident and children may exhibit heightened sensitivity to sound, touch, and bright light. A number of children with Fragile X will also have co morbid autism.

Phenylketonuria (PKU)

A number of disabilities can be caused by recessive genes. One of the most commonly occurring recessive disorders that can cause serious mental retardation is phenylketonuria, or *PKU*. Infants born with two recessive genes lack a necessary enzyme which is responsible for converting one of the basic amino acids (phenylalanine) into a product (tyrosine) that is essential to body functioning. If the enzyme is not present, phenylalanine will continue to build, reaching toxic levels that can damage the central nervous system (CNS). Unchecked, the infant will develop progressive mental retardation and if not found prior to 1 year of age, the infant will become permanently retarded. Detected early, parents of children with PKU are advised to provide the infant a diet low in phenylalanine so that they can develop normally and reach a normal level of intelligence.

3.5.2 Environmental Factors

Mental retardation can result when the foetus is exposed to environmental toxins (called taratogens) that can cause damage to the unborn foetus when they cross the placenta during pregnancy when vital organs and the nervous system are in the process of being developed.

Maternal Substance Use/Abuse

Babies born to mothers who use cocaine can suffer a wide range of side effects after birth, including physical defects and brain dysfunction in haemorrhages and seizures. Mothers who are addicted to crack often give birth to infants who suffer from low birth weight and damage to the CNS.

Foetal alcohol syndrome (FAS)

Approximately 33% of all babies born to mothers who are heavy consumers of alcohol will be born with foetal alcohol syndrome (FAS). Clinical features of FAS include central nervous system dysfunction (mental retardation, hyperactivity, irritability); impaired motor coordination and over activity. Physically, these children often evidence slow growth and unusual facial features, including underdeveloped upper lip, flattened nose, or short and upturned widely spaced eyes, and small head. Although facial features become less pronounced with age, cognitive deficits remain. If a child has a milder set of symptoms, often associated with less maternal alcohol consumption during pregnancy, the resulting syndrome is referred to as foetal alcohol effects.

Exposure to Toxins

Environmental pollutants like mercury and lead can cause poisoning and mental retardation. Mercury may be ingested by eating affected fish. Lead is found in

lead-based paints, smog, and the exhaust from automobiles that burn leaded fuel. Exposure to lead-based paint has been implicated in many complications regarding pregnancy, birth, and infant/child outcomes. Lead-based paint can be consumed by infants from paint chips that fall off the walls of older residences, or pregnant women can be exposed to these conditions. Prenatal exposure to lead-based paint has been linked to brain damage and a host of physical side effects like kidney damage, anaemia, and seizures. A number of studies have demonstrated the harmful effects of lead exposure to human and animals in addition to IQ in areas of attention, learning, memory, school performance, and behaviour.

Other proven or suspected environmental developmental neuro-toxicants include PCB, dioxins, pesticides, tobacco smoke, maternal use of tobacco, marijuana, and cocaine and thalidomide.

Infectious Diseases

When in utero the foetus is at increased risk of mental retardation resulting from maternal infectious diseases such as rubella (German measles). The extent of impairment of the unborn child depends upon when the mother is exposed to rubella relative to foetal development. The greatest impairments in the foetus occur if exposure coincides with the embryonic period (3 to 8 weeks gestation). Mothers who contract rubella during this time frame expose the unborn embryo to a 50% chance of impairments in the formation of eye, ear, heart, inner organs, and mental capacity. As a result of exposure to rubella in utero, children born with congenital rubella syndrome often have multiple handicaps including low IQ, sensory impairments (vision, hearing loss), and demonstrate self-injurious behaviours or aggression.

Cytomegalovirus, toxoplasmosis, rubella, herpes simplex, and syphilis are all maternal infections that can cause both physical deformities and mental retardation. The mother may experience slight or no symptoms from the infections, but the on the developing foetus can be devastating. Pregnant women who go for prenatal checks are given a blood test for syphilis. Women today can also have their blood tested to determine whether they are immune to rubella and if not they are advised to be vaccinated at least six months before becoming pregnant.

HIV infection has become a significant cause of mental retardation. When not treated for HIV infection during pregnancy and delivery, an HIV positive woman is more likely to pass on the virus to the developing foetus, and about half of these infected infants develop mental retardation.

Infectious diseases can also affect a child's developing brain after birth. Encephalitis and meningococcal meningitis may cause irreversible brain damage and even death if contracted in infancy and early childhood.

Birth Trauma and Problems at Birth

A lack of oxygen at birth (anoxia) can result due to several reasons including having the cord wrapped around the babies' neck, or the baby presenting in a difficult position for birth (e.g., breech position requiring delivery to be feet first). A lack of oxygen supply to the brain could result in higher risk for intellectual deficits.

Prematurity

Prematurity (in particular, birth weight around or under 1000 g) is a well-known risk factor. Survival rates for infants born prematurely in neonatal care centres increase with each week of gestational age from 22 (0–21%) to 26 weeks (75–93%). The majority of the survivors will be free of major disability, even though about 20 per cent will later be diagnosed as having mental retardation and another 40–50 percent may have subtle neurodevelopmental or neuropsychiatric disabilities in the school and teenage years. Even birth weights under about 3000 g can cause increased risk for school identified disability including MR.

Traumatic brain injury increases the risk for MR as well as for a number of adverse behavioural outcomes. Children exposed to violence, accidents (falls, near drowning, and automobile accidents) often lead to traumatic brain injury and mental retardation. Trauma-related psychological distress may also cause significant reductions of IQ.

3.5.3 Psychosocial Factors

Psychosocial factors interact with environmental factors in a variety of ways to produce a range of clinical presentations in the field of MR. Psychosocial deprivation can lead to reduction in IQ. The effects can be transient in some cases where the psychosocial environment is changed for the better at an early stage. However, they can also be long-term, possibly permanent, in cases of long-standing deprivation (including in children raised in extremely under-stimulating orphanages or homes). In such cases, the effects on IQ are likely to occur through permanently altered brain function. Psychosocial deprivation is much more likely to account for an important proportion of MR variance in underdeveloped countries, and in slums.

Self Assessment Questions

Multiple Choices

1) One of the definitional criterions of mental retardation is that it should occur before age .....

   a) 15

   b) 18

   c) 16

   d) 21

2) According to the *DSM–IV–TR*, which of the following children would be considered to have a moderate degree of MR?

   a) Ram, who has an IQ of 48 and has three adaptive deficits

   b) Om, who has an IQ of 56 and has two adaptive deficits

   c) George, who has an IQ of 30 and has four adaptive deficits

   d) Hari, who has an IQ of 34 and has three adaptive deficits

3) Given the moderate level of retardation, academic expectations would be equivalent to:

   a) Grade 6 level

b) pre-academic skills

c) about a Grade 2 level

d) Grade 5 level.

4) Down syndrome was initially classified as:

a) Warren's syndrome.

b) Mongolism.

c) Fragile X syndrome.

d) Moronic syndrome.

5) Which of the following is not an intelligence test?

a) Bayley Scales of Infant Development

b) Wechsler Intelligence Scale for Children

c) Vineland Adaptive Behaviour Scales

d) The Stanford –Binet

6) Which of the following is not a teratogen?

a) Alcohol

b) Anoxia

c) lead-based paint

d) PCB

3.6 PREVENTION AND TREATMENT OF MENTAL RETARDATION

Prevention of mental retardation depends on understanding its causes. The importance of prevention and early intervention cannot be overemphasised. Prevention programs have to be launched at all levels of intervention from prenatal awareness campaigns (Effects of drug abuse and alcohol; genetic counselling) to early intervention programs targeting parenting skills and early stimulation programs. The impact of early intervention programs within the first 5 years of life has been documented in various studies in the prevention of cognitive declines.

Interventions for children with MR vary widely depending on the specific area (behavioural or intellectual) targeted for improvement. The majority of interventions focus on the reduction of behavioural/emotional issues, or increasing social, educational, or adaptive functions.

3.6.1 Behavioural Interventions

Behavioural programs have been very successful in targeting and altering problematic social, emotional, and behavioural concerns. The reason for the success of the behavioural programs can be linked to their focus on breaking down problem behaviours into component parts (simplicity) and to systematically shape behaviours into more socially adaptive behaviours through contingency management. There is a wealth of empirical support for the use of behavioural methods with MR populations.

There are many different techniques that can be adapted to suit programs across the developmental spectrum and can be applicable to a wide range of problem behaviours (e.g., behaviour chaining, secondary rewards, token economies).

Applied Behaviour Analysis (also known as Intensive Behavioural Intervention or IBI) is one of the more effective teaching strategies devised for helping mentally retarded children to learn. The approach is based squarely on learning theory and classical and instrumental learning approaches.

Applied behaviour analysis takes complex tasks (such as eating) and breaks them down into their most fundamental parts (pick up spoon, scoop food from plate onto spoon, bring spoon to mouth, remove food with lips, chew and swallow food). Skills are systematically introduced in small steps. As one small skill is mastered, the next is introduced. Students learn by making simple associations between causes and effects. They are presented with a stimulus (an object or a signal) and given an instruction. If they respond appropriately, they are immediately rewarded and inappropriate behaviours are ignored, redirected, or discouraged. Applied behaviour analysis's emphasis on providing immediate rewards for correct behaviour is crucial to motivation.

Behavioural programs that use *contingency management* techniques (such as consequences for good behaviour i.e. rewards; or consequences for inappropriate behaviours, such as removal of privileges) can be developed to either decrease inappropriate behaviours (aggression, noncompliance) or increase deficit behaviours (compliance, social skills) at school and in the home.

3.6.2 Cognitive Interventions

Many children with mental retardation fail to use strategies in solving problems, and when they do have strategies, they often do not apply them effectively. *Self-instructional training* teaches these children to guide their problem-solving efforts through speech. Meichenbaum and Goodman (1971) outlined a five-step procedure.

- The teacher performs the task, speaking instructions aloud to himself or herself while the child watches and listens.
- The child listens and performs the task while the teacher says instructions to the child.
- The child repeats the task while giving himself /herself instructions aloud.
- The child repeats the task again while whispering the instructions.
- Finally, the child is ready to perform the task while uttering instructions silently to her/him.
- Children with more severe retardation use signs rather than speech to guide themselves trough the tasks.

Self-instructional training has been employed to teach retarded children self-control and how to pay attention as well as how to master academic tasks. Children with severe retardation can effectively master self-help skills through this technique.

3.6.3 Computer Assisted Instructions

Computer assisted instruction is increasingly found in educational settings of all kinds. It might be especially helpful in the education of individuals with mental retardation. The visual and auditory components of computers help maintain the attention of distractible students. The level of the material can be made to suit the level of the child and also the computer can meet the need for numerous repetitions of material without getting bored or impatient as a human teacher might.

Fig.3.3:Computer-assisted instruction is well suited for children with MR

3.6.4 Parent Training Programmes

Including parents in the intervention process (whether academic, behavioural, or social) is extremely important. Research has demonstrated that parents can be effective monitors of their child's progress and improve overall success by helping children to transferring skills from one situation to the next. There are many ways that parents can increase their child's success, such as helping in transferring skills learned at school to the home environment or skills learned in leisure activities to social activities. Transferring information across situations is one of the more difficult tasks for children with mental retardation.

Self Assessment Questions

1) Define Mental Retardation?

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2) Name the different levels of mental retardation?

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3) What is Phenylketonuria (PKU)?

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4) Write about the environmental hazards in causing mental retardation?

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5) What is Applied Behaviour Analysis?

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3.7 LET US SUM UP

Since 1876, the American Association for Mental Retardation (AAMR) has been instrumental in shaping how MR is defined and conceptualised. Mental retardation is coded on Axis II, due to its lifelong nature. The three criteria for diagnosis include: significantly subnormal intelligence (IQ 70 or less); impaired adaptive functioning, and onset before age 18. The *DSM* recognises four levels of severity of MR: Mild (IQ 50–55 to 70), Moderate (IQ 35–40 to 50–55), Severe (20–25 to 35–40), and Profound (IQ below 20–25). Contemporary view focuses more on the strengths of the individual with mental retardation than on their placement to a particular level of MR.

The more severe forms of mental retardation have a biological basis, such as the chromosomal trisomy that causes Down syndrome. Certain infectious diseases in the pregnant mother, such as HIV, rubella, and syphilis, as well as illnesses that affect the child directly, such as encephalitis, can effect cognitive and social development, as can malnutrition, severe falls, and accidents that injure the brain. Environmental factors are considered the principal causes of mild retardation. Using operant conditioning, self-instructional training, and modelling, therapists have been able to treat successfully many of the behavioural problems and to improve their intellectual functioning.

3.8 UNIT END QUESTIONS

1) Explain the three traditional criteria used to define mental retardation?
2) Give a brief summary of the characteristics of people at each level of mental retardation?
3) Describe in detail the genetic or chromosomal causes of mental retardation?
4) Explain how infectious diseases and birth trauma cause mental retardation?
5) Give an account of types of interventions used for mental retardation?

3.9 SUGGESTED READINGS

Barlow, D.H., & Durand, V.M. 2007. *Abnormal Psychology: An Integrative Approach.* Thomson Learning Inc., New Delhi.

Carson, R. C., Butcher, J. N., Mineka, S., Hooley, J.M. 2007. *Abnormal Psychology.* Pearson Education: New Delhi.

Sarason, I.G., & Sarason, B.R.2005. *Abnormal Psychology: The Problem of Maladaptive Behaviour.* Prentice-Hall of India: New Delhi.

3.10 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) b, 2) a, 3) c, 4) b, 5) c 6) b

Self Assessment Questions 2

According to DSM-IV TR, mental retardation is defined as significantly sub-average intellectual functioning along with deficits in adaptive behaviour and occurring prior to age eighteen.

The *DSM* recognises four levels of severity of MR: Mild (IQ 50–55 to 70), Moderate (IQ 35–40 to 50–55), Severe (20–25 to 35–40), and Profound (IQ below 20–25).

Phenylketonuria is one of the most commonly occurring recessive disorders. In PKU the baby appears normal at birth but lacks an enzyme needed to break down phenylalanine, an amino acid found in protein foods. When this condition is undetected, the phenylalanine builds up in the blood and leads to brain damage and MR.

Several environmental pollutants can cause MR. Toxic agents, such as carbon monoxide and lead cause brain damage during foetal development or after birth. In some instances certain drugs taken by the mother during pregnancy may lead to congenital malformations, or an overdose of drugs administered to the infant may result in toxicity and brain damage. Similarly intake of alcohol or smoking by mother during pregnancy can also lead to mental retardation.

Applied behaviour analysis (ABA) is the science of applying experimentally derived principles of behaviour to improve socially significant behaviour. It involves the breakdown of all skills into small, discrete tasks, taught in a highly structured and hierarchical manner. Central to the successful application of this method is the art of differential reinforcement. That is, the therapist, parent, or caregiver learns how to systematically reward or reinforce desired behaviour, and ignore, redirect, or discourage inappropriate behaviours.

UNIT 4 PERVASIVE DEVELOPMENTAL DISORDERS

Structure

4.0 INTRODUCTION

The pervasive developmental disorders are a group of severely disabling conditions that are among the most difficult to understand and treat. Persons with pervasive developmental disorders all experience problems with language, socialisation, and cognition. The word *pervasive* means that these problems are not minor, but significantly affect individuals throughout their lives. In this unit we would study pervasive developmental disorders, their characteristic features and different types. Included under pervasive developmental disorders are autistic disorder (or autism), Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder-not otherwise specified. Unfortunately, there is very little research on these categories except autism. In addition there has been considerable disagreement concerning the validity of

childhood disintegrative disorder and whether it is distinct from autistic disorder. It is also not clear if Asperger's disorder differs qualitatively from autistic disorder or if it differs only in severity. Because of these limitations, in this unit we will illustrate the pervasive developmental disorders by focusing in detail on autistic disorder by describing its clinical picture, causal factors and treatment.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define Pervasive Developmental disorders;
- Describe their characteristic features;
- Describe various types of pervasive developmental disorders covered in DSM-IV-TR;
- Define autism;
- Explain the clinical picture and causal factors of autism; and
- Analyse the different treatment methods for pervasive developmental disorders.

4.2 PERVASIVE DEVELOPMENTAL DISORDERS

Not until the middle of the twentieth century was there a name for a disorder that affects thousands of children, a disorder that causes disruption in families and unfulfilled lives for many children. In 1943 Dr. Leo Kanner of the Johns Hopkins Hospital studied a group of 11 children and introduced the label *early infantile autism* into the English language. At the same time a German scientist, Dr. Hans Asperger, described a milder form of the disorder that became known as Asperger syndrome. Thus these two disorders are today listed in the *Diagnostic and Statistical Manual of Mental Disorders* DSM-IV-TR (fourth edition, text revision) as two of the five pervasive developmental disorders (PDDs), more often referred to today as autism spectrum disorders (ASD).

Pervasive developmental disorders are a group of neurobiological disorders that demonstrate deficits in

1) Social interaction,
2) Verbal and nonverbal communication, and
3) Repetitive behaviours or interests.

In addition, they will often have unusual responses to sensory experiences, such as certain sounds or the way objects look, and stereotyped behaviours (e.g., hand flapping, rocking, twirling). Cognitive deficits or uneven skill development are often present. Each of these symptoms runs the gamut from mild to severe. These are present in each individual child differently. For instance, a child may have little trouble learning to read but exhibit extremely poor social interaction. Each child will display communication, social, and behavioural patterns that are individualistic but fit into the overall diagnosis of Pervasive developmental disorders.

Children with Pervasive developmental disorders do not follow the typical patterns of child development. In some children, hints of future problems may be apparent from birth. In most cases, the problems in communication and social skills become more noticeable as the child lags further behind other children of the same age. Some other children start off well enough. Oftentimes it is between 12 and 36 months, the differences in the way they react to people and other unusual behaviours become apparent. Some parents report the change as being sudden, and that their children start to reject people, act strangely, and lose language and social skills they had previously acquired. In other cases, there is a "plateau," or levelling, of progress so that the difference between the child with autism and other children the same age becomes more noticeable.

Fig. 4.1: The communication deficits typical of autism often lead to social isolation

4.3 CHARACTERISTIC FEATURES OF PERVASIVE DEVELOPMENTAL DISORDERS

Pervasive Developmental Disorder is defined by the combination of broad range of symptoms in domains such as social interaction, play, language and communication, restrictive and repetitive activities and interests etc. (see Table 4). These behavioural characteristics are described below.

4.3.1 Impairment in Social Interaction

From the start, typically developing infants are social beings. Early in life, they gaze at people, turn toward voices, grasp a finger, and even smile. In contrast, most children with pervasive developmental disorders seem to have tremendous difficulty learning to engage in the give-and-take of everyday human interaction.

Even in the first few months of life, many do not interact and they avoid eye contact. They seem indifferent to other people, and often seem to prefer being alone. They may resist attention or passively accept hugs and cuddling. Later, they seldom seek comfort or respond to parents' displays of anger or affection in a typical way.

Research has suggested that although children with pervasive developmental disorders are attached to their parents, their expression of this attachment is unusual and difficult to "read." To parents, it may seem as if their child is not attached at all. Parents who looked forward to the joys of cuddling, teaching, and playing with their child may feel crushed by this lack of the expected and typical attachment behaviour.

Children with pervasive developmental disorders also are slower in learning to interpret what others are thinking and feeling. Subtle social cues—whether a smile, a wink, or a grimace—may have little meaning. To a child who misses these cues, "Come here" always means the same thing, whether the speaker is smiling and extending her arms for a hug or frowning and planting her fists on her hips. Without the ability to interpret gestures and facial expressions, the social world may seem bewildering.

To compound the problem, people with pervasive developmental disorders have difficulty seeing things from another person's perspective. Most 5-year-olds understand that other people have different information, feelings, and goals than they have. A child with pervasive developmental disorder may lack such understanding. This inability leaves them unable to predict or understand other people's actions.

Although not universal, it is common for children with pervasive developmental disorders also to have difficulty regulating their emotions. This can take the form of "immature" behaviour such as crying in class or verbal outbursts that seem inappropriate to those around them. The individual with Autism Spectrum Disorder (ASD) might also be disruptive and physically aggressive at times, making social relationships still more difficult. They have a tendency to "lose control," particularly when they are in a strange or overwhelming environment, or when angry and frustrated. They may at times break things, attack others, or hurt themselves. In their frustration, some bang their heads, pull their hair, or bite their arms.

4.3.2 Communication Difficulties

By age 3, most children have passed predictable milestones on the path to learning language; one of the earliest is babbling. By the first birthday, a typical toddler says words, turns when he hears his name, points when he wants a toy, and when offered something distasteful, makes it clear that the answer is "no."

Some children diagnosed with pervasive developmental disorders remain mute throughout their lives. Some infants who later show signs of pervasive developmental disorders coo and babble during the first few months of life, but they soon stop.

Others may be delayed, developing language as late as age 5 to 9. Some children may learn to use communication systems such as pictures or sign language. Those who do speak often use language in unusual ways. They seem unable to combine words into meaningful sentences.

Some speak only single words, while others repeat the same phrase over and over. Some children with pervasive developmental disorders parrot what they hear, a condition called *echolalia*. Although many children with no pervasive

developmental disorders go through a stage where they repeat what they hear, it normally passes by the time they are 3.

Some children only mildly affected may exhibit slight delays in language, or even seem to have precocious language and unusually large vocabularies, but have great difficulty in sustaining a conversation. The "give and take" of normal conversation is hard for them, although they often carry on a monologue on a favourite subject, giving no one else an opportunity to comment. Another difficulty is often the inability to understand body language, tone of voice, or "phrases of speech." They might interpret a sarcastic expression such as "Oh, that's just great" as meaning it really IS great.

While it can be hard to understand what pervasive developmental disorders children are saying, their body language is also difficult to understand. Facial expressions, movements, and gestures rarely match what they are saying. Also, their tone of voice fails to reflect their feelings. A high-pitched, sing-song, or flat, robot-like voice is common.

Some children with relatively good language skills speak like little adults, failing to pick up on the "kid-speak" that is common in their peers. Without meaningful gestures or the language to ask for things, children with pervasive developmental disorders are at a loss to let others know what they need.

As a result, they may simply scream or grab what they want. Until they are taught better ways to express their needs, children with pervasive developmental disorders do whatever they can to get through to others. As children with pervasive developmental disorders grow up, they can become increasingly aware of their difficulties in understanding others and in being understood. As a result they may become anxious or depressed.

4.3.3 Restricted and Repetitive Behaviours

Although children with pervasive developmental disorders usually appear physically normal and have good muscle control, odd repetitive motions sets them off from other children. These behaviours might be extreme and highly apparent or more subtle. Some children and older individuals spend a lot of time repeatedly flapping their arms or walking on their toes. Some suddenly freeze in position.

As children, they might spend hours lining up their cars and trains in a certain way, rather than using them for pretend play. If someone accidentally moves one of the toys, the child may be tremendously upset.

Children with pervasive developmental disorders need, and demand, absolute consistency in their environment. A slight change in any routine—in mealtimes, dressing, taking a bath, going to school at a certain time and by the same route—can be extremely disturbing.

Perhaps order and sameness lend some stability in a world of confusion. Repetitive behaviour sometimes takes the form of a persistent, intense preoccupation. For example, the child might be obsessed with learning all about vacuum cleaners, train schedules, or lighthouses. Often there is great interest in numbers, symbols, or science topics.

CASE STUDY

Sham was an active and busy child. But his parents were worried about him. Compared with the other 3-year-olds they knew, Sham was different—he wasn't talking, and he didn't seem to want or try to play with his sister. At nursery school Sham wouldn't join in with the other kids, but he really enjoyed playing with water. He would splash and play at the sink for hours, with a big smile on his face. After a year of expressing concern to their paediatrician, Sham's parents finally obtained a referral to a psychologist who diagnosed Sham as having pervasive developmental disorder.

4.3.4 Sensory Problems

When children's perceptions are accurate, they can learn from what they see, feel, or hear. On the other hand, if sensory information is faulty, the child's experiences of the world can be confusing. Many children with pervasive developmental disorders are highly attuned or even painfully sensitive to certain sounds, textures, tastes, and smells.

Some children find the feel of clothes touching their skin almost unbearable. Some sounds—a vacuum cleaner, cooker whistle, a ringing telephone, a sudden storm, even the sound of waves lapping the shoreline—will cause these children to cover their ears and scream.

In pervasive developmental disorders, the brain seems unable to balance the senses appropriately. Some children with pervasive developmental disorder are oblivious to extreme cold or pain. A child with pervasive developmental disorder may fall and break an arm, yet never cry. Another may bash his head against a wall and not wince, but a light touch may make the child scream with alarm.

Table: Symptom Categories in the Pervasive Developmental Disorders

Social	Impairment of interpersonal relatedness, impaired capacity for empathy, lack of interest in others
Communication	Deficits in language, abnormalities of form, and/or content of language, deficits in nonverbal communication
Behaviour	Stereotyped behaviour, need for constancy in the environment, resistance to change

4.4 TYPES OF PERVASIVE DEVELOPMENTAL DISORDERS

The term pervasive developmental disorders (PDDs) is a relatively new classification which was first used in the 1980s to describe a class of childhood-onset brain disorders that resulted in severe and *pervasive* impairments in functioning. Disorders within this classification share common characteristics of impairments in social interaction, imaginative activity, verbal and nonverbal communication skills, and a limited number of interests and activities that tend to be repetitive. The latest revision of the *DSM–IV–TR* (APA, 2000) recognises five disorders under the category of Pervasive Developmental Disorders (see table. for comparison of pervasive developmental disorders):

1) Autistic disorder
2) Asperger's disorder or Asperger's Syndrome (AS)
3) Rett's disorder
4) Childhood Disintegrative Disorder (CDD)
5) Pervasive Developmental Disorder Not Otherwise Specified, or PDDNOS

4.4.1 Autistic Disorder

The best known of these disorders, is characterised by sustained impairment in comprehending and responding to social cues, aberrant language development and usage, and restricted, stereotypical behavioural patterns. Individuals with Autism vary widely in symptom expression, cognitive level, and adaptive abilities.

4.4.2 Asperger's Disorder

Asperger's disorder is characterised by impairment and oddity of social interaction and restricted interest and behaviour similar to those seen in autistic disorder. It is regarded as a mild version of autism. Unlike autistic disorder, in Asperger's disorder no significant delays occur in language, cognitive development, or age-appropriate self-help skills.

Asperger's Disorder appears to have a somewhat later onset than Autistic Disorder, or at least is recognised later. An individual with Asperger's Disorder does not possess a significant delay in language development; however, he or she may have difficulty understanding the subtleties used in conversation, such as irony and humour. Also, while many individuals with autism have mental retardation, a person with Asperger's possesses an average to above average intelligence. Asperger's is sometimes incorrectly referred to as "high-functioning autism."

4.4.3 Rett's Disorder

Rett's syndrome is relatively rare, affecting almost exclusively females, one out of 10,000 to 15,000. After a period of normal development, sometime between 6 and 18 months, autism-like symptoms begin to appear. The little girl's mental and social development regresses. Children with Rett's Disorder follow an apparently normal prenatal and perinatal period of development, with typical, early psychomotor development and normal head circumference at birth.

This period of fairly typical development is followed by a gradual loss of speech and purposeful hand use and the development of microcephaly (deceleration of head growth) , seizures, autistic features, difficulties in coordinating gait or trunk movements, and stereotypic hand movements (such as hand wringing, licking or biting the fingers and tapping or slapping).

Interest in social engagement diminishes in the first few years following onset, but may re-emerge later. Children with Rett's Disorder have severe impairment in language development, severe psychomotor retardation, and severe to profound mental retardation. Some of the problems associated with Rett's disorder can be treated. Physical, occupational, and speech therapy can help with problems of coordination, movement, and speech.

4.4.4 Childhood Disintegrative Disorder

Childhood Disintegrative Disorder (CDD), also termed Heller's syndrome, is characterised by a marked regression in several areas of functioning following normal development in the first 2 years of life.

Regression can occur any time after the first 2 years and before age 10, but onset typically occurs before 4 years of age. After the deterioration, the children closely resemble children with autistic disorder. The core features of the disorder include loss of communication skills, marked regression of reciprocal interactions, and the onset of stereotyped movements and compulsive behaviour.

Emotional symptoms are common, particularly anxiety and also is the regression of self-help skills, such as bowel and bladder control. Very few children who have pervasive developmental disorder diagnosis meet the criteria for childhood disintegrative disorder (CDD).

An estimate based on four surveys of pervasive developmental disorders found fewer than 2 children per 100,000 with pervasive developmental disorders could be classified as having CDD. This suggests that CDD is a very rare form of pervasive developmental disorders. It has a strong male dominance. The long period of normal development before regression helps differentiate CDD from Rett's syndrome.

4.4.5 Pervasive Developmental Disorder Not Otherwise Specified

A diagnosis of Pervasive Developmental Disorder not otherwise specified (PDDNOS) is given when there exists clinically significant impairments in social interaction and/or communication, or restricted interests and behaviours, but criteria for a specific pervasive developmental disorder are not met or do not have the *degree* of impairment described in any of the above four pervasive developmental disorders specific types This usually occurs in cases where symptoms are present but are too few in number to meet criteria for a specific diagnosis. The condition usually shows a better outcome than autistic disorder.

Table: Comparison of Pervasive Developmental Disorder Diagnoses

Features	Autistic Disorder	Asperger's Disorder	Rett's Disorder	Childhood Disintegrative Disorder
Age at Onset	< 3 years, usually in first year	Typically > 3 years; no delays in language and cognitive development	Deceleration of head growth, 6–18 months; loss of purposeful hand skills, 6–30 months	2–10 years; normal development prior to 2 years of age
Gender	4–5 times more likely in males than in females	At least 5 times more likely in males than in females	Reported almost exclusively in females	Occurs in slightly more males than females
Relationship to mental retardation (MR)	Typically mild to profound MR; females likely to exhibit more severe MR	None	Severe to profound MR	Severe MR

Degenerative	No	No	Yes	In most children, degeneration stabilizes; occasionally some skills regained
Seizures	Occur in up to 25% of children and adolescents; more common in adolescence	No	Yes	Increased risk of Seizures
Examples of associated conditions	Fragile X syndrome; tuberous sclerosis; neurofibromatosis; chromosomal aberrations	Chromosomal aberrations; obsessive compulsive disorder; depression; attention deficit hyperactivity disorder	Not applicable	Metachromatic leukodystrophy; Schilder's disease

Self Assessment Questions

Multiple Choices

1) The term pervasive developmental disorder is a relatively new category of classification. The term was first used in the:
   a) 1960s
   b) 1940s
   c) 1980s
   d) 1990s

2) The latest revision of the *DSM–IV–TR* (APA, 2000) recognises _____ disorders under the category of Pervasive Developmental Disorders.
   a) Three
   b) Five
   c) Two
   d) Four

3) Which of the following is not true regarding Rett's disorder?
   a) functional hand use is replaced by hand wringing movements
   b) deceleration of head growth
   c) onset of poor coordination, gait
   d) loss of speech function

4) Which of the following is false regarding prevalence rates for pervasive developmental disorders?

   a) The ratio of autism to Asperger's disorder has been reported as 4 to 1

   b) Males are more likely to be diagnosed with autism than females

   c) Females have less severe forms of autism than males

   d) Males are 5 times more likely to be diagnosed with Asperger's syndrome than females.

5) Which of the following is true regarding Rett's disorder?

   a) Males who have the mutated gene die shortly after birth

   b) Males cannot inherit the disorder because it is on an X chromosome

   c) Only females are affected by the mutated gene

   d) Males are not susceptible to the genetic mutation.

4.5 AUTISM

Autism or autistic disorder or childhood autism, or Kanner's autism is described as one of the most common and most puzzling and disabling of the pervasive developmental disorders. It is a developmental disorder that involves a range of behaviours including deficits in language, and perceptual and motor development; defective reality testing; and an inability to function in social situations.

Autism in infancy and childhood was first described by Kanner (1943). Autistic disorder is believed to occur at a rate of about 8 cases per 10,000 children (0.08 percent). By definition, the onset of autistic disorder is before the age of 3 years, although in some cases, it is not recognised until a child is much older.

Autistic disorder is four to five times more frequent in boys than in girls. Girls with autistic disorder are more likely to have more severe mental retardation. There is no clear relation to socio-economic status; the links with high socio-economic status as suggested by early studies was probably due to referral bias.

4.5.1 The Clinical Picture in Autism

The most important clinical manifestations of autistic disorder are markedly abnormal development in social interaction and communication skills, and patterns of restrictive, repetitive, and stereotyped behaviour and interests.

These manifestations are evident in the first 3 years of life but may present differently at various developmental stages. Children and adolescents with autistic disorder may be unable to understand that others have needs or may not be aware of others' feelings or distress.

They may treat others as objects, tools, or mechanical aids. In addition, children and adolescents with autistic disorder may show impairment in their nonverbal social behaviours (e.g., lack of eye-to-eye gaze, reciprocal smiling, and affectionate contact) and in their inability engage in symbolic or imaginative play.

In addition, a high prevalence of sleep problems has been reported for autistic children. Failure to cooperate in toilet training and aversion to certain foods creates added difficulty for parents of autistic children and may disrupt family life.

Self-injurious behaviour (e.g., head banging, self-biting, hair pulling) can occur in more severely affected children and adolescents. Some children and adolescents with autistic disorder may have "islets of precocity" (i.e., highly developed skills in very narrow and specific areas, such as the ability to decode numbers, list things from memory, or draw or play music exceptionally well) that contrast markedly with the level of their general cognitive functioning.

A Mothers Story

Ryan, always in a whirl of activity, has had many labels. He was diagnosed with PDDNOS at age three and a half. When he went to preschool, his label was "developmentally delayed." Now he's 8 years old, and his label is "autistic." He spends most of his time in a 2nd grade class. He's doing great, but he still needs lots of extra help—speech therapy, occupational therapy, and physical therapy. He loves playing football with kids in his class. His disability is only one part of who he is; he also has lots of strengths and talents. Every day still has its challenges, but we love him. He's not a label—he's Ryan.

4.5.2 Signs of Autism in Infancy, Childhood and Adolescence

Infancy

Infants with autistic disorder may show little interest in being held, or they may not be comforted by physical closeness with their parents. They have significant limitations in social smiling, eye contact, vocalisation, and social play. Infants with autistic disorder display little interest in the human face.

Early Childhood

Children may not follow (shadow) their parents at home, preferring to be alone. They may not show anxiety in being separated from their parents but may become noticeably agitated in response to minor changes in their environment or routine.

They often display echolalia (stereotyped repetition of another person's words or phrases), repetitive motor behaviour, and unusual attachments to objects. As they grow older they tend not to make friends and do not exhibit social or emotional reciprocity.

Children commonly demonstrate delays in or total lack of development of spoken language.

Middle Childhood

Children rarely share pleasure or excitement with others, and their social and vocal expressions and interactions are limited.

Adolescence

Adolescents show significant deficits in understanding social expectations and have few or no friendships. They may exhibit unusual affect and perseverative (persistent and repetitive), ritualistic speech or behaviours.

4.5.3 Causal Factors in Autism

Genetic Factors

Current evidence supports a genetic basis for the development of autistic disorder in most cases, with a contribution of up to four or five genes. Family studies have demonstrated a 50 to 200 times increase in the rate of autism in siblings of a child with autistic disorder. Additionally, even when not affected with autism, siblings are at increased risk for a variety of developmental disorders often related to communication and social skills. The specific modes of inheritance are not yet clear.

Current research has revealed promising leads on genes likely to cause the development of autistic disorder. Linkage analyses have demonstrated that regions of chromosomes 7, 2, 4, 15, and 19 are likely to contribute to the genetic basis of autism. It now appears that multiple genes are involved in the development of autism.

The results of the two of the largest twin studies show that the rate of autistic disorder was 36 percent in monozygotic pairs versus 0 percent in dizygotic pairs in one study and about 96 percent in monozygotic pairs versus about 27 percent in dizygotic pairs in the second study. High rates of cognitive difficulties, even in the non autistic twin in monozygotic twins with perinatal complications, suggest that perinatal problems along with genetic vulnerability may lead to autistic disorder.

Fragile X syndrome, a genetic disorder in which a portion of the X chromosome fractures, appears to be associated with autistic disorder. Approximately 1 percent of children with autistic disorder also have fragile X syndrome. Children with fragile X syndrome tend to show gross motor and fine motor difficulties as well as relatively poorer expressive language compared with children with autism without fragile X syndrome.

Tuberous sclerosis is a rare genetic disorder that causes benign tumours to grow in the brain as well as in other vital organs. It has a consistently strong association with pervasive developmental disorders. One to 4 percent of people with pervasive developmental disorders also have tuberous sclerosis.

Biological Factors

The high rate of mental retardation among children with autistic disorder and the higher-than-expected rates of seizure disorders further support the biological basis for autistic disorder. Approximately 70 percent of children with autistic disorder have mental retardation. About one third of these children have mild to moderate mental retardation, and close to half of these children are severely or profoundly mentally retarded. Children with autistic disorder and mental retardation typically show more marked deficits in abstract reasoning, social understanding, and verbal tasks than in performance tasks, such as block design and digit recall.

Of persons with autism, 4 to 32 percent have grand mal seizures at some time, and about 20 to 25 percent show ventricular enlargement on computed tomography (CT) scans. Various electroencephalogram (EEG) abnormalities are found in 10 to 83 percent of autistic children, and although no EEG finding is

specific to autistic disorder, there is some indication of failed cerebral lateralisation.

Perinatal Factors

A higher-than-expected incidence of perinatal complications seems to occur in infants who are later diagnosed with autistic disorder. Maternal bleeding after the first trimester and meconium in the amniotic fluid have been reported in the histories of autistic children more often than in the general population. In the neonatal period, autistic children have a high incidence of respiratory distress syndrome and neonatal anaemia.

Autistic disorder is also associated with neurological conditions, notably congenital rubella, phenylketonuria (PKU), and tuberous sclerosis. The finding that autistic children have significantly more minor congenital physical anomalies than expected suggests abnormal development within the first trimester of pregnancy.

Males with autism, as a group, have been found to be the products of longer gestational age and were heavier at birth than babies in the general population. Females with autism are more likely to be the product of post-term pregnancies than babies in the general population.

Socio-cultural Factors

At first, theorists thought that family dysfunction and social stress were the primary causes of autism. When he first identified autism, for example, Kanner argued that particular personality characteristics of the parents created an unfavourable climate for development and contributed to the child's disorder. He saw these parents as very intelligent yet cold-"refrigerator parents."

These claims had enormous influence on the public and on the self-image of the parents themselves, but research has totally failed to support a picture of rigid, cold, rejecting, or disturbed parents. Similarly, some clinical theorists have proposed that a high degree of social and environmental stress is a factor in autism. Once again, however, research has not supported this notion. Investigators who have compared children with autism to children without the disorder have found no differences in the rate of parental death, divorce, separation, financial problems, or environmental stimulation.

Psychological Factors

According to certain theorists, people with autism have a central perceptual or cognitive disturbance that makes normal communication and interactions impossible. One influential explanation holds that individuals with the disorder fail to develop a theory of mind i.e. an awareness that other people base their behaviours on their own beliefs, intentions, and other mental states, not on information that they have no way of knowing.

By 3 to 5 years of age, most children can interpret and understand from the perspective of another person and use it to anticipate what the person will do. In a way, they learn to read others' minds. Let us say, for example, that we watch Sunil place a marble in a container and then we observe Ram moves the marble to a nearby basket while Sunil is playing elsewhere.

We know that later Sunil will search first in the container for the marble because he is not aware that Ram moved it. We know that because we take Sunil's perspective into account. A normal child would also anticipate Sunil's search correctly. A person with autism would not. He or she would expect Sunil to look in the nearby basket because that is where the marble actually is. Sunil's own mental processes would be unimportant to the person.

Studies show that people with autism do have this kind of "mind blindness," although they are not the only kinds of individuals with this limitation. They thus have great difficulty taking part in make-believe play, using language in ways that include the perspectives of others, developing relationships, or participating in human interactions.

Children with autism who score above an IQ of 70 are referred to as having *high functioning autism (HFA).* Within the diagnosis of autism, males are 9 times more likely than females to be labelled as HFA.

4.6 INTERVENTIONS

No one therapy or method will work for all individuals with Autistic Disorder or pervasive developmental disorders. Many professionals and families will use a range of treatments simultaneously, including behaviour modification, structured educational approaches, medications, speech therapy, occupational therapy, and counselling.

These treatments promote more typical social and communication behaviour and minimise negative behaviours (e.g., hyperactivity, meaningless, repetitive behaviour, self-injury, aggressiveness) that interfere with the child's functioning and learning. There has been an increasing focus on treating preschool children with pervasive developmental disorders by working closely with family members to help the children cope with the problems encountered at home before they enter school. Many times, the earlier these children begin treatment, the better the outcome.

4.6.1 Behavioural Issues

As children with pervasive developmental disorders struggle to make sense of the many things that are confusing to them, they do best in an organised environment where rules and expectations are clear and consistent. The child's environment needs to be very structured and predictable. Many times a behaviour problem indicates that the child is trying to communicate something — confusion, frustration or fear.

Think of the child's behaviour problem as a message to be decoded. Try to determine the possible cause of the behaviour. Has the child's routine or schedule changed recently? Has something new been introduced that may be distressing or confusing the child? When a child's communication skills improve, behaviour problems often diminish—the child now has a means of expressing what is bothering him or her, without resorting to negative behaviour. The use of positive behavioural support strategies for these children has proved effective.

4.6.2 Appropriate Educational Programme

Education is the primary tool for treating pervasive developmental disorders. Many children with pervasive developmental disorders experience the greatest difficulty in school, where demands for attention and impulse control are virtual requirements for success. Behavioural difficulties can prevent some children from adapting to the classroom. However, with appropriate educational help, a child with pervasive developmental disorders can succeed in school. The most essential ingredient of a quality educational program is a knowledgeable teacher. Other elements of a quality educational program include:

- structured, consistent, predictable classes with schedules and assignments posted and clearly explained;
- information presented visually as well as verbally;
- opportunities to interact with non-disabled peers who model appropriate language, social, and behavioural skills;
- a focus on improving a child's communications skills using tools such as communication devices;
- reduced class size and an appropriate seating arrangement to help the child with pervasive developmental disorders avoid distraction;
- modified curriculum based on the particular child's strengths and weaknesses;
- using a combination of positive behavioural supports and other educational interventions; and
- frequent and adequate communication among teachers, parents, and the clinician.

4.6.3 Psychological Treatment

Counselling may be helpful to families to help them adjust to raising a child with a disability. If the child is already attending a school program, both parents and teachers need to be told of the symptoms of pervasive developmental disorders and how those symptoms may affect the child's ability to function at home, in the neighbourhood, in school, and in social situations.

Psychologists can also provide ongoing assessments, school consultation, case management, and behaviour training. Some children also benefit from counselling from an experienced practitioner who knows about pervasive developmental disorders. Family teamwork can ease the burden on the primary home caregiver, who needs a support system.

The Lovaas Method

This method (which is a type of Applied Behaviour Analysis [ABA]), developed by psychologist Ivar Lovaas at UCLA, is an intensive intervention program originally designed for preschool-aged children with autism. It uses behavioural techniques such as modelling and reinforcement (rewarding desired behaviour, and ignoring or discouraging undesirable actions) to achieve its goals. Generally, this method consists of 30 to 40 hours a week of basic language skills, behaviour, and academic training.

Therapy usually consists of 4 to 6 hours per day of one-on-one training, 5 to 7 days a week. Some research has shown remarkable progress in about 50% of the children receiving this therapy. The Lovaas Method is getting wide attention, but, as with other therapies, it needs more study.

Medical Treatment

There is no one specific medication that helps all children with pervasive developmental disorders. Some medications have been found to be helpful, but for many children with autism or pervasive developmental disorders, medication levels need to be experimented with until the optimal combination and dosage are found. Since this differs with each child, there is no set medical treatment for children with pervasive developmental disorders but, rather, an individual medication regimen for each.

Because of these complexities, in the eyes of many, medication therapy is viewed as a treatment to be used only when other types of treatment have been unsuccessful. The most commonly used medication for treating behaviour problems in autistic children is haloperidol, an antipsychotic medication frequently used in the treatment of schizophrenia.

This drug has been shown to reduce social withdrawal, stereotyped motor behaviour, and maladaptive behaviour, such as self-mutilation and aggression. But many children with autism do not respond positively to the drug. This drug has also not shown any effect on the other aspects of autism, such as language impairment and abnormal interpersonal relationships. Haloperidol also has potentially serious side-effects.

The primary aim of medical treatment of children with pervasive developmental disorders is to ensure physical and psychological health. A good preventive health care program should include regular physical checkups to monitor growth, vision, hearing, and blood pressure; immunisation according to schedule; and attention to diet and hygiene.

Children with pervasive developmental disorders are not the only ones who need extra help and support. Parenting a child with special needs is a demanding task. Learning and accepting that a child has a disability is a very emotional process. Initially, parents may feel alone and not know where to begin their search for information, assistance, and support. Parent groups offer parents and families a place to share information, give and receive emotional and practical support, and work as a team to address common goals.

Self Assessment Questions

1) What are pervasive developmental disorders?

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2) Describe the symptom categories in the pervasive developmental disorders?

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3) Name the types of disorders covered in pervasive developmental disorders?

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4) What is childhood disintegrative disorder?

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5) What is “islets of precocity?”

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4.7 LET US SUM UP

Pervasive developmental disorders (PDDs) are a group of neurobiological disorders characterised by fundamental deficits in social interaction skills or communication skills, or by the presence of stereotyped (purposeless and repetitive) behaviours, interests, or activities. Common features include difficulty with transitions or change, unusual sensory interests or sensitivities, an extremely narrow and intense focus of interest, and stereotyped behaviours (e.g., hand flapping, rocking, twirling). Cognitive deficits or uneven skill development are often present. There are five different categories of Pervasive Developmental Disorders that are currently recognised by the *DSM–IV–TR* (APA, 2000), including: Rett's disorder, childhood disintegration disorder, autism, Asperger's disorder, and PDDNOS.

Autistic disorder, the best known of these disorders, is characterised by sustained impairment in comprehending and responding to social cues, aberrant language development and usage, and restricted, stereotypical behavioural patterns. Asperger's disorder is a condition in which the child is markedly impaired in social relatedness and shows repetitive and stereotyped patterns of behaviour without a delay in language development. In Asperger's disorder, a child's cognitive abilities and adaptive skills are normal. Rett's disorder appears to occur exclusively in girls; it is characterised by normal development for at least 6 months, stereotyped hand movements, a loss of purposeful motions, diminishing social engagement, poor coordination, and decreasing language use. In childhood disintegrative disorder, development progresses normally for the first 2 years, after which the child shows a loss of previously acquired skills in two or more of the following areas: language use, social responsiveness, play, motor skills, and bladder or bowel control.

Autistic disorder was originally believed to be the result of coldness and aloofness in parents and their rejection of their children, but research gives no credence to such notions. A biological cause is suspected for a number of reasons: its early onset; family and twin studies give compelling evidence of a genetic predisposition; abnormalities have been found in the brains of autistic children. The most promising treatments of autism and pervasive developmental disorders are psychological in nature, involving modelling and operant conditioning procedures. Although the progress for children with pervasive developmental disorders remains poor in general, parental involvement may help children to participate meaningfully in social interactions. Various drug treatments have been used but have proved to be less effective than behavioural treatments.

4.8 UNIT END QUESTIONS

1) Describe in detail the main characteristic features of pervasive developmental disorders?
2) What is autism and discuss the clinical picture in autistic disorder?
3) What are the biological factors in autism?
4) Discuss the psychological causes of autism?
5) Describe in depth the various interventions for pervasive developmental disorders?

4.9 GLOSSARY

Echolalia : Repetition or echoing of the speech of others, a normal intermediate step in the development of speech skills. Originally thought to be a unique symptom of autism, it is now seen as evidence of developmental delay involved in that disorder.

Fragile X syndrome : Pattern of abnormality caused by a defect in the X chromosome resulting in mental retardation, learning problems, and unusual physical characteristics.

Microcephaly : Means "small headedness". It involves impaired development of the brain and a failure of the cranium to attain normal size.

4.10 SUGGESTED READINGS AND REFERENCES

Carson, R. C., Butcher, J. N., & Mineka, S. 2003. *Abnormal Psychology and Modern Life*. Pearson Education: New Delhi.

Sarason, I.G., & Sarason, B.R.2005. *Abnormal Psychology: The Problem of Maladaptive Behaviour.* Prentice-Hall of India: New Delhi.

Davison, G.C., Neale, J.M., Kring, A.M. *Abnormal Psychology,* 9th edition. Wiley & Sons:USA.

References

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) (DSM-IV-TR). Washington, DC: American Psychiatric Association.

Barkley, R. A., Fischer, M., Edelbrock, C. S., & Smallish, L. (1990). The adolescent outcome of hyperactive children diagnosed by research criteria: 1. An 8 year perspective follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 233–256.

Barlow, D.H., & Durand, V.M. 2007. *Abnormal Psychology: An Integrative Approach.* Thomson Learning Inc., New Delhi.

Bennett, Paul. 2005. *Abnormal and Clinical Psychology: An Introductory Textbook,* 2nd Ed. Open University Press, McGraw-Hill Education: England.

Bettelheim, B. (1973). Bringing up children. *Ladies Home Journal,* 90, 28.

Biederman, J., Faraone, S., Mick, E., Wozniak, J., Chen, L., Oullette, C., et al. (1996). Attention deficit hyperactivity disorder and juvenile mania: An overlooked comorbidity? *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 997–1008.

Birmaher, B., Axelson, D., Strober, M., Gill, M. K., Valeri, S., Chiappetta, L., et al. (2003). Clinical course of children and adolescents with bipolar spectrum disorders. *Archives of General Psychiatry, 63,* 175–183.

Brent, D.A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., Iyengar, S., & Johnson, B.A. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive. *Archives of General Psychology*., 54,877-85.

Carson, R. C., Butcher, J. N., & Mineka, S. 2003. *Abnormal psychology and modern life*. Pearson Education: New Delhi.

Christakis, S. A., Zimmerman, F. J., DiGiuseppe, D. L., & McCarty, C. A. (2004). Early television exposure and subsequent attentional problems in children. *Pediatrics, 113*, 708–713.

Claude, D., & Firestone, P. (1995). The development of ADHD boys: A 12-year follow-up. *Canadian Journal of Behavioural Science.* 27, 226-249.

Cole, D.A., Martin, J.M., Peeke, L. G., Seroczynski, A., & Hoffman, K. (1998). Are cognitive errors of underestimation predictive or reflective of depressive symptoms in children: A longitudinal study. *Journal of Abnormal Psychology.* 107(3), 481-96.

Comer, R.J. 2010. *Abnormal Psychology*, 7th edition. Worth Publishers. New York.

Crick, N. R., & Dodge, K. A. (1996). Social information–processing mechanisms in reactive and proactive aggression. *Child Development, 67*, 993–1002.

Davison, G.C., Neale, J.M., Kring, A.M. *Abnormal Psychology,* 9th edition. Wiley & Sons:USA.

Halgin, R.P., & Whitbourne, S.K. 1997. *Abnormal Psychology: The Human Experience of Psychological Disorders*. Brown & Benchmark Publishers: London.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behaviour in youth*. New York: Guilford.

Hinshaw, S.P. (1994). Conduct disorder in childhood: conceptualisation, diagnosis, comorbidity, and risk status for antisocial functioning in adulthood. In D.C. Fowles, P. Sutker, & S. H. Goodman (Eds.), *Progress in experimental personality and psychopathology research.* New York: Springer.

Klin, A., Volkmar, F. R. 1997. Asperger's syndrome. In Cohen DJ, Volkmar FR, eds., *Handbook of Autism and Pervasive Developmental Disorders* (2nd Ed.) (pp. 94–122). New York, NY: John Wiley & Sons.

Kramer, R.A., Warner, V., Olfson, M., & Weissman, M. M. (1998). General medical problems among the offspring of depressed parents: A 10-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry.* 37(6), 602-11.

Lyons, M. J., True, W.S., Eisen, A., Meyer, J. M., et al. (1995). Differential heritability of adult and juvenile antisocial traits. *Archives of General Psychiatry*. 52, 906-915.

Mangal, S.K. 2006. *Abnormal Psychology.* Sterling publishers: New Delhi.

Milberger, S., Biederman, J., Faraone, S., & Chen, L. (1996). Is maternal smoking during pregnancy a risk factor for ADHD in children? *American Journal of Psychiatry.* 153, 1138-1142.

Moffitt, T. E (1993). The neuropsychology of conduct disorder. *Development and Psychopathology, 5*(1–2), 135–151.

Moffitt, T. E., & Henry, B. (1989). Neuropsychological assessment of executive functions in self-reported delinquents. *Development and Psychopathology, 1*,105–118.

National Institute of Mental Health (NIMH) Fact Sheet. (2000). Depression in children and adolescents: A fact sheet for physicians. Retrieved from http://www.mental-healthmatters.com/articles/article.php?artID=320

Patterson, G. R., Capaldi, D., & Bank, L. (1991). An early starter model for predicting delinquency. In D. Pepler & K. H. Rubin (Eds.), *The development and treatment of childhood aggression* (pp. 139–168). Hillsdale, NJ: Erlbaum.

Sarason, I.G., & Sarason, B.R.2005. *Abnormal Psychology: The problem of maladaptive behaviour.* Prentice-Hall of India: New Delhi.

Sharma, R., 2006. *Abnormal Psychology*. Atlantic Publishers & Distributors: New Delhi.

Sieg, K.G., Gaffney, G. R., Preston, D. F., & Hellings, J. A. (1995). SPECT brain imaging abnormalities in attention deficit hyperactivity disorder. *Clinical Nuclear Medicine*. 20, 55-60.

Slutske, W. S., Heath, A. C., Dinwiddie, S. H., & Martin, N. G. (1997). Modelling genetic and environmental influences in the etiology of conduct disorder: A study of 2,682 adult twin pairs. *Journal of Abnormal Psychology.* 106, 266-279.

Sparrow, S. S., Balla, D. A., & Cicchetti, D. V. (1984). *Vineland Adaptive Behaviour Scales.* Circle Pines, MN: American Guidance Service.

Spencer, T. J., Biederman, J., & Harding, M. (1996). Pharmacotherapy of attention deficit-hyperactivity disorder across the life cycle. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 409–432.

Swanson, J., McBurnett, K., & Wigal, T. (1995). Stimulant medications and the treatment of the children with ADHD. In T.H. Ollendick & R.J. Prinz (Eds.), *Advances in Clinical Child Psychology* (Vol 17, pp. 265-322). New York: Plenum.

Weiss, G., & Hechtman, L. (1993). *Hyperactive children grow up* (2nd Ed.). New York: Guilford.

Weissman, M. M., Fendrich, M., & Wickramaratne, P. (1992). Incidence of psychiatric disorder in offspring at high and low risk for depression. *Journal of the American Academy of Child and Adolescent Psychiatry.* 31, 640-48.

4.11 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) c, 2) b, 3) d, 4) c, 5) A

Self Assessment Questions 2

Pervasive developmental disorders are a group of neurobiological disorders characterised by fundamental deficits in social interaction skills, communication skills, and by the presence of stereotyped (purposeless and repetitive) behaviours, interests, or activities.

There are three symptom categories in pervasive developmental disorders. They are social, communication and behaviour. Social category involves impairment of interpersonal relatedness, impaired capacity for empathy, lack of interest in others. Communication involves deficits in language, deficits in verbal and nonverbal communication. Behaviour category involves stereotyped behaviour, need for constancy in the environment and resistance to change.

There are five different categories of Pervasive Developmental Disorders that are currently recognised by the *DSM–IV–TR:* Autism, Asperger's disorder, Rett's disorder, childhood disintegration disorder, and pervasive developmental disorder not otherwise specified.

Childhood disintegrative disorder is a rare condition wherein development progresses normally for the first 2 years then the child shows marked regression in multiple areas such as language use, social responsiveness, play, motor skills, and bladder or bowel control.

One of the most fascinating cognitive phenomena in autistic disorder is the presence of so-called "islets of precocity" or "splinter skills". Approximately 10 percent of individuals with autism exhibit splinter skills—high performance on a specific skill in the presence of mild or moderate mental retardation. This phenomenon tends to occur among a narrow range of skills—memorising lists or other trivial information, calculations, visual-spatial skills such as drawing, musical skills such as perfect pitch or ability to memorise a piece of music after hearing it once.

UNIT 1 ANXIETY DISORDER

Structure

1.0 INTRODUCTION

This unit focuses on anxiety disorders. It gives an introduction to anxiety disorders and then go on to give the various categories of anxiety disorders. Discussing the common symptoms of anxiety disorders, the unit mentions specifically about the physiological and psychological symptoms. Anxiety up to a point is conducive for performance and beyond a point where the anxiety becomes overwhelming; the performance of the individual gets adversely affected. These are being discussed in detail in this unit. The various causative factors of anxiety disorders are presented and different approaches to intervention are discussed which includes psychoanalytical, cognitive, behavioural and biological perspectives.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- Define anxiety disorders;
- Enlist various types of anxiety disorders;
- Describe the Symptoms anxiety disorders;
- Explain the causes of anxiety disorders;
- Analyse the various approaches to treatment of anxiety disorders; and
- Describe the Interventional approaches for anxiety disorders.

1.2 ANXIETY DISORDERS

In everyday life almost everybody gets anxious or feels nervous before a test, or an important business meeting. Even rich or poor, famous or general public suffers from this anxiety may be in the terms of worries and fears. The term 'anxiety disorders' is a term that covers pathological fear and anxiety. These terms to an extent became more popular in psychiatry at the very end of the 19th century.

One could state that anxiety disorders as a term had also started during Sigmund Freud's time. Freud and his disciples considered anxiety as a warning signal that endangers or threatens the id impulses of undesirable nature which are also against social norms and which were about to enter the conscious mind. Freud argued that anxiety can be adaptive if the discomfort with it motivates people to learn new ways of approaching life's challenges.

It is normal to experience anxiety when faced with any stress or threatening situations, but it becomes abnormal to feel strong, chronic anxiety in the absence of a visible cause. There is a growing evidence of most of the people suffering from anxiety disorders are overly sensitive to threat cues, they exhibit a heightened sensitivity, vigilance or readiness to attend to potential threats.

Current psychiatric diagnostic criteria recognises a wide variety of anxiety disorders. Vulnerability is the lack of "perceived control" over stressful life circumstances. While the presence of environmental stressors may set the stage for the development of an anxiety disorder, researchers have found it is not only the actual presence of environmental stressors that create anxiety; but rather, anxiety is greatly determined by a person's perceived ability to control a potentially stressful event. It is important to realise that this lack of control may, or may not be accurate. Rather, it is the person's perception about their degree of control that is important.

It is believed that people's perceptions of control are heavily influenced by childhood experiences. When children repeatedly experience a "lack of control" or a sense of unpredictability over the events in their lives, they may come to view the world as unpredictable and dangerous. This world view may lead to feelings of helplessness, and a tendency to expect negative outcomes, no matter how they may try to prevent them.

Examples of early life experiences that may influence a person's perception of control include:

1) family dynamics such as parenting style (i.e., overprotective parenting style, and its opposite, under-protective, low-care style),
2) significant life stressors such as loss of, or separation from, primary caregivers, and
3) traumatic experiences such as childhood abuse (physical, emotional, and/or sexual).

This is not to say that our psychological trajectory is fixed in childhood and that nothing can be done to change it.

Instead, it simply means that early experiences may have contributed to this psychological vulnerability and explains, in part, why some people are more prone to experience anxiety than others. The perceived lack of control extends to a person's experience of their anxiety disorder. People with anxiety disorders often report they have no control over their symptoms and this lack of control is highly distressing to them. This fact may explain why the often good intentioned attempts by loved ones, to offer reassurance, are often met with doubt by the person with an anxiety disorder.

The term anxiety is mainly defined as vague, diffuse and a very unpleasant feeling of fear and apprehension. The individual shows combinations of the symptoms like rapid heart rate, shortness of breath, diarrhea, fainting, dizziness, sweating, sleeplessness, frequent urination and tremors. People who feel anxious are not aware of the reasons for their fear. Thus even though fear and anxiety involve similar reactions , the cause of worry is readily apparent.

Fear and stress reactions are essential for human survival. They enable people to pursue important goals and to respond appropriately to danger. In a healthy individual, the stress response (fight, fright, or flight) is provoked by a genuine threat or challenge and is used as a spur for appropriate action.

An anxiety disorder, however, involves an excessive or inappropriate state of arousal characterised by feelings of apprehension, uncertainty, or fear. The word is derived from the Latin, *angere*, which means to choke or strangle. The anxiety response is often not triggered by a real threat. Nevertheless it can still paralyze the individual into inaction or withdrawal. An anxiety disorder persists, while an appropriate response to a threat resolves, once the threat is removed.

Anxiety disorders involve a state of distressing chronic but fluctuating nervousness that is inappropriately severe for the person's circumstances.

Anxiety disorders can make people sweat, feel short of breath or dizzy, have a rapid heartbeat, tremble, and avoid certain situations.

These disorders are usually diagnosed using specific established criteria.

Drugs, psychotherapy, or both can substantially help most people.

Anxiety is a normal response to an actual or perceived threat or to psychological stress and is experienced occasionally by everyone. Normal anxiety has its roots in fear and serves an important survival function. When someone is faced with a dangerous situation, anxiety induces the fight or flight response. With this response, a variety of physical changes, such as increased blood flow to the heart and muscles, provide the body with the necessary energy and strength to deal with life-threatening situations, such as running from an aggressive animal or fighting off an attacker.

However, when anxiety occurs at inappropriate times, occurs frequently, or is so intense and long-lasting that it interferes with a person's normal activities, it is considered a disorder.

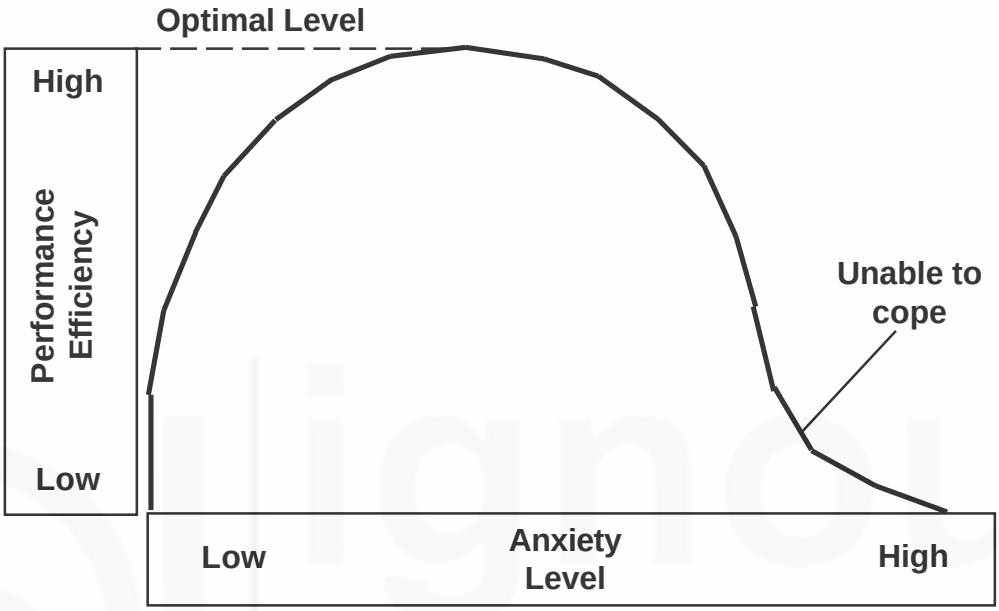
Anxiety disorders are more common than any other category of mental health disorder and are believed to affect about 15% of adults in the United States. However, anxiety disorders often are not recognised by people who have them

or by health care practitioners and consequently are seldom treated. The graph below presents the detail.

Anxiety and Performance

Anxiety affects performance up to a point anxiety enhances the performance but beyond a point that is when anxiety is overwhelming, the performance goes down considerably. This is illustrated in the graph given below.

How Anxiety Affects Performance



The effects of anxiety on performance can be shown on a curve. As the level of anxiety increases, performance efficiency increases proportionately, but only up to a point. As anxiety increases further, performance efficiency decreases. Before the peak of the curve, anxiety is considered adaptive; because it helps people prepare for a crisis and improve their functioning. Beyond the peak of the curve, anxiety is considered maladaptive, because it produces distress and impairs functioning.

1.2.1 Common Symptoms of Anxiety Disorders

All types of anxiety disorders have one common feature. This causes a general problem with the persons ability to have a normal everyday routine and normal life. All of the anxiety disorders lead to a pessimistic outlook on life and a feeling of a loss of control over an upcoming bad situation.

The symptoms of anxiety are:

- Nervousness
- Vigilance
- Sleeplessness
- Breathlessness
- Feeling faint
- Lack of concentration
- Worry or apprehension

- Trembling
- Sweating
- Feeling tired
- Frequency of urination
- Palpitation almost pounding of heart
- Muscle tension
- Headaches
- Insomnia
- Restlessness
- Irritability
- Hot flashes or chills
- Hyperventilation
- Nausea or stomach cramps etc.

Thus on the whole even though the symptoms have been separately mentioned, they are interrelated and affect the daily living of the individual. Despite no clear definition has been yet formulated for anxiety disorder, most psychologists have made distinction between normal anxiety and neurotic anxiety or anxiety disorders.

Normal anxiety occurs when people react appropriately to the anxiety causing situation. In contrast anxiety disorders are disproportionately intense in which real danger is little or only posed by either situation. This stimulates intense feelings of anxiety that can affect or derail a persons' desires or obligations.

Self Assessment Questions

1) How would you define anxiety disorders?

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2) Write up the major symptoms of anxiety disorders.

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3) How are anxiety disorders identified?

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1.2.2 Category of Anxiety Disorders

According to a standard manual for mental health clinicians the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition text revised of DSM IV TR) categorises anxiety disorders under the following headings:

i) **Generalised Anxiety Disorders:** This consists of more prolonged ,vague, unexplained but intense fears that do not seem to be attached to any particular object. It resembles normal fears but no actual danger is present in most of the cases. A person who has experienced six month or more persistent and excessive worry is diagnosed with generalised anxiety disorder. The symptoms of this disorder are of four types, which may be experienced individually or in combination. They are:

- Motor Tension
- Apprehensive feelings about the future
- Automatic reactivity
- Hyper vigilance

ii) **Panic Disorder:** Panic Disorders may come about with no warning signs. The indicators are mostly similar to generalised anxiety disorders except that they are magnified and usually have a sudden onset. Panic attacks also have shortness of breath, increased heart rate, dizziness and a feeling of helplessness. The victims fear that they will die, or go crazy or do something uncontrolled and they report a variety of unusual psycho sensory symptoms.

These attacks mainly ranges in length from a few seconds to many hours and even days. They also differ in severity and in the degree of incapacitation.

Symptoms of Panic Attacks

1) Dizziness, unsteadiness or faintness
2) Trembling, shaking or sweating
3) Heart palpitations or high heart rate
4) Chest pain or discomfort
5) Numbness or tingling
6) Fear of death or losing control

This disorder also affect women more than men and younger age groups more than the elderly. Compared to other anxiety disorders panic attacks appear to be more distressing and sometimes severe panic states are followed by periods of psychotic disorganisation in which there is a reduced capacity to test reality.

iii) **Obsessive Compulsive Disorder:** According to DSMIV(TR) either obsessions or compulsions need to be present. But most people who have obsessive compulsive disorder demonstrate both. This illness is very much what it sounds like. This disorder mainly conveys the driven quality of the thoughts and rituals seen in people with this condition. Obsessions are recurring thoughts, impulses or images that the person tries to eliminate or resist but either cannot or has extreme difficulty in doing so.

The Person does not have the control on their obsessions which leads to increase anxiety and to the method generally used to try to control the obsessions. People usually involve in doubt, hesitation, fear of contamination or fear of ones own aggression. Compulsions are thought or action that provide relief are generally used to suppress the obsession.

The compulsions are not connected realistically with the obsessions they are excessive in their nature. The exact incidence of obsessive compulsive disorder is hard to determine. The victims tend to be secretive about their pre occupations and frequently are able to work effectively in spite of their problems.

Symptoms of Obsessive Compulsive disorder:

1) Obsessivness to check the door locks
2) Obsessive of sexual thoughts
3) Obsession of counting
4) Washing the hands continuously.
5) Lots of doubt
6) Brushing the teeth continuously under compulsion

Thus obsessive compulsive disorder causes marked distress and takes considerable time to overcome the problem.

iv) **Phobias:** Phobia is a term derived from the Greek word “Phobos”. It is an intense irrational and persistent fear of certain situations, activities, things etc. People with this disorder know exactly for what they are afraid of, except for their fears of specific objects, phobic situations, individuals etc. Physically there does not seem to be anything wrong with them, but their fears are out of proportion with reality seem to be inexplicable and are beyond their voluntary control. Phobics do not need the actual presence of the feared object or situation to experience intense tension and discomfort. It tends to grow progressively broader. Phobias may begin with a generalised anxiety attack but that anxiety in course of time gets crystallised around a particular object or situation.

One study on phobic patients showed that their fears fell into five categories, viz., (i) separation, (ii) animals, (iii) bodily mutilation, (iv) social situation and (v) nature. Phobias like other forms of maladaptive behaviour do not come in isolation. They are usually intertwined with a host of other problems. In consequence it is difficult to estimate their frequency accurately. Mild phobias are common, though phobias which are serious enough to be clinically diagnosed and recommended for treatment etc., occur infrequently.

It has been experienced by the psychologists that phobias were obtained more commonly among women in all age groups, and these were found to be the second most common illness among men older than 25 years of age.

Classification of Phobias

Phobias are many and are classified according to the feared object. For instance a person having phobia for heights will be considered as having phobia called "Acora phobia" that is fear of heights. Then we have fear of opens spaces, closed spaces and so on and these are presented below:

i) Agora phobia: Fear of open places

ii) Claustro phobia: Fear of closed spaces

iii) Xeno phobia: Fear of strangers

iv) Ochlo phobia: Fear of crowd

v) Hemo phobia: Fear of blood

vi) Somni phobia: Fear of sleep

vii) Phasmo phobia: Fear of ghosts

viii) Myso phobia: Fear of dirt

ix) Algophobia: Fear of pain

x) Andro phobia: Fear of men

xi) Aqua phobia: Fear of water

xii) Hydro phobia (commonly used terms); Fear of water

xiii) Arachno phobia: Fear of spiders

xiv) Social phobia: Fear and embarrassment in dealing with others.

Symptoms of Phobia

There are typical characteristic symptoms of phobias and these include the following:

- Intense and disabling fear, panic and anxiety
- Fear becomes too much excessive and unreasonable
- Avoiding certain places and situation for fear
- Avoidance becomes prominent and affects the normal life
- Obsessive thinking
- Fleeing from the situation
- Persistent worry
- Shaking and palpitation

Thus phobias have been seen more prevalent than generalised anxiety disorder and have no specific known cause for happening.

v) **Post Traumatic Stress Disorder:** This is a disorder that develops after a person experiences a traumatic or terrifying event. For example physical or sexual assault, unexpected death of loved ones, natural disasters causing heavy damage and death and destruction, etc. Longtime after the event had

occurred the person mentally remains occupied along with the same feelings of anxiety that the original event had produced.

According to DSMIV (TR) (Diagnostic Statistical Manual) the symptoms like persistent re experiencing of event, avoidance or emotional numbing remain for more than one month .It causes significant impairment in social, occupational or in other areas of functioning. Mainly in the occurrence of post traumatic disorder the physical and psychological trauma comes in combination and affect the life of the individual. It has been said by the Psychologist atkinetal (2000) that posttraumatic stress disorder is cause by physical or psychological trauma caused by human such as by rape, war or terror attack. Sometimes possible sources also come from childhood, assault, drug-addiction, illness, medical complications or employment in occupations exposed to war or disaster. Sometimes heredity brain functioning also affects the human being life.

Symptoms of Post Traumatic Stress Disorder

i) Anger and irritability

ii) Flashbacks

iii) Feelings of intense distress

iv) Depression and hopelessness

v) Feeling jumpy and easily startled

vi) Rapid breathing nausea and muscle tension

vii) Suicidal thoughts

viii) Feelings of alienated

ix) Chest pain

Thus post traumatic stress disorder is gradual and ongoing process. Individual need to be confident and strong to overcome from this disorder otherwise it leads to worsening the situation.

vi) **Acute Stress Disorder:** It is a psychological condition arising in response to a terrifying or traumatic event. Disorder is similar to posttraumatic stress disorder but experienced immediately after the traumatic event. The onset of a stress response is associated with specific physiological actions in the sympathetic nervous system. Both directly and indirectly through the release of epinephrine from the medulla of the adrenal glands.

Symptoms of Acute Stress Disorder

i) Numbing

ii) Detachment

iii) Derealisation

iv) Depersonalisation

v) Dissaociative amnesia

vi) Flashbacks

vii) Avoidance of any stimulation

The acute stress disorder and posttraumatic stress disorder are more or less is some if this disorder persists longer than one month the diagnosis is changed to posttraumatic stress disorder.

Self Assessment Questions

1) Describe some of the important features of anxiety disorders as given in DSM IVTR.

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2) List out types of anxiety disorders. Categorise them as per by DSM IV TR.

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3) What is the assessment of the overlap between posttraumatic stress disorder and acute stress disorder?

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4) What is the difference between Panic attacks and phobia?

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1.3 CAUSES OF ANXIETY DISORDER

The causes of anxiety disorders are not fully known, but both physical and psychological factors are involved. Because anxiety disorders are prevalent in some families, heredity probably plays a role. Anxiety is viewed at a psychological level as a response to environmental stresses, such as the breakup of a significant relationship or exposure to a life threatening disaster.

When a person's response to stresses is inappropriate or a person is overwhelmed by events, an anxiety disorder can arise. For example, some people find speaking before a group exhilarating. But others dread it, becoming anxious with symptoms such as sweating, fear, rapid heart rate, and in some cases also tremors.

Such people may avoid speaking even in a small group. Anxiety disorders may also be caused by a physical disorder or the use of a drug. For example, an overactive thyroid or adrenal gland can cause anxiety, as can a tumor called a pheochromocytoma. Drugs that can cause anxiety include corticosteroids, cocaine, amphetamines, ephedrine, and sometimes caffeine if too much is consumed. Withdrawal from alcohol or certain sedatives can also cause symptoms of an anxiety disorder. In older people, dementia may be the most common cause of anxiety. Although the exact cause of these anxiety disorders are not fully understood.

1.3.1 Causes

The causative factors include the following:

- Genetics
- Substance Abuse
- Stressful Life
- Mental or physical abuse
- Changes in living situation
- Illness
- Death of a loved one
- Faulty relationship
- Brain chemistry
- Changing of jobs or school
- Migration
- Traumatic experience
- Fixation with objects, situations
- Witnessing bad experience
- Embarrassment
- Torture
- Natural disaster

Thus with the high prevalence of these anxiety disorders the necessary thing is need to be quite cautious regarding the said disorders and public awareness. The

social stigma associated with it may decrease and encourage those who suffer from it to seek professional help.

Self Assessment Questions

1) List out some causes of anxiety disorders.

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2) What type of relationship can lead towards anxiety disorders and how.

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3) How migration can affect the daily life of the individuals and causes anxiety disorder. Cite one example.

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1.4 APPROACHES TO INTERVENTION IN ANXIETY DISORDERS

Whether specific or general but anxiety disorder is a major component of this unit. It needs to be dealt with by various approaches to manage the suffering individuals.

1.4.1 Psychodynamic Perspective

This perspective believes in that the major determinant of anxiety disorders is intra-psychic events and unconscious motivation. It is being accepted that anxiety is an alarm reaction that appears when person is threatened. It is normal to experience some overt anxiety, the amount of anxiety and the nature of the threat that determine whether an instance of anxiety is normal or pathological. The theorists in this approach targets the causes of anxiety that reaches clinical proportions like perceptions of oneself as helplessness in coping with surrounding pressure, privation, loss of emotional support or dangerous impulses which comes close to breaking into consciousness.

This approach views that anxiety disorder stems from the psychological conflict and unconscious mental processes. Any situation or object has symbolic significance and can be regarded as a stand in for something else that one is frightened of something that is completely beyond ones awareness. It represents an unresolved psychological conflict. Obsessive ideas and compulsive activity comes from significant distressing unconscious thoughts.

Psychoanalysts believe that these thoughts involve aggression and rage that may have first been aroused in the battle for autonomy between the growing child and the mother or the care giver. Sigmund Freud father of psychoanalysis emphasised the roles of several defense mechanisms in the development of various anxiety disorders. These include isolation, undoing and reaction formation. Psychotherapy is proved to be the focus clinical tool of the psycho dynamically oriented clinician. It deals with the psychodynamic roots of the maladaptive behaviour. Most specialists believe that such behaviour occur when a person becomes preoccupied with relieving anxiety.

These specialists use catharsis technique which targets in ventilating the repressed thoughts of the person. These all can only get success through free association method between the therapist and the patient. It is believe to be the way of squeezing out all the hidden unresolved issues disturbing the individuals.

1.4.2 Behavioural Perspective

Behaviour therapists have challenged the approaches of psychotherapists. Psychotherapists believe that in order to change abnormal behaviour one must remove or reduce the conflict underlying the behaviour .According to behaviourists anxiety which reaches clinical proportions is a learned or acquired response a symptom that has been created by environmental conditions.

B.F Skinner the leading behaviourist preferred exclusively on observable stimulus and response variable. In this approach the new learning for eliminating anxiety is associated with conditioning, reinforcement and extinction. Behaviour therapy has been directed at discovering the variables that help defuse highly emotional responses**.**

Expose therapy introduced by the behaviourists has been used in treating phobias, obsessive compulsive disorders and other anxiety disorders. It motivates the client or patient to maintain contact with the actual noxious stimuli or with their imagined presence until he or she becomes used to them. In association to this technique three other types of therapy also can be used like systematic desensitisation, implosive therapy and vivo exposure.

In **systematic desensitisation** the treatment of strong fears is based on conditioning principles. The patient or client is taught to relax and then is presented with a series of stimuli that are graded from low to high according to their capacity to evoke anxiety. Usually the process in reduction of the level of any emotional response to particular stimulus is gradually.

Implosive therapy is based on the belief that many conditions including anxiety disorders are outgrowth of painful of prior experiences. Therapists ask their clients to imagine scenes related to particular personal conflicts and to recreate the anxiety felt in those scenes. The target of the therapist is to strive to heighten the realism

of the recreation and to help the patient extinguish the anxiety that was created by the original aversive conditions client is also helped to adapt the more mature forms of behaviour.

In Vivo exposure is carried out in a real life setting not simply in the imaginations of the client and the therapist as they sit in the therapist clinic. Sometimes in this therapy someone relieves their specific fear in three sessions only**.**

Modelling is used often to anxiety provoking stimuli. Therapists models a response and then provides corrective feedback as the patient performs the same behaviour. Modelling play a vital role in guided mastery in which therapists guide the client toward mastery over frightening situations and maladaptive behaviour.

1.4.3 Cognitive Perspective

Cognitive therapy is highly effective in reducing anxiety, regardless of client feels relaxed or anxious during their exposure. It seeks to help the patient overcome the difficulties by identifying and changing dysfunctional thinking, behaviour and emotional responses.

Modeling proves to be an important cognitive element from overcoming intense fear and acquire self confidence. Sometimes the way people think about certain things changes when they acquire new response capacities. According to cognitive theorists thinking disturbances that occur only in certain places or in relation to specific problems are the sources of anxiety. These types of thoughts include unrealistic appraisals of situations and consistent overestimation of their dangerous aspects. The therapist tries to highlight the distortions and encourages the patient to change his or her attitudes. The different techniques used to effect change using cognitive therapy are:

Rationale Emotive Therapy

It is based on the belief that for any individual most of the problems originate in irrational thought. The principle of this therapy is the relationships between thinking, feelings and action. It is an analysis model which deals with what is going on. It has its own self control procedures. This helps in becoming able to easily influence the situation and also help in gaining insight in new ways of thinking.

Cognitive Restructuring

This motivates the patient or client attention to the unrealistic thoughts that serve as cues for his or her maladaptive behaviour. It is the responsibility of the client or patient to review their irrational beliefs and expectations to develop more rational ways of life.

Thought Stopping

It is one of the techniques in cognitive perspective which works on the assumption that a sudden distracting stimulus can serve to terminate obsessional thoughts successfully.

Cognitive Rehearsal

It is an approach where patient can mentally rehearse adaptive approaches to problematic situations. This is particularly useful for problems that cannot be

conveniently stimulated in a clinical setting. If someone suffering from a social phobia can imagine being in a group and can mentally rehearse behaviour and internal statements designed to improve his or her interpersonal relationships, it would go a long way in making the person give up the fear being in a group or social situation.

1.4.4 Combination of Cognitive and Behavioural Approaches

These two approaches in combination aim to solve issues concerning dysfunctional emotions, behaviours and cognitions through a goal oriented systematic procedure. The cognitive behavioural technique is effective for the treatment of a variety of problems including mood, anxiety, personality, eating, substance abuse and psychotic disorders. The program has been used in a series of clinical studies with social phobia and generalised anxiety disorder patients. Thus this therapy involves in helping patients on the overall aspects. It supports in modifying beliefs, identifying distorted thinking, changing behaviour etc.

1.4.5 Biological Perspective

It has been seen by the psychologists that different reactions are caused by an individual's biological state. It is an accepted fact that people whose nervous system is particularly sensitive to stimulation appear more likely to experience severe anxiety. Heredity has shown a strong influence on such characteristics as timidity, fearfulness and aggressiveness. A study found that children of people treated for anxiety disorders were more anxious and fearful and showed more school difficulties, worries and had greater number of problems as compared to children of normal parents. Psychologists have also supported the effect of more genetic factor and a statistically significant and weaker effect for a family environment factor.

Drug Therapies

Drugs in the form of medications have also proved effective in treating specific anxiety disorders. Benzodiazepines the tranquilising drugs are the most commonly used somatic therapy in the treatment of anxiety. Anti depressants is also one of drugs to treat anxiety disorders and group of disorders.

From this unit which has dealt with anxiety disorders, types, symptoms, causes and treatment it is clear that all categories are overlapping. The symptoms are more or less the same, with too being similar and having in all cases certain core cause for all but only need to have vigilance over the activities of the individual without shyness and social stigma.

If the awareness is spread out in the society then problem can be diagnosed at the initial stage.

Self Assessment Questions

1) Psychodynamic Approach states .....

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2) Systematic Desensitisation is .....

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3) Cognitive restructuring focuses .....

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1.5 LET US SUM UP

Let us sum up this unit that anxiety disorders are often debilitating chronic conditions which come from an early age or suddenly can be triggered in life of an individual. These disorders are often co morbid with other mental disorders particularly clinical depression which is less disturbing in the daily life than anxiety disorders. As a student of abnormal psychology, in this unit, you have studied anxiety disorders which you know are integral part of our life whether or not we recognise their effect in our behaviour.

1.6 UNIT END QUESTIONS

1) Describe anxiety disorders.
2) Define the types of anxiety disorders.
3) Explain the common signs and symptoms of anxiety disorders. With examples.
4) Describe the causes of anxiety disorders.
5) How common are anxiety disorders.

1.7 SUGGESTED READINGS AND REFERENCES

Barlow.H.David(2008) *Abnormal Psychology :An Integrative Approach*, Canada, Wadsworth Cenanage Learning(Pub).

Barlow &Durand(2005) *Essentials of Abnormal Psychology,*New York, Thomson Wadsworth(Pub).

Davison C .Gerald (2005) *Abnormal Psychology*, John Wiley&Sons(Pub).

References

Abramowitz, J. S., Franklin, M. E., & Foa, E. B. (2002). Empirical status of cognitive-behavioural therapy for obsessive-compulsive disorder: A meta-analytic review. Romanian *Journal of Cognitive and Behavioural Psychotherapies*, 2, 89-104.

Altrocchi John(1985).Abnormal Behaviour,New York,Harcourt Brace Jovanovich.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (Revised 4th Ed.)*. Washington, DC: Author.

Baer, L., & Jenike, M. A. (1992). Personality disorders in obsessive compulsive disorder. *Psychiatric Clinics of North America*, 15, 803-812.

Barlow, D. H., Craske, M. G., Cerny, J. A., & Klosko, J. S. (1989). Behavioural treatment of panic disorder. *Behaviour Therapy*, 20, 261-282.

Barlow, D. H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist*, 1247-1263.

Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic (2nd ed.)*. New York: Guilford Press.

Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic (2nd ed.)*. New York: Guilford Press.

Hales RE, Yudofsky SC, Talbott JA(1999) eds. *APA Textbook of Psychiatry*. 3rd ed. Washington, DC: American Psychiatric Press; .

Huppert, J. D. (2009). Anxiety disorders and depression comorbidity. In: Oxford handbook of anxiety and related disorders (pp. 576-586). Antony, Martin M. (Ed.); Stein, Murray B. (Ed.); New York, NY, US: Oxford University Press.

Lazarus, R. S. (1977). Cognitive and coping processes in emotion. In A.Monat & R. S. Lazarus (Eds.) *Stress and coping: An anthology* (pp 145-158). New York, NY: Columbia University Press.

Lazarus, R. S. & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer Publishing Company.

Ledley, D. R., Marx, B. P., & Heimberg, R.G. (2005). *Making cognitive-behavioural therapy work: Clinical process for new practitioners*. New York, NY: The Guilford Press.

McLaughlin, K. A., & Hatzenbuehler. M. L. (2009). Stressful life events, anxiety sensitivity, and internalising symptoms in adolescents. *Journal of Abnormal Psychology*, 118(3), 659-669.

National Institute of mental health (2008). The numbers count: Mental disorders in America

Neziroglu, F., Bubrick, J., & Yaryura-Tobias, J. (2004). *Overcoming compulsive hoarding: Why you save & how you can stop*. Oakland, CA: New Harbinger Publications.

Norton, P. J., & Price, E. C. (2007). A meta-analytic review of adult cognitive-behavioural treatment outcome across the anxiety disorders. *The Journal of*

Nervous and Mental Disease, 195, 521-531.

Pfeiffer PN, Ganoczy D, Ilgen M, Zivin K, Valenstein M. (2009) Comorbid anxiety as a suicide risk factor among depressed veterans.

Pollack MH, Simon NM, Worthington JJ, et al. Combined paroxetine and clonazepam treatment strategies compared to paroxetine monotherapy for panic disorder. *J Psychopharmacol*. Sep 2003.

Sarson & Sarson(1993) Abnormal Psychology: The problem of Maladaptive Behaviour (seventh ed) ,New Jersey: Prentice Hall.

Johnston, J. E. (2006). The complete idiot's guide to controlling anxiety. New York: Penguin Group.

Websites

Anxiety disorders Association of America

Association for Behavioural and Cognitive Therapies

National Institute of Mental Health

UNIT 2 SOMATOFORM AND DISSOCIATIVE DISORDERS

Structure

2.0 INTRODUCTION

This unit deals with the somatoform disorders and dissociative disorders. The unit commences with a definition and conceptualisation of the disorders and presents the characteristic features of somatoform disorder. This is followed by types of somatoform disorder and causes of this disorder. The type of treatment interventions are then taken up and the various treatment interventions such as psychotherapy, cognitive behaviour therapy etc. are discussed. This is followed by detailed presentation of dissociative disorders and the types of these disorders, the causes and the various treatment interventions.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and conceptualise somatoform and somatisation disorders;
- Explain the characteristic features of this disorder;

- Delineate the types of somatoform disorders;
- Describe the treatment interventions in regard to the somatoform disorder;
- Define and conceptualise dissociative disorders;
- Describe the symptoms of dissociative disorders;
- Explain the causative factors leading to dissociative disorders; and
- Describe the treatment interventions for the dissociative disorders.

2.2 DEFINITION AND CONCEPT

Somatoform disorders are a category or a group of psychiatric disorders which are characterised by conversion of emotional distress into physical symptoms. These symptoms of physical illness have no actual organic cause but people do suffer and complain about the problem. In one sense it may be stated that people suffering from these disorders are preoccupied with a slight or non existent issues in the sense that eventhough the symptoms are physical, like paralysis of the limbs etc., there is no real identificable physical cause. All efforts to find the physical cause through various pathological tests prove nil and thus the person is referred to a psychologist or psychiatrist for further investigations and diagnosis. This somatoform disorder is also called as psychosomatic disorders. People with this disorder do not fake illness but they are commitedly believe that they have a serious physical problem.

It has been long discussed by the experts that how mind and body interact and influence health of the individual. Sometimes social and mental stress can aggravate many physical disorders like diabetes mellitus, coronary artery disease and asthma. Such stress can trigger, worsen or prolong physical symptoms.

Physical symptoms can evolve from stress or mental symptoms in anyone, including people who do not have a serious underlying mental health disorders. Such physical symptoms are often mild and transient. They sometimes become difficult for a doctor to diagnose. Mental factors can also influence the course of a disorder. Conversely a physical disorder can also influence or lead to a mental condition. For example, people with a life threatening, recurring or chronic physical disorder may become depressed. The depression in turn may worsen the effects of the physical disorder.

2.2.1 Characteristics of the Disorder

The disorder which is characterised by psychosomatic or somatisation process may be considered to lie in a continuum from those in which symptoms develop consciously and volitionally to development of symptoms at an unconscious level.

The continuum includes somatoform disorders, factious disorders and malingering. Somatoform disorders are more physically oriented which are not fully explained by another disorder physical or mental. These are distressing and often impair social, occupational , academic, or some other aspects of functioning.

Factious disorder involve the conscious and volitional feigning of symptoms without any external causes.

Patients gain gratification from assuming the sick role through the simulation, exaggeration or aggravation of symptoms and signs. Malingering is intentional feigning of physical or mental symptoms motivated by an external incentive. Thus after clustering the three continuums it can only be said that patients suffers which can be worse but without any external causes.

Somatoform disorders are commonly found more in women than in men and it can be evidenced in the ineffective role performance and disturbed body image. It includes chronic syndrome of multiple somatic symptoms that cannot be explained medically but are associated with psychosocial stress, but these mental problems are not characterised by physical disease.

As a group the disorders are difficult to recognise and treat because patients often have long histories of medical or surgical treatment with several different doctors. In addition the physical symptoms are not under the patient's conscious control so that he or she is not intentionally trying to confuse the doctor or complicate the process of diagnosis. Somatoform disorders are however a significant problem for the health care system because patients with these disturbances overuse medical services. It is clear that many of the bodily complaints that physicians are asked to treat suggest physical pathology, but no actual impairment can be found.

Although failure to diagnose a case medically might be due to the doctors lack of knowledge of psychiatric syndromes or to a faulty laboratory test. In a large number of cases the symptoms may be due to psychological rather than physiological factors. Though psychological it does not mean that the symptoms are consciously produced but actually unconsciously felt by the patients.

Somatoform disorders are also known as Briquets syndrome (named after Paul Briquet) or Brissaual Marie syndrome (named after Edward Brissaul and Pierro Marie). This disorder is characterised by physical symptom that mimic physical disease or injury for which there does not exist any identifiable physical cause. People with somatoform medical tests results are either normal or do not explain the person's symptoms. People who have this disorder may undergo several medical evaluations and tests to be sure that they do not have an illness related to a physical cause or some major lesion.

Patients become often very worried about their health because the doctors are unable to find a cause for their health problems. Their symptoms are similar to the symptoms of physical illness and lasts for several years. No treatment helps and finally they are referred to psychiatrists or psychologists.

In brief, it may stated that Somatoform is defined by DSM IV (Diagnostic Statistical Manual 4th Ed) as being characterised by physical symptoms that cannot be explained by any medical condition. As stated in DSM IV these are inclusive characteristics that result in mental or emotional stress. It is a recognition of the connection between a person's mind and body. It is a condition in which a person feels pain in the joints, back and pelvic region and often accompanied by frequent headaches.

Self Assessment Questions

1) Define and elucidate the concept of somatoform disorders.

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2) What are the typical features of this disorder?

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3) What is Briquet syndrome?

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4) Define somatoform disorder in terms of DSM IV criteria.

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2.3 TYPES OF SOMATOFORM DISORDERS

The somatoform disorders recognised by DSM IV TR are:

- Conversion disorders
- Hypochondriasis
- Somatisation disorders
- Body dysmorphic disorders
- Pain disorders

Thus somatoform disorders are classified in various categories with typical signs and symptoms. They represent a group of disorders. Let us take up one by one these disorders and discuss:

i) **Conversion Disorders:** It is a condition where patients present with neurological symptoms like numbness, blindness, paralysis or fits. The term conversion comes from the origin in that anxiety is converted into physical symptoms. The old term for conversion disorders was hysteria. Physicians in ancient Greece believed that hysteria only occurred in females and it was caused by the uterus wandering in the body. The term conversion came into being used in the twentieth century. It was derived by Freud who believed that in times of extreme emotional stress, painful feelings or conflicts are repressed and are converted into physical symptoms to relieve anxiety.

   This disorder is from the family of somatoform disorders, the defining characteristic being that of having no evidence of medical causes but the symptoms are present in intense form. It is believed that the many psychological problems are converted into physical symptoms and thus the disorder gets its name conversion disorder. The DSM IV (TR) classifies conversion disorder as one of the somatoform disorders which includes pseudo neurological syndrome, hysterical neurosis and psychogenic disorder.

   It has been estimated that 25-72% of patients who visit with these types of disorders suffer from conversion disorder wherein patients are believed to convert their emotional problems into physical symptoms. Research has shown that such patients spend nine times more for health care as compared to people who do not have somatisation disorder or who do not convert their emotional problems into physical disorder. Of persons who suffer from somatisation disorder, 82% of adults stop working because they feel that they suffer from some major problem.

   In fact the problem faced by them is somewhat complicated and generally results from psychological trauma. Conversion disorder is also referred to as hysteria which is thought to be caused by stress and conflict, in which people experience physical problems in the form of conversion. It tends to develop during late childhood or early adulthood, or at any age. This disorder is more common in women than in men. DSM IV TR (2000) specifies six criteria for conversion disorders. With this specification, it has also been seen that conversion occurs with some motor and sensory symptoms or convulsions and sometimes with mixed presentations.

   According to psychodynamic theory the symptoms of conversion develop to defend against unacceptable impulses. Conversion symptom is to bind anxiety and keep the conflict internal, that is within the self at an unconscious level. The symptom has a symbolic value that is a representation and partial solution of a deep seated psychological conflict to avoid running away from the situation.

   While psychodynamic explanation nis coversion of psychological conflict into physical symptoms, according to learning theory conversion symptoms are a learned maladaptive response to stress. Patients try to achieve secondary gain by avoiding activities that are particularly offensive to them and gain support from family.

Common symptoms of conversion disorder

- Poor coordination or balance
- Paralysis in an arm or a leg
- Lump in throat
- Inability to speak
- Impaired vision
- Loss of balance
- Hallucinations
- Difficulty in walking

Some categorised specific symptoms

Sensory symptoms: It includes anesthesia, loss of pain, tingling or crawling sensations.

Motor symptoms: In this all body muscles become disorganised or immobile.

Visceral symptoms: This includes trouble in swallowing, frequent belching, coughing or vomiting all carried to an extreme.

ii) **Hypochondriasis:** It is similar in many ways to undifferentiated somatoform disorder. The patient shows an unrealistic fear of disease in spite of reassurance that his or her social or occupational functioning is not impaired. Patient is convinced that the physical symptoms they are experiencing are the signs of a major illness with obsessive pre occupations.

Patients are concerned over the condition of their bodily organs and continually worry about their health. Hypochondriasis is more organ specific. Generally patients tend to misunderstand the nature of the significance of psychological activity and exaggerate the symptoms when they occur. It was earlier known as hypochondriacal disorder. It is generally considered a disorder in young adults but is now increasingly recognised in children and adolescents. It also develops in elderly people with previous history of health related fears accounting equally among men and women. Hypochondriasis may persist over a number of years but usually occurs in a series of episodes rather than continuous treatment seeking. The flare ups of the disorder are often correlated with stressful events in the patient's life. This also results in part from the patient's unconscious imitation of their parents behaviour.

Common symptoms of hypochondriasis

- Poor co-ordination or balance
- Headaches
- Sweating
- Many symptoms of physical illnesses

iii) **Somatisation disorder:** It was formerly called Briquet's syndrome, named after the French physician. It is a pattern of symptoms in different parts of the patient's body that cannot be accounted for by medical illness. It begins before the age of 30 and is more common in women. Patients with somatisation disorder believe that they are sick and they generally provide

long and detailed histories in support of their belief, with large quantities of medicines. These individuals almost share many common features of histrionic personality disorders including a self centered attitude and exaggerated expression of emotions. Anxiety and depression are common features as is manipulativeness which may take the form of suicide threats and attempts. It has been described that generally somatisers are considered as immature and overly excitable persons. It is not uncommon for a family to have more than one somatiser. People who are classified as having a somatising disorder tend to be suggestible thereby causing many other family members too develop such symptoms. Thus the high prevalence of the disorder in certain families may reflect the influence of a somatising parent rather than heredity.

Symptoms

i) Pain in the body

ii) Gastro-intestinal symptoms

iii) Sexual symptoms

iv) Pseudo-neurological symptoms

iv) **Body dysmorphic disorder:** This is another category of somatoform disorder. It is generally described as a preoccupation with an imagined or exaggerated defect in appearance. Most of the cases involve features on the patient's face and head but especially those associated with sexual attraction, are the focus of concern in this disorder.

It is regarded as a chronic condition that begins in the patient's late teens and fluctuates over the course of time. Generally patients in this disorder misconceptualise their body and show more inclination towards the procedure to repair or treat the defect through plastic surgery. It affects both the sex equally.

Symptoms

i) Imaginary physical flaws

ii) Acne

iii) Scarring

iv) Facial lines

v) Marks

vi) Pale skin

vii) Thinning of hair

v) **Pain disorder:** It is marked by the presence of severe pain. Patient's pain appears to be largely due to psychological factors but in other cases the pain is derived from a medical condition as well as the patient's mental problems. It is relatively common in the general population especially among older adults nearly equal among both the sexes. Sometimes pain is often so severe that it disables the patient from proper functioning which can last from a few days in the short spell to many years in the long run. It is especially defined by APA (2000) that this disorder may begin at any age and is observed

more among women than in men. This also often occurs after an accident or an illness that may have caused genuine pain.

Symptoms

i) Chronic headaches

ii) Back problem

iii) Arthritis

iv) Cramps

v) Muscle aches and

vi) Pelvic pain

Self Assessment Questions

1) What are the major types of somatoform disorders?

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2) Enlist the symptoms of conversion disorders.

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3) How does somatisation disorder differ from pain disorder?

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2.4 CAUSES OF SOMATOFORM DISORDERS

Somatoform disorders have been categorised and diagnosed for more than a century. It has been studied from current explanations that there is a concept of misconnection between mind and body. Different theories state that the mind has a finite capacity to cope with stress and strain. The increasing social and emotional stresses beyond a certain point can be experienced as physical symptoms principally affecting the digestive, nervous and reproductive systems.

Presently researchers have found a connection between the brain immune system and the digestive system which could be the reason why somatoform affects these systems of the patient. The major causes are as follows:

- Defence against psychological distress
- Heightened sensitivity to physical sensations
- Catastrophic thoughts
- Discomfort or pain in the body
- Family stress
- Parental modeling
- Cultural influence
- Genetic factors

Thus this group of disorders come without any medical explanations by the doctors making the patient fearful. Anxiety causes the focal point even more intensely on their symptoms turn the individual more disabling causing hypothetical suffering.

Self Assessment Questions

1) What are the causes of somatoform disorders?

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2) Write down causes of hypochondriasis

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3) How does psychological feeling make an individual sick without any actual bodily symptoms, clarify.

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2.5 INTERVENTIONS

Accurate diagnosis with proper intervention is required for somatoform disorders. This can protect the individuals from unnecessary surgery, laboratory tests or other treatments or procedures.

The interventions required are:

2.5.1 Relationship with the Primary Care Practitioner

Due to long term medical history of these patients safeguard relationship with the practitioner is needed. This can able the person to avoid unnecessary treatment. Many practitioners prefer to schedule brief appointments on a regular basis with the patients.

2.5.2 Psychotherapy

Patients with these types of disorders are considered only for insight oriented psycho therapy. Generally they are benefitted from supportive approaches to treatment that is aimed at symptom reduction and stabilisation of the patient's personality. Sometimes patients with pain disorders benefit from group therapy or supports group therapy. Family therapy is also recommended for children or adolescents with somatoform disorders.

2.5.3 Cognitive Behavioural Therapy

This has been proven effective. In a study of 54 body dysmorphic disorder patients who were assigned to cognitive behavioural therapy intervention were found to have had decreased symptoms in 82% cases in comparison to other techniques.

2.5.4 Alternative Treatment

Patients with these disorders are helped by a variety of alternative techniques like hydrotherapy, massage, meditation, homeopathic treatment. They have often got relief from pain and physical stress. This also facilitates emotional as well as spiritual well being.

2.5.5 Psycho Education Technique

This is a technique initiated by psychologists. It is useful in explaining stress or any emotional distress. Relaxation, stress management etc. It is of great help in decreasing the emotional and bodily arousals.

2.5.6 Medications

Sometimes in extreme cases patients are also given anti anxiety drugs or anti depressant drugs. In general it is better to avoid medication because patient may become drug dependent and they should be encouraged to try other therapies.

Thus, in brief one may state that somatoform disorder is a group of problems which are characterised by persistent physical symptoms which can be indicative of a medical disorder, a problem without any demonstrative basis.

The origin of this disorder to the human body is still unknown, but some studies have shown that primary somatoform disorders is related to the occurrence of heightened awareness of the normal bodily sensations of a person. Many

psychological interventions are now incorporated to address these disorders. Psychological theorists believed that by encouraging people can be a way in articulating their emotions and using the alternate medical techniques.

Self Assessment Questions

1) What are the treatment techniques for somatoform disorders?

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2) Describe anyone of the technique.

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3) Describe the importance of relationship between patient and doctor during treatment.

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2.6 DISSOCIATIVE DISORDERS

These disorders are defined as conditions that involve breakdown of memory, identity, awareness, perception etc. It interferes in person's general functioning.

Dissociative disorders are a group of psychiatric syndromes. The APA and DSM IV(TR) include one category for atypical dissociative disorders. The person's identity may be temporarily forgotten or a new identity assumed or there may be a feeling that one's sense of reality is lost.

Maladaptive behaviour arises from dissociative disorders. They provide a striking contrast to those that arise from post traumatic stress disorder and adjustment disorders. People with dissociative disorders use a variety of dramatic maneuvers to escape from the anxiety and conflicts aroused by stress.

Their behaviour involves sudden and temporary alterations of consciousness which serve to reduce the individual's painful experiences.

Sometimes these disorders appear to begin and end abruptly and are precipitated by stressful experiences. Disorders mostly occurs in childhood but there is a history of serious family turmoil.

According to DSM IV (TR) and APA the four major dissociative categories are. (i) Dissociative amnesia (ii) Dissociative Identity disorder (iii) Dissociative fugue (iv) Depersonalisation disorder. Let us take up these and deal with them in detail.

2.6.1 Dissociative Amnesia (earlier known as psychogenic amnesia)

It is a feature of temporary or permanent loss of a part or all of their memory. Person becomes incapable of recalling important personal information that becomes more extensive than explained by normal forgetfulness. It also happens due to extreme psychosocial stress. This stress can get related with catastrophic events. Different types of memory loss have been identified in person with dissociative amnesia and they are:

Localised amnesia: This happens for a particular event. The disease renders the afflicted unable to recall the details of an usually traumatic event such as violent incestual rape. This is generally experienced in battle or situations of torture.

Selective amnesia: It is as the name says that individual becomes selective in the manner to recall or remember. Often person remembers certain general occurrences of a trauma situation and not the specific parts which make it so.

Continuous amnesia: It occurs when patients have no money of events up to and including the present time. It means patients are alert and aware but not able to remember.

2.6.2 Dissociative Identity Disorder (Earlier Known as Multiple Disorders)

It is the most dramatic among all disorders. A women who had been physically and sexually abused by her father throughout her childhood and adolescence exhibit four personalities as an adult. Each personality was of a different age, representing the phases of the woman's experience like fearful child, rebellious teenager, protective which the women was consciously aware. In addition to these experienced harsh trauma individuals seem prone to go into spontaneous hypnotic trances.

2.6.3 Dissociative Fugue (Earlier Known as Psychogenic Fugue)

It has its own exceptional feature of unexpected travel away from home and customary workplace. The travel and behaviour seen in a person in fugue are more purposeful than any wandering that may also take place in amnesia often they suffer from post-traumatic stress.

2.6.4 Depersonalisation Disorder

It generally leads to observable distress in the affected individual often occurs in individual who are also affected by some other psychological non-dissociative disorder who suffers from sleep deprivation at the onset of depersonalisation disorder.

Self Assessment Questions

1) What is dissociative disorder?

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2) Describe major types of dissociative disorders.

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3) Define identity disorder.

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4) What is dissociative fugue? Explain.

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2.6.5 Symptoms of Dissociative Disorder

i) Low speech

ii) Anxious mood

iii) Limited concentration

iv) Impaired memory

v) Lack of insight

vi) Irritability

vii) Poor long term memory

viii) Frequently off orientation

ix) Un-relatedness

2.6.6 Causes of Dissociative Disorder

i) Stressful Life events

ii) Traumatic experiences

iii) Natural disorder

iv) Personalised stress

v) Shocking death of loved ones

vi) Unbearable pressure

vii) Horrifying past

viii) Sexual or emotional abuse

ix) Childhood trauma

x) Disparate self concepts

Thus dissociative disorders are difficult to explain. More or less all types of dissociative disorders are same and have similar etiology. Often it is unclear whether a given case involves association or is some sort of psychotic manifestations.

Self Assessment Questions

1) What are the major causes of dissociative disorders?

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2) Write down the various symptom.

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3) What are the types of amnesia?

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2.7 TREATMENT

Relaxation technique

Relaxation technique (also known as relaxation training) is a method, process, procedure, or activity that helps a person to relax. It helps the individual to attain a state of increased calmness, or reduce levels of anxiety, stress and anger. Relaxation techniques are often employed to decrease muscle tension, lower the blood pressure and slow down heart and breathing rates, among other health benefits. It includes deep breathing, visualisation, progressive muscle relaxation, meditation, and yoga. All these can help the individual activate his or her relaxation response. When practiced regularly, these activities lead to a reduction in the person's everyday stress levels and a boost in the person's feelings of joy and serenity.

Cognitive behavioural technique

It is in combination of cognitive and behavioural approaches, based on the idea that thoughts cause the feelings and behaviour but not the external things. There are several approaches to cognitive behavioural therapy, including Rational Emotive Behaviour Therapy, Rational Behaviour Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behaviour Therapy. Thus the therapist uses approaches and interventions that would maximally benefit the client or patient by changing their maladaptive behaviours and developing positive relationship between the therapist and the client. Therapist also believes that clients change their behaviour because they learn to think differently and they act on that learning. The therapist also focuses on teaching the client rational self counseling. The therapist' s role is to facilitate client to achieve goals and in this process, the client learns many new methods to get over his stress and anxiety. He then implements whatever he has learnt whenever he faces a conflict or a problem or a symptom.

Psychological interventions

It is also useful like the attention training, using distraction tools, hypnosis or environmental manipulation. These techniques reduce the person's preoccupation or overattention to the body part and the awareness of physiological disturbances (Looper, 2002). Patients with Somatisation disorder usually refuse to undergo psychotherapy because they already have clearly set in their mind that the physical symptoms that they have is in fact an illness.

In Conversion disorder, behaviour therapy is very useful. Stress management counseling is used to prevent the recurrence of the abnormal gait, which was understood as a maladaptive response to stress.

Hypnosis can also be used in this disorder. Other treatments such as the use of electromyography biofeedback, behavioural reinforcement combined with strategic "double bind" therapy, hypnosis combined with lorazepam and amobarbital interviewing.

In Hypochondriasis disorder, the physician should answer all the questions given by the patient. In this way the patient might reduce his anxiety through the physician's explanations (or explanatory therapy).

Psychosocial interventions

It is specific to somatoform disorders In somatisation disorder, patients may resist suggestions for individual or group psychotherapy because they view their illness as a medical problem. Patients who accept psychotherapy may be able to reduce health care utilisation. Psychosocial interventions that focus on maintaining social and occupational function despite chronic medical symptoms may be helpful.

Conversion disorder: Limited studies about specific psychotherapy exist for conversion disorder. Behaviour therapy or hypnosis may be effective. Symptoms often resolve spontaneously.

Hypochondrias: Hypochondrias is physicians should attempt to answer questions and reduce the patient's fear of a specific illness. Group psychotherapy may provide social support and reduce anxiety. Cognitive therapy strategies may help by focusing on distorted disease related cognitions. Individual insight oriented psychotherapy has not been proven effective.

Pain disorder: Behaviour therapy, including biofeedback can be helpful. Hypnosis also may be considered for chronic pain syndromes. Some outcome data supports the effectiveness of individual psychotherapy. Exploration of interpersonal effects of chronic pain may reduce social complications of pain.

2.8 LET US SUM UP

Thus individuals with somatoform and dissociative disorders all have interpersonal, biological and interpersonal factors which contribute in its development. This tend to differ from on to another. Many prior experience with real physical problems usually among other family members tend to influence the later choice of specifics dissociative and somatic symptoms that patient tend to adopt symptoms with which they are familiar. These symptoms are the part of a larger constellation of psychopathology. Individuals may have a marked biological vulnerability to develop the disorder when under stress with biological process. For the countless some other cases however biological contributing factors seem to be less important than the overriding influence of interpersonal factors.

2.9 UNIT END QUESTIONS

1) Discuss the somatoform disorders.

2) What are the characteristics of somatoform disorders?

3) Define various somatoform disorders with their types .And also cite examples.

4) Difference between Somatoform Disorders and dissociative disorders.

5) Define the similarity and differences between dissociative disorder and dissociative identity disorder. Elaborate with examples.

6) What are the causal factors of dissociative disorders.

2.10 SUGGESTED READINGS AND REFERENCES

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders*. ed., text revision. Washington, DC: American 4th Psychiatric Association.

Butcher, James, N. and Mineka, Susan & Hooley, Jill, M. (2006). *Abnormal Psychology My Psych Lab*, MI.

Coleman, J.C. (2000). *Abnormal Psychology And Modern Life*. Allyn & Bacon, NJ

Sharpe, M., and A. C. D. C. Williams. 2002. Treating patients with somatoform pain disorder and hypochondriasis. In Psychological Approaches to Pain Management: A Practitioner's Handbook, edited by D. C. Turk and R. J. Gatchel. New York: Guilford Press.

References

Arnow, B. A., E. M. Hunkeler, C. M. Blasey, J. Lee, M. J. Constantino, B. Fireman, et al. 2006. Comorbid depression, chronic pain, and disability in primary care. Psychosomatic Medicine 68: 262-268.

Becker, N., A. Bondegaard Thomsen, A. K. Olsen, P. Sjogren, P. Bech, and J. Eriksen. 1997. Pain epidemiology and health related quality of life in chronic non-malignant pain patients referred to a Danish multidisciplinary pain center. Pain 73: 393-400.

Brinkhaus, B., C. M. Witt, S. Jena, K. Linde, A. Streng, S. Wagenpfeil, et al. 2006. Acupuncture in patients with chronic low back pain: A randomized controlled trial. Archives of Internal Medicine 166: 450-457.

Clark, D. M., P. M. Salkovskis, A. Hackmann, A. Wells, M. Fennell, J. Ludgate, et al. 1998. Two psychological treatments for hypochondriasis. British Journal of Psychiatry 173: 218-225.

Dahl, J., and T. Lundgren. 2006. Living Beyond Your Pain: Using Acceptance and Commitment Therapy to Ease Chronic Pain. Oakland, CA: New Harbinger Publications.

Elliott, A. M., B. H. Smith, K. I. Penny, W. C. Smith, and W. A. Chambers. 1999. The epidemiology of chronic pain in the community. Lancet 354: 1248-1252.

Fallon, B. A. 2004. Pharmacotherapy of somatoform disorders. Journal of Psychosomatic Research 56: 455-460.

Fink, P., M. S. Hansen, and M.-L. Oxhoj. 2004. The prevalence of somatoform disorders among internal medical inpatients. Journal of Psychosomatic Research 56: 413-418.

Fishbain, D. A., M. Goldbery, T. M. Khalil, S. S. Asfour, E. Abdel-Moty, R. Meagher, et al. 1988. The utility of electromyographic biofeedback in the treatment of conversion paralysis. American Journal of Psychiatry 145: 1572-1575.

Grabe, H. J., C. Meyer, U. Hapke, H.-J. Rumpf, H. J. Freyberger, H. Dilling, et al. 2003. Specific somatoform disorder in the general population. Psychosomatics: Journal of Consultation Liaison Psychiatry 44: 304-311.

Hiller, W., M. M. Fichter, and W. Rief. 2003. A controlled treatment study of somatoform disorders including analysis of healthcare utilisation and cost-effectiveness. Journal of Psychosomatic Research 54: 369-380.

Kabat-Zinn, J., L. Lipworth, and R. Burney. 1985. The clinical use of mindfulness meditation for the self-regulation of chronic pain. Journal of Behavioural Medicine 8: 163-190.

Kabat-Zinn, J., L. Lipworth, R. Burney, and W. Sellers. 1987. Four-year follow-up of a meditation-based program for the self-regulation of chronic pain: Treatment outcomes and compliance. Clinical Journal of Pain 2: 159-173.

Kashner, T. M., K. Rost, B. Cohen, M. Anderson, and G. R. Smith. 1995. Enhancing the health of somatisation disorder patients: Effectiveness of short-term group therapy. Psychosomatics 36: 462-470.

Lidbeck, J. 1997. Group therapy for somatisation disorders in general practice: Effectiveness of a short cognitive-behavioural treatment model. Acta Psychiatrica Scandinavica 96: 14-24.

Liddle, S. D., G. D. Baxter, and J. H. Gracey. 2004. Exercise and chronic low back pain: What works? Pain 107: 176-190.

Looper, K. J., and L. J. Kirmayer. 2002. Behavioural medicine approaches to somatoform disorders. Journal of Consulting and Clinical Psychology 70: 810-827.

Manheimer, E., A. White, B. Berman, K. Forys, and E. Ernst. 2005. Meta-analysis: Acupuncture for low back pain. Annals of Internal Medicine 142: 651-663.

Marcus, D. A. 2002. Pharmacoeconomics of opioid therapy for chronic non-malignant pain. Expert Opinion on Pharmacotherapy 3: 229-235.

Masheb, R. M., and R. D. Kerns. 2000. Pain disorder. In Effective Brief Therapies: A Clinician's Guide, edited by M. Hersen and M. Biaggio. San Diego, CA: Academic Press.

Moene, F. C., K. E. L. Hoogduin, and R. Van Dyck. 1998. The inpatient treatment of patients suffering from (motor) conversion symptoms: A description of eight cases. International Journal of Clinical and Experimental Hypnosis 46: 171-190.

Newton-John, T. R., S. H. Spence, and D. Schotte. 1995. Cognitive-behavioural therapy versus EMG biofeedback in the treatment of chronic low back pain. Behaviour Research and Therapy 33: 691-697.

Nicholas, M. K., A. R. Molloy, and C. Brooker. 2006. Using opioids with persisting noncancer pain: A biopsychosocial perspective. Clinical Journal of Pain 22: 137-146.

Patterson, D. R. 2004. Treating pain with hypnosis. Current Directions in Psychological Science 13: 252-255.

Patterson, D. R., and M. P. Jensen. 2003. Hypnosis and clinical pain. Psychological Bulletin 129: 495-521.

Rooijmans. 1995. Cognitive behavioural therapy for medically unexplained physical symptoms: A randomised controlled trial. British Medical Journal 311: 1328-1332.

Scharff, L. 1997. Recurrent abdominal pain in children: A review of psychological factors and treatment. Clinical Psychology Review 17: 145-166.

Skapinakis, P., G. Lewis, and V. Mavreas. 2003. Cross-cultural differences in the epidemiology of unexplained fatigue syndromes in primary care. British Journal of Psychiatry 184: 205-209.

Smith, B. H., A. M. Elliott, W. A. Chambers, W. C. Smith, P. C. Hannaford, and K. Penny. 2001. The impact of chronic pain in the community. Family Practice 18: 292-299.

Speckens, A. E. M., A. M. van Hemert, P. Spinhoven, K. E. Hawton, J. H. Bolk, and H. G. M.

Speed, J. 1996. Behavioural management of conversion disorder: Retrospective study. Archives of Physical Medicine and Rehabilitation 77: 147-154.

Stewart, W. F., R. B. Lipton, D. D. Celentano, and M. L. Reed. 1992. Prevalence of migraine headache in the United States. Relation to age, income, race, and other sociodemographic factors. Journal of the American Medical Association 267: 64-69.

Thomas, K. J., H. MacPherson, J. Ratcliffe, L. Thorpe, J. Brazier, M. Campbell, et al. 2005. Longer term clinical and economic benefits of offering acupuncture care to patients with chronic low back pain. Health Technology Assessment 9: iii-iv, ix-x, 1-109.

Turk, D. C. 1994. Perspectives on chronic pain: The role of psychological factors. Current Directions in Psychological Science 3: 45-48.

Volz, H. P., H. Murck, S. Kasper, and H. J. Moller. 2002. St. John's wort extract (LI 160) in somatoform disorders: Results of a placebo-controlled trial. Psychopharmacology 164: 294-300.

Wallis, C. 2005. The right (and wrong) way to treat pain. Time, Feb. 28, 47-57.

Warwick, H. M., D. M. Clark, M. Cobb, and P. M. Salkovskis. 1996. A controlled trial of cognitive-behavioural treatment of hypochondriasis. British Journal of Psychiatry 169: 189-195.

Waxman, R., A. Tennant, and P. Helliwell. 2000. A prospective follow-up study of low back pain in the community. Spine 25: 2085-2090.

UNIT 3 EATING DISORDERS

Structure

3.0 INTRODUCTION

In this unit we will be dealing with different types of eating disorders, their causes, symptoms and treatment. The unit begins with defining eating disorders and elucidating its characteristic features. This is followed by presenting different types of eating disorders scuch as anorexia nervosa, bulimia nervosa and the binge eating disorders. The causes are then given in detail for each of these disorders followed by treatment interventions which include psychotherapy, cognitive therapies and medications.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define eating disorders;
- Elucidate the characteristics of eating disorders;
- Describe the various types of eating disorders;
- Elucidate the Symptoms of eating disorders;
- Explain the causes of eating disorders; and
- Describe the treatment interventions for each of the eating disorders.

3.2 DEFINITION AND CONCEPT

Eating disorders have been one of the increasing disorders in the developed and developing countries. The drive for thinness not only affects the actress but the young , middle aged and older adults. This disorder generally refers to a group of conditions characterised by abnormal eating habits which may involve insufficient or excessive food intake in the body of the individual.

The disorder afflicts millions of people, thousands of whom may die from them yearly. The history of eating disorders has been in existence even from the ancient Roman times. The ancient Romans were known for many accomplishments as well as decadences and one of these was the overindulgence or known as 'orgy'. Romans were the first orgy who used to eat more .

It is well known that in this disorder, particularly in serious conditions, one finds that individuals are preoccupied with are food and weight. There is no specific reason for this disorder to come about, however it can involve many environmental and familial conditions and situations. Studies have shown that females have greater chance of developing eating disorders as compared to males especially in the adolescent years. It is often marked by extremes and manifests itself in the form of severe disturbances in eating behaviour, like extreme reduction of food intake or overeating or feelings of extreme distress or concern about body weight or shape etc. Person starts with eating small or large amount of food than usual but at the same time urge to eat less or more spirals out of control. It is very complex and despite different scientific research the illness remains elusive in terms of understanding the psychodynamics underlying the problem.

It frequently appears during adolescence or young adulthood but some reports indicate that they can also develop during childhood or in later adulthood. People with eating disorders suffer from a number of physical problems like heart or kidney failure and many other severe gastro intestinal or cardio vascular disorders which may eventually lead to death. This disorder coexists with other psychiatric disorders, and clearly with the potentially life threatening conditions it has become a growing, intricate and complex problem.

Despite the collective label, these disorders are not about food. It is a way of coping with a deeper problem that a person finds too difficult or painful to deal with directly. These are the complex conditions that signal difficulties with identity, self concept and self esteem. Eating disorders are cross cultural, and have racial and socio economic boundaries which affect men and women almost equally.

Eating disorder is a serious psychological condition in which the sufferer is obsessed with food, diet and often body image to the point where their quality of life suffers and their health is at extreme risk from long term poor or inadequate diet. This disorder is not a sign of a person mentally ill etc., but the problem is of intake of food and the disorder is actually only the symptom of some underlying problem in that person's life.

In addition there are many cases of abnormal eating that have the same features of eating disorders which have been diagnosed. Obesity is classified as a general medical condition and not as an eating disorder because it is not consistently associated with psychological or behavioural problems. Thus millions of people suffer from this eating disorder which starts mainly from the age of twenty or even adolescent years and continues. This condition as illness is often hidden so sometimes it becomes difficult to diagnose. This typically affects young women than men with a pattern of eating less or over eating. Obviously the amount of fat deposited is related to the energy absorbed from the food and by the hormonal changes which generally occur in the young age.

3.2.1 Definition of Eating Disorder

Eating disorder is defined as a psychological disorder centering on the avoidance, excessive consumption or purging of food. It is also said regarding eating disorder that it is a type of dependency. Eating becomes the object of dependency and disturbs the balance of daily life. Others define eating disorders as an illness that causes a person to adapt harmful eating habits. These disorders are more common amongst teenage girls and young women. Eating disorder is defined by psychologists as a psychological disorder that impairs normal eating behaviour. Over eating, anorexia and bulimia are examples of eating disorders.

3.2.2 Characteristics of Eating Disorder

This disorder is marked by extremes. It is present when a person experiences a severe disturbance in eating behaviour such as extreme distress or concern about body weight or shape. Unlike hysteria eating disorder does not so much mimic a physical illness but manipulates food intake and becomes obsessive about one's own body's shape and weight. It has been also found that eating disorder is a personality disorder.

When a patient has a personality disorder and an eating disorder, the therapist would do well to first tackle the eating disorder. Personality disorders are intricate and intractable. They are rarely curable (though certain aspects, like obsessive-compulsive behaviours, or depression can be ameliorated with medication or modified). The treatment of personality disorders requires enormous, persistent and continuous investment of resources of every kind by everyone involved.

From the patient's point of view, the treatment of her personality disorder is not an efficient allocation of scarce mental resources. Neither are personality disorders the real threat. An eating disorder is both a signal of distress ("I wish to die, I feel so bad, somebody help me") . This is where we can and should begin to help the patient by letting her regain control of her life. The family or other supporting figures must think what they can do to make the patient feel that she is in control, that she is managing things her own way, that she is contributing, has her own schedules, her own agenda, and that she, her needs, preferences, and choices matter.

Further problems about accepting a psychological explanation for the eating disorder are first that many women have found after careful testing to have a normal personality and second the personality scores of normal people and those who suffer from eating disorder overlap considerably. Psychological explanations have been suggested one of which is the concept that some obese women use eating as a substitute for love. A person who feels lonely, empty and unloved unless she has constant company may eat to compensate. From this it follows that psychological factors may be involved in explaining why individuals who have an eating disorder persist with their eating disorder.

Self Assessment Questions

1) Discuss the concept of eating disorder.

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2) Define in your own words eating disorder and cite a few examples.

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3) What are the typical characteristics of eating disorders?

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3.3 TYPES OF EATING DISORDERS

Eating disorders are basically of three types and these are presented below:

- Anorexia nervosa
- Binge eating disorders
- Bulimia nervosa

Let us deal with each of these in detail.

3.3.1 Anorexia Nervosa

This term has been in use since 1700 especially for a condition in which a person refused to maintain a healthy body weight. Much later, as per medical opinion anorexia nervosa was considered to be the result of an endocrine disturbance, which possibility remains even today and it is said that this condition is due to a disorder of the hypothalamus. The term anorexia nervosa literally means "nervous lack of appetite", in which people with anorexia lack in appetite and battle with hunger every day.

Person suffers from the fear of becoming fat is an anorectic's faulty perception of her body. In reality anorectics self esteem is clearly tied to this distorted view of her body. Continued weight loss is considered by anorectics to be a sign of achievement and self discipline while any weight gain even if it brings them close to a healthy body weight is considered a sign of weakness of lack of self control. It can cause menstruation to stop and often leads to bone loss, loss of skin integrity etc. The risk of death is greatly increased in the individual with this disease.

It is a variety of external and internal conflicts like stress, anxiety, unhappiness and feelings of life being out of control. Not eating or anorexia is a negative way to cope with emotions, feel happy and satisfied. Problems range from frequent infections and general poor health to life threatening conditions. Research suggests that anorexia nervosa has the highest death rate of any psychiatric disorder.

Generally people with this disorder are characterised by an irrational dread of becoming fat coupled with a relentless pursuit of thinness. Even though they do not eat and starve, they appear to have excessive energy to go on working in the usual manner. These persons not only maintain a dangerously low body weight but also carry on their work as if there is nothing wrong with them.

It also attempts to deal with perfectionism and desire to control things by strictly regulating food and weight. Mainly young women and more so in industrialised countries appear to be afflicted by this disorder where cultural expectations encourage women to be thin.

The key symptoms are:

i) Refusal to sustain a minimal normal body weight

ii) Intense fear of gaining weight

iii) Distorted view of one's body or weight

iv) Severe starvation

v) Obsession in regard to Food and weight

vi) Intense and overwhelming fear of gaining weight

vii) Thinning of hair

viii) Dry skin

ix) Low blood pressure

x) Fatigue and exhaustion

xi) Loss of memory to an extent.

xii) Obsessive Compulsive behaviour

xiii) Depression

xiv) Osteoporosis

xv) Fast heart rhythms

xvi) Anxiety

xvii) Low self esteem

Thus people with anorexia continue to think that they are over weight even after they become extremely thin, and are very ill and near death condition. Although idealisation of thinness in a certain culture plays a vital role in the development of anorexia, there are other contributing factors like genetics, personality traits and family environment which all contribute to the development of this disorder.

Causes

1) **Biological causes:** It has been suggested by psychologists that genetic predisposition to anorexia plays a major role. If a young girl has a sibling with anorexia she is 10 to 20 times more likely than the general population to develop anorexia. People with anorexia have high levels of cortisol, brain hormone most related to stress, decreased levels of neurotransmitters such as serotonin and norepinephrine which are associated with feelings of well being.

Studies of twins have shown a higher rate of eating disorders when they are identical. Samples of DNA, substance inside cells that carry genetic information, have all shown in research studies that there are abnormalities in the structure or activity of the hypothalamus, causing the concerned problem. a brain structure becomes responsible for irregular eating behaviour. Abnormal neuro transmitter levels have been shown to exist in people with anorexia.

ii) **Psychological causes:** People with anorexia are emotionally driven not only in weight loss but also in other areas of their life like career, school work or fitness. It includes the psychological disturbances like:

- Low self esteem
- Depression
- Anxiety
- Irritability
- Mood swings

People appear to have it all together on the surface inside they feel helpless, inadequate and worthless. Generally anorexics feel harshly critical and have no confidence thus some of the traits that occur in anorexics may be a result rather than a cause of the disorder.

iii) **Family and social pressure**: Anorexia develops as a struggle for independence and individuality. It is likely to surface in adolescence when new demands for independence occur. Sometime family and other members become responsible for a member to become anorexic by showing attitudes towards the person the following:

i) Overprotection

ii) Rigid

iii) Extreme closeness

iv) Criticizing the child's weight

v) Sexually abusive

vi) Overvaluing appearance

All these negative stressful life events trigger anorexia and the disorder develops as a struggle for independence and individuality.

iv) **Cultural pressure:** Standards of beauty for women in societies and bombarded messages from the media push women to diet for meeting the standards. This idealised ultra thin body shape is almost impossible for most women to achieve since it does not fit with the biological and inherited factors that determine natural body weight. Certain occupations like modeling, sports, running etc. pressurise the individual to maintain specific body weight.

Life transitions

This also triggers anorexia in those who are already vulnerable because of the factors like

i) Beginning of adolescence

ii) Beginning or failing in school

iii) Breakup of a relationship

iv) Death of a loved ones

These factors make it more difficult to stop from and makes individual obsessive in continuing their anorexic thoughts.

Treatment:

The types of treatments are being used as follows:

i) **Individual psychotherapy**

It is the major step especially for people who are beyond adolescence. In this cognitive behavioural approach helps in developing healthy ways of thinking and pattern of behaviour and reenter in new relationship.

ii) **Family therapy**

It is important for family members who also push the individual towards the tendency of anorexic. This approach can assess the impact of the disorder on the family help members in overcoming from certain guilt and inferiority. This helps the individual to develop practical strategies for overcoming.

iii) **Group therapy**

This is important in the hospital or in intensive day treatment. Some groups are task oriented and may focus on eating food, body image, etc. The other group may aim at understanding the psychological factors that may lead to the development.

iv) **Medication**

In comparison to other interventions medication can prove effective. Depression and other emotional problems are often a result of starvation, it is best to focus on weight gain rather than medication.

v) **Support group**

It is generally led by non professionals which can be useful in different circumstances. This provides support to people with anorexia and their families with mutual support and advice about how to cope with disorders.

3.3.2 Bulimia Nervosa

It is an overeating characterised by retaining of food intake. This results in feelings of guilt and low self esteem.

This term is appropriate on many levels as bulimia is a repeated cycle of binge eating and purging. Binge eating is the abnormal over intake of large amount of food that she or he has eaten by either making herself to vomit, taking an excessive amount of laxatives, diuretics or engaging in fasting and or excessive exercise. People with bulimia known as bulimica engage in such behaviour at least two times a week for a period of six months or more.

It is generally associated with depression and other psychiatric disorders. Sometimes the symptom may also be associated with anorexia nervosa. Many people with bulimia can maintain a normal weight and be able to keep their condition a secret for years. Bulimics are usually ashamed of their behaviour and attempt to hide their illness from others. If it is not treated bulimia can lead to nutritional deficiencies and may have fatal complications.

Symptoms of Bulimia include the following:

i) Binge eating of high carbohydrate foods

ii) Eating until painfully full

iii) Dehydration

iv) Constipation, nausea, abdominal pain

v) Bad breath

vi) Sore throat

vii) Depression

viii) Excessive exercising

ix) Alternative eating

x) Using laxatives

xi) Frequent mood fluctuations

xii) Lack of energy

xiii) Bloating or fullness

xiv) Feelings of Guilt

xv) Suicidal tendencies

Currently with these symptoms no particular or specific known cause has been found. Usually individual suffering from bulimia have low self esteem, feelings of helplessness etc.

Causes

i) **Culture:** Culture does play a role in determining whether or not someone will develop bulimia. For example, women in the different countries and in different advertisements are bombarded with images of the "ideal" or "perfect" woman, and these women are always thin. Seeing this often enough can make it difficult for an ordinary woman to ever see herself as beautiful. Men are even starting to suffer from the same sort of self image problems as women.

ii) **Low self-esteem:** This is a major factor when it comes to developing bulimia and is one of the causes of bulimia. It is not surprising that people who see themselves as worthless and unattractive are at high risk. Growing up and living in an environment conducive to abuse, criticism, pushing for perfection and depression can contribute to people becoming bulimic.

iii) **Dieting:** Dieting can actually be one of the causes of bulimia. This happens because dieting too much can lead to developing an eating disorder. Drastic dieting can bring about the deprivation that may be a trigger to binge eating. Once this happens binge and purge cycle will start and continue.

iv) **Genetic involvement**: Many people who are bulimic have mothers or sisters who also have bulimia. Someone with parents who over value looks and judge the ways their children look are more likely to develop bulimia or some other eating disorder. These types of parents definitely belong on the list of causes of bulimia. There is also research that shows low levels of serotonin may play a part.

v) **Major life changes:** Major life changes such as going to a hostel for higher studies or taking up a modeling job etc., have been found to be one of the causes of bulimia. Episodes can be triggered by stressful situations such as relocating or the end of a relationship. The binge and purge cycle can be a way to try to handle the stresses these events bring. Traumatic events such as rape can also be a trigger. People who **are in professions or activities that require an attractive appearance** may become bulimic. Professions such as ballet dancers, gymnasts, models, actors, wrestlers, or runners are at high risk of developing bulimia.

Treatment

i) **Breaking the binge and purge cycle**

This is the phase of treatment which focuses on stopping the vicious cycle of bingeing and purging and restoring normal eating patterns. The person learns to monitor his or her eating habits, avoid situations that trigger binges, cope with stress in ways that do not involve food, eat regularly to reduce food cravings, and fight the urge to purge.

ii) **Changing unhealthy thoughts and patterns**

The second phase of bulimia treatment focuses on identifying and changing the dysfunctional beliefs about weight, dieting, and body shape. The person is helped to explore attitudes about eating, and rethink the idea that self worth is based on weight.

iii) **Solving emotional issues**

The final phase of bulimia treatment involves targeting emotional issues that caused the eating disorder in the first place. Therapy may focus on relationship issues, underlying anxiety and depression, low self-esteem, and feelings of isolation and loneliness.

3.3.3 Binge Eating Disorder

Binge eating is a pattern of disorder which consists of episodes of uncontrollable eating. In such binges, a person rapidly consumes an excessive amount of food. Most people who have eating binges try to hide this behaviour from others, and often feel ashamed about being overweight or depressed about their overeating.

Eating binges can be followed by the so called compensatory behaviour, that is acts by which the person tries to compensate for the effects of overeating. Although people who do not have any eating disorder may occasionally experience episodes of overeating, frequent binge eating is often a symptom of an eating disorder.

Binge eating is a central feature of bulimia nervosa and binge eating disorder. It is also practiced by some people with an eating disorder not otherwise specified or anorexia nervosa. Binge eating symptoms are also present in bulimia nervosa.

Additionally, bulimics are typically of normal weight, are underweight but have been overweight before, or are slightly overweight. Those with binge eating disorder are more likely to be overweight or obese.

Binge eating disorder is similar to, but distinct from, compulsive overeating. Those with Binge eating disorder do not have a compulsion to overeat and do not spend a great deal of time fantasizing about food.

On the contrary, some people with binge eating disorder have very negative feelings about food. As with other eating disorders, binge eating is an "expressive disorder", a disorder that is an expression of deeper psychological problems.

Some researchers believe that Binge eating disorder is a milder form or subset of bulimia nervosa, while others argue that it is its own distinct disorder. Currently, the DSM-IV categorises it under Eating disorder not otherwise specified (EDNOS), an indication that more research is needed.

Symptoms

i) The person does not have control over consumption of food.

ii) Eats an unusually large amount of food at one time, far more than a normal person would eat in the same amount of time.

iii) Eats much more quickly during binge episodes than during normal eating times.

iv) Eats until physically uncomfortable and nauseated due to the amount of food just consumed.

v) Eats when depressed or bored.

vi) Eats large amounts of food even when not really hungry.

vii) Usually eats alone during binge eating episodes, in order to avoid discovery of the disorder.

viii) Often eats alone during periods of normal eating, owing to feelings of embarrassment about food.

ix) Feels disgusted, depressed, or guilty after binge eating.

x) Rapid weight gain, and/or sudden onset of obesity.

Causes

i) **Developmental aspect**

It is the belief that pressure to look a certain way and fit in through being thin is greatest during the period of adolescence. Girls are more affected by inner turmoil at this time low self esteem, anxiety and being self conscious. This approach suggests that boys usually find forming an identity somewhat easier than girls. Society also recognises continually changing in terms of expectations of the female role.

ii) **Cognitive aspect**

It is all about identifying and challenging negative behaviours, feelings and thoughts and beliefs about oneself. Emphasis comes on learning to interrupt destructive behaviour or thought patterns which serve to keep the vicious cycle. This includes misusing laxatives, diet pills and diuretics.

iii) **Genetic aspect**

Genetic element associated with the mental health conditions. Some individuals develop bulimia even due to genetic risk and responsible for triggering the conditions. With these factors family systems, socio cultural models and individual factor also play a major role in developing bulimia disorders.

Treatment

People who suffer from bulimia are less likely to end up in hospitals as in patients. They can all be treated as outpatients with the help of medications and pharmacology. They are generally invidually treated which in turn gives the patient positive outcome and a healthy balanced life.

Other methods of psychological treatment include psychotherapy, cognitive therapy etc.

i) **Psychotherapy**

Psychotherapy and cognitive behavioural technique prove to be more effective for modifying thoughts and engaging in behavioural changes. In CBT, records are maintained as to how much food they eat and periods of vomiting etc. Thesen records help in identifying and avoiding emotional fluctuations that bring on episodes of bilumia on regular basis.

ii) **Nutritional Counseling**

This focuses on health rather than weight. A nutritionist or dietician can help those with eating disorders to understand adequate nutritional needs and to change eating behaviours. Dietary counseling may involve having the person keep a food diary to facilitate a return to normal dietary intake or to become aware of triggers for bingeing.

iii) **Medical Treatment**

This involves careful monitoring of the person with an eating disorder, such as weight, fluid and electrolyte balance, cardiac status, growth and development (such as bone growth) and vital signs. It may involve injecting intravenous fluids or in very serious cases, feeding against the will of the person.

iv) **Pharmacology**

It is especially for those with eating disorders. This consists of antidepressants medication and with vitamins and mineral supplements.

Self Assessment Questions

1) What are the major types of eating disorders?

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2) Discuss the causes underlying the various eating disorders.

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3) Differentiate and show the similarity of bulimia and binge eating disorder.

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4) What are the main causes in binge eating disorder?

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5) What treatment interventions are available for these disorders?

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Thus the approach of the therapist or psychologist is to offer encouragement, support throughout the treatment process and help in overcoming it fast.

Other common types of eating disorders are:

i) Binge eating disorder (Bulimia)

ii) Obesity

iii) Childhood obesity

With the overall study it is clear that researchers are using tools to better understand eating disorders. New studies currently underway however are aiming to remedy the lack of information available about treatment. Severe imbalances in eating behaviours, such as severe and unhealthy decrease of food intake or extreme

overeating, in addition to these the feelings of depression, distress, or extreme concern over body shape and weight.

An eating disorder can in general be expressed as a condition where a person's nutrition is not managed correctly, which can cause severe harm to the body. The types of eating disorders develop in adolescence or in early stages of adulthood. However in rare cases, it develops in childhood or at later stages of adulthood.

Females are more likely than males to develop an eating disorder. Only about 5% to 15% are male anorexics or bulimics and 35% are binge eaters.

3.4 LET US SUM UP

Eating disorders are one of the most difficult mental illnesses to diagnose and cure. There appears to be a connection between all the major types of eating disorders and this is depression. Furthermore all these disorders are marked by extremes in behaviour. Also, this person experiences severe disturbances in eating behaviour such as extreme reduction of food intake or extreme overeating or feeling of extreme distress or concern about body shape. It is all interrelated and focuses on some factual cause but still remains elusive for all.

Whatever the source of the psychological needs, control and comfort are the two words that probably best sum up the needs that are filled by eating disorders. Trauma a big upset or long term turbulence in life, can also influence a person to do whatever they can to bring control to life, and food and weight can be easy targets for control. Under eating and overeating have been shown to activate calming brain chemicals, which may be why those experiencing emotional pain turn to these eating patterns.

Furthermore, "Mastery" is also an important aspect of eating disorder psychology. This is the sense that one can reach an achievement that others can not even if that "achievement" is a too strict a diet.

Personalities: According to psychologists at the National Institute of Mental Health, most people with eating disorders share these personality characteristics such as low self-esteem, perfectionism, feelings of helplessness, and anxiety. They have overly high expectations and have "all-or-nothing" thinking patterns. One can see how these traits connect to over control eating. The problem is, disordered eating patterns aren't triggered by these characteristics, but they may make it more difficult to recover.

Emotional causes: Anger and other emotions that are not expressed easily can feed a disorder. In fact, therapists believe that eating disorders are more about trying to relieve uncomfortable feelings and solving life problems than they are about food. The person often is afraid to express these emotions verbally and directly, so he or she does it indirectly through disordered eating patterns. For some, a strong emotion will trigger an eating binge. Others may overeat to mask and numb out difficult emotions. Non eaters are able to feel something, even if it's physical pain, which may be easier to deal with than their actual emotions.

3.5 UNIT END QUESTIONS

1) Describe the overall concept of eating disorder.
2) Discuss anorexia nervosa with its symptoms and causes.
3) Elaborately write important treatment tips for eating disorder patients.
4) Whether anorexia nervosa disorder can be controlled– Explain.
5) What is bulimia nervosa? Put forward the characteristic features of the same.
6) What are the various treatment interventions to overcome bulimia?
7) What is binge eating? Elucidate.

3.6 SUGGESTED READINGS AND REFERENCES

Coleman, J.C. (200). *Abnormal Psychology and Modern Life*. Allyn & Bacon , New Delhi.

Barlow, David H. and Durand, Mark V. (2002). *Abnormal Psychology An Intergative Approach* Wadsworth Cengage publisher. NY

Cave, Susan, (2005). *Classification and Diagnosis of Psychological Abnormality*. Rutledge , NY.

References

American Psychiatric Association. Diagnostic and Statistical Manual for Mental Disorders, fourth edition (DSM-IV). Washington, DC: American Psychiatric Press, 1994.

American Psychiatric Association (APA). Let's Talk Facts About Eating Disorders. 2005.

American Psychiatric Association Work Group on Eating Disorders. Practice guideline for the treatment of patients with eating disorders (revision). *American Journal of Psychiatry*, 2000; 157(1 Suppl): 1-39.

Andersen AE. Eating disorders in males. In: Brownell KD, Fairburn CG, eds. *Eating disorders and obesity: a comprehensive handbook.* New York: Guilford Press, 1995; 177-187.

Anderson AE. Eating disorders in males: Critical questions. In R Lemberg (ed), *Controlling Eating Disorders with Facts, Advice and Resources*. Phoenix, AZ: Oryx Press, 1992, pp.20-28.

Arnold LM, McElroy SL, Hudson JI, Wegele JA, Bennet AJ, Kreck PE Jr. A placebo-controlled randomized trial of fluoxetine in the treatment of binge-eating disorder. *Journal of Clinical Psychiatry, 2002; 63:1028-1033*.

Becker AE, Grinspoon SK, Klibanski A, Herzog DB. Eating Disorders. *New England Journal of Medicine*, 1999; 340(14): 1092-1098.

Birmingham CL, Su J, Hlynsky JA, Goldner EM, Gao M. The mortality rate of anorexia nervosa. *International Journal of Eating Disorders*. 2005 Sep; 38(2):143-146.

Bridge JA, Iyengar S, Salary CB, Barbe RP, Birmaher B, Pincus HA, Ren L, Brent DA. Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment, a meta-analysis of randomized controlled trials. *Journal of the American Medical Association*, 2007; 297(15): 1683-1696.

Bryant-Waugh R, Lask B. Childhood-onset eating disorders. In CG Fairburn, KD Brownell (eds.), *Eating disorders and obesity: A comprehensive handbook*, 2nd ed. New York: Guilford Press, 2002, pp. 210-214.

Bulik CM, Sullivan PF, Kendler KS. Medical and psychiatric comorbidity in obese women with and without binge eating disorder. *International Journal of Eating Disorders*, 2002; 32: 72-78.

Eisler I, Dare C, Hodes M, Russel G, Dodge, and Le Grange D. Family therapy for adolescent anorexia nervosa: The results of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry*, 2000; 1: 727-736.

Fitzgerald KD, Welsh RC, Gehring WJ, Abelson JL, Himle JA, Liberzon I, Taylor SF. Error-related hyperactivity of the anterior cingulated cortex in obsessive-compulsive disorder. *Biological Psychiatry*, February 1, 2005; 57 (3): 287-294.

Halmi CA, Agras WS, Crow S, Mitchell J, Wilson GT, Bryson S, Kraemer HC. Predictors of treatment acceptance and completion in anorexia nervosa: implications for future study designs. *Archives of General Psychiatry*; 2005; 62: 776-781.

Insel TR and Quirion R. Psychiatry as a clinical neuroscience discipline. *Journal of the American Medical Association*, November 2, 2005; 294 (17): 2221-2224.

Lasater L, Mehler P. Medical complications of bulimia nervosa. *Eating Behaviour*, 2001; 2:279-292.

Lock J, Agras WS, Bryson S, Kraemer, HC. A comparison of short-and long-term family therapy for adolescent anorexia nervosa, *Journal of the American Academy of Child and Adolescent Psychiatry*, 2005; 44: 632-639.

Lock J, Couturier J, Agras WS. Comparison of long-term outcomes in adolescents with anorexia nervosa treated with family therapy. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2006; 45: 666-672.

Lock J, Le Grange D, Agras WS, Dare C. Treatment Manual for Anorexia Nervosa: A Family-based Approach. New York: Guilford Press, 2001.

McIntosh VW, Jordan J, Carter FA, Luty SE, et al. Three psychotherapies for anorexia nervosa: a randomized controlled trial. *The American Journal of Psychiatry*, Apr. 2005; 162: 741-747.

Meyer-Lindenberg AS, Olsen RK, Kohn PD, Brown T, Egan MF, Weinberger DR, et al. Regionally specific disturbance of dorsolateral prefrontal-hippocampal functional connectivity in schizophrenia. *Archives of General Psychiatry*, April 2005; 62(4).

National Institute for Clinical Excellence (NICE). Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and binge eating disorder, 2004: London: British Psychological Society.

Pezawas L, Meyer-Lindenberg A, Drabant EM, Verchinski BA, Munoz KE, Kolachana BS, et al. 5-HTTLPR polymorphism impacts human cingulated-amygdala interactions: a genetic susceptibility mechanism for depression. *Nature Neuroscience*, June 2005; 8 (6): 828-834.

Pope HG, Gruber AJ, Choi P, Olivardi R, Phillips KA. Muscle dysmorphia: an underrecognised form of body dysmorphic disorder. *Psychosomatics*, 1997; 38: 548-557.

Romano SJ, Halmi KJ, Sarkar NP, Koke SC, Lee JS. A placebo-controlled study of fluoxetine in continued treatment of bulimia nervosa after successful acute fluoxetine treatment. *American Journal of Psychiatry*, Jan. 2002; 151(9): 96-102.

Russell GF, Szmuckler GI, Dare C, Eisler I. An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry*, 1987; 44: 1047-1056.

Spitzer RL, Yanovski S, Wadden T, Wing R, Marcus MD, Stunkard A, Devlin M, Mitchell J, Hasin D, Horne RL. Binge eating disorder: its further validation in a multisite study. *International Journal of Eating Disorders*, 1993; 13(2): 137-153.

Steiner H, Lock J. Anorexia nervosa and bulimia nervosa in children and adolescents: a review of the past ten years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 1998; 37: 352-359.

Streigel-Moore RH, Franko DL. Epidemiology of Binge Eating Disorder. *International Journal of Eating Disorders*, 2003; 21: 11-27.

Taylor CB, Bryson S, Luce KH, Cunning D, Doyle AC, Abascal LB, Rockwell R, Dev P, Winzelberg AJ, Wilfley DE. Prevention of Eating Disorders in At-risk College-age Women. *Archives of General Psychiatry*; 2006 Aug; 63(8):881-888.

Walsh et al. Fluoxetine after weight restoration in anorexia nervosa: a randomized controlled trial. *Journal of the American Medical Association*. 2006 Jun 14; 295(22): 2605-2612.

Wilson GT and Shafran R. Eating disorders guidelines from NICE. *Lancet*, 2005; 365: 79-81.

Wonderlich SA, Lilenfield LR, Riso LP, Engel S, Mitchell JE. Personality and anorexia nervosa. *International Journal of Eating Disorders*, 2005; 37: S68-S71

UNIT 4 SUBSTANCE USE DISORDER

Structure

4.0 INTRODUCTION

This unit deals with substance use and abuse disorders. It starts with definition and Concept of Substance Use disorders. Within this we discuss disorders Drug addiction, Alcohol related disorder, Amphetamine related disorder, Caffeine addiction related disorders, Cannabis addiction, Cocaine addiction, Hallucinogens addiction, Addiction to Inhalents., Nicotine substance abuse disorder, Phencyclidine addiction, Sedative, Hypnotic, Anxiolytic related disorders, and Polysubstance use disorder. Each disorder is discussed in terms of the symptoms, causes, and treatment interventions.

4.1 OBJECTIVES

On completing this unit, you will be able to:

- Define substance use disorder;
- Elucidate the various types of substance use disorders;
- Explain the symptoms various substance use disorders;
- Analyse the various causes of substance abuse disorders; and
- Describe the Treatment for the substance use disorders.

4.2 DEFINITION AND CONCEPT OF SUBSTANCE USE DISORDER

Substance use related disorders are those which are related to intoxication, drug dependence, drug abuse, withdrawal syndromes of substance abuse etc., caused by different substances legal or illegal. This is an umbrella term used for describing all major substance use and associated disorders. This disorder is obtained when an individual persists in use of alcohol or other drugs despite problems related to the use of the substance. Such cases are diagnosed as , substance abuse or use or substance dependence disorder.

Generally youngsters during pre adolescence and adolescence stages try these on an experimental curiosity basis. The disorder ranges from none to minor to life threatening severity. Sometimes the occasional use can also put adolescents at risk of very significant harm which includes over dose, motor vehicle collisions, consequences of sexual contact and violent behaviour.

Substance dependence can be diagnosed with physiological symptoms in which one finds the person developing increased tolerance for the existing dosage and increasing the frequency and the strength of the concerned drug. For instance, if a person was taking 25 mg of the drug, now he will require 50 mg of the drug to obtain the same effect of intoxication. Similarly if he has been using the drug twice a day, now he may use it four times a day. Withdrawal symptoms may also increase in such cases. That is when the person does not take the drug for a while or misses a dose or takes lesser dose, it produces many painful and undesirable symptoms such as pain in the body, vomiting etc.

According to DSM IV (TR) substance related disorders can be sub categorised into substance use disorder and substance induced disorder. Both can be differentiated on the basis of their conditions in attributing the use of substance.

Substance induced disorders include intoxication, l substance induced withdrawal psychosis and substance induced mood disorders. Second substance use disorder includes substance abuse and substance dependence. Combining the two in DSM V the conditions are called the substance use disorders.

Mostly youth and Adolescents engage in these behaviours and are always at a higher risk of harm to themselves. Parental attitudes, societal provocation etc., also play important role in this type of dependence.

As per DSM IV, the above mentioned substance use or substance dependence is characterised by continued use of substance even after the user has experienced serious substance use related problems such as giddiness, nausea, discomfort etc. Drug dependent persons desire for that particular drug when ever their bodily system craves for it and they need more of the same substance to achieve the effect that a lesser amount of the substance induced in the past. The continued use of a substance for a long period of time, get the person hooked on to the drug and the individual concerned is unable to continue even his routine work. Their relationship with their own people and friends gets adversely affected. Such a person prefers the company of other drug users or may take the drug in isolation.

When the disorder becomes severe, the person may develop delusions and manifest hallucinations. For instance, Substance induced psychotic disorder is categorised based on delusions or hallucinations. Delusions are fixed false beliefs and hallucinations are false perception, that is false hearing, false seeing, false taste or smell of things that are not present.

The DSM IV TR has put forward certain subcategories of substance use disorders and these are discussed below:

i) Addiction

ii) Alcohol related disorder

iii) Amphetamine related disorder

iv) Caffeine related disorder

v) Cannabis related disorder

vi) Cocaine related disorder

vii) Hallucinogen related disorder

viii) Inhalant related disorder

ix) Nicotine related disorder

x) Opioid related disorder

xi) Phenycyclidine related disorder

xii) Sedative, hypnotic or anxiolytic related disorder

xiii) Polysubstance disorder

Let us take each of the above and discuss in detail.

4.2.1 Drug Addiction

It has been defined as a physical and psychological dependence on psycho active substances. Addiction is a continued involvement with the concerned substance. It is a primary chronic disease having memory problems and related circuitry. It is an impairment in behavioural control and results in disability or premature death.

In addition it includes drug addiction, substance dependence and behavioural addiction. Addiction is a compulsive and repetitive use of the concerned drug which ultimately results in impairment of many cognitive and behavioural functions. It is an illness that requires treatment. People often assume that those with addictions should be able to quit simply by making up their mind. However it is not easy to give up the drug and even if they have been deaddicted or detoxified of a certain drug, yet after sometime there can be a relapse and the person may go back to that drug and become all the more addicted to it. Addiction is possible for a wide range of chemical and other related substances.

Symptoms of drug addiction

i) Withdrawal symptoms related to that drug

ii) Ulcer

iii) Suicidal thoughts

iv) Stress and anxiety

v) Reduced social contacts

vi) Destructive tendencies

No single criteria is indicative of the so called addiction, but in reality drug becomes more addictive after a pattern of behaviour takes place over time.

Causes

The following are the causes involved in developing addictions:

i) Genetics

ii) Environment

iii) Pattern of drug Abuse

iv) Emotional disorder

v) Low frustration tolerance

Treatment:

i) **Medication:** The forms of treatment include replacement drugs such as methadone, suboxone/subutex both generically known as buprenorphine, are all used as substitutes for illicit opiate drugs.

Although these drugs are themselves addictive, the goal of opiate maintenance is to provide a clinically supervised, stable dose of a particular opioid in order to provide a measure of control to both pain and cravings. This provides a chance for the addict to function normally and to reduce the negative consequences associated with obtaining sufficient quantities of controlled substances illicitly, by both reducing opioid cravings and also the withdrawal symptoms.

ii) **Behavioural therapy:** Cognitive behaviour therapy is based on the idea that feelings and behaviours are caused by a person's thoughts. That is, people may not be able to change their circumstances, but they can change how they think about themselves and therefore change how they feel and behave.

In the treatment for alcohol and drug dependence, the goal is to teach the person to recognise situations in which they are most likely to drink or use drugs, avoid these circumstances if possible, and cope with other problems and behaviours which may lead to their substance abuse

iii) **Counseling:** Counselor tries to understand the client's internal frustration, repressed wishes and the various conflicts which all provoke the client towards addiction. The nature of counseling generally is empathetic which can facilitate the client with understanding and motivate him towards the goal of giving up the drug habit.

4.2.2 Alcohol Related Disorder

More alcohol seeking or excess consumption of alcohol is defined by American Psychiatric association (APA) as "alcoholism" or alcohol dependence. It is a complex disorder that includes social and inter personal issues. Long term and

uncontrollable harmful consumption can cause alcohol related disorders. It is contained in beer, wine and hard liquor and is a chemical compound known as ethyl alcohol or ethanol.

Alcohol acts on the central nervous system as a blocker of messages transmitted from one nerve cell to the next. The APA recognises alcohol disorder as alcohol abuse. It is similar to dependence in that the use of alcohol impairs the affected person's ability to achieve goals and fulfill his personal and social responsibilities. It also affects his or her interpersonal relationships to a great extent. This disorder affects the person's metabolism, gastrointestinal tract, nervous system, bone marrow and endocrine system.

Symptoms of alcohol addiction

The various symptoms manifested by the person who is addicted to alcohol include the following:

i) Tolerance

ii) Withdrawal

iii) Disorientation to time, place and person

iv) Hallucinations, visual, auditory and tactile

v) Delusions of suspicion, paranoid feelings, delusions of grandeur.

vi) Preoccupation with obtaining alcohol by any means.

vii) Disordered perception

viii) Overnight abstinence

ix) Irritability

x) Nausea and vomiting.

This disorder occurs twice as often in males than in females. It develops in people of all races and socio economic classes. The alcohol abuse depends upon the following causes

Behaviourally it relates to internal and external motivation. Internal state person experiences personally certain pleasurable feelings after consumption of alcohol and thus is induced to go for such pleasures again and again. As for the external aspect, the alcohol consuming behaviour is learned from others (friends etc.) in the society and gets reinforced also by them.

Biologically repeated or continued use of alcohol can impair brain levels of a pleasure neurotransmitter called dopamine. Neurotransmitters are the chemicals in the brain which pass impulses from one nerve cell to the next.

Genetic studies have shown more susceptibility to alcohol. Sons of alcoholics are four times more likely to be alcoholic than are sons of non alcoholics. Genetic predisposition to alcohol is growing and it is now widely accepted by researchers.

Psychodynamical aspect describes the typical addict who develops an alcohol problem as an oral dependent personality. This approach believes that the person's basic need for oral gratification was not satisfied early in the person's life. This lack of satisfaction drives the individual towards oral satisfaction and personality becomes dependent on alcohol.

Treatment

i) **Detoxification:** It is the goal to get rid of the toxic effects of alcohol. For this, the person is injected certain drugs which induce vomiting as and when the person takes or even smells alcohol. It is because a person's body has become accustomed to alcohol, whenever the person does not take alcohol, the body is deprived of alcohol and the whole system craves for alcohol and develops certain symptoms such as twitching, cramps etc. in the absence of alcohol. The moment the body receives alcohol, all the withdrawal symptoms such as cramps etc., disappear and the person feels comfortable. Whenever the doctor keeps the person off alcohol, the painful withdrawal symptoms are common and the individual if has to be helped should also be supported as he or she goes through withdrawal. Withdrawal symptoms and their intensity differ from one person to another depending upon the severity of the alcoholism as measured by the quantity of intake.

This phase of detoxification is usually over in about three to five days. Patients going through mild withdrawal are simply monitored carefully to make sure that more severe symptoms do not develop. No medications are necessary. However in the case of severe withdrawal symptoms, the patient needs to be monitored carefully and when necessary have to be administered substitute drugs to reduce the severity of the withdrawal symptoms.

ii) **Rehabilitation:** After the patient has been detoxified, and sent back home after three or four weeks of stay in the hospital, the possibility of the person getting back to the drug is very high unless there is a very close monitoring of his movements and behaviours. Generally the earlier friends tempt the patient to try a little along with them and this temptation of little drinking extends to heavy drinking and the patient is back on to his drug habit. Such relapse can be avoided if the patient is put through intensive counseling and psychotherapy including where necessary cognitive behaviour therapy, family therapy, couple therapy and so on. A comprehensive rehabilitation programme is required and the patient as well as their family members can be given therapy to make them learn the process of support mechanism.

iii) **Medications:** It affects the metabolism of alcohol and cause unpleasant effects in patients who consume alcohol while taking the medicines. People with alcohol dependence with other disorders like depression can work with their physician to determine if medication might be a feasible treatment for them.

iv) **Additional treatment:** There is also a need to relieve stress apart from symptomatic treatment through medications. Alcoholics can be given massage, meditation and hypno therapy. The mal nutrition of long term alcohol use, is addressed by nutritionists or dieticians to make patients healthy. Acupuncture is also believed to be one of the methods for decreasing the symptoms.

4.2.3 Amphetamine Related Disorder

This is a highly addictive drug which dramatically affect the central nervous system. Several amphetamines like dextroamphetamine (Dexedrine)

methamphetamine (desoxyn) and methylphenidate (Ritalin) etc., are generally used. Though it is initially used for medicinal purposes in course of time with continous usage, it becomes addictive. When the patients are given this to ingest, they may fall asleep at all odd times, and cannot remain normal. Amphetamines are administered to patients suffering from Attention Deficit Hyperactivity Disorder, obesity and depression. This amphetamine is prescribed also to chronic or episodic binges and also refers to serious maladaptive behavioural or psychological changes that develop due to substance abuse.

Symptoms of amphetamine addiction

i) Paranoid behaviour

ii) Schizophrenia

iii) Hallucinations

iv) Delusions

v) Aggression

vi) High feeling of euphoria

vii) Repetitive behaviour

viii) Grandiosity

ix) Impaired judgment

x) Stroke.

C**auses of amphetamine addiction**

i) Amphetamine intoxication

ii) Binge pattern use of the substance

iii) Co morbid psychiatric disorders

iv) Abuse of other substances like alcohol or illicit drugs

v) Dehydration

vi) Potential for serotonin syndrome in those prescribed serotonin re uptake inhibitors.

Treatment

The offending substance may be eliminated by means of acidification of the urine. Psychotropic medication can be used to stabilise an agitated patient also manifesting psychosis. Apart from all other activities patients can consult neurologist, or an internal medicine specialist and or psychiatrist who can help reduce the effects of amphetamine produced symptom.

4.2.4 Caffeine Addiction Related Disorders

It is a white bitter crystalline alkaloid which is derived from coffee and tea. It is classified together with amphetamines and cocaine as an analeptic or central nervous system stimulant. Tea, cocoa, coffee are an abundant source of caffeine. These are less likely to produce the same degree of physical or psychological dependence as other drugs of abuse. Symptoms are more common with anxiety disorders difficult to differentiate.

Symptoms

i) Restlessness

ii) Nervousness

iii) Excitement

iv) Insomnia

v) Gastro intestinal disturbance

vi) Muscle twitching

vii) Tachycardia

viii) Periods of inexhaustibility

ix) Psychomotor agitation

Causes

The immediate cause of caffeine intoxication and other related disorders is consumption of an amount of caffeine sufficient to produce the symptoms depending upon the tolerance of the body.

Caffeine tastes bitter and serves to limit the intake of caffeine products which are responsible for causing inclinations towards continuing to ingest caffeine related substances. Some of these substances include the following: Brewed coffee, instant coffee, powdered cappuccino beverage, Snapple iced tea, mountain dew, diet colas, coffee yoghurt, dark chocolate, Excedrin are all some of the substances that may cause addiction if taken over a long period of time.

Treatment

It generally involves lowering the consumption from beverages containing caffeine. Consumption has the advantage of having social reinforcement by which a person can become caffeinated or non caffeinated. Thus physical dependence on caffeine is less complicated by social factors that reinforce nicotine and other drug habits. People also recover from caffeine intoxication without difficulty.

4.2.5 Cannabis Addiction

It is commonly called as marijuana, which consists of dried leaves and flower tops of the cannabis plant. This cannabis refers to the several varieties of cannabis sativa or Indian hemp plant that contains the psychoactive drug 'delta-tetrahydracannabinol' (THC). The solidified resin called 'hashish' can be used to produce psychoactive effects. This has been used since thousands of years and described as early as the fifth century B.C when the Greek historian Herodotus told of a tribe of nomads who after inhaling the smoke of roasted hemp seeds, went into a kind of insensibility experiences. Cannabis is the abbreviation for the Latin name of the hemp plant "cannabis sativa"

All parts of this plant contain psychoactive substances with THC making up the highest percentage. There are more than 200 slang terms for marijuana. Including pot, herb, weed, marijuana, gross, tea, and ganja. It is usually chopped and rolled into a cigarette or in smoke pipe. By the year 2000 the debate for proving marijuana as a medicine continued. THC is known to successfully treat nausea in cancer treatment, acquire immune deficiency syndrome or glaucoma.

For addiction marijuana is generally taken by either eating or smoking parts of the cannabis plant. When the smoke is inhaled it is spread across the surface of the lungs quickly absorbed into the bloodstream and carried to the brain in a few seconds. Marijuana suppresses the production of male hormones, decreases the size and weight of the prostrate gland and testes and inhibits sperm production, although these effects appear to be reversible. It also impairs short term memory and slows down learning ability. This disorder includes cannabis dependence, cannabis abuse and cannabis intoxication.

Symptoms of cannabis addiction:

i) Social withdrawal

ii) Respiratory disorder

iii) Cough and phlegm

iv) Chronic bronchitis

v) Frequent chest cold

vi) Slow heart rate

vii) Impaired learning

viii) Slow memory

ix) Distraction of attention

x) Accident in motor function

xi) Slow performance in work, school etc.

xii) Lethargy

xiii) Inappropriate laughter

xiv) Feeling of grandiosity

xv) Depression.

Causes of cannabis addiction

The causes for cannabis addiction is almost similar or the same that of the causes of other addictive substances. The initial desire for a high combine with held perception that cannabis use is not dangerous leads to experimentation in the teen. Long term use leads to changes in the brain and makes the person prone towards ingesting these addictive substances. The greater availability, higher potency and lower price for cannabis in recent years all are responsible for the cannabis addiction.

Treatment of cannabis addiction

The goal of cannabis treatment is abstinence. It starts from in patient department in hospital with detoxification, and followed up with rehabilitation programme in rehabilitation centre and includes intensive counseling sessions with the patient, his family members and others. Cognitive behaviour therapy seems to work in these cases but the relapse rate is also quite high once the patient goes back to the society from the rehab centers as he is drawn into smoking marihuana by his erstwhile friends and fellow addicts. Patients are also given anti-anxiety drugs, and antidepressant medications depending on the symptoms manifested by them. They need to be taken up on a comprehensive psychological treatment.

4.2.6 Cocaine Addiction

The main active drug is in the leaves of the coca bush that grows on the eastern slopes of the Andes Mountain in South America. The Indians of Peru and Bolivia have used its leaves for centuries to increase endurance and decrease hunger so that they can cope better with the rigors of their economically marginal high altitude existence.

Cocaine is extracted from the coca plant which grows in central and South America. It is dangerously addictive and users of the drug experience a high feeling of euphoria or happiness along with hyper vigilance, increased sensitivity, etc. In powder form cocaine named as coke, blow, cornflake, snow and toot, is commonly inhaled or snorted. It is either injected or dissolved in water and taken.

DSM IV TR categorised cocaine related disorders in cocaine use disorder and cocaine induced disorders.

Cocaine use disorder is classified as:

- Cocaine dependence
- Cocaine abuse

Cocaine induced disorder is classified as:

i) Cocaine intoxication
ii) Cocaine withdrawal
iii) Cocaine induced psychotic disorder with delirium
iv) Cocaine induced psychotic disorder with hallucinations
v) Cocaine induced mood disorder
vi) Cocaine induced anxiety disorder
vii) Cocaine induced sexual dysfunction
viii) Cocaine induced sleep disorder
ix) Cocaine related disorder not otherwise specified.

Symptoms of cocaine addiction

i) Elevated heart rate
ii) Elevated blood pressure
iii) Panic attacks
iv) Low self esteem
v) Diminished appetite
vi) Low of contact from reality
vii) Depressed mood
viii) Irritability
ix) Difficulty sleeping
x) Hypervigilance.

Causes of cocaine addiction

i) Physiological

ii) Reinforcement

Treatment of cocaine addiction

First and foremost thing for cocaine is that the cocaine dependent person must become convinced that treatment is necessary. Sometimes addicts are induced to come in for treatment only by pressure from family members, employers or the law. Cocaine users also join mutual help group which encourage them to decrease the intake of cocaine and thereby reduce addiction. Members admit their powerlessness to control their drug use so they are being given psychotherapy, CBT which can facilitate addicts in coping with the withdrawal syndromes following non intake of cocaine. These persons also benefit from cocaine addiction support group therapy as well as alternative therapy such as brief psychotherapy, cognitive therapies, meditation, yoga etc.

4.2.7 Hallucinogens Addiction

Hallucinogens are chemically diverse group of drugs that cause changes in a person's thought process, perception of the physical world and sense of time passing. These are also called as psychedelic drugs. Hallucinogenes are as old as civilisation. Shamans in Siberia were known to eat the hallucinogenic mushroom amanitamuscaria.

Peyota a spineless cactus native to the South Western United States and Mexico was used by native people. The best known hallucinogens are lysergic acid diethylmide (LSD), mescaline, and psilocybin which all produce visual hallucination.

Hallucinogens like other drugs have similar physical and psychological effects and they are a diverse group of compounds. Hallucinogens compound binds with serotonin receptors, and serotonin is blocked from those receptor sites and the nerve transmitter is altered. In hallucinogen intoxicated person is unconscious or dissociated.

Symptoms of Hallucinogen addiction

i) Distortion of sight, sound

ii) Confusion of the senses

iii) Delusions of physical invulnerability

iv) Anxiety attacks

v) Reduced inhibitions

vi) Increased empathy

vii) Long term

viii) Increased blood pressure

ix) Increased heart rate

x) Sweating

xi) Diarrheoa

xii) Restlessness

Causes of hallucinogen addiction

The origin of the disorder are not clearly known but it is believed that this may be caused by the destruction of inhibitory neurons that regulate and filter the sensory information. Still it is a rare disorder but depends much on the situational factors and sometimes due to psychiatric disorder also it develops.

Treatment of hallucinogen addiction

Acute treatment is aimed at preventing the patient from harming himself or anyone. Drugs like lorazepam are given for anxiety. Complication in treatment occurs when the hallucinogen has been contaminated with other street drugs or chemicals. But for more effect long term psychotherapy may prove more successful. In continuation with this, we may also offer support group and alternative therapy such as relaxation exercises, meditation, yoga etc.

4.2.8 Addiction to Inhalents

Inhalent abuse disorders are a heterogenous group of illness caused by the abuse of solvents, glues, paint, fuels or other volatile substances. The resurgence of this new found phenomena is believed to be due to a number of variables like peer influence, rapid mood elevating quality, etc., which have made its potentially fatal activity popular among many young people today. The inhalants share a common route of administration that is they are all drawn into the body by breathing. They are usually taken either by breathing in the vapors directly from a container by inhaling fumes of the substances placed in a bag or by inhaling the substances from a cloth soaked with the substance.

DSM IV TR lists inhalants dependence and inhalant abuse as substance use disorders:

Symptoms of inhalents abuse disorder

i) Tolerance

ii) Loss of control

iii) Inability to stop

iv) Interference with activities

v) Harm to self

vi) Interference with role fulfillment

vii) Legal problems

viii) Lethargy

ix) Fatigue

x) Psychomotor retardation

xi) Blurred vision

xii) Weak muscle

Causes of inhalant abuse disorder

i) Poverty

ii) History of childhood abuse

iii) Poor grades in schools

iv) Dropping out of school

v) Peer influence

vi) Group settings where inhalants are used.

4.2.9 Nicotine Substance Abuse Disorder

This is a main psychoactive ingredient in tobacco. It is physically and psychologically addictive drug. Pure nicotine is a colorless liquid that turns brown and smells like tobacco when exposed to air. Nicotine can be absorbed through skin lining of the mouth and nose, moist tissues lining the lungs.

Cigarettes are the most efficient nicotine delivery system, which is inhaled and reaches the brain in less than 15 seconds. Nicotine in chewing tobacco and snuff is absorbed through the mucous membranes lining the mouth and nasal passages.

Symptoms of nicotine abuse disorder

i) Irritability

ii) Sleep disturbances

iii) Increased anger

iv) Depression

v) Anxiety

vi) Constant thoughts about smoking

vii) Decreased heart rate

viii) Coughing

ix) Withdrawal

x) Mood disorder.

Causes nicotine abuse disorder

i) Peer pressure

ii) Inadequate coping skills

iii) Emotional resources

iv) Relieving tension

v) Abolishing loneliness

vi) Stress.

4.2.10 Phencyclidine (PCP) Addiction

It is best known as a street drug and is popularly known as angel dust. This causes physiological changes to the nervous and circulatory system and causes disturbances in thinking and behaviour. This drug was first synthesized by a pharmaceutical company in the 1950s. It has side effects including agitated behaviour and hallucinations. It is easy to manufacture and is inexpensive .The effect of (PCP) is manifested in both behavioural and physiological symptoms. According to DSM IV TR, PCP can induce mood disorder and psychotic disorder.

Symptoms of Phencyclidine abuse disorder

i) Involuntary rapid movements of the eye

ii) High blood pressure

iii) Drooling from the mouth

iv) Racing heart rate

v) Lack of muscle coordination

vi) Coma

vii) Death

Causes of Phencyclidine abuse disorder

i) Easy availability

ii) Inexpressible

iii) Readily soluble

iv) Easily eaten ,smoked or injected.

4.2.11 Sedative, Hypnotic or Anxiolytic Related Disorder

These are types of tranquillisers which can be abused to produce an overly clamming effect. At high doses or when they are abused, these drugs can cause unconsciousness and even death. These are used in anesthesia to produce and maintain unconsciousness. Many hypnotic drugs are habit forming and due to a large number of factors they are known to disturb the human sleep pattern. Elderly people are more sensitive to the side effects of these drugs and a meta analysis showed that the risks generally outweigh any marginal benefits of hypnotic in the elderly.

Symptoms of Sedative, hypnotic abuse disorder

i) Withdrawal

ii) Depersonalisation

iii) Illusions

iv) Insomnia

v) Symptom reemergence

vi) Cardiovascular disorder

Causes of Sedative, hypnotic abuse disorder

i) Psychological addiction

ii) Tolerance for the drugs

iii) Sedative dependence

iv) Physical addiction

v) Hostility

vi) Aggression

vii) Mood swings

viii) Slurred speech

ix) Anxiety

Treatment of Sedative, hypnotic abuse disorder

Physiological treatment

The successful treatment of sedative dependence is based on the idea of gradually decreasing the amount of drug the patient uses in order to keep withdrawal symptoms to a manageable level. This is called a drug taper. The rate of taper depends on the dependency dose of the drug, the length of time the drug has been taken, a person's individual mental and physical response to drug withdrawal, and any complicating factors such as other substance abuse or other physical or mental illness.

For people dependent on a low dose of sedatives, the current level of use is determined, and then the amount of drug is then reduced by 10 to 25 percent. If withdrawal symptoms are manageable, reduction is continued on a weekly basis. If withdrawal symptoms are too severe, the patient is stabilised at the lowest dose with manageable symptoms until tapering can be re started. This gradual reduction of use may take weeks, and the rate must be adjusted to the response of each patient individually. The tapering process begins, but more gradually than with low dose dependency. Often other drugs are given to combat some of the withdrawal symptoms.

Psychological treatment

Cognitive behavioural therapy may be used in conjunction with drug tapering. This type of therapy has basically two aims (i) to educate patients to recognise and cope with the symptoms of anxiety associated with withdrawal, and (ii) to help patients change their behaviour in ways that promote coping with stress. Patients are also taught to mentally talk their way through their anxiety and stress. Some people find support groups and journal keeping to be helpful in their recovery.

Medications

This is to initially treat a patient who has taken an overdose of sedative hypnotics like any other patient with drug intoxication. These medicines help in the following ways:

- Provide an adequate airway and ventilation.
- Stabilise and maintain the hemodynamic status.

Once initial measures have been carried out, consider inducing emesis (vomiting), performing lavage (washing out of body organ) and administering activated charcoal to a patient who has orally ingested the drug, depending on the time of ingestion and level of consciousness.

Emesis, lavage, and/or activated charcoal prevent absorption of the drug into the system and absorption of the drug or active metabolites through enterohepatic recirculation.

Laxatives may be used to induce catharsis.

4.2.12 Polysubstance Use Disorder

This refers to a type of substance dependence disorder in which an individual uses at least three different classes of substances indiscriminately and does not have a favourite drug that qualifies for dependence on its own.

According *to* DSM-IV-TR when an individual meets criteria for dependence on a group of substances (at least three different types used in the same 12 month period) he or she is given the diagnosis of polysubstance dependence. For example, an individual may use cocaine, sedatives, and hallucinogens indiscriminately (i.e., no single drug predominated; there was no "drug of choice") for a year or more. The individual may not meet criteria for cocaine dependence, sedative dependence, or hallucinogen dependence, but may meet criteria for substance dependence when all three drugs are considered as a group.

Symptoms of Polysubstance use Disorder

- Tolerance (needing to use increasingly larger amounts of the drugs to get the same effect).
- Withdrawal (experiencing withdrawal symptoms when discontinuing use of the drugs).
- Loss of Control (using more drugs than planned, or using drugs longer or more often than planned).
- Inability to Stop Using (unsuccessfully attempting to stop using drugs) the drug.
- Time (spending a significant amount of time obtaining or using drugs) spent in obtaining the drug.
- Interference with daily routine previously enjoyed activities (giving up previously enjoyed activities to use drugs).
- Causing self injury or harm to Self (continuing to use drugs despite the fact that they cause physical or psychological harm).

Causes of Polysubstance use Disorder

i) Depression

ii) Sleep disorder

iii) Cognitive impairment

iv) Withdrawal

v) Social commitment

Treatment

The polysubstance abuse dependence can be treated in outpatient and inpatient departments. The cognitive behavioural technique is proved to be the more appropriate because it facilitates the patient with changing thoughts, concept and expose patients with new learning.

Self Assessment Questions

1) What are the common substance use disorders?

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2) What are the symptoms of cocaine addiction?

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3) What are the symptoms of hallucinogen addiction? How do you treat this disorder?

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4) What is cannabis addiction, what are the causes underklying this addiction?

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5) Write the most common symptoms in all substance use disorders.

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6) How can alcoholism be treated.?

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7) What are the various treatment available to treat sedative, hypnotic abuse disorder?

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8) What is meant by polusubstance use disorder? How is this disorder treated? What are its characteristic features?

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4.3 LET US SUM UP

Thus the mission for learning the substance use disorder is to improve outcomes for families affected by this disorder. To accomplish the goal it is needed to have effective practice of the various treatment models. These models could be adopted by community and the agencies in the society. It is the responsibility of society to eradicate this disorder so that adolescents, youth and older adults especially the children in school can live a healthy life. Thus the knowledge for research gaps in challenges in substance abuse disorder are needed to be discussed so as to meet and deal with challenges effectively.

Priority should be given to substance abuse as it not only affects individuals, that too youngsters in their prime age, psychologically but leads the individual towards ill health and makes the person totally unproductive and helpless. Such youngsters become a liability on the society.

There is a need to spread this knowledgein the society about the harmful effects of drugs and how to make them inaccessible and unavailable and how to use the legal system to prevent such drug sellers and drug pushers from hooking youngsters on to the drug etc. A concerted and countrywide campaign is required to prevent the drug use and abuse.

It is necessary to ensure that wellness promotion for chronic disease prevention is needed. The link with primary health care would facilitate the rural people to get rid of these problems. The psychologists, social workers, health care professionals etc., can play a significant role in discouraging use of drugs by all sections of society especially the youngsters.

4.4 UNIT END QUESTIONS

1) Define DSMIV category substance use disorders with their symptoms.

2) How do addiction and alcoholism disorders differ? Discuss with examples.

3) Describe cocaine and nicotine disorders symptoms and their causes. Cite examples.

4) Cognitive behavioural technique is the most effective for the substance use disorder. Elaborate on this.

5) What are polysubstance disorder? How we can eradicate it from society. Explain with your own understanding.

4.5 SUGGESTED READINGS AND REFERENCES

Coleman, J.C. (2000). *Abnormal Psychology and Modern Life.* Allyn & Bacon , London.

Bennett, Paul.(2003). *Abnormal & Clinical Psychology : An Introductory Text Book.* Open University publisher, NY.

David H Barlow &V Mark Durand *by Abnormal Psychology An Intergative Approach* (Wadsworth Cengage publisher).

Charles E Dodgan & W .Michael Shea (2000). *Substance use Disorders: Assessment & Treatment* Academic Press, London.

American Psychiatric Association.(2000). *Diagnostic and Statistical Manual of Mental Disorders*. 4th edition, text revised. Washington, DC: American Psychiatric Association, Washington.

References

Johnston LD, O'Malley PM, Bachman JG: National Survey Results of Drug Use From the Monitoring the Future Study, 1975–1994, vol 1: Secondary School Students: NIH Publication 95-4026. Rockville, Md, National Institute on Drug Abuse, 1995

Kandel DB, Yamaguchi K, Chen K: Stages of progression in drug involvement from adolescence to adulthood: further evidence for the gateway theory. J Stud Alcohol 1992; 53:447–457

Oetting ER, Beauvais F: Adolescent drug use: findings of national and local surveys. J Consult Clin Psychol 1990; 58:385–394

Maisto SA, McKay JR: Diagnosis, in Assessing Alcohol Problems: A Guide for Clinicians and Researchers: National Institute on Alcohol Abuse and Alcoholism Treatment Handbook Series 4: NIH Publication 95-3745. Edited by Allen JP, Columbus M. Bethesda, Md, National Institutes of Health, 1995

National Household Survey on Drug Abuse: Population Estimates 1994: DHHS Publication 94-3063. Rockville, Md, Department of Health and Human Services, 1994

Patrick, D. Dual diagnosis: substance-related and psychiatric disorders. The Nursing Clinics of North America. 2003; 38: 67-73.

Windle M: Alcohol use and abuse: some findings from the National Adolescent Student Health Survey. Alcohol Health Res World 1991; 15:5–10

Spitzer RL: Psychiatric diagnosis: are clinicians still necessary? Compr Psychiatry 1983; 24:399–411

Nelson-Gray RO: DSM-IV: empirical guidelines from psychometrics. J Abnorm Psychol 1991; 100:308–315

Rinaldi RC, Steindler EM, Wilford BB, Goodwin D: Clarification and standardisation of substance abuse terminology. JAMA 1988; 259:555–557

Rounsaville BJ, Bryant K, Babor T, Kranzler H, Kadder R: Cross system agreement for substance use disorders: DSM-III-R, DSM-IV and ICD-10. Addiction 1993; 88:337–348

Regier DA, Boyd JH, Burke JD Jr, Rae DS, Myers JK, Kramer M, Robins LN, George LK, Karno M, Locke BZ: One-month prevalence of mental disorders in the United States: based on five Epidemiologic Catchment Area sites. Arch Gen Psychiatry 1988; 45:977–986

Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen H-U, Kendler KS: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Arch Gen Psychiatry 1994; 51:8–19

Grant BF, Harford TC, Dawson DA, Chou SP, Pickering RP: Prevalence of DSM-IV alcohol abuse and dependence: United States, 1992. Alcohol Health Res World 1994; 18:243–248

Caetano R: Two versions of dependence: DSM-III and the alcohol dependence syndrome. Drug Alcohol Depend 1985; 15:81–103

Grant BF, Towle LH: A comparison of diagnostic criteria: DSM-III-R, proposed DSM-IV, and proposed ICD-10. Alcohol Health Res World 1991; 15:284–292

Grant BF, Chou SP, Pickering RP, Hasin DS: Empirical subtypes of DSM-III-R alcohol dependence: United States, 1988. Drug Alcohol Depend 1992; 30:75–84

Martin CS, Kaczynski NA, Maisto SA, Bukstein OM, Moss HB: Patterns of DSM-IV alcohol abuse and dependence symptoms in adolescent drinkers. J Stud Alcohol 1995; 56:672–680

Rounsaville BJ, Spitzer RL, Williams JBW: Proposed changes in DSM-III substance use disorders: description and rationale. Am J Psychiatry 1986; 143:463–468

Harrison PA, Fulkerson JA, Beebe TJ: Multiple substance use among adolescent physical and sexual abuse victims. Child Abuse Negl 1997; 21:529–539

Widiger TA, Trull TJ: Diagnosis and clinical assessment. Annu Rev Psychol 1991; 42:109–133

Winters K, Stinchfield R, Fulkerson J, Henly G: Measuring alcohol and cannabis use disorders in an adolescent clinical sample. Psychol of Addictive Behaviours 1993; 7:185–196

Martin CS, Langenbucher JW, Kaczynski NA, Chung T: Staging in the onset of DSM-IV alcohol symptoms in adolescents: survival/hazard analyses. J Stud Alcohol 1996; 57:549–558

Harrison PA: Adolescent alcohol and drug problems: who is at risk? (University Microfilms number 9117615). Dissertation Abstracts International 1991; 52(1-B):518

Saunders JB, Conigrave KM: Early identification of alcohol problems. Can Med Assoc J 1990; 143:1060–1069

Edwards G, Gross MM: Alcohol dependence: provisional description of a clinical syndrome. Br J Addict 1976; 1:1058–1061.

UNIT 1 SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

Structure

1.0 INTRODUCTION

This unit deals with schizophrenia, a severe mental disorder which has relatively poorer prognosis. The unit starts with concept and definition of schizophrenia, the common symptoms of schizophrenia such as the negative and positive symptoms, the cognitive and affective symptoms etc. Then the unit presents the various types of schizophrenia, their symptoms, causes and treatment. The common symptoms of schizophrenia are then discussed and the causes thereof. Amongst the various treatment interventions, apart from medicines, the unit presents the psychosocial treatment of schizophrenia. The rehabilitation of schizophrenics and education to the family as to how to look after these patients are presented in detail.

1.1 OBJECTIVES

On completing this unit, you will be able to:

- Define schizophrenic disorders;
- Describe various types of schizophrenia;
- Elucidate the symptoms of schizophrenia;
- Explain the causes of schizophrenia; and
- Delineate the treatment approaches for schizophrenia.

1.2 CONCEPT AND DEFINITION OF SCHIZOPHRENIA

Schizophrenia also sometimes called as split personality disorder. It is a chronic, severe, debilitating mental illness which affects about two percent of the population. It is one of the psychotic mental disorders and is characterised by behavioural and social abnormalities.

The individual with this disorder also develop disorganised speech, disorganised rigid or lax behaviour, significantly decreased appropriate behaviours or feelings as well as development of delusions. Delusions are false beliefs which for example believe someone is out to kill him while actually there is no such person who has any intention to kill the person. It is thus a false belief. The person however believed in it as such a reality that he is unable to distinguish between what is real and unreal. Thus based on the delusions his behaviour becomes highly bizarre. Sometimes such persons may attack another without reason based on his delusions.

Most cases of schizophrenia appear in the late teens or early adulthood. This is a disease of the brain and one of the most disabling and emotionally devastating illness and for a long time has not been properly diagnosed and quite often misjudged and misunderstood.

Persons with this illness are stigmatized and are generally avoided by everyone. In severe condition they are sent to hospitals for mental diseases. Like cancer and diabetes, schizophrenia has a biological basis. It is relatively a common disease affecting one to two percent of the population.

The Prevalance Rate for schizophrenia is approximately 1.1% of the population over the age of 18 (source: NIMH) or, in other words, at any one time as many as 51 million people worldwide suffer from schizophrenia, including;

6 to 12 million people in China (a rough estimate based on the population)

4.3 to 8.7 million people in India (a rough estimate based on the population)

2.2 million people in USA

285,000 people in Australia

Over 280,000 people in Canada

Over 250,000 diagnosed cases in Britain

According to Robin Murray, Rates of schizophrenia are generally similar from country to country—about 0.5% to 1 percent of the population.

Another way to express the prevalence of schizophrenia at any give time is the number of individuals affected per 1,000 total population. In the United States that figure is 7.2 per 1,000. This means that a city of 3 million people will have over 21,000 individuals suffering from schizophrenia.

Incidence: The number of people who will be diagnosed as having schizophrenia in a year is about one in 4,000. So about 1.5 million people will be diagnosed with schizophrenia this year, worldwide. About 100,000 people in the United States will be diagnosed with schizophrenia this year.

Note: The term 'prevalence' of Schizophrenia usually refers to the estimated population of people who are living with Schizophrenia at any given time.

The term 'incidence' of Schizophrenia refers to the annual diagnosis rate, or the number of new cases of Schizophrenia diagnosed each year.

1.2.1 The Course of Schizophrenia

Early intervention and early use of new medications lead to better medical outcomes for the individual.

The earlier someone with schizophrenia is diagnosed and stabilised on treatment, the better the long-term prognosis for their illness.

Teen suicide is a growing problem — and teens with schizophrenia have approximately a 50% risk of attempted suicide.

In rare instances, children as young as five can develop schizophrenia.

According to National Institute of Mental Health (NIMH) Anti-psychotic medications are the generally recommended treatment for schizophrenia. If medication for schizophrenia is discontinued, the relapse rate is about 80 percent within 2 years. With continued drug treatment, only about 40 percent of recovered patients will suffer relapses.

Wide variation occurs in the course of schizophrenia. Some people have psychotic episodes of illness lasting weeks or months with full remission of their symptoms between each episode; others have a fluctuating course in which symptoms are continuous but rise and fall in intensity. Others have relatively little variation in

the symptoms of their illness over time. At one end of the spectrum, the person has a single psychotic episode of schizophrenia followed by complete recovery. At the other end of the spectrum is a course in which the illness never abates and debilitating effects increase. Recent research increasingly shows that the disease process of schizophrenia gradually and significantly damages the brain of the person, and that earlier treatments (medications and other therapies) seem to result in less damage over time.

After 10 years, of the people diagnosed with schizophrenia:

25% Completely Recover

25% Much Improved, relatively independent

25% Improved, but require extensive support network

15% Hospitalised, unimproved

10% Dead (Mostly Suicide)

After 30 years, of the people diagnosed with schizophrenia:

25% Completely Recover

35% Much Improved, relatively independent

15% Improved, but require extensive support network

10% Hospitalised, unimproved

15% Dead (Mostly Suicide)

6% are homeless or live in shelters

6% live in jails or prisons

5% to 6% live in Hospitals

10% live in Nursing homes

25% live with a family member

28% are living independently

20% live in Supervised Housing (group homes, etc.)

1.2.2 Suicide Risk in Schizophrenia

People with the schizophrenia condition have a 50 times higher risk of attempting suicide than the general population. The risk of suicide is very serious in people with schizophrenia. Suicide is the number one cause of premature death among people with schizophrenia, with an estimated 10 percent to 13 percent killing themselves and approximately 40% attempting suicide at least once (and as much as 60% of males attempting suicide). The extreme depression and psychoses that can result due to lack of treatment are the usual causes. These suicide rates can be compared to the general population, which is somewhere around 0.01%.

1.2.3 Schizophrenia and Violence

People with schizophrenia are far more likely to harm themselves than be violent toward the public. Violence is not a symptom of schizophrenia.

Most people with schizophrenia, however, are not violent toward others but are withdrawn and prefer to be left alone. Drug or alcohol abuse raises the risk of violence in people with schizophrenia, particularly if the illness is untreated, but also in people who have no mental illness.

1.2.4 Schizophrenia and Jail

The vast majority of people with schizophrenia who are in jail have been charged with misdemeanors such as trespassing.

As many as one in five (20%) of the 2.1 million Americans in jail and prison are seriously mentally ill, far outnumbering the number of mentally ill who are in mental hospitals. The American Psychiatric Association estimated in 2000 that one in five prisoners were seriously mentally ill, with up to 5 percent actively psychotic at any given moment.

Many individuals with schizophrenia revolve between hospitals, jails and shelters. In Illinois 30% of patients discharged from state psychiatric hospitals are rehospitalised within 30 days. In New York 60% of discharged patients are rehospitalised within a year.

Although it affects both the sexes equally in frequency and often appears earlier in men usually in the late teens or early twenties, but women are affected in between twenties to early thirties. It is found all over the world. The severity of the symptoms and long lasting pattern of schizophrenia often cause a high degree of disability. Medications and other treatments for schizophrenia when used regularly and as prescribed can reduce and control the distressing symptoms of the illness. Even it has been seen that treatment is effective with persisting consequences of the illness like lost opportunities, stigma, residual symptoms and medication side effects which may be very troubling.

1.2.5 The First Signs of Schizophrenia

The first signs of schizophrenia appear as confusing or even shocking changes in behaviour. The activity of chemical messengers at certain nerve endings in the brain is unusual and may be a clue to the cause of the disorder. When it is severe this can lead to intense panic, anger, depression, elation or other activity. This can be treated giving the majority of people chance to live an ordinary life. Schizophrenia is a group of psychotic disorder that interferes with thinking and mental or emotional responsiveness, which disintegrates the entire personality.

This disorder has important symptoms such as auditory hallucinations, paranoid or bizarre delusions or disorganised speech and thinking, and it is accompanied by significant social or occupational dysfunction. The onset of symptoms typically occurs in young adulthood with a global lifetime prevalence.

Genetic, early environment, neurobiology, psychological and social process appear to be important contributory factors in the development of the disorder. Although no common cause of schizophrenia has been identified in all individuals and diagnosed with the condition. In the recent days the researchers and clinicians believe it results from a combination of both brain vulnerabilities and life events.

1.2.6 Historical Perspective of Schizophrenia

The history of schizophrenia begins with the name of Emile Krapelin (1856-1926) a German Psychiatrist who adopted the term dementia praecox to classify a group of disorders that had as their common feature intellectual and cognitive deterioration early in life.

Dementia refers to severe intellectual deterioration while praecox refers to the early onset of this disorder. Kraeplin stated that this disorder involves deterioration of cognitive functions overtime and these are not alike other disorders such as unipolar depression etc.

Eugene Bleuler was another person who worked on schizophrenia and coined the term schizophrenia. This term *schizophrenia* is derived from the Greek words 'schizo' (split) and 'phrene' (mind) and thus was coined by Eugene Bleuler to refer to the lack of interaction between thought processes and perception. Bleuler changed the name from Dementia Praecox to schizophrenia as it was obvious that Krapelin's name was misleading.

The word "praecox" implied precocious or early onset, hence premature dementia, as opposed to senile dementia from old age. Bleuler realised the illness was not a dementia (it did not always lead to mental deterioration) and could sometimes occur late as well as early in life and was therefore misnamed.

With the name 'schizophrenia' Bleuler tried to capture the separation of function between personality, thinking, memory, and perception. However, it is commonly misunderstood to mean that affected persons have a 'split personality'. Schizophrenia is commonly, although incorrectly, confused with multiple personality disorder (now called 'dissociative identity disorder').

Although people diagnosed with schizophrenia may 'hear voices' and may experience the voices as distinct personalities, schizophrenia does not involve a person changing between distinct multiple personalities. The confusion perhaps arises in part due to the meaning of Blueler's term 'schizophrenia' (literally 'split mind'). Interestingly, the first known misuse of this word schizophrenia to mean 'split personality'

Eugen Bleuler worked with Sigmund Freud and used the term Schizophenia. He then used the term which refers to splitting of mental associations. Schizophrenic disorders are known by the diagnostic criteria being given by DSM IV TR (2000).

Schizophrenia is defined as any of several psychotic disorders characterised by distortions of reality and disturbances of thought and language and withdrawal from social contact.

Schizophrenia is also defined as a mental disorder characterised by a disintegration of the process of thinking and of emotional responsiveness. Diagnosis is based on the patient's self reported 'split' phren- 'mind'). Schizophrenia does not imply a "split mind" and it is not the same as dissociative identity disorder. It is not "multiple personality disorder" or "split personality" a condition with which it is often confused in public perception.

1.3 SYMPTOMS OF SCHIZOPHRENIA

The diagnostic criteria of DSM IV (TR) include negative symptoms. These symptoms are as a rule, do not respond well to treatment and to many medications. Behaviour or functions that are deficient or absent in a schizophrenic individual's behaviour and thus refer to a loss or reduction of normal functions. The schizophrenic with negative symptoms has also a deficit or a lack in these behaviours and are considered as deteriorated.

But the positive symptoms on the other hand come with individuals normal behavioural repertoire and include delusions and hallucinations as well as psychomotor agitation, bizarre behaviour and minimal cognitive impairment. It also includes Type I and Type II Schizophrenia. These also include positive and negative symptoms and respectively include with more emphasis on biology and on medication efficacy. Type I schizophrenics respond well to antipsychotic medications and have normal sized brain ventricles but the other one Type II does not respond well to medications and may have enlarged ventricles and abnormalities in their frontal lobe.

Signs and symptoms of schizophrenia generally are divided into three categories — positive, negative and cognitive.

1.3.1 Positive Symptoms

In schizophrenia, positive symptoms reflect an excess or distortion of normal functions. These active, abnormal symptoms may include:

Delusions: Delusions are false beliefs. These beliefs are not based in reality and usually involve misinterpretation of perception or experience. They are the most common of schizophrenic symptoms.

Hallucination: These usually involve seeing or hearing things that do not exist, although hallucinations can be in any of the senses. Hearing voices is the most common hallucination among people with schizophrenia. These are called auditory hallucinations.

Thought disorder: Difficulty speaking and organising thoughts may result in stopping speech midsentence or putting together meaningless words, sometimes known as "word salad."

Disorganised behaviour: This may show in a number of ways, ranging from child like silliness to unpredictable agitation.

1.3.2 Negative Symptoms

Negative symptoms refer to a diminishment or absence of characteristics of normal function. They may appear months or years before positive symptoms. They include:

- Loss of interest in everyday activities
- Appearing to lack emotion
- Reduced ability to plan or carry out activities
- Neglect of personal hygiene
- Social withdrawal
- Loss of motivation

1.3.3 Cognitive Symptoms

Cognitive symptoms involve problems with thought processes. These symptoms may be the most disabling in schizophrenia, because they interfere with the ability to perform routine daily tasks. A person with schizophrenia may be born with these symptoms, but they may worsen when the disorder starts. They include:

- Problems with making sense of information
- Difficulty paying attention
- Memory problems

1.3.4 Affective Symptoms

Schizophrenia also can affect mood, causing depression or mood swings. In addition, people with schizophrenia often seem inappropriate and odd in regard to their moods, causing others to avoid them, which leads to social isolation.

People with schizophrenia often lack awareness that their difficulties stem from a mental illness that requires medical attention. So it usually falls to family or friends to get them help.

1.3.5 Suicidal Thoughts

Suicidal thoughts and behaviour are common among people with schizophrenia. If you suspect or know that your loved one is considering suicide, seek immediate help. Contact a doctor, mental health provider or other health care professional.

1.3.6 Common Symptoms

- Social withdrawal
- Flat ,expressionless gaze
- Inapropriate laughter or crying
- Depression
- Insomnia or oversleeping
- Delusions
  - Delusions of persecution
  - Delusions of reference
  - Delusions of grandeur
  - Delusions of control
- Hallucinations
  - Auditory hallucinations
  - Visual hallucinations in some cases
- Disorganised speech
- Disorganised behaviour
- Clumsy in motor functions
- Rigidity, tremor, jerking arm movements, or involuntary movements of the limbs
- Awakard Walking
- Unusual gestures and postures
- Inability to experience joy or pleasure from activities (called anhedonia)
- Appearing desireless or seeking nothing
- Feeling indifferent to important events
- Low motivation or No motivation
- Suicidal thoughts in some cases
- Rapidly changing mood.

Self Assessment Questions

1) What is schizophrenia?

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2) What are negative and positive symptoms of schizophrenia?

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3) What are the cognitive symptoms of schizophrenia?

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4) Enlist the common symptoms of schizophrenia.

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1.4 TYPES OF SCHIZOPHRENIA

The nature of symptoms taken into account while determining the disease of schizophrenia varies greatly with the progression of the disease. There are 5 types of schizophrenia, the subtypes are defined in accordance with the most prominent characteristics. The same person maybe analysed with different types of schizophrenia as the illness proceeds. The types of schizophrenia are:

i) Paranoid schizophrenia

ii) Disorganised schizophrenia (hebephrenia)

iii) Catatonic schizophrenia

iv) Undifferentiated schizophrenia

v) Residual type schizophrenia.

These are being discussed below in detail.

1.4.1 Paranoid Schizophrenia

The paranoid type of schizophrenia is marked by thoughts of conspiracy or persecution and in some cases also auditory hallucinations. The patients however are more capable of working and are better at relationships than those having the other types of schizophrenia. The life is much more normal, especially if they can manage the disease. Though the reason is unknown, it could probably be leading from the fact that those suffering from this schizophrenic type begin to show their symptoms during the later part of life, and have thus already managed to grasp better functioning before the illness could settle.

The patients may be hesitant in discussing their illness, and need not categorically look unusual or odd. Their delusions and hallucinations circle around particular themes which do not change frequently. In schizophrenia paranoid type the overall behaviour and temperament depends on the nature of their thoughts. For instance, somebody who imagines to be unjustly persecuted could become hostile easily or short tempered. These indications are generally understood by professionals when extra stress triggers the symptoms. It is precisely in such situations that the patient might realise the requirement for help. They may take such steps that might attract attention.

However, as the features are barely visible, it becomes important for the patient to discuss their thought reflections openly. This could be difficult where paranoia or suspicions are high. There can be variations over the same time period, in regard to its severity and nature. The thought process may get disorganised when the condition is on the path of worsening or exacerbation.

During such phases, the patient may find it tougher to remember even the recent events, or might speak incoherently, behaving in an irrational or in a disorganised pattern. Since these are features prominently characteristic to other subtypes, based on the state of their illness, the given symptoms may vary in several degrees in paranoid subtype patients. Family and friends should be supportive, encouraging the patient to seek help from a professional.

Signs and Symptoms

- Delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy.
- Hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing.
- Hallucinations of smell or taste, or of sexual or other bodily sensations.
- Visual hallucinations may occur but are rarely predominant.
- Incoherent speech
- Marked loosening of associations
- Flat or grossly inappropriate affect

Causes

- Family history of schizophrenia
- Exposure to viruses while in the womb
- Poor nutrition while in the womb
- Stressful life events
- Older paternal age
- Addiction of psychoactive drugs during adolescence

Treatment

- The main treatments for paranoid schizophrenia are:
- Medications
- Psychotherapy
- Hospitalisation
- Electroconvulsive therapy (ECT)
- Vocational skills training

1.4.2 Disorganised Schizophrenia (Hebephrenic)

As evident from its very name, this type of schizophrenia is marked by disorganised thought patterns, with less of delusion and hallucination difficulties. The ability to normal functioning of regular living might get seriously impaired, and might include trouble in performing routine activities such as brushing, bathing, etc.

This is one of those sub types of schizophrenia where emotional impairment may be observed. For instance, the patient's emotions may fluctuate greatly, or might be unjustified in a given circumstance, with unordinary responses of emotions (flat or blunted effect). The patient is unusually giddy or jocular, like one who chuckles at a solemn occasion like funeral.

The communication ability might get impaired, with a practically incomprehensible speech, owing to disorganised thought patterns. It is important to look out for speech which is marked with difficulties in forming of sentences with correct word ordering than difficulties arising form articulation or enunciation.

Symptoms

- Delusions of persecution
- Delusion of reference, exalted birth, special mission, bodily change, or jealousy;
- Hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing;
- Hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.

Causes

The exact cause of paranoid schizophrenia is unknown. A genetic and enviornment cause have been suggested, more common in families with psychotic mood disorders, most notably paranoid schizophrenia and delusional disorders.

Biochemical factors and childhood experience have also been suggested as possible causes.

Treatment

The main treatments for paranoid schizophrenia are:

- Medications
- Psychotherapy
- Hospitalisation

1.4.3 Catatonic Schizophrenia

Catatonic disorders are a group of symptoms characterised by disturbances in motor (muscular movement) behaviour that may have either a psychological or a physiological basis. The best known of these symptoms is immobility, which is a rigid positioning of the body held for a considerable length of time. Patients diagnosed with a catatonic disorder may maintain their body position for hours, days, weeks or even months at a time.

Alternately, catatonic symptoms may look like agitated, purposeless movements that are seemingly unrelated to the person's environment. The condition itself is called **catatonia** . A less extreme symptom of catatonic disorder is slowed-down motor activity. Often, the body position or posture of a catatonic person is unusual or inappropriate; in addition, he or she may hold a position if placed in it by someone else.

Symptoms

These symptoms include:

- Catalepsy, or motionlessness maintained over a long period of time.
- Catatonic excitement, marked by agitation and seemingly pointless movement.
- Catatonic stupor, with markedly slowed motor activity, often to the point of immobility and seeming unawareness of the environment.
- Catatonic rigidity, in which the person assumes a rigid position and holds it against all efforts to move him or her.
- Catatonic posturing, in which the person assumes a bizarre or inappropriate posture and maintains it over a long period of time.
- Waxy flexibility, in which the limb or other body part of a catatonic person can be moved into another position that is then maintained. The body part feels to an observer as if it were made of wax.
- Akinesia, or absence of physical movement.

Causes

- Brain, including the limbic system, the frontal cortex, and the basal ganglia.
- Irregularities in production of neurotransmitters within the brain.
- Numerous medical conditions

Treatment

- Medications

- Psychotherapy
- Family education
- Hospitalisation

1.4.4 Undifferentiated Schizophrenia

Patients with undifferentiated schizophrenia do not experience the Paranoia associated with paranoid schizophrenia. The catatonic state seen in patients with catatonic schizophrenia, or the disorganised thought and expression observed in patients with disorganised schizophrenia are not obtained here. However, they do experience psychosis and a variety of other symptoms associated with schizophrenia, including behavioural changes which may be noticeable to family and friends.

This mental disorder is challenging to diagnose, and it can take weeks or months to confirm a diagnosis of schizophrenia. During this process, other causes for the symptoms are ruled out, and the patient is observed to collect information about changes in the patient's personality, modes of expression, and mood. Family members and friends may also be interviewed and asked for information with a goal of painting a more complete picture of what is going on inside the patient's mind.

In this schizophrenia type, the patient's symptoms may fluctuate, or might stay excessively stable, causing a doubt in placing it under any other sub type. The best schizophrenia type's definition for this type of schizophrenia is 'mixed clinical condition'.

Symptoms

This disorder does not have any specific symptoms and mostly similar to main symptoms of Schizophrenia, which are as follows:

- Delusions
- Hallucinations
- Disorganised speech
- Grossly disorganised or catatonic behaviour
- Negative symptoms

Causes

- Genetic
- Migration
- Virus
- Family environment

Other Causes

Sometimes individuals born in cold and urban environments are more likely to develop undifferentiated schizophrenia. Those infected with influenza, poliovirus, CNS, respiratory diseases have a 10 to 50 percent higher chance of developing schizophrenia. During the prenatal stage, those children subjected to famine, separated from mother/parents/family, depression, bereavement and total damage of everything during flood etc., are all more likely to develop schizophrenia

Treatment

- Psychotherapy
- Pharmacotherapy

There are a number of treatment options available for undifferentiated schizophrenia. Patients can discuss treatment options with their physicians, although it is important to be aware that it can take time for treatment to be effective. Once patients start experiencing a change, they may require periodic adjustments to their medications and treatment regimen to respond to changes they experience over time. Undifferentiated schizophrenia cannot be cured, but it can be managed with a cooperative effort.

1.4.5 Residual Type Schizophrenia

The symptoms are less severe as compared to the undifferentiated schizophrenia or the disorganised schizophrenia. They do manifest idiosyncratic behaviours, delusions or hallucinations and they appear less prominent as they were in the worst days of illness. Just like varying types of schizophrenia, the ramifications are highly varying too.

Different impairments affect different people in different degrees. While some need custodial care, others may have a fairly normal career and family life. Though generally patients do not stand at either of the two extreme points, they generally have to opt for waning and waxing treatments marked with hospitalisation visits, requiring outside support etc. On the other hand, a weaker prognosis is marked by sinister and gradual onsets, starting from adolescence or childhood. They cause abnormalities in the brain structure which can be revealed by imaging studies often causing permanent damages after severe incidents.

Symptoms

- Social withdrawal
- Depersonalisation (intense anxiety and a feeling of being unreal)
- Loss of appetite
- Loss of hygiene
- Delusions

Hallucinations (distorted perception that is for example, hearing things when there is none talking, seeing thing swhen there is none present)

The sense of being controlled by outside forces

Causes

- Genetic cause
- Enviornmental cause

Treatment

- Psychotherapy
- Pharmacotherapy

Self Assessment Questions

1) What is Catatonic schizophrenia?

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2) Discuss the symptoms of disorganised schizophrenia and also the causes of hebephrenia.

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3) What do you understand by undifferentiated schizophrenia? Put forward the symptoms, causes and course of the illness?

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4) What is residual type schizophrenia?

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1.5 CAUSES OF SCHIZOPHRENIA

There are many factors that may cause schizophrenia. Scientists are still working on this aspect, trying to identify all of them. The most common causes are:

1.5.1 Genetics

The genetic vulnerability and environmental factors can act in combination so as to result in diagnosis of schizophrenia. Research suggests that genetic vulnerability to schizophrenia is multi factorial, caused by interactions of several genes.

Both individual and twin studies and meta-analyses of twin studies estimate the heritability of risk for schizophrenia to be approximately 80% (this refers to the proportion of variation between individuals in a population that is influenced by genetic factors, not the degree of genetic determination of individual risk).

Concordance rates between monozygotic twins was close to 50%; whereas dizygotic twins was 17%. Adoption studies have also indicated a somewhat increased risk in those with a parent with schizophrenia even when raised apart.

Studies suggest that the phenotype is genetically influenced but not genetically determined. The variants in genes are generally within the range of normal human variation and have low risk associated with them each individually, and that some interact with each other and with environmental risk factors. These may not necessarily be specific to schizophrenia

Some twin studies have found rates as low as 11.0% to 13.8% among monozygotic twins, and 1.8% to 4.1% among dizygotic twins. Tyronne Cannon reviewed the situation, stating: "Previous twin studies have reported estimates of broad heritability ranging from 0.41 to 0.87"Yet, in the "Pairs of Veteran Twins" study, for example, 338 pairs were schizophrenic with only 26 pairs concordant, and it was concluded in one report: "the role of the suggested genetic factor appears to be a limited one; 85 percent of the affected monozygotic pairs in the sample were discordant for schizophrenia". In addition, some scientists criticize the methodology of the twin studies, and have argued that the genetic basis of schizophrenia is still largely unknown or open to different interpretations.

1.5.2 Prenatal Obstetric Complications

This occurs in approximately 25 to 30% of the general population and the vast majority do not develop schizophrenia, and likewise the majority of individuals with schizophrenia have not had a detectable obstetric event. Nevertheless, the increased average risk is well-replicated, and such events may moderate the effects of genetic or other environmental risk factors. The specific complications or events most linked to schizophrenia, and the mechanisms of their effects, are still under examination.One epidemiological finding is that people diagnosed with schizophrenia are more likely to have been born in winter or spring.

1.5.3 Fetal Growth

Lower than average birth weight has been one of the most consistent findings, indicating slowed fetal growth possibly mediated by genetic effects. Almost any factor adversely affecting the fetus will affect growth rate, however, so the association has been described as not particularly informative regarding causation.

1.5.4 Hypoxia

Hypoxia has been recently described as one of the most important of the external factors that influence susceptibility, although studies have been mainly epidemiological. Such studies place a high degree of importance on hypoxic influence, but because of familial pattern of the illness in some families, propose a genetic factor also; stopping short of concluding hypoxia to be the sole cause. Fetal hypoxia, in the presence of certain unidentified genes, has been correlated with reduced volume of the hippocampus, which is in turn correlated with schizophrenia.

1.5.5 Infections

Numerous viral infections, in utero or in childhood, have been associated with an increased risk of later developing schizophrenia. Schizophrenia is somewhat more common in those born in winter to early spring, when infections are more common.Influenza has long been studied as a possible factor. A 1988 study found that individuals who were exposed to the Asian flu as second trimester fetuses were at increased risk of eventually developing schizophrenia.

1.5.6 Other Factors

Childhood antecedents: The antecedents of schizophrenia are subtle. Average group differences from the norm may be in the direction of superior as well as inferior performance. Overall, birth cohort studies have indicated subtle nonspecific behavioural features, some evidence for psychotic-like experiences (particularly hallucinations), and various cognitive antecedents. There have been some inconsistencies in the particular domains of functioning identified and whether they continue through childhood and whether they are specific to schizophrenia. A prospective study found average differences across a range of developmental domains, including reaching milestones of motor development at a later age, having more speech problems, lower educational test results, solitary play preferences at ages four and six, and being more socially anxious at age 13. Lower ratings of the mother's skills and understanding of the child at age 4 were also related.

Substance Use: The relationship between schizophrenia and drug use is complex, meaning that a clear causal connection between drug use and schizophrenia has been difficult to tease apart. There is strong evidence that using certain drugs can trigger either the onset or relapse of schizophrenia in some people. It may also be the case, however, that people with schizophrenia use drugs to overcome negative feelings associated with both the commonly prescribed antipsychotic medication and the condition itself, where negative emotion, paranoia and anhedonia are all considered to be core features. The rate of substance use is known to be particularly high in this group. In a recent study, 60% of people with schizophrenia were found to use substances and 37% would be diagnosable with a substance use disorder.

Social adversity: It has been seen that chance of developing schizophrenia has been found to increase with the number of adverse social factors present in childhood Stressful life events generally precede the onset of schizophrenia. A personal or recent family history of migration is a considerable risk factor for schizophrenia, which has been linked to psychosocial adversity, social defeat from being an outsider, racial discrimination, family dysfunction, unemployment and poor housing conditions. Childhood experiences of abuse or trauma are risk factors for a diagnosis of schizophrenia later in life. Recent large-scale general population studies indicate the relationship is a causal one, with an increasing risk with additional experiences of maltreatment although a critical review suggests conceptual and methodological issues require further research .

Urbanicity: The association between living in an urban environment and the development of schizophrenia, even after factors such as drug use, ethnic group and size of social group have been controlled for. A recent study of 4.4 million men and women in Sweden found a 68%–77% increased risk of diagnosed

psychosis for people living in the most urbanised environments, a significant proportion of which is likely to be described as schizophrenia.

The effect does not appear to be due to a higher incidence of obstetric complications in urban environments. He risk increases with the number of years and degree of urban living in childhood and adolescence, suggesting that constant, cumulative, or repeated exposures during upbringing occurring more frequently in urbanised areas are responsible for the association.

Various possible explanations for the effect have been judged unlikely based on the nature of the findings, including infectious causes or a generic stress effect. It is thought to interact with genetic dispositions and, since there appears to be nonrandom variation even across different neighborhoods, and an independent association with social isolation, it has been proposed that the degree of "social capital" (e.g. degree of mutual trust, bonding and safety in neighbourhoods) can exert a developmental impact on children growing up in these environments

1.6 TREATMENT

1.6.1 Psychosocial Treatment for Schizophrenia

While medication is almost always a necessary component of schizophrenia treatment, it does not offer a complete solution. People with schizophrenia also need psychosocial treatments to help them cope with their illness, obtain services, and become more independent. People who receive psychosocial treatment for schizophrenia are more likely to take their medication regularly and avoid relapse and hospitalisation.

1.6.2 Supportive Therapy

The goal of supportive therapy for schizophrenia is to help people adjust to their illness and navigate the challenges of daily living. Individual and group therapy provide the much needed emotional support for people with schizophrenia, while simultaneously teaching them how to solve problems in their daily lives, improve their relationships, and participate in their own recovery.

1.6.3 Illness Management

A primary focus of supportive therapy is patient education. Patients learn about common schizophrenia symptoms and problems, treatment options, and the importance of medication. This knowledge helps them take an active role in treatment and better manage their illness. People with schizophrenia can learn to monitor their progress, watch for signs of relapse, take their medication regularly, and deal with side effects.

1.6.4 Coping with Symptoms

Supportive therapy can also teach people how to cope with symptoms of schizophrenia that persist despite medication and treatment. Using cognitive-behavioural techniques, patients learn to challenge delusional beliefs, ignore the voices in their heads, or motivate themselves.

1.6.5 Rehabilitation

Vocational and social rehabilitation teaches basic life skills to people with schizophrenia so they can function in their families or communities. There are many different types of rehabilitation programs, but the shared focus is on helping patients take care of themselves and make the most of their capabilities. Depending on the individual's personal goals and degree of illness, rehabilitation may include training in handling finances, using public transportation, communicating with others, and finding living arrangements. For those who want to work, vocational rehabilitation includes work assessment, job skills training, and assistance finding full or part-time employment.

1.6.6 Family Education and Support

Family support makes a difference in the outlook for people with schizophrenia. When family members are involved in treatment, patients are more likely to avoid relapse and achieve a higher level of functioning. If you have a family member with schizophrenia, educating yourself about the illness will give you a clearer understanding of your loved one and the challenges of treatment and recovery.

1.6.7 Antipsychotic Drugs

The most common medical treatment for schizophrenia is the use of antipsychotic medication. 70% of people using medications for schizophrenia improve, and medicine can also cut the relapse rate for the disorder by half, reducing it to 40%. Classic schizophrenia medication includes Thorazine, Fluanxol, and Haloperidol. These medications are effective in treating the positive symptoms of schizophrenia. Newer "atypical" medications include Risperdal, Clozaril, and Aripiprazole. These medications are recommended for first-line treatment and are excellent at reducing negative symptoms.

1.6.8 Antidepressant Drugs

Antidepressants are recommended for those suffering from schizoaffective disorder. Antidepressants can successfully reduce the symptoms of depression in these patients.

Self Assessment Questions

1) What are the causes of schizophrenia?

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2) How can schizophrenia be treated?

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3) What is psychotherapy?

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1.7 LET US SUM UP

In this unit we discussed the definition and description of schizophrenia. We took up the symptoms of schizophrenia and focused on both positive and negative symptoms and how they affect the disorder. Then we took up the various types of schizophrenia such as the hebephrenic, paranoid, catatonic, undifferentiated etc., and discussed each of their symptoms, causes and treatment of the same. In regard to the causes of schizophrenia, general causes were discussed and supporting twin studies for genetic factors were also discussed. Thus the family study, twin study and adoption study all show a major contributor for schizophrenia. It is a lifetime risk and correlates quite well with the proportion of genes shared with an affected family member. The socio-economic role is also important and lower group are always at the risk of the disorder. By and large all the symptoms of schizophrenia, the causes or the etiological factors and the various available treatment for the disorder have been presented in this unit.

1.8 UNIT END QUESTIONS

1) Describe Schizophrenia with its symptoms.

2) What are negative, positive and cognitive symptoms of schizophrenia? Explain in detail

3) Describe the different types of schizophrenia and present the causes and treatment for each type of schizophrenia

4) What is hebephrenia? Describe its causes and symptoms?

5) What are the treatment interventions available for treating schizophrenia?

1.9 SUGGESTED READINGS AND REFERENCES

Green, Michael, Foster. (2003). *Schizophrenia Revealed: From Neurons to Social Interaction*. Skylane Publishing, NY

Keefe, Richard S.E. & Harvey, Phillip D. (2005). *Understanding Schizophrenia: A Guide to the New Research on Causes and Treatment* , NAMI, Texas.

Torrey, Fuller,E. (2005). *Surviving Schizophrenia: A Manual for Families, Patients, and Providers* . Robert W. Wance, NY

Sadock BJ, Sadock VA (2007). *Schizophrenia*. In Kaplan and Sadock's Synopsis of Psychiatry. 10th ed., pp. 467-497. Philadelphia: Lippincott Williams and Wilkins.

References

Ho BC, et al. (2003). Schizophrenia and other Psychotic disorders. In R E Hales, SC Yudofsky, eds., Textbook of Clinical Psychiatry, 4th ed., pp. 379-438. Washington, DC: American Psychiatric Publishing.

Buchanan RW, Carpenter WT Jr (2005). Schizophrenia. In BJ Sadock, VA Sadock, eds., Kaplan and Sadock's Textbook of General Psychiatry, 8th ed., vol. 1, pp. 1329-1558. Philadelphia: Lippincott Williams and Wilkins.

Sørensen HJ, et al. (2003). Do hypertension and diuretic treatment in pregnancy increase the risk of schizophrenia in offspring? American Journal of Psychiatry, 160(3): 464-468.

American Psychiatric Association (2000). Schizophrenia section of Schizophrenia and other psychotic disorders. In Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text rev., pp. 287-313. Washington, DC: American Psychiatric Association.

Bustillo JR, et al. (2001). The psychosocial treatment of schizophrenia: An update. American Journal of Psychiatry, 158(2): 163-175.

Lehman AF, et al. (2004). Practice guideline for the treatment of patients with schizophrenia, second edition. American Journal of Psychiatry, 161(2, Suppl): 1-56.

Drake RE, et al. (2000). Evidence-based treatment of schizophrenia. Current Psychiatry Reports, 2(5): 393-397.

Buchner DM (2008). Physical activity. In L Goldman, D Ausiello, eds., Cecil Textbook of Medicine, 23rd ed., pp. 64-67. Philadelphia: Saunders. Tamminga CA, Holcomb HH. Phenotype of schizophrenia: a review and formulation. *Mol Psych* 2005;10:27–39.

Picchioni MM, Murray RM. Schizophrenia. *BMJ* 2007;335:91–95.

Kane JM, Honigfeld G, Singer J, et al. Clozapine for the treatment-resistant schizophrenic. *Arch Gen Psychiatry* 1988;45:789–796.

McGrath JJ. Variations in the incidence of schizophrenia: data versus dogma. *Schizophr Bull*. 2006;32:195–197.

Aleman A, Kahn RS, Selten JP. Sex differences in the risk of schizophrenia. Evidence from meta-analysis. *Arch Gen Psychiatry* 2003;60:565–571.

Hegarty JD, Baldessarini RJ, Tohen M, et al. One hundred years of schizophrenia: a meta-analysis of the outcome literature. *Am J Psychiatry* 1994;151:1409–1416.

Jablensky A, Sartorius N, Ernberg G, et al. Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organisation ten-country study. *Psychol Med Monogr Suppl* 1992; 20:1–97.

Johnstone EC. Schizophrenia: problems in clinical practice. *Lancet* 1993;341:536–538.

Thornley B, Adams C. Content and quality of 2000 controlled trials in schizophrenia over 50 years. *BMJ* 1998;317:1181–1184. Search date 1997; primary sources hand searches of conference proceedings, Biological Abstracts, Cinahl, The Cochrane Library, Embase, Lilacs, Psychlit, Psyindex, Medline, and Sociofile.

UNIT 2 PERSONALITY DISORDERS

Structure

2.0 INTRODUCTION

In this unit we will be dealing with concept and definition of personality disorders. In this we will deal with cluster A, B, and C personality disorders. This will be followed by historical development of personality disorders, and definition and concept of personality disorders. Then we will take up types of personality disorders which will include paranoid, schizophrenic and schizotypal personality disorders. After cluster A, we will take up personality disorders under cluster B which will consist of antisocial personality disorder, borderline personality disorder, histrionic and narcissistic personality disorders. This will be followed by the cluster C personality disorders which will consist of avoidant personality disorders, dependent personality disorder and the obsessive compulsive personality disorder. In all these disorders the symptomatology, causes and treatments of these disorders will be discussed.

2.1 OBJECTIVES

On completing this unit, you will be able to:

- Define personality disorders;
- Describe the characteristic features of personality disorders;
- Explain various types of personality disorders;
- Elucidate the Symptoms of personality disorders;
- Analyse the causes of personality disorders; and
- Explain the various Treatment approaches for personality disorders.

2.2 CONCEPT AND DEFINITION OF PERSONALITY DISORDERS

A person characteristics ways of responding are referred to his or her personality. Personality styles can be maladaptive if an individual is unable to modify the behaviour when the environment changes. This inability to change is referred to as disorder. Personality disorder is a longstanding, maladaptive and inflexible ways of relating to the enviiornment. These disorders sometimes may be noticed in childhood or latest by early adolescence. These disorders cause problems for the persons who suffer from it and also to people who are significant in the individual's life.

People with psychological personality disorders have traits that cause them to feel and behave in socially distressing ways. Depending on the specific disorder, these personalities are generally described in negative terms such as hostile, detached, needy, antisocial or obsessive (Dobbert 2007).

Classification of Personality Disorders

Personality disorders are classified by DSM IV (TR) into three clusters of disorders.

There are currently 10 conditions that are considered personality disorders, some of which have very little in common. Mental health professionals group those personality disorders that share characteristics into one of three clusters:

2.2.1 Cluster A Personality Disorders

These are considered to be marked by odd, eccentric behaviour. Paranoid, Schizoid and Schizotypal Personality Disorders are in this category.

i) **Paranoid Personality Disorder (PPD)**

PPD is a type of psychological personality disorder characterised by an extreme level of distrust and suspiciousness of others. Paranoid personalities are generally difficult to get along with, and their combative and distrustful nature often elicits hostility in others. The negative social interactions that result from their behaviour reinforces their original pessimistic expectations.

Persons with PPD are unlikely to form many close relationships and are typically perceived as cold and distant. They are quick to challenge the loyalty of friends and loved ones and tend to carry long grudges (Dobbert 2007)

ii) **Schizoid Personality Disorder**

Individuals with schizoid personality are characteristically detached from social relationships and show a restricted range of expressed emotions. Their social skills, as would be expected, are weak, and they do not typically express a need for attention or approval. They may be perceived by others as somber and of, and often are referred to as "loners."

iii) **Schizotypal Personality Disorder**

Schizotypal personalities are characterised by odd forms of thought, perception and beliefs. They may have bizarre mannerisms, an eccentric appearance, and speech that is excessively elabourate and difficult to follow. However, these cognitive distortions and eccentricities are only considered to be a disorder when the behaviours become persistent and very disabling or distressing.

In social interactions, schizotypals may react inappropriately, or not react at all, or talk to themselves. They may believe that they have extra sensory powers or that they are connected to unrelated events in some important way. However, they tend to avoid intimacy and typically have few close friends. Although schizotypals may marry and hold down jobs, they are prone to feel nervous around strangers (Dobbert 2007).

2.2.2 Cluster B Personality Disorders

These are evidenced by dramatic, erratic behaviours and include Histrionic, Narcissistic, Antisocial and Borderline Personality Disorders.

There are four Cluster B personality disorders: antisocial, borderline, narcissistic, and histrionic. The DSM-IV views these as a subset of personality disorders that are characterised by dramatic, emotional or erratic behaviour. Let us take up antisocial personality disorders.

i) **Antisocial Personality Disorder (APD)**

According to DSM-IV, antisocial personality disorder is a "pervasive pattern of disregard for, and violation of, the rights of others that begins in early childhood or early adolescence and continues into adulthood." People with antisocial personality disorder have been described as lacking empathy and may often be deceitful or break the law.They never feel bad or regret their wrong actions. Despite being punished or jailed in certain cases, they continue to indulge in wrong and deviant activities. Antisocial personality disorder is also associated with impulsive behaviour, aggression (such as repeated physical assaults), disregard for their own or other's safety, irresponsible behaviour, and lack of remorse.

ii) **Borderline Personality Disorder (BPD)**

BPD is associated with specific problems in interpersonal relationships, self-image, emotions, behaviours, and thinking. People with BPD tend to have intense relationships characterised by a lot of conflict, arguments and break-ups. They also have difficulties related to the stability of their identity or sense of self. They report many "ups and downs" in how they feel about themselves. Individuals with BPD may say that they feel as if they are on an emotional roller coaster, with very quick shifts in mood (for example, going from feeling OK to feeling extremely down or blue within a few minutes).

BPD is associated with a tendency to engage in risky behaviours, such as going on shopping sprees, drinking excessive amounts of alcohol or abusing drugs, engaging in promiscuous sex, binge eating, or self-harming.

iii) **Narcissistic Personality Disorder**

The next disorder in group B is the Narcissistic personality disorder, which is characterised by an inflated sense of self-importance. People with narcissistic personality disorder often believe that they are "special," require excessive attention, take advantage of others, lack empathy, and are described by others as arrogant.

iv) **Histrionic Personality Disorder**

The next disorder in this group B is the histrionic personality disorder. The central features of histrionic personality disorder are intense expressions of emotion and excessive attention seeking behaviour. People with histrionic personality disorder often seek out attention and are uncomfortable when others are receiving attention. They may often engage in seductive or sexually promiscuous behaviour, or use their physical appearance to draw attention to themselves. They also may demonstrate rapidly shifting emotions and express emotion in a very dramatic fashion.

2.2.3 Cluster C Personality Disorders

These are distinguished by anxious, fearful behaviour commonly seen in Obsessive-Compulsive, Avoidant and Dependent Personality Disorders.

Let us deal with each of the disorders in each of the clusters. First taking up Cluster A Personality Disorders, in which we have paranoid, schizoid and schizotypal personality disorders.

In this group we have obsessive compulsive personality disorder, avoidant personality disorder and dependent personality disorder. Let us take up the Obsessive compulsive personality disorder.

i) **Obsessive-Compulsive Personality Disorder**

People suffering from OCPD, also called Anankastic Personality Disorder, are so focused on order and perfection that their lack of flexibility interferes their ability to get things done, and to enjoy life in general. Little is accomplished because, whatever the task, for the obsessive-compulsive, it is never good enough. These individuals become involved and overwhelmed in detail and are often unable to see the big picture.

ii) **Avoidant Personality Disorder (AvPD)**

Those with AvPD experience an intense level of social anxiety. Extremely self-conscious, they tend to avoid social situations and gravitate to jobs that involve little interpersonal contact. Avoidants often feel inadequate or inferior to others and are hypersensitive to rejection. Unlike individuals with schizoid personality disorder, those with AvPD do crave social relationships but feel that social acceptance is unattainable (Dobbert 2007).

iii) **Dependent Personality Disorder (DPD)**

DPD is a psychological personality disorder in which the individuals are dependent on others to an extreme extent. They want to be taken care of, cling to those they depend on, and often rely on others to make decisions for them. They have a strong fear of rejection and may become suicidal when faced with a disintegrating relationship. Those with DPD require excessive reassurance and advice, and are commonly over-sensitive to criticism or disapproval.

All these disorders are dealt with in detail at a later section in this unit.

2.2.4 Historical Perspective

Three hundred years ago, in 1801 the French psychiatrist Pinel spoke of maniac sans delire that is mania without delirium. Pinel defined what might now be called Dissocial Personality Disorder and believed that it was characterised by unexplained outbursts of rage and violence in the absence of impaired intellectual function or delusion. At that time delusions were regarded as the central factor of mental illness and Gelder et al (1989) presumed that this group also included those mentally ill patients who were not deluded as for example those suffering from mania or mood disorder.

In 1835, a doctor at Bristol Infirmary, Pritchard, formulated a new term, Moral Insanity, defined as a morbid perversion of the natural feelings, affection, inclination, temper, habits, moral dispositions and natural impulses. This referred to both personality and mood disorders.

Further classifications were suggested through out the 19th century including Monel's cognitive delusions in 1852, followed by Degenerative Deviation, Moral Imbecility, Constitutional Inferiority and Moral Delinquency. Later in the century, a recognition of mentally ill without delusions occurred, and distinctions were drawn between schizophrenia and affective or mood disorders. The concept of moral insanity was consequently modified.

In 1872, Lombroso spoke of the unborn criminal and in 1884 Henry Maudsley wrote" it is not our business to explain psychologically the origins and nature of this depraved instincts, it is sufficient to establish their existence as facts of observation." This concept of "no capacity for true moral feeling" became the forerunner to psychopathic states. In 1891 a German Doctor Koch, introduced the term psychopathic inferiority. Kraepelin in 1905 replaced inferiority with personality. He defined the psychopathic personality as falling into 7 types: excitable, unstable, eccentric, liars, swindlers, antisocial, quarrelsome.

N 1923, Schneider, a German psychiatrist extended classification of psychiatry to include 10 sub classifications incorporating not only those who caused suffering to others but also those causing suffering to themselves.

In 1941, Cleckley coined the phrase, the "Mask of Insanity" and Sir David Henderson defined psychopaths as people who through out thjeir lives have exhibited disorders of conduct of an antisocial or asocial in nature, recurrent or episodic. Henderson included three groups of psychopaths, aggressive, inadequate and creative. This classification included those prone to suicide, drug and alcohol abuse, pathological lying, hypochondriasis, instability and insensitivity.

Thus historically the Personality disorders have gone through considerable modifications. These disorder were earlier known as character disorders. The term implies to a diagnostic category of psychiatric disorders characterised by chronic, inflexible and maladaptive pattern of behaviour which is evident in the way a person thinks, feels and behaves. A person with an untreated personality disorder is rarely able to enjoy sustained, meaningful, and rewarding relationships with others, and any relationships they do form are often fraught with problems and difficulties.

2.3 DEFINITION OF PERSONALITY DISORDERS

American Psychiatric Association (APA) defines personality disorders as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the culture of the individual who exhibits it". The different behavioural patterns in personality disorders are typically associated with severe disturbances in the behavioural tendencies of an individual, usually involving several areas of the personality, and are nearly always associated with considerable personal and social disruption.

The onset of these patterns of behaviour can typically be traced back to late adolescence and the beginning of adulthood and, in rarer instances, childhood. It is therefore unlikely that a diagnosis of personality disorder will be appropriate before the age of 16 or 17 years.

Personality disorders are long term patterns of thoughts and behaviours that cause serious problems with relationships and work. People with personality disorders have difficulty dealing with everyday stresses and problems.

2.3.1 General Symptoms of Personality Disorders

These are given below:

- Frequent mood swings
- Stormy relationships
- Social isolation
- Angry outbursts
- Suspicion and mistrust of others
- Difficulty making friends
- A need for instant gratification
- Poor impulse control
- Alcohol or substance abuse

As per American Psychiatric Association definition, a personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. It is pervasive and inflexible and has an onset in adolescence or early adulthood. It is stable over time, and leads to distress or impairment.

Some defines personality disorder as " disorders of character and patterns of perceiving and relating to the environment and oneself, marked by inflexible

traits that cause subjective (personal) distress and/or impairment in occupational or social functioning."

Thus Personality disorders are patterns of perceiving, reacting, and relating to other people and events that are relatively inflexible and that impair a person's ability to function socially. Everyone has characteristic patterns of perceiving and relating to other people and events (personality traits). That is, people tend to cope with stresses in an individual but consistent way.

Self Assessment Questions

1) What is a personality disorder?

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2) Trace historically the emergence of personality disorders as an entity.

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3) Discuss common symptoms of personality disorders.

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4) How is personality disorders defined?

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Types of Personality Disorders

The DSM-IV lists ten personality disorders, which are grouped into three clusters:

- Cluster A (odd or eccentric disorders)
  - Paranoid personality disorder
  - Schizoid personality disorder
  - Schizotypal personality disorder
- Cluster B (dramatic, emotional, or erratic disorders)
  - Antisocial personality disorder
  - Borderline personality disorder
  - Histrionic personality disorder
  - Narcissistic personality disorder
- Cluster C (anxious or fearful disorders)
  - Avoidant personality disorder
  - Dependent personality disorder
  - Obsessive-compulsive personality disorder (not the same as Obsessive-compulsive disorder)

The DSM-IV also contains a category for behavioural patterns that do not match these ten disorders, but nevertheless have the characteristics of a personality disorder. This category is labelled Personality Disorder NOS (Not Otherwise Specified).

2.4 TYPE OF PERSONALITY DISORDERS CLUSTER A

2.4.1 Paranoid Personality Disorder

People with paranoid personality disorder (PPD) have long-term, widespread and unwarranted suspicions which make them hostile, threatening or demeaning. These beliefs are steadfastly maintained in the absence of any real supporting evidence. The disorder, whose name comes from the Greek word for "madness".

They suspect strangers, and even people they know, of planning to harm or exploit them when there is no good evidence to support this belief. As a result of their constant concern about the lack of trustworthiness of others, patients with this disorder often have few intimate friends or close human contacts.

They do not fit in and they do not make good "team players." Interactions with others are characterised by wariness and not infrequently by hostility. If they marry or become otherwise attached to someone, the relationship is often characterised by pathological jealousy and attempts to control their partner. They often assume their sexual partner is "cheating" on them.

People suffering from PPD are very difficult to deal with. They never seem to let down their defenses. They are always looking for and finding evidence that others are against them. Their fear, and the threats they perceive in the innocent

statements and actions of others, often contributes to frequent complaining or unfriendly withdrawal or aloofness. They can be confrontational, aggressive and disputatious. It is not unusual for them to sue people they feel have wronged them. In addition, patients with this disorder are known for their tendency to become violent.

Symptoms

- Suspiciousness and distrust of others
- Questioning hidden motives in others
- Feelings of certainty, without justification or proof, that others are intent on harming or exploiting them
- Social isolation
- Aggressiveness and hostility
- Little or no sense of humor

Causes

The prevalence of Paranoid Personality Disorder is about 0.5% to 2.5% of the general population. It is seen in 2% to 10% of psychiatric outpatients. This disorder occurs more commonly in males. No one knows what causes paranoid personality disorder, although there are hints that familial factors may influence the development of the disorder in some cases.

There seem to be more cases of paranoid personality disorder in families that have one or more members who suffer from such psychotic disorders as schizophrenia or delusional disorder . This disorder is more common among first degree biological relatives of those with Schizophrenia and Delusional Disorder, Persecutory Type.

Other possible interpersonal causes have been proposed. For example, some therapists believe that the behaviour that characterises PPD might be learned. They suggest that such behaviour might be traced back to childhood experiences. According to this view, children who are exposed to adult anger and rage with no way to predict the outbursts and no way to escape or control them develop paranoid ways of thinking in an effort to cope with the stress. PPD would emerge when this type of thinking becomes part of the individual's personality as adulthood approaches.

Studies of identical (or monozygotic) and fraternal (or dizygotic) twins suggest that genetic factors may also play an important role in causing the disorder. Twin studies indicate that genes contribute to the development of childhood personality disorders, and paranoid personality disorders.

Treatments

Because they are suspicious and untrusting, patients with this disorder are not likely to seek therapy on their own. A particularly disturbing development or life crisis may prompt them to get help. More often, however, the legal system or the patient's relatives order or encourage him or her to seek professional treatment.

Psychotherapy: The primary approach to treatment for such personality disorders is psychotherapy . The problem is that patients with paranoid personality disorders

do not readily offer therapists the trust that is needed for successful treatment. As a result, it has been difficult to gather data that would indicate what kind of psychotherapy would work best. Therapists face the challenge of developing rapport with someone who is, by the nature of his personality disorder, distrustful and suspicious.

Medications: With individual supportive psychotherapy is the treatment of choice for this disorder, medications are sometimes used on a limited basis to treat the symptoms In addition, during periods of extreme agitation and high stress that produce delusional states, the patient may be given low doses of antipsychotic medications.

2.4.2 Schizoid Personality Disorder

Schizoid personality disorder is one of a group of conditions called eccentric personality disorders. People with these disorders often appear odd or peculiar. People with schizoid personality disorder also tend to be distant, detached, and indifferent to social relationships. They generally are loners who prefer solitary activities and rarely express strong emotion. Although the names sound alike and they might have some similar symptoms, schizoid personality disorder is not the same thing as schizophrenia. Many people with schizoid personality disorder can function fairly well. They tend to choose jobs that allow them to work alone, such as night security officers and library or labouratory workers.

Symptoms

- Detachment from other people.
- Little or no desire to form close relationships with others.
- Rarely participates in activities for fun or pleasure.
- A sense of indifference to praise and affirmation, as well as to criticism or rejection.
- Often described as cold, uninterested, withdrawn, and aloof
- Difficulty in relating with others
- Don’t desire any close relationship even with family members
- Aloof from any emotion
- Suffering from daydream and create vivid fantasies of complex inner lives.

Causes

The schizoid personality disorder has its roots in the family of the affected person. These families are typically emotionally reserved, have a high degree of formality, and have a communication style that is aloof and impersonal. Parents usually express inadequate amounts of affection to the child and provide insufficient amounts of emotional stimulus. This lack of stimulus during the first year of life is thought to be largely responsible for the person’s disinterest in forming close, meaningful relationships later in life.

People with schizoid personality disorder have learned to imitate the style of interpersonal relationships modeled in their families. In this environment, affected people fail to learn basic communication skills that would enable them to develop relationships and interact effectively with others. Their communication is often vague and fragmented, which others find confusing.

Treatments

i) **Psychodynamically oriented therapies**

A psychodynamic approach would typically not be the first choice of treatment due to the patient's poor ability to explore his or her thoughts, emotions, and behaviour. When this treatment is used, it usually centers around building a therapeutic relationship with the patient that can act as a model for use in other relationships.

ii) **Cognitive behavioural therapy**

Attempting to cognitively restructure the patient's thoughts can enhance self-insight. Constructive ways of accomplishing this would include concrete assignments such as keeping daily records of problematic behaviours or thoughts.

iii) **Group therapy**

Group therapy may provide the patient with a socialising experience that exposes them to feedback from others in a safe, controlled environment. It can also provide a means of learning and practicing social skills in which they are deficient.

iv) **Family and marital therapy**

It is unlikely that a person with schizoid personality disorder will seek this therapy.Many people with this disorder do not marry and end up living with and are dependent upon first-degree family members.

v) **Medications**

Some patients with this disorder show signs of anxiety and depression which may prompt the use of medication to counteract these symptoms. In general, there is to date no definitive medication that is used to treat schizoid symptoms.

2.4.3 Schizotypal Personality Disorder

People with classic schizotypal personalities are apt to be loners. They feel extremely anxious in social situations, but they're likely to blame their social failings on others. They view themselves as alien or outcast, and this isolation causes pain as they avoid relationships and the outside world. People with schizotypal personalities may ramble oddly and endlessly during a conversation. They may dress in peculiar ways and have very strange ways of viewing the world around them. Often they believe in unusual ideas, such as the powers of ESP or a sixth sense. At times, they believe they can magically influence people's thoughts, actions and emotions. In adolescence, signs of a schizotypal personality may begin as an increased interest in solitary activities or a high level of social anxiety.

Symptoms

- Incorrect interpretation of events, including feeling that external events have personal meaning
- Indifferent thinking, beliefs or behaviour
- Belief in special powers, such as telepathy
- Perceptual alterations, in some cases bodily illusions, including phantom pains or other distortions in the sense of touch

- Idiosyncratic speech, such as loose or vague patterns of speaking or tendency to go off on tangents
- Suspicious or paranoid ideas
- Flat emotions or inappropriate emotional responses
- Lack of close friends outside of the immediate family
- Persistent and excessive social anxiety that doesn't abate with time.

Schizotypal personality disorder can easily be confused with schizophrenia, a severe mental illness in which affected people lose all contact with reality (psychosis), While people with schizotypal personalities may experience brief psychotic episodes with delusions or hallucinations.

Causes

The schizoid personality disorder has its roots in the family of the affected person. These families are typically emotionally reserved, have a high degree of formality, and have a communication style that is aloof and impersonal. Parents usually express inadequate amounts of affection to the child and provide insufficient amounts of emotional stimulus. This lack of stimulus during the first year of life is thought to be largely responsible for the person's disinterest in forming close, meaningful relationships later in life.

People with schizoid personality disorder have learned to imitate the style of interpersonal relationships modeled in their families. In this environment, affected people fail to learn basic communication skills that would enable them to develop relationships and interact effectively with others.They often communicate vaguely and fragmented which generally confuse others and so they are being misunderstood.

Treatments

i) **Psychodynamically oriented therapies**

A psychodynamic approach would typically seek to build a therapeutically trusting relationship that attempts to counter the mistrust most people with this disorder intrinsically hold. More highly functioning schizotypals who have some capacity for empathy and emotional warmth tend to have better outcomes in psychodynamic approaches to treatment.

ii) **Cognitive-behavioural therapy**

Cognitive approaches will most likely focus on attempting to identify and alter the content of the schizotypal's thoughts. Distortions that occur in both perception and thought processes would be addressed.. This would relax some of the social anxiety felt in most interpersonal relationships and allow for some exploration of the thought processes.

iii) **Interpersonal therapy**

Treatment using an interpersonal approach would allow the individual with schizotypal personality disorder to remain relationally distant while he or she "warms up" to the therapist. Gradually the therapist would hope to engage the patient after becoming "safe" through lack of coercion.

iv) **Group therapy**

It provide the patient with a socialising experience that exposes them to feedback from others in a safe, controlled environment. It is typically recommended only for schizotypals who do not display severe eccentric or paranoid behaviour.

v) **Family and marital therapy**

It is unlikely that a person with schizoid personality disorder will seek family or marital therapy. Many schizoid types do not marry and end up living with and being dependent upon first-degree family members. If they do marry they often have problems centered on insensitivity to their partner's feelings or behaviour.

vi) **Medications**

There is considerable research on the use of medications for the treatment of schizotypal personality disorder due to its close symptomatic relationship with schizophrenia. Among otherslike Amoxapine fluoxetine have also been used successfully to reduce symptoms of anxiety, paranoid thinking, and depression.

2.5 TYPE OF PERSONALITY DISORDERS CLUSTER B

2.5.1 Antisocial Personality Disorder

Antisocial personality disorder is a type of chronic mental illness in which a person's ways of thinking, perceiving situations and relating to others are abnormal and destructive.

People with antisocial personality disorder typically have no regard for right and wrong. They may often violate the law and the rights of others, landing in frequent trouble or conflict. They may lie, behave violently, and have drug and alcohol problems. And people with antisocial personality disorder may not be able to fulfill responsibilities to family, work or school.

Antisocial personality disorder is sometimes known as sociopathic personality disorder. A sociopath is a particularly severe form of antisocial personality disorder. On the other hand about 80-85% of incarcerated criminals have Antisocial Personality Disorder. However, only about 20% of these criminals would qualify for a diagnosis of being a psychopath. Most psychopaths meet the criteria for Antisocial Personality Disorder, but most individuals with Antisocial Personality Disorder are not psychopaths. Psychopaths account for 50 percent of all the most serious crimes committed, including half of all serial killers and repeat rapists.

Symptoms

- They lack of conforming to laws and repeatedly commit crimes
- Repeatedly deceitful in relationships
- Failure to think or plan ahead
- Tendency of irritability, anger and aggression
- Disregard for personal safety or safety for others.
- Persistant lack of taking responsibility
- Lack of guilt for any wrong activity

Causes

Studies of adopted children indicate that both genetic and environmental factors influence the development of this disorder. Both biological and adopted children of people diagnosed with the disorder have an increased risk of developing it. Children born to parents diagnosed with antisocial personality but adopted into other families resemble their biological more than their adoptive parents. The environment of the adoptive home, however, may lower the child's risk of developing the mentioned disorder.

Researchers have linked antisocial personality disorder to childhood physical or sexual abuse,some undiagnosed neurological disorders and low IQ. But, as with other personality disorders, no one has identified any specific cause or causes of antisocial personality disorder. Persons diagnosed with antisocial personality also have an increased incidence of somatisation and substance-related disorders.

Treatment

Antisocial personality disorder is highly unresponsive to any form of treatment, in part because persons with antisocial personality disorder rarely seek treatment voluntarily. There are medications that are effective in treating some of the symptoms of the disorder, noncompliance with medication regimens or abuse of the drugs prevents the widespread use of these medications. The most successful treatment programs for this personality disorders are long-term structured residential settings in which the patient systematically earns privileges as he or she modifies behaviour. It is unlikely, however, that they would maintain good behaviour if they left the disciplined environment. Unfortunately, these approaches are rarely if ever effective. Many persons with this disorder use therapy sessions to learn how to turn "the system" to their advantage.

2.5.2 Borderline Personality Disorder

Borderline personality disorder is a personality disorder described as a prolonged disturbance of personality function in a person, characterised by depth and variability of moods. The disorder typically involves unusual levels of instability in mood; black and white thinking, or splitting; the disorder often manifests itself in idealisation and devaluation episodes, as well as chaotic and unstable interpersonal relationships, self-image, identity, and behaviour; as well as a disturbance in the individual's sense of self. In extreme cases, this disturbance in the sense of self can lead to periods of dissociation.

This disorder splitting includes a switch between idealising and demonising others. This, combined with mood disturbances, can undermine relationships with family, friends, and co-workers. This disorder disturbances also may include self-harm. Without treatment, symptoms may worsen, leading (in extreme cases) to suicide attempts.

Symptoms

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships
- Identity disturbance,
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

- Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
- Emotional instability due to significant reactivity of mood Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Stress-related paranoid thoughts or severe dissociative symptoms
- Distortions in cognition.

Causes

It has been seen that borderline personality disorder develops as a result of biological, genetic and environmental factors. There is strong evidence to support a link between distressing childhood experiences, particularly involving caregivers, and borderline personality disorder. The types of experiences that may be associated with this disorder include, but are not limited to, physical and sexual abuse, early separation from caregivers, emotional or physical neglect, emotional abuse, and parental insensitivity.

In particular, studies have shown that a variation in a gene which controls the way the brain uses serotonin (a natural chemical in the brain) may be related to borderline personality disorder. It appears that individuals who have this specific variation of the serotonin gene may be more likely to develop this disorder if they also experience difficult childhood events (e.g., separation from supportive caregivers). In addition, a number of studies have shown that people with this disorder have differences in both the structure of their brain and in brain function. Borderline personality disorder has been associated with excessive activity in parts of the brain that control the experience and expression of emotion.

Treatment

i) **Schema Focused Therapy:** Schema focused therapy for this focuses on confronting maladaptive beliefs that are developed as a result of early life events.

ii) **Mentalisation Based Therapy:** Mentalisation based therapy for the disorder focuses on helping the client to recognise mental states, such as thoughts, feelings, and wishes, in themselves and in others.

iii) **Transference Focused Psychotherapy:** Transference focused psychotherapy uses elements of the relationship between the client and the therapist to help reduce the symptoms.

iv) **Medications:** Some of the most commonly prescribed medications for the disorder include antidepressants, antipsychotics, anxiolytics (anti-anxiety), and mood stabilisers/anticonvulsants. Other potential treatments, such as omega-3-fatty acids, are also being explored.

v) **Hospitalisation:** BPD is associated with very intense emotional experiences. As a result, people with BPD may need intensive BPD treatment.

2.5.3 Histrionic Personality Disorder

Histrionic personality disorder, often abbreviated as (HPD), is a type of personality disorder in which the affected individual displays an enduring pattern of attention-

seeking and excessively dramatic behaviours beginning in early adulthood and present across a broad range of situations. Individuals with HPD are highly emotional, charming, energetic, manipulative, seductive, impulsive, erratic, and demanding.

It has a unique position among the personality disorders in that it is the only personality disorder explicitly connected to a patient's physical appearance.. Some research has suggested that the connection between histrionic personality disorder and physical appearance holds for women rather than for men. Both women and men express a strong need to be the center of attention. Individuals with the disorder exaggerate, throw temper tantrums, and cry if they are not the center of attention. Cognitive style can be defined as a way in which an individual works with and solves cognitive tasks such as reasoning, learning, thinking, understanding, making decisions, and using memory.

Symptoms

- Center of attention
- Sexually seductive
- Shifting emotions
- Physical appearance.
- Speech style
- Dramatic behaviours
- Suggestibility
- Overestimation of intimacy

Causes

This disorder is not definitively known, it is thought that HPD may be caused by biological, developmental, cognitive, and social factors. Neurotransmitters are chemicals that communicate impulses from one nerve cell to another in the brain and these impulses dictate behaviour.

The tendency towards an excessively emotional reaction to rejection, common among patients with HPD, Most psychoanalysts agree that a traumatic childhood contributes towards the development of HPD. Bio social issues also contribute to the development of personality.

Socio cultural and personal variables have found some connections between the age of individuals with HPD and the behaviour displayed by these individuals. The symptoms of HPD are long-lasting; however, histrionic character traits that are exhibited may change with age.

Treatment

i) **Psychodynamic therapy**

Like other personality disorders, may require several years of therapy and may affect individuals throughout their lives. Some professionals believe that psychoanalytic therapy is a treatment of choice for this disorder because it assists patients to become aware of their own feelings. Long-term psychodynamic therapy needs to target the underlying conflicts of individuals with HPD and to assist patients in decreasing their emotional reactivity.

ii) **Cognitive-behavioural therapy**

Cognitive therapy is a treatment directed at reducing the dysfunctional thoughts of individuals with this disorder. Such thoughts include themes about not being able to take care of oneself. Cognitive-behavioural training in relaxation for an individual with HPD emphasises challenging automatic thoughts about inferiority and not being able to handle one's life.

iii) **Group therapy**

Group therapy is suggested to assist individuals with HPD to work on interpersonal relationships. Psychodrama techniques or group role play can assist individuals with HPD.

iv) **Family therapy**

Family therapy can support family members to meet their own needs without supporting the histrionic behaviour of the individual with HPD who uses dramatic crises to keep the family closely connected.

v) **Medications**

Pharmacotherapy is not a treatment of choice for individuals with HPD unless HPD occurs with another disorder.

vi) **Alternative therapies**

Meditation has been used to assist extroverted patients with this disorder to relax and to focus on their own inner feelings. Some therapists employ hypnosis to assist individuals with HPD to relax.

2.5.4 Narcissistic Personality Disorder

Narcissistic personality disorder is a condition characterised by an inflated sense of self-importance, need for admiration, extreme self-involvement, and lack of empathy for others. Individuals with this disorder are usually arrogantly self-assured and confident. They expect to be noticed as superior. Many highly successful individuals might be considered narcissistic. However, this disorder is only diagnosed when these behaviours become persistent and very disabling or distressing. The word "narcissism" comes from a Greek myth in which a handsome young man named Narcissus sees his reflection in a pool of water and falls in love with it.

Narcissistic personality disorder is one of a group of conditions called dramatic People with these disorders have intense, unstable emotions and a distorted self-image. Narcissistic personality disorder is further characterised by an abnormal love of self, an exaggerated sense of superiority and importance, and a preoccupation with success and power.

Symptoms

- Self centered and boastful
- Seek constant attention and admiration
- Considering ownselves better than others
- Exaggerate own talents and achievements
- Believing for own special treatments

- Setting unrealistic goal
- Believing that you're better than others
- Fantasizing about power, success and attractiveness
- Exaggerating your achievements or talents
- Expecting constant praise and admiration
- Failing to recognise other people's emotions and feelings
- Expecting others to go along with your ideas and plans
- Taking advantage of others.

Causes

According to Freud concept that the root of narcissim lies from the childhood itself. It starts with the problem in parent child relationship. Child grows out of primary narcissism through opportunities to be mirrored by (i.e., gain approval from) his or her parents and to idealise them, acquiring a more realistic sense of self and a set of personal ideals and values through these two processes. On the other hand, if the parents fail to provide appropriate opportunities for idealisation and mirroring, the child remains "stuck" at a developmental stage in which his or her sense of self remains grandiose and unrealistic while at the same time he or she remains dependent on approval from others for self-esteem.

This also views that the disorder roots in the child's defense against a cold and unempathetic parent, usually the mother. Emotionally hungry and angry at the depriving parents, the child withdraws into a part of the self that the parents value, whether looks, intellectual ability, or some other skill or talent. This part of the self becomes hyperinflated and grandiose. Any perceived weaknesses are "split off" into a hidden part of the self. Splitting gives rise to a lifelong tendency to swing between extremes of grandiosity and feelings of emptiness and worthlessness. On the other dimension of disorder also count due to social and historical context.

Treatment

i) **Hospitalisation**

The hospitalisation of patients with severe Narcissistic Personality occurs frequently. For some, such as those who are quite impulsive or self-destructive, or who have poor reality-testing, r. Hospitalisations should be brief, and the treatment specific to the particular symptom involved.

ii) **Psychosocial Treatment**

i) Individual Psychotherapy: Most psychiatrists will, as a practical matter, treat most of their severely narcissistic patients for symptoms related to crises and relatively external. Positive transference and therapeutic alliance should not be relied upon, since the patient may not be able to acknowledge the real humanness of the therapist but may have to see him/her as either superhuman or devalued

ii) Group Therapy: The goals are to help the patient develop a healthy individuality (rather than a resilient narcissism) so that he or she can acknowledge others as separate persons, and to decrease the need for self-defeating coping mechanisms.

2.6 TYPES OF PERSONALITY DISORDERS CLUSTER C

2.6.1 Avoidant Personality Disorder

Anxious (Avoidant) Personality Disorder is a condition characterised by extreme shyness, feelings of inadequacy, and sensitivity to rejection. These individuals feel inferior to others. This disorder is only diagnosed when these behaviours become persistent and very disabling or distressing. This diagnosis should be used with great caution in children and adolescents for whom shy and avoidant behaviour may be appropriate (e.g., new immigrants).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), avoidant personality disorder (APD) is characterised by a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. Individuals who meet the criteria for avoidant personality disorder are often described as being extremely shy, inhibited in new situations, and fearful of disapproval and social rejection.

Similar to other personality disorders, avoidant personality disorder becomes a major component of a person's overall character and a central theme in an individual's pattern of relating to others. Also similar to other personality disorders, the diagnosis is rarely made in individuals younger than 18 years, even if the criteria are met. The literature regarding childhood avoidant personality disorder is extremely limited.

Symptoms

- Extreme shyness
- Sensitivity to criticism and rejection
- Low self-esteem and feelings of inadequacy
- A desire for closeness with others but difficulty forming relationships with people outside of immediate family.
- Avoidance of social situations, including those related to school or work.
- Person avoids occupational activities
- Person is reluctant to participate in any social involvement.
- Person is preoccupied with criticized or rejected.

Causes

The cause of avoidant personality disorder is not clearly defined, and may be influenced by a combination of social, genetic, and biological factors. Avoidant personality traits typically appear in childhood, with signs of excessive shyness and fear when the child confronts new people and situations.

These characteristics are also developmentally appropriate emotions for children, however, and do not necessarily mean that a pattern of avoidant personality disorder will continue into adulthood. Many persons diagnosed with avoidant personality disorder have had painful early experiences of chronic parental criticism and rejection.

The need to bond with the rejecting parents makes the avoidant person hungry for relationships but their longing gradually develops into a defensive shell of self-protection against repeated parental criticisms.

Treatment

i) **Psychodynamically oriented therapies:** These approaches are usually supportive; the therapist empathizes with the patient's strong sense of shame and inadequacy in order to create a relationship of trust. Therapy usually moves slowly at first because persons with avoidant personality disorder are mistrustful of others.

ii) **Cognitive-behavioural therapy:** Cognitive-behavioural therapy (CBT) may be helpful in treating individuals with avoidant personality disorder. This approach assumes that faulty thinking patterns underlie the personality disorder, and therefore focuses on changing distorted cognitive patterns by examining the validity of the assumptions behind them.

iii) **Group therapy:** It may provide patients with avoidant personality disorder with social experiences that expose them to feedback from others in a safe, controlled environment. They may, however, be reluctant to enter group therapy due to their fear of social rejection.

iv) **Family and marital therapy**: Family or couple therapy can be helpful for a patient who wants to break out of a family pattern that reinforces the avoidant behaviour..

v) **Medications:** The use of monoamine oxidase inhibitors (MAOIs) has proven useful in helping patients with avoidant personality disorder to control symptoms of social unease and experience initial success.

2.6.2 Dependent Personality Disorder

Dependent personality disorder is one of a group of conditions called anxious personality disorders, which are marked by feelings of nervousness and fear. DPD also is marked by helplessness, submissiveness, a need to be taken care of and for constant reassurance, and an inability to make decisions. This is one of the most frequently diagnosed personality disorders. It appears to occur equally in men and women, and usually appears in early to middle adulthood. It was formerly known as asthenic personality disorder, is a personality disorder that is characterised by a pervasive psychological dependence on other people. The difference between a 'dependent personality' and a 'dependent personality disorder' is somewhat subjective, which makes a diagnosis sensitive to cultural influences such as gender role expectations.

Symptoms

- Chronic and pervasive pattern of dependent, submissive, and needy behaviour
- Seek out excessive advice, approval, and encouragement
- Sensitivity to criticism or rejection
- Low self-confidence and self-esteem.
- An inability to make decisions without direction from others
- Feelings of helplessness when alone

- An inability to disagree with others
- Extreme devastation when close relationships end and a need to immediately begin a new relationship
- Difficulty in making everyday decisions.

Causes

It is commonly thought that the development of dependence in these individuals is a result of over-involvement and intrusive behaviour by their primary caretakers. Families of those with dependent personality disorder are often do not express their emotions and are controlling; they demonstrate poorly defined relational roles within the family unit.

Individuals with dependent personality disorder often have been socially humiliated by others in their developmental years. They may carry significant doubts about their abilities to perform tasks, take on new responsibilities, and generally function independently of others. This reinforces their suspicions that they are incapable of living autonomously.

Treatment

i) **Psychodynamically oriented therapies**

The preferred approach is a time-limited treatment plan consisting of a predetermined number of sessions. This has been proved to facilitate the exploration process of dependency issues more effectively than long-term therapy in most patients.

ii) **Cognitive-behavioural therapy**

Cognitive-behavioural approaches attempt to increase the affected person's ability to act independently of others, improve their self-esteem, and enhance the quality of their interpersonal relationships.

iii) **Interpersonal therapy**

Treatment using an interpersonal approach can be useful because the individual is usually receptive to treatment and seeks help with interpersonal relationships. The therapist would help the patient explore their long-standing patterns of interacting with others, and understand how these have contributed to dependency issues.

iv) **Family and marital therapy**

Individuals with dependent personality disorder are usually brought to therapy by their parents. They are often young adults who are struggling with neurotic or psychotic symptoms. Marital therapy can be productive in helping couples reduce the anxiety of both partners who seek and meet dependency needs that arise in the relationship.

v) **Medications**

Individuals with dependent personality disorder can experience anxiety and depressive disorders as well. In these cases, it may occasionally prove useful to use antidepressants or anti-anxiety agents.

2.6.3 Obsessive Compulsive Personality Disorder

Obsessive-compulsive personality disorder (OCPD) is a type of personality disorder marked by rigidity, control, perfectionism, and an overconcern with work at the expense of close interpersonal relationships. Persons with this disorder often have trouble relaxing because they are preoccupied with details, rules, and productivity. They are often perceived by others as stubborn, stingy, self-righteous, and uncooperative.

Symptoms

- Preoccupation with details, rules, lists, order, organisation, or schedules to the point at which the major goal of the activity is lost.
- Excessive concern for perfection in small details that interferes with the completion of projects.
- Dedication to work and productivity that shuts out friendships and leisure-time activities, when the long hours of work cannot be explained by financial necessity.
- Excessive moral rigidity and inflexibility in matters of ethics and values that cannot be accounted for by the standards of the person's religion or culture.

Causes

Faulty parenting has been viewed as a major factor in the development of personality disorders. Current studies have tended to support the importance of early life experiences, finding that healthy emotional development largely depends on two important variables: parental warmth and appropriate responsiveness to the child's needs. When these qualities are present, the child feels secure and appropriately valued.

By contrast, many people with personality disorders did not have parents who were emotionally warm toward them. Patients with OCPD often recall their parents as being emotionally withholding and either overprotective or overcontrolling. Children with this type of upbringing are also likely to choke down the anger they feel toward their parents; they may be outwardly obedient and polite to authority figures, but at the same time treat younger children or those they regard as their inferiors harshly.

Genetic contributions to OCPD have not been well documented. Cultural influences may, however, play a part in the development of OCPD.

Self Assessment Questions

1) What is antisocial personality disorder?

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2) Define antisocial personality disorder.

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3) What is avoidant personality disorder?

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2.7 LET US SUM UP

Thus personality disorder does not mean that some one's personality is fatally flawed or represent some freak behaviours, but in fact these disorders are not very uncommon and deeply troubling and painful. Personality disorders cannot be understood independently from healthy personalities. Everyone has a personality and personality disorders reflect a variant form of normal healthy personality. Thus personality disorder exists as a special case of a normal healthy personality in much the same way as a square is a special case of the more general construct of a rectangle. Recently many psychologists and psychiatrists felt that sometimes treatment did not help people with a personality disorder, but specific types of talk therapy have experienced more beneficial for improvement.

In this unit we discussed about the different personality disorders in terms of the three clusters, viz., A, B, C, and each of these disorders were taken up and dealt with in detail, in regard to symptomatology, causes and treatment of the disorders.

2.8 UNIT END QUESTIONS

1) Discuss personality disorders with its common symptoms.

2) Differentiate between antisocial and borderline personality disorder.

3) Discuss narcissist personality disorder with its symptoms and causes.

4) What are the general treatments necessary for personality disorders? Discuss.

2.9 SUGGESTED READINGS AND REFERENCES

Millon, Theodore and Seth, Grossman. (2002). *Personality Disorders In Modern Life* ,John Wiley and Sons, NY

Dobbert, Duanne (2004). *Understanding Personality Disorders: An Introduction* Praeger publisher Westport.

References

Allen, J.G., Fonagy, P. (Eds.). (2006). *The Handbook of Mentalisation Based Treatment*. Chicester: Wiley and Sons.

Alden, L. E., Laposa, J.M., Taylor, C.T., Ryder, A.G. (2002). Avoidant Personality Disorder: Current Status and Future Directions. *Journal of Personality Disorders*, 16(1):1-29.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th ed., Text Revision)*. Washington, DC: Author.

Bartz, J., Kaplan, A., Hollander, E. (2007). Obesessive Compulsive Personality Disorder. In O'Donohue, W.T., Fowler, K.A., Lilienfeld, S.O. (Eds.). *Personality Disorders: Toward the DSM V*. Thousand Oaks: Sage Publications.

UNIT 3 PARAPHILIAS

Structure

3.0 INTRODUCTION

Paraphilias are sometimes referred to as sexual deviations or perversions. Paraphilias include fantasies, behaviours, or sexual urges focusing on unusual objects, activities, or situations. Paraphilias include sexual urges or sexual fantasies with non-human objects. It also involves humiliation or suffering of oneself or another person. This rare disorder classified by DSM IV TR and characterised by six month period of recurrent, intense, sexually arousing fantasies or sexual urges involving a specific act depending on the paraphilia. The act is commonly followed by arousal and orgasm usually achieved by masturbation and fantasy. These are not very much recognised and often are difficult to treat for several reasons. People who have these disorders conceal them; experience guilt and shame have financial or legal problems and are generally uncooperative. In this unit we will be discussing the paraphilias that is sexual deviations as an abnormality and present the definitions and concepts of paraphilias. We will then present the different types of paraphilias and how these are caused and what types of treatment are available for the same.

3.1 OBJECTIVES

By the end of this unit, you will be able to:

- Define paraphilia;
- Enlist various types of paraphilia;

- Symptoms and causes of paraphilia; and
- Treatment approaches of paraphilia.

3.2 CONCEPT AND TYPES OF PARAPHILIAS

The paraphilias are a group of persistence sexual behaviour patterns in which unusual objects, rituals or situations are required for full sexual satisfaction. The difference between the normal and paraphilic persons is that sexuality focuses on the acts or objects in question, without which orgasm is impossible.

Paraphilias have a compulsive quality, of orgasmic release 4 to 10 times a day. They generally do not change their sexual preferences.

3.2.1 Definition of Paraphilias

Paraphilia (in Greek *para* ðáñÜ = beside and *-philia* öéëßá = friendship, having the meaning of love) is a biomedical term used to describe sexual arousal to objects, situations, or individuals that are not part of normative stimulation and that may cause distress or serious problems for the paraphiliac or persons associated with him or her. A paraphilia involves sexual arousal and gratification towards sexual behaviour that is atypical and extremeNon-human objects.

The view of paraphilias as disorders is not universal. Some groups seeking greater understanding and acceptance of sexual diversity have lobbied for changes to the legal and medical status of unusual sexual interests and practices. In the current version of the DSM (DSM-IV-TR), a paraphilia is not diagnosable as a psychiatric disorder unless it causes distress to the individual or harm to others.

The DSM-5 draft adds a terminology distinction between the two cases, stating that "paraphilias are not *ipso facto* psychiatric disorders", and defining *paraphilic disorder* as "a paraphilia that causes distress or impairment to the individual or harm to others".

Paraphilias are sexual feelings or behaviours that may involve sexual partners that are not human, not consenting, or that involve suffering by one or both partners.

According to the *Diagnostic and Statistical Manual of Mental Disorders (known as the* DSM) fourth edition text revised (*DSM-IV-TR*), the manual used by mental health professionals to diagnose mental disorders, it is not uncommon for an individual to have more than one paraphilia.

3.2.2 Types of Paraphilias

The *DSM-IV-TR* lists the following paraphilias. The *DSM-IV-TR* also includes a category for paraphilia not otherwise specified, which is the category for the less common paraphilias, including necrophilia, zoophilia, and others.

The 8 different types of paraphilias are given below:

- Fetishism
- Transvestic fetishism
- Voyeurism

- Exhibitionism
- Sexual sadism
- Sexual masochism
- Pedophilia
- Fotteurism

3.2.3 Causes of Paraphilias

Almost all paraphilias are males.

Male vulnerability to paraphilias is linked to their greater dependency on visual sexual imagery.

People with paraphilias have generally more than one paraphilia.

3.2.4 Treatment for Paraphilias

Treatment combining cognitive and behavioural elements appear relatively more successful in treating this condition.

Aversion therapy is another treatment technique that seems to work effectively for this condition. That is, aversive conditioning to deviant sexual fantasies.

Assisted covert sensitisation: This therapy involves having the patient imagine a deviant sexual arousal scene. At the point where arousal is high, the patient imagines aversive consequences and a foul odour is introduce via an open vial to help condition a real aversion to these deviant ones.

3.3 TYPES OF PARAPHILIAS

As mentioned earlier there eight different types of paraphilias. Let us deal with these one by one.

3.3.1 Fetishism

Sexual paraphilia, or sexual fetishism this is where Sexual arousal or pleasure is derived from being robbed, conned, cheated, blackmailed or otherwise forced to loose out fiscally by a partner or complete stranger.

The strong emotions of frustration, annoyance, rage, fear or submission are subconsciously drawn upon by the person with Chremastistophilia and focused into sexual arousal/gratification. This is seen as Edge play as it can be genuinely life threatening to seek out a stranger to rob oneself purely for sexual release. In recent years the genera of fetish websites focused at such people has grown dramatically. It has been stated that financial dominants, chat with their 'financial submissives' and talk about what the dominant will do with money 'taken' from the submissive, etc., generally stir the strong emotions that fuel this paraphilia.

Symptoms

- Sexual arousal gained from wearing clothes of the opposite gender
- Sexual pleasure associated with wearing clothes of the opposite gender
- Recurring intense sexual fantasies involving wearing clothes of the opposite gender

- Recurring intense sexual urges involving wearing clothes of the opposite gender
- Recurring intense sexual behaviours involving wearing clothes of the opposite gender

3.3.2 Transvestism

This is a practice of wearing the clothes of the opposite sex (cross-dressing), generally to derive some kind of sexual pleasure. It is often mistakenly associated with homosexuality; in fact, however, transvestites may be either heterosexual or homosexual, and the practice of cross-dressing is sometimes even ridiculed among homosexuals. The transvestite must also be distinguished from the transsexual, who desires to become a functioning member of the opposite sex; most transvestites are men who comfortably fill male roles in society and are satisfied with their biological sex. Transsexuals, both male and female, are uncomfortable with their sex .

Symptoms

Symptoms of transvestic fetishism mostly involve touching or wearing items of clothing that are considered typically feminine. This initial interest may progress to wearing undergarments or other items that can be hidden from the view of others while providing arousal to the wearer.

Over time, the extent of dressing in women's clothing expands, sometimes to the point of dressing as a woman on a regular basis. A developed transvestic fetish often involves feminine hair styling and the use of women's cosmetics and accessories.

In some persons diagnosed with transvestic fetishism, the motivation for cross-dressing may change over time from a search for sexual excitement to simple relief from stress, depression, or anxiety.

Causes

The basis for a transvestic fetish is obtaining sexual gratification by dressing in clothing appropriate for the opposite sex. The cause may be adolescent curiosity. A person with a transvestic fetish may not be aware of its roots. Transvestic fetishism sometimes begins when a young boy dresses up in the clothes of an older sister or his mother. The activity is continued because it is enjoyable but the reasons for the enjoyment remain unconscious. In other cases a boy's mother may initiate the cross-dressing by dressing him as if he were a girl. This behaviour is sometimes related to the mother's anger at men or to a preference for having daughters rather than sons.

Persons with transvestic fetishes should not be assumed to be homosexual. According to *DSM-IV-TR*, most men who practice cross-dressing are basically heterosexual in their orientation. Some, however, have occasional sexual encounters with other men.

Treatment

In the earliest period of behaviour therapy, transvestic fetishes were narrowly viewed as inappropriate behaviour that was confined to a limited range of situations, and were sometimes treated with aversion therapy. This approach

was largely unsuccessful. Persons with fetishes have also been treated by using a form of behavioural therapy known as orgasmic reorientation, which attempts to help people learn to respond sexually to culturally appropriate stimuli. This treatment also has had limited success.

Most persons who have a transvestic fetish never seek treatment from professionals. Most are capable of achieving sexual gratification in culturally appropriate situations. Their preoccupation with cross-dressing is viewed as essentially harmless to other persons, since transvestism is not associated with criminal activities or forcing one's sexual preferences on others. As of 2002, American society has developed tolerance for transvestites, thus further reducing the demand for professional treatment.

3.3.3 Voyeurism

This comes from a French term *voyeur*, "one who looks") can take several forms, but its principal characteristic is that the voyeur does not normally relate directly with the subject of their interest, who is often unaware of being observed. Voyeurism is a psychosexual disorder in which a person derives sexual pleasure and gratification from looking at the naked bodies and genital organs or observing the sexual acts of others. The voyeur is usually hidden from view of others. Voyeurism is a form of paraphilia.

A variant form of voyeurism involves listening to erotic conversations. This is commonly referred to as telephone sex, although it is usually considered voyeurism primarily in the instance of listening to unsuspecting persons.

The object of voyeurism is to observe unsuspecting individuals who are naked, in the process of undressing or engaging in sexual acts. The person being observed is usually a stranger to the observer. The act of looking or peeping is undertaken for the purpose of achieving sexual excitement. The observer generally does not seek to have sexual contact or activity with the person being observed.

Frequently, a voyeur may have a fantasy of engaging in sexual activity with the person being observed. In reality, this fantasy is rarely consummated.

Symptoms

- Recurrent, intense or sexually arousing fantasies, sexual urges, or behaviours
- Fantasies, urges, or behaviours that cause significant distress to an individual or are disruptive of his or her everyday functioning.
- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.
- The fantasies, sexual urges, or behaviours cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Causes

There is no scientific consensus concerning the basis for voyeurism. Most experts attribute the behaviour to an initially random or accidental observation of an unsuspecting person who is naked, in the process of disrobing, or engaging in

sexual activity. Successive repetitions of the act tend to reinforce and perpetuate the voyeuristic behaviour.

Treatment

For treatment to be successful, a voyeur must want to modify existing patterns of behaviour. This initial step is difficult for most voyeurs to admit and then take. Most must be compelled to accept treatment. This may often be the result of a court order.

Behavioural therapy is commonly used to try to treat voyeurism. The voyeur must learn to control the impulse to watch non-consenting victims, and just as importanly to acquire more acceptable means of sexual gratification. Outcomes of behavioural therapy are not known. There are no direct drug treatments for voyeurism.

Voyeurism is a criminal act in many jurisdictions. It is usually classified as a misdemeanor. As a result, legal penalties are often minor. The possibility of exposure and embarrassment may deter some voyeurs. It is also not easy to prosecute voyeurs as intent to watch is difficult to prove. In their defense statements, they usually claim that the observation was accidental.

3.3.4 Exhibitionism

Exhibitionism, colloquially referred to flashing, is behaviour by a person that involves the exposure of private parts of his or her body to another person in a situation when they would not normally be exposed, such as in a public place, with a tendency toward an extravagant.

Exhibitionism is described in the *DSM-IV-TR* as the exposure of one's genitals to a stranger, usually with no intention of further sexual activity with the other person. For this reason, the term exhibitionism is sometimes grouped together with expression, "voyeurism," ("peeping," or watching an unsuspecting person or people, usually strangers, undressing or engaging in sexual activity) as a "hands-off" paraphilia.

This contrasts with the "hands on disorders" which involve physical contact with other persons. The act may be at least partially sexual or intended to attract the attention of another or others, or to shock. Some people have a psychological compulsion to sexually expose themselves.

The condition is sometimes called apodysophilia. In some situations exposing in public is a crime of indecent exposure or public nuisance. Though the offense is not often prosecuted, it is considered serious when the flasher is a man. Public exhibitionism by women has been recorded since classical times, often in the context of women shaming groups of men into committing, or inciting them to commit, some public action.

In some cases, the exhibitionist masturbates while exposing himself (or while fantasizing that he is exposing himself) to the other person.

Some exhibitionists are aware of a conscious desire to shock or upset their target; while others fantasize that the target will become sexually aroused by their display.

Types of exposure

i) **Anasyrma:** The lifting of the skirt when not wearing underwear, to expose genitals.

ii) **Flashing:** Chiefly the momentary display of bare female breasts by a woman with an up-and-down lifting of the shirt and/or bra. It can also involve the exposure of a man's or woman's genitalia.

iii) **Martymachlia:** A paraphilia which involves sexual attraction to having others watch the execution of a sexual act.

iv) **Mooning:** The display of bare buttocks by pulling down of trousers and underwear. There tends to be a gendered double standard here: with males, the act is most often done for the sake of humor, disparagement, and/or mockery than for sexual excitement, whereas with females, the reverse tends to be true, and sexual arousal (or at least sexual attention) of those mooned is the intent.

v) **Streaking:** The act of running nude through a public place.

vi) **Candaulism:** When a person exposes their partner in a sexually explicit manner.

Symptoms

These symptoms can be mild, moderate or severe or catastrophic and these are explained below.

i) **Mild:** The person has recurrent fantasies of exposing himself, but has rarely or never acted on them.

ii) **Moderate:** The person has occasionally exposed himself (three targets or fewer) and has difficulty controlling urges to do so.

iii) **Severe:** The person has exposed himself to more than three people and has serious problems with control.

A fourth level of severity, catastrophic, would not be found in exhibitionists without other paraphilias. This level denotes the presence of sadistic fantasies which, if acted upon, would result in severe injury or death to the victim.

Because exhibitionism is a hands-off paraphilia, it rarely rises above the level of moderate severity in the absence of other paraphilias.

Causes

i) **Biological theories:** These generally hold that testosterone, the hormone that influences the sexual drive in both men and women, increases the susceptibility of males to develop deviant sexual behaviours. Some medications used to treat exhibitionists are given to lower the patients' testosterone levels.

ii) **Learning theories:** Several studies have shown that emotional abuse in childhood and family dysfunction are both significant risk factors in the development of exhibitionism.

iii) **Psychoanalytical theories:** These are based on the assumption that male gender identity requires the male child's separation from his mother psychologically so that he does not identify with her as a member of the

same sex, the way a girl does. It is thought that exhibitionists regard their mothers as rejecting them on the basis of their different genitals. Therefore, they grow up with the desire to force women to accept them by making women look at their genitals.

iv) **Head trauma:** There are a small number of documented cases of men becoming exhibitionists following traumatic injury (TBI) without previous histories of alcohol abuse or sexual offenses.

A childhood history of attention-deficit/hyperactivity disorder (ADHD). The reason for the connection is not yet known, but researchers at Harvard have discovered that patients with multiple paraphilias have a much greater likelihood of having had ADHD as children than men with only one paraphilia.

Treatments

Psychotherapy

Several different types of psychotherapy have been found helpful in treating exhibitionism:

Cognitive-behavioural therapy (CBT): This approach is generally regarded as the most effective form of psychotherapy for exhibitionism. Patients are encouraged to recognise the irrational justifications that they offer for their behaviour, and to alter other distorted thinking patterns.

Orgasmic reconditioning: In this technique, the patient is conditioned to replace fantasies of exposing himself with fantasies of more acceptable sexual behaviour while masturbating.

Group therapy

Couples therapy

Medications

Selective serotonin reuptake inhibitors (SSRIs). The SSRIs show promise in treating the paraphilias, as well as depression and other mood disorders. It has been found that decreased levels of serotonin in the brain result in an increased sex drive.

The SSRIs are appropriate for patients with mild- or moderate-level paraphilias; these patients include the majority of exhibitionists.

Female hormones. Estrogens have been used to treat sexual offenders since the 1940s. Medroxyprogesterone acetate, or MPA, is the most widely used hormonal medication in the U.S. for the treatment of people with exhibitionism..

3.3.5 Sexual Sadism

The essential feature of sexual sadism is a feeling of sexual excitement resulting from administering pain, suffering, or humiliation to another person. The pain, suffering, or humiliation inflicted on the other is real; it is not imagined and may be either physical or psychological in nature. A person with this disorder is also called as a sadist.

The name of the disorder is derived from the proper name of the Marquis Donatien de Sade (1740-1814), a French aristocrat who became notorious for writing novels around the theme of inflicting pain as a source of sexual pleasure.

Symptoms

Individuals with sexual sadism derive sexual excitement from physically or psychologically administering pain, suffering, and/or humiliation to another person, who may or may not be a consenting partner.

A description of symptoms related to Sexual Masochism and Sadism, recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.

Difficulty with sleep, such as difficulty falling asleep, restless, broken sleep, a need for more sleep or, over sleeping.

A change in appetite either eating more or eating less.

The disorder is characterised by either intense sexually arousing fantasies, urges, or behaviours in which the individual is sexually aroused by causing humiliation or physical suffering of another person.

Causes

There is no such cause or theory explaining the origin of sexual sadism, or of sadomasochism. Some researchers attempt to explain the presence of sexual paraphilias in general as the result of biological factors. Evidence for this viewpoint comes from abnormal findings from neuropsychological and neurological tests of sex offenders.

It is also believed that brain injury, schizophrenia or any other mental disorders often lead to sexual disorders. Another theory about paraphilias is derived from learning theory. It suggests that paraphilias develop because the person is required to suppress, or squelch the inappropriate sexual fantasies.

Because the fantasies are not acted out initially, the urge to carry them out increases. When the person finally acts upon the fantasies, they are in a state of considerable distress and/or arousal.

Rather than suppressing fantasies, most people who are eventually arrested for crimes involving sexual sadism begin with milder forms of acting on them and progressing to more harmful ways of acting out. In other words, the severity of sadistic acts tends to increase over time.

Treatment

i) Behaviour therapy

This is mostly used to treat paraphilias. This approach to treatment includes the management and conditioning of arousal patterns and masturbation. Therapies involve cognitive restructuring, social skill training**.**

ii) Medication

This may be used to reduce fantasies and behaviour relating to paraphilias. This form of treatment is especially recommended for people who exhibit sadistic behaviours that are dangerous to others. The medications that may be used include female hormones (most commonly medroxyprogesterone acetate, or MPA), which

speed up the clearance of testosterone from the bloodstream. Also, antiandrogen medications, which block the body's uptake of testosterone. and the selective serotonin reuptake inhibitors, or SSRIs.

Treatment of sexual sadism may also be complicated by health problems related to sexual behaviour. Sexually transmitted diseases and other medical problems may be present, especially when the sadistic behaviour involves the release of blood or other body fluids.

3.3.6 Sexual Masochism

The essential feature of sexual masochism is the feeling of sexual arousal or excitement resulting from receiving pain, suffering, or humiliation. The pain, suffering, or humiliation is real and not imagined and can be physical or psychological in nature. A person with sexual masochism is sometimes called a masochist. Sexual masochism falls under the psychiatric sexual disorders category of paraphilias, meaning "abnormal or unnatural attraction."

Sexual masochism refers to engaging in or frequently fantasizing about being beaten, bound, or otherwise made to suffer, resulting in sexual satisfaction. Blindfolding, spanking and humiliation in the form of defecation, urination, etc. are methods used by these patients. Masochists may inflict their own pain through shocking, pricking or choking.

Approximately 30 percent of paraphilic patients also participate in sadistic behaviour.

One particularly dangerous method is called hypoxyphilia (near-asphyxiation) caused by reducing oxygen level in the brain. This results in the accidental death of one or two per million people per year. To achieve near-asphyxiation, masochists might place a noose around their necks, chest compression, put airtight bags over their heads or use amyl nitrates ("poppers").

Symptoms

Individuals with sexual masochism experience sexual excitement from physically or psychologically receiving pain, suffering, and/or humiliation. They may be receiving the pain, suffering, or humiliation at the hands of another person, who may or may not be a sadist, or they may be administering the pain, suffering, or humiliation themselves.

They experience distressed or impaired functioning because of the masochistic behaviours, urges, and fantasies.

Causes

There is no such accepted cause or theory explaining the origin of sexual masochism, or sadomasochism in general. However, there are some theories that attempt to explain the presence of sexual paraphilias in general. One theory is based on learning theory that paraphilias originate because inappropriate sexual fantasies are suppressed. Because they are not acted upon initially, the urge to carry out the fantasies increases and when they are finally acted upon, a person is in a state of considerable distress and/or arousal. In the case of sexual masochism, masochistic behaviour becomes associated with and inextricably linked to sexual behaviour.

There is also a belief that masochistic individuals truly want to be in the dominating role.

This causes them to become conflicted and thus submissive to others.

Another theory suggests that people seek out sadomasochistic behaviour as a means of escape.

They get to act out fantasies and become new and different people.

Treatments

i) **Behaviour therapy**

This is often used to treat paraphilias. This can include management and conditioning of arousal patterns and masturbation. Therapies involving cognitive restructuring etc.

ii) **Medication**

This is also used to reduce fantasies and behaviour relating to paraphilias. This is especially true of people who exhibit severely dangerous masochistic behaviours.

Treatment can also be complicated by health problems relating to sexual behaviour. Sexually transmitted diseases and other medical problems, especially when the sadomasochistic behaviour involves the release of blood, can be present. Also, people participating in hypoxyphilia and other dangerous behaviours can suffer extreme pain and even death.

3.3.7 Pedophilia

It is typically defined as a psychiatric disorder in adults or late adolescents (persons age 16 and older). It is characterised by a primary or exclusive sexual interest in prepubescent children (generally age 13 years or younger, though onset of puberty may vary).

The child must be at least five years younger in the case of adolescent pedophiles. The word comes from the Greek: ðá?ò(*paîs*), meaning "child," and öéëßá (*philía*), "friendly love" or "friendship".

Though this literal meaning has been altered toward sexual attraction in modern times, under the titles "child love" or "child lover", by pedophiles who use symbols and codes to identify their preferences.

The International Classification of Diseases (ICD) defines pedophilia as a "disorder of adult personality and behaviour" in which there is a sexual preference for children of prepubertal or early pubertal age.

The term has a range of definitions as found in psychiatry, psychology, the vernacular, and law enforcement.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM), pedophilia is a paraphilia in which a person has intense and recurrent sexual urges towards and fantasies about prepubescent children and on which feelings they have either acted or which cause distress or interpersonal difficulty.

The current DSM-5 draft proposes to add hebephilia to the diagnostic criteria, and consequently to rename it to *pedohebephilic disorder*. Although most pedophiles are men, there are also women who exhibit the disorder. In popular usage, pedophilia means any sexual interest in children or the act of child sexual abuse, often termed "pedophilic behaviour".

Pedophilia was first formally recognised and named in the late 19th century. A significant amount of research in the area has taken place since the 1980s. At present, the exact causes of pedophilia have not been conclusively established. Research suggests that pedophilia may be correlated with several different neurological abnormalities, and often co-exists with other personality disorders and psychological pathologies. In the contexts of forensic psychology and law enforcement, a variety of typologies have been suggested to categorize pedophiles according to behaviour and motivations.

Symptoms

A pedophile is often very attractive to the children who are potential victims. Potential pedophiles may volunteer their services to athletic teams, Scout troops, or religious or civic organisations that serve youth. In some cases, pedophiles who are attracted to children within their extended family may offer to baby-sit for their relatives. They often have good interpersonal skills with children and can easily gain the children's trust.

Some pedophiles offer rationalisations or excuses that enable them to avoid assuming responsibility for their actions. They may blame the children for being too attractive or sexually provocative. They may also maintain that they are "teaching" the child about "the facts of life" or "love"; this rationalisation is frequently offered by pedophiles who have molested children related to them. All these rationalisations may be found in pornography with pedophilic themes.

Causes

A variety of different theories exist as to the causes of pedophilia. A few researchers attribute pedophilia along with the other paraphilias to biology. They hold that testosterone, one of the male sex hormones, predisposes men to develop deviant sexual behaviours. As far as genetic factors are concerned, as of 2002 no researchers have claimed to have discovered or mapped a gene for pedophilia.

Some regard pedophilia as the result of a distorted need to dominate a sexual partner. Since children are smaller and usually weaker than adults, they may be regarded as nonthreatening potential partners. This drive for domination is sometimes thought to explain why most pedophiles are males.

Treatments

In the earliest stages of behaviour modification therapy, pedophiles may be narrowly viewed as being attracted to inappropriate persons. Such aversive stimuli as electric shocks have been administered to persons undergoing therapy for pedophilia. This approach has not been very successful.

In 2002, the most common form of treatment for pedophilia was psychotherapy. It does not have a high rate of success in inducing pedophiles to change their behaviour.

Pedophilia may also be treated with medications. The three classes of medications most often used to treat pedophilia (and other paraphilias) are: female hormones, particularly medroxyprogesterone acetate, or MPA; luteinising hormone-releasing hormone (LHRH) agonists, which include such drugs as triptorelin (Trelstar), leuprolide acetate, and goserelin acetate; and anti-androgens, which block the uptake and metabolism of testosterone as well as reducing blood levels of this hormone.

Most clinical studies of these drugs have been done in Germany, where the legal system has allowed their use in treating repeat sexual offenders since the 1970s. The anti-androgens in particular have been shown to be effective in reducing the rate of recidivism.

3.3.8 Frotteurism

It refers to a paraphilic interest in rubbing, usually one's pelvis or erect penis, against a non consenting person for sexual gratification. It may involve touching any part of the body including the genital area.

A person who practices frotteurism is known as a frotteur. The majority of frotteurs are male and the majority of victims are female, although female on male, female on female, and male on male frotteurs exist. Adult on child frotteurism can be an early stage in child sexual abuse.

This activity is often done in circumstances where the victim cannot easily respond, in a public place such as a crowded train or concert.

Usually, such nonconsensual sexual contact is viewed as a criminal offense: a form of sexual assault albeit often classified as a misdemeanor with minor legal penalties. Conviction may result in a sentence or psychiatric treatment.

Symptoms

The primary focus of frotteurism is touching or rubbing one's genitals against the clothing or body of a nonconsenting person. This behaviour most often occurs in situations that allow rapid escape. Frottage (the act of rubbing against the other person) is most commonly practiced in crowded places such as malls, elevators, on busy sidewalks, and on public transportation vehicles.

The most commonly practiced form of frotteurism is rubbing one's genitals against the victim's thighs or buttocks. A common alternative is to rub one's hands over the victim's genitals or breasts.

Most people who engage in frottage (sometimes called frotteurs) usually fantasize that they have an exclusive and caring relationship with their victims during the moment of contact. However, once contact is made and broken, the frotteur realises that escape is important to avoid prosecution.

Recurrent, intense, or sexually arousing fantasies, sexual urges, or behaviours that involve touching and rubbing against a nonconsenting person.

The person has acted on these sexual urges, or the fantasies or urges cause significant distress to the individual or are disruptive to his everyday functioning.

Causes

There is no scientific consensus concerning the cause of frotteurism. Most experts attribute the behaviour to an initially random or accidental touching of another's genitals that the person finds sexually exciting. Successive repetitions of the act tend to reinforce and perpetuate the behaviour.

Treatments

For treatment to be successful, the frotteur must modify existing patterns of behaviour. This initial step is difficult for most people with this disorder to take.

Behaviour therapy is commonly used to try to treat frotteurism. The frotteur must learn to control the impulse to touch nonconsenting victims. Medroxyprogesterone, a female hormone, is sometimes prescribed to decrease sexual desire.

Frotteurism is a criminal act in many jurisdictions. It is usually classified as a misdemeanor. As a result, legal penalties are often minor. It is also not easy to prosecute frotteurs as intent to touch is difficult to prove. In their defense statements, the accused often claim that the contact was accidental.

Self Assessment Questions

1) What is paraphilia?

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2) Enlist major types of paraphilia

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3) What is exhibitionsim?

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4) Describe in detail the eight types of paraphilias.

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5) Discuss the causes, symptoms and treatment for pedophilia and frotteurism.

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3.4 LET US SUM UP

In this unit we have defined paraphilias and discussed the eight types of paraphilias. We have presented the symptoms for each paraphilia, along with causes and treatment for the same. Most paraphilias seem to be treated more by behaviour modification and cognitive behaviour therapy. Generally it has been found that they do not come for treatment on their own, but sometimes being forced by the court or by the law or by their relatives or neighbours who would have been a victim. As for the causes of paraphilias in general, one has to understand the sexual preferences as well as it has been noited that basically the problem is biological in nature. The biological perspectives receives the most attention and focuses as a main cause for deviation. Each of the perspectives have something to offer understanding the paraphilias. It is because many of the paraphilic types behaviour are being carried out in private areas and come to public attention. Conventional psychotherapy is ineffective but biological treatments involve female hormonal treatment which have been used with benefits on a long term basis. In some cases, desensitisation has proved useful for the cases.

3.5 UNIT END QUESTIONS

1) What are paraphilias? Why does it occur?

2) What are the various symptoms of paraphilias?

3) What are the different types of paraphilias?

4) Enumerate the causes, symptoms and treatment of fetishism and voyeurism.

5) What are the symptoms, causes and treatment of transvestism and pedophilia?

6) Why it is psychotherapy is not effective in most of the paraphilia cases? Discuss.

3.6 SUGGESTED READINGS AND REFERENCES

Hickey , Eric, W. (2005). *Sex Crimes and Paraphilia* Sage Publicartion, NY.

Holmes, R.M. (2007). *Sex Crimes and Paraphilia*. Prentice Hall, London.

Medline World Health Organisation. *The International Statistical Classification of Diseases and Health Related Problems, Tenth Revision*. 2nd ed. World Health Organisation; 2004.

References

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: American Psychiatric Association; 2000:566 - 576.

Sartorius A, Ruf M, Kief C, Demirakca T, Bailer J, Ende G. Abnormal amygdala activation profile in pedophilia. *Eur Arch Psychiatry Clin Neurosci*. Aug 2008;258(5):271-7.

Andersen ML, Poyares D, Alves RS, Skomro R, Tufik S. Sexsomnia: abnormal sexual behaviour during sleep. *Brain Res Rev*. Dec 2007;56(2):271-82.

Cowell DD. Autoerotic asphyxiation: secret pleasure—lethal outcome?. *Pediatrics*. Nov 2009;124(5):1319-24.

Abdo CH, Hounie A, de Tubino Scanavino M, Miguel EC. OCD and transvestism: is there a relationship?. *Acta Psychiatr Scand*. Jun 2001;103(6):471-3; discussion 473.

Abouesh A, Clayton A. Compulsive voyeurism and exhibitionism: a clinical response to paroxetine. *Arch Sex Behav*. Feb 1999;28(1):23-30.

Allgeier AR, Allgeier ER. Atypical sexual activity. In: Miller J, Brooks CL, Rachlin H, O'Dea M, Michaels T, Roll M. *Sexual Interactions*. 2nd ed. Canada: D.C. Heath & Company; 1988:619-641/ 21.

Allnutt SH, Bradford JM, Greenberg DM, Curry S. Co-morbidity of alcoholism and the paraphilias. *J Forensic Sci*. Mar 1996.

UNIT 4 MOOD DISORDERS (BIPOLAR, MAJOR DEPRESSION)

Structure

4.0 INTRODUCTION

Mood disorders are characterised by a disturbance in the regulation of mood, behaviour, and affect. Mood disorders are subdivided into (1) depressive disorders, (2) bipolar disorders, and (3) depression in association with medical illness or alcohol and substance abuse. All disorders are differentiated from bipolar disorders by the absence of a manic or hypomanic episode. The World Health Organisation, (WHO) specified that, unipolar major depression ranked fourth among all diseases in terms of disability adjusted life years and was projected to rank second by year 2020.

Mood disorders, also called affective disorders, are a group of illnesses that have as their distinguishing characteristic, an experience of mood that is unusual for the circumstances. Most mood disorders are at least somewhat treatable with drugs and psychotherapy.

In many cases, the root cause of the disorder may be some type of chemical imbalance that is affecting the function of the thyroid or causing the brain to not produce the correct ratio of different neurotransmitters. Mood disorders with this type of origin can often be corrected with the use of medication, sometimes coupled with nutritional supplements.

In this unit we will be dealing with mood disorders, their definition, their types, symptoms and causes. For each of the mood disorders, the treatment will also be presented.

4.1 OBJECTIVES

On completing this unit, you will be able to:

- Define mood disorders;
- Elucidate various types of mood disorders;
- Describe the Symptoms of various mood disorders;
- Elucidate the causes of mood disorders; and
- Analyse the Interventional approaches used in mood disorders.

4.2 CONCEPT AND DEFINITION OF MOOD DISORDERS

Mood disorders are defined as a group of mental disorders involving a disturbance of mood along with either a full or partial excessively happy or extremely sad syndrome not caused by any other physical or mental disorder. It refers to a prolonged emotion.

Thus it can be said that mood disorders are combination of sometimes happiness and sadness. It is the emotional outbursts of the individuals.

The American Heritage dictionary called any of a group of psychiatric disorders including depression and bipolar disorder, characterised by a pervasive disturbance of mood that is not caused by an organic abnormality. Also this syndrome is called affective disorder. This definition clarifies that mood disorders are merely caused by disturbances in life.

Thus a variety of conditions characterised by a disturbances in mood which may be mild to severe and contains signs of major depressive disorder or dysthymic reaction or a symptoms of bipolar disorder. It is termed by DSM IV (R) as mood disorder. It is the most common diagnoses in psychiatry and is persistently emotional .

The best available evidence suggests that mood disorders lie on a continuum with normal mood. Although mania and depression are often viewed as opposite ends of the mood spectrum, they can occur simultaneously in a single individual within a brief period, giving rise to the concept of mixed mood states.

As per Diagnostic and Statistical Manual of Mental Disorders, 4th edition, The major categories of mood disorders are:

- Unipolar Mood Disorders
- Major depressive disorders
- Dysthymic disorder
- Bipolar mood disorders
- Bipolar I disorder,
- Bipolar II disorder
- Cyclothymic disorder
- Substance Induced Mood Disorder
- Mood Disorder of General Medical Condition

Thus the essential feature of disorders in this category is that all of them reflect a disturbances in mood or emotional reaction that is not due to any other physical or mental disorder. When an individual suffers from a mood disorder, their ability to function and lead a productive and full life may suffer. Some emotional shifts are normal, especially as a reaction to current events, such as the death of a loved one. However, if the individual experiences depression that lingers with no obvious cause or elation that seems out of balance with her life, she may have a mood disorder.

Self Assessment Questions

1) Define mood disorder

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2) What are the characteristic features of mood disorders?

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3) What are the symptoms of mood disorders?

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4) What are the major categories of mood disorders?

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4.3 MAJOR DEPRESSION

It also known as recurrent depressive disorder, clinical depression, major depression, or unipolar disorder. This mental disorder is characterised by an all low mood accompanied by low self esteem, and by loss of interest or pleasure in normally enjoyable activities. The term "depression" is ambiguous. Major depressive disorder is a disabling condition which adversely affects a person's family, work or school life, sleeping and eating habits, and general health.

The understanding of the nature and causes of depression has evolved over the centuries, though this understanding is incomplete and has left many aspects of depression as the subject of discussion and research. Proposed causes include psychological, psycho-social, hereditary, evolutionary and biological factors.

Certain types of long-term drug use can both cause and worsen depressive symptoms. Psychological treatments are based on theories of personality, interpersonal communication, and learning.

4.3.1 Biological Factors

Most biological theories focus on the monoamine chemicals serotonin, norepinephrine and dopamine, which are naturally present in the brain and assist communication between nerve cells. This disorder may begin at any age, with an average age at onset in the mid-20s.

Some individuals have isolated episodes that are separated by many years without any depressive symptoms, whereas others have clusters of episodes, and still others have increasingly frequent episodes as they grow older. After the first episode of this disorder, there is a 60% chance of having a second episode. After the second episode, there is a 70% chance of having a third, and after the third episode, there is a 90% chance of having a fourth.

About 5%-10% of individuals with this disorder subsequently develop Bipolar I Disorder. The acute onset of severe depression, especially with psychotic features and psychomotor retardation, in a young person without prepubertal psychopathology is more likely to predict a bipolar course.

A family history of Bipolar Disorder may also be suggestive of subsequent development of Bipolar Disorder. In two-thirds of cases, the Major Depressive Episode ends with complete recovery. For individuals that have only a partial recovery, there is a greater likelihood of developing additional episodes of this disorder and of continuing the pattern of partial interepisode recovery.

Individuals who have pre existing Dysthymic Disorder prior to the onset of this disorder are more likely to have additional Major Depressive Episodes, have poorer inter episode recovery, and also face more difficulty to treat Major Depressive Episodes.

One year after the diagnosis of this disorder, 40% have no mood disorder; 20% are partially recovered, and 40% still have symptoms that are sufficiently severe to meet the criteria for a full Major Depressive Episode. The severity of the initial Major Depressive Episode appears to predict persistence. Chronic general medical conditions are also a risk factor for more persistent episodes. Among those with an onset of depression in later life; there is evidence of subcortical white matter hyper intensities associated with cerebro vascular disease. These vascular depressions are associated with greater neuropsychological impairments and poorer responses to standard therapies.

Episodes of this disorder often follow a severe psychosocial stressor, such as the death of a loved one or divorce. Stressors may play a more significant role in the precipitation of the first or second episode of this disorder and play less of a role in the onset of subsequent episodes. Chronic medical conditions and Substance Dependence (particularly Alcohol or Cocaine Dependence) may contribute to the onset or exacerbation of this disorder.

According to the Diagnosticians there are several subtypes of depressive disorder and these are given below.

4.3.2 Atypical Depression

It is characterised by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain, excessive sleep or somnolence (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection.

4.3.3 Melancholic Depression

Melancholic depression is have loss of pleasure (anhedonia) in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in

the morning hours, early morning waking, psychomotor retardation, excessive weight loss (not to be confused with anorexia nervosa), or excessive guilt.

4.3.4 Psychotic Major Depression (PMD)

PMD or simply psychotic depression is the term for a major depressive episode, particularly of melancholic nature, where the patient experiences psychotic symptoms such as delusions or, less commonly, hallucinations. These are most commonly mood-congruent (content coincident with depressive themes).

4.3.5 Catatonic Depression (CD)

CD is a rare and severe form of major depression involving disturbances of motor behaviour and other symptoms. Here the person is mute and almost stuporose, and either immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms can also occur in schizophrenia, a manic episode, or be due to neuroleptic malignant syndrome.

4.3.6 Postpartum Depression (PPD)

PPD refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which has incidence rate of 10–15%, typically sets in within three months of labour, and lasts for long. However, postpartum depression is different because it can cause significant hardship and impaired functioning at home, work, or school as well as possibly difficulty in relationships with family members, spouses, friends, or even problems bonding with the newborn.

4.3.7 Seasonal Affective Disorder (SAD)

SAD also known as “winter depression” or “winter blues”, is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times over a two-year period or longer.SAD is also more prevalent in people who are younger and typically affects more females than males.

4.3.8 Symptoms of Depression

- Exhibits a very low mood
- Inability to experience pleasure
- inappropriate guilt or regret, helplessness
- Hopelessness, and self-hatred
- withdrawal from social situations and activities
- Reduced sex drive
- Thoughts of death or suicide
- Hyposomania or insomnia
- Thoughts and feelings of worthlessness
- Inappropriate guilt or regret
- Helplessness, hopelessness
- self-hatred
- Agitated or lethargic.

4.4 CAUSES OF DEPRESSION

The cause of major depressive disorder is a combination of anxiety, medical illness, brain chemistry, family history, and psychosocial environment. This is not certain which of these factors dominates, but abnormal levels of the neurotransmitters norepinephrine, serotonin, and dopamine are closely linked with depression. Thus, the cause of depression is often attributed to a "chemical imbalance." These neurotransmitters play important roles in how we experience pleasure and moods.

4.4.1 Genetic Risk Factors for Depression

The statistics shows that children of parents who suffer from depression are more likely to develop the disorder themselves. A person has a 27% chance of inheriting a mood disorder from one parent, and this chance doubles if both parents are affected. Studies of the occurrence of depression in twins show a 70% chance for both identical twins to suffer from depression, which is twice the rate of occurrence in fraternal twins.

4.4.2 Psychosocial and Environmental Risk Factors for Depression

Depression is more common in people who have a history of trauma, sexual abuse, physical abuse, physical disability, bereavement at a young age, alcoholism, and insufficient family structure. In adults, the loss of a spouse is the most common cause of a depressive episode. Women are at increased risk for depression during and within the first few months after pregnancy (called postpartum depression). Chronic depression may be more common in areas afflicted with war, natural disasters, poverty, or neglect.

The following cognitive factors (which affect judgment and perception) are associated with depression:

- Chronic low self-esteem
- Distorted perception of others' views
- Distorted sense of life experience
- Inability to acknowledge personal accomplishment
- Negative idea of self
- Pessimistic outlook
- Quick and exaggerated temper.

4.4.3 Age and Depression Risk

It is known that depression can occur at any age, its onset is typically between the ages 24 and 44. Later onset may correlate with the absence of a family history of depression. Fifty percent of people with major depressive disorder experience their first episode of depression at about age 40, but this may be shifting to the 30s. Studies find that the rate of incidence is higher among middle aged people. Teenagers are more at risk for depression. The evidence is in teen suicide rates, which are increasing yearly. Problems with self esteem may result from failure or disinterest in meeting these expectations. Low self esteem can lead to a negative perspective of life and depression.

4.4.4 Gender and Depression Risk

Gender wise it has been seen that 10% of men and 20% of women are affected. Hormonal differences may put women at a higher risk for depression. Hormone levels are influenced by pregnancy, and many women experience depression after delivery. The disparity between rates of depression in men and women may reflect behaviours based on learned gender roles. Learned helplessness and socio-economic stressors may result in depression in women.

4.4.5 Race and Class and Depression Risk

The race and class of the individuals are also affected by depression. The socio-economic background is the major factor for predisposing the depressive behaviour.

4.4.6 Anxiety

Anxiety in a person with major depression leads to a poorer response to treatment, poorer social and work function, greater likelihood of chronicity and an increased risk of suicidal behaviour. 80 to 90% of individuals with depressive disorder invariably also have anxiety symptoms.

4.4.7 Medical Illness

It has been found that about 5% of individuals initially diagnosed as having Major Depressive Disorder subsequently are found to have another medical illness which was the cause of their depression. 25% of individuals with severe, chronic medical illness (e.g., diabetes, myocardial infarction, carcinomas, stroke etc.) develop depression. Medical conditions often causing depression are: Endocrine disorders such as hypothyroidism, hyperparathyroidism, Cushing's disease, and diabetes mellitus.

4.5 TREATMENT

Psychotherapy can be used both at individual and group levels, by mental health professionals, including psychotherapists, psychiatrists, psychologists, clinical social workers, counselors, and suitably trained psychiatric nurses.

Medication should only be offered in conjunction with a psychological therapy, such as CBT, interpersonal therapy, or family therapy. Psychotherapy has been shown to be effective in older people. The most studied form of psychotherapy for depression is CBT, which teaches clients to challenge self defeating, but enduring ways of thinking (cognitions) and change counter productive behaviours.

Antidepressants are given in smaller dosage to those with mild or moderate depression but a heavy dosage is given tothose with very severe depression. The effects of antidepressants are somewhat superior to those of psychotherapy, especially in cases of chronic major depression, although in short term trials more patients, especially those with less serious forms of depression stop medication than stop psychotherapy, most likely due to adverse effects from the medication and to patients' preferences for psychological therapies over pharmacological treatments. Antidepressant medication treatment and even up to one year of continuation is recommended.

4.6 DYSTHYMIC DISORDER

Dysthymia is a low grade depression. It comes from the Greek word dysthymia means bad state of mind. It presents with a chronic feeling of ill being and lack in interest in any enjoyable activities. Unlike in major depression individuals are unable to work but in dysthymic are able to work and function at a less than peak performance. It has been seen that 50% of patients with dysthymic disorder recover soon than any other depression.

4.6.1 Symptoms

- poor appetite or overeating
- insomnia or hypersomnia
- low energy or fatigue
- low self-esteem
- poor concentration or difficulty making decisions
- feelings of hopelessness low energy,
- sleep disturbances,
- appetite disturbances,
- irritable or angered easily,
- low self-esteem are usually part of the clinical picture as well.
- inability to concentrate,
- feelings of worthlessness,
- sad mood

4.6.2 Causes

i) **Biochemical:** The significance of these changes is still uncertain, but they may eventually help pinpoint causes. The naturally occurring brain chemicals called neurotransmitters, which are linked to mood, also may play a role in causing dysthymia.

ii) **Genes:** In dysthymia there is also biological condition that appears to be the most common amongst people who suffer from this disorder.

iii) **Environment:** Environment contributes to dysthymia. Environmental causes are situations in your life that are difficult to cope with, such as the loss of a loved one, financial problems and a high level stress.

iv) **Physical Causes of Dysthymia:** Physical causes of dysthymia include biochemical changes, genetic factors, medical illness and medications and changes in physiological brain activity. Research studies undertaken on twins have identified that there exists a genetic link to depression as when one identical twin suffers from the illness the other has around a 70% chance of also being affected by depression.

v) **Medical illness:** This includes heart attack and those who are prone to heart attacks are 40% more likely to suffer from depression due to also certain medications such as steroids etc. This may also lead to episodes of the condition.

vi) **Psychosocial Causes of Dysthymia:** Difficulty in family relationships, poor coping skills and lack of social support increase the likelihood of depression. In addition tragedy, bereavement, loss, trauma and abuse may lead to dysthymia. This is more common among children and adolescents who are more vulnerable and also lack positive relationships.

4.6.3 Treatment

Only one in five who have dysthymia or other forms of depression needs help. Dysthymia is a very treatable disorder. With the right kind of treatment, nearly every patient can experience significant relief in 12 to 14 weeks. Untreated, many dysthymics eventually develop major depression.

Often, psychotherapy is recommended first for three months, followed by antidepressants if therapy alone is not effective. Sometimes, a combination of psychotherapy and antidepressants is used early on.

Other forms of therapy used are:

- Cognitive-behavioural therapy, which shows patients how to change self-defeating and disturbed thought patterns into more positive and productive ways of thinking. Interpersonal therapy, which focuses on developing better relationships.
- Cultural analysis, which points out unrealistic societal messages that contribute to low self-esteem and a sense of powerlessness, especially for women .
- Group therapy and self-help, which provide a source of emotional support and vital social connections.

BIPOLAR DISORDERS

Bipolar disorder is of two types: Bipolar I and Bipolar II. Let us take up Bipolar disorder I.

4.7 BIPOLAR DISORDER I

Bipolar disorder or manic depressive disorder, which is also referred to as bipolar affective disorder or manic depression. It is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated energy levels, cognition, and mood with or without one or more depressive episodes.

The elevated moods are clinically referred to as mania or, if milder, hypomania. Individuals who experience manic episodes also commonly experience depressive episodes, or symptoms, or mixed episodes in which features of both mania and depression are present at the same time. These episodes are usually separated by periods of “normal” mood; but, in some individuals, depression and mania may rapidly alternate, which is known as rapid cycling.

Diagnosis is based on the person’s self-reported experiences, as well as observed behaviour, which includes distress, disruption and risk of suicide. The term “bipolar disorder” origins and refers to the cycling between high and low episodes (poles).

A relationship between mania and melancholia had long been observed, although the basis of the current conceptualisation can be traced back to French psychiatrists in the 1850s. The term "manic-depressive illness" or psychosis was coined by German psychiatrist Emil Kraepelin in the late nineteenth century, originally referring to all kinds of mood disorder.

German psychiatrist Karl Leonhard split the classification again in 1957, employing the terms unipolar disorder (major depressive disorder) and bipolar disorder.

4.7.1 Symptoms of Bipolar Disorder I

- Feeling unusually "high" and optimistic or irritibality
- Unrealistic, grandiose beliefs about one's abilities or powers
- Sleeping very little, but feeling extremely energetic
- Talking so rapidly that others can't keep up
- Racing thoughts; jumping quickly from one idea to the next
- Highly distractible, unable to concentrate
- Impaired judgment and impulsiveness.

4.7.2 Causes of Bipolar Disorder I

i) **Genetic Factors**

When talking about biological causes, the first issue is whether bipolar disorder can be inherited. This question has been researched through multiple family, adoption and twin studies. In families of persons with bipolar disorder, first-degree relatives (parents, children, siblings) are more likely to have a mood disorder than the relatives of those who do not have bipolar disorder (3). Studies of twins indicate that if one twin has a mood disorder, an identical twin is about three times more likely than a fraternal twin .

ii) **Neurochemical Factors in Bipolar Disorder**

Bipolar disorder is primarily a biological disorder that occurs in a specific area of the brain and is due to the dysfunction of certain neurotransmitters, or chemical messengers, in the brain.

iii) **Environmental Factors in Bipolar Disorder**

An life event can trigger a mood episode in individuals with a genetic disposition for this kind of disorder. The bipolar disorder appears at increasingly early age. life event may trigger a mood episode in a person with a genetic disposition for bipolar disorder.

4.7.3 Treatment of Bipolar Disorder I

i) **Medications**

There is a wide variety of medications that are used in treatment. Each group of medications treats a particular set of symptoms. Side effects are common: some may cause a patient to discontinue the medication, others may go away with time or be tolerable or treatable.

ii) **Psychological Therapy**

Psychiatrists, psychologists, therapists and counselors. Primary physicians, psychiatric nurses, social workers and psychopharmacologists.

iii) **Psychiatric Hospitalisation**

Sometimes it is necessary to get 24-hour monitoring and treatment.the hospital can only provide control and proper care.

4.8 BIPOLAR DISORDER II

According to the definition in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), bipolar II disorder is characterised by one or more major depressive episodes accompanied by at least one hypomanic episode.

The key difference between bipolar 1 and bipolar 2 is that bipolar 2 has hypomanic but not manic episodes. However, in bipolar II disorder, the "up" moods never reach full during the mani episodes.

The less intense elevated moods in bipolar II disorder are called hypomanic episodes, or hypomania. A person affected by bipolar II disorder has had at least one hypomanic episode in life. Most people with bipolar II disorder also suffer from episodes of depression.

This is where the term "manic depression" comes from. In between episodes of hypomania and depression, many people with bipolar II disorder live normal lives.

4.8.1 Symptoms of Bipolar Disorder II

- Decreased energy
- Weight loss or gain
- Despair
- Irritability
- Uncontrollable crying

Symptoms and characteristics of hypomania include:

- Grandiosity
- Decreased need for sleep
- Pressured speech
- Racing thoughts
- Distractibility
- Tendency to engage in behaviour that could have serious consequences, such as spending recklessly or inappropriate sexual encounters
- Excess energy

4.8.2 Causes of Bipolar Disorder II

i) **Genetic Factors**

The first issue in bipolar disorder is of inheritence. In families of persons with bipolar disorder, first degree relatives (parents, children, siblings) are more likely to have a mood disorder than the relatives of those who do not have bipolar disorder. Studies of twins indicate that if one twin has a mood disorder, an identical twin is about three times more likely than a fraternal twin to have a mood disorder as well.

ii) **Neurotransmitters**

The neurotransmitter system has received a great deal of attention as a cause of bipolar disorder. Some studies suggest that a low or high level of a specific neurotransmitter such as serotonin, norepinephrine or dopamine is the cause.

iii) **StressTriggers**

For mental, emotional and environmental issues, stressful life events are thought to be the main element in the development of bipolar disorder. These can range from a death in the family to the loss of a job, from the birth of a child to a move.

4.8.3 Treatment of Bipolar Disorder II

i) **Mood stabilising medications**

These are usually the first choice to treat bipolar disorder. In general, people with bipolar disorder continue treatment with mood stabilisers for years. Except for lithium, many of these medications are anticonvulsants. Anticonvulsant medications are usually used to treat seizures, but they also help control moods. These medications are commonly used as mood stabilisers in bipolar disorder:

ii) **Antidepressant medications**

These medicines are sometimes used to treat symptoms of depression in bipolar disorder. People with bipolar disorder who take antidepressants often take a mood stabiliser too.

Some psychotherapy treatments used to treat bipolar disorder include the following:

iii) **Cognitive behavioural therapy (CBT)**

This helps people with bipolar disorder learn to change harmful or negative thought patterns and behaviours.

iv) **Family focused therapy**

This includes family members. It helps enhance family coping strategies, such as recognising new episodes early and helping their loved one. This therapy also improves communication and problem solving.

v) **Interpersonal and social rhythm therapy**

This therapy helps people with bipolar disorder improve their relationships with others and manage their daily routines. Regular daily routines and sleep schedules may help protect against manic episodes.

vi) **Psychoeducation**

This aims to teach people with bipolar disorder about the illness and its treatment. This treatment helps people recognise signs of relapse so they can seek treatment early, before a full blown episode occurs. Usually done in a group, psychoeducation may also be helpful for family members and caregivers.

4.9 CYCLOTHYMIC DISORDER

Cyclothymia is a mood disorder that causes hypomanic and mild depressive episodes. A single episode of hypomania is sufficient to diagnose cyclothymic disorder. However, most individuals also have dysthymic periods. The diagnosis of cyclothymic disorder is not made when there is a history of mania or major depressive episode or mixed episode.

The lifetime prevalence of cyclothymic disorder is 0.4 to 1%. The rate appears equal in men and women, though women more often seek treatment. Cyclothymia is similar to bipolar II disorder in that it presents itself in typical hypomanic episodes. Because hypomania is often associated with exceptionally creative, outgoing, and high-functioning behaviour, both conditions are often undiagnosed. As with most of the disorders in the bipolar spectrum, it is the depressive phase that leads most sufferers to get help.

4.9.1 Symptoms

i) **Dysthymic phase**

Symptoms of the *dysthymic phase* include difficulty making decisions, problems concentrating, poor memory recall, guilt, self-criticism, low self-esteem, pessimism, self-destructive thinking, continuously feeling sad, apathy etc.

ii) **Euphoric phase**

Symptoms of the *euphoric phase* include unusually good mood or cheerfulness (euphoria), extreme optimism, inflated self-esteem, poor judgment, rapid speech, racing thoughts, aggressive or hostile behaviour, being inconsiderate of others, agitation, increased physical activity, risky behaviour, spending sprees.

4.9.2 Hypomanic Phase of Cyclothymic Disorder

1) Unusually good mood or cheerfulness (euphoria)
2) Extreme optimism
3) Inflated self-esteem
4) Poor judgment
5) Rapid speech

4.9.3 Depressive Phase of Cyclothymic Disorder

1) Sadness
2) Hopelessness
3) Suicidal thoughts or behaviour
4) Anxiety

5) Guilt

6) Sleep problems

The cause of cyclothymic disorder is unknown. Although the changes in mood are irregular and abrupt, the severity of the mood swings is far less extreme than that seen with bipolar disorder (manic depressive illness). Unlike in bipolar disorder, periods of hypomania in cyclothymic disorder do not progress into actual mania.

4.9.4 Treatment of Cyclothymic Disorder

i) **Antidepressant Medication for Cyclothymia**

A trial of lithium carbonate is often tried, especially if the mood swings seem to be similar to those found in bipolar disorder. Prescription of such a medication though should be dependent upon a thorough clinical examination and history of the patient.

ii) **Psychotherapy for Cyclothymia**

Psychological treatment often focuses on the life adjustment problems that develop because of the Cyclothymia, and in helping the individual recognise the onset of a Cyclothymia and take corrective action. Treatment often takes the form of individual psychotherapy, although group treatment can also be helpful for this disorder.

iii) **Self Help for Cyclothymia**

Lifestyle improvements always have a positive impact, however can take more effort to actually do as the depression becomes more severe. Self-help methods for the treatment of this disorder are often overlooked by the medical profession because very few professionals are involved in them

4.10 SUBSTANCE INDUCED MOOD DISORDER

A substance induced mood disorder is characterised by depressions or manic episodes which develop during a time when the person is taking a medication which causes depression or the manic symptoms a time when the person is intoxicated by a drug or a time when the person is withdrawing from an intoxicating drug.

The symptoms of substance induced mood disorder are the same as during other types of depression, that is it has symptoms of sadness, emptiness, loss of interest and pleasure, irritability and anger, changes in appetite, sleep problems, restlessness, slow movement and thinking, fatigue, worthlessness and guilt, poor concentration, thoughts about death and suicide.

The manic symptoms are the same as those experienced during other manic episodes...elation, confidence, delusional thinking, high level of energy, increased activity, productivity, loud and rapid speech, racing thoughts, risky behaviour, impulsive behaviour, increased sexual behaviour, over spending, fast reckless driving, wild business schemes, overeating, drinking too much, irritability, anger, and agitation.

4.10.1 Causes of Substance Induced Mood Disorder

Medications and drugs which can cause substance induced mood disorder include the following:

- Antihypertensives such as reserpine, methyldopa, clonidine, guanethidine, hydralazine, and prazosin hydrodhloride
- Gastrointestinal medications such as cimetidine
- Anticonvulsant medications such as clonazepam
- Steroids
- Oral contraceptives such as progesterone
- Anti-inflammatory medications such as indomethacin
- L-dopa
- Antipsychotic medications
- All sedatives including barbiturates such as phenobarbital, benzodiazepines such as diazepam, meprobamate, methaqualone, gultethimide, elhchlorvynol, chloral hydrate, and ethanol
- Amphetamines (stimulates)
- Methadone
- Heroin
- Cocaine

4.10.2 Treatment of Substance Induced Mood Disorder

i) **Medical Care**

If the substance induced mood disorder symptoms are severe or cause significant risk of harm to the patient or others, inpatient psychiatric care needs to be considered. Specific indications for inpatient care include

1) serious suicidal ideation, which may include a plan,
2) homicidal ideation,
3) severe impairments in judgment leading to a moderate or high risk for danger to self or others, or
4) an inability to care for oneself safely. If unsure about the diagnosis, a prompt evaluation by the local emergency mental health system or a local emergency department is indicated.

Regular assessment of suicide risk is mandatory in any patient with depression or mania. Other risk factors for suicide include agitation, psychosis, past suicide attempts, a family history of suicide, or recent psychiatric admission.

If the mood symptoms do not subside within 4 weeks, consider other etiologies for the depression.

ii) **Consultations**

If the patient is suicidal, psychosis or mania is suspected, or depressive symptoms are severe, consult a mental health professional. Patients may need intensive

outpatient or inpatient mental health care until the severity of the symptoms decline.

4.11 MOOD DISORDER OF GENERAL MEDICAL CONDITION

Mood disorder due to a general medical condition is characterised by depression or manic episodes which are caused by a medical condition.

The symptoms of mood disorder due to a general medical condition are the same as during other types of depressions, such as sadness, emptiness, loss of interest and pleasure, irritability and anger, changes in appetite, sleep problems, restlessness, slow movement and thinking, fatigue, worthlessness and guilt, poor concentration, thoughts about death and suicide.

4.11.1 Symptoms

- Poor appetite or overeating.
- Insomnia or hypersomnia.
- Low energy or fatigue.
- Low self-esteem.
- Poor concentration or difficulty making decisions.
- Feelings of hopelessness.
- Psychomotor agitation or retardation nearly every day.

4.11.2 Causes

- Cardiovascular conditions such as myocardial infarction (heart attack)
- Gastrointestinal conditions
- Neurological disorders such as Huntington's Disease, Alzheimer's Disease, and brain tumors
- diseases of the pancreas
- Thyroid abnormalities
- Addison's Disease
- Cushing's Disease
- Pheumatoid Arthritis
- Infectious diseases such as Mononucleosis
- Cancer
- Malnutrition
- Electrolyte disturbances

4.11.3 Treatment

Treatment for mood disorder due to a general medical condition must include treatment of the medical condition causing the depression or manic disorder.

i) **Psychiatric and psychological treatment**

This treatment intervention of the mood disorder is also often needed. Psychiatric treatment will include medication to reduce the depressive or manic symptoms. Psychological treatment will provide the person with emotional support and help him develop coping skills.

Self Assessment Questions

1) What is major depressive disorder?

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2) Enlist the causes of depression.

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3) What are the causes of bipolar I disorder?

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4.12 LET US SUM UP

Thus mood disorders reflects a disturbance in mood or emotional response that is not only due to physical but also due to some emotional distortions. All these disorders type are more or less similar to one another and have a greater risk to women than men. On thing is confirmed that bipolar depression are much higher than that for any other general depression.

4.13 UNIT END QUESTIONS

1) Discuss the types and symptoms of unipolar disorders.

2) What is a Bipolar II disorder? Discuss with symptoms and its causes.

3) What are the major risk factors in depression?

4.14 SUGGESTED READINGS AND REFERENCES

Miller, Laura J. (2008). *Post Partum Mood Disorder.* American Psychiatry Press

Parker, Gordon, Straton,David (2007). *Dealing with Depression.* Mc Phersons Printing Group

Sloman, Leon (2002). *Subordination and Defeat: An Evolutionary Approach to Mood Disorders and Their Therapy.* Lawrence Erlbaum Associates

References

Dunner DL, Gershon ES, Goodwin FK: Heritable factors in the severity of affective illness. Biological Psychiatry 11:31-42, 1976

Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, American Psychiatric Association, 1994

Cassano GB, Dell'Osso L, Frank E, et al: The bipolar spectrum: a clinical reality in search of diagnostic criteria and an assessment methodology. Journal of Affective Disorders 54:319-328, 1999

Altshuler LL, Curran JG, Hauser P, et al: T_2 hyperintensities in bipolar disorder: magnetic resonance imaging comparison and literature meta-analysis. American Journal of Psychiatry 152:1139-1144, 1995

Kato T, Kunugi H, Nanko S, et al: Association of bipolar disorder with the 5178 polymorphism in mitochondrial DNA. American Journal of Medical Genetics 96:182-186, 2000

Akiskal HS, Maser JD, Zeller PJ, et al: Switching from "unipolar" to bipolar II: an 11-year prospective study of clinical and temperamental predictors in 559 patients. Archives of General Psychiatry 52:114-123, 1995

Benazzi F: Depression with DSM-IV atypical features: a marker for bipolar II disorder. European Archives of Psychiatry and Clinical Neuroscience 250:53-55, 2000

Benazzi F, Rihmer Z: Sensitivity and specificity of DSM-IV atypical features for bipolar II disorder diagnosis. Psychiatry Research 93:257-262, 2000

Coryell W, Endicott J, Reich T: A family study of bipolar II disorder. British Journal of Psychiatry 145:49-54, 1984

Koukopoulos A, Reginaldi D, Laddomada P, et al: Course of the manic-depressive cycle and changes caused by treatments. Pharmacopsychiatry 13:156-167, 1980

Benazzi F: A comparison of the age of onset of bipolar I and bipolar II outpatients. Journal of Affective Disorders 54:249-253, 1999

Endicott J, Nee J, Andreasen N, et al: Bipolar II: combine or keep separate? Journal of Affective Disorders 8:17-28, 1985

Savino M, Perugi G, Simonini E, et al: Affective comorbidity in panic disorder: is there a bipolar connection? Journal of Affective Disorders 28:155-163, 1993

Pini S, Cassano GB, Simonini E, et al: Prevalence of anxiety disorders comorbidity in bipolar depression, unipolar depression, and dysthymia. Journal of Affective Disorders 42:145-153, 1997

Endicott N: Psychophysiological correlates of “bipolarity.” Journal of Affective Disorders 17:47-outpatients. Comprehensive Psychiatry 41:106-110, 2000

Kupfer DJ, Carpenter DL, Frank E: Is bipolar II a unique disorder? Comprehensive Psychiatry 29:228-236, 1988

Cooke RG, Young LT, Levitt AJ, et al: Bipolar II: not so different when co-morbidity is excluded. Depression 3:154-56, 1995

Greil W, Kleindienst N: Lithium versus carbamazepine in the maintenance treatment of bipolar II disorder and bipolar disorder not otherwise specified. International Clinical Psychopharmacology 14:283-285, 1999

Greil W, Kleindienst N: The comparative prophylactic efficacy of lithium and carbamazepine in patients with bipolar I disorder. International Clinical Psychopharmacology 14:277-281, 1999.