
UNIT 1 A BRIEF HISTORY OF PSYCHOPATHOLOGY

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1.0 INTRODUCTION

Throughout history, human civilisations have held quite different views of the problems that we consider now to be mental disorders. The search for explanations of the causes of abnormal behaviour dates to ancient times, as do conflicting opinions about the aetiology of mental disorders. There have also been a number of approaches to treat these mental disorders or psychopathologies. Ancient beliefs attributed abnormal behaviour to the disfavour of a supernatural power or the mischief of demons. A second stream of beliefs started attributing mental disorders to some physiological dysfunctions and biochemical imbalances in the body. This was only late nineteenth or early twentieth century when psychological explanations of nature, aetiology and treatment of mental disorders began to be conceptualised and getting importance. In this unit we will be dealing with the ancient supernatural beliefs followed by Biological Models where in we discuss early Greek contributions and the 19th century writers and the 20th century concepts. This will be followed by the next section which will consider the psychological approaches which will consider psychoanalytic, humanistic and behavioural approaches.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain supernatural belief regarding causes and treatment of psychopathology;
- Describe the biological approach to psychopathology;
- Explain the psychoanalytic theory of psychopathology;

- Present an account humanistic approach to psychopathology; and
- Understand the relevance of behaviouristic approach in explanation of psychopathology.

1.2 THE ANCIENT SUPERNATURAL BELIEFS

Throughout history, human civilisations have held quite different views of the problems that we consider now to be mental disorders. The search for explanations of the causes of abnormal behaviour dates to ancient times, as do conflicting opinions about the aetiology of mental disorders. There have also been a number of approaches to treat these mental disorders or psychopathologies. Ancient beliefs attributed abnormal behaviour to the disfavour of a supernatural power or the mischief of demons. A second stream of beliefs started attributing mental disorders to some physiological dysfunctions and biochemical imbalances in the body. This was only late nineteenth or early twentieth century when psychological explanations of nature, aetiology and treatment of mental disorders began to be conceptualised and getting importance.

The ancient human civilisations believed that abnormal behaviours are caused by some supernatural magic, evil spirits, demons, moon and the stars. There was a strong belief that our behaviours, affects and thought are governed by the agent situated outside our bodies and environment. These agents included supernatural entities (divinities, demons and spirits), celestial objects (stars and moon) and other phenomena like magnetic fields.

1.2.1 Witchcraft and Demonology

The individuals suffering from mental disorders were supposed to be possessed and controlled by magical, evil spirits and demons. Nature of the spirit was judged by the nature of behaviour exhibited by the affected person. Excessive spiritual behaviours were attributed to holy spirits, while destructive behaviours were thought to be caused by evil spirits. The treatments included punishments like chaining them or keeping them in cages or horrible ritual of boring a hole in the skull. These victims after going through an unfair trial were condemned as witches or demons were burned alive or hanged.

1.2.2 Moon and Stars

The Latin word for moon is Luna, this inspired people to use the word lunatic for abnormal people, but now this word, is not used any more. According to this notion the movements of the full moon and the stars have an effect on behaviour of people. This view is reflected by followers of astrology who think that their behaviour as well as major events in their lives can be predicted by the position of the planets.

1.2.3 Mass Hysteria

It is a phenomenon in which the experience of an emotion seems to spread to those in the surroundings around. If an individual is frightened and sad this feeling and experience spreads to nearby people and soon this feeling further escalates, develops into a panic and the whole community is affected. The Supernatural model is still popular and used in undeveloped cultures where poverty is high and literacy rate is low and mental health professionals are not permitted to play their role. People still look towards magic and rituals performed by holy persons for the solutions of mental disorders.

1.3 BIOLOGICAL MODELS

With the rising interest in biological sciences supernatural explanations were started to be discounted. Biological models attributed mental disorders to physical diseases and biochemical imbalances in the body.

1.3.1 Early Greek Contributions: Hippocrates and Galen

The Greek physician Hippocrates ridiculed demonological accounts of illness and insanity. Instead, Hippocrates hypothesized that abnormal behaviour, like other forms of disease, had natural causes. Health depended on maintaining a natural balance within the body, specifically a balance of four body fluids (which were also known as the four humors): blood, phlegm, black bile, and yellow bile.

Hippocrates argued that various types of disorder or psychopathology resulted from either an excess or a deficiency of one of these four fluids. The Hippocratic perspective dominated medical thought in Western countries until the middle of the nineteenth century. People trained in the Hippocratic tradition viewed “disease” as a unitary concept. In other words, physicians did not distinguish between mental disorders and other types of illness. All problems were considered to be the result of an imbalance of body fluids, and treatment procedures were designed in an attempt to restore the ideal balance.

Galen a Roman physician adopted Hippocratic theory and advocated that the four fluids relate to the Greek environmental concepts such as heat (blood), dryness (black bile), moisture (yellow bile) and cold (phlegm). Each fluid was related to one quality. Excess of one or more fluids were treated by regulating the environment to increase or decrease heat, dryness, moisture and cold depending on the deficiency of the fluid. For example, when King Charles the sixth got sick he was treated according to the following concept of Galen. He was moved to less stressful countryside environment to restore the balance of his body fluids. Rest, good diet and exercise were recommended.

Early biological models of mental disorders used some unique techniques of treatment. One of these was bloodletting, a technique where a measured amount of blood was removed by leeches to minimise aggressive tendencies. Induced vomiting was used to reduce Depression. The diagnosed person was forced to eat tobacco and half boiled cabbage for vomiting.

1.3.2 Nineteenth Century: J.P. Grey and E. Kraepelin

J. P. Grey theorised that mental disorder (insanity) was always due to physical causes and emphasis should be on rest and diet, proper room temperature and ventilation. He even invented the rotary fan and used it at State Hospital in New York. Emil Kraepelin contributed in the area of diagnosis and classification of Psychological Disorders. Each psychological disorder had a different age of onset and time course to follow, along with a different cluster of presenting symptoms. His descriptions of schizophrenia are still useful. He described schizophrenia as a psychotic disorder having 11 subtypes where reality contact was severely lost with delusions (false beliefs) and hallucinations.

1.3.3 Twentieth Century: Insulin Shock Therapy and Electroconvulsive Therapy

In 1927 Manfred Sakel, a Viennese physician, began using higher and higher dosages

of Insulin, the patients had convulsions and went into a state of coma but surprisingly these patients recovered so physicians started to use it frequently. The method was abandoned because it was dangerous, caused coma and even death. Joseph Meduna, in 1920 observed that Schizophrenia was rarely found in epileptics (which later did not prove to be true) and his followers concluded that induced brain seizures might cure Schizophrenia. Electroconvulsive Therapy (ECT) was used extensively and frequently by doctors but was a controversial method some doctors even used it to penalise the difficult unmanageable patients. It is effective with suicidal patients.

Self Assessment Questions

- 1) Explain the early supernatural approach of understanding psychopathology.
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- 2) Describe the early Greek contributions in development of biological models of psychopathology.
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- 3) Explain the contribution of J.P. Grey and E. Kraepelin in development of psychopathology.
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- 4) Give an account of insulin shock therapy and electroconvulsive therapy.
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1.4 PSYCHOLOGICAL APPROACHES

Psychological viewpoints stressed that there were so many emotional problems that could not be attributed to any organic disorder. These approaches emphasise on psychological, interpersonal, social and cultural factors in explanation and treatment of abnormality.

1.4.1 Early Psychological Approaches

Psychological approaches began with the moral and mental hygiene movement which advocated humane and responsible care of the institutionalised patients and encouraged and reinforced social interaction with them. Mental hygiene movement started with the concept of moral therapy. Pioneers in the mental reforms were P. Pinel (1745-1826), William Tuke (1732-1822), Benjamin Rush (1745-1813) and Dorothea Dix (1802-1887). All these individuals were the pioneers in the mental hygiene movement which led to asylum reforms in Europe and America.

In Europe during the Middle Ages mentally ill and mentally retarded, commonly called as the “lunatics” and “idiots”, aroused little interest and were given marginal care. Disturbed behaviour was considered to be the responsibility of the family rather than the community or the state. In the 1600s and 1700s, “insane asylums” were established. Early asylums were little more than human warehouses, but as the nineteenth century began, the moral treatment movement led to improved conditions in at least some mental hospitals. Founded on a basic respect for human dignity and the belief that humanistic care would help to relieve mental illness, moral treatment reform efforts were instituted by leading mental health professionals of the time.

In the middle of the 1800s, Dorothea Dix argued that treating the mentally ill in hospitals was to be more humane and more economical than caring for them haphazardly in their communities. She urged that special facilities be provided to house mental patients. The creation of large institutions for the treatment of mental patients led to the development of a new profession of psychiatry.

By the middle of the 1800s, superintendents of asylums for the insane were almost always physicians who were experienced in taking care of people with severe mental disorders. The Association of Medical Superintendents of American Institutions for the Insane (AMSAAI), which later became the American Psychiatric Association (APA), in 1844. In 1833, the state of Massachusetts opened a public supported asylum for the people with mental disorders, in Worcester. Samuel Woodward, the asylum’s first superintendent, also became the first president of the AMSAAI. Woodward claimed that mental disorders could be cured just like other types of illnesses. Treatment at the Worcester Lunatic Hospital included a blend of physical and moral procedures.

1.4.2 Psychoanalytic Approach

Psychoanalysis was pioneered by Sigmund Freud (1856-1939). He learned the art of hypnosis from France. He experimented with somewhat different procedures of hypnosis. He used hypnosis in an innovative way. He encouraged his patients to talk freely about their problems, conflicts and fears. He discovered the unconscious mind and its influence in psychopathology by using the techniques of free association, dream analysis and Freudian slips. Freud emphasised on internal mental processes and childhood experiences. The core elements of this approach include:

- a) Analysis of Mental Structures
- b) Levels of Consciousness
- c) Stages of Psychosexual Development
- d) Anxiety and Defense Mechanisms
- e) Psychoanalytic Therapy

a) **Analysis of Mental Structures:** The human psyche consists of the *id*, the *ego* and the *super ego*, the thoughts attitudes and behaviours of three are in state of conflict called intra-psyche conflict. The Id is the unorganised reservoir of wishes or passions related to our sexual and aggressive drives. It strives for immediate gratification that bypasses demands of reality, order, logic and reason. The Id is like a child when it wants something it wants it there and then without regard for consequences, so Id operates on pleasure principle. The energy within the Id is labelled as the libido. The Id has its own characteristic way of processing information, cognitive style referred as primary process. The thinking patterns of Id are illogical, irrational, emotional immature and purely selfish.

Selfish and dangerous drives of the Id do not go unchecked and the Ego ensures that we must find ways to meet our basic needs without offending everyone around us. The Ego operates according to the reality principle and the cognitive operations of the ego are characterised by logic, reason and are referred as the secondary process. The ego tries to resolve conflicts between the demands of the Id within the permitted boundaries of super ego.

The Ego has the role to mediate conflict between the Id and the Super ego according to realities of the world. If it mediates successfully we see an individual who is well adjusted while if the Ego is unsuccessful either the Id or the Super ego becomes strong.

If the Super ego is strong we see a pure, rigid, nonflexible individual. Super ego is the storehouse of moral and ethical standards taught by parents, teachers and culture. It also refers to the conscience of the psyche. It operates according to the moral principle. When we do something wrong and ethical and moral standards are violated the Super ego generates guilt.

b) **Levels of Consciousness:** Freud describes three different layers of consciousness: conscious, preconscious/sub conscious and unconscious. According to Freud that part of the mind about which we are aware is consciousness. It is place where the Ego resides but it is a small part of mental life. The preconscious comprises of thoughts or activities that are easily made conscious by an effort to remember. The largest segment is the unconscious, which comprise the Id, is not easily reachable, yet it gives rise on to important needs and influences our behaviour. The Super ego resides at all the three levels of consciousness. Along with the mental structure, levels of consciousness describe the Freudian topographical structure of personality.

c) **Stages of Psychosexual Development:** Freud theorised that during childhood we pass through a number of psycho sexual stages of development. Each stage of development represent a specific period of development where our basic needs arise and an under or over gratification of the needs at any stage leaves a strong impression on the individual in form of a fixation or psychopathology reflected throughout the adult life. In each of these stages energy of sexual instinct, *libido*, is situated in different parts of the body.

Oral Stage (Birth to 2 years): In the oral stage the major source of pleasure is the mouth where the infant sucks, bites, through mouth, any fixation at this stage appears in form of nail biting , chewing pencils, paper etc. smoking cigarettes.

Anal Stage (2 to 3 years): In the anal stage, which extends from two to three years, toilet training begins. Any conflict or fixation at this stage appears in form of a person who is very neat, clean and strict in following rules/norms.

Phallic Stage (3 to 5 years): Phallic stage begins at three years and goes up to five years. In this stage boys have oedipal complex, a wish to have sexual attachment with their mothers, while girls shift away from mother and get closer to father, an experience labelled as Electra complex.

Latency (5 to 12 years): In this stage sex drives are subsided and child is mainly engaged in acquiring social, academic and professional skills.

Genital 12 years and onwards): Latency stage is where interest in sexual drive is less but it is the genital stage where interest in and tendency to impress opposite sex develops. One is more preoccupied to make a good impression on the members of opposite sex through one's looks, dress and conversation. Often you see a young growing up standing in front of the mirror and either trying to focus how to look even better etc. Each stage of development is important for a healthy adjustment and fixation at any stage may result in formation of psychopathology or an immediate behaviour.

d) **Anxiety and Defense Mechanisms**: Freud noted that a major drive for most people is the reduction in tension, and that a major cause of tension was anxiety. He identified three different types of anxiety.

Reality Anxiety: This is the most basic form of anxiety and is typically based on fears of real and possible events, such as being bitten by a dog or falling from a ladder. The most common way of reducing tension from Reality Anxiety is taking oneself away from the situation, running away from the dog or simply refusing to go up the ladder.

Neurotic Anxiety: This is a form of anxiety which comes from an unconscious fear that the basic impulses of the Id (the primitive part of our personality) will take control of the person, leading to eventual punishment (this is thus a form of Moral Anxiety).

Moral Anxiety: This form of anxiety comes from a fear of violating values and moral codes, and appears as feelings of guilt or shame.

The ego is always threatened by the possibility of expression of irrational and antisocial sexual and aggressive drives of the id. Thus, the ego fights a battle to stay on top of id and super ego. The conflicts between id and super ego produce anxiety that is a threat to ego. The threat or anxiety experienced by ego is a signal that alerts the ego to use unconscious protective processes that keep primitive emotions associated with conflicts in check. These protective processes are defense mechanisms or coping styles.

All defense mechanisms share two common properties: They often appear unconsciously and they tend to distort, transform, or otherwise falsify reality. In distorting reality, there is a change in perception which allows for a lessening of anxiety, with a corresponding reduction in felt tension. Freud's list of basic defense mechanisms includes:

- Denial: claiming/believing that what is true to be actually false.
- Displacement: redirecting emotions to a substitute target.
- Intellectualisation: taking an objective viewpoint.
- Projection: attributing uncomfortable feelings to others.

- Rationalisation: creating false but credible justifications.
- Reaction Formation: overacting in the opposite way to the fear.
- Regression: going back to acting as a child.
- Repression: pushing uncomfortable thoughts into the subconscious.
- Sublimation: redirecting ‘wrong’ urges into socially acceptable actions.

e) **Psychoanalytic Therapy:** Psychoanalytic therapy involves reliving repressed fantasies and fears both in feeling and in thought. This process involves transference, i.e. a projection of the attitudes and emotions, originally directed towards the parents, onto the analyst. This is necessary for successful treatment. Access to these repressed fears is gained often through dream interpretation, where the manifest content in dreams is understood as a symbolic expression of the hidden or latent content. (Internal censorship demands that the wish be transformed, leading to a disguised or symbolic representation.) The sources of dream content results from lost memories, linguistic symbols and repressed experiences.

Dreams are “guardians of sleep”, i.e. wish fulfilments that arise in response to inner conflicts and tensions whose function is to allow the subject to continue sleeping. Dream –Work is the production of dreams during sleep- the translation of demands arising from the unconscious into symbolic objects of the preconscious and eventually the conscious mind of the subject. Dream Interpretation is the decoding of the symbols (manifest content) and the recovery of their latent content, i.e. the unconscious and, hence, hidden tensions and conflicts that give rise to the dreams in the first place.

Evaluation: Some of the criticisms typically raised against the Freudian theory are:

- 1) Freud’s hypotheses are neither verifiable nor falsifiable. It is not clear what would count as evidence sufficient to confirm or refute theoretical claims.
- 2) The theory is based on an inadequate conceptualisation of the experience of women.
- 3) The theory overemphasises the role of sexuality in human psychological development and experience.

Self Assessment Questions

1) Explain the early psychological approaches of understanding psychopathology.

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2) Describe the Freudian topographical structure of personality.

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3) Explain the importance of stages of psychosexual development in understanding psychopathology.

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4) Give an account of the concepts of anxiety and defense mechanisms as explained by Freud.

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5) Elucidate the process of psychoanalytic therapy.

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1.4.3 Humanistic Approach

Humanistic view puts emphasis on the positive aspects of life, free choices and personal growth experiences. According to this approach abnormality results from refusal to accept personal responsibility for one's own actions and thoughts. So human behaviour is caused by the choices we make voluntarily. The humanistic theorists assume that human nature is inherently good and abnormal/aggressive behaviour is caused is by the society but not by the individual.

Carl Rogers, along with Abraham Maslow, rejected the deterministic nature of both psychoanalysis and behaviourism and maintained that we behave as we do because of the way we perceive our situation. As no one else can know how we perceive, we are the best experts on ourselves. Like Freud, Rogers developed his theory based on his work with emotionally troubled people but unlike Freud, Rogers claimed that we have a remarkable capacity for self healing and personal growth leading towards self-actualisation. Freud emphasised the importance of psychological continuity and hence believed our past to be a strong determinant of the present, whereas Rogers placed emphasis on the person's current perception and how we live in the here-and-now.

i) **Self and Congruence:** Central to Rogers' theory is the notion of self or self-concept. This is defined as "the organised, consistent set of perceptions and beliefs about oneself". It consists of all the ideas and values that characterise 'I' and 'me' and includes perception and valuing of 'what I am' and 'what I can do'. Consequently, the self-concept is a central component of our total experience and influences both our perception of the world and perception of oneself. For instance, a woman who

perceives herself as strong may well behave with confidence and come to see her actions as actions performed by someone who is confident.

The self-concept does not necessarily always fit with reality, and the way we see ourselves may differ greatly from how others see us. According to Rogers, we want to feel, experience and behave in ways which are consistent with our self-image and which reflect what we would like to be like, our ideal-self. The closer our self-image and ideal-self are to each other, the more consistent or congruent we are and the higher our sense of self-worth. A person is said to be in a state of incongruence if some of the experience are unacceptable and are denied or distorted in the self-image. As we prefer to see ourselves in ways that are consistent with our self-image, we may use defence mechanisms like denial or repression in order to feel less threatened by some of what we consider to be our undesirable feelings. A person whose self-concept is incongruent with their real feelings and experiences will defend themselves because the truth hurts. For example, a person on occasion may feel possessive but not want to see themselves as possessive. They will therefore push it out of their awareness, leaving them with a self-image of a generous person, not at all possessive.

The total experiencing individual including all feelings and experiences, denied or accepted is called the organismic self by Rogers. The greater the gap between the organismic self and the self-concept, the greater the chance of confusion and maladjustment. The self-concept of the congruent person, however, reflects the inevitability of change that occurs in the environment and is therefore, flexible. Similarly, as stated above, the closer the ideal-self is to the self-image (i.e. the closer the person you would like to be is to how you see yourself), the more fulfilled and happier the person you will be. So, we can see that two kinds of incongruence can develop: incongruence between self-concept and organismic self and incongruence between ideal-self and self-image.

ii) **Person Centered Therapy:** In order to enhance congruence and move towards self-actualisation the person needs to be self-accepting and to replace the conditions of worth with truer, organismic values. This is established according to Rogers by having at least one relationship in which the person experiences unconditional positive regard, where the person is totally accepted and supported regardless of what they do, think or feel. The relationship obviously must be controlled or directed not by the other person in the relationship but by oneself. The person him/herself is at the centre, hence the term 'person-centred'.

Any relationship which reduces incongruence is a therapeutic relationship according to Rogers. Such a relationship is characterised by one person experiencing another person who communicates: (a) unconditional positive regard, (b) empathy (i.e. accepting that another person experiences the world in an entirely different manner from yourself and reflecting back what this is like) (c) genuineness (i.e. being oneself rather than playing a role, of say, therapist, friend, parent or teacher)

If a person demonstrates these three qualities consistently in a relationship, they are offering a therapeutic context to the other person. If a person feels these three qualities in a relationship, they are said to be in a therapeutic, healing or growing relationship.

Evaluation: Some of the criticisms raised against the humanistic approach are:

1) This approach criticized behaviourism for not acknowledging mental events, though the humanistic theorists overlooked scientific methods of studies.

- 2) Wishful thinking of man is not supported by scientific investigation and facts.
- 3) Humanistic approach used the terms like intuition and reasoning, which were philosophy and could not be tested.
- 4) This approach rejected animal research in psychology.
- 5) Concepts of this approach are sometimes not amenable to clear definition and verification.

1.4.4 Behavioural Approach

The behavioural perspective is identified with the Russian physiologist Ivan Pavlov (1849–1936), the discoverer of the conditioned reflex, and the American psychologist John B. Watson (1878–1958), the father of behaviourism. The behavioural perspective focuses on the role of learning in explaining both normal and abnormal behaviour. From a learning perspective, abnormal behaviour represents the acquisition, or learning, of inappropriate, maladaptive behaviours. From the learning perspective the abnormal behaviour itself is the problem. In this perspective, abnormal behaviour is learned in much the same way as normal behaviour. Why do some people behave abnormally? It may be that their learning histories differ from other people's. For example, a person who was harshly punished as a child for masturbating might become anxious, as an adult, about sexuality.

Poor child-rearing practices, such as capricious punishment for misconduct and failure to praise or reward good behaviour, might lead to antisocial behaviour. Children with abusive or neglectful parents might learn to pay more attention to inner fantasies than to the world outside and have difficulty distinguishing reality from fantasy.

Watson and other behaviourists, such as Harvard University psychologist B. F. Skinner (1904–1990), believed that human behaviour is the product of our genetic inheritance and environmental or situational influences. Like Freud, Watson and Skinner discarded concepts of personal freedom, choice, and self-direction. But whereas Freud saw us as driven by irrational forces, behaviourists see us as products of environmental influences that shape and manipulate our behaviour. Behaviourists also believed that we should limit the study of psychology to behaviour itself rather than focus on underlying motivations. Therapy, in this view, consists of shaping behaviour rather than seeking insight into the workings of the mind. Behaviourists focus on the roles of two forms of learning in shaping both normal and abnormal behaviour, classical conditioning and operant conditioning.

Role of Classical Conditioning: The Russian physiologist Ivan Pavlov discovered the conditioned reflex (now called a *conditioned response*) quite by accident. In his laboratory, he harnessed dogs to an apparatus to study their salivary response to food. Along the way he observed that the animals would salivate and secrete gastric juices even before they started to eat. These responses appeared to be elicited by the sound of the food cart as it was wheeled into the room.

So Pavlov undertook an experiment that showed that animals could learn to salivate in response to other stimuli, such as the sound of a bell, if these stimuli were *associated* with feeding. Because dogs don't normally salivate to the sound of bells, Pavlov reasoned that they had acquired this response. He called it a **conditioned response** (CR), or conditioned reflex, because it had been paired with what he called an **unconditioned stimulus** (US)—in this case, food—which naturally elicited salivation. The salivation to food, an unlearned response, Pavlov called the

unconditioned response (UR), and the bell, a previously neutral stimulus; he called the **conditioned stimulus** (CS).

Phobias or excessive fears may be acquired by classical conditioning. For instance, a person may develop a phobia for riding on elevators following a traumatic experience on an elevator. In this example, a previously neutral stimulus (elevator) becomes paired or associated with an aversive stimulus (trauma), which leads to the conditioned response (phobia).

Watson himself had demonstrated how a fear response could be acquired through classical conditioning. Together with his research assistant who was later to become his wife, Rosalie Rayner, Watson classically conditioned an 11-month-old boy, who is well known in the annals of psychology as “Little Albert,” to develop a fear response to a white rat (Watson & Rayner, 1920). Prior to conditioning, the boy showed no fear of the rat and had actually reached out to stroke it. Then, as the boy reached for the animal, Watson banged a steel bar with a hammer just behind the boy’s head, creating a loud, aversive sound. After repeated pairings of the jarring sound and the presence of the animal, Albert sure enough showed a conditioned response, displaying fear to the rat alone. From the learning perspective, normal behaviour involves responding adaptively to stimuli, including conditioned stimuli. After all, if we do not learn to be afraid of putting our hand too close to a hot stove after one or two experiences of being burned or nearly burned, we might repeatedly suffer unnecessary burns. On the other hand, acquiring inappropriate and maladaptive fears on the basis of conditioning may cripple our efforts to function in the world.

Role of Operant Conditioning: Classical conditioning can explain the development of simple, reflexive responses, such as salivating to cues associated with food, as well as the emotional response of fear to stimuli that have been paired with painful or aversive stimuli. But classical conditioning does not account for more complex behaviours, such as studying, working, socialising, or preparing meals. The behavioural psychologist B. F. Skinner (1938) called these types of complex behaviours operant responses because they operate on the environment to produce effects or consequences. In operant conditioning, responses are acquired and strengthened by their consequences.

We acquire responses or skills, such as raising our hand in class that lead to reinforcement. Reinforcers are changes in the environment (stimuli) that increase the frequency of the preceding behaviour. Behaviours that lead to rewarding consequences are strengthened—that is, they are more likely to occur again. Over time, such behaviours become habits (Staddon & Cerutti, 2003). For example, you likely acquired the habit of raising your hand in class on the basis of experiences early in grade school when your teachers responded to you only if you first raised your hand.

Skinner identified two types of reinforcers. Positive reinforcers, which are commonly called rewards, boost the frequency of behaviour when they are introduced or presented. Most of Skinner’s work focused on studying operant conditioning in animals, such as pigeons. If a pigeon gets food when it pecks a button, it will continue to peck a button until it has eaten its fill. If we get a friendly response from people when we hold the door open for them, we’re more likely to develop the habit of opening the door for others.

Negative reinforcers increase the frequency of behaviour when they are removed. If picking up a crying child stops the crying, the behaviour (picking up the child) is negatively reinforced (made stronger) by the removal of the negative reinforce (the crying, an aversive stimulus).

Adaptive, normal behaviour involves learning responses or skills that lead to reinforcement. We learn behaviours that allow us to obtain positive reinforcers or rewards, such as food, money, and approval, and that help us remove or avoid negative reinforcers, such as pain and disapproval. But if our early learning environments do not provide opportunities for learning new skills, we might be hampered in our efforts to develop the skills needed to obtain reinforcement. A lack of social skills, for example, may reduce our opportunities for social reinforcement (approval or praise from others), which may lead in turn to depression and social isolation.

Punishment can be considered the flip side of reinforcement. Punishments are aversive stimuli that decrease the frequency of the behaviour they follow. Punishment may take many forms, including physical punishment, removal of a reinforcing stimulus, assessment of monetary penalties, taking away privileges, or removal from a reinforcing environment.

Social-Cognitive Theory: Social-cognitive theory represents the contributions of theorists such as Albert Bandura, Julian B. Rotter, and Walter Mischel. Social-cognitive theorists expanded traditional learning theory by including roles for thinking, or cognition, and learning by observation, which is also called modelling (Bandura, 2004). A phobia for spiders, for example, may be learned by observing the fearful reactions of others in real life, on television, or in the movies.

Social-cognitive theorists believe that people have an impact on their environment, just as their environment has an impact on them (Bandura, 2001, 2004). Social-cognitive theorists agree with traditional behaviourists like Watson and Skinner that theories of human nature should be tied to observable behaviour. However, they argue that factors within the person, such as expectancies and the values placed on particular goals, also need to be considered in explaining human behaviour. For example, people who hold more positive expectancies about the effects of a drug are more likely to use the drug and to use larger quantities of the drug than are people with less positive expectancies.

Behaviour Modification: Processes and techniques used for treatment of maladaptive behaviours based on different theories of behaviouristic approach are called behaviour modification. Conditions suitable for behaviour therapy are phobic disorders, obsessive compulsive disorders, generalised anxiety disorder, panic disorders, habit disorders, sexual deviations/dysfunctions, social skills deficits and enuresis. Major techniques used under behaviour modification are relaxation therapy, systematic desensitisation, biofeedback, aversion therapy, habit reversal, modelling, shaping, token economy and cognitive behaviour therapy.

Evaluation: Learning perspectives have spawned a model of therapy, called behaviour therapy (also called behaviour modification), that involves systematically applying learning principles to help people change their behaviour. Behaviour therapy techniques have helped people overcome a wide range of psychological problems, including phobias and other anxiety disorders, sexual dysfunctions, and depression. Moreover, reinforcement based programs are now widely used in helping parents learn better parenting skills and helping children learn in the classroom. Some of the criticisms raised against the behaviouristic theories are:

- 1) Behaviourism alone cannot explain the richness of human behaviour and that human experience cannot be reduced to observable responses.
- 2) Many learning theorists too, especially social-cognitive theorists, have been dissatisfied with the strict behaviouristic view that environmental influences (rewards and punishments) mechanically control our behaviour.

- 3) Humans experience thoughts and dreams and formulate goals and aspirations. Behaviourism does not seem to address much of what it means to be human.
- 4) Social-cognitive theorists have broadened the scope of traditional behaviourism, but critics claim that social-cognitive theory places too little emphasis on genetic contributions to behaviour and doesn't provide a full enough account of subjective experience, such as self-awareness and the flow of consciousness.

Self Assessment Questions

- 1) Explain the basic assumptions of humanistic approaches to psychopathology.

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- 2) Describe the role of self-concept and congruence in development of unhealthy personality as explained by Carl Rogers.

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- 3) Explain the assumptions of learning theories regarding maladaptive behaviour.

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- 4) Present an account of the theory of classical conditioning in explaining acquired fears and anxiety.

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- 5) Elucidate that how the theory of operant conditioning explains abnormal behaviours.

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6) Describe the importance of cognitive behaviour theories in explaining abnormal behaviours.

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1.5 LET US SUM UP

The ancient human civilisations believed that abnormal behaviours are caused by some supernatural magic, evil spirits, demons, moon and the stars. There was a strong belief that our behaviours, affects and thought are governed by the agent situated outside our bodies and environment. These agents included supernatural entities (divinities, demons and spirits), celestial objects (stars and moon) and other phenomena like magnetic fields. With the rising interest in biological sciences supernatural explanations were started to be discounted. Biological models attributed mental disorders to physical diseases and biochemical imbalances in the body.

Psychological approaches began with the moral and mental hygiene movement which advocated humane and responsible care of the institutionalised patients and encouraged and reinforced social interaction with them. Mental hygiene movement started with the concept of moral therapy. Psychodynamic perspectives reflect the views of Freud, who believed that abnormal behaviour stemmed from psychological causes based on underlying psychic forces within the personality. Humanistic theorists believe it is important to understand the obstacles that people encounter as they strive toward self-actualisation and authenticity. Learning theorists posit that the principles of learning can be used to explain both abnormal and normal behaviour. Cognitive theorists focus on the role of distorted and self-defeating thinking in explaining abnormal behaviour.

1.6 UNIT END QUESTIONS

- 1) Explain the early supernatural approach of understanding psychopathology.
- 2) Describe the contributions of biological models in the historical development of psychopathology.
- 3) Explain the early psychological approaches of understanding psychopathology.
- 4) Present an account of Freudian psychoanalytical theory in research and practice in psychopathology.
- 5) Critically evaluate humanistic approach to psychopathology. Also enumerate the points of difference with psychoanalysis and learning theories.
- 6) Explain the behaviouristic approach to psychopathology.

1.7 GLOSSARY

Demonology : An ancient belief that the individuals suffering from mental disorders were be possessed and controlled by magical, evil spirits and demons.

- Mass Hysteria** : A phenomenon in which the experience of an emotion seems to spread to those in the surroundings around.
- Biological Models** : A model that attribute mental disorders to physical diseases and biochemical imbalances in the body.
- The Id** : The part of personality which is the unorganised reservoir of wishes or passions related to our sexual and aggressive drives striving for their immediate gratification.
- The Ego** : The part of personality which operates according to the reality principle characterised by logic, reason.
- Neurotic Anxiety** : This is a form of anxiety which comes from an unconscious fear that the basic impulses of the Id will take control of the person, leading to eventual punishment.
- Defense Mechanisms** : Defense mechanisms are unconscious protective processes employed by the Ego that keep primitive emotions associated with conflicts in check and protect from threat or anxiety experienced by ego.
- Self-Concept** : Self-concept is defined as the organised, consistent set of perceptions and beliefs about oneself.
- Classical Conditioning** : When a neutral stimulus (conditioned stimulus, CS) is paired with a natural stimulus (unconditioned stimulus, UCS), neutral stimulus alone acquires the ability to elicit the response (conditioned response, CR) which naturally occurs (unconditioned response, UCR) after natural stimulus.
- Positive Reinforcers** : Commonly called as rewards, positive reinforcers increase the likelihood of behaviour when they are introduced or presented.
- Negative Reinforcers** : Negative reinforcers increase the likelihood of behaviour when they are removed.
- Punishment** : Punishments are aversive stimuli that decrease the likelihood of the behaviour they follow.
- Social Cognitive Theory** : A learning-based theory that emphasises observational learning and incorporates roles for cognitive variables in determining behaviour.

1.8 SUGGESTED READINGS

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UNIT 2 CLASSIFICATION OF PSYCHOPATHOLOGY: DSM IV TR

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 Meaning and Purpose of Classification of Psychopathology
 - 2.2.1 Approaches to the Classification of Psychopathology
- 2.3 History of Classification of Psychopathology
 - 2.3.1 Development of ICD
 - 2.3.2 Classification of Mental Disorders in ICD-10
- 2.4 Diagnostic and Statistical Manual of Mental Disorders (DSM)
 - 2.4.1 A Brief History of DSM
 - 2.4.2 Revisions of DSM
- 2.5 DSM-IV (TR): The Current Version of DSM
 - 2.5.1 Multi-Axial Classifications
- 2.6 Evaluation of DSM-IV (TR)
- 2.7 Let Us Sum Up
- 2.8 Unit End Questions
- 2.9 Glossary
- 2.10 Suggested Readings

2.0 INTRODUCTION

Classification is the core of science. Therefore, classification systems are developed with which we could define or classify behaviour. Abnormal psychology is based on the assumption that behaviour is part of one category or disorder and not of another one. A thorough account of classification of mental disorders will be presented in this unit. First of all, we will discuss meaning, purposes and approaches of classification of mental disorders. This will be followed by a description of history of classification of mental disorders. We will then discuss widely used DSM-IV (TR), the current version of DSM. Finally, DSM-IV (TR) will be evaluated.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain meaning, purpose and approaches of classification of mental disorders;
- Present an account of history of classification of mental disorders;
- Explain ICD-10 for the classification of mental disorders;
- Understand the development of DSM as a system of classification of mental disorders;

- Present an account of DSM-IV (TR); and
- Evaluate DSM-IV (TR).

2.2 MEANING AND PURPOSE OF CLASSIFICATION OF PSYCHOPATHOLOGY

In order to classify the psychological disorders we need a classification system. The term classification refers to process to construct categories and to assign people to these categories on the basis of their attributes. Classification in scientific context refers to taxonomy. It also refers to nomenclature, which describes the names and labels that may make up a particular disorder such as schizophrenia or depression. Classification is at the heart of every science. If we cannot label and order objects or experiences or behaviours scientists could not communicate with one another and our knowledge will not advance.

Without labelling and organising patterns of abnormal behaviour, researchers could not communicate their findings to one another, and progress toward understanding and decision about these disorders would come to a halt. Certain psychological disorders respond better to one therapy than another or to one drug than another. Classification also helps clinicians predict behaviour. Finally, classification helps researchers identify populations with similar patterns of abnormal behaviour. By classifying groups of people as depressed, for example, researchers might be able to identify common factors that help explain the origins of depression. Classification of psychopathology fulfils following five primary purposes:

- 1) Communication
- 2) Control
- 3) Comprehension
- 4) Distinction
- 5) Prognosis/prediction

2.2.1 Approaches to the Classification of Psychopathology

Psychologists use three approaches or strategies to classify disorders:

- i) **Categorical approach:** It was Kraepelin, the first psychiatrist to classify psychological disorders from a biological or medical point of view. For Kraepelin in term of physical disorders, we have one set of causative factors which do not overlap with other disorders. We have one defining criteria, which everybody in the category or in the group should meet, e. g. Schizophrenia. After a category has been defined, an object is either a member of the category or it is not. A categorical approach to classification assumes that distinctions among members of different categories are qualitative. In other words, the differences reflect a difference in kind (quality) rather than a difference in amount (quantity).
- ii) **Dimensional approach:** A second strategy is a dimensional approach, in which we note the variety of cognitions, moods and behaviours with which the patient presents and quantify them on a scale. For example, on a scale of 1 to 10, a patient might be rated as severely anxious (10), moderately depressed (5), and mildly manic (2) to create a profile of emotional functioning (10, 5, 2). Although dimensional approaches have been applied to psychopathology, they are relatively

unsatisfactory. Dimensional approach to classification describes the objects of classification in terms of continuous dimensions. Rather than assuming that an object either has or does not have a particular property, it may be useful to focus on a specific characteristic and determine how much of that characteristic the object exhibits.

- iii) **Prototypical approach:** A third approach, for organising and classifying behavioural disorders which is an alternative to the first two. It is called a prototypical approach. It identifies some essential characteristics of a disorder and it also allows for certain non-essential variations that do not necessarily change the classification. With this approach classifying the disorder by different possible features or properties any candidate must meet (but not all) of them to fall in that category. In depression, there are five important symptoms such as: depressed mood all the day, weight loss, insomnia, fatigue and feeling of worthlessness. For a person might have three or four of the characteristics of the depression but not all five of them. Yet we still diagnose the person as depressed.

2.3 HISTORY OF CLASSIFICATION OF PSYCHOPATHOLOGY

The most ancient classification of psychopathology was of senile deterioration, melancholia and hysteria. The oldest systematic classification finds its mention in the Ayurveda, an Indian body of thought. The Greek philosopher Hippocrates (460–370 B.C.) classified mental illness into delirium, mania, paranoia, hysteria, melancholia resulting from 4 basic temperaments. Philippe Pinel's (1745–1826) father of modern psychiatry, classification system was based on functional disorders of nervous system. He described four functional disorders: dementia, mania, melancholia and idiotism. Karl Ludwig Kahlbaum (1828-1899) distinguished organic and non organic mental disorders. Emil Kraepelin's (1856- 1926) classification system was based on clinical features of disorders: cause, course and outcomes. His primary classifications were manic depressive psychosis and dementia praecox. Eugen Bleuler combined Kraepelin and Meyerian approaches and classified mental disorders on the basis of psychopathological processes.

2.3.1 Development of ICD

In 1893 1st international list of causes of death was published. This stimulated worldwide organised effort for classification of diseases which resulted in the publication of International Statistical Classification of Diseases and Related Health Problems-1 (ICD-1) by the World Health Organisation in 1900. However, it was only ICD-6 which was published with a separate section on mental disorder in 1949. ICD-8 was published in 1972 with a comprehensive glossary of mental disorders. ICD-9 was published in 1977 with greater clinical modification. Vol. 1 and 2 of ICD-9 described diagnostic codes, while vol. 3 explained procedure codes for the Mental and Behavioural Disorders.

ICD-10: In 1978, WHO entered into a long-term collaborative project with the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) in the USA, aiming to facilitate further improvements in the classification and diagnosis of mental disorders, and alcohol and drug related problems. A series of workshops brought together researchers and practitioners from a number of different psychiatric traditions and cultures, reviewed knowledge in specified areas, and developed recommendations

for future research. A major international conference on classification and diagnosis was held in Copenhagen, Denmark, in 1982 to review the recommendations that emerged from these workshops and to outline a research agenda and guidelines for future work. Several major research efforts were undertaken to implement the recommendations of the Copenhagen conference. All these efforts resulted in the publication of ICD-10 in 1992 in which in chapter V (F) pertained to the classification of mental disorders explaining their inclusion and exclusion terms.

2.3.2 Classification of Mental Disorders in ICD-10

A brief description of classification of mental disorders as per ICD-10 is given below:

- F00-F09: Organic, including symptomatic, mental disorders: Dementia, delirium, organic.
- F10-F19: Mental and behavioural disorders due to use of psychoactive substances: Alcohol, cocaine and tobacco.
- F20-F29: Schizophrenia, schizotypal and delusional disorders.
- F30-F39: Mood (affective) disorders: Manic, bipolar, depressive.
- F40-F48: Neurotic, stress-related and somatoform disorders: Phobia, OCD, adjustment, dissociative.
- F50-F59: Behavioural syndromes associated with physiological disturbances and physical factors: Eating, sleep, sexual disorders.
- F60-F69: Disorders of personality and behaviour in adult persons: Specific, impulse disorder, gender identity.
- F70-F79: Mental retardation
- F80-F89: Disorders of psychological development: Speech and language, pervasive development.
- F90-F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence: Hyperkinetic, conduct, tic.
- F-99: Unspecified mental disorders.

Self Assessment Questions

1) Explain meaning of classification of psychopathology.

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2) Describe the purpose of classification of psychopathology.

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3) Give an account of approaches to the classification of psychopathology.

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4) Explain the initial efforts of classification of psychopathology.

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5) Describe the importance of ICD in classification of psychopathology.

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6) Present an account of classification of mental disorders prescribed in ICD-10.

2.4 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, is the handbook used most often in diagnosing mental disorders in the United States and other countries.

2.4.1 A Brief History of DSM

Need of statistical information regarding mental disorders stimulated revolution in the efforts of development of a classification system in the United States. The National census of 1840 used a single category, “idiocy/insanity”. Seven categories of mental disorders were mentioned in the 1880 census: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. The American Psychiatric Association (APA), then known as Committee on Statistics, together with the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the “Statistical Manual for the Use of Institutions for the Insane” in 1917, which included 22 diagnoses. Subsequently, this was revised several times by APA over the years.

2.4.2 Revisions of DSM

In view of needs arisen from World War II, a committee headed by psychiatrist and brigadier general William C. Menninger with the help of US psychiatrists developed a new classification scheme called Medical 203 in 1943.

DSM-I (1952): In 1949, the World Health Organisation published the sixth revision of the International Statistical Classification of Diseases (ICD-10) which included a section on mental disorders for the first time. Consequently, an APA Committee on Nomenclature and Statistics was empowered to develop a classification system for use in the United States. In 1950 the APA committee undertook a review and consultation to circulate the Diagnostic and Statistical Manual of Mental Disorders-1 (DSM-I) which was approved in 1951 and published in 1952. The structure and conceptual framework were the same as in Medical 203, and many passages of text identical. The manual was 130 pages long and listed 106 mental disorders. DSM-I made 94% changes in nomenclature from the prior system and seventy disorder terms used “Reaction,” e.g., schizophrenic reaction. This included reaction to internal conflict. DSM-I is criticised on the basis that it was psychoanalytic in its theoretical orientation. The term “Unconscious” was mentioned a few times in describing psychoneurotic disorders in DSM-I.

DSM-II (1968): Despite APA’s involvement in the revision of the mental disorder section of the ICD-8 in 1968, it also published a revision of the DSM in 1968, listed 182 disorders, and was 134 pages long. It was quite similar to the DSM-I. The term “reaction” was dropped but the term “neurosis” was retained. Both the DSM-I and the DSM-II reflected the predominant psychodynamic psychiatry, although they also included biological perspectives and concepts from Kraepelin’s system of classification. Symptoms were not specified in detail for specific disorders. Many of the disorders were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis (roughly, anxiety/depression broadly in touch with reality, or hallucinations/delusions appearing disconnected from reality). Sociological and biological knowledge was also incorporated, in a model that did not emphasise a clear boundary between normality and abnormality. After wide post publication criticism of DSM-II, the term “Homosexuality” was replaced with “Ego-dystonic Homosexuality” in 1973.

DSM-III (1980): To make the DSM nomenclature consistent with the International Statistical Classification of Diseases and Related Health Problems (ICD) the decision to create a new revision of the DSM was made in 1974 with Robert Spitzer as chairman of the task force. This revision was aimed at improving the uniformity and validity of psychiatric diagnosis, standardising diagnostic practices across the world and to facilitate the pharmaceutical regulatory process to avoid criticisms levelled on DSM-II. The criteria for many of the mental disorders were taken from the Research Diagnostic Criteria and Feighner Criteria. New categories of disorder and their criteria were established by consensus during meetings of the committee. The psychodynamic or physiologic view was abandoned, in favour of a regulatory or legislative model. A new “multi-axial” system attempted to yield a picture more amenable to a statistical population census, rather than just a simple diagnosis. DSM conceptualised each of the mental disorders as a clinically significant behavioural or psychological syndrome.

Finally published in 1980, the DSM-III was 494 pages long and listed 265 diagnostic categories. It rapidly came into widespread international use. DSM-III was published with 93% changes in nomenclature from the earlier version of DSM with diagnostic

criteria for each of the disorders mentioned. There was a multi-axial classification with five axes. DSM-III provided a vast increase in background information about each disorder, adding diagnostic features, associated features, cultural and gender features; prevalence, course, familiar patterns, differential diagnosis, decision trees and glossary. However, DSM-III was later criticized on the ground that 20-30 percent of the population would have been diagnosed as having behavioural disorders without having any serious mental problems.

DSM-III-R (1987): The DSM-III-R was published as a revision of DSM-III in 1987. Categories were renamed, reorganised, and significant changes in criteria were made. Six categories were deleted, while some new categories were added. Controversial diagnoses such as pre-menstrual dysphoric disorder and Masochistic Personality Disorder were discarded. “Sexual orientation disturbance” was also removed and was largely subsumed under “sexual disorder not otherwise specified” which can include “persistent and marked distress about one’s sexual orientation.” DSM-III-R contained 292 diagnoses and was 567 pages long.

DSM-IV (1994): DSM-IV was published in 1994 listing 297 disorders in 886 pages. Process of development of DSM-IV included extensive literature review of diagnoses, analyses to determine required change in criteria and multicenter field trials relating diagnoses to clinical practice. A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning”.

DSM-IV (TR) (2000): A “Text Revision” of the DSM-IV, known as the DSM-IV-TR, was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged. The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes in order to maintain consistency with the ICD.

2.5 DSM-IV (TR): THE CURRENT VERSION OF DSM

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard for classifying mental disorders that are used by mental health professionals in the United States. It is intended to be applicable in a wide variety of contexts and used by clinicians and researchers of many different orientations, for example; biological, psychodynamic, cognitive, behavioural, interpersonal, family/systems.

The DSM IV (Text Revision) has been designed for use across settings such as inpatient, outpatient, partial hospitalisation, consultation-liaison, clinic, private practice and primary care. Professionals that use the DSM diagnosis are psychiatrists, psychologists, social workers, nurses, occupational and rehabilitation therapists, counsellors and other health and mental health professionals. The DSM is also a necessary tool for collecting and communicating accurate public health statistics. The DSM consists of three major components/features: the diagnostic classification, the diagnostic criteria sets and the descriptive text.

i) **The Diagnostic Classification:** The DSM-IV (TR) is a categorical classification system. The categories are prototypes, and a patient with a close approximation to the prototype is said to have that disorder with qualifiers, for example mild, moderate or severe forms of a disorder. For nearly half the disorders, symptoms must be sufficient to cause clinically significant distress or impairment in social, occupational,

or other important areas of functioning, although DSM-IV-TR removed the distress criterion from tic disorders and several of the paraphilias. Making a DSM diagnosis consists of selecting those disorders from the classification that best reflects the signs and symptoms that are afflicting the individual being evaluated. Associated with each diagnostic label is a diagnostic code, which is used primarily by institutions and agencies for data collection. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the ICD-9-CM.

ii) **The Diagnostic Criteria:** Each disorder included in the DSM-IV (TR) includes a set of diagnostic criteria including symptoms that are present and for how long. These criteria called inclusion criteria as well as those symptoms that must not be present called exclusion criteria qualify an individual for a particular diagnosis. Many users of the DSM-IV (TR) find these diagnostic criteria useful because they provide a compact description of each disorder. Use of this diagnostic criterion has increased diagnostic reliability and the likelihood that different individuals will assign the same diagnosis. It is important to remember that these criteria are meant to be used as a guideline by an informed clinician.

iii) **Descriptive Text:** The third component of the DSM-IV (TR) is the descriptive text that accompanies each disorder. The text of the DSM-IV (TR) systematically describes each disorder under the following headings: Diagnostic Features; Subtypes and/or Specifics; Recording Procedures; Associated Features and Disorders; Specific Culture, Age, and Gender Features; Prevalence; Course; Familial Pattern; and Differential Diagnosis.

2.5.1 Multi-Axial Classifications

The DSM-IV (TR) recommends clinicians to assess an individual's mental state across five factors or axes. Together the five axes provide a broad range of information about the individual's functioning, not just a diagnosis. The system contains the following axes.

- 1) **Axis I:** *Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention:* This axis incorporates 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 I also includes relationship problems, academic or occupational problems, and bereavement, conditions that may be the focus of diagnosis and treatment but that do not in themselves constitute definable psychological disorders. Also coded on Axis I are psychological factors that affect medical conditions, such as anxiety that exacerbates an asthmatic condition or depressive symptoms that delay recovery from surgery. The Axis I clinical disorder categories are as follows:
 - 1) Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
 - 2) Delirium, Dementia, and Amnesic 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) Other Conditions That May Be a Focus of Clinical Attention
- 2) **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). This axis includes following disorders:
- 1) Paranoid Personality Disorder
 - 2) Narcissistic Personality Disorder
 - 3) Schizoid Personality Disorder
 - 4) Avoidant Personality Disorder
 - 5) Schizotypal Personality Disorder
 - 6) Dependent Personality Disorder
 - 7) Antisocial Personality Disorder
 - 8) Obsessive-Compulsive Personality disorder
 - 9) Borderline Personality Disorder
 - 10) Personality Disorder Not Otherwise Specified
 - 11) Histrionic Personality Disorder
 - 12) Mental Retardation
- 3) **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.
- 4) **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. Table 1 lists examples from this axis.

Table 1: Psychosocial and Environmental Problems

Problem Categories	Examples
Problems with primary support group	Death of family members; health problems of family members; marital disruption in the form of separation, divorce, or estrangement; sexual or physical abuse within the family; child neglect; birth of a sibling
Problems related to the social environment	Death or loss of a friend; social isolation or living alone; difficulties adjusting to a new culture (acculturation); discrimination; adjustment to transitions occurring during the life cycle, such as retirement
Educational problems	Illiteracy; academic difficulties; problems with teachers or classmates; inadequate or impoverished school environment
Occupational problems	Work-related problems including stressful workloads and problems with bosses or co-workers; changes in employment; job dissatisfaction; threat of loss of job; unemployment
Housing problems	Inadequate housing or homelessness; living in an unsafe neighbourhood; problems with neighbours or landlord
Economic problems	Financial hardships or extreme poverty; inadequate welfare support
Problems with access to health care services	Inadequate health care services or availability of health insurance; difficulties with transportation to health care facilities
Problems related to interaction with the legal system/crime	Arrest or imprisonment; becoming involved in a lawsuit or trial; being a victim of crime
Other psychosocial problems	Natural or human-made disasters; war or other hostilities; problems with caregivers outside the family, such as counsellors, social workers, and physicians; lack of availability of social service agencies

Source: Adapted from the *DSM-IV-TR* (APA, 2000)

- 5) **Axis V: Global Assessment of Relational Functioning (GARF):** The clinician rates the client's current level of psychological, social, and occupational functioning using a 0-100 scale. 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. The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship (APA, 2000).

Table 2: Global Assessment of Functioning (GAF) Scale

Code	Severity of Symptoms	Examples
91-100	Superior functioning across a wide variety of activities of daily life	Lacks symptoms Handles life problems without them “getting out of hand”
81-90	Absent or minimal symptoms, no more than everyday problems or concerns	Mild anxiety before exams Occasional argument with family members
71-80	Transient and predictable reactions to stressful events, or no more than slight impairment in functioning	Difficulty concentrating after argument with family Temporarily falls behind in schoolwork
61-70	Some mild symptoms, or some difficulty in social, occupational, or school functioning, but functioning pretty well	Feels down, mild insomnia Occasional truancy or theft within household
51-60	Moderate symptoms, or moderate difficulties in social, occupational, or school functioning	Occasional panic attacks Few friends, conflicts with co-workers
41-50	Serious symptoms, or any serious impairment in social, occupational, or school functioning	Suicidal thoughts, frequent shoplifting Unable to hold job, has no friends
31-40	Some impairment in reality testing or communication, or major impairment in several areas	Speech illogical Depressed man or woman unable to work, neglects family, and avoids friends
21-30	Strong influence on behaviour of delusions or hallucinations, or serious impairment in communication or judgment, or inability to function in almost all areas	Grossly inappropriate behaviour, speech sometimes incoherent Stays in bed all day, no job, home, or friends
11-20	Some danger of hurting self or others, or occasionally fails to maintain personal hygiene, or gross impairment in communication	Suicidal gestures, frequently violent Smears feces
1-10	Persistent danger of severely hurting self or others, or persistent inability to maintain minimal personal hygiene, or seriously suicidal act	Largely incoherent or mute Serious suicidal attempt, recurrent violence

Source: Adapted from the *DSM-IV-TR* (APA, 2000)

2.6 EVALUATION OF DSM-IV (TR)

DSM has provided a common language for discussing diagnoses. There has been an increase in attention to behaviours and the facilitation of the overall learning of psychopathology. Seligman (1990) has indicated that knowledge of diagnosis is important for counsellors so that they may provide a diagnosis for clients. In addition, the DSM diagnosis assists with accountability, record keeping, treatment planning, communication with other helping professionals and identification of client with issues beyond areas of expertise. The disadvantages associated with using the DSM have included the promotion of a mechanistic approach to mental disorder assessment. There is a false impression that the understanding of mental disorders is more advanced than is actually the case. There is an excessive focus on the signs and symptoms of mental disorders to the exclusion of a more in depth understanding of the client's problems including human development. The major issues of criticisms against DSM-IV (TR) are as follow:

- i) **Validity and reliability:** The most fundamental scientific criticism of the DSM concerns the validity and reliability of its diagnoses. This refers, roughly, to whether the disorders it defines are actually real conditions in people in the real world that can be consistently identified by its criteria. These are long-standing criticisms of the DSM, originally highlighted by the Rosenhan experiment in the 1970s, and continuing despite some improved reliability since the introduction of more specific rule-based criteria for each condition (Dalal & Sivakumar, 2009).

Critics argue that the DSM lacks validity because it has no relation to an agreed scientific model of mental disorder and therefore the decisions taken about its categories (or even the question of categories vs. dimensions) were not scientific ones; and that it lacks reliability partly because different diagnoses share many criteria, and what appear to be different criteria are often just rewordings of the same idea, meaning that the decision to allocate one diagnosis or another to a patient is to some extent a matter of personal prejudice (McLaren, 2007).

- ii) **Superficial symptoms:** By design, the DSM is primarily concerned with the signs and symptoms of mental disorders, rather than the underlying causes. It claims to collect them on the basis of statistical or clinical patterns and avoids causative or explanatory basis/biases. The DSM is based on an underlying structure that assumes discrete medical disorders that can be separated from each other by symptom patterns. However, its claim to be "atheoretical" is held to be unconvincing because it makes sense only if all mental disorders are categorical by nature, which only a biological model of mental disorder can satisfy. However, the Manual recognises psychological causes of mental disorder, e.g. PTSD, so that it negates its only possible justification (McLaren, 2007).

The DSM's focus on superficial symptoms is claimed to be largely a result of necessity (assuming such a manual is nevertheless produced), since there is no agreement on a more explanatory classification system. Reviewers note, however, that this approach is undermining research, including in genetics, because it results in the grouping of individuals who have very little in common except superficial criteria as per DSM or ICD diagnosis (Dalal & Sivakumar, 2009).

- iii) **Unjustified Categorical Distinctions:** Despite caveats in the introduction to the DSM, it has long been argued that its system of classification makes unjustified categorical distinctions between disorders, and uses arbitrary cut-offs between normal and abnormal. A psychiatric review noted that attempts to demonstrate

natural boundaries between related DSM syndromes or between a common DSM syndrome and normality have failed (Dalal & Sivakumar, 2009). Some argue that rather than a categorical approach, a fully dimensional, spectrum or complaint-oriented approach would better reflect the evidence (Bentall, 2006).

In addition, it is argued that the current approach based on exceeding a threshold of symptoms does not adequately take into account the context in which a person is living and to what extent there is internal disorder of an individual versus a psychological response to adverse situations (Wakefield, Schmitz, First, & Horwitz, 2007).. Axis IV of the DSM-IV (TR) includes a step for outlining “Psychosocial and environmental factors contributing to the disorder” once someone is diagnosed with that particular disorder. Because an individual’s degree of impairment is often not correlated with symptom counts and can stem from various individual and social factors, the DSM’s standard of distress or disability can often produce false positives (Spitzer & Wakefield, 1999). On the other hand, individuals who don’t meet symptom counts may nevertheless experience comparable distress or disability in their life.

- iv) **Cultural Bias:** Some psychiatrists argue that diagnostic standards of DSM-IV (TR) rely on an exaggerated interpretation of neurophysiological findings and so understate the scientific importance of social-psychological variables (Widiger, & Sankis, 2000). It is contended that the cultural and ethnic diversity of individuals is often discounted by researchers and service providers. In addition, current diagnostic guidelines have been criticized as having a fundamentally Euro-American outlook. It is argued that even when diagnostic criteria set is accepted across different cultures, it does not necessarily indicate that the underlying constructs have any validity within those cultures and reliable application can only demonstrate consistency, not legitimacy (Widiger, & Sankis, 2000).
- v) **Influence of Drug Companies:** The way the categories of the DSM-IV (TR) are structured and the number of categories have been substantially expanded is often attributed to the influence of pharmaceutical companies and psychiatrists (Healy, 2006). Roughly half of the authors who selected and defined the DSM-IV psychiatric disorders had financial relationships with the pharmaceutical industry at one time, raising the prospect of a direct conflict of interest.

In view of these criticisms and in pursuit of continuous improvements, the next (fifth) edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, is currently in consultation, planning and preparation. It is due for publication in May 2013. APA has made its draft versions public which includes several changes, including proposed deletion of several types of schizophrenia.

Self Assessment Questions

1) Explain the process of development of various editions of DSM.

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2) Describe the major components of DSM-IV (TR).

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3) Present an account of multi-axial approach to the classification of psychopathology as provided by DSM-IV (TR).

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4) Evaluate DSM-IV (TR) with its merits and demerits.

2.7 LET US SUM UP

Classification of psychological disorders refers to the process to construct categories of abnormal behaviours and to assign people to these categories on the basis of their behavioural attributes and dysfunctional symptoms. It fulfils the basic purposes of communication, control, comprehension, distinction and prognosis/prediction of psychological disorders. Psychologists use three approaches or strategies to classify disorders: categorical, dimensional and prototypical approach. There have been a number of individual efforts of classification of mental disorders. This worldwide organised effort for classification of diseases was stimulated by the publication of International Statistical Classification of Diseases and Related Health Problems-1 (ICD-1) by the World Health Organisation in 1900. However, it was only ICD-6 which was published with a separate section on mental disorder in 1949. The most recent, tenth edition of ICD was published in 1992 in which chapter V (F) pertained to the classification of mental disorders explaining their inclusion and exclusion terms.

The most influential efforts of classification of psychological disorders began with The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association which is now used as the handbook for diagnosing mental disorders in the United States and other countries. After publication of its first edition, DSM-1 in 1952, its five subsequent editions have been published. The current version of DSM is DSM-IV (TR) published in 2000. The DSM-IV (TR) consists of three major components/features: the diagnostic classification, the diagnostic criteria sets and the descriptive text. The DSM-IV (TR) recommends clinicians to assess an individual's mental state across five factors or axes. Together the five axes provide a broad range of information about the individual's functioning, not just a diagnosis. Axis I assesses clinical disorders and other conditions that may be a focus of clinical attention. This axis incorporates 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. Axis II assesses Personality Disorders and Mental Retardation. 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. The psychosocial and environmental problems that affect the diagnosis, treatment, or outcome of a mental disorder are placed on Axis IV. On Axis V, Global Assessment of Relational Functioning (GARF), the clinician rates the client's current level of psychological, social, and occupational functioning using a 0-100 scale. DSM-IV (TR) is criticised on the issues of validity and reliability; classifying mental disorders on the basis of superficial symptoms, culturally biased and unjustified categorical distinctions; and influence of drug companies in classification.

2.8 UNIT END QUESTIONS

- 1) Explain meaning, purpose of and approaches to classification of psychopathology.
- 2) Describe the history of history of classification of psychopathology.
- 3) Describe the importance of ICD in classification of psychopathology and present an account of classification of mental disorders prescribed in ICD-10.
- 4) Provide a historical account of development of various editions of DSM and describe the major components of DSM-IV (TR).
- 5) Present an account of multi-axial approach to the classification of psychopathology as provided by DSM-IV (TR).
- 6) Evaluate DSM-IV (TR) with its merits and demerits.

2.9 GLOSSARY

Classification of Psychological Disorders	: classification of psychological disorders refers to process to construct categories and to assign people to these categories on the basis of their attributes.
Categorical Approach	: A categorical approach to classification assumes that distinctions among members of different categories are qualitative.
Dimensional Approach	: Dimensional approach to classification describes the objects of classification in terms of continuous dimensions.
Prototypical Approach	: A prototypical approach identifies some essential characteristics of a disorder and it also allows for certain non-essential variations that do not necessarily change the classification.
Diagnostic Criteria	: A diagnostic criteria provides a compact description of a disorder.
Multi-axial Classification	: Assessing an individual's mental state across various factors or axes to provide a broad range of information about the individual's functioning, not just a diagnosis, recommended by DSM-IV (TR).

- Personality Disorders** : 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** : Mental retardation involves pervasive intellectual impairment.
- Global Assessment of Relational Functioning (GARF)** : A 0-100 scale on which the clinician rates the client's current level of psychological, social and occupational functioning using.
- Validity and reliability of a Classification System** : This refers to whether the disorders as a classification system defines are actually real conditions in people in the real world that can be consistently identified by its criteria.

2.10 SUGGESTED READINGS

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UNIT 3 DEVELOPMENTAL PATHOGENESIS

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Developmental Pathogenesis: Risk Factors
- 3.3 Developmental Causes of Psychopathologies
- 3.4 Biological Causes
 - 3.4.1 Genetic Vulnerabilities
 - 3.4.2 The Neuro-Endocrine System
 - 3.4.3 Physical Handicaps
 - 3.4.4 Early Physical Deprivation
- 3.5 Psychosocial Causes
 - 3.5.1 Parental Deprivation and Separation
 - 3.5.2 Childhood Traumas
 - 3.5.3 Parental Psychopathology
 - 3.5.4 Parenting Styles
 - 3.5.5 Inadequate Communication
 - 3.5.6 Disrupted Family Relationships
- 3.6 Socio-Cultural Causes
 - 3.6.1 The Socio-Cultural Environment
 - 3.6.2 Pathogenic Societal Influences
 - 3.6.3 Disorder Engendering Social Roles
 - 3.6.4 Social Change and Uncertainty
- 3.7 Let Us Sum Up
- 3.8 Unit End Questions
- 3.9 Glossary
- 3.10 Suggested Readings

3.0 INTRODUCTION

The intricacies of human development have always fascinated psychologists. Psychologists have studied developmental processes and used the knowledge gained from these investigations for better understanding of the changes that predictably occur in the later stage of life. This has made possible to link more effectively early precursors to the later expression of maladaptive and deviated behaviours. First of all, we will discuss general issues related to developmental pathogenesis. This will be followed by a description of biological causes of psychopathological development. Finally, psychosocial and socio-cultural factors of psychopathologies will be discussed.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Understand the risk factors of psychopathology;
- Explain the biological perspectives of developmental pathogenesis;

- Discuss the psychosocial causes of psychopathology; and
- Describe the socio-cultural factors of psychopathology.

3.2 DEVELOPMENTAL PATHOGENESIS: RISK FACTORS

The risk factor model is a paradigm that facilitates the understanding of developmental deviations. It can be applied at any stage of development. Risk factors have been divided into three large categories: those at the level of the individual, the family and the community.

The first category of risk factors is defined at the level of the individual. Both physical and emotional considerations are relevant. Examples include atypical genetic polymorphisms, deficits in perception and high levels of generalized anxiety. Variable possibilities for adaptation exist, but for a trait or condition to be considered a risk factor, there must be a demonstrated increase in the probability of subsequent emotional or behavioural disorder associated with the factor.

The second category of risk factors is conceptualised at the level of the family. One of the classic examples of a familial risk factor is a parent with a serious mental illness. It is difficult to define the mechanism by which this risk is transmitted. Each parent provides exactly one-half of the genome of the child. However, parents are also in a powerful position to shape the early environment of their children. The full range of family risk factors is quite broad, and extends beyond the influence of single individuals within the family to include the impact of family dynamics, which influence the development of the child. For example, a scapegoated child in a family environment that tolerates overt child maltreatment is at particularly high risk for the development of psychopathology.

The third category of risk factors is defined at the level of the community. Discrimination based on ethnic or racial status falls into this group of risk factors, as does social disadvantage. Although there is little controversy regarding the negative consequences of discrimination and poverty, the quantification of this risk has been problematic. Community risk factors rarely occur in the absence of individual and familial risk factors, making it difficult fully to understand their specific influence.

3.3 DEVELOPMENTAL CAUSES OF PSYCHOPATHOLOGIES

There have been a number of viewpoints regarding causal factors of psychopathologies. These viewpoints represent any of the many approaches to study human behaviour. None of these viewpoints completely explains abnormal behaviours and therefore, integrative evaluation of these viewpoints is essential. The major viewpoints of developmental pathogenesis are biological, psychodynamic, behavioural, psychosocial and socio-cultural viewpoints. All these viewpoints explain abnormal behaviour with the help of certain sets of causal factors.

3.4 BIOLOGICAL CAUSES

Biological viewpoint believes that cognitive, emotional and behavioural symptoms of psychological disorders originate from disorders of nervous system and endocrine system or they are inherited. A number of these causes are operative during pre-natal and post-natal developmental stages. These causes include genetic vulnerabilities, constitutional liabilities and physical deprivation.

3.4.1 Genetic Vulnerabilities

Genetics means what we inherit from our parents. This suggests how we look, feel and behave is predetermined by our genetic makeup. The field of behaviour genetics deals with phenomenon how genetic information in form of chromosomes from both father and mother is transmitted to children. Chromosomes contain genes; the genes transmit a biochemical code, which is responsible for determining the structure and activity of the body's protein. At the biochemical level, the genetic code leads to physiological and physical differences. These differences include like height, weight, colour of hair and colour of eyes, which are the result of number of different genes.

Behaviour genetics is the study of individual differences in behaviour that are attributable in part to differences in genetic makeup. The total genetic makeup of an individual, consisting of inherited genes, is referred to as the *genotype* (physical sequence of DNA), which is an individual's unobservable genetic constitution. In contrast, the totality of observable, behavioural characteristics, such as level of anxiety, is referred to as the *phenotype*. The genotype is fixed at birth, but it should not be viewed as a static entity. Genes controlling various features of development switch off and on at specific times, for example, to control various aspects of development. Indeed, genetic programs are quite flexible—they respond in remarkable ways to things that happen to us.

The phenotype changes over time and is generally viewed as the product of an interaction between the genotype and the environment. For example, an individual may be born with the capacity for high intellectual achievement, but whether he or she develops this genetically given potential depends on such environmental factors as upbringing and education. Hence, any measure of intelligence is best viewed as an index of the phenotype. A recent study by Turkheimer and colleagues confirmed this proposition (Turkheimer et al., 2003). A number of studies have demonstrated high heritability for IQ (Plomin, 1999). What Turkheimer et al. found, though, was that heritability depended on environment. The study included 319 twin pairs of 7-year-olds (114 identical, 205 fraternal). Many of the children were living in families either below the poverty line or with a low family income. Among the families of lower socioeconomic status (SES), 60 percent of the variability in children's IQ was attributable to the environment. Among the higher SES families, the opposite was found. That is, variability in IQ was more attributable to genes than environment. Thus, being in an impoverished environment may have deleterious effects on IQ whereas being in a more affluent environment may not help all that much.

As we noted above, we know now that genes and environments work together. Life experience shapes how our genes are expressed, and our genes guide us in behaviours that that a given person's sensitivity or reaction to an environmental event is influenced by genes. Adoption studies can be a method for studying gene–environment interaction. In one study three groups of adoptees were compared on the criterion of antisocial personality disorder (APD): (1) adoptees who had a biological parent with APD and were raised in an unhealthy adoptive family (e.g., parental conflict, abuse, alcohol/drugs in the adoptive family), (2) adoptees who had a biological parent with APD but were raised in a healthy family; and (3) adoptees who had no biological parent with APD but were raised in an unhealthy adoptive family. This was found that adoptees of the first group were more likely to develop APD than two other groups of adoptees (Cadoret et al., 1995). Thus, genes (APD biological parent) and environment (unhealthy adoptive family) worked together to increase the risk for developing antisocial personality disorder.

A different (and true) example of a gene–environment interaction involves depression. In one longitudinal study, a large sample of children in New Zealand was followed across time from the age of five until their mid-twenties (Caspi et al., 2003). Across this time, the researchers assessed a number of variables, including early childhood maltreatment (abuse) and depression as an adult. They also measured a particular gene called the **serotonin transporter gene** (5-HTT). This gene has a polymorphism such that some people have two short alleles; some have two long alleles, and some have one short and one long allele.

They found that those individuals who had either the short-short allele or the short-long allele combinations of the 5-HTT gene and were maltreated as children were more likely to have depression as adults than either those people who had the same gene combination but no childhood maltreatment or those people who were maltreated as children but had the long-long allele combination of the gene. Thus, having the gene was not enough to predict depression, nor was the presence of early life stress. Rather, it was the specific combination of the gene configuration and environmental events that predicted depression. They found the same gene–environment interaction for having at least one short allele of the gene and reports of stressful life events. That is, those people who reported a good deal of stressful life events and had at least one short allele of the 5-HTT gene were at greater risk of developing depression.

It is critical to recognise that various mental disorders are disorders of the phenotype, not of the genotype. Thus, it is not correct to speak of the direct inheritance of schizophrenia or anxiety disorders; at most, only the genotypes for these disorders can be inherited. Whether these genotypes will eventually engender the phenotypic behaviour disorders will depend on environment and experience; a predisposition, also known as a *diathesis*, may be inherited, but not the disorder itself. A genetic diathesis is a tendency that can be expressed or not depending on environmental circumstances.

3.4.2 The Neuro-Endocrine System

The neuro-endocrine system has been implicated in psychopathology and the most important neuro-endocrine system system is the *HPA axis*. The HPA axis is central to the body's response to stress, and stress figures prominently in many of the psychological disorders. When under stress or faced with threat, the hypothalamus causes corticotrophin releasing hormone (CRF) to be released, which then communicates with the *pituitary gland*. The pituitary then releases adreno-corticotrophic hormone, which travels via the blood to the adrenal glands. The outer layers of the adrenal glands are referred to as the *adrenal cortex*, the stress hormone. This is not a fast moving system like the autonomic nervous system rather; it takes about 20 to 40 minutes for cortisol release to peak. After the stress or threat has remitted, it can take up to an hour for cortisol to return to baseline (i.e., before the stress) levels (Dickerson & Kemeny, 2004).

Studies in this area are uniquely integrative. That is, they begin with a psychological concept, stress and examine how stress is manifested in the body, the HPA axis. For example, in a series of animal studies, researchers have shown that rats and primates that are exposed to early trauma, such as being separated from their mothers, show elevated activity in the HPA axis when they are exposed to stressors later in life (Gutman & Nemeroff, 2003). Like gene–environment interactions, it is hard to consider biology and environment separately—biology may create increased reactivity to the environment, and early experiences may influence biology. Thus, chronic stress and

its effects on the HPA axis are linked to disorders as diverse as schizophrenia, depression, and posttraumatic stress disorder.

3.4.3 Physical Handicaps

Pre or post-natal abnormalities or environmental conditions may result in physical defects. The most common birth difficulty associated with later mental disorders is low birth weight. Low birth weight is most often a factor in premature births. Nutritional deficiencies, disease, exposure to radiation, drugs, severe emotional stress, or the mother's excessive use of alcohol or tobacco are some common causes of low birth weight. As might be expected, socio-economic status is related to fetal and birth difficulties, the incidence of which is several times greater among mothers of lower socio-economic levels (Kopp & Kaler, 1989). Because low birth weight is often associated with so many environmental adversaries, it is often difficult to disentangle which actually play a causal role in the negative outcomes that may result.

3.4.4 Early Physical Deprivation

Through a remarkable set of complex processes, our digestive, circulatory, and other bodily functions work to maintain our body's physiological equilibrium integration. However, injuries and diseases strike all of us from time to time and upset our normal equilibriums, the psychological repercussion from such events can be profound. Depressions, for example, frequently accompany significant physical illnesses, in part because illnesses painfully remind us of the limits of our control over our lives. Even without serious illness or disability, people may experience challenges to their equilibriums. In the following section, we deal with two such situations deprivation of basic physiological needs and non-optimal levels of stimulation.

Deprivation of Basic Physiological Need: The most basic human requirements are those for food, oxygen, water, sleep, and the elimination of wastes. It is recognised that chronic but even relatively mild sleep deprivation can have adverse emotional consequences in children and adolescents. For example, in an extensive review of the empirical literature Carskadon (1990) demonstrated that over the course of adolescence there is a pattern of decreasing total sleep time. This pattern was associated with a good deal of daytime sleepiness. She argued that the performance lapses that are associated with excessive sleepiness could in turn lead to an increased vulnerability to accidents and to the use of caffeine and alcohol, and to mood and behaviour problems.

Prolonged food deprivation also affects psychological functioning. In one study, semi-starved persons became irritable, unsociable, and increasingly unable to concentrate on or daydream about anything but food. The men's predominant mood was one of gloom and depression, accompanied by apathy, feelings of inadequacy, and loss of interest in sex (Keys et al, 1950). The most tragic deprivation is seen in malnourished young children. Severe malnutrition is associated with a host of other potentially damaging variables such as parental neglect and limited access to health care (Lozoff, 1989) impairs physical development and lowers resistance to disease. It also blocks brain growth resulting in markedly lowered intelligence and enhanced risk for disorders such as attention-deficit disorder (Lozoff, 1989).

Stimulation and Activity: We have known for some time that healthy mental development depends on a child's receiving adequate amounts of stimulation from the environment. In addition to psychological vulnerabilities that can be induced by too little stimulation the physical development of the brain is adversely affected by a lesser environmental

stimulation. Conversely, biological development is enhanced by enriched and complex environment. These include changes in brain chemistry and structure. On the other hand, there are limits to how much stimulation is beneficial to a developing organism. We know that sensory overload can impair adult functioning, and although we do not yet have evidence on this, we might assume that infants and children are similarly affected. In general, we each seem to have an optimal level of stimulation and activity that psychological functioning. Under excessive pressure, we may strive to reduce some conditions-such as boredom-we may strive to increase the level of stimulation by doing something engaging, such as antisocial personalities, have higher-than average needs for excitement.

Self Assessment Questions

1) Explain the risk factors in developmental pathogenesis.

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2) Describe a general outline of biological causes of psychopathology.

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3) Give an account of genetic vulnerabilities for psychopathology.

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4) Explain the role played by neuro-endocrine system in developmental pathogenesis.

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5) Explain physical handicaps and early physical deprivation as the causes of psychopathology.

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3.5 PSYCHOSOCIAL CAUSES

3.5.1 Parental Deprivation and Separation

Some children are raised in an institution where, compared with an ordinary home, there is less warmth and physical contact; less intellectual, emotional, and social stimulation and a lack of encouragement and help in positive learning. It is clear that many children deprived of normal parenting in infancy and early childhood show maladaptive personality development and are at risk for psychopathology. Institutionalisation later in childhood in a child who has already had good attachment experience is not so damaging (Rutter, 1987). However, even among those institutionalised at an early age, some show resilience and do well in adulthood. One important protective factor found to influence was whether the child went from the institution into a harmonious family or a discordant one (Rutter, 1990). Other influential protective factors were having some good experiences at school, whether in the form of social relationship, or athletic or academic success, or having a supportive marital partner to a better sense of self-esteem or self-efficacy.

Most infants subjected to parental deprivation are not separated from their parents, but rather suffer from inadequate care at home. In these situations, parents typically neglect or devote little attention to their children and are generally rejecting. Parental rejection of a child may be demonstrated in various ways-by physical neglect, denial of love and affection, lack of interest in the child's activities and achievements, failure to spend time with the child and lack of respect for the child's rights and feeling. In a minority of cases, it also involves cruel and abusive treatment. Parental rejection may be partial or complete, passive or active, or subtly or overtly cruel.

The effects of such deprivation and rejection may be very serious. For example, delineated failure to thrive that is a serious disorder of growth and development frequently requiring admission to the hospital. Such children are thought to be at risk for behaviour problems, delays in development and severe depression. Abused and maltreated infants and toddlers are also quite likely to develop atypical patterns of attachment (Cicchetti & Toth, 1995) characterised by bizarre, disorganised and inconsistent behaviour with the caregiver.

Bowlby (1973) summarized the traumatic effects for children for 2 to 5 years old of being separated from their parents during prolonged periods of hospitalisation. First, there are the short-term or acute effects of the separation, which can include significant despair during the separation and detachment from the parents upon reunion. Bowlby considered this to be a normal response to prolonged separation, even in securely attached infants. Children who undergo such separation may develop an insecure attachment. In addition, there can be long-term effects of early separation from one or both parents. For example, such separation can cause an increased vulnerability to stressors in adulthood making it more likely that the person will become depressed (Bowlby, 1980).

3.5.2 Childhood Traumas

The term psychic trauma is used to describe any aversive experience that had harmful psychological effects on an individual. Such traumas make psychological wounds that may never completely heal. As a result, later stress that reactivates these wounds may be particularly difficult for an individual to handle; this often explains why a person has difficulty with a problem that is not especially stressful to another.

3.5.3 Parental Psychopathology

In general, it has been found that parents who have various forms of psychopathology, including schizophrenia, depression, anti social personality disorder and alcoholism, tend to have children who are at heightened risk for a wide range of developmental difficulties. Although some of these effects undoubtedly have a genetic effects component, many researchers believe that genetic effects cannot account for all of the adverse effects that parental psychopathology has on children. For example, the children of seriously depressed parents are at enhanced risk for disorder themselves (Cicchetti & Toth, 1995), at least partly because depression makes for unskilful parenting, notably including inattentiveness to a child's many needs and being ineffective in managing and disciplining the child. In addition children of alcoholics have elevated rates of truancy and substance abuse and greater likelihood of dropping out of school, as well as higher levels of anxiety and depression and lower levels of self-esteem (Chassin, Rogosch, & Barrera, 1991).

3.5.4 Parenting Styles

There are also less extreme differences in parenting styles than may occur with various forms of parental psychopathology that nonetheless can have a significant impact on a child's development and increase their risk for psychopathology. In the past, discipline was conceived of as a method for both punishing undesirable behaviour and preventing or deterring such behaviour in the future. Discipline is now thought of more positively as providing needed structure and guidance for promoting a child's healthy growth.

The authoritative style is one in which the parents are both very warm and careful to set clear limits and restrictions regarding certain kinds of behaviour, but also allow considerable freedom within certain limits. This style of parenting is associated with the most positive early social development, with the children tending to be energetic and friendly and showing development of general competencies for dealing with others and with their environments (Baumrind, 1975). When followed into adolescence in a longitudinal study, children of authoritative parents continue to show positive outcomes. Parents with an authoritarian style are high on control but low on warmth and their children tend to be conflicted, irritable, and moody (Baumrind, 1975). When followed into adolescence, these children had more negative outcomes, with the boys doing particularly poorly in social and cognitive skills. If such authoritarian parents also use overly severe discipline in the form of physical punishment as opposed to the withdrawal of approval and privileges, the result tends to be increased aggressive behaviour on the part of the child.

A third parenting style is the permissive-indulgent style, in which parents are high on warmth but low on discipline and control. This style of parenting is associated with impulsive and aggressive behaviour in children (Baumrind, 1975). Overly indulged children are characteristically spoiled, selfish, inconsiderate and demanding. In a classic study Sears (1961) found that much permissiveness and little discipline in a home were correlated positively with antisocial and aggressive behaviour, particularly during middle and later childhood. Unlike rejected and emotionally deprived children, indulged children enter readily into interpersonal relationship but they exploit people for their own purpose in the same way that they have learned to exploit their parents. Finally, parents who are low both on warmth and on control represent the neglectful-uninvolved style. This style of parental uninvolvedness is associated with disruptions in attachment during childhood and with moodiness, low self-esteem and conduct problems later in childhood (Baumrind, 1991). These children of uninvolved parents also have problems with peer relations and with academic performance.

3.5.5 Inadequate Communication

Parents sometimes discourage a child from asking questions and in other ways fail to foster the information exchange essential for helping the child develop essential competencies. Inadequate communication may take a number of forms. Some parents are too busy or preoccupied with their own concerns to listen to their children and to try to understand the conflicts and pressures they are facing. As a consequence, these parents often fail to give needed support and assistance, particularly when there is crisis. Other parents have forgotten that the world often looks different to a child or adolescent—rapid social change can lead to a communication gap between generations. In other instances, faulty communication may take more deviant forms in which messages become completely garbled because a listener distorts, disconfirms, or ignores a speaker's intended meaning.

3.5.6 Disrupted Family Relationships

The disturbed family structure is an overarching risk factor that increases an individual's vulnerability to particular stressors. We will distinguish between intact families where there is significant marital discord and families that have been disrupted by divorce or separation. In some cases of marital discord or conflict, one or both of the parents is not gaining satisfaction from the relationship. One spouse may express feelings of frustration and disillusionment in hostile ways such as nagging, criticizing, and doing things purposely to annoy the person. Seriously discordant relationships of long standing are likely to be frustrating, harmful and generally damaging in their effects on the adults and their children (Emery & Kitzman, 1995). More severe cases of marital discord may expose children to one or more of the stressors we have already discussed: child abuse or neglect, the effects of living with a parent with a serious mental disorder, authoritarian or neglectful/uninvolved parenting, and spouse abuse. In all these cases, the children are caught up in an unwholesome and irrational psychological environment and as they grow up they may find it difficult to establish and maintain marital and other intimate relationships.

In many cases a family is incomplete as a result of death, divorce, separation or some other circumstance. Effects of Divorce on children Divorce can have traumatic effects on children. Feeling of insecurity and rejection may be aggravated by conflicting loyalties and by the spoiling the children receive while staying with one of the parents. Not surprisingly, some children do develop serious maladaptive responses. Delinquency and a wide range of other psychological problems are much more frequent among those from intact families, although it is likely that a contributing factor here is prior or continuing parental strife. Finally a number of studies have demonstrated that there may well be long-term effects of divorce on adaptive functioning into adulthood, such as lower educational attainment, lower income and lower life-satisfaction. The effects of divorce on children are often more favorable than the effects of remaining in a home torn by marital conflict (Emery & Kitzman 1995).

3.6 SOCIO-CULTURAL CAUSES

Discussion of the socio-cultural factors that increase our vulnerability to the development of abnormal behaviour will be focused by the role of culture in affecting an individual's behaviour patterns. There are several factors in the social environment that may increase vulnerability: low socio-economic class, disorder-engendering social roles, prejudice and discrimination, economic and employment problems and social change and uncertainty.

3.6.1 The Socio-Cultural Environment

In much the same way that we receive a genetic inheritance, we also receive a socio-cultural inheritance that is the end product of thousands of years of social evolution. Because each group fosters its own cultural patterns by systematically teaching its offspring, all its members tend to be somewhat alike to conform to certain basic personality types. Children reared among head-hunters become head-hunters; children in societies that do not sanction violence learn to settle their differences in nonviolent ways. This more uniform and thorough the education of the younger member of a group, the more alike they will become.

Subgroup within a general socio-cultural environment, such as family, sex, age, class, occupational, ethnic and religious group foster beliefs and norms of their own, largely by means of social roles that their members learn to adopt. Expected role behaviours exist for a student, a teacher, an army officer, a priest, a nurse and so on. Because most people are members of various subgroups, they are subject to various role demands, which also change over time. In fact, an individual's life can be viewed as a succession of roles—child, student, worker, spouse, parents and senior citizen. When social roles are conflicting, unclear or uncomfortable or when an individual is unable to achieve a satisfactory role in a group, healthy personality development may be impaired—just as it is when a child is rejected by juvenile peer group.

3.6.2 Pathogenic Societal Influences

There are many sources of pathogenic social influences, some of which stem from socio-economic factors and other from socio-cultural factors regarding role expectation and the destructive forces of prejudice and discrimination. An inverse correlation exists between socio-economic status (SES) and the prevalence of abnormal behaviour—the lower the socio-economic class, the higher the incidence of abnormal behaviour. The strength of the correlation seems to vary with different types of disorders. For example, antisocial personality disorder is strongly related to social class, occurring at three times the rate in the lowest income category as in the highest income category, whereas depressive disorders occur only about 50 percent more often in the lowest income category as in the highest income category (Kessler et al., 1994).

3.6.3 Disorder Engendering Social Roles

An organised society, even an “advanced” one sometimes asks its members to perform roles in which the prescribed behaviours either are deviant themselves or may produce maladaptive reactions. Soldiers who are called upon by their superiors (and ultimately by their society) to deliberately kill and hurt other human being may subsequently develop serious feeling of guilt. They may also have latent emotional problems resulting from the horrors commonly experienced in combat and hence be vulnerable to disorder.

3.6.4 Social Change and Uncertainty

The rate and pervasiveness of change today are different from anything our ancestors ever experienced. All aspects of our lives are affected—our education, our jobs, our families, our leisure pursuits, our finances and our beliefs and values. Constantly trying to keep up with the numerous adjustments demanded by these changes is a source of constant and considerable stress. Simultaneously, we confront inevitable crises as the earth's consumable natural resources fall off and as our environment become increasingly noxious with pollutants. Certain societies have increasing problems

with drugs and crime. On the contrary, our attempts to cope with exiting problems increasingly seem to create new problems that are as bad or worse. The resulting despair, demoralisation and sense of helplessness are well-established predisposing conditions for abnormal reaction to stressful events (Seligman, 1998).

Self Assessment Questions

- 1) Explain parental deprivation, separation and childhood traumas as potential causes of psychopathology.

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- 2) Describe the parental psychopathology and parenting styles contributing to the development of psychopathology.

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- 3) Present an account of Inadequate Communication Disrupted Family Relationships in developmental pathogenesis.

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- 4) Evaluate various socio-cultural causes in development of psychopathology.

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3.7 LET US SUM UP

The intricacies of human development have always fascinated psychologists. Psychologists have studied developmental processes and used the knowledge gained from these investigations for better understanding of the changes that predictably occur in the later stage of life. This has made possible to link more effectively early precursors to the later expression of maladaptive and deviated behaviours. The risk factor model is a paradigm that facilitates the understanding of developmental deviations. It can be applied at any stage of development. Risk factors have been divided into three large categories: those at the level of the individual, the family and the community. There have been a number of viewpoints regarding causal factors of

psychopathologies. These viewpoints represent any of the many approaches to study human behaviour. None of these viewpoints completely explains abnormal behaviours and therefore, integrative evaluation of these viewpoints is essential. The major viewpoints of developmental pathogenesis are biological, psychodynamic, behavioural, psychosocial and socio-cultural viewpoints. All these viewpoints explain abnormal behaviour with the help of certain sets of causal factors.

Biological viewpoint believes that cognitive, emotional and behavioural symptoms of psychological disorders originate from disorders of nervous system and endocrine system or they are inherited. A number of these causes are operative during pre-natal and post-natal developmental stages. These causes include genetic vulnerabilities, neuro-endocrine system and physical handicaps and deprivation. Psychosocial factors include Parental Deprivation and Separation, Childhood Traumas, Parental Psychopathology, Parenting Styles, Inadequate Communication and Disrupted Family Relationships. Socio-cultural factors that increase our vulnerability to the development of abnormal behaviour are dominated by the role of culture in affecting an individual's behaviour patterns. There are several factors in the social environment that may increase vulnerability: low socioeconomic class, disorder-engendering social roles, prejudice and discrimination, economic, employment problems, social change, and uncertainty.

3.8 UNIT END QUESTIONS

- 1) Present an account of the risk factors of psychopathology and give an outline of causal factors of psychopathology.
- 2) Explain the biological perspectives of developmental pathogenesis.
- 3) Discuss the psychosocial causes of psychopathology.
- 4) Describe the socio-cultural factors of psychopathology.

3.9 GLOSSARY

The risk factor model	: The risk factor model is a paradigm that facilitates the understanding of developmental deviations.
Behaviour genetics	: Behaviour genetics is the study of individual differences in behaviour that are attributable in part to differences in genetic makeup.
Genotype	: The total genetic makeup of an individual, consisting of inherited genes, is referred to as the genotype.
Phenotype	: Phenotype is any <i>observable characteristic</i> , trait or behaviour of an individual resulting from the expression of an organism's genes as well as the influence of environmental factors and the interactions between the two.
The HPA axis	: The HPA axis is central to the body's response to stress, and stress figures prominently in many of the psychological disorders, which includes hypothalamus, pituitary and adrenal cortex.

- Authoritative parenting** : The authoritative parenting style is one in which the parents are both very warm and careful to set clear limits and restrictions regarding certain kinds of behaviour, but also allow considerable freedom within certain limits.
- Authoritarian parenting** : Authoritarian parenting refers to a style in which Parents are high on control but low on warmth toward the child.
- Permissive-indulgent parenting** : The permissive-indulgent parenting style is one in which parents are high on warmth but low on discipline and control.

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UNIT 4 CHILDHOOD MENTAL DISORDERS

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Pervasive Developmental Disorders
 - 4.2.1 Autistic Disorder
 - 4.2.2 Rett's Disorder
 - 4.2.3 Asperger Syndrome
 - 4.2.4 Childhood Disintegrative Disorder (CDD)
 - 4.2.5 Pervasive Developmental Disorder not otherwise Specified (PDD-NOS)
- 4.3 Attention Deficit Hyperactive Disorders (ADHD)
- 4.4 Other Childhood Psychopathologies
 - 4.4.1 Oppositional Defiant Disorder
 - 4.4.2 Conduct Disorder
 - 4.4.3 Anxiety Disorders: Separation Anxiety Disorder
 - 4.4.4 Tick Disorders
 - 4.4.5 Childhood Depression
- 4.5 Mental Retardation
- 4.6 Let Us Sum Up
- 4.7 Unit End Questions
- 4.8 Glossary
- 4.9 Suggested Readings

4.0 INTRODUCTION

Although it is sometimes assumed that childhood and adolescence are times of carefree bliss, many 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. First, we will discuss various types of pervasive developmental disorders as prominent childhood mental disorders. This will be followed by a description of Attention Deficit Hyperactive Disorders (ADHD). We will then discuss other childhood psychopathologies and mental retardation.

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain pervasive developmental disorders as prominent childhood mental disorders;

- Present an account of various types of pervasive developmental disorders;
- Explain Attention Deficit Hyperactive Disorders (ADHD);
- Understand other childhood psychopathologies; and
- Present an account of mental retardation.

4.2 PERVASIVE DEVELOPMENTAL DISORDERS

The term “pervasive development disorders,” also called PDDs, refers to a group of conditions that involve delays in the development of many basic skills, most notably the ability to socialise with others, to communicate, and to use imagination. Children with these conditions often are confused in their thinking and generally have problems understanding the world around them. Because these conditions typically are identified in children around 3 years of age, a critical period in a child’s development, they are called developmental disorders. Although the condition begins far earlier than 3 years of age, parents often do not notice a problem until the child is a toddler who is not walking, talking, or developing as well as other children of the same age.

The use of the word “pervasive” to describe these illnesses is somewhat misleading. The definition of pervasive is “to be present throughout,” but children with PDDs generally do not have problems in all areas of functioning. Rather, most children with PDDs have specific problem areas and often function very well in other areas. Children with PDDs, such as autism, can display a wide range of symptoms that can range in severity from mild to disabling. They also vary widely in their individual abilities, intelligence, and behaviour. General symptoms that may be present to some degree in a child with a PDD include:

- Difficulty with verbal communication, including problems using and understanding language
- Difficulty with non-verbal communication, such as gestures and facial expressions
- Difficulty with social interaction, including relating to people and to his or her surroundings
- Unusual ways of playing with toys and other objects
- Difficulty adjusting to changes in routine or familiar surroundings
- Repetitive body movements or patterns of behaviour, such as hand flapping, spinning and head banging
- Changing response to sound (The child may be very sensitive to some noises and seem to not hear others)
- Temper tantrums
- Difficulty sleeping
- Aggressive behaviour
- Fearfulness or anxiety (nervousness).

4.2.1 Autistic Disorder

Autism is a developmental disorder that is characterised by impaired development in communication, social interaction, and behaviour. Autism afflicts one out of every 100 to 166 children and it affects the lives of many children and their families

(DiCicco-Bloom et al, 2006). It tends to affect about five boys to every one girl (First, 2008). Autism is classified as a pervasive developmental disorder (PDD), a category of disorders that is often described interchangeably with the broad spectrum of developmental disorders affecting young children and adults called the autistic spectrum disorders (ASD). The range of these disorders varies from severely impaired individuals with autism to other individuals who have abnormalities of social interaction but normal intelligence, Asperger's syndrome. The ways in which autism is exhibited can differ greatly. Additionally, autism can be found in association with other disorders such as mental retardation and certain medical conditions. The degree of autism can range from mild to severe. Mildly affected individuals may appear very close to normal. Severely afflicted individuals may have an extreme intellectual disability and unable to function in almost any setting.

In the past, autism has been confused with childhood schizophrenia or childhood psychosis. It has also been misunderstood as schizotypal personality disorder in some adults. As additional research information about autism becomes available, the scope and definition of the condition continues to become more refined. Some of the past confusion about the disorder has been resolved.

Symptoms of autism

The current revision of Diagnosis and Statistical Manual of Mental Disorders, DSM-IV-TR identifies three features that are associated with autism:

- Impairment in social interaction
- Communication and
- Behaviours

Impairment in social interaction

Individuals with autism fail to develop normal personal interactions in virtually every setting. This means that affected persons fail to form the normal social contacts that are such an important part of human development. This impairment may be so severe that it even affects the bonding between a mother and an infant. It is important to note that, contrary to popular belief, many, if not most, persons with this disorder are capable of showing affection, demonstrating affection bonding with their mothers or other caregivers. However, the ways in which individuals with autism demonstrate affection and bonding may differ greatly from the ways in which others do so. Their limited socialisation may erroneously lead parents and paediatricians away from considering the diagnosis of autism.

As the child develops, interaction with others continues to be abnormal. Affected behaviours can include eye contact, facial expressions, and body postures. There is usually an inability to develop normal peer and sibling relationships and the child often seems isolated. There may be little or no joy or interest in normal age-appropriate activities. Affected children or adults do not seek out peers for play or other social interactions. In severe cases, they may not even be aware of the presence of other individuals.

Communication

Communication is usually severely impaired in persons with autism. What the individual understands (receptive language) as well as what is actually spoken by the individual (expressive language) are significantly delayed or nonexistent. Deficits in language

comprehension include the inability to understand simple directions, questions, or commands. There may be an absence of dramatic or pretend play and these children may not be able to engage in simple age-appropriate childhood games. Teens and adults with autism may continue to engage in playing with games that are for young children.

Individuals with autism who do speak may be unable to initiate or participate in a two-way conversation (reciprocal). Frequently the way in which a person with this disorder speaks is perceived as unusual. Their speech may seem to lack the normal emotion and sound flat or monotonous. The sentences are often very immature: “want water” instead of “I want some water please.” Those with autism often repeat words or phrases that are spoken to them. For example, you might say, “Look at the airplane!” and the child may respond “at airplane,” without any knowledge of what was said. This repetition is known as echolalia. Memorisation and recitation of songs, stories, commercials, or even entire scripts is not uncommon. While many feel this is a sign of intelligence, the autistic person usually does not appear to understand any of the content in his or her speech.

Behaviours

Persons with autism often exhibit a variety of repetitive, abnormal behaviours. There may also be a hypersensitivity to sensory input through vision, hearing, or touch (tactile). As a result, there may be extreme intolerance to loud noises or crowd, visual stimulation or things that are felt. Birthday parties and other celebrations can be disastrous for some of these individuals. Wearing socks or tags on clothing may be perceived as painful. Sticky fingers, playing with modelling clay, eating birthday cake or other foods, or walking barefoot across the grass can be unbearable. On the other hand, there may be an underdeveloped (hyposensitivity) response to the same type of stimulation. This individual may use abnormal means to experience visual, auditory, or tactile (touch) input. This person may head bang, scratch until blood is drawn, scream instead of speaking in a normal tone, or bring everything into close visual range. He or she might also touch an object, image or other people thoroughly just to experience the sensory input.

Children and adults who have autism are often tied to routine and many everyday tasks may be ritualistic. Something as simple as a bath might only be accomplished after the precise amount of water is in the tub, the temperature is exact, the same soap is in its assigned spot and even the same towel is in the same place. Any break in the routine can provoke a severe reaction in the individual and place a tremendous strain on the adult trying to work with him or her.

There may also be non-purposeful repetition of actions or behaviours. Persistent rocking, teeth grinding, hair or finger twirling, hand flapping and walking on tiptoe are not uncommon. Frequently, there is a preoccupation with a very limited interest or a specific plaything. A child or adult may continually play with only one type of toy. The child may line up all the dolls or cars and the adult line up their clothes or toiletries, for example, and repeatedly and systematically perform the same action on each one. Any attempt to disrupt the person may result in extreme reactions on the part of the individual with autism, including tantrums or direct physical attack. Objects that spin, open and close, or perform some other action can hold an extreme fascination. If left alone, a person with this disorder may sit for hours turning off and on a light switch, twirling a spinning toy, or stacking nesting objects. Some individuals can also have an inappropriate bonding to specific objects and become hysterical without that piece of string, paper clip, or wad of paper.

Since autism was first added to the psychiatric literature about fifty years ago, there have been numerous studies and theories about its causes. Researchers still have not reached agreement regarding its specific causes. First, it must be recognised that autism is a set of a wide variety of symptoms and may have many causes. This concept is not unusual in medicine. For instance, the set of symptoms that we perceive of as a “cold” can be caused by literally hundreds of different viruses, bacteria, and even our own immune system.

Although some remain convinced that certain vaccines, vaccine preservatives or medications taken to treat side effects of vaccines that may cause autism, conventional wisdom continues to agree that immunisations do not cause autism. Autism is thought to be a biological disorder. In the past, some researchers had suggested that autism was the result of poor attachment skills on the part of the mother. This belief has caused a great deal of unnecessary pain and guilt on the part of the parents of children with autism, when in fact, the inability of the individual with autism to interact appropriately is one of the key symptoms of this developmental disorder.

In support of a biological theory of autism, several known neurological disorders are associated with autistic features. Autism is one of the symptoms of these disorders. These conditions include:

- Tuberous sclerosis and the fragile X syndrome (inherited disorder)
- Cerebral dysgenesis (abnormal development of the brain)
- Rett’s syndrome (a mutation of a single gene)
- Some of the inborn errors of metabolism (biochemical defects)

Autism, in short, seems to be the result or “final common pathway” of numerous disorders that affect brain development. Brain studies have also demonstrated that persons with autism tend to have a number of abnormalities in brain size. In general, however, when clinicians make the diagnosis of autism, they are excluding the known causes of autistic behaviours. However, as the knowledge of conditions that cause autism advances, fewer and fewer cases will likely be thought of as being “pure” autism and more individuals will be identified as having autism due to specific causes.

There is a strong association between autism and seizures. This association works in two ways. First, many patients (20% to 30%) with autism develop seizures. Second, patients with seizures, which are probably due to other causes, may develop autistic-like behaviours. One special and often misunderstood association between autism and seizures is the Landau-Kleffner Syndrome. This syndrome is also known as acquired epileptic aphasia. Some children with epilepsy develop a sudden loss of language skills—especially receptive language (the ability to understand). Many often also develop the symptoms of autism.

Certainly, disorders such as the fragile X syndrome and tuberous sclerosis, which are both associated with autism, are inherited. There are many families with more than one child with autism where the autism is not clearly due to another cause. Recent studies have found that the gene for at least one kind of familial autism may be on chromosome 13. In some families, autism seems to be passed from generation to generation. In other families, autism is not found in prior generations but it affects siblings. The results of this research make it clear that at least one “autism gene” will eventually be found.

However, the majority of individuals with autism do not have a strong family history,

which supports the premise, that environment or a combination of environmental and genetic factors contribute to the development of autism. In this context, environmental is meant to indicate any non-genetic factor, including infections, toxins, nutrition, or others.

4.2.2 Rett's Disorder

Rett's disorder is an X-linked dominant neurological disorder that affects only girls and is one of the most common causes of mental retardation in females. Girls with the syndrome show normal development during the first 6-18 months of life followed first by a period of stagnation and then by rapid regression in motor and language skills. The hallmark of Rett's syndrome is the loss of purposeful hand use and its replacement with stereotyped hand wringing. Screaming fits and inconsolable crying are common.

Other key features include loss of speech, behaviour reminiscent of autism, panic-like attacks, grinding of teeth, rigid gait, tremors, intermittent hyperventilation and microcephaly (small head). Seizures occur in about half of cases. The girls typically survive into adulthood, but are at risk of sudden unexplained death. Rett's syndrome is due to mutation in the MECP2 gene (methyl-CpG-binding protein-2) on chromosome Xq28. The vast majority of cases are sporadic and result from a new mutation in the girl with Rett's syndrome or inheritance of the mutation from a parent who has somatic or germline mosaicism with the MECP2 mutation in only some of their cells. Atypical Rett's syndrome with MECP2 mutations has been found in patients previously diagnosed with autism, mild learning disability, and mental retardation with spasticity or tremor. Rett's syndrome is a uniform and striking, progressive neurologic developmental disorder and one of the most common causes of mental retardation in females.

After normal development up to the age of 6 to 18 months, developmental stagnation occurs followed by rapid deterioration of high brain functions. Within 1 to 2 years, this deterioration progresses to loss of speech, severe dementia, behaviour reminiscent of autism, stereotypic hand-wringing movements, loss of purposeful use of the hands, jerky ataxia (wobbliness) of the trunk, intermittent hyperventilation, and microcephaly (small head). Thereafter, a period of apparent stability lasts for decades. But additional neurological abnormalities intervene insidiously. These abnormalities include what is called spastic paraparesis (paralysis and spasticity of the legs) and epilepsy (seizures). A striking deceleration of growth has been found across all measurements in most girls with Rett's syndrome who end up with short stature and microcephaly. The mortality (death) rate among children with Rett's syndrome is increased (1.2% per year). A high proportion (26%) of the deaths is sudden and associated with a heart conduction problem, namely an abnormally prolonged QT interval on the electrocardiogram.

4.2.3 Asperger Syndrome

Asperger syndrome is one of the neuro-developmental disorders that have effects on an individual's behaviour, use of language and communication, and pattern of social interactions. Asperger disorder is characterised as one of the autism spectrum disorders, although Asperger syndrome is considered to be at the milder, or higher-functioning, range of this spectrum. There is still some controversy as to whether Asperger syndrome should be regarded as a separate clinical entity or it simply represents a high-functioning form of autism. People with Asperger syndrome have normal to above-average intelligence but typically have difficulties with social interactions and

often have pervasive, absorbing interests in special topics. Asperger syndrome is 5 times more common in boys than in girls. Asperger syndrome has been estimated to affect 2.5 out of every 1000 children, based upon the total number of children with autistic disorders.

Asperger syndrome is named for Dr. Hans Asperger, an Austrian pediatrician, who first described the condition in 1944. Dr. Asperger described four boys who showed “a lack of empathy, little ability to form friendships, one-sided conversation, intense absorption in a special interest, and clumsy movements.” Because of their obsessive interests in and knowledge of particular subjects, he termed the boys “little professors.” The American Psychiatric Association (APA) recognised Asperger disorder as a specific entity and published diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) in 1994.

Social-behavioural symptoms of Asperger syndrome can begin as early as infancy. Some of the symptoms that may be present are:

- 1) Lack of social awareness
- 2) Lack of interest in socialising/making friends
- 3) Difficulty making and sustaining friendships
- 4) Inability to infer the thoughts, feelings, or emotions of others
- 5) Either gazing too intently or avoiding eye contact
- 6) Lack of changing facial expression, or use of exaggerated facial expressions
- 7) Lack of use or comprehension of gestures
- 8) Failure to respect interpersonal boundaries
- 9) Unusually sensitive to noises, touch, smell, tastes, or visual stimuli
- 10) Inflexibility and over-adherence to or dependence on routines
- 11) Stereotypes and repetitive motor patterns such as hand flapping or arm waving.

Many experts in the field stress the particular gifts and positive aspects of Asperger syndrome and consider it to represent a different, but not necessarily defective, way of thinking. Positive characteristics of people with Asperger syndrome have been described as beneficial in many professions that include:

- The increased ability to focus on details
- The capacity to persevere in specific interests without being swayed by others’ opinions
- The ability to work independently
- The recognition of patterns that may be missed by others
- Intensity
- An original way of thinking.

4.2.4 Childhood Disintegrative Disorder (CDD)

Childhood disintegrative disorder, also known as Heller’s syndrome, is a condition in which children develop normally until ages 2 to 4, but then demonstrate a severe

loss of social, communication and other skills. Childhood disintegrative disorder is very much like autism. Both are among the group of disorders known as pervasive developmental disorders, or autism spectrum disorders. Both involve normal development followed by significant loss of language, social, play and motor skills. However, childhood disintegrative disorder typically occurs later than autism and involves a more dramatic loss of skills. In addition, childhood disintegrative disorder is far less common than autism. Loss of developmental milestones may occur abruptly over the course of days to weeks or gradually over an extended period. Children with childhood disintegrative disorder typically show the following signs and symptoms:

Dramatic loss of previously acquired skills in two or more of the following areas:

- Language, including a severe decline in the ability to speak and have a conversation
- Social skills, including significant difficulty relating to and interacting with others
- Play, including a loss of interest in imaginary play and in a variety of games and activities
- Motor skills, including a dramatic decline in the ability to walk, climb, grasp objects and other movements
- Bowel or bladder control, including frequent accidents in a child who was previously toilet-trained

Lack of normal function or impairment also occurs in at least two of the following three areas:

- Social interaction
- Communication
- Repetitive behaviour & interest patterns

There is no known cause of childhood disintegrative disorder. There is likely a genetic basis for autism spectrum disorders. The theory is that an abnormal gene is switched on in the early stages of development, before birth, and that this gene affects other genes that coordinate a child's brain development. Environmental exposure may contribute to these effects, such as to a toxin or infection. It is also possible that an autoimmune response play a role in the development of childhood disintegrative disorder. In an autoimmune response, body's immune system perceives normal body components as foreign and attacks them. Childhood disintegrative disorder often occurs along with other conditions, including:

- Tuberous sclerosis: In this condition, noncancerous (benign) tumours grow in the brain.
- Lipid storage diseases: In this rare group of inherited metabolic disorders, a toxic build up of excess fats (lipids) occurs in the brain and nervous system.
- Sub acute sclerosis panencephalitis: This chronic infection of the brain is caused by a form of the measles virus that results in brain inflammation and the death of nerve cells.

It is unknown whether these conditions play a part in triggering childhood disintegrative disorder or share genetic or environmental risk factors.

4.2.5 Pervasive Developmental Disorder not Otherwise Specified (PDD-NOS)

Pervasive developmental disorder not otherwise specified (PDD-NOS), also called atypical autism, is a neurobiological disorder characterised by impairment in ability to interact with others and by abnormalities in either communication, or behaviour patterns and interests. PDD-NOS is described as atypical autism, because individuals with the disorder exhibit some but not all of the same symptoms associated with autism (sometimes called classic autism). Likewise, “not otherwise specified,” indicates that an individual’s symptoms are nonspecific, meaning that they differ from symptoms characteristic of other pervasive developmental disorders, such as Rett’s syndrome and childhood disintegrative disorder.

PDD-NOS affects boys four times more often than girls. The overall prevalence of the disorder remains unclear, because of the varying clinical definitions used for diagnosis. Many children who have only several symptoms of an autism like condition, which prevents a definitive diagnosis of autism, are often diagnosed instead with PDD-NOS. Symptoms associated with PDD-NOS appear after age of three and the pattern in which symptoms manifest and the behaviours displayed by affected children vary widely. Most children with the disorder appear to develop normally in the first several years of life and then experience an unusual delay in the development of social abilities. It is usually at this point in the child’s development when other features of PDD-NOS become apparent. These features may include gaze avoidance, lack of expressive facial responses, irregularities in speech, repetitive and obsessive behaviours, and delayed development of motor skills. The incidence of severe intellectual disability in PDD-NOS patients is low relative to other pervasive developmental disorders.

Self Assessment Questions

1) Explain meaning and symptoms of pervasive developmental disorders.

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2) Describe the symptoms and causes of autism.

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3) Give an account of Rett’s Disorder.

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4) Explain the symptoms of Asperger Syndrome.

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5) Present a clinical picture of Childhood Disintegrative Disorder (CDD).

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6) Present an account of Pervasive Developmental Disorder not otherwise Specified (PDD-NOS).

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Although the precise cause of PDD-NOS is unknown, abnormalities in certain structures and in neuronal pathways in the brain have been implicated. Researchers also suspect underlying genetic defects may be involved. Treatment for PDD-NOS consists primarily of behavioural therapy, though some children may require the administration of medications to stabilize mood or behaviour.

4.3 ATTENTION DEFICIT HYPERACTIVE DISORDERS (ADHD)

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behaviour, and hyperactivity (over-activity). Inattention, hyperactivity and impulsivity are the key behaviours of ADHD. It is normal for all children to be inattentive, hyperactive or impulsive sometimes, but for children with ADHD, these behaviours are more severe and occur more often. To be diagnosed with the disorder, a child must have symptoms for six or more months and to a degree that is greater than other children of the same age. Some of the signs of ADHD are present in many kids. Others are rarely present unless people have disabling ADHD.

a) **Inattention:** Six or more of the following symptoms of inattention must persist for at least six months to a degree that is maladaptive and inconsistent with the developmental level.

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- Often has difficulty sustaining attention in tasks or play activities

- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to failure to understand instructions)
- Often have difficulty organising tasks and activities
- Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

Hyperactivity-impulsiveness: Six or more of the following symptoms must persist for at least 6 months to a degree that is maladaptive and inconsistent with the developmental level.

- Often fidgets with hands or feet or squirms in seat
 - Often leaves seat in classroom or in other situations in which remaining seated is expected
 - Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents, this may be limited to subjective feelings of restlessness)
 - Often has difficulty playing or engaging in leisure activities quietly
 - Is often “on the go” or often acts as if “driven by a motor”
 - Often talks excessively
 - Often blurts out answers before questions have been completed
 - Often has difficulty awaiting turn
 - Often interrupts or intrudes on others (e.g., butts into conversations or games)
- b) Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
- c) Some impairment from the symptoms is present in two or more settings (e.g., at school and at home)
- d) There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

There are three kinds of ADHD: ADHD without hyperactivity (symptoms and signs of attention deficit only), ADHD hyperactive-impulse type (symptoms and signs of hyperactivity-impulsiveness only) and combined type (symptoms and signs of both attention deficit and hyperactivity-impulsiveness). However, ADHD is not just about being impulsive, hyperactive and inattentive. Recent studies have shown that people with ADHD have some other interesting problems. These include:

Clumsiness

Children with ADHD tend to fall down more, tip over more things accidentally, and have worse fine motor skills than other children. While some of this is related to their

hyperactivity, a good part of it is not. This is partly the reason that people with ADHD have more accidents, have poorer handwriting, and always seem to be spilling things. This poor coordination predicts a poor outcome as adults. Those children who have marked coordination problems and ADHD are much more likely to have trouble with the law, reading problems, work difficulties and substance abuse problems as adults.

Problem in Time perception

To be coordinated and get things done, we need to have a stable internal clock. People with ADHD have much more difficulty figuring out how much time has really passed either in the short term (while trying to coordinate a movement) or in the long term (trying to decide how fast to work to get something done in a certain time frame). This inability to judge time does improve with medication.

Causes of ADHD

Like many other illnesses, ADHD probably results from a combination of factors. In addition to genetics, researchers are looking at possible environmental factors, and are studying how brain injuries, nutrition, and the social environment might contribute to ADHD.

Genes: Inherited from our parents, genes are the “blueprints” for who we are. Results from several international studies of twins show that ADHD often runs in families. Researchers are looking at several genes that may make people more likely to develop the disorder (Faraone et al, 2005; Khan, S. A., & Faraone, S. V., 2006). Knowing the genes involved may one day help researchers prevent the disorder before symptoms develop. Learning about specific genes could also lead to better treatments. Children with ADHD who carry a particular version of a certain gene have thinner brain tissue in the areas of the brain associated with attention (Shaw et al, 2007).

Environmental factors: Studies suggest a potential link between cigarette smoking and alcohol use during pregnancy and ADHD in children.^{5,6} In addition, preschoolers who are exposed to high levels of lead, which can sometimes be found in plumbing fixtures or paint in old buildings, may have a higher risk of developing ADHD (Braun et al, 2006).

Brain injuries: Children who have suffered a brain injury may show some behaviour similar to those of ADHD. However, only a small percentage of children with ADHD have suffered a traumatic brain injury. Over the last few years, researchers have looked at the brain in people with ADHD and have found some clear abnormalities. MRI scanners take a very detailed picture of the brain in cross section. They show that parts of the base of the brain associated with attention are smaller on the right in people with ADHD. The part of the brain that connects the left and right front of the brain has also been found to be smaller in a couple of studies using MRI. When researchers look at how much work different parts of the brain are doing, they have found decreased activity in the front parts of the brain in ADHD. Special tests can show that the brain is not as efficient in ADHD when doing certain tasks and rather than being able to use a small part of the brain, a larger part must be used.

Sugar: The idea that refined sugar causes ADHD or makes symptoms worse is popular, but more research discounts this theory than supports it. In one study, researchers gave children foods containing either sugar or a sugar substitute every other day. The children who received sugar showed no different behaviour or learning

capabilities than those who received the sugar substitute (Wolraich et al, 1985). Another study in which children were given higher than average amounts of sugar or sugar substitutes showed similar results.

In another study, children who were considered sugar-sensitive by their mothers were given the sugar substitute aspartame, also known as Nutrasweet. Although all the children got aspartame, half their mothers were told their children were given sugar, and the other half were told their children were given aspartame. The mothers who thought their children had gotten sugar rated them as more hyperactive than the other children and were more critical of their behaviour, compared to mothers who thought their children received aspartame (Hoover, D. W., & Milich, R., 1994)

Food additives: Recent British research indicates a possible link between consumption of certain food additives like artificial colours or preservatives, and an increase in activity (McCann et al, 2007). Research is under way to confirm the findings and to learn more about how food additives may affect hyperactivity.

4.4 OTHER CHILDHOOD PSYCHOPATHOLOGIES

4.4.1 Oppositional Defiant Disorder

The American Psychiatric Association's *Diagnostic and Statistical Manual, Fourth Edition (DSM IV)*, defines oppositional defiant disorder (ODD) as a recurrent pattern of negativistic, defiant, disobedient, and hostile behaviour toward authority figures that persists for at least 6 months. Behaviours included in the definition include the following: losing one's temper; arguing with adults; actively defying requests; refusing to follow rules; deliberately annoying other people; blaming others for one's own mistakes or misbehaviour; and being touchy, easily annoyed or angered, resentful, spiteful, or vindictive. When ODD is present with ADHD, depression, tourette's, anxiety disorders, or other neuropsychiatric disorders, it makes life with that child far more difficult. For Example, ADHD plus ODD is much worse than ADHD alone, often enough to make people seek treatment.

ODD is usually diagnosed when a child has a persistent or consistent pattern of disobedience and hostility toward parents, teachers, or other adults. The primary behavioural difficulty is the consistent pattern of refusing to follow commands or requests by adults. Children with ODD are often easily annoyed; they repeatedly lose their temper, argue with adults, refuse to comply with rules and directions, and blame others for their mistakes. Stubbornness and testing limits are common, even in early childhood.

The criteria for ODD are met only when the problem behaviours occur more frequently in the child than in other children of the same age and developmental level. These behaviours cause significant difficulties with family and friends, and the oppositional behaviours are the same both at home and in school. Sometimes, ODD may be a precursor of a conduct disorder. ODD is not diagnosed if the problematic behaviours occur exclusively with a mood or psychotic disorder.

4.4.2 Conduct Disorder

Conduct disorder refers to a group of behavioural and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill. Many factors may contribute to a child developing conduct disorder, including brain

damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences. Children or adolescents with conduct disorder may exhibit aggression to people and animals, destruction of property, deceitfulness, lying, or stealing and serious violations of rules.

Children who exhibit these behaviours should receive a comprehensive evaluation. Many children with a conduct disorder may have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders, which can also be treated. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

4.4.3 Anxiety Disorders: Separation Anxiety Disorder

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* separation anxiety is a fairly common anxiety disorder that consists of excessive anxiety beyond that expected for the child's developmental level. It is related to separation or impending separation from the attachment figure (e.g., primary caretaker, close family member) occurring in children younger than 18 years and lasting for at least 4 weeks. Features include clinically significant symptoms of anxiety (severe distress or impairment of function), unrealistic worries about the safety of loved ones, reluctance to fall asleep without being near the primary attachment figure, excessive distress (tantrums) when separation is imminent, nightmares with separation-related themes and homesickness. In addition, physical/somatic symptoms (especially frequent in older children and adolescents), such as dizziness, light headedness, nausea, stomach ache, cramps, vomiting, muscle aches, or palpitations, may be present and problematic, causing the child and family to seek medical treatment because of impaired ability to attend school or meet social responsibilities.

4.4.4 Tick Disorders

A tic is a problem in which a part of the body moves repeatedly, quickly, suddenly and uncontrollably. Tics can occur in any body part, such as the face, shoulders, hands or legs. They can be stopped voluntarily for brief periods. Sounds that are made involuntarily (such as throat clearing) are called vocal tics. Most tics are mild and hardly noticeable. However, in some cases they are frequent and severe, and can affect many areas of a child's life.

The most common tic disorder is called "transient tic disorder" and may affect up to 10 percent of children during the early school years. Teachers or others may notice the tics and wonder if the child is under stress or "nervous." Transient tics go away by themselves. Some may get worse with anxiety, tiredness, and some medications. Some tics do not go away. Tics which last one year or more are called "chronic tics." Chronic tics affect less than one percent of children and may be related to a special, more unusual tic disorder called Tourette's Disorder. Children with Tourette's Disorder have both body and vocal tics (throat clearing). Some tics disappear by early adulthood, and some continue. Children with Tourette's Disorder may also have problems with attention, and learning disabilities. They may act impulsively, and/or develop obsessions and compulsions. Sometimes people with Tourette's Disorder may blurt out obscene words, insult others, or make obscene gestures or movements. They cannot control these sounds and movements. Punishment

by parents, teasing by classmates, and scolding by teachers will not help the child to control the tics but will hurt the child's self-esteem and increase their distress.

Through a comprehensive evaluation, often involving paediatrician and/or neurologic consultation, a child and adolescent psychiatrist can determine whether a youngster has Tourette's Disorder or another tic disorder. Treatment for the child with a tic disorder may include medication to help control the symptoms. The child and adolescent psychiatrist can also advise the family about how to provide emotional support and the appropriate educational environment for the youngster.

4.4.5 Childhood Depression

Childhood depression is different from the normal mood shifts and everyday emotions that occur as a child develops. Just because a child seems depressed or sad, does not necessarily mean they have depression. If these symptoms become persistent, disruptive and interfere with social activities, interests, schoolwork and family life, it may indicate that he or she is suffering from the medical condition depression.

The symptoms of depression in children vary. Early medical studies focused on "masked" depression, where a child's depressed mood was evidenced by acting out or angry behaviour. While this does occur, particularly in younger children, many children display sadness or low mood similar to adults who are depressed. The primary symptoms of depression revolve around sadness, a feeling of hopelessness, and mood changes and may include:

- Irritability or anger
- Continuous feelings of sadness, hopelessness
- Social withdrawal
- Increased sensitivity to rejection
- Changes in appetite (either increased or decreased)
- Changes in sleep (sleeplessness or excessive sleep)
- Vocal outbursts or crying
- Difficulty concentrating
- Fatigue and low energy
- Physical complaints (such as stomach aches, headaches) that do not respond to treatment
- Reduced ability to function during events and activities at home or with friends, in school, extracurricular activities, and in other hobbies or interests
- Feelings of worthlessness or guilt
- Impaired thinking or concentration
- Thoughts of death or suicide

Not all children have all of these symptoms. In fact, most will display different symptoms at different times and in different settings. Although some children may continue to function reasonably well, most kids with significant depression will suffer a noticeable change in social activities, loss of interest in school and poor academic performance, or a change in appearance. Children may also begin using drugs or alcohol, especially if they are over the age of 12.

4.5 MENTAL RETARDATION

Mental retardation is a developmental disability that first appears in children under the age of 18. It is defined as an intellectual functioning level (as measured by standard tests for intelligence quotient) that is well below average and significant limitations in daily living skills (adaptive functioning). Mental retardation begins in childhood or adolescence before the age of 18. In most cases, it persists throughout adulthood. A diagnosis of mental retardation is made if an individual has an intellectual functioning level well below average and significant limitations in two or more adaptive skill areas. Intellectual functioning level is defined by standardised tests that measure the ability to reason in terms of mental age (intelligence quotient or IQ). Mental retardation is defined as IQ score below 70-75. Adaptive skills are the skills needed for daily life. Such skills include the ability to produce and understand language (communication); home-living skills; use of community resources; health, safety, leisure, self-care, and social skills; self-direction; functional academic skills (reading, writing, and arithmetic); and work skills.

In general, mentally retarded children reach developmental milestones such as walking and talking much later than the general population. Symptoms of mental retardation may appear at birth or later in childhood. Time of onset depends on the suspected cause of the disability. Some cases of mild mental retardation are not diagnosed before the child enters preschool. These children typically have difficulties with social, communication, and functional academic skills. Children who have a neurological disorder or illness such as encephalitis or meningitis may suddenly show signs of cognitive impairment and adaptive difficulties.

Mental retardation varies in severity. *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (*DSM-IV*) is the diagnostic standard for mental healthcare professionals in the United States. The *DSM-IV* classifies four different degrees of mental retardation: *mild*, *moderate*, *severe*, and *profound*. These categories are based on the functioning level of the individual.

- i) **Mild mental retardation:** Approximately 85% of the mentally retarded population is in the mildly retarded category. Their IQ score ranges from 50-75, and they can often acquire academic skills up to the 6th grade level. They can become self-sufficient and in some cases live independently, with community and social support.
- ii) **Moderate mental retardation:** About 10% of the mentally retarded population is considered moderately retarded. Moderately retarded individuals have IQ scores ranging from 35-55. They can carry out work and self-care tasks with moderate supervision. They typically acquire communication skills in childhood and are able to live and function successfully within the community in a supervised environment such as a group home.
- iii) **Severe mental retardation:** About 3-4% of the mentally retarded population is severely retarded. Severely retarded individuals have IQ scores of 20-40. They may master very basic self-care skills and some communication skills. Many severely retarded individuals are able to live in a group home.
- iv) **Profound mental retardation:** Only 1-2% of the mentally retarded population is classified as profoundly retarded. Profoundly retarded individuals have IQ scores under 20-25. They may be able to develop basic self-care and communication skills with appropriate support and training. Their retardation is often caused by an accompanying neurological disorder. The profoundly retarded need a high level of structure and supervision.

The American Association on Mental Retardation (AAMR) has developed another widely accepted diagnostic classification system for mental retardation. The AAMR classification system focuses on the capabilities of the retarded individual rather than on the limitations. The categories describe the level of support required. They are *intermittent support*, *limited support*, *extensive support*, and *pervasive support*. To some extent, the AAMR classification mirrors the *DSM-IV* classification. Intermittent support, for example, is support needed only occasionally, perhaps during times of stress or crisis. It is the type of support typically required for most mildly retarded individuals. At the other end of the spectrum, pervasive support, or life-long, daily support for most adaptive areas, would be required for profoundly retarded individuals.

Causes of Mental Retardation

Low IQ scores and limitations in adaptive skills are the hallmarks of mental retardation. Aggression, self-injury, and mood disorders are sometimes associated with the disability. The severity of the symptoms and the age at which they first appear depend on the cause. Children who are mentally retarded reach developmental milestones significantly later than expected, if at all. If retardation is caused by chromosomal or other genetic disorders, it is often apparent from infancy. If retardation is caused by childhood illnesses or injuries, learning and adaptive skills that were once easy may suddenly become difficult or impossible to master.

In about 35% of cases, the cause of mental retardation cannot be found. Biological and environmental factors that can cause mental retardation include:

Genetics: About 5% of mental retardation is caused by hereditary factors. Mental retardation may be caused by an inherited abnormality of the genes, such as fragile X syndrome. Fragile X, a defect in the chromosome that determines sex, is the most common inherited cause of mental retardation. Single gene defects such as phenylketonuria (PKU) and other inborn errors of metabolism may also cause mental retardation if they are not found and treated early. An accident or mutation in genetic development may also cause retardation. Examples of such accidents are development of an extra chromosome 18 (trisomy 18) and Down syndrome. Down syndrome, also called mongolism or trisomy 21, is caused by an abnormality in the development of chromosome 21. It is the most common genetic cause of mental retardation.

Prenatal illnesses and infections: Fetal alcohol syndrome affects one in 600 children in the United States. It is caused by excessive alcohol intake in the first twelve weeks (trimester) of pregnancy. Some studies have shown that even moderate alcohol use during pregnancy may cause learning disabilities in children. Drug abuse and cigarette smoking during pregnancy have also been linked to mental retardation. Maternal infections and illnesses such as glandular disorders, rubella, toxoplasmosis, and cytomegalovirus infection may cause mental retardation. When the mother has high blood pressure (hypertension) or blood poisoning (toxemia), the flow of oxygen to the fetus may be reduced, causing brain damage and mental retardation.

Birth defects that cause physical deformities of the head, brain, and central nervous system frequently cause mental retardation. Neural tube defect, for example, is a birth defect in which the neural tube that forms the spinal cord does not close completely. This defect may cause children to develop an accumulation of cerebrospinal fluid on the brain (hydrocephalus). Hydrocephalus can cause learning impairment by putting pressure on the brain.

Childhood illnesses, infections and injuries: Hyperthyroidism, whooping cough,

chickenpox, measles and Hib disease (a bacterial infection) may cause mental retardation if they are not treated adequately. An infection of the membrane covering the brain (meningitis) or an inflammation of the brain itself (encephalitis) causes swelling that in turn may cause brain damage and mental retardation. Traumatic brain injury caused by a blow or a violent shake to the head may also cause brain damage and mental retardation in children.

Environmental factors: Ignored or neglected infants who are not provided the mental and physical stimulation required for normal development may suffer irreversible learning impairments. Children who live in poverty and suffer from malnutrition, unhealthy living conditions, and improper or inadequate medical care are at a higher risk. Exposure to lead can also cause mental retardation. Many children have developed lead poisoning by eating the flaking lead-based paint often found in older buildings.

Diagnosis: If mental retardation is suspected, a comprehensive physical examination and medical history should be done immediately to discover any organic cause of symptoms. Conditions such as hyperthyroidism and PKU are treatable. If these conditions are discovered early, the progression of retardation can be stopped and, in some cases, partially reversed. If a neurological cause such as brain injury is suspected, the child may be referred to a neurologist or neuropsychologist for testing.

A complete medical, family, social, and educational history is compiled from existing medical and school records (if applicable) and from interviews with parents. Children are given intelligence tests to measure their learning abilities and intellectual functioning. Such tests include the Stanford-Binet Intelligence Scale, the Wechsler Intelligence Scales, the Wechsler Preschool and Primary Scale of Intelligence, and the Kaufmann Assessment Battery for Children. For infants, the Bayley Scales of Infant Development may be used to assess motor, language, and problem-solving skills. Interviews with parents or other caregivers are used to assess the child's daily living, muscle control, communication, and social skills. The Woodcock-Johnson Scales of Independent Behaviour and the Vineland Adaptive Behaviour Scale (VABS) are frequently used to test these skills.

<p>Self Assessment Questions</p> <p>1) Present a clinical picture of Attention deficit hyperactivity disorder (ADHD).</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>2) Describe oppositional defiant disorder.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>3) Give an account of conduct disorder.</p> <p>.....</p>
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4) Explain the childhood anxiety disorders (separation anxiety disorder).

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5) Describe the tick disorders and childhood depression.

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6) Present an account of mental retardation.

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4.6 LET US SUM UP

The term “pervasive development disorders,” also called PDDs, refers to a group of conditions that involve delays in the development of many basic skills, most notably the ability to socialise with others, to communicate, and to use imagination. Children with these conditions often are confused in their thinking and generally have problems understanding the world around them. PDDs include autism, Asperger’s syndrome, childhood disintegrative disorder, Rett’s syndrome and pervasive development disorder not otherwise specified (PDDNOS). Children with autism have problems with social interaction, pretend play, and communication. They also have a limited range of activities and interests. Many (nearly 75%) of children with autism also have some degree of mental retardation. Like children with autism, children with Asperger’s syndrome have difficulty with social interaction and communication, and have a narrow range of interests. However, children with Asperger’s have average or above average intelligence, and develop normally in the areas of language and cognition. Children with Asperger’s also have difficulty concentrating and may have poor coordination. Children childhood disintegrative disorder begin their development normally in all areas, physical and mental. At some point, usually between 2 and 10 years of age, a child with this illness loses many of the skills he or she has developed. In addition to the loss of social and language skills, a child with disintegrative disorder may lose control of other functions, including bowel and bladder control. Children with Rett’s syndrome have the symptoms associated with a PDD and suffer problems with physical development. They generally suffer the loss of many motor or movement, skills, such as walking and use of their hands and develop poor coordination. Pervasive

development disorder not otherwise specified (PDDNOS) is used to refer to children who have significant problems with communication and play, and some difficulty interacting with others, but are too social to be considered autistic.

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behaviour, and hyperactivity (over-activity). Inattention, hyperactivity and impulsivity are the key behaviours of ADHD. It is normal for all children to be inattentive, hyperactive or impulsive sometimes, but for children with ADHD, these behaviours are more severe and occur more often. To be diagnosed with the disorder, a child must have symptoms for six or more months and to a degree that is greater than other children of the same age. Some of the signs of ADHD are present in many kids. Others are rarely present unless people have disabling ADHD. There are many disorders which are often found with/or without ADHD. These include oppositional defiant disorder, conduct disorder, anxiety disorders (separation anxiety disorder), tick disorders and childhood depression. Mental retardation is a developmental disability that first appears in children under the age of 18. It is defined as an intellectual functioning level (as measured by standard tests for intelligence quotient) that is well below average and significant limitations in daily living skills (adaptive functioning). Mental retardation begins in childhood or adolescence before the age of 18. In most cases, it persists throughout adulthood. A diagnosis of mental retardation is made if an individual has an intellectual functioning level well below average and significant limitations in two or more adaptive skill areas. Intellectual functioning level is defined by standardised tests that measure the ability to reason in terms of mental age (intelligence quotient or IQ). Mental retardation is defined as IQ score below 70-75. Adaptive skills are the skills needed for daily life. Such skills include the ability to produce and understand language (communication); home-living skills; use of community resources; health, safety, leisure, self-care, and social skills; self-direction; functional academic skills (reading, writing, and arithmetic); and work skills.

4.7 UNIT END QUESTIONS

- 1) Explain meaning and general symptoms of pervasive developmental disorders.
- 2) Describe the symptoms and causes of autism.
- 3) Describe Rett's disorder, Asperger syndrome, childhood disintegrative disorder (CDD) and pervasive developmental disorder not otherwise specified (PDD-NOS) as autism spectrum disorders.
- 4) Present a complete clinical picture of attention deficit hyperactivity disorder (ADHD).
- 5) Explain the disorders which are often found with/or without ADHD.
- 6) Elaborate the meaning, types and causes of mental retardation.

4.8 GLOSSARY

Pervasive Development Disorders	: Pervasive development disorders refer to a group of conditions that involve delays in the development of many basic skills.
Autism	: Autism is a developmental disorder characterised by impaired development in communication, social interaction and behaviour.

- Rett's Disorder** : Rett's disorder includes the loss of purposeful hand use, screaming fits, inconsolable crying, loss of speech, behaviour reminiscent of autism, panic-like attacks, grinding of teeth, rigid gait, tremors, intermittent hyperventilation and microcephaly.
- Asperger Syndrome** : Asperger syndrome is one of the neurodevelopmental disorders that have effects on an individual's behaviour, use of language and communication and pattern of social interactions.
- Childhood Disintegrative Disorder** : Childhood disintegrative disorder is a condition in which children develop normally until ages 2 to 4 but then demonstrate a severe loss of social, communication and other skills.
- Attention Deficit Hyperactivity Disorder (ADHD)** : ADHD is one of the most common childhood disorders with the symptoms of difficulty in focusing and paying attention, difficulty in controlling behaviour and hyperactivity.
- Oppositional Defiant Disorder (ODD)** : ODD is a recurrent pattern of negativistic, defiant, disobedient, and hostile behaviour toward authority figures.
- Conduct Disorder** : Conduct disorder refers to a group of behavioural and emotional problems in children that include great difficulty in following rules and behaving in a socially acceptable way.
- Separation Anxiety** : Separation anxiety is related to excessive anxiety of separation or impending separation from the attachment figure (e.g., primary caretaker, close family member).
- Tick Disorders** : A tic is a problem in which a part of the body moves repeatedly, quickly, suddenly and uncontrollably.
- Mental Retardation** : Mental retardation refers to an individual's intellectual functioning level well below average and significant limitations in two or more adaptive skill areas.

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UNIT 1 ANXIETY DISORDERS, PANIC AND PHOBIAS

Structure

- 1.0 Introduction
- 1.1 Objectives
- 1.2 Nature of Anxiety and Anxiety Disorders
- 1.3 Panic Attack: Symptoms and Clinical Features
 - 1.3.1 A Case Study of Panic Attack
- 1.4 Epidemiology of Panic Attacks
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1.0 INTRODUCTION

Feeling anxious about how to finish this large course within stipulated time? You may welcome this anxiety, at least to a certain extent. It would help you learn quickly and to get good marks. Anxiety is, indeed, a common reaction to stress. It saves us from being careless and hence from accidental disasters. Unless you have anxiety about your examination, you would not study. Unless the mother has anxiety over her baby's health she might forget to care for the infant. Unless you have anxiety you would step over the snake and get bitten. But anxiety turns into a disorder when you are so anxious that you have a breakdown at the examination hall, forgetting everything. Anxiety is a disorder when the mother is so anxious that her baby may fall ill that she spends the day and night praying to God, and ultimately fails to feed the baby. Anxiety is a disorder when you faint if somebody names a snake.

You can readily remember many such examples from your daily life. How would you recognise pathological anxiety as different from normal anxiety? What are the various patterns that anxiety disorder may take? What are the causes of anxiety disorders?

How should you deal with it? In this Unit, and also in the following Units you would learn about some such anxiety disorders.

Anxiety disorder is a group of disorders each of which need special attention and understanding. You know that in classifying disorders, we usually follow either the Diagnostic and statistical Manual, Version IV TR (DSM IV TR) or International Classification of Diseases, Version 10 (ICD 10). According to DSM IV TR, the primary types of Anxiety disorders include:

- Panic disorder with or without agoraphobia
- Phobic disorders of the specific or social type
- Generalised anxiety disorder
- Obsessive compulsive disorder
- Post traumatic stress disorder

However in this unit, we would focus on two specific anxiety disorders in detail: Panic Disorders and Phobias. You would also read case studies exemplifying the typical symptoms. The names in all case studies are fictitious and all important identifying information has been changed to maintain anonymity of the persons.

1.1 OBJECTIVES

After you complete this unit, you will be able to:

- Define and explain anxiety and fear;
- Distinguish between normal and pathological anxiety;
- Describe the nature of anxiety disorders;
- Elucidate the symptoms of Panic disorder;
- Discuss the aetiology of Panic disorder;
- Elucidate the treatment of Panic disorder;
- Analyse Panic disorder from real life;
- Describe the symptoms of Phobic disorder;
- Explain the types of Phobic disorders;
- Discuss the aetiology of Phobic disorder; and
- Elucidate the treatment of Phobic disorder.

1.2 NATURE OF ANXIETY AND ANXIETY DISORDERS

Anxiety Disorder is a blanket term that covers a number of disorders. In this context, you must be aware of the difference between fear and anxiety. Fear is a basic emotion of human beings. It is associated with the perception of a real threatening situation and involves the ‘fight or flight’ response activated by the sympathetic nervous system. If a thug attacks you in the street, you would feel intense fear. Then, you would either run for dear life, or hit him back. Thus fear involves cognition of the threatening object, subjective cognition of being in danger, physiological components like increased heart rate, and behavioural components like running or hitting.

Anxiety also involves subjective perception of threat, physiological changes and some kind of behavioural reaction. But unlike fear, it has no immediate threat. If you cannot go out of your home because you are always apprehending an attack from

a hoodlum, it is anxiety. You are projecting the threatening situation in future and reacting to it as if it is imminent.

You may note that anxiety serves a kind of adaptive function as well, because it prepares a person for fight or flight if the danger really comes. But if the person avoids the very situation that in her perception may cause the danger, and if such imagined situations are unrealistic, then the effect becomes debilitating. Thus you may distinguish between adaptive anxiety and pathological anxiety by assessing the realistic probability of the occurrence of the object of anxiety and by assessing how dysfunctional it makes the person.

Before you go into learning the specific symptoms of each, you should know the common characteristics of anxiety disorders.

Cognition or subjective perception of danger which may be accompanied by vivid and occasionally morbid images of the difficulties encountered.

Physiological responses through activation of sympathetic nervous system. Usually it includes increased heart rate, trembling, breathing discomfort, dilated pupils, nausea etc.

On the behavioural level, there is usually a tendency to avoid the dreaded situation. However, in some cases, as in Obsessive compulsive disorder and some instances of Post traumatic Stress disorder, repetitive behaviour is also observed.

In this Unit, you would learn specifically about **Panic attacks and Phobias**.

Self Assessment Questions

1) What are the primary types of anxiety according to DSM IV TR?

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2) State *True* or *False* beside each statement

- a) Fear is imaginary; anxiety is response to a really possible event ().
- b) Real and pathological anxiety can be distinguished in terms of degree of dysfunction ().
- c) Sympathetic nervous system is activated during anxiety ().

1.3 PANIC ATTACK: SYMPTOMS AND CLINICAL FEATURES

Have you ever encountered any situation where a person has all on a sudden started behaving as if under severe stress? She sweats, almost faints and complains that she cannot breathe. People around may start thinking that she has a heart attack, but after some time she recovers and gradually becomes normal. While this may be an actual transient cardiac problem, it can also be a panic attack.

Panic attack is an episode of intense fear or apprehension with a sudden onset. Such symptoms develop abruptly and usually reach its peak within 10 - 15 minutes. During such attack the victim becomes completely overpowered by the symptoms, many of which are physiological in nature.

Panic attacks are characterised by their unexpectedness. The DSM IV TR mandates that a person would be diagnosed as suffering from panic disorder if she had

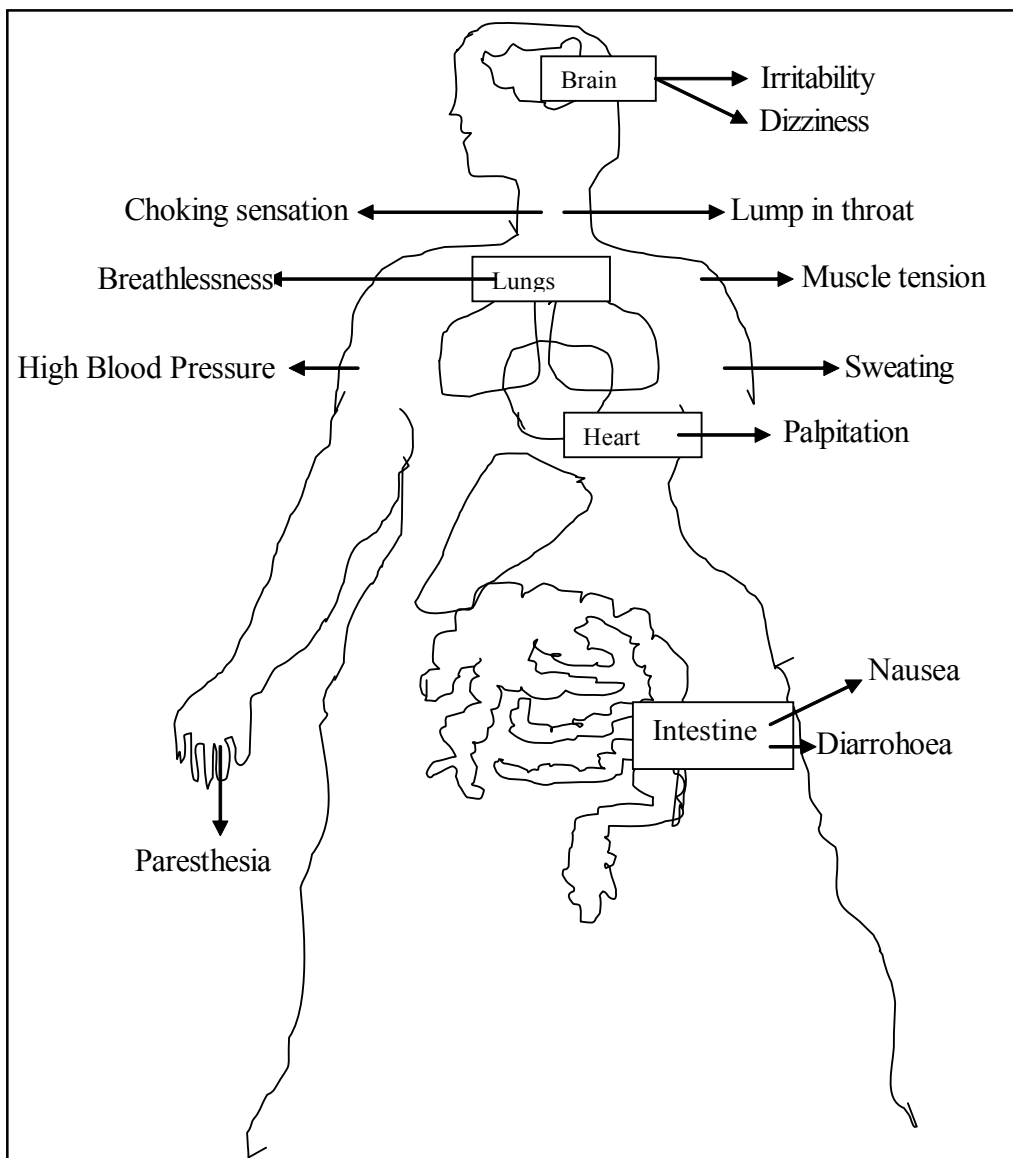
experienced recurrent unexpected attacks and is persistently concerned with having another attack. This condition must go on for at least one month. Also, the person must have at least four of the following thirteen symptoms during the attack:

- Palpitation or pounding heart
- Sweating
- Trembling or shaking
- Sensation of shortness of breath or being smothered
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, lightheaded or faint
- Derealisation or depersonalisation
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias
- Chill or hot flushes.

The typical clinical description of panic attack is featured by intense terror, at times in the form of fear of dying or going crazy. Nervousness, shaking and stress are common. The person seems to have no control on oneself. Sometimes one feels like the beginning of a heart attack, as difficulty in breathing (as if one is not getting enough air), palpitation, hyperventilation, rapid heart bits, chest pain and choking sensation along with profuse sweating predominate. Often there is a dizziness, lightheadedness, nausea and fainting. One feels dissociated from reality – one almost seems to be detached from the immediate surroundings and drawn in a whirlpool of odd sensations. Occasionally there are hot flashes or sudden chills, burning sensation in facial and neck area, tingling in fingers and toes (paresthesia). Difficulty in vision is also observed in the form of flashing vision and tunnel vision (loss of peripheral vision). The most prominent underlying characteristic is of being out of control in all respects.

The reactions are usually those associated with activation of sympathetic nervous system. You must know that panic attack is not dangerous, but it can be truly frightening. There are numerous cases when the patient has been admitted for emergency cardiac care, particularly because the symptoms are mostly physiological and mimics cardiac symptoms.

You need to be acquainted with the word ‘Agoraphobia’ in the context of panic attack. The word Agoraphobia derives from the Greek word ‘agora’ which means public places or assembly of people. Panic attacks can be with or without agoraphobia. Typically, panic attacks with agoraphobia seem to be precipitated by attending a cinema hall, a shopping mall, a cue for tickets, tunnels, trains and aircrafts or so on, where a large number of people congregate and escape in case of a panic attack may be difficult.



1.3.1 A Case Study of Panic Attack

Maya is a young lady studying at the University. She comes from a middle class family living in a suburban place. Maya is somewhat introvert, apparently cool and rational, and determined to finish her education. She regularly takes the underground Metro rail to come to the University. One day while waiting for the train, she had some kind of physical discomfort. However, she ignored it and boarded the train. The train was moderately crowded and she did not get a seat. She stood in front of the seat reserved for ladies. A few minutes later, she felt choked and nauseated, started sweating profusely and her discomfort was so strong that she asked the elderly lady sitting in front of her for help. This lady immediately offered her a seat and asked her what her problem was. By that time, Maya was trembling and had started crying. “I am going to die” – she cried. Other passengers came forward to help, gave her water to drink, and at the next station they took Maya out of the train and contacted the authority. Maya was taken to a hospital and her father was informed. By the time her father arrived, Maya had been feeling much better. The doctors had found a rapid pulse rate, but did not get anything indicating cardiac problem. Maya had retrospectively reported extreme fear of being choked to death, especially as she was in an underground train and could not jump out and run for the sunlight up on the streets.

Initially, everybody thought that this was just a stray episode. But it so happened that the experience left Maya extremely fearful of travel by underground train. She

understands that this is irrational, but cannot face traveling by underground train again. She cannot even take crowded buses. Now she takes auto rickshaws for her travel. She has to change vehicles a number of times to reach the University in time. Often she insists that her father accompany her. Her confidence has lowered considerably. She has been diagnosed of panic attack with agoraphobia.

1.4 EPIDEMIOLOGY OF PANIC ATTACKS

How prevalent is panic disorder? Estimations of prevalence of panic disorder and panic attacks at some point of life ranges between 3% to 5% of the population. It is usually more common in women, and the age of onset is usually between 15 and 24. You need to be sensitive to the fact that this gender difference may be attributed to cultural factors, as unrealistic fear is tolerated more in women, but men need to keep up a brave face. Thus, in different cultures with different gender role prescriptions, the male female ratio may change.

1.5 AETIOLOGY OF PANIC DISORDER

You must be curious to know what causes panic disorder. The aetiology of panic disorder may be divided in biological and psychosocial factors. The biological factors include genetic factors and biochemical abnormalities in the brain. The psychosocial factors are more concerned with understanding the changes in the individual's perception which triggers panic attacks. They include learning factors and a number of cognitive variables that may trigger or maintain panic attacks. In this section you will learn about these factors in some detail.

1.5.1 Biological Factors

- 1) **Genetic factors:** Family and twin studies indicate that panic disorder runs in families. Identical twins seem to have greater possibilities of panic disorder, while concordance is less in fraternal twins. The specific genes responsible for panic disorder are yet to be discovered. However, there seems some evidence that panic disorder and phobia may have some genetic commonness.
- 2) **Brain and biochemical abnormalities:** Attempts have been made to associate panic attacks with biochemical characteristics of the brain. It has been observed that exposure to certain biochemicals generate panic attack in those who are already suffering from panic disorder, while this may not have any impact on others. Thus there has been a suggestion that there might be definite neurobiological differences between the normal persons and those with panic disorder. Some of such substances which may be considered panic provocation agents are sodium lactate, carbon dioxide, caffeine etc.

However, the brain mechanisms associated with the action of these substances are not identical and there have been suggestions that *no single neurobiological mechanism* may be held responsible for all types of panic attacks.

Some of the brain mechanisms implicated in panic attack are the increases activity in the *hippocampus* and *locus coeruleus*, which are responsible for monitoring external and internal stimuli and moderates brain's reactions to them. The *amygdala* is critically important in fear reaction, and is involved in the 'fear network' of the brain. Abnormal sensitivity in this region may cause repeated anxiety attacks. Increased noradrenergic activity simulates cardiac problem by enhancing heart rate and breathing problems. It has also been suggested that people with panic disorder may have abnormalities in their benzodiazepine receptors which help in anxiety reduction. The role of GABA neurotransmitter may be important in this respect.

1.5.2 Psychological Factors

- 1) **Learning factor:** The learning theorists have tried to explain panic attacks as learnt phenomena – specifically as responses to conditioned stimuli. You already know how conditioning occurs and how apparently neutral stimulus may acquire a significance to elicit some response. Take the case of Maya as an instance. The panic attack happened for her for the first time in the underground train. Subsequently the situation of the train becomes the conditioned stimulus, and Maya is afraid that the next panic attack may also occur in the crowded vehicle. Thus the initial learning is reinforced and increases in vigour by reinforcements in cyclic pattern. This explanation is also known as ‘fear of fear’.

Sometimes, an internal stimulus may act as the trigger to panic attack. For example, an increased heart rate may be so associated with panic attack experiences that if heart rate increases for any reason, panic attack starts. Thus oversensitivity to internal stimuli can also be a cause of panic disorder.

- 2) **Cognitive factors:** The cognitive approach to panic attack focuses on the interpretation of bodily sensations and external cues that may trigger the attack. While the learning approach highlights the oversensitivity to bodily cues, the cognitive approach further affirms that a catastrophic meaning may be assigned to the bodily sensation. For example the racing of the heart may be attributed to a serious malfunctioning of the cardiac system, rather than to the medicine one has taken. If the person is not aware of this catastrophic thought, it may fall within the arena of ‘automatic thoughts’ that non-consciously result in the attack. You may note that the role of interpretation is crucial here. This has been highlighted by experiments where the heart rate has been increased in panic disorder patients by using drugs. If the person knows about the possible effects of the drug, panic attack does not take place or occurs to a much milder degree.

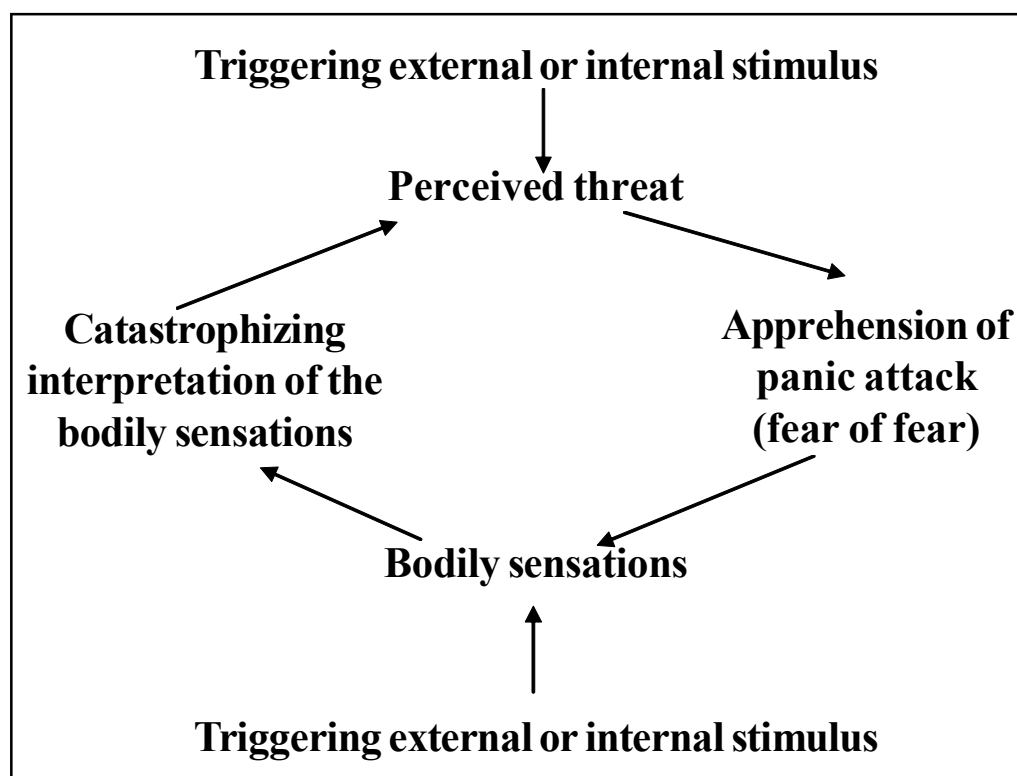


Fig.: The vicious Panic Cycle

Panic disorder patients are also known to demonstrate cognitive bias toward certain experiences and symbols. For example they may be more prone to words like ‘fainting’ or ‘shortness of breath’. There is however controversy as to whether these biases have been generated after repeated panic attacks or were already present before the first attack.

However, there seems to be accumulating evidence that a special kind of cognitive orientation is present in some people, which make them more amenable to consider certain stimuli as triggers of panic attack more quickly than others.

1.6 TREATMENT OF PANIC DISORDER

How would you deal with panic disorder? Panic disorder may be treated by pharmacology or psychotherapy, or a combination of both. Tranquilizers from the Benzodiazepine group of drugs (alprazolam or clonazepam) are often used to handle panic attacks. These however, have the side effect of being addictive. Antidepressants like Tricyclics and SSRIs (Selective Serotonin Reuptake Inhibitors (SSRIs) have also been used with efficacy to deal with panic attacks.

While these drugs, particularly SSRIs do not have the immediate calming effect like the Benzodiazepine group of drugs, these are relatively free from addiction and have better result in long term treatment. Although extrapyramidal effects like dryness of mouth may be occasional side effects, these are better tolerated by most people also.

Psychotherapy is also useful in dealing with panic disorder. You can teach relaxation techniques and breathing exercises to the patient for self management. These techniques include gradually relaxing the muscles of your body, progressively from one extremity to another, and also controlling breathing so that the internal cues of fear are regulated and under control.

Besides you can also employ the Cognitive technique to identify the erroneous automatic thoughts and review them in the light of reality orientation. For example, you may ask the patient to imagine the worst that can happen to her and to judge the probability of its occurrence in real life. You can also ask her to identify the triggering cues and to dissociate them by practice from the immediate physiological responses. It has been suggested that cognitive technique is more helpful than medicine for long term maintenance of the cure in case of panic disorder.

Self Assessment Questions

1) How many of the thirteen symptoms must be there for panic attack to be diagnosed?

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2) What is ‘fear of fear’?

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3) What are the relative merits and demerits of Benzodiazepine and SSRI in treating panic disorder?

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4) Write *True* (T) or *False* (F) beside the statement

- a) A specific neurobiological mechanism has been specified for panic attacks ().
- b) Panic attacks may be stimulated by internal cues ().
- c) Panic disorder is prevalent in less than 1% of the population ().

1.7 PHOBIA: SYMPTOMS AND CLINICAL FEATURES

The word ‘Phobia’ derives from the name of the Greek god ‘Phobos’ who used to frighten his enemies. A phobia is an intense and irrational fear of some object, living being or situation. Do you get notably disturbed if a cockroach flies around and falls on your body? Of course nobody would love to caress a cockroach, but some people get completely panicky at the thought of touching it. Depending upon how severe it is, this may be a phobic reaction.

DSM IV – TR specifies that to be diagnosed as suffering from phobic disorder, one must have a persistent and disproportionate fear of some specific object, social situation or crowded place that actually carries little danger. Exposure to the phobic stimulus almost invariably produces intense anxiety response. The patient usually knows that the fear is unreasonable, but she has no control on the reaction. The phobic situation is usually avoided, or if forced to endure, may be tolerated with great discomfort.

When forced to encounter the phobic stimulus, the reactions may be like panic attack, or a little less severe than it. The attention of the person facing the phobic object is directed completely toward it, the affect is intense fear and the behavioural reaction is escape. As soon as the person can escape from the presence of the phobic stimulus, the negative affect and accompanying physiological reactions subside. Thus the flight reaction is reinforced as it provided relief from tension.

According to DSM IV – TR, phobias can be of three types: Specific Phobia, Social Phobia and Agoraphobia. Specific phobias are the irrational fear of specific objects, animals or situations. Some typical examples are: fear of closed space or claustrophobia, fear of heights or acrophobia, fear of blood or haemophobia, fear of snake or Ophidiophobia, fear of spider or arachnophobia, fear of fire or pyrophobia and even fear of phobias or phobophobia. You can get a list of the phobias on internet by clicking http://en.wikipedia.org/wiki/List_of_phobias

The specific phobias can be divided in some subtypes like

- animal type - cued by animals or insects

- natural environment type - cued by objects in the environment, such as storms, heights, or water
- blood-injection-injury type - cued by witnessing some invasive medical procedure
- situational type - cued by a specific situation, such as public transportation, tunnels, bridges, elevators, flying, driving, or enclosed spaces
- other type - cued by other stimuli than the above, such as of choking, vomiting, or contracting an illness.

Social phobias, as you may guess from its name, are persistent irrational fear associated with presence of other people. Remember how we sometimes get tongue tied at the interview boards? Social phobia is an extreme form of this kind of discomfort. Often extreme feelings of shyness and self-consciousness build into a powerful fear, so that it becomes difficult to participate in everyday social situations. People with social phobia can usually interact easily with close and familiar persons. But meeting new people, talking in a group, or speaking in public can trigger the phobic reaction. Often situations where one might be evaluated become the phobic situation. All of us may have occasional social anxieties, especially under judgmental situation. But a person with diagnosable social phobia often becomes incapable of normal social interaction.

You have already read about Agoraphobia in connection with panic disorder. You know that it refers to the fear of public spaces where many people congregate. Agoraphobia without history of panic disorder has been given a special emphasis in DSM IV – TR. It develops slowly and insidiously from early adolescence or late childhood, and gradually becomes debilitating. If it is a part of the panic attack, it should be coded within Panic disorders. If it occurs as a source of anxiety and a strong urge to avoid, but does not constitute a palpable panic attack, it should be coded within Phobia.

1.7.1 A Case Study of Specific Phobia

Kalu, now about 24, comes from a lower class family of fishermen. They earn their livelihood by fishing in shallow backwater or rivulets streaming from big rivers. He had studied up to class IV in the local school, and then left it due to poverty. As a child, he used to accompany his father to the backwaters, especially where they cultivated prawns. Very occasionally crocodiles swim in from the big river with which the backwater may be connected, and there has been tales about crocodiles killing men around the village. Everybody had heard these tales, but since the appearance of crocodiles is quite rare, everybody works in knee deep water without much anxiety. From early adolescence onward, Kalu gradually became afraid of crocodiles, which then turned into specific phobia. He was unable to work in the water, because if he sees any shadow, even of underwater plants and fish, he suffers from uncontrollable fear. Since Kalu's family has no land to cultivate, and Kalu hardly has any other skill, not being able to work in water has practically made him a non-earning member of the poor family. Kalu understands that his fear is irrational, and never in his life time has he heard of a crocodile actually attacking a man in their locality. He understands that he is becoming a burden on his family; but he cannot overcome the intense fear. While he attributes the fear to the stories he had listened to in childhood, he knows that these are not enough to provoke such strong reactions.

1.8 EPIDEMIOLOGY OF PHOBIC DISORDER

Not all phobias are of equal prevalence. Social phobias are more common than specific phobias. While specific phobias are estimated to be around 4.5%, the estimated prevalence of social phobia is around 11%. Phobias, like panic disorders, are more common in women than men.

1.9 AETIOLOGY OF PHOBIC DISORDER

Like Panic disorder, you may understand the origin of phobias in terms of biological and psychological factors.

1.9.1 Biological Factors

Biological factors are of less importance in phobias than in panic disorders. The genetic basis of phobias has been suggested by some studies, but it has not been well established.

At best the impact of genetic factors is modest. It has been suggested however, that temperament plays a significant role in developing phobia. Some children are temperamentally jumpy or easily aroused. This lability-stability dimension is a function of the predisposition of the autonomic activity. Those who are easily aroused may have greater chance of developing anxiety disorders in later life.

There have been some attempts to provide evolutionary biological explanation of phobic disorders. People are more likely to develop fear of snakes or heights than of books or cups. Thus there seems to be a 'preparedness' to consider some objects as more phobic than others. This preparedness has been retained by nature because the primates who identified these danger signals quickly had a survival advantage. However, for the normal person, the reality of the danger is judged, while for the phobic person the reaction is exaggerated.

1.9.2 Psychological Factors

You may study the psychological factors as viewed from different theoretical approaches.

- 1) **Psychoanalytical theory:** You already know that psychoanalytical approach emphasises the role of unconscious needs and conflicts. Freud, in his description of fear of horses in little Hans proposed that phobias are the ego's way of dealing with childhood conflict. For example, Hans could not resolve his oedipal conflict properly and his fear of father was displaced onto horses. Other psychoanalytical models attribute phobias not to id drives, but to disastrous interpersonal experiences. The mistrust and generalised fear of environment seems to be displaced on the phobic object or situation. You may note that social phobia may be particularly well explained by this latter view.

The psychoanalytical model has been criticized by learning theorists as they state that many phobias develop as result of association with a fear eliciting object, and we need not go to the deeper id impulses for explaining them.

- 2) **Learning theories:** When you learnt about classical conditioning, you came across the experiments of Watson and Rayner, who conditioned little Albert to fear furry objects by associating a rat with a loud bang. The learning theory explanation of phobia takes this experiment on avoidance conditioning as the

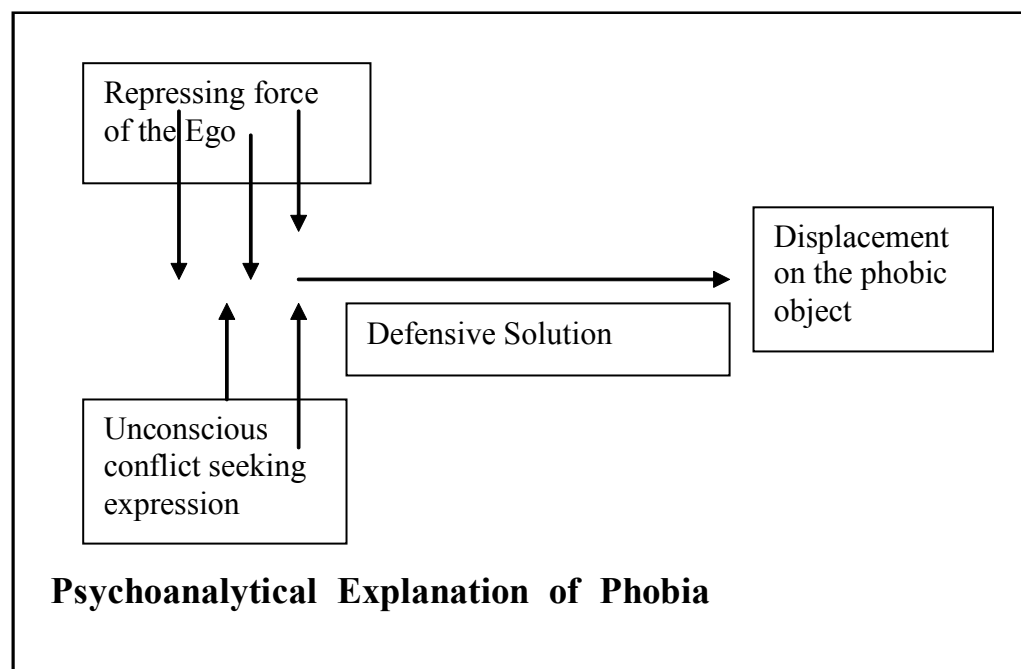
model of phobic reactions. It is believed that phobia is the end result of a process of a neutral stimulus being turned into a phobic object due to unwarranted association in time with a feared object. Initially the association creates the fear of the neutral stimulus, and then escape or avoidance of the stimulus results in relaxation. This relaxation in turn acts as a reinforcer and maintains the phobia.

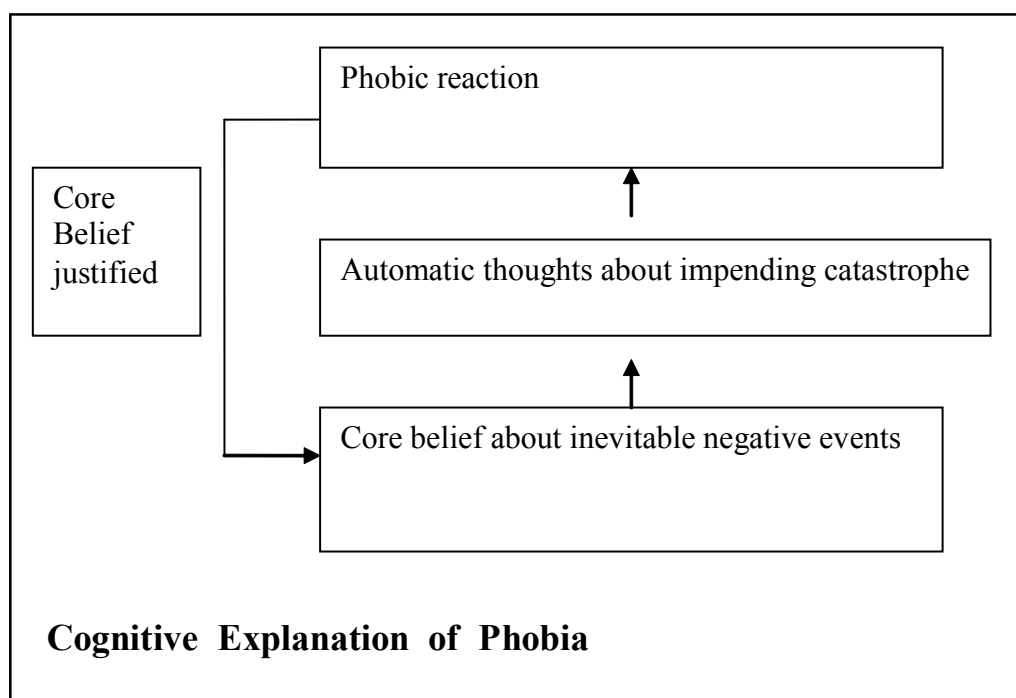
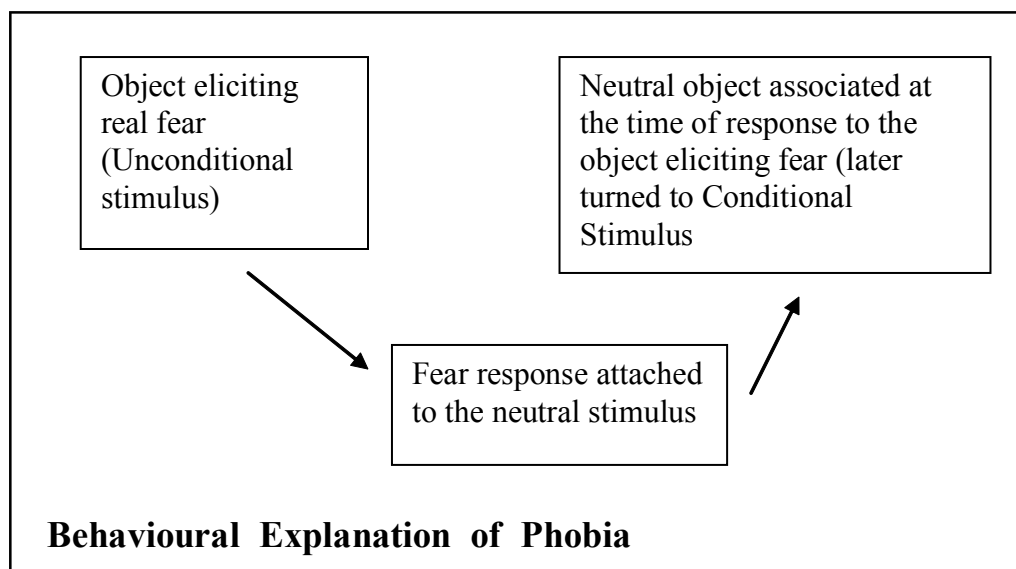
Another process emphasised within the learning approach is modeling of phobias. While learning about Bandura's social learning theory, you have come across the concept of vicarious learning. It refers to the fact that a child models behaviours, but also attitudes and emotions. If a child repeatedly sees her mother being afraid of something, the same would be observed in the child also. The modeling theory proposes that phobias are learnt via observational learning processes.

While learning theory justifies the origin of a number of phobias in some cases, not all phobias can be explained by this theory. Particularly, the role of preparedness that you have learnt earlier in connection with biological factors remains a significant issue. It may be stated that learning may play a role in phobia, but it cannot be the whole story.

- 3) **Cognitive theories:** Cognitive approach to phobias indicates a greater selective attention toward the phobic object. There is often an underlying core belief that negative things are going to happen. Particularly in case of social phobia, but also in other specific phobias, catastrophic outcomes are believed to be inevitable, thus distorting the reality for the person.

Cognitive theory also admits that the core belief may remain at a non-conscious level, thus making it difficult to modify. However, if the person is taught to look into her own erroneous assumptions and cognitive biases, the distortion in thought process may be identified. Figure Diagram explaining psychoanalytical, behavioural and cognitive explanation of phobia





1.10 TREATMENT OF PHOBIC DISORDER

As in case of panic disorder, anxiolytics and anti-depressants are used for treating phobic disorders, particularly social phobia. However, psychological treatments are of greater effectiveness. You can go for psychoanalytical, behavioural or cognitive therapies depending upon your orientation and specific case history.

Psychoanalytical therapies try to unearth repressed conflicts and deal with them at a mature level than by displacing them onto objects and situations.

Among the *behavioural approaches* to treatment, you can try systematic desensitisation, flooding and relaxation techniques.

Systematic desensitisation is a process of exposing the person to the phobic object in a graded way. Before starting systematic desensitisation, you need to teach your client the relaxation technique scientifically. Then you prepare 'hierarchies of anxiety', and design situations to expose her gradually from the lowest level of

anxiety to the highest. For example, if your client is afraid of snakes, you can first show her a cartoon picture of a snake, which would probably not elicit phobic responses in her. You ask her to relax in the presence of this picture, and she can very well do it. Next you show her a perfectly realistic photograph of a snake, and, let us say, she can relax even though she is a bit uncomfortable. Then you show her a 3D picture, and she is now disturbed. You continue working with her till she learns to relax in front of it. Then you show here a video – and so on. When finally she is ready to take her chance, you take her to a snake park and ask her to relax and enjoy.

Flooding is the opposite of graded exposure – here you expose your client straightaway to the feared situation or object and ask her to relax. This is also known as exposure therapy. Once she can manage the situation, she becomes confident of her control. Usually this is the technique rural people take for teaching swimming to young boys. They throw the protesting child in water with a cloth tightly wound around his waist. The child struggles and gasps in water, and at last through random movements float up. He may be rescued at any moment with the help of the cloth tied around his body. The same may be used with phobic people, but the risk is that some of them may be traumatized. So flooding needs to be done cautiously.

Modelling is another recommended technique. Seeing others in a group facing the situation without fear may help in trying to do the same.

The *cognitive approach* to treating specific phobic disorders has not been the best option of choice, since the person already knows the unreasonableness of her fear. Simply making her see the irrationality is of little help.

Exposure to the situation seems to be essential for reduction of specific phobia. However, cognitive behaviour therapy is useful in case of social phobia.

There are often automatic thoughts about self and others underlying social phobia.

Exploring such erroneous automatic thought and making the client approach it from a new perspective have been helpful in treating social phobia.

In fact, in real life therapeutic situation, you may go for a combination of therapies depending upon the specific need of the client.

Self Assessment Questions

1) How many types of phobias have been identified by DSM?

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2) What are the subtypes of Specific phobia?

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3) What is liability-stability dimension?

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4) Write *True* (T) or *False* (F) beside the statement

- a) The psychoanalytical model attributes phobias to unconscious conflict ().
- b) Specific phobia is more prevalent in population than social phobia ().
- c) Systematic desensitisation is used for treating phobic disorder ().

1.11 LET US SUM UP

In this unit we have learnt that anxiety can be a common reaction to stress and we have to differentiate between normal and pathological anxiety. We have learnt the general nature of anxiety disorders and focussed specifically on Panic disorders and Phobias. Panic disorders can be with or without Agoraphobia. Phobias can be Specific phobia, Social phobia and Agoraphobia. We have learnt the symptoms and clinical features of the panic disorders and phobias. We have learnt about their aetiologies in terms of biological and psychological factors. We have also been acquainted with some of the treatment approaches to these disorders.

1.12 UNIT END QUESTIONS

- 1) Distinguish between anxiety and fear.
- 2) Critically discuss the difference between normal and pathological anxiety.
- 3) Discuss the symptoms and clinical features of different kinds of Panic disorder with case examples.
- 4) State the prevalence rate of Panic disorder.
- 5) Discuss the aetiological factors of Panic disorder.
- 6) Discuss the treatment options of Panic disorder.
- 7) Discuss the symptoms and clinical features of different kinds of Phobias with case examples.
- 8) State the prevalence rate of different categories of Phobias.
- 9) Compare the relative prevalence of Panic disorder and Phobia.
- 10) Discuss the aetiological factors of Phobias.
- 11) Discuss the treatment options of Specific Phobia.
- 12) Discuss the treatment options of Social Phobia.

1.13 GLOSSARY

- Anxiety disorder** : A group of disorders characterised by irrational fear of something or some situation. The person is usually aware of the irrationality. It includes panic disorder, phobic disorder, generalised anxiety disorder, obsessive compulsive disorder and post traumatic stress disorder.
- Panic attack** : Panic attack is an episode of irrational intense fear or apprehension that is of sudden onset. It is accompanied by strong autonomic arousal and numerous bodily symptoms often mimicking cardiac attack.
- Agoraphobia** : Irrational intense fear of crowded places from where escape might be difficult.
- Specific Phobia** : Irrational intense fear of specific objects, animals or situations.
- Social Phobia** : Irrational intense fear of being exposed to public places, specially where one has to perform and be evaluated.
- Systematic desensitisation** : A therapeutic technique based on behavioural approach where the client is exposed to the phobic object or its image in graded stages, starting from a point where she is fully relaxed, and then guided progressively toward staying relaxed even in situations where she experienced intense fear.
- Flooding** : A therapeutic technique based on behavioural approach where the client is exposed all at once to the phobic object. She is instructed to relax instead of being afraid. Once she can relax in oresence of the phobic object she may be able to master her fear.
- Relaxation technique** : A behavioural technique that includes any method, process, procedure, or activity that helps a person to relax and to be free from stress and anxiety. This can be done by progressive muscular relaxation, controlled breathing , biofeedback etc.

1.14 SUGGESTED READINGS

Kaplan, H. I. & Sadock, B. J. *Synopsis of Psychiatry*. Philadelphia: Lippincott Williams.

Semple, D., Smyth, R. Burns, J., DArjee, R. & McIntosh, A. (2005) *Oxford Handbook of Psychiatry*. London: OUP.

UNIT 2 GENERALISED ANXIETY DISORDER AND OBSESSIVE COMPULSIVE DISORDER

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 Generalised Anxiety Disorder: Symptoms and Clinical Features
 - 2.2.1 A Case Study of Generalised Anxiety Disorder
- 2.3 Prevalence of Generalised Anxiety Disorder
- 2.4 Aetiology of Generalised Anxiety Disorder
 - 2.4.1 Biological Factors
 - 2.4.2 Psychological Factors
- 2.5 Treatment of Generalised Anxiety Disorder
- 2.6 Obsessive Compulsive Disorder: Symptoms and Clinical Features
 - 2.6.1 A Case Study of Obsessive Compulsive Disorder
- 2.7 Prevalence of Obsessive Compulsive Disorder
- 2.8 Aetiology of Obsessive Compulsive Disorder
 - 2.8.1 Biological Factors
 - 2.8.2 Psychological Factors
- 2.9 Treatment of Obsessive Compulsive Disorder
- 2.10 Let Us Sum Up
- 2.11 Unit End Questions
- 2.12 Glossary
- 2.13 Suggested Readings

2.0 INTRODUCTION

Would I be able to go to office in time? Is my dress suitable for my job? Am I capable of what I am supposed to do? Will the boss be angry over me? Would my children come back from school safely? What if my wife forgets to put off the gas cylinder and have a terrible accident? Is it possible that I am robbed of my belongings on my way back home?

You must have come across some persons around you who are known as nervous and shaky in general. They seem to be high strung, and anxious over every single step in life.

In some of such persons the anxiety becomes so severe that their everyday functioning may be impaired. You may also notice that in some persons there is an unnatural concern for doing certain things in a right way. Am I clean enough? Did I lock the door properly? Could it so happen that I might actually choke my baby girl to death while playing with her? Such doubts and over concern with unnecessary and at times bizarre issues constitute another category of anxiety disorders.

In this unit you would learn about two such disorders: Generalised Anxiety Disorder and Obsessive Compulsive Disorder. Both these disorders are characterised by prolonged and continuous anxiety. In the earlier unit you have learnt about panic attack and phobia, which are episodic and may be in response to specific conditions. The two disorders that you would be learning in this section are characterised by relatively persistent anxiety and reduce the overall functionality of the individual. You would also read case studies exemplifying the typical symptoms. The names of all case studies used here are fictitious and all important identifying information has been changed to maintain anonymity of the persons.

2.1 OBJECTIVES

After you complete this unit, you will be able to:

- Define generalised anxiety disorders;
- Describe the symptoms of generalised anxiety disorder;
- Discuss the aetiology of generalised anxiety disorder;
- Explain the treatment of generalised anxiety disorder;
- Describe the symptoms of obsessive compulsive disorder;
- Analyse the aetiology of obsessive compulsive disorder; and
- Elucidate the treatment of obsessive compulsive disorder.

2.2 GENERALISED ANXIETY DISORDER (GAD): SYMPTOMS AND CLINICAL FEATURES

You may very well guess from the nomenclature itself that Generalised Anxiety Disorder (popularly known as GAD) is an over generalised anxiety over many things. GAD is characterised by excessive and irrational anxiety over minor things. The DSM IV –TR characterises GAD in terms of persistent excessive anxiety and worries which the person finds difficult to control. There are 6 specific symptoms among which at least 3 must be present to be diagnosed as GAD. These are:

- Restlessness or feeling keyed up
- Being easily fatigued
- Difficulty in concentrating
- Irritability
- Muscle tension
- Sleep disturbance

GAD is also known as free floating anxiety in psychodynamic terms, because the anxiety does not seem to be bound to one or few specific issues. The person typically is terrified of different possible mishaps. If you convince the person of the irrationality of one issue, or if, in the course of natural affairs, one issue is resolved, the person takes up a second and a third issue and focuses on them. Concentration to anything for a given period of time becomes extremely difficult, as some or other point of anxiety always comes up. Somatic complaints like sweating, flushing, palpitation, upset stomach, lump in throat, frequent urination, rapid breathing, twitches and tics are common. The person becomes fidgety, irritable and easily fatigued. Often vivid imageries of the disaster accompany the restlessness. Impatience, anger outbursts and insomnia are common.

Many persons with GAD lead their life more or less normally without consulting any doctor. They have some functional impairment and difficulties within the family; but the problems may be somewhat manageable with some support from the close ones. For about one third cases, spontaneous recovery takes place at some point in life. For others the problem is severe enough to seek medical consultation, although the chief complaint is often presented as somatic problems or insomnia.

2.2.1 A Case Study of Generalised Anxiety Disorder

Fatema, now a housewife of 35 years of age, had always been nervous since her childhood. During her school days, she had been anxious for her studies and examinations. She was also extremely upset if any of her friends talked ill about her or the teachers scolded her. At home she became greatly worried if her father came home later than usual. She apprehended some accident. She was admitted to college, but did not finish her graduation. She married at the age of 22. Her husband had a small business in the town. Fatema was from the very beginning apprehensive about the possible failure of her husband's business and worried over any temporary loss that occurred. Initially her husband was glad to see her worried, as he interpreted it as her attachment to him. Gradually he became irritated at the constant worry and negative predictions she had. He tried to convince her that every business has its own ups and downs, and there is nothing to be worried about. The effort was of little effect. At the age of 26 Fatema gave birth to a girl, and after four years to a boy. During pregnancy she was extremely fearful that the pregnancy would go wrong and some damage might occur to her unborn child. Fatema's family consulted some 'pirbaba' (local saint) who gave her some pious water and assured her that everything would be alright, and she was consoled a bit. Now her daughter being in puberty, Fatema is extremely worried that some harm might befall her, and remains anxious till the girl comes back home from school. Fatema fears that she might be assaulted on her way back home. Fatema's son is also growing up, and Fatema is worried that he might hurt himself during play. She reports bad dreams and apprehends that these might come true. She restricts her son's movement causing lots of argument and dissatisfaction within the family. However, she becomes so anxious and starts crying instead of rationally justifying her stand that her husband and children ultimately compromise with her demands. Fatema remained happy and relaxed for a negligible period of her life, always apprehending that some danger might befall her and her loved ones. She is a frequent visitor to the 'pirbaba', and remains temporarily calm only after he had blessed her for a safe life.

2.3 PREVALENCE OF GENERALISED ANXIETY DISORDER

The prevalence rate of GAD is quite high, estimated to be about about 3% to 5% of the general population. It usually begins in the teens and is more common in women. It often has other anxiety disorders and mood disorders as co-morbid condition.

2.4 AETIOLOGY OF GENERALISED ANXIETY DISORDER

The aetiology of GAD may be classified into two groups i.e.

- i) biological and
- ii) psychological factors.

2.4.1 Biological Factors

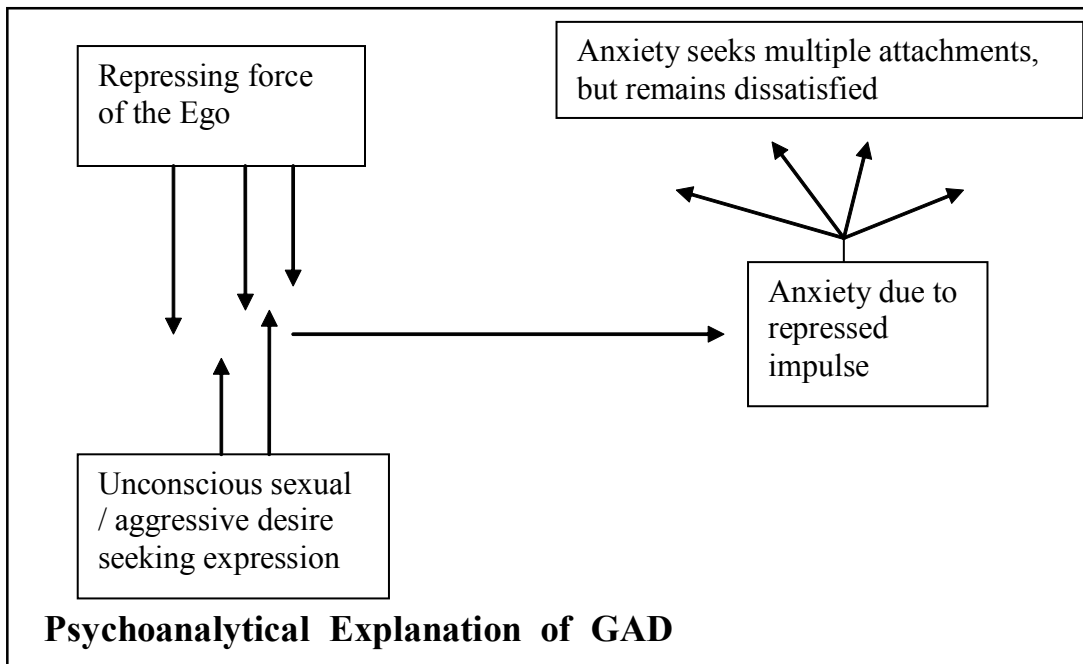
- 1) **Genetic factors:** Research indicates a moderate role of genetic factors. The research in this area has been confounded by the different expressions of anxiety. There is also some indication that GAD and major depressive disorder may share a common underlying genetic predisposition.
- 2) **Brain and biochemical abnormalities:** The neurotransmitter called Gamma aminobutyric acid (GABA) has been implicated in GAD. Deficiency in GABA seems to predispose one toward anxiety. Furthermore, since the cortisol level goes up under stress, the corticotrophine releasing hormone (CRH) has also been considered as playing a significant role in GAD. There are some indications that serotonin and norepinephrine may also have some role in producing GAD.

2.4.2 Psychological Factors

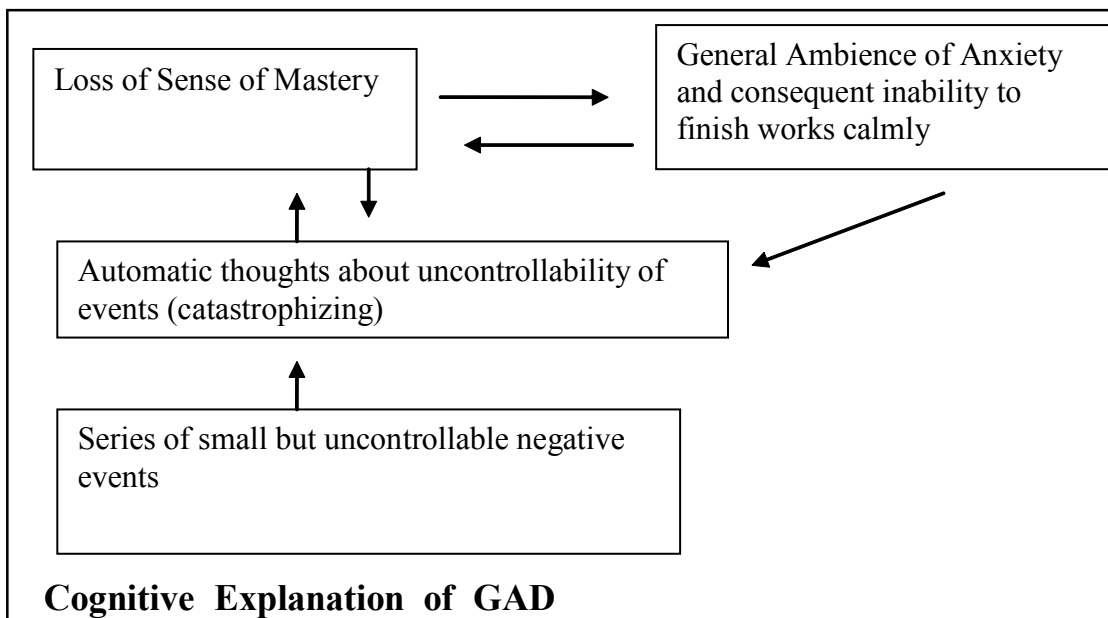
- 1) **Psychoanalytical approach:** The psychoanalytical approach traces the free floating anxiety in GAD to the unconscious conflict between the ego and id impulses, usually sexual and aggressive in nature. It states that we often have socially unaccepted desires, and these desires do not come out in the consciousness because of the repression of the ego. These desires are continuously seeking expression, but are repeatedly thwarted and hence the anxiety. The source of the anxiety is in the unconscious, and therefore, not known. It seeks to be attached to one object or another, with little success.
- 2) **Cognitive behavioural approach:** In the cognitive behavioural approach, the role of worry and sense of mastery has been emphasised. It has been noted that actual occurrence of uncontrollable negative events in life has a role to play in GAD. If you go through the life story of a person suffering from GAD, you may find that the events are usually not as traumatic as in the cases of Post Traumatic Stress Disorder. But there is often a series of small events that generate a perception of lack of control on things around. You may also note that the person's early environment was so construed that she was never allowed to feel safe and relax. A relative lack of safety signals characterises the person with GAD.

You need to remember in this context that worry and anxiety has some positive functions. Anxiety helps you to avoid catastrophe, avoid deeper and disturbing emotional thoughts, coping and preparing for negative events and motivating to do certain things. On the other hand worry impairs the ability to stay happy, reduces sense of well being and makes you vulnerable to uncontrolled or intrusive thoughts. It has also been noted that if you try to stop being anxious, it often has a rebound effect to encourage more intrusive thoughts. Thus a vicious cycle may be formed.

Cognitive theorists have also noted that the information processing of the person with GAD is biased. She detects the threatening events more quickly in comparison to the non-threatening ones. Also, the imagery associated with negative events seems to linger longer and prominently in them.



Cognitive Explanation of Generalised Anxiety Disorder



2.5 TREATMENT OF GENERALISED ANXIETY DISORDER

So far the biochemical treatment is concerned; different drugs from the Benzodiazepine category have been used extensively. While this drug relieves anxiety immediately, it may be habit forming. Another drug called Buspirone is also being prescribed for GAD; however it takes a few weeks to work. Different antidepressants have also been used.

To deal with the psychological factors, you may use a combination of cognitive and behavioural techniques. However, GAD remains one of the relatively difficult anxiety problems to treat, because the direct effort to stop negative thoughts usually results in a renewed invasion of such thoughts. Muscular relaxation may be combined with cognitive restructuring. You may also point out the biased nature of information processing and train your client to avoid catastrophizing tendencies.

Self Assessment Questions

- 1) How many of the six symptoms must be there for GAD to be diagnosed?
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.....
.....
- 2) What is free floating anxiety?
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.....
.....
- 3) What is the nature of cognitive bias in GAD?
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.....
.....
- 4) Write *True* (T) or *False* (F) beside the statement
 - a) In a person with GAD, there are often histories of series of small negative events ().
 - b) Buspirone is a very quick acting drug ().

2.6 OBSESSIVE COMPULSIVE DISORDER (OCD): SYMPTOMS AND CLINICAL FEATURES

You must be acquainted with the word obsessive and compulsive – these two terms have actually been part of everyday language. But you must learn at the very outset to distinguish the layman’s usage of obsession and compulsion from their technical usage. Obsession in everyday usage means being engrossed in specific thoughts – you speak of being obsessed with your looks, your daughter’s studies, your girlfriend’s whereabouts while she is away from you. You also talk of being obsessed with a particular art form, of guns and rifles, of cars, of stamps from different countries. Compulsion means you are forced or compelled to do something. In ordinary language we may use it to be forced from outside (compelled by my parents) or from inside (compelled by my conscience). But you must remember that these are not technically correct use of the terms obsession and compulsion. So long you are happy and in control of these thoughts, and so long these are not intrusive despite your earnest effort to ward them away they are simply fancy words and not components of a disorder.

Technically, obsession means intrusive thoughts, images and impulses often of a negative or unacceptable kind, despite one’s desire to get rid of it. Compulsion means being compelled from within to perform certain ritualistic acts, because otherwise you are afraid of some danger befalling you. According to DSM IV- TR, obsessions are recurrent and persistent thoughts, impulses or images that are experienced as intrusive and generate considerable anxiety. These thoughts do not concern real life problems at the moment, and are often irrelevant to present reality. The person has insight and tries to remove these thoughts, but often cannot succeed.

If you look into the content of the obsessive thoughts, you may find unusual fear of contamination, fear of harming oneself or one’s own loved ones, religious themes, themes of sexuality specially the unacceptable forms, wishing ill for others (for example

wishing one's mother dead), doubt about whether one has accomplished things properly. The person does not want to think of these, and when particularly aggressive and sexual thoughts predominate, considers herself 'bad'. Yet the thoughts continue to haunt her.

Compulsions are repetitive overt behaviours like washing or checking or mental acts like counting or praying in response to an obsessive thought. Compulsions are to be done following rigid rules to prevent or reduce the impact of some dreaded thing or action. After a compulsion is performed the person temporarily feels relieved, but again succumbs to the same cycle.

There are a few primary kinds of compulsive acts. These are cleaning (for example, repeated washing), checking (for example, repeatedly coming back to home to check if the door has been locked properly), counting (for example, counting the number of steps one takes before getting on the bed), repeating (for example, coming back to the first word of the line as one is not sure if she has read it properly), hoarding (for example, collecting things and not being able to dispose of these things), and ordering (for example, arranging books on the table in a particular order each time one leaves the table).

While in most cases, you will find obsessions and compulsion as coexistent, there may be cases where only obsession or compulsion predominates. The obsessions and compulsions take plenty of time from one's daily routine and slow down the entire life process. For some, rituals take the whole day resulting in the sufferer's inability to anything else at all. Sometimes it results in health hazard; you may rub and clean your skin so much and with such material (like raw dettol) that there are wounds on your body. Also for most people there are multiple obsessions and compulsions.

The anxiety accompanying OCD is two fold. In the first place, the obsessive thoughts are unpleasant and anxiety provoking. Compulsions reduce them to some extent, but the very insight that one is compelled to do such useless things causes lack of confidence and severe distress. In fact World Health Organization found obsessive compulsive disorder to be the world's leading cause of disability. It has also been associated with unemployment, marital problem and separation, and impaired social functioning.

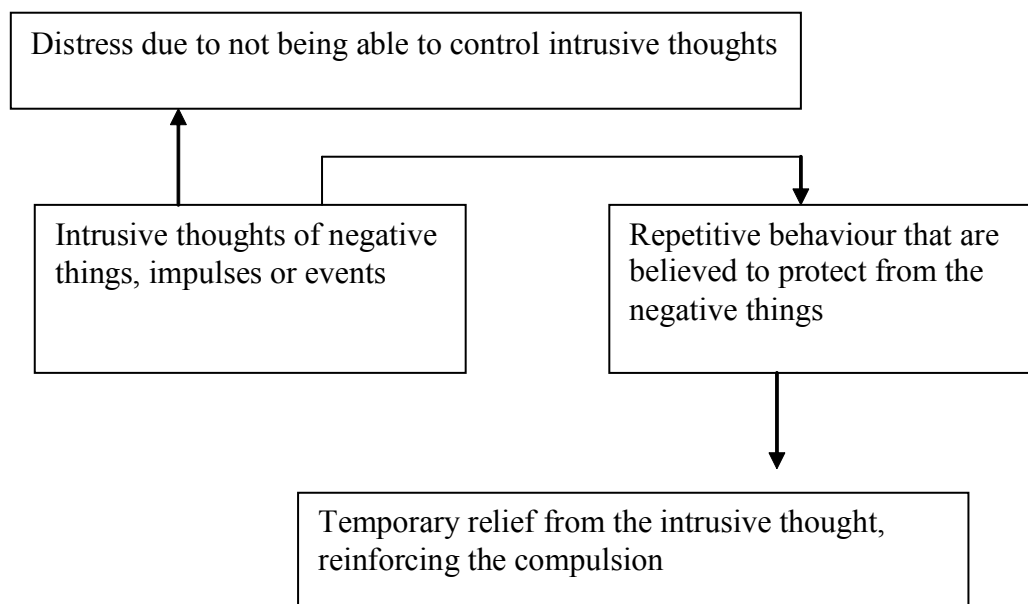


Fig.: Relation between Obsession and Compulsion

2.6.1 A Case Study of Obsessive Compulsive Disorder

Raj is a 26 years old man of considerable intelligence. He comes from an upper middle class family. He is presently employed at a private firm. His difficulty started some ten years back at the late teens, when he was walking on the pavement. He accidentally stepped on something which he did not bother about at the moment. But back home, it came to his mind that it might have been a used condom. He felt very unclean and washed himself thoroughly. He knew that he might have been wrong in his interpretation, but the thought continued to haunt him. Gradually he became afraid of stepping over anything dirty on the street, be it condom, faeces, or sputum. What particularly disturbs him is the vivid imagery of the person who has soiled the street. Now he takes pains to look at the road very carefully before stepping and if ever he sees anything he avoids that particular street for a few days if possible. It so happens that the city he lives in is not particularly clean and often there are actually dirty things on the street. If he sees anything like this he has to wash himself following certain rituals after he reaches home.

Intrusive imagery of filthy sticky things haunts him till he is back home and washes himself. He first washes his face ten times, then his arms, chest, back and legs for specific number of times. He has to take care of his feet particularly, being forced to wash them twenty five times each. The washing ritual has to be completed irrespective of heat and cold, and irrespective of his health, even if he has fever.

He also has to wash the surface of the soap he uses, as that too might be contaminated. Since he needs about three hours to wash himself, he takes dinner quite late and has difficulty waking up in the morning and coping with the stress of his job. As he has to avoid certain streets on certain days, he is often late at his office.

His concentration is failing since he is always thinking if there are filthy things stuck in his feet. With repeated warnings and humiliations from his boss he is thinking of leaving this job and look for another with lower salary but less demanding conditions.

2.7 PREVALENCE OF OBSESSIVE COMPULSIVE DISORDER

OCD seems to be present in about 2% to 3% of general population. Its onset may be in adolescence or early adulthood, and has a gradual onset. Childhood onset is also possible. Usually the cases with childhood onset tend to be very severe. If it becomes severe, it usually turns chronic. The risk is equal for both sexes. However, the content of obsession and compulsion may vary across age and sex. OCD may occur concurrently with depression, phobia, panic disorder, GAD and also body dysmorphic disorder.

2.8 AETIOLOGY OF OBSESSIVE COMPULSIVE DISORDER

Biological and psychological factors play significant role in the genesis of OCD. The obsessive and compulsive symptoms are often similar across cultures and across social class, though the specific content may vary a bit.

2.8.1 Biological Factors

Biological factors include genetic factors and brain abnormality.

- 1) **Genetic factors:** Moderate genetic inheritance has been observed in case of OCD. There is a moderate concordance rate for monozygotic twins. One

strong evidence in favour of genetic basis is the connection of OCD and Tourette's syndrome. Tourette's syndrome is a childhood disorder of chronic tics and has a strong genetic basis. It has been found that a large number of first degree relatives of children with Tourette's syndrome has OCD. OCD has also been found to be associated with childhood autism, again a disease with genetic causes. Evolutionary perspective further suggests that as in case of phobia, there is a preparedness factor in OCD. For example, obsession about contamination is much more common than obsession about pencils.

- 2) **Brain and biochemical abnormalities:** Some parts of the brain, particularly caudate nucleus, orbital frontal cortex and the cingulate cortex have been found to show excessive metabolic activity in OCD patients. Diseases like encephalitis and brain tumours have also been found to ritualistic behaviour, thus implicating certain parts of the brain abnormality for OCD. There has also been some evidence that increased activity of the neurotransmitter called serotonin and enhanced sensitivity of the stated brain structures to serotonin are also associated with OCD.

2.8.2 Psychological Factors

- 1) **Psychoanalytical theory:** Psychoanalytical approach attributes obsession to a fixation to the anal phase of life. Too strict toilet training predisposes the child toward over conscientiousness. The unconscious impulse to soil and play with filth, natural in a child of anal phase is so strongly prohibited that the child takes recourse to defenses like reaction formation by being overly clean and undoing by rituals. Paradoxically, obsession also provides a way of vicarious satisfaction of the prohibited impulse. If you are thinking for the whole day about how to stay away from dirt, you are, in a way, thinking of dirt only.
- 2) **Learning theories:** Neutral stimuli may be associated through classical conditioning with frightening ideas and become capable of eliciting intense anxiety. For example, Raj may have acquired the fear of dirty things on the street because he was thinking of something negative while walking on the street, and the object on the street became associated with it. Since the connection was not logical, Raj could not explain it. Learning theory further states that since compulsions reduce anxiety to a large extent, they become reinforced and continue in a cyclic manner. One implication of this theory is that if you expose the person to the object that provokes obsession, and then prevent the ritualistic compulsive behaviour, the reinforcement of the compulsion would be withdrawn. Gradually, the person would be able to understand that anxiety reduction is possible without compulsive acts.
- 3) **Cognitive theories:** Cognitive approaches suggest that there are negative automatic thoughts behind obsession. Often the persons with OCD are apparently excessively responsible and perfectionistic. This may have been the result of childhood training. However, if they think of something obnoxious, which we all do occasionally, they cannot separate it from acting it out in reality. This is called thought-action fusion. This fusion makes it easier for catastrophic thinking to take place. Of course, if you think that some harm may come to your friend, and you confuse it with your actually harming the friend, the results would be catastrophic.

Cognitive bias is of course apparent in obsession. The attention of persons with OCD goes easily to the concern of obsession in comparison to any other neutral

stimulus. They seem to have problem in information processing as well. Their memory seems to be selectively distorted as they cannot remember if they have done a thing properly or not, resulting in repetitive behaviour. They also have difficulty in suppressing irrelevant information.

2.9 TREATMENT OF OBSESSIVE COMPULSIVE DISORDER

Psychoanalytically oriented therapy or insight therapies are of little use for OCD patients. Behaviour therapy and medication are most popularly used modes of therapy. Behaviour therapy seems to have a higher percentage of completed treatment, compared to medication.

The specific behaviour therapy that works best for the OCD is the Exposure and Response Prevention (E&RP). In E&RP you need to encourage the person to expose themselves to their obsessions. Then they must prevent themselves from the ritualistic acting out of the compulsions to get rid of the anxiety generated by the obsession. As they are repeatedly faced with their fear and can reduce their anxiety without compulsion they get 'habituated' to the new experience.

For example if you want to treat a lady who is bothered by the intrusive thought of possible harm of her husband, and then counts up to seven to protect him from the harm, you must first allow her to be subject to the thought. This is exposure. Then you have to prevent her from counting. You may distract her by discussing the possibility of the harm and after some talking she may feel the fear of harm a bit less. Then you reinforce this behaviour and ask her to practice it. You can give her homework as well so that she may record the number of successful response prevention at home. Gradually she may be convinced that obsessive anxiety may go away even without the counting.

Among the medicines used most frequently with OCD cases are Clomipramine and Fluoxetine.

It has been observed that the improvement rate is moderate. Particularly when the medicine is discontinued there is chance of relapse unless behaviour therapy has been continued along with medicine.

You need to remember that OCD is one of the most difficult to cure diseases. However, even if the entire range of obsessive thoughts and compulsive acts cannot be cured, it is possible to reduce its severity considerably so that one can lead a considerably successful life.

Self Assessment Questions

1) Define obsession and compulsion.

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.....
.....

2) How prevalent is OCD in the population?

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.....
.....

3) What is thought-action fusion?
.....
.....
.....
.....

4) Write *True* (T) or *False* (F) beside the statement

a) There can be cases with obsessions only with no symptom of compulsion ().

b) In terms of learning theory compulsions are maintained by reinforcement, since they reduce anxiety ().

c) E&RP stands for Exposure and Repeated Practice ().

2.10 LET US SUM UP

In this unit we have focussed specifically on two Anxiety disorders which have relatively long term and pervasive impact on functionality. We have learnt the symptoms and clinical features of the Generalised Anxiety Disorder and Obsessive Compulsive Disorder. The prevalence of these disorders in the general population and time of onset have also been discussed. We have learnt about their aetiologies in terms of biological and psychological factors. We have also been acquainted with some of the biological and psychological treatment approaches to these disorders. For both of these disorders medicine has only moderate success. Psychoanalytically oriented treatment also has little impact. Cognitive behavioural approach seems to be the best option.

2.11 UNIT END QUESTIONS

- 1) Discuss the symptoms and clinical features of Generalised Anxiety Disorder with case examples.
- 2) State the prevalence rate of Generalised Anxiety Disorder.
- 3) Discuss the aetiological factors of Generalised Anxiety Disorder.
- 4) Discuss the treatment options of Generalised Anxiety Disorder.
- 5) Discuss the symptoms and clinical features of Obsessive Compulsive Disorder with case examples.
- 6) State the prevalence rate of Obsessive Compulsive Disorder.
- 7) Discuss the aetiological factors of Obsessive Compulsive Disorder.
- 8) Discuss the treatment options of Obsessive Compulsive Disorder.

2.12 GLOSSARY

Generalised Anxiety Disorder : Persistent excessive anxiety and worry on a number of things, which the person finds difficult to control.

- Obsessive Compulsive Disorder** : A psychiatric disorder characterised by intrusive thoughts or images of some negative event, impulse or thing (obsession) and ritualistic acts to undo or prevent these obsessive thoughts (compulsion).
- Tourette's syndrome** : A disorder characterised by muscle and vocal tics.
- Thought – action fusion** : Inability to separate thinking of something from acting it out. This is typical of obsessive compulsive disorder, where one seems to be disturbed by the mental thoughts and impulses, although these are not occurring in reality.
- Exposure and Response Prevention** : A behavioural treatment of Obsessive Compulsive Disorder where the person is exposed to the feared thought and the compulsive act is prevented. Gradually the person becomes habituated to dealing with the obsessive anxiety without resorting to the compulsion.

2.13 SUGGESTED READINGS

Kaplan, H. I. & Sadock, B. J. *Synopsis of Psychiatry*. Philadelphia: Lippincott Williams.

Semple, D., Smyth, R., Burns, J., Darjee, R. & McIntosh, A. (2005) *Oxford Handbook of Psychiatry*. London: OUP.

UNIT 3 POST TRAUMATIC STRESS DISORDER (PTSD)

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Post- Traumatic Stress Disorder: Symptoms and Clinical Features
 - 3.2.1 The Clinical Picture of Children with PTSD
 - 3.2.2 Time of Onset of PTSD
- 3.3 Different Situations Eliciting Post Traumatic Stress Disorder
 - 3.3.1 Trauma of Military Combat
 - 3.3.2 Trauma of Natural Disaster
 - 3.3.3 Trauma of Man-made Disaster
 - 3.3.4 Trauma due to Severe Threat to Personal Security and Safety
- 3.4 Prevalence of Post Traumatic Stress Disorder
- 3.5 Aetiology of Post Traumatic Stress Disorder
 - 3.5.1 Biological Factors
 - 3.5.2 Psychological Factors
 - 3.5.3 Socio-Cultural Factors
- 3.6 Prevention and Treatment of Post Traumatic Stress Disorder
 - 3.6.1 Prevention of Post Traumatic Stress Disorder
 - 3.6.2 Treatment of Post Traumatic Stress Disorder
- 3.7 Let Us Sum Up
- 3.8 Unit End Questions
- 3.9 Glossary
- 3.10 Suggested Readings

3.0 INTRODUCTION

You have seen on the TV terrorist attacks on the railway station and the Taj in Mumbai, the pictures of Tsunami, the accident of the Jnaneswari Express and other such disastrous incidents. Some of you may have actually been victims of these events. Some others may have friends and relatives who had suffered. Some others have simply heard and seen the reports in media. What impact do such traumatic events leave on the life of the individual? These events come completely unexpected, and shatter every dream we cherish in our hearts. Some of these are man-made, like the terrorist attack, some are natural like the Tsunami and some are partly accidental and partly due to human negligence like the Bhopal Gas leak. Do the reactions differ among these? You may have noted that all the examples given here are disasters affecting a large number of people. There are other disasters as well that affect only a single person. Examples are rape, individual assaults or individual accidents.

You may guess that the impact of such trauma may be immense on the surviving victim's mind. While there are always a brave few who withstand the trauma gracefully, short term reactions are observed in most. For a good number of people the impact is long term. The relatively long term psychiatric condition that develops as a result of exposure to severe trauma is known as *Post Traumatic Stress Disorder (PTSD)*.

In this unit you would learn about the symptoms, expressions, causes and intervention of PTSD. You would also read case studies exemplifying the typical symptoms. The names of all case studies used here are fictitious and all important identifying information has been changed to maintain anonymity of the persons.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the symptoms of post traumatic stress disorder;
- Describe the situations eliciting post traumatic stress disorder;
- Discuss the aetiology of post traumatic stress disorder; and
- Discuss the prevention and treatment of post traumatic stress disorder.

3.2 POST-TRAUMATIC STRESS DISORDER: SYMPTOMS AND CLINICAL FEATURES

Post-Traumatic Stress Disorder (PTSD) is a psychiatric condition developed as an aftermath of severe trauma often involving violence and demolition. DSM IV – TR requires that for diagnosing a person as suffering from PTSD, there must be a history of exposure to severe trauma. The person may have experienced, witnessed or been confronted with an event or events that involved actual or threatened death, serious injury or threat to integrity of self and others. The reactions of the person would be predominantly fear, helplessness, and terror.

In PTSD, the victim cannot get rid of the memory of the traumatic experience. At least one of the following symptoms of intrusive memory is present: recurrent and intrusive recollection of the event, distressing dream, intense distress if any internal or external cue symbolizes or resembles the traumatic event. For example, after a terrorist attack, the sound of a car tyre bursting may remind the victim of the sound of firing and bring back the distress.

At least three of the following behaviours must be present. The victim tries to get rid of the thoughts, feelings and activities related to the trauma, though the effort is often not successful. She feels a kind of detachment and experiences a restricted range of emotions. For example a victim may feel that she is incapable of loving anybody. Indeed, after the Second World War many captives of the Nazi camp had this feeling of not being able to relate to others. Many of them remained single throughout life, and for some who married, inability to love became a problem. At times the memory of the victim is distorted. She cannot recall significant parts of her experience. Sometimes she has a sense of foreshortened future, that is, she cannot visualise a normal education, career or family life.

The PTSD victim also has at least two of the following symptoms of excessive arousal. She has difficulty falling or staying asleep, irritability, outburst of anger, problem in concentration and exaggerated startle response.

You may notice all or many of these symptoms immediately after the trauma in most victims. But a section of trauma victims grow out of these symptoms within a short period, especially if they are kept in safe place. But for some the problem lingers. To be diagnosed as suffering from PTSD, one must have these symptoms for at least one month. On the other extreme, for some people the symptoms persist for the rest of the life. PTSD can be acute or chronic. If the duration of the symptoms is less than three months, it is known as acute. If it is more than that, it may be called chronic.

In some cases of PTSD, the clinical picture involves intense guilt and depression. Under emergency situation, the victim may feel that she has not played her role adequately. Perhaps a moment's negligence has caused the loss of a loved one. This is known as the survivor's guilt. This has been studied extensively in connection to combat stress and natural disasters. Some other reactions are anger, substance abuse in the form of self medication, low output at workplace and interpersonal problem. If you scrutinize the records of the US war veterans at Vietnam, you would find that many of them were discharged from the army with a bad report that complained of anger outburst and excessive alcohol intake. Much later these behaviours were interpreted as symptoms of PTSD. On certain occasions, especially when the surrounding is unsupportive, extreme depression and suicidal thoughts predominate. Behavioural aberrations may last a lifetime.

In other words, you may guess rightly that trauma does not demolish only those who had died. It can demolish the existence of those who survive.

3.2.1 The Clinical Picture of Children with PTSD

When you see a child victim of a trauma, you may observe that they express the responses in a manner different from the adults. Children often have greater difficulty in verbally expressing their pain, especially when physical or sexual abuse has been involved. You may have heard of horrible experiences of children during riots. They may have been subject to assaults themselves or have witnessed their parents assaulted. If you visit some of the rescue camps after the riots you may observe a numbness in children. Often the experiences are beyond their understanding and they simply lack the language. Sleep disorder and nightmares are very common. Some smaller children lose the already acquired developmental skills. For example the child may lose speech or forget toilet training. Change in behaviour is also more common in children. A happy outgoing child may become introvert or a shy child may become unduly aggressive.

You may understand that PTSD, especially when it involves children posits an enormous burden on the society. Victims of PTSD, especially children remain prone to psychiatric disorders and physical health hazards for the rest of the life. They may develop mood disorder, other anxiety disorders like Generalised Anxiety Disorder or Obsessive Compulsive Disorder, and Substance Abuse Disorder. Such children are also more likely to fail in academics, carer and relationship. They may be more prone to cardiac problems in later life.

3.2.2 Time of Onset of PTSD

When does PTSD begin? This is indeed a controversial issue, as in many cases it has been observed that symptoms show up not immediately after the event, but months or years later. There are two contending explanations. On the one hand it is possible that the victim of the trauma has initially erected a strong defence, but gradually it failed to serve its purpose and the memory of the trauma returns with full severity. A second and alternative explanation is that the trauma at best developed a vulnerable personality in the victim. In the course of life she has encountered another trauma of relatively milder nature and that has served as a cue to the earlier one. A third explanation is that the delayed symptoms are not at all related to the original trauma but are reactions to some recent life events. Since the person has a memorably traumatic past, the symptoms are wrongly attributed to the earlier trauma. While we do not know the final answer, you must keep in mind the possibility that either of these can happen and only detailed case history may solve the dilemma in each individual case.

3.3 DIFFERENT SITUATIONS ELICITING POST TRAUMATIC STRESS DISORDER

In this section you would learn about different situations of PTSD and how they might affect victim's emotions and behaviour.

3.3.1 Trauma of Military Combat

The trauma of military combat revolves around a few issues. While army training prepares the soldiers to withstand the trauma of warfare, during actual exposure the killings and uncertainties may take a different meaning. Particularly when the war is not against another equally equipped country, but against guerrillas and ordinary civilians as is often required to deal with terrorism, the moral issues often come forth to the forefront. Survival guilt is also common in military combat.

A case study: Mohan, 41, an ex-serviceman was referred for psychiatric consultation with the complaint of depression and alcoholism. Quite some years back Mohan saw his friend and colleague Suraj dying in a combat in front of his eyes. The earlier night they had talked together and Suraj had expressed his frustration at the manner in which their duties were being allotted. Mohan had comforted his friend and went to sleep. Next day, during a cross fire, Suraj was hit and died instantly. Mohan did not get any chance to have a last word with him. He just remembers that Suraj looked at him plaintively, probably trying to say something. The look haunts Mohan till date. He feels that he has no moral right to live, because Suraj was a better person than him. He also feels that he could have taken the particular position that Suraj had taken and got hit; it was just a matter of chance that he is surviving. He considers himself a useless person, suffers from low mood and self blame, and has lost interest in everything. The last look of his friend and other horrors of combat return in his nightmare. Mohan has taken early retirement and started drinking a lot to deal with his problem. It can relieve his guilt and depression only temporarily. His family life is now disrupted. He believes he is not going to live long.

3.3.2 Trauma of Natural Disaster

It includes events like earthquake, cyclone, Tsunami, flood and similar other conditions. Such situations are primarily characterised by helplessness as the destructive force of nature is beyond human control. However, after the initial disaster has passed, the role of the Government and rescue operations conducted become crucial.

A case study: On December 26, 2004, Thirumal, 10, had just had his breakfast and begged his mother's permission to go for a walk on the beach before he sat for his studies. Thirumal's father was a Government employee posted on the beautiful island where they lived. Suddenly Thirumal saw a big wave erupting from the sea and heard a strange rumbling sound. He ran for his house, but never reached there; the wave was faster. He got stuck to a tree trunk and clasped it. Later on he discovered that his mother and sister had perished. Thirumal was found wandering alone amidst the debris far from his house and taken to a rescue camp. Fortunately his father was away from home and survived the disaster. Using his influence as a Government Official he could find his son rather quickly and took him away from the camp. Thirumal did not speak at all for days, and then responded only in monosyllables. He had developed a tic in the form of continuous eye blinking whenever anybody talks to him. Even after two months he had not disclosed how he discovered his mother and sister to be dead, if he saw their bodies and what he did after that. He did not weep, but wore a strange blank look on his face and ate very little. Thirumal

could not sleep peacefully, groaning and shrieking in his sleep. But he could not remember the dreams.

3.3.3 Trauma of Man-Made Disaster

This includes a variety of disasters like Industrial accidents (like gas leak) and long term impacts of planning insensitivity (like arsenic pollution), terrorist attacks, flood due to opening of dam gates and so on. Here anger toward the perpetrators is an essential element. You need to understand in this context that often the perpetrator is not one single person, but a government policy, an industrial company or a team of people in charge. Sometimes when a single perpetrator can be identified among the group (for example, a single terrorist who has been caught alive while others in the group had either fled or died) the hatred and anger is thrust on him. At other times, the directionless nature of anger adds to the difficulty of the victim.

A case study: Majid 22, a small scale entrepreneur, is a survivor of a big fire that burnt down a building along with a bazaar in a congested area. There was a godown of fireworks near it. Majid and other young men of the locality had long since tried to shift it from that area, but could not do it due to political pressure from different quarters. One night, Majid was awakened from sleep by his distraught father who was shouting 'Fire – fire'. Majid saw smoke entering the room from all sides. Majid and his parents somehow escaped, but all their belongings were burnt in the fire. The meagre compensation from the Government received after prolonged negotiation, was nothing compared to the loss.

After a year, Majid who used to be a smart and sociable young man, is now an anxious and moody person. He has occasional anger outbursts which goes out of proportion. He says that the moments of his escape and the cries all around come back to his mind repeatedly and he cannot get rid of them. Though he does not have nightmares, his sleep is disturbed and appetite is very low. He cannot tolerate the sound of a number of people shouting together, even if it is about a game of cricket. He expresses his extreme frustration at the way the politicians and the Government deals with safety issues. He says he has become detached about most things in the world. He is disinterested in his business also and his father has to look after it. At times he expresses his extreme anger with the local MLA, who did not pay heed to their appeals before the fire. He should be hanged, Majid opines.

3.3.4 Trauma due to Severe Threat to Personal Security and Safety

This includes personal accidents, rape, confinement, torture and targeted violence including domestic violence. Usually the trauma consists of extreme fear, helplessness and uncertainty. You may observe three major phases in the appraisal of personal trauma. The first is the 'Apprehension phase' (that the car is skidding, or one is being followed by a man with seemingly bad motive) and corresponding effort at control. Then comes the 'Impact Phase' when the event itself is happening and one is left helpless at mercy of the external force, and finally the post traumatic situation when one has to take charge of oneself again. This last phase may be divided in two sub phases. One is the 'Recoil phase' when fear and anxiety, and may be guilt (in case of rape and assault victims) predominates. Next comes the 'Reconstruction Phase' which starts after the initial medical treatment. You may try to diagnose PTSD as a psychiatric category at this phase. The depression, anxiety, intrusive memories and all other signs and the struggle of the person with them starts at this phase.

A case study: While driving along a narrow mountain road in the evening, Asim felt his wheels skid and he tried his best to stop the car. But it was a fraction too late

and before Asim understood anything his car was dangling at the side of the road. Asim does not remember when he unfastened the seat belt or how the door opened, but the next moment he felt himself falling down beside his car which was also spinning and falling. He got stuck to an entanglement of stones and bushes, while the car fell further down and burst into flames. Asim tried to get himself free and felt that he was unable to move his right hand. Now he felt the extreme pain and he realised that the hand had broken at the elbow. Asim reckons he had become unconscious for a while and then regained consciousness. For some moment he felt as if detached from his body. Then he heard another car passing by and shouted at the top of his voice. The passengers stopped and arranged to rescue him. During the last one year Asim has been suffering from flashbacks of the moment when he understood that the accident has actually happened. He had recurrent nightmares of the car burning below him and he often sees a burning body in it. He cannot concentrate in his office work, has become irritable and moody. He has got an exaggerated startle response to any sudden visual or auditory stimulus. He had experienced a panic attack while trying to drive a car for the first time after the accident and had abandoned trying since then. He also believes that death is after him and he would not have a full life.

3.4 PREVALENCE OF POST TRAUMATIC STRESS DISORDER

Since PTSD is the result of traumatic events themselves, its occurrence depends on the number of events. It has been estimated that about 9% of the general population had developed PTSD at some point in their lifetimes. It has also been observed that occurrence of PTSD would depend upon the nature of the trauma and how society looks upon it. For example about 65% of rape victims develop PTSD while 15% of Vietnam combat veterans developed the symptoms.

Self Assessment Questions

1) How many arousal symptoms must be present for diagnosis of Post Traumatic Stress disorder?

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2) What is the estimated life time prevalence of Post Traumatic Stress disorder?

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3) What is survivor's guilt?

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4) Write *True* (T) or *False* (F) beside the statement

a) Intrusive thoughts characterise Post Traumatic Stress disorder ().

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| <p>b) Children's symptoms of Post Traumatic Stress disorder are identical with that of adults ().</p> <p>c) Post Traumatic Stress disorder may be last one's life time ().</p> |
|--|

3.5 AETIOLOGY OF POST TRAUMATIC STRESS DISORDER

Now you know that not all persons who encounter traumatic events develop PTSD in the long run. What predisposes them who succumb to the symptoms? You may learn about the biological, psychological and social factors in the section below.

3.5.1 Biological Factors

The biological factors include the temperamental factors that may contribute to development of vulnerable personality. Twin studies have shown that vulnerable personalities may run in families. Besides, exposure to trauma may activate the noradrenergic system. As a result the norepinephrine level is elevated. This in turn may result in exaggerated startle responses and heightened emotional arousal.

3.5.2 Psychological Factors

Although psychoanalytic, behavioural and cognitive approaches have tried to explain PTSD, none of them can adequately explain why some persons develop PTSD and others do not. It seems that personality and life events are very important in this regard. You must also note that ultimately there is a breaking point for every individual. Some succumb to symptoms earlier and some later. It has also been observed that the severity of symptoms is directly proportional to the severity of the trauma. For example, the symptoms in combat stress are directly related to the number of killings.

- 1) **Vulnerable personality and life events:** are a number of risk factors in PTSD. Some of these are being female, early separation from parents, family history of psychiatric disorder and pre-existing Anxiety or Mood disorders. Sometimes people are exposed to multiple traumas. For example, during partition of India, many people lost their land and migrated to a different place. There, instead of being provided for, they had to suffer deprivation and humiliation. Some also lost their close ones in the process. Thus, in many situations the traumatic events are multiplied, enhancing the risk of PTSD.
- 2) **Psychoanalytical approach:** This approach proposes that people either consciously suppress or unconsciously repress the painful memories of the traumatic event. The PTSD is the resultant of the ego's struggle to assimilate the experience into the pre-existing structure of personality. Often PTSD symptoms represent a maladaptive compromise of the ego.
- 3) **Learning theory approach:** This approach assumes that PTSD results from classical conditioning. This is a sort of avoidance response. A person who has suffered a terrible railroad accident would be afraid to board a train ever again as the association with the scene is terrifying.
- 4) **Cognitive approach:** The cognitive approach assumes that the person exposed to trauma adopts a faulty coping mechanism. The coping style of the person with PTSD is often emotion focussed rather than problem focussed. Furthermore, they often take personal responsibility for failures resulting in survivor guilt. Also the information processing of the trauma victims may be distorted. The person remains extremely sensitive to cues suggesting the event. Intrusive memory and thoughts cannot be controlled and the person is very quick to pick up certain cues that revive the memory.

- 5) **Existential approach:** The existential model suggests that exposure to trauma disturbs the meaning of life. Each of us develops through our experiences a number of expectations about life and relationship. For example we would expect to help a baby in distress. During traumatic events, not only these expectations are not fulfilled, but sometimes exact opposite things happen. For example a mother may throw her baby down the river to save herself. These experiences are difficult to integrate once we are back to safety. Often it develops a kind of nihilism in us and cynicism about anything good in life. The treatise by Viktor Frankl on existential problems of concentration camp survivors is a famous account of the existential viewpoint.

3.5.3 Socio-Cultural Factors

It has been observed that in combat related stress, when the group morale is strong and the combatants are committed to the job, the PTSD symptoms are less common and less severe. Also if after the traumatic event one is placed in a supportive environment the severe symptoms can be avoided. Indeed, the entire purpose of army training is to develop a community that supports combatant mentality and glorifies it. PTSD would be less under the circumstances. In case of rape, on the other hand, society often blames the victim thus enhancing the risk of symptoms. Adequate social support and cultural assimilation of the traumatic events help the person to struggle with the experience.

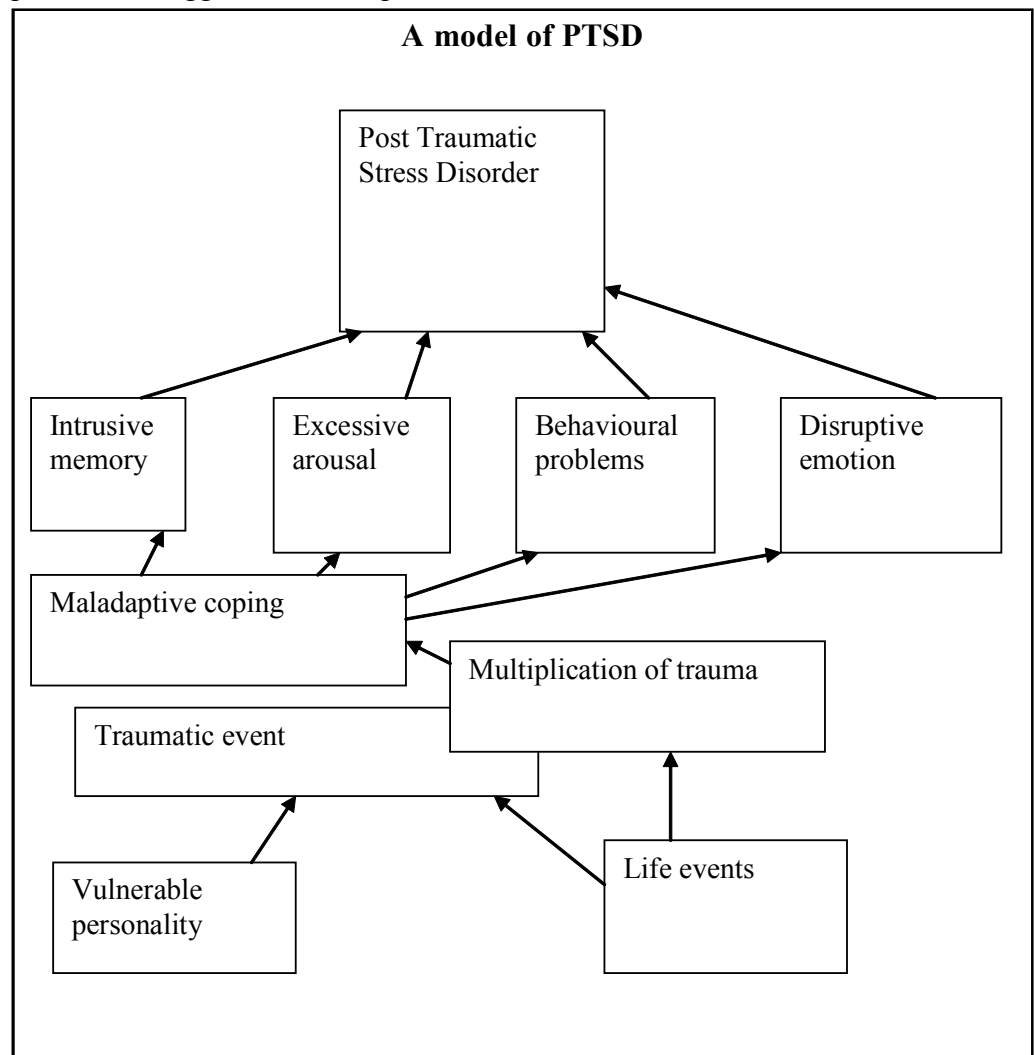


Fig.: Aetiological factors and the major symptoms of PTSD

3.6 PREVENTION AND TREATMENT OF POST TRAUMATIC STRESS DISORDER

3.6.1 Prevention of Post Traumatic Stress Disorder

If you know that a person is going to be exposed to extreme conditions and probable traumatic experiences, you may think of training her up as a preventive measure. Though reality may exceed the imagination, at least some information and anticipation of danger might help. You may induce *Stress inoculation training*, which usually includes three stages. Initially you may provide information about the kind of situation the person is going to face, the stresses that can occur and how people may deal with them. In the second phase you can ask them to make self statements like 'This pain is not going to last for ever, don't panic'. The third stage consists of actually exposing the person to threatening situations created for the purpose and have the person practice it. However, one cannot be prepared for all disasters in that way.

3.6.2 Treatment of Post Traumatic Stress Disorder

Immediately after the trauma, often a range of *psychoactive drugs* may be used with the victims of trauma to ease out the terror. Antidepressants and tranquilising medicines have found to have some effect. Especially SSRIs have been particularly successful. Apart from medicines, *Short term crisis therapy* may also be needed at these difficult times. Here you have to be proactively engaged with the persons, giving information, supporting and clarifying things as far as possible.

In the long run, however, you must provide ways for integrating the experiences into the daily life of the person. For all approaches, the key is to gradually expose the person to the memories of the trauma and to teach her the coping skills. Usually after the event or series of events, the person loses trust and sense of security in the world. Sometimes fear of losing one's stability predominates. As a therapist your first task would be to educate the person about the nature and expected symptoms of PTSD and emphasise that these can be handled.

Much about PTSD has been learnt during the World War II and Vietnam war. During World War II combat exhausted soldiers were treated with *narcosynthesis*. Sodium Pentathol (truth serum) was used on the person to induce a drowsy state. Then she was asked about the trauma and often a vivid and horrible description emerged. As the patient woke up, a discussion of the terrifying events ensued. The purpose was to make the patient believe that the events have been in the past and are no longer a threat.

In 1971, Robert Jay Lifton of Yale University worked with Vietnam war veterans and formed a *rap group*. The rap group dealt with residual guilt and anger of the war veterans. Their guilt concerned what they had to do as part of their duty in fighting guerrilla warfare. They were also angry for being left in this dubious position by their own Government. In the rap groups formed as self help groups the combatants came to share their experiences with each other and had a scope to work through the trauma.

Psychoanalytically oriented approach

This also requires the persons to expose themselves to the re-living of trauma. However, the emphasis here is on the interaction between pre-trauma personality disposition and the nature of the event. Following the usual technique of

psychoanalytically oriented therapy, the emphasis is on analysing defences and transference. However controlled studies examining its efficacy is not available.

The Trauma-focused cognitive-behavioural therapy

This is one of the most widely used techniques. You need to encourage the victim to gradually expose herself to those thoughts, feelings, and situations that are associated with the trauma and those that she has carefully tried to avoid so long. In line with the principles of Cognitive behavioural therapy, this technique also utilises exploration of core beliefs and automatic thoughts. The erroneous irrational thoughts about the traumatic event need to be analysed and understood by the person. Then you can slowly induce her to replace the erroneous thoughts with a more reality oriented one.

EMDR (Eye Movement Desensitisation and Reprocessing)

This is a technique that has been used for disaster victims. It was developed by Francine Shapiro in 1987. It may be conceptualised as an off-shoot of cognitive-behavioural therapy. Here you utilise the eye movements, hand taps or sounds, which are essentially different forms of rhythmic, left-right stimulation. It is based on the premise that sometimes the traumatic memories are ‘stuck’ in the brain in such a way that talking cannot neutralise them. It is believed that bilateral stimulation may unfreeze the brain’s information processing system, and the unpleasant memories can be integrated into a cohesive memory and processed.

Existential approach

This approach was suggested by *Viktor* Frankl who suggested that the trauma of subhuman treatment can only be neutralised by integrating it to a broader framework of existential meaning.

Frankl’s approach is also known as logotherapy, the word ‘logos’ implying meaning. The task of the therapist is to identify the paradoxical intentions (for example compulsive rituals) or dereflexions (exaggerated involvement with and watching over self) and make the person see a broader perspective. Often Socratic dialogue is used for this purpose. It includes a conversation between the therapist and the client to raise into consciousness the possibility of looking for meaning in one’s life.

Family therapy

This is often essential for dealing with PTSD. As you must have imagined, trauma disrupts the entire system of relationships, bringing in a new dimension never thought about before. It is not only the individual victim, but also the family that needs to integrate the aftermath of trauma. The close persons of the victims often need guidance and help. Also, PTSD of the victim is well controlled if put within a supportive environment. If you work with the entire family, you may be able to help each member and also help each to help the other.

Self Assessment Questions

1) What is narcosynthesis?

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2) What is the usual coping style of persons with Post Traumatic Stress disorder?

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3) What is a rap group?

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4) Write *True* (T) or *False* (F) beside the statement

- a) During stress cortical level is lowered ().
- b) Viktor Frank's technique of dealing with Post Traumatic Stress disorder is known as EMDR ().
- c) Integration of trauma to present existence is the key of treating Post Traumatic Stress disorder ().

3.7 LET US SUM UP

In this unit we have learnt about Post Traumatic Stress Disorder. We have learnt that this disorder, commonly known as PTSD develops after being exposed to a traumatic experience. The symptoms and clinical features have been discussed. We have also learnt that the features differ between a child and an adult, as the child has less ability to express the affect. The prevalence of these disorders in the general population and time of onset have also been discussed. We have learnt about their aetiologies in terms of biological, psychological and cultural factors. We have also learnt that persons with vulnerable personalities are more likely to develop PTSD. We have known about the preventive measure known as Stress inoculation training if there is anticipatory stress. But in most cases disaster strikes unexpectedly and one may not be prepared. Treatment includes short term crisis intervention as well as long term adjustment and integration. Different treatment approaches have been discussed.

3.8 UNIT END QUESTIONS

- 1) Discuss the symptoms and clinical features of different types of Post Traumatic Stress Disorders with case examples.
- 2) Distinguish between the usual clinical features of Post Traumatic Stress Disorder of children and adults.
- 3) Discuss the aetiological factors of Post Traumatic Stress Disorder.
- 4) Discuss the prevention technique of Post Traumatic Stress Disorder.
- 5) Discuss the treatment options of Post Traumatic Stress Disorder.

3.9 GLOSSARY

- Post traumatic stress disorder** : Post Traumatic Stress Disorder (PTSD) is a psychiatric condition developed as an aftermath of severe trauma often involving violence and demolition. It is characterised by intrusive memory of the trauma, excessive arousal, behavioural problems and emotional difficulties.
- Survivor's guilt** : When a person's close one's die in a disaster or combat the person tends to blame oneself for letting them die. This is known as survivor's guilt.
- Stress inoculation training** : A stage by stage preparation for an apprehended traumatic experience. This involves information, training of coping techniques and practice of techniques in simulated stressful conditions.
- Trauma focussed cognitive behavioural therapy** : In Trauma-focused cognitive-behavioural the victim is encouraged to gradually expose herself to the thoughts, feelings, and situations that are associated with the trauma. The erroneous irrational thoughts about the traumatic event need to be analysed and replaced with a more reality oriented one.
- Narco synthesis** : Injection of Sodium Pentathol to induce a drowsy state in the person with Post traumatic Stress Disorder and allow emergence of the traumatic memory. Later on, in awakened state, this memory is integrated to the present.
- Logo therapy** : 'Logos' means meaning. Logo therapy refers to Viktor Frank's proposed mode of therapy where it is believed that trauma of subhuman treatment can only be neutralised by integrating it to a broader framework of existential meaning.
- EMDR** : EMDR (Eye Movement Desensitisation and Reprocessing) is a technique developed by Francine Shapiro in 1987. Here you utilise the eye movements, hand taps or sounds, which are essentially different forms of rhythmic, left-right stimulation. It is based on the premise that sometimes the traumatic memories are 'stuck' in the brain and bilateral movement unfreezes them.

3.10 SUGGESTED READINGS

Kaplan, H. I. & Sadock, B. J. *Synopsis of Psychiatry*. Philadelphia: Lippincott Williams.

Semple, D., Smyth, R., Burns, J., Darjee, R. & McIntosh, A. (2005) *Oxford Handbook of Psychiatry*. London: OUP

UNIT 4 SOMATOFORM DISORDER AND DISSOCIATIVE DISORDER

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Somatoform Disorders: Symptoms and Clinical Features
 - 4.2.1 Somatisation Disorder
 - 4.2.2 Pain Disorder
 - 4.2.3 Hypochondriasis
 - 4.2.4 Conversion Disorder
 - 4.2.5 Body Dysmorphic Disorder
- 4.3 Prevalence of Somatoform Disorders
- 4.4 Aetiology of Somatoform Disorders
 - 4.4.1 Biological Factors
 - 4.4.2 Psychological Factors
- 4.5 Treatment of Somatoform Disorders
- 4.6 Dissociative Disorders: Symptoms and Clinical Features
 - 4.6.1 Dissociative Amnesia and Fugue
 - 4.6.2 Depersonalisation Disorder
 - 4.6.3 Dissociative Identity Disorder
- 4.7 Prevalence of Dissociative Disorders
- 4.8 Aetiology of Obsessive Dissociative Disorders
 - 4.8.1 Biological Factors
 - 4.8.2 Psychological Factors
 - 4.8.3 Cultural and Social Factors
 - 4.8.4 Vulnerable Personality and Stressful Life Events
- 4.9 Treatment of Dissociative Disorders
- 4.10 Let Us Sum Up
- 4.11 Unit End Questions
- 4.12 Glossary
- 4.13 Suggested Readings

4.0 INTRODUCTION

Let us go for an embarrassing memory. Let us remember a situation where you were humiliated in front of your classmates or colleagues for a reason which was not entirely your fault, but, yes, partially due to some lapse of yours. You were anxious of course, but not only simply anxious. You were wishing that it had never happened. How could you ever be so foolish? What would you like best now? Have a magic and have the memory of the event obliterated from everybody's brain? Something unusual to happen at the moment so that everybody's attention is directed away from you? May be if you can put forth an excuse, may be of a severe disease, you could

plea not guilty? The two disorders we would study in this unit involves this kind of wish fulfilling mechanism to wipe away the difficulty in handling an emotionally difficult situation.

In the earlier three units you have learnt about different types of Anxiety disorders. In all those disorders the anxiety in response to stressful situation was the most prominent symptom. In the present unit you would learn about two groups of disorders where stressful situation is not responded to by overt expression of anxiety. Both of these two groups of disorders involve attempts on the part of the person to *escape the unpleasant stressful situation by using particular intrapsychic mechanism*. The overt anxieties are not present, but are replaced by either physical symptoms or distorting the relation between self and reality by selective modification of memory and identity. These are, respectively, the Somatoform Disorders and the Dissociative Disorders. You would also read case studies exemplifying the typical symptoms. The names of all case studies are fictitious and all important identifying information has been changed to maintain anonymity of the persons.

As you encounter persons suffering from these two groups of disorders, you may discover a dramatic expression of the symptoms. But you must not presuppose that these people are necessarily faking or ‘malingering’. The dramatisation occurs at a level below the consciousness, and the person, at her conscious level actually feels only whatever she reports. This process makes it a challenge for the mental health professional to differentiate Somatoform and Dissociative Disorders from Malingering and intentional falsification. While in children the symptoms are often transient, in adults these disorders may take a chronic and disabling form.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define somatoform disorders;
- Describe the types and symptoms of somatoform disorders;
- Explain the aetiology of somatoform disorders;
- Elucidate the treatment of somatoform disorders;
- Define dissociative disorders;
- Describe the types and symptoms of dissociative disorders;
- Explain the aetiology of dissociative disorders; and
- Elucidate the treatment of dissociative disorders.

4.2 SOMATOFORM DISORDERS: SYMPTOMS AND CLINICAL FEATURES

When you have been under considerable stress, you may have experienced bodily symptoms like headache or gastric problem. The psychological pain seems to take a physical or somatic form. This is quite common in children and not so uncommon among adults. Teachers in junior schools are well aware of how frequently children develop symptoms like stomach ache and nausea in response to academic or interpersonal stress. Again, you may have seen or heard stories of people fainting whenever they encounter any stress. Sometimes they may be simply faking the

symptoms to draw attention or to avoid immediate embarrassment. But many a times they truly experience the bodily pain or truly lose consciousness. These may be examples of Somatoform Disorders.

Somatoform disorders refer to a group of disorders where the person reports physical complaints characteristic of bodily dysfunction. But investigation usually fails to elicit any actual physical defect. In this unit you would learn about the symptoms and clinical features of five major types of Somatoform Disorders, namely,

- Somatisation Disorder
- Pain Disorder
- Hypochondriasis
- Conversion Disorder
- Body Dysmorphic Disorder

4.2.1 Somatisation Disorder

You may recognise Somatisation disorder by the presence of multiple physical symptoms at different locations of the body. DSM IV –TR mandates that that it must begin before 30 years of age. There must be at least 4 pain symptoms in different sites of the body (for example, head, neck, back etc.), at least 2 gastrointestinal symptoms (like diarrhoea, nausea etc.), 1 sexual symptom other than pain (for example erectile dysfunction, lack of desire) and 1 pseudoneurological symptom (for example fainting). Adequate medical investigation must have been made to exclude all known organic origin of the symptoms.

The symptoms of Somatisation disorder are vague. The person often goes for doctor shopping and frequent hospitalisation. Sometimes as a result of unwarranted faulty treatment and invasive interventions, actual physical symptoms may occur to complicate the issue. Depression and anxiety may accompany the Somatisation symptoms.

A Case Study of Somatisation Disorder: Rina is a 24 year old middle class married woman. She had lost her mother in her childhood and has been reared up by her father. Before her marriage she suffered from migraine and frequent cold. After marriage she had encountered difficulty at her in-laws house. Her mother-in-law expected her to take some household responsibilities which she could not complete due to her frequent headache. She disliked her mother-in-law and wished her dead. Her husband was initially supportive of her, but gradually became irritated due to her constant complaints. Rina became depressed and developed pain in her neck and back which prevent her from sitting straight for long. Her headache has become more frequent and severe. She also has frequent sore throats. She developed problem of digestion and often had diarrhoea and nausea. Her hand trembles at the slightest provocation and she had fainted a few times after quarrelling with her husband. Her sexual desire is on the wane and she complains of pain during intercourse. Her husband is very dissatisfied with the state of affairs and is contemplating divorce.

4.2.2 Pain Disorder

You may find that some people experience persistent pain in certain specific areas of the body. No physical cause can usually be identified through investigations. Even if some organic problem is observed, it is inadequate to explain the stated subjective degree of pain. The psychological factors are recognised as significant precipitator of the pain symptom.

A Case Study of Pain Disorder: Joseph is a 17 year old manual labourer from a tribal area, working in the city. He is the oldest of three siblings. His father was also a labourer but lost his job due to alcoholism. Joseph had too often seen the plight of his mother at home. In their village, Joseph often stayed away from home and wandered around the forests. He had also attended school which he liked, especially because of a teacher who loved him. Joseph wanted to study in the school and had an ambition of working in an office. As his father lost his job, Joseph's mother asked him to go for work. One of his father's friends has arranged the same job for him. Joseph hated leaving school, but ultimately had to agree. He did not like the work he had to do, but did it for six months. Then one day he fell from a pile of bricks and hurt his ankle. Treated by a doctor he recovered, but developed a pain the back. He attributed it to the fall and said that it had been neglected by the doctor. The pain increased and he had to leave the job. He had seen doctors who had investigated the probable cause of pain. But nothing was found to explain it. Now he sits idly at home while his younger brother goes for work.

4.2.3 Hypochondriasis

Hypochondriasis is characterised by fear of physical disease. You may have come across persons who suspect that they have serious diseases like cancer and cardiac problems. Investigations however reveal that no organic pathology is present. While many of us may occasionally read some bodily discomfort as a sign of some serious problem, the person with hypochondriasis is quite convinced about the presence of the disease.

DSM IV –TR states that preoccupation with fear of contracting or having a serious disease is the main criterion of Hypochondriasis. The conviction is based on misinterpretation of some transitory bodily symptom. For example a person may interpret a sore throat as the first sign of throat cancer.

You will often find the persons with Hypochondriasis at the doctor's door. But the assurances of the doctor as to the absence of any pathology do not change their conviction. Rather they change doctor frequently and start the investigations afresh. Often the disease they imagine is a fatal one like cancer, severe cardiac problem or HIV / AIDS. Such persons often read medical bulletins, self diagnose themselves and also try to treat themselves. The treatment modes can be magical or semi scientific.

How would you differentiate between Somatisation disorder and Hypochondriasis? In the first place severity of conviction of a fixed diagnosis is greater in Hypochondriasis. Secondly, Hypochondriasis is not necessarily about many disorders, but like Pain disorder may be located in one or two sites.

A Case Study of Hypochondriasis: Dinesh, 35, an upper-middle class educated employed man from a metropolitan city had an affair with a girl who later turned out to be a sophisticated prostitute. Dinesh learnt it the hard way and was both heartbroken and appalled. That was about six years back. He was afraid that he might have contracted HIV, and after much deliberation, consulted a doctor who recommended blood test. Dinesh turned out to be negative, to his immediate relief. However, this assurance seemed to be short lived, as he never came to believe permanently that he was not afflicted with HIV. After the first testing, he had a bout of severe cold which he attributed to the same undetected virus. He had read plenty of information on HIV / AIDS and had learnt that a positive finding on the blood test ensures that you have HIV, but a negative finding may be misleading. He went for retesting and was again found negative. Now he interprets every little stomach upset and feverish

feeling as indicative of HIV. He spends the whole evening scrutinizing his body looking for swollen glands and skin rashes. He goes to doctors for every small ailment, though he does not always reveal his suspicion about HIV. He insists on being treated with strong antibiotics as he believes that he has low immunity. He rejects those doctors who prefer to treat with lesser medicines or recommends natural cure.

4.2.4 Conversion Disorder

You must have heard about hysteria. The word comes from the Greek word ‘hysteros’ which means the womb. It was wrongly believed at one time that hysteria occurs only in women because of their suppressed sexual desire. The most common symptom was fainting or paralysis of the limbs under psychosocial duress. Sigmund Freud’s concept of the unconscious emerged from his treating of patients with hysteria. His patient Anna O, a young lady with paralysis, has been famous in the history of Psychology and Psychoanalysis for being key to Freud’s understanding of the nature of the unconscious.

Presently, the word hysteria is no more in scientific use. Conversion disorder is the term that comes closest to hysteria. In Conversion disorder the person suffers from a real disability – often loss of a sensory or voluntary motor function. DSM IV –TR states that the symptoms would imply a neurological condition. However upon examination no neurological problem would be found. Some common examples of Conversion are partial paralysis, blindness, deafness and pseudoseizures. DSM IV – TR further states that psychological factors should be judged to be associated with the symptom, as these symptoms often develop after severe conflict or other stressors.

You need to be aware of the signs that distinguish Conversion disorder from real neurological problems. You may wonder why you need to know these, because the neurological investigation itself would establish the validity or invalidity of the disorder. However, we know only a very small part of our brain functions and it is possible that we may have missed some indication in the physical tests. Therefore you must be able to cross check the diagnosis with functional signs as well. In the first place, the Conversion symptoms are often preceded by a stressor, though the person is unaware of and even denies any connection. Secondly, the symptoms may be in contradiction to what would have been expected from a neurological perspective. For example, in ‘glove anesthesia’, the person feels her hands numbed up to the wrist, while the nerves run up to the arm, and any true neurological problem would affect the entire nerve. This may be induced by hypnosis. Third, there seems to be a peculiar lack of concern and anxiety that should have happened in case of a real loss of function. A blind person seems unconcerned about his sudden loss of vision. This lack of apparent concern is known as ‘la belle indifference’. Finally, the paralysis may be selective in time and space. A person with a paralysed leg may be able to move the legs during sleep.

A Case Study of Conversion Disorder: Akhtar, a 30 year old man from a middle class family was an employee of a Government Undertaking. His job was to supervise the loading and unloading of goods by the workers. He happened to be on the factory floor when an accident took place resulting in many workers getting wounded. Akhtar was also hurt in the face and on the head and became unconscious. Later on he was treated duly and declared fit by the Medical Board of the Company. However, from after a few days of the accident, Akhtar had been telling that he had become blind. He was tested thoroughly by the doctors who declared that there is nothing wrong either in the peripheral (at the level of the eyes) or central (in the brain)

mechanisms of his vision. Akhtar sticks to his claim, and considers himself unfit for joining his job. He walks with the help of his mother and has to take her help in all matters like finding the shirt and guiding him to the items of food. He stays at his home and spends time in front of the TV saying that he cannot see, but he can listen to the music and conversations and he enjoys that. He wants compensation for his disability and is planning to sue against the Company.

4.2.5 Body Dysmorphic Disorder

Is your friend so concerned about the shape of his ears that he wears his hair long and tries to hide his ears under locks of hair? Body Dysmorphic Disorder refers to the undue concern over body features. According to DSM IV –TR it is defined as unnecessary preoccupation with an imagined or exaggerated defect in appearance.

This imagined defect may be anywhere as for example the person may have an idea that his nose is too large etc., big nose, small ears, skin blemishes, shape of the breasts or genitalia, too fat or too thin limbs and so on. Sometimes you may detect a slight real anomaly or lack of proportion, but in the person's own judgment it has been magnified many times.

You may find the person with Body Dysmorphic Disorder often viewing oneself in the mirror and asking others for opinion about the slightest change in that part of her body. However these assurances do not help them to get out of the problem. She also tries to hide the defect under heavy make up or other accessories, or even go for plastic surgery. Unfortunately even plastic surgery does not always satisfy her.

A Case Study of Body Dysmorphic Disorder: Ratna believes that she has a 'too flat bone of nose'. At the age of 20 she is introvert and immensely soft spoken, particularly because she does not want to draw anybody's attention to her 'ugly nose'. She cannot speak to anybody spontaneously as she feels that everybody is looking at her nose and suppressing a big laugh. She looks at the mirror many times a day, and tries to pull her nose bone up. She sometimes covers her nose with her palm and evaluates her beauty minus the nose. Her parents have told her many times that her nose is perfectly within the normal range of sizes, but she is disconsolate. She has confided the problem to a friend who had assured her, but to no avail. She has developed the habit of placing her palm on the nose while forced to converse with anybody. It becomes difficult for other people to hear what she is saying and this makes her a poor socialiser. This in turn further reduces her self esteem and adds to her distress. She is thinking of visiting a plastic surgeon for remedy, but knows that she cannot afford the cost at the moment.

4.3 PREVALENCE OF SOMATOFORM DISORDERS

How common are the Somatoform disorders? Prevalence of the different types of Somatoform disorders is not the same. Somatisation Disorder usually begins in adolescence. It is more common in lower socio-economic class and among women. Lifetime prevalence is 0.2% to 2% in women and 0.2% in men. The prevalence of Pain Disorder in general population is not known. It is seen more often in women. Hypochondriasis is the most commonly seen Somatoform disorder, being present in 2% to 7% of the general population. It often starts in early adulthood and is equal in both sexes. Conversion Disorder was quite common at one time, but with knowledge of the dynamics of this disorder and with psychological sophistication of the general population, it has come down to less than .005% of the population. It is rare in the

urban educated group, and seen somewhat in the rural and low socio-economic status groups where knowledge of conversion as a defence is not available. It is seen more in women. The exact prevalence of the Body Dysmorphic Disorder is not known as many of us may have slight preoccupation with body parts. An estimated 2% to 5% of general population may have crossed the limit of normal preoccupation and may be said to be suffering from the disorder. It is equal across both sexes.

4.4 AETIOLOGY OF SOMATOFORM DISORDERS

The aetiology of all the somatoform disorders would be discussed together. You may learn about the biological and psychological factors in the section below.

4.4.1 Biological Factors

The biological factors, at least so far the present knowledge goes, are of less significance than the psychological factors in the aetiology of Somatoform disorders. There has been some overlap between OCD and Body Dysmorphic disorder, implying possible common genetic disposition. However, twin studies have not been able to provide strong biological evidence till date. At best a vulnerable personality may have been inherited.

4.4.2 Psychological Factors

Among the psychological factors, you would learn about the psychoanalytical approach, learning approach and cognitive approach. You would also know about the possible role of stressors and vulnerable personality.

- i) **Psychoanalytical Approach:** At the basis of psychoanalytical approach to Somatoform disorders is the concept of unconscious conflict and gain. It is assumed that psychic pain and distress is projected onto the body for the purpose of some kind of advantage.
- ii) **Primary Gain:** The primary gain helps to preserve the integrity of ego in the face of the stressful situation. It is often related to internal motivation. When any uncontrollable yet unacceptable sexual or aggressive impulse attempts to burst out, the ego is under threat of disruption. It tries to maintain control, and in that attempt may use repression whereby the emotion is disowned and an escape or a punishment may be arranged by projecting disability onto the body. Take for example the case of a girl who had to stay homebound for long due to his father's last illness. When her father expired she was free at last to move around at will. The realisation that she was happy at her father's death caused strong guilt in her. The next morning she could no longer move her leg and was supposedly paralysed. She had twofold advantage by being immobilised through paralysis. Her need for acknowledging the unacceptable emotion was prevented and she could also inflict upon herself a punishment for his guilt by not being able to move at all.
- iii) **Secondary Gain:** The secondary gain is the interpersonal, social or material advantage later accrued from the symptom. Patients acquire a number of advantages as a result of being in the *sick role*, for example – being excused from obligations; receiving company of the beloved one, getting special attention etc. It is mostly unconscious, and results in some kind of secondary benefit. Such was the case of Akhtar stated earlier whose blindness might earn him a fat compensation. Thus it makes the disorder more persistent and resistant to treatment.

Both Conversion Disorder and some instances of Hypochondriasis can be explained by this view. Psychoanalytical approach offers similar explanation for the other Somatoform disorders. However, it fails to explain why Somatisation and Pain disorders are located at certain body parts. That is the content of somatising is less well explained by this approach. Fig. given below represents the psychoanalytical model of Somatoform disorder.

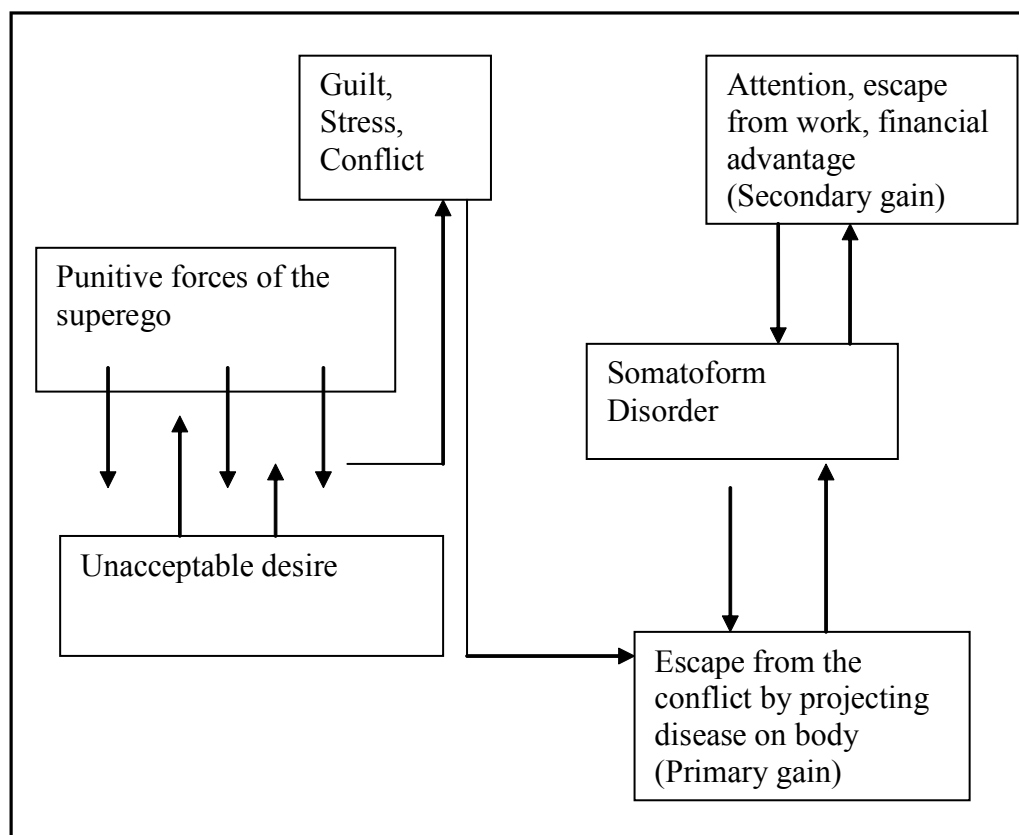


Fig.: Psychoanalytical model of Somatoform disorder

- iv) **Learning Theory Approach:** The learning approach emphasises conditioning and modelling. If you look into the history of the persons with Somatoform disorder you may find that in their childhood and also in their immediate environment, the sick role has been reinforced in various ways. They might have been excused from heavy work or attention had been showered on them. In this sense, the concept of secondary gain is used in a different language by the learning theorists. You may also observe that in case of Hypochondriasis and Pain disorders there may have been a patient in the family who actually suffered from that disease. For example seeing a cancer patient at home may predispose one to believe that she also is suffering from cancer. Thus imitation and modelling seems to play a role.
- v) **Cognitive Approach:** The cognitive approach to the aetiology of Somatoform disorders emphasises problems in information processing and cognitive bias. It has been observed that persons with Somatoform disorder selectively pay greater attention to and have selectively more accurate memory of bodily symptoms. They also tend to consider any passing mild symptom as catastrophic. The cognitive approach to Conversion disorder and Hypochondriasis suggests that the person reflects through the disorders only what she knows and expects in a particular disorder. For example in 'glove anaesthesia', the lack of knowledge about the nerves running through the hand is crucial. Thus these two disorders

come very close to deliberate malingering. However, most researchers agree that there is real difference of these diseases from malingering per se.

- vi) **Vulnerable Personality and Life Events:** It has been found observed that persons who are more suggestible or have labile emotions are more vulnerable to certain types of Somatoform disorders, like Conversion disorder. Obsessive predisposition overlaps with Hypochondriasis and Body Dysmorphic Disorder. Often the person with vulnerable personality encounters some traumatic or stressful event and the disorder ensues as a result of the interaction.

4.5 TREATMENT OF SOMATOFORM DISORDERS

Treatment of Somatisation disorder is very difficult since the patient focuses on multiple loci of discomfort. One moderately effective treatment may be of a supportive kind. You may try to find a physician whom the person may visit regularly. This physician would check the client for the complaints but would not unnecessarily engage her in expensive investigations. There has been evidence that over long time the physical complaints subside to some extent. Cognitive therapy dealing with the secondary gain from the disorder may be used along with this supportive therapy.

Psychoanalysis and hypnotic therapy, directed toward unravelling the unconscious conflict has traditionally been used with Conversion disorder. From the behavioural perspective, non-reinforcement of sick role and reinforcement of normal movement / sensation may be helpful in some cases. You may also use cognitive restructuring approach to challenge secondary gains. You may also try to enhance coping skills and cognitive restructuring of the self. In the context of Conversion disorder, you must remember that in many cases spontaneous recovery occurs after a certain period when the primary gain has served its function.

Hypochondriasis, Body Dysmorphic disorder and Pain disorder are amenable to Cognitive Behavioural therapy. On the behavioural part, you may take help of the family for withdrawal of reinforcement of unwanted behaviour and introduce reinforcing desired behaviour. You may focus on the selective attention and cognitive bias toward specific bodily symptoms. The constant checking for bodily symptoms may be stopped through behavioural instruction. The belief about illness and utility of sick role may be challenged. You may also point out the misinterpretation, especially the tendency to catastrophize the bodily symptoms. Antidepressant medicine may be of moderate help in most of these cases.

Self Assessment Questions

- 1) What is the main difference between Somatisation disorder and Pain disorder?

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- 2) What is the cultural explanation of decrease in prevalence of Conversion disorder in recent years?

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3) What is the nature of cognitive bias in Somatoform disorders?

4) Write *True* (T) or *False* (F) beside the statement

- a) Behaviour therapy works best for Conversion disorder ().
- b) Persons with Body Dysmorphic disorder often have first degree relatives with OCD ().
- c) Somatisation disorder can be healed easily through insight therapy ().

4.6 DISSOCIATIVE DISORDERS: SYMPTOMS AND CLINICAL FEATURES

You must have seen films and read stories where, after a psychological shock, the hero seems to have lost his memory. He cannot recognise people. Nor can he remember his own identity. Then suddenly, after a chain of events that make up the story, his memory returns and everything ends happily. Such stories reflect, often in an exaggerated and over-simplified fashion, the essence of Dissociative Disorders.

The term ‘dissociation’ refers to the separation of the activities of a person from conscious awareness. While psychoanalysis has long since highlighted the irrational aspects of human mind, cognitive psychology has also been concerned in recent years with non-conscious processes. In this section you would learn about three major Dissociative disorders. These are:

- 1) Dissociative Amnesia and Fugue
- 2) Depersonalisation Disorder
- 3) Dissociative Identity Disorder

4.6.1 Dissociative Amnesia and Fugue

- i) **Dissociative Amnesia:** Amnesia means inability to remember. Amnesia may appear as a psychological escape from stress. But it may be a symptom in many organic diseases also. Dissociative amnesia has been defined by DSM IV – TR as a disturbance in one or more episodes of life or inability to recall significant events.

How would you differentiate between the amnesia caused due to actual brain damage and due to psychological causes? Of course neurological investigation would give you the first lead. But there are other functional differences as well. When amnesia has an organic basis usually you will find that the person is unable to remember all or most of the recent or remote past, or is unable to retain newly acquired information. Contrarily in Dissociative amnesia, the person is unable to retrieve selective portions of personal history and that forgetting is

not explained by biological causes. This usually happens following some stressful condition. The information is not permanently lost. These can be retrieved by hypnosis, narcotic analysis and sometimes spontaneously.

Dissociative amnesia can be localised to a specific period of life or may be generalised over a major part of the person's life. It can be selective, that is specific events may be lost. It can be continuous also, that is nothing is remembered beyond a certain point. Localised and selective amnesia are more common.

- ii) **Dissociative Fugue:** The word 'fugue' means flight. Dissociative fugue is a sudden unexpected travelling away from home or work. This is often accompanied with amnesia. You may find the person with fugue confused about personal identity and she may also assume a new identity. If you look into her case history you may discover that the fugue occurred after a stressful event which probably was difficult to handle staying in the same place. You know that even in Alzheimer's Dementia, which is an organic disease, people tend to wander away. The motive to flight along with absence of other symptoms of Dementia distinguishes Dissociative fugue from wandering in the Alzheimer's disease.

A Case Study of Dissociative Demementia and Fugue: Bobby, 35, was a middle manager at the sales department of a private firm. For the last few months he was being consistently unable to reach the target and was receiving unpleasant feedback from the boss and the subordinates alike. At home also he was having marital problems. One day he did not come back home from work. His wife waited for him till midnight and then informed the police. After about seven days he was found wandering in a small town far off from the city. He was having an altercation with the local people near a tea shop where he had stopped for a cup of tea. He had identified himself as Navin, and affirmed that he was looking for a job. However he could not produce any identification or could not say anything about his past. The local people had been suspicious, held him back, and informed the police. When the police found Navin alias Bobby, he could not remember his identity or how he had reached this place. He was wearing the same dress he had on seven days back. However his orientation to the time and date was intact.

4.6.2 Depersonalisation Disorder

Sometimes, under duress, you may have felt somewhat detached from reality. As if what is happening is not true, or as if you are observing the sequence of events as an outsider. This is one mode of tolerating immense pain, used automatically by the human mind. Depersonalisation means feeling as if one is not oneself. Derealisation means as if what is happening around is not real. While this may happen to anybody under extreme conditions, if a person persistently and recurrently suffers from this kind of experiences, you may think of diagnosing her as suffering from Depersonalisation disorder.

During this disorder, the person feels herself detached from her body and own mental processes. However, reality testing remains intact, that is hallucination and delusions do not occur. The person feels strangely detached from the internal and external events. Some may imagine oneself floating above one's body. There is usually a dreamlike character in the flow of existence, and one might be puzzled at the isolated and unfamiliar nature of the environment.

A Case Study of Depersonalisation Disorder: Meena, 20, works as a maid servant in an affluent house. She had been there for about three years. The mistress of the

house had recently noted that sometimes, when instructed to do some job, Meena stands for a while in a strange manner and looks vaguely around. Sometimes she stumbles over things and goes away to any random direction. Since at other times Meena had been a lovable girl and had worked well, the mistress had come to look upon her with compassion. She suspected some epileptic problem and took Meena to a neurologist. There Meena reported that for the last few months she had been occasionally feeling ‘out of the body’, and as if ‘having no control on her mind’. At those moments her thinking gets clouded and she can ‘come back only by shaking herself violently’. No neurological problem was found in the investigations. Case history revealed that some time back she had fallen in love with a married man and knew that it was impossible to be united with him. Neither her own family, nor the family where she worked, would approve of this union. The symptoms had appeared after she had strictly forbidden the man to see her.

4.6.3 Dissociative Identity Disorder

The most well known example of Dissociative Identity Disorder is the story of Dr. Jekyll and Mr. Hyde. One was a philanthropist and the other a killer. How would you feel if you go to sleep in your night suit at night, and wake up in the morning to find yourself in completely different attire and your shoes clad with mud? You do not know what you did at night. If it happens for days, may be you are having a different personality at night.

Dissociative Identity disorder is the modern name of what was earlier known as Multiple Personalities. DSM IV – TR requires that to diagnose a person as suffering from Dissociative Identity disorder, you must ensure that she has at least two separate ego states (known as alters) and they would be in complete control of your thinking, feeling and acting for different periods of times. Sometimes these alters are in touch with each other; often at least one alter is unaware of the existence of another. Therefore gaps in memory are common signs. The existence of the different alters is persistent and recurrent and not introduced by any chemical substance. These alters may have different or even opposite nature; they may dress, eat, interact differently. Often the subordinate alter works at a covert level while the host or original personality is operating at the surface. In such cases, this subordinate alter is said to be co-conscious. Gradually this alter makes its presence felt, and at one point takes over the control from the host.

You may have seen the movies ‘Three faces of Eve’ or ‘Sybil’. These are based on real documented cases of Dissociative Identity disorder. Evelyn had three alters and Sybil had sixteen. After prolonged treatment some of the alters may be integrated with the host.

A Case Study of Dissociative Identity Disorder: Munna was a young boy in his teens known to be an obedient, if not a very good student at school. He came from a middle class family and lived with his parents in a city. He was shy by nature and introvert, though good at games. At one point of time, his parents started observing that Munna was becoming fidgety and suppressive, unable to explain some of his time away from home. There were reports from the school that he was being absent while Munna could not remember anything. His parents suspected that Munna might be involved in addiction, and brought him to a psychiatrist. While being asked by the doctor about his activities, Munna suddenly spoke in a different tone and identified himself as Munim, a rough and tough fellow with an aggressive personality and lack of concern for social rules. Munim said that he knows all about Munna, the boy who feigns innocence. He bunked school and went to ‘bad boys’ to learn their ways to

fight the outer world. Munim also said that he had appeared to save Munna from his plight. Later on Munna revealed that as a small child he had witnessed gross physical and sexual torture of his mother by his father and grandparents. He was so afraid that he never let his parents know what he had seen. Upon asked, the parents admitted the truth of the family violence, which was dowry related and particularly poignant while Munna's grandparents were alive. Munna's parents patched up the relation after the older generation passed away and Munna grew up. Munim seemed to compensate for the suppressed aggression Munna had against his father's family.

4.7 PREVALENCE OF DISSOCIATIVE DISORDERS

The prevalence of Dissociative disorders in population is not well researched. Amnesia probably occurs in about 5% to 7% of the population. Fugue is much less common, about 0.2%. Depersonalisation disorder occurs in about 2% to 3%. Dissociative Identity disorder was once considered to be very rare. Later on its diagnosis has been influenced by the scientific culture of the time. Some doctors diagnose it more, some merge it with schizophrenia. It may be prevalent in 1% to 2 % of the population.

4.8 AETIOLOGY OF DISSOCIATIVE DISORDERS

4.8.1 Biological Factors

Like Somatoform disorder, biological factors are of secondary importance in Dissociative disorders also. At best a vulnerable personality with greater suggestibility may have some genetic implication.

4.8.2 Psychological Factors

The psychological causes are at the root of dissociative disorders.

- i) **Psychoanalytic Approach:** The psychoanalytic explanation highlights the operation of the defences of repression and denial in amnesia and fugue. When certain unconscious conflicts are extremely painful, and no acceptable escape route is left open, the ego may take resort to repression, making the content of the conflict unavailable, at least temporarily. Another important defence mechanism is operative in all Dissociative disorders, which is isolation of emotion and event. This is most prominent in Depersonalisation disorder.
- ii) **Behavioural Approach:** The learning approach attributes dissociation to the attempt of the person to avoid extreme stress. This dissociation is reinforced as it relieves the person from the stress. Sometimes they may self – hypnotize to go into the dissociated states.
- iii) **Cognitive Approach:** The cognitive perspective suggests that selective memory deficits takes place. Usually the person's episodic or autobiographical memory is affected, leaving the semantic memory relatively intact. Some case reports imply that implicit memory is intact while explicit memory only is disturbed. For example, a man with dissociative amnesia may not be able to remember his wife's name. But if he is asked to guess the wife's name from a list of possible names he might strike on the right name.

4.8.3 Cultural and Social Factors

Some cultures tolerate or even encourage dissociative phenomena like possession

and trance. Disturbances of identity gain a support within the culture and are reinforced. There have been some indications that dissociated identity in the form of possession by spirit is more common in non-western cultures.

4.8.4 Vulnerable Personality and Stressful Life Events

There are substantial evidences that those with dissociative disorder underwent severe trauma in childhood. Some had experienced physical abuse; some others had been sexually abused or forced into incestual relations. Dissociative disorders are common in PTSD also, after natural or man made disasters. It has also been found that some persons are high in hypnotisability and they are more prone to develop Dissociative Identity disorder after a trauma.

4.9 TREATMENT OF DISSOCIATIVE DISORDERS

Dissociation is an escape from stress. Therefore, when you are dealing with a person with Dissociative amnesia and fugue, the first thing you must make sure is to keep her in a safe environment. If you can elicit from her case history the precipitating stressful event, you may assure her that she is safe from that danger. Sometimes, staying away from perceived danger leads to spontaneous recovery. Psychoanalytically oriented therapies and hypnotherapy may help to bring out the lost memory. Sometimes anxiolytic medicines are also used as adjunct to psychotherapy.

One word of caution here. Not all memories that are retrieved from the person with amnesia are reliable. You need to cross validate them from independent sources. And you must remember that simply reviving the memory is not the end of treatment. You need to work through the retrieved material so that the memories are properly contextualised.

There has been no systematic and controlled study about treating Depersonalisation Disorders. Antidepressants have been used, but their effectiveness is unknown. Hypnotherapy and training for self hypnosis may be of some use.

Dissociative Identity disorder has been claimed to be treated successfully by some therapists. Hypnotherapy and insight therapy have been used. The purpose of therapy is to integrate the personalities and convince each of them that there is no need to stay separate. The person needs to understand that coping can be done without splitting. As a therapist you need to be empathic toward each of the identities and deal with each on a fair level.

Self Assessment Questions

1) Define dissociation.

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2) What is dissociative fugue?

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3) State the difference between depersonalisation and derealisation.

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4) Write *True* (T) or *False* (F) beside the statement

- a) Dissociative amnesia can be selective about certain events ().
- b) In Dissociative Identity Disorder, the alters never know each other ().
- c) During depersonalisation the reality testing is usually badly affected ().

4.10 LET US SUM UP

In this unit we have focussed specifically on Somatoform Disorders and Dissociative Disorders. . We have learnt the symptoms and clinical features of five Somatoform disorders, namely Somatisation disorder, Pain disorder, Hypochondriasis, Conversion disorder and Body Dysmorphic disorder. We have also learnt about three Dissociative disorders namely Dissociative amnesia and fugue, Depersonalisation disorder and Dissociative Identity disorder. The prevalence of these disorders in the general population and time of onset have also been discussed. We have learnt about their aetiologies in terms of biological and psychological factors. We have also known that there are persons with vulnerable personalities who are more prone to developing these disorders when they encounter a stressful situation. We have also been acquainted with some of the biological and psychological treatment approaches to these disorders. Psychoanalytically oriented treatment and insight therapies are more applicable for some of these disorders. Medicine has relatively little impact. Cognitive behavioural approach seems to be another option.

4.11 UNIT END QUESTIONS

- 1) Discuss the symptoms and clinical features of different types of somatoform disorders with case examples.
- 2) Discuss the prevalence of different somatoform Disorders.
- 3) Discuss the aetiological factors of somatoform Disorders.
- 4) Discuss the treatment options of somatoform Disorders.
- 5) Discuss the symptoms and clinical features of different types of dissociative disorders with case examples.
- 6) Discuss the prevalence of different dissociative disorders.
- 7) Discuss the aetiological factors of dissociative disorders.
- 8) Discuss the treatment options of dissociative disorders

4.12 GLOSSARY

- Somatoform disorder** : Somatoform disorders refer to a group of disorders where the person reports physical complaints characteristic of bodily dysfunction. But investigation usually fails to elicit any actual physical defect.
- Dissociative disorder** : Dissociative Disorders refers to a group of disorders where the activities of a person are separated from conscious awareness. One may forget one's own identity or feel detached from oneself.
- Malingering** : Malingering refers to deliberately imitating the symptoms of a physical or psychological disease with the purpose of some practical advantage.
- La Belle Indifference** : A state of mind in Conversion disorder where the person has lost some sensory or motor function suddenly, but the affective reaction to this loss is not as intense as it should be. Rather a kind of indifference is observed.
- Primary gain** : This term is used in connection with Somatoform Disorders, especially Conversion Disorder. It refers to the primary unconscious purpose that is served by the disorder. Its basic motive is to protect and maintain the integrity of the ego. When any uncontrollable yet unacceptable sexual or aggressive impulse attempts to burst out, the ego is under threat of disruption. In the attempt to maintain control, it may use repression. As a result, a physical symptom in the form of sudden loss of sensory or motor function is observed. It solves the dilemma at least temporarily.
- Secondary gain** : Secondary gain refers to the advantages one derives secondarily after any Somatoform disorder, especially Conversion disorder has taken place in the form of a physical illness. Usually getting attention, financial advantage or escape from work are the motives for secondary gain.
- Amnesia** : Amnesia refers to inability to remember all or certain parts of personal history and identity. It may occur in organic brain disorders like Dementia or in psychiatric conditions like Dissociation.
- Fugue** : The word fugue means flight. In Dissociative fugue the person suddenly wanders away from

work or home. This state is accompanied with
amnesia.

- Depersonalisation** : Depersonalisation means feeling as if one is not oneself. The person seems detached from one's body and mind.
- Derealisation** : Derealisation is a dissociated state of mind where one feels what is happening around is not real.
- Alter** : In Dissociative Identity Disorder, two or more ego states may appear and be in complete control of one's thinking, feeling and acting for different periods of times. These ego states are known as alters.

4.13 SUGGESTED READINGS

Kaplan, H. I. & Sadock, B. J. *Synopsis of Psychiatry*. Philadelphia: Lippincott Williams.

Semple, D., Smyth, R., Burns, J., Darjee, R. & McIntosh, A. (2005) *Oxford Handbook of Psychiatry*. London: OUP.

UNIT 1 MILD, MODERATE AND MAJOR DEPRESSIVE DISORDER

Structure

- 1.0 Introduction
- 1.1 Objectives
- 1.2 Depressive Disorders
- 1.3 Mild Depressive Disorder
 - 1.3.1 Symptoms of Mild Depression
 - 1.3.2 Dysthymic Disorder
- 1.4 Moderate Depressive Disorder
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- 1.5 Major Depressive Disorder
 - 1.5.1 Causes of Major Depression
 - 1.5.2 Treatment
 - 1.5.2.1 Cognitive Behaviour Therapy
 - 1.5.2.2 Interpersonal Psychotherapy
- 1.6 Let Us Sum Up
- 1.7 Unit End Questions
- 1.8 Glossary
- 1.9 Suggested Readings

1.0 INTRODUCTION

Mood disorder is the term designating a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorder (DSM IV TR) classification system where a disturbance in the person's mood is hypothesized to be the main underlying feature. Mood disorders are emotional disturbances consisting of prolonged periods of excessive sadness, excessive joyousness, or both. Mood disorders are categorised as depressive or bipolar. A mood disorder is diagnosed when sadness or elation is overly intense and persistent and is accompanied by a requisite number of other mood disorder symptoms. In such cases, intense sadness is termed depression, and intense elation is termed mania. Depressive disorders are characterised by depression; bipolar disorders are characterised by varying combinations of depression and mania. In this unit we will discuss mild, moderate, and major depressive disorders. First we will deal with minor depressive disorders, then we will throw some light on moderate depressive disorders, and finally we will come across major depressive disorders.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the different types of mood disorders;
- Describe the symptoms of mood disorder;
- Explain the symptoms of mild depressive disorder;

- Explain the symptoms and treatment of dysthymic disorder;
- Describe the adjustment disorder with depressed mood;
- Elucidate the types, causes and treatment of major depressive disorder; and
- Analyse the differences between mild and major depressive disorders.

1.2 DEPRESSIVE DISORDERS

We all go through ups and downs in our mood. Sadness is a normal reaction to life's struggles, setbacks, and disappointments. Many people use the word "depression" to explain these kinds of feelings, but depression is much more than just sadness. Depression is a form of what is known as a mood or affective, disorder, because it is primarily concerned with a change in mood.

On the basis of following symptoms depressive disorders are usually distinguished from other mental disorders:

- Feelings of helplessness and hopelessness:** A bleak outlook—nothing will ever get better and there's nothing you can do to improve your situation.
- Loss of interest in daily activities:** No interest in former hobbies, pastimes, social activities, or sex. You've lost your ability to feel joy and pleasure.
- Appetite or weight changes:** Significant weight loss or weight gain—a change of more than 5% of body weight in a month.
- Sleep change:** Either insomnia, especially waking in the early hours of the morning, or oversleeping (also known as hypersomnia).
- Irritability or restlessness:** Feeling agitated, restless, or on edge. Your tolerance level is low; everything and everyone gets on your nerves.
- Loss of energy:** Feeling fatigued, sluggish, and physically drained. Your whole body may feel heavy, and even small tasks are exhausting or take longer to complete.
- Self-loathing:** Strong feelings of worthlessness or guilt. You harshly criticize yourself for perceived faults and mistakes.
- Concentration problems:** Trouble focusing, making decisions, or remembering things.
- Unexplained aches and pains:** An increase in physical complaints such as headaches, back pain, aching muscles, and stomach pain.

Depression can be categorised in the following manner:

- 1) Depression that is originating from a bad or disturbing event in one's life
- 2) Depression which appears without apparent cause.

The first type of depression is easier for us to tackle because the cause is known. The first step is to deal with the event that triggered depression. It may have started as a result of death, an accident, a divorce or any other type of setback.

The second type of depression is more difficult to deal with as the source is unknown. It is the most common form of depression.

Mood disorders are also differentiated by

- 1) severity, that is the number of dysfunctions experienced in various areas of living and the relative degree of impairment evidenced in those areas and
- 2) duration, whether the disorder is acute, chronic, or intermittent (with periods of relatively normal functioning between the episodes of disorder).

There are several different diagnoses for depression, mostly determined by the intensity of the symptoms and the duration of the symptoms. The term depression is often used to refer to any of several depressive disorders.

Three are classified in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Revision (DSM-IV-TR) by specific symptoms:

Major depressive disorder (often called major depression)

Dysthymia

Depressive disorder not otherwise specified

Two others are classified by etiology:

Depressive disorder due to a general physical condition

Substance-induced depressive disorder

- i) **Major Depression:** Major depression is a problem with mood in which there are severe and long lasting feelings of sadness or related symptoms that get in the way of a person's functioning.
- ii) **Dysthymic Disorder:** A less severe type of depression, dysthymic disorder, involves long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good.

1.3 MILD DEPRESSIVE DISORDER

The term depression is often used to explain the feeling of sadness due to certain situations like failing an exam, having a row with a close friend, losing a job, etc. However, this feeling of sadness cannot be exactly called depression because most likely it disappears in a day or two. However, for some people, the feeling of sorrow remains with them for a long time, so much so that it affects their daily life and activities. When such a situation arises, the person is said to be depressed. This mental condition of depression can be further divided into three forms which are mild, moderate and severe.

Among the three, moderate and severe forms of depression are talked about a lot and most do not know whether something like mild depression even exists. However, it is said that mild depression is a common phenomenon that many people experience. As people do not know about it, they are not able to recognise the signs that indicate a person to be suffering from mild depression. Though mild depression is not as serious as the other two versions of depression, if this condition is untreated, chances are there for the individual to go into severe depression. Therefore, it becomes important for people to know about what exactly happens when a person has mild depression and also about the ways one can adopt to treat this condition.

1.3.1 Symptoms of Mild Depression

The causes of mild depression is nothing different from the reasons that cause other types of depression. The difference is only in the impact that the situation has on that person. Hence, the focus is on the symptoms that can be observed when an individual is suffering from mild depression. Let us take a look at some of the symptoms of mild depression.

- i) **Reduced Concentration:** A person who is mildly depressed may feel very low, but still may continue with his daily activities like work related as well as household duties. However, he may have some difficulty in getting these things done. This is because individuals who are suffering from mild depression usually have problems like lack of concentration or reduced ability to think which hampers the activities that they used to execute easily.
- ii) **Fatigue and Sleeplessness:** Tiredness and fatigue is another symptom that affects a person who has mild depression. He may feel less energized, even after sleeping for a long time. This may happen because sometimes mild depression brings with it sleepless nights or insomnia.
- iii) **Physical Problems:** Along with the mental and emotional problems, a person experiencing mild depression may also have some physical problems. It is common to see people with depression suffer from pains and aches like headache, backache, etc. Often, people go to the physician to find a solution for their pain, however, no concrete cause is found out. In such cases, mild depression is one of the reasons that cause such kind of body ache. Apart from this, mild depression can also lead a person to lose interest in sexual intercourse. Change in eating habits is also one of the common symptoms of mild depression i.e. people may lose their appetite totally or may eat too much
- iv) **Loss of Interest:** Another sign of mild depression is loss of interest in any kind of activities. It is quite commonly seen that people no longer find enthusiasm in indulging in activities that they used to love earlier, when suffering from mild depression. This includes taking part in some kind of sports activities or may be indulging in one of their hobbies. Some people may feel uncomfortable meeting people and this may affect his social life.
- v) **Feeling of Guilt and Worthlessness:** People who are suffering from depression may experience the feeling of guilt and worthlessness as they are unable to perform their daily tasks and activities. They may feel frustrated the whole time and due to this are likely to cry or may experience anger bouts without any specific reason. This feeling of ineptitude may also trigger the thoughts of ending their life by committing suicide.

Dysthymic disorder is a form of mild depression. Many people are affected by it. It can be triggered by a specific incident or medical problem, or it can appear with no apparent cause. Often people don't realise that they're actually suffering from a medical condition because symptoms are mild and are easy to overlook until they start to affect your daily functioning.

1.3.2 Dysthymic Disorder

Mild or low level depressive symptoms that persist for two or more than two years are classified as dysthymia. Symptoms typically begin insidiously during adolescence and follow a low-grade course over many years or decades (diagnosis requires a course of ≥ 2 yr); dysthymia may intermittently be complicated by episodes of major

depression. Affected patients are habitually gloomy, pessimistic, humorless, passive, lethargic, introverted, and hypercritical of self and others, and complaining.

According to DSM-IV (TR) dysthymia is characterised by an overwhelming yet chronic state of depression, exhibited by a depressed mood for most of the days, for more days than not, for at least 2 years. (In children and adolescents, mood can be irritable and duration must be at least 1 year.)

In addition, no Major Depressive Episode has been present during the first two years (or one year in children and adolescents) and there has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder. Further, the symptoms cannot be due to the direct physiological effects of the use or abuse of a substance such as alcohol, drugs or medication or a general medical condition.

The symptoms must also cause significant distress or impairment in social, occupational, educational or other important areas of functioning. Dysthymia is a chronic long-lasting form of depression sharing many characteristic symptoms of major depressive disorder. These symptoms tend to be less severe but do fluctuate in intensity. To be diagnosed, an adult must experience 2 or more of the following symptoms for at least two years:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness
- Low sex drive
- Irritability

Symptoms exclude “manic, hypomanic or mixed episodes commonly associated with bipolar disorders. People with dysthymia have a higher than average chance of developing major depression. As dysthymia is a chronic disorder, a person may often experience symptoms for many years before it is diagnosed, if diagnosis occurs at all.

As a result, he or she tends to believe that depression is a part of their character. This, subsequently, may lead sufferers not to even discuss their symptoms with doctors, family members or friends.

Dysthymia, like major depression, tends to run in families. Some sufferers describe being under chronic stress. When treating diagnosed individuals, it is often difficult to tell whether they are under unusually high environmental stress or if the dysthymia causes them to be more psychologically stressed in a standard environment.

Treatment for Dysthymic Disorder

Psychotherapy is the treatment of choice for this psychological problem. Often, antidepressant medication is also recommended because of the chronic nature of the depression in Dysthymia. Psychotherapy is used to treat this depression in several ways. First, supportive counseling can help to ease the pain, and can address the

feelings of hopelessness. Second, cognitive therapy is used to change the pessimistic ideas, unrealistic expectations, and overly critical self-evaluations that create the depression and sustain it.

Cognitive therapy can help the depressed person recognise which life problems are critical, and which are minor. It also helps them to learn how to accept the life problems that cannot be changed. Third, problem solving therapy is usually needed to change the areas of the person’s life that are creating significant stress, and contributing to the depression. Behavioural therapy can help to develop better coping skills, and interpersonal therapy can assist in resolving relationship conflicts.

<p>Self Assessment Questions</p> <p>1) What do you mean by mood disorder? Discuss its different types?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>2) Discuss the symptoms of mild depressive disorder.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>3) Describe the symptoms and treatment of dysthymic disorder.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
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1.4 MODERATE DEPRESSIVE DISORDER

DSM-IV includes two main categories for depressions of mild to moderate severity: dysthymia and adjustment disorder with depressed mood. We have already discussed dysthymic disorder under mild depression category. Now we will turn to consider adjustment disorder with depressed mood under moderate depressive category.

1.4.1 Adjustment Disorder with Depressed Mood

This category describes depression that occurs in response to a major life stressor or crisis. This is also called a “reactive depression.” Basically adjustment disorder with depressed mood is behaviourally indistinguishable from dysthymia. It differs from dysthymia in that it does not exceed six months in duration, and it requires the existence of an identifiable (presumably precipitating) psychological stressors in the client’s life. The justification of keeping it in a distinct clinical diagnosis is that the client is experiencing impaired social or occupational functioning.

The diagnosis of an adjustment disorder implies that specific psychological symptoms have developed in response to a specific and identifiable psychosocial stressor. However, this diagnostic group (adjustment disorders) is a “last resort” category. If the symptom picture suggests that the person meets the diagnostic criteria for another psychological disorder, than this diagnosis is not used. For example, if a person experiences a trauma, and develops the symptoms of a major depression, then the diagnosis of adjustment disorder is not used, even though the depression developed in response to a psychosocial stressor. So, adjustment disorder with depression is used to categorise mild to moderate depression, following a stressful event.

Also, the depressive symptoms related to an adjustment disorder should be treated and dissipate within six months following the end of the stress that produced the reaction. If the symptoms last longer, then the diagnosis of Depression, not otherwise specified, is probably more appropriate. There is an exception to this rule, as some stressors continue over a long period of time, rather than occurring as a single event. For example, if a person is harassed on the job, that can continue for months. In such a case, the depression may not be severe enough for a diagnosis of major depression, but it would continue for more than six months. But, since the stress is continuing, then the adjustment disorder diagnosis could still be used. Despite these problems with the formal diagnostic criteria, there are doubtless many cases of relatively brief but moderately serious depression.

The symptom picture is similar to other depressive disorders, and the recommended treatment is still cognitive-behavioural therapy and/or interpersonal therapy. However, because of the relationship between the symptoms and a specific stressor, there is more emphasis put on resolving the problem that created the stress. This may involve making concrete changes in the way the person manages his/her life, and may require specific action and decision making. (e.g. If job stress is resulting in depression, the person may need to decide whether changing jobs is the most appropriate solution.) Often people become depressed in reaction to psychosocial stressors when they don't believe a solution exists to their problem. In such cases, helping the person develop a reasonable solution is a key part of the treatment process.

Self Assessment Questions

1) Point out the symptoms and treatment of adjustment disorder with depressed mood.

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2) Differentiate between dysthymic disorder and adjustment disorder with depressed mood.

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1.5 MAJOR DEPRESSIVE DISORDER

Major Depressive disorder, commonly called major depression, unipolar depression, or clinical depression, where a person has one or more major depressive episode. After a single episode, Major Depressive Disorder (single episode) would be diagnosed. After more than one episode, the diagnosis becomes Major Depressive Disorder (Recurrent). Depression without periods of mania is sometimes referred to as unipolar depression because the mood remains at one emotional state or “pole”. Major depression is a disabling condition which adversely affects a person’s family, work or school life, sleeping and eating habits, and general health. In the United States, around 3.4% of people with major depression commit suicide, and up to 60% of people who commit suicide had depression or another mood disorder.

The diagnosis of major depressive disorder is based on the patient’s self-reported experiences, behaviour reported by relatives or friends, and a mental status exam. If depressive disorder is not detected in the early stages it may result in a slow recovery and affect or worsen the persons physical health. The most common time of onset is between the ages of 20 and 30 years, with a later peak between 30 and 40 years.

Major depression significantly affects a person’s family and personal relationships, work or school life, sleeping and eating habits, and general health. Its impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes.

A person having a major depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were formerly enjoyed. They develop feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred. In severe cases, depressed people may have symptoms of psychosis. Insomnia is common among the depressed. Hypersomnia or oversleeping can also happen. A depressed person may also report multiple physical symptoms such as fatigue, headaches, or digestive problems.

The DSM-IV-TR recognises five further subtypes of MDD, called *specifiers*, in addition to noting the length, severity and presence of psychotic features:

Atypical Depression (AD) is characterised by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite (“comfort eating”), excessive sleep or hypersomnia, a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection.

Melancholic Depression is characterised by a loss of pleasure 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, or excessive Guilt.

Catatonic Depression 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 remains immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms also occur in schizophrenia or in manic episodes, or may be caused by neuroleptic malignant syndrome

Psychotic Major Depression (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).

Postpartum Depression (PPD) is listed as a course specifier in DSM-IV-TR; it 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 as long as three months. It is quite common for women to experience a short term feeling of tiredness and sadness in the first few weeks after giving birth; 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.

Seasonal Affective Disorder (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. It is commonly hypothesized that people who live at higher latitudes tend to have less sunlight exposure in the winter and therefore experience higher rates of SAD, but the epidemiological support for this proposition is not strong (and latitude is not the only determinant of the amount of sunlight reaching the eyes in winter). SAD is also more prevalent in people who are younger and typically affects more females than males.

1.5.1 Causes of Major Depression

As far as etiology of major depressive disorder is concerned biological, psychological, and social factors all play a role in causing depression. Several models and approaches have been proposed by psychologists and psychiatrists to account for the causes of depression. For example Diathesis Model stresses that that depression results when a preexisting vulnerability, or diathesis, is activated by stressful life events.

The preexisting vulnerability can be either genetic, an interaction between nature and nurture, or schematic, resulting from views of the world learned in childhood. Family studies suggest that prevalence of mood disorder is higher among blood relatives of persons with clinically diagnosed mood disorder than in the population at large (e.g., Plomin, De Fries, Mc Cleary, & Rutter, 1997). Twin studies also suggested that there is a moderate genetic contribution to major depression. Plomin et.al. (1997) reviewed evidence from five different studies showing that monozygotic co-twins of a twin with major depression are about four to five times as likely to develop major depression as are dizygotic co-twins of a depressed twin.

Various aspects of personality and its development appear to be integral to the occurrence and persistence of depression with negative emotionality as a common precursor. Although depressive episodes are strongly correlated with adverse events, a person’s characteristic style of coping may be correlated with their resilience (Kessler, 1997). Additionally, low self-esteem and self-defeating or distorted thinking are related to depression.

Depressed people were found to have a distinctly negative view of themselves and the world around them (Beck, 1967), and their perception of stress may result, at least to some extent, from the cognitive symptoms of their disorder rather than causing their disorder (Kessler, 1997). Beck, following on from the earlier work of Kelly and Ellis, developed what is now known as a cognitive model of depression in the early 1960s.

He proposed that three concepts underlie depression: a triad of negative thoughts composed of cognitive errors about oneself, one's world, and one's future; recurrent patterns of depressive thinking, or *schemas*; and distorted information processing. According to American psychologist Seligman (1974, 1975) depression in humans is similar to learned helplessness in laboratory animals, who remain in unpleasant situations when they are able to escape, but do not because they initially learned they had no control.

Attachment theory, developed by Bowlby in the 1960s, predicts a relationship between depressive disorder in adulthood and the quality of the earlier bond between the infant and their adult caregiver. In particular, it is thought that "the experiences of early loss, separation and rejection by the parent or caregiver (conveying the message that the child is unlovable) may all lead to insecure internal working models.

Internal cognitive representations of the self as unlovable and of attachment figures as unloving [or] untrustworthy would be consistent with parts of Beck's cognitive triad" (Seligman, 1975). While a wide variety of studies has upheld the basic tenets of attachment theory, research has been inconclusive as to whether self-reported early attachment and later depression are demonstrably related.

According to Bandura (1978) depressed individuals have negative beliefs about themselves, based on experiences of failure, observing the failure of social models, a lack of social persuasion that they can succeed, and their own somatic and emotional states including tension and stress. These influences may result in a negative self-concept and a lack of self-efficacy; that is, they do not believe they can influence events or achieve personal goals. Depressed individuals often blame themselves for negative events, as shown in the study of Pinto and Francis (1993) on hospitalised adolescents with self-reported depression, those who blame themselves for negative occurrences may not take credit for positive outcomes. This tendency is characteristic of a depressive attributional or pessimistic explanatory style.

The studies conducted on depression in women indicates that vulnerability factors—such as early maternal loss, lack of a confiding relationship, responsibility for the care of several young children at home, and unemployment—can interact with life stressors to increase the risk of depression (Bandura, 1998). For older adults, the factors are often health problems, changes in relationships with a spouse or adult children due to the transition to a care-giving or care-needing role, the death of a significant other, or a change in the availability or quality of social relationships with older friends because of their own health-related life changes (Brown and Harris, 2001).

The understanding of depression has also received contributions from the psychoanalytic and humanistic psychology. From the classical psychoanalytic perspective of Freud depression or melancholia may be related to interpersonal loss and early life experiences (Hinrichsen and Emery, 2006). The founder of humanistic psychology, Abraham Maslow suggested that depression could arise when people are unable to attain their needs or to self-actualise (to realise their full potential).

Social: Poverty and social isolation associated with increased risk of mental health problems in general. Child abuse (physical, emotional, sexual, or neglect) is also associated with increased risk of developing depressive disorders later in life (Kessler, 1997). Abuse of the child by the caregiver is bound to distort the developing personality and create a much greater risk for depression and many other debilitating mental and emotional states. Disturbances in family functioning, such as parental (particularly maternal) depression, severe marital conflict or divorce, death of a

parent, or other disturbances in parenting are additional risk factors. In adulthood, stressful life events are strongly associated with the onset of major depressive episodes. In this context, life events connected to social rejection appear to be particularly related to depression (Kessler, 1997).

1.5.2 Treatment

Various psychological treatments are available for depressive disorders. Some of them are briefly listed below. In general, a combination of an antidepressant plus a psychological treatment is better than either treatment alone. Typically, most psychological treatments for depression last in the range of 12-20 weekly sessions of 1-2 hours per session.

Those most commonly used for moderate or severe depression are:

1.5.2.1 Cognitive Behavioural Therapy (CBT)

Briefly, cognitive behavioural therapy is based on the idea that certain ways of thinking can trigger, or fuel, certain mental health problems such as depression. The therapist helps the client to understand his thought patterns. In particular, to identify any harmful or unhelpful ideas or thoughts which the client has that can make him depressed. The aim is then to change his ways of thinking to avoid these ideas. Behavioural therapy aims to change such behaviours which are harmful or not helpful. CBT is a combination of cognitive therapy and behavioural therapy. In short, CBT helps people to achieve changes in the way that they think, feel and behave.

1.5.2.2 Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) focuses on resolving interpersonal problems and stresses in existing relationships and/or building the skills to form important new interpersonal relationship. IPT is based on the idea that our personal relationships may play a large role in affecting our mood and mental state. The therapist helps us to change our thinking and behaviour and improve our interaction with others. For example, IPT may focus on issues such as bereavement or disputes with others that may be contributing to the depression.

Self Assessment Questions

1) Discuss the symptoms and types of major depressive disorder.

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2) Explain the etiology and treatment of major depressive disorder.

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3) Differentiate between mild depressive disorder and major depressive disorder.

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1.6 LET US SUM UP

Mood disorder is the term designating a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorder (DSM IV TR) classification system where a disturbance in the person’s mood is hypothesized to be the main underlying feature. Depression is a form of what is known as a mood or affective, disorder, because it is primarily concerned with a change in mood.

There are several different diagnoses for depression, mostly determined by the intensity of the symptoms and the duration of the symptoms. The term depression is often used to refer to any of several depressive disorders. Depressive disorders may be classified as mild to moderate depressive disorder and major depressive disorder. DSM-IV includes two main categories for depressions of mild to moderate severity: dysthymia and adjustment disorder with depressed mood. To qualify for a diagnosis of dysthymia, a person must have a persistent depressed mood, more than not, for at least two years. In addition, dysthymics must have at least two of the following six symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. Adjustment disorder with depressed mood differs from dysthymia in that it does not exceed six months in duration, and it requires the existence of an identifiable (presumably precipitating) psychological stressors in the client’s life. The diagnostic criteria for major depressive disorder require that the person exhibit more symptoms than are required for dysthymia and the symptoms be more persistent. A person having a major depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were formerly enjoyed. They develop feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred. In severe cases, depressed people may have symptoms of psychosis. Insomnia is common among the depressed. Hypersomnia or oversleeping can also happen. A depressed person may also report multiple physical symptoms such as fatigue, headaches, or digestive problems. As far as etiology of major depressive disorder is concerned biological, psychological, and social factors all play a role in causing depression. Cognitive behavioural therapy and interpersonal psychotherapy are most commonly used for the treatments of depressive disorders. In general, a combination of an antidepressant plus a psychological treatment is better than either treatment alone. Typically, most psychological treatments for depression last in the range of 12-20 weekly sessions of 1-2 hours per session.

1.7 UNIT END QUESTIONS

- 1) How does mood disorder differ from other types of mental disorders?
- 2) Describe different types of mood disorders.
- 3) Discuss the symptoms and treatment of mild mood disorder.
- 4) Explain the diagnosis and treatment of dysthymic disorder.

- 5) Discuss the symptoms and treatment of adjustment disorder with depressed mood.
- 6) Differentiate between dysthymic disorder and adjustment disorder with depressed mood.
- 7) Describe the diagnosis and types of major depressive disorder.
- 8) Explain the causes and treatment of major depressive disorder.
- 9) Differentiate between mild depressive disorder and major depressive disorder.

1.8 GLOSSARY

Adjustment disorder with depressed mood	: Moderately severe depressive disorder that occurs as a result of an identifiable life event and that is expected to disappear when the event's impact ceases, and not exceeding six months in duration.
Behaviour therapy	: Use of therapeutic procedures based on principles of classical and operant conditioning.
Bipolar disorder	: Mood disorder in which a person experiences both manic and depressive episodes.
Cognitive Behaviour therapy	: Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
Depression	: Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
Depressive disorder	: Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
Dizygotic twins	: Twins that develop from two separate eggs.
Dysthymia	: A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
Episodic (disorder)	: Term used to describe a disorder that tends to abate and to recur.
Interpersonal psychotherapy	: A form of psychotherapy that focuses on increasing client's social effectiveness and the extent they feel cared about by others.
Learned helplessness	: Acquired belief in one's helplessness to deal with a situation or control one's environment. Concept has been applied to explain depression in humans.
Major depressive disorder	: A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts.

- Depressive episodes occur most of everyday for at least two weeks.
- Monozygotic twins** : Identical twins developed from one fertilised egg.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

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UNIT 2 BIPOLAR DISORDER

Structure

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- 2.2 Bipolar Disorders
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2.0 INTRODUCTION

Bipolar disorder or manic-depressive disorder, which is also referred to as bipolar affective disorder or manic depression, 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 episode 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. In the present unit we will first discuss the symptoms and types of bipolar disorder, after that we will explain the causes of bipolar disorder and finally we will come across to the treatment and prognosis of bipolar disorder.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of bipolar disorder;
- Describe the symptoms of bipolar disorder;
- Understand the different types of bipolar disorder;
- Explain the causes of bipolar disorder;
- Describe the treatment and prognosis of bipolar disorder; and
- Analyse the difference between bipolar disorder and other forms of depressive disorder.

2.2 BIPOLAR DISORDERS

Although recurrent cycles of mania and depression were recognised as early as sixth century, but it was Kraepelin in 1899 who first introduced the term manic-depressive insanity and to clarify the clinical picture. Kraepelin described the disorder as a series of attack of delation and depression, with periods of relative normality in between, and a general favorable prognosis. Bipolar disorder has traditionally been thought to be much less common than depression.

Earlier it was opined that depressive disorders were four to five times more frequent than bipolar disorder. But recent studies disagree with this view and believe that depressive and bipolar disorder are really very similar (Bowden, 1993). The reason is that depression has traditionally been considered to be more common, and accordingly many individuals suffering from bipolar disorder are wrongly classified as suffering from unipolar disorder because a manic or hypomanic episode has not yet occurred. Sometimes, a person with severe episodes of mania or depression has psychotic symptoms too, such as hallucinations or delusions.

The psychotic symptoms tend to reflect the person's extreme mood. For example, psychotic symptoms for a person having a manic episode may include believing he or she is famous, has a lot of money, or has special powers. In the same way, a person having a depressive episode may believe he or she is ruined and penniless, or has committed a crime. As a result, people with bipolar disorder who have psychotic symptoms are sometimes wrongly diagnosed as having schizophrenia, another severe mental illness that is linked with hallucinations and delusions.

2.2.1 Symptoms of Bipolar Disorder

Bipolar disorder is distinguished from major depression by at least one episode of mania. Any given episode is classified as depressive, manic, or mixed, according to its predominant features. If individuals experience only one of these moods (for example, either mania or depression), they are said to suffer only Unipolar mood disorder. Since the experience of manic symptoms alone is extremely rare, almost all individuals with unipolar mood disorders suffer from unipolar depression.

If the individual alternates between experiences of depression and mania he/she is said to be suffering from a bipolar disorder. Bipolar disorder is a condition in which people experience abnormally elevated (manic or hypomanic) and, in many cases, abnormally depressed states for periods of time in a way that interferes with functioning.

2.2.1.1 Depressive Episode

A depressive episode has features typical of major depression, including depressed mood, anhedonia, psychomotor retardation, and feelings of pessimism and guilt. Sleeping and eating often increase. Delusions of guilt accompanied by self-loathings are common in psychotic depression, and some patients have hallucinations. Signs and symptoms of the depressive phase of bipolar disorder include persistent feelings of sadness, anxiety, guilt, anger, isolation, or hopelessness; disturbances in sleep and appetite; fatigue and loss of interest in usually enjoyable activities; problems in concentration, loneliness, self-loathing, apathy or indifference; loss of interest in sexual activity; shyness or social anxiety, irritability, chronic pain (with or without a known cause); lack of motivation; and morbid suicidal ideation. In severe cases, the individual may become psychotic – a condition also known as severe bipolar depression with psychotic features. Features of depressive form of bipolar disorders are usually clinically indistinguishable from those of major depression (Perris, 1992, American Psychiatric Association, 1994), although some studies report higher rates of psychomotor retardation, overeating, and oversleeping in the depressive phase of bipolar disorder (Cassano, et.al., 1992; Whybrow, 1997).

2.2.1.2 Manic Episode

A manic episode is defined as one or more than one week of a persistently elevated, expansive, or irritable mood plus three or more than three of the following additional symptoms:

Inflated self-esteem or grandiosity, decreased need for sleep, greater talkativeness than usual, persistent elevation of mood, flight of ideas or racing of thoughts, distractibility, and increased goal-directed activity.

People suffering from bipolar disorder commonly experience an increase in energy and a decreased need for sleep. A person's speech may be pressured, with thoughts experienced as racing. Attention span is low, and a person in a manic state may be easily distracted. Judgment may become impaired, and sufferers may go on spending sprees or engage in behaviour that is quite abnormal for them. They may indulge in substance abuse, particularly alcohol or other depressants, cocaine or other stimulants, or sleeping pills. Their behaviour may become aggressive, intolerant, or intrusive. People may feel out of control or unstoppable. People may feel they have been "chosen" and are "on a special mission" or have other grandiose or delusional ideas. Sexual drive may increase.

Manic patients may inexhaustibly, excessively, and impulsively involved in various pleasurable, high-risk activities (e.g. gambling, dangerous sports, promiscuous sexual activity) without insight into possible harm. Symptoms are so severe that they impair functioning. Typically, patients in a manic episode are exuberant and flamboyantly or colorfully dressed; they have an authoritative manner with a rapid, unstoppable flow of speech. Patients may make clang associations (new thoughts that are triggered by word sounds rather than meaning). Easily distracted, patients may constantly shift from one theme or endeavor to another. However, they tend to believe they are in their best mental state. Lack of insight and an increased capacity for activity often lead to intrusive behaviour and can be a dangerous combination. Interpersonal friction results and may cause patients to feel that they are being unjustly treated or persecuted. As a result, patients may become a danger to themselves or to other people. Accelerated mental activity is experienced as racing thoughts by patients and is observed as flights of ideas by the physician.

2.2.1.3 Hypomanic Episode

A hypomanic episode is a less extreme variant of mania involving a distinct episode that lasts four or more than four days and is distinctly different from the patient's usual nondepressed mood. Hypomania is generally a mild to moderate level of mania, characterised by optimism, pressure of speech and activity, and decreased need for sleep. Generally, hypomania does not inhibit functioning like mania. Many people with hypomania are actually in fact more productive than usual. Some people have increased creativity while others demonstrate poor judgment and irritability. Many people experience hypersexuality. These persons generally have increased energy and tend to become more active than usual. They do not, however, have delusions or hallucinations. During the hypomanic period, mood brightens, the need for sleep decreases, and psychomotor activity accelerates. For some patients, hypomanic periods are adaptive because they produce high energy, creativity, confidence, and supernormal social functioning. Many do not wish to leave the pleasurable, euphoric state. Some function quite well, and in most, functioning is not markedly impaired. However, in some patients, hypomania manifests as distractibility, irritability, and labile mood, which the patient and others find less attractive.

2.2.1.4 Mixed Episode

A mixed episode blends depressive and manic or hypomanic features; the criteria for both mania and depression are met. For example, patients may momentarily switch to tearfulness during the height of mania, or their thoughts may race during a depressive period. Often, the switch follows circadian factors (e.g. going to bed depressed and waking early in the morning in a hypomanic state). In at least one third of people with bipolar disorder, the entire episode is mixed. A common presentation consists of a dysphorically excited mood, crying, curtailed sleep, racing thoughts, grandiosity, psychomotor restlessness, suicidal ideation, persecutory delusions, auditory hallucinations, indecisiveness, and confusion. This presentation is called dysphoric mania (i.e. prominent depressive symptoms superimposed on manic psychosis).

2.2.2 Classification of Bipolar Disorder

In DSM-IV-TR and ICD-10 bipolar disorder is conceptualised as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists three specific subtypes and one for non-specified:

- Bipolar I Disorder
- Bipolar I Disorder
- Cyclothymia
- Bipolar Disorder NOS (Not Otherwise Specified)

2.2.2.1 Bipolar I Disorder

Bipolar I Disorder is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behaviour. A person with bipolar disorder experiences episodes of mania and, usually, major depressive episodes as well. A very small number of people may experience one or more periods of mania without ever experiencing depression (Goodwin and Jamison, 1990).

2.2.2.2 Bipolar II Disorder

Bipolar II Disorder is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes. Hypomanic episodes do not go to the full extremes of mania (*i.e.*, do not usually cause severe social or occupational impairment, and are without psychosis), and this can make bipolar II more difficult to diagnose, since the hypomanic episodes may simply appear as a period of successful high productivity and is reported less frequently than a distressing, crippling depression. Thus bipolar II disorder differs from Bipolar I in that – rather than experiencing one or more florid, dramatic manic episodes – the manic behaviour is present to a lesser degree. People who experience a hypomanic episode may not see it as pathological, although those around them may be concerned about the erratic behaviour they see.

2.2.2.3 Cyclothymia

Cyclothymia, or Cyclothymic Disorder, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder. Symptoms of cyclothymic disorder are depressed mood for most of the day, for more days than not, for one year, including the presence of two of the following symptoms: poor appetite or overeating; insomnia/hypersomnia; low energy/fatigue; poor concentration; feelings of hopelessness. Symptoms are less severe than those of a major depressive episode but are more persistent. A history of hypomanic episodes with periods of depression that do not meet criteria for major depressive episodes. There is a low-grade cycling of mood which appears to the observer as a personality trait, and interferes with functioning.

2.2.2.4 Bipolar Disorder NOS (Not Otherwise Specified)

Bipolar Disorder Not Otherwise Specified (BP-NOS) is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behaviour. This is a catchall category, diagnosed when the disorder does not fall within a specific subtype. Bipolar disorders NOS can still significantly impair and adversely affect the quality of life of the patient.

2.2.3 Causes of Bipolar Disorder

Although causes of bipolar disorder likely vary between individuals. But studies suggest that both biological and psychological factors seem to play a role in determining whether a person will develop symptoms of bipolar disorder.

2.2.3.1 Biological Factors

Studies conducted on the families of people diagnosed with bipolar disorder show that there is strong tendency for other family members also to have higher than expected risk for a mood disorder of some type including bipolar disorder (Mitchell et.al., 1993). Results of studies indicated that about nine percent of the first degree relatives of a person with bipolar illness can also be expected to have bipolar disorder (nine times the rate of the disorder in the general population) (Katz and McGuffin 1993; Plomin et.al., 1997). Although family studies cannot by themselves establish a genetic basis for the disorder, results from twin studies also point to a

genetic basis. Twin studies have been limited by relatively small sample sizes but have indicated a substantial genetic contribution, as well as environmental influence.

The concordance rates for these disorders are much higher for identical twins than for fraternal twins (Kallman, 1958). The study of Bertelsen, Harvald, and Hauge (1977) estimated that monozygotic twins were three times more likely to be concordant (67 percent) for a diagnosis of bipolar disorder than were dizygotic twins (20 percent). About three-quarters of the affected cotwins had the same form of disorder (bipolar), but nearly one-quarter had unipolar disorder. This study further suggests that genes account for over 80 percent of the variance in the tendency to develop (that is liability for) bipolar depression. For bipolar I, the (probandwise) concordance rates in modern studies have been consistently put at around 40% in monozygotic twins (same genes), compared to 0 to 10% in dizygotic twins (Kieseppa et. al., 2004). A combination of bipolar I, II and cyclothymia produced concordance rates of 42% vs. 11%, with a relatively lower ratio for bipolar II that likely reflects heterogeneity.

The overall heritability of the bipolar spectrum have been put at 0.71 (Edvardsen et. al., 2008). There is overlap with unipolar disorder and if this is also counted in the co-twin the concordance with bipolar disorder rises to 67% (monozygotic) and 19% (dizygotic) (McGuffin et.al., 2003) The relatively low concordance between dizygotic twins brought up together suggests that shared family environmental effects are limited, although the ability to detect them has been limited by small sample sizes.

Genetic studies of bipolar disorder have also used recombinant DNA technology in an attempt to locate genetic markers. The studies have suggested many chromosomal regions appearing to relate to the development of bipolar disorder, but the results are not consistent and often not replicated (Kato, 2007). Although the first genetic linkage finding for mania was in 1969 (Reich et. al., 1969), the linkage studies have been inconsistent (Burmeister et. al., 2008). Recent meta-analyses of linkage studies detected either no significant genome-wide findings or, using a different methodology, only two genome-wide significant peaks, on chromosome 6 and on chromosome 11.

Studies also suggest that abnormalities in the structure and/or function of certain brain circuits could underlie bipolar and other mood disorders. Imaging studies show how the brains of people with bipolar disorder may differ from the brains of healthy people or people with other mental disorders. For example, one study using MRI found that the pattern of brain development in children with bipolar disorder was similar to that in children with “multi-dimensional impairment,” a disorder that causes symptoms that overlap somewhat with bipolar disorder and schizophrenia (Gogtay, et. al. 2007). This suggests that the common pattern of brain development may be linked to general risk for unstable moods. Some studies have also found anatomical differences in areas such as the amygdale (Strakowski, 1999), prefrontal cortex and hippocampus (Kempton et. al., 2008). However, despite 25 years of research involving more than 7,000 MRI scans, studies continue to report conflicting findings and there remains considerable debate over the neuroscientific findings. Two fairly consistent abnormalities found in a meta-analysis of 98 MRI or CT neuroimaging studies were that groups with bipolar disorder had lateral ventricles which were on average 17% larger than control groups, and were 2.5 times more likely to have deep white matter hyperintensities.

Studies on conducted on the causes of mood disorder suggest that neurotransmitter also play important role in the development of bipolar disorder. As we know that neurotransmitter is brain chemical which helps in the transmission of information from one neuron to other at synapse. Neurobiological investigations suggest that norepinephrine and serotonin are such two transmitters which are associated with

depression. For example, Joseph and Schildkraut (1965) suggested that at least some forms of depressions are associated with low levels of norepinephrine. Conversely he suggested that elation or mania was associated with an excess of this neurotransmitter, which is called noradrenalin. This hypothesis, called *catecholamine hypothesis*, was developed after researcher had observed an unexpected drug effect. The drug reduced the levels of norepinephrine, which caused the people to become very depressed.

A second theory, known as *indolamine hypothesis*, suggests that low levels of serotonin (one of the indolamines) were associated with and perhaps caused depression (Glossman and Platman, 1969). It has also been observed that neurotransmitter system has many subtypes and interact in many complex ways with other neurotransmitters and neuromodulators (products of endocrine system). For example reserpine (used to reduce blood pressure) also affects dopamine, and in turn, causes to produce depression. Like reserpine, serotonin was also found to reduce levels of neurotransmitter and thus causes to increase the depression. Researchers also became interested in the endocrine system when they found that patients with such diseases which affect the endocrine system became depressed. Hypothyroidism, or Crushing's disease, affecting the adrenal cortex, leads to excessive secretion of cortisol and, often, depression.

It has been suggested that a hypersensitivity of the melatonin receptors in the eye could be a reliable indicator of bipolar disorder, in studies called a trait marker, as it is not dependent on state (mood, time, etc.). In studies, patients diagnosed as bipolar reliably showed a melatonin-receptor hypersensitivity to light during sleep, causing a rapid drop in sleep time melatonin levels compared to controls (Lewy et. al., 1985)). Another study showed that drug-free, recovered, bipolar patients exhibited no hypersensitivity to light (Whalley et.al , 1991). It has also been shown in humans that valproic acid, a mood stabiliser, increases transcription of melatonin receptors and decreases eye melatonin-receptor sensitivity in healthy volunteers while low-dose lithium, another mood stabiliser, in healthy volunteers, decreases sensitivity to light when sleeping, but doesn't alter melatonin synthesis (Hallam et al., 2005). The extents to which melatonin alterations may be a cause or effect of bipolar disorder are not fully known.

2.2.3.2 Psychological Factors

Evidence suggests that psychological factors play a significant role in the development and course of bipolar disorder, and that individual psychosocial variable may interact with genetic dispositions (Serretti & Mandelli, 2008). There is fairly consistent evidence from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes, as they do for onsets and recurrences of unipolar depression (Alloy et. al., 2005). Environmental stressors can sometimes be important in setting off either an initial or additional manic episode.

Two-thirds of manic episodes experienced by patients in one study were preceded by a life related stress of some kind (Ambelas, 1987). Stressful events can also cause a manic episode in people with a past history of manic episodes or bipolar disorder. For example, when a major hurricane struck Long Island, New York, in 1985, there was a dramatic increase in manic episodes among patients with bipolar disorder who were being treated with lithium (Aronson and Shukla, 1987). All the people who relapsed already had a high level of stress in their lives and most lacked social support from a close, confiding relationship.

For each of these people the hurricane resulted in additional stress besides that from the storm itself. Findings of the studies also suggest that between a third and a half of adults diagnosed with bipolar disorder report traumatic/abusive experiences in childhood, which is associated on average with earlier onset, a worse course, and more co-occurring disorders (Gabriele et.al. 2006). The total number of reported stressful events in childhood is higher in those with an adult diagnosis of bipolar spectrum disorder compared to those without, particularly events stemming from a harsh environment rather than from the child's own behaviour (Louisa et. al., 2007).

Early experiences of adversity and conflict are likely to make subsequent developmental challenges in adolescence more difficult, and are likely a potentiating factor in those at risk of developing bipolar disorder (Miklowitz et. al., 2008).

2.2.4 Treatment

There are a number of pharmacological and psychotherapeutic techniques used to treat Bipolar Disorder. Hospitalisation may be required especially with the manic episodes present in Bipolar I.

Because bipolar disorder is a lifelong and recurrent illness, people with the disorder need long term treatment to maintain control of bipolar symptoms. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity.

2.2.4.1 Medications

Some of the types of medications generally used to treat bipolar disorder are listed below:

2.2.4.1.1 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. The following medications are commonly used as mood stabilisers in bipolar disorder:

Lithium (sometimes known as Eskalith or Lithobid) was the first mood-stabilising medication approved by the U.S. Food and Drug Administration (FDA) in the 1970s for treatment of mania. It is often very effective in controlling symptoms of mania and preventing the recurrence of manic and depressive episodes.

Valproic acid or divalproex sodium (Depakote), approved by the FDA in 1995 for treating mania, is a popular alternative to lithium for bipolar disorder. It is generally as effective as lithium for treating bipolar disorder.

More recently, the anticonvulsant lamotrigine (Lamictal) received FDA approval for maintenance treatment of bipolar disorder.

Other anticonvulsant medications, including gabapentin (Neurontin), topiramate (Topamax), and oxcarbazepine (Trileptal) are sometimes prescribed. No large studies have shown that these medications are more effective than mood stabilisers.

2.2.4.1.2 Atypical Antipsychotic Medications

These are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications. Atypical antipsychotic medications are called "atypical" to set them apart from earlier medications, which are called "conventional" or "first-generation" antipsychotics.

Olanzapine (Zyprexa), when given with an antidepressant medication, may help relieve symptoms of severe mania or psychosis. Olanzapine can be used for maintenance treatment of bipolar disorder as well, even when a person does not have psychotic symptoms.

Aripiprazole (Abilify), like olanzapine, is approved for treatment of a manic or mixed episode.

Aripiprazole is also used for maintenance treatment after a severe or sudden episode. As with olanzapine, aripiprazole also can be injected for urgent treatment of symptoms of manic or mixed episodes of bipolar disorder.

Quetiapine (Seroquel) relieves the symptoms of severe and sudden manic episodes. In that way, quetiapine is like almost all antipsychotics. In 2006, it became the first atypical antipsychotic to also receive FDA approval for the treatment of bipolar depressive episodes.

Risperidone (Risperdal) and ziprasidone (Geodon) are other atypical antipsychotics that may also be prescribed for controlling manic or mixed episodes.

2.2.4.1.3 Antidepressant Medications

These are sometimes used to treat symptoms of depression in bipolar disorder. People with bipolar disorder who take antidepressants often take a mood stabiliser too, because taking only an antidepressant can increase a person's risk of switching to mania or hypomania, or of developing rapid cycling symptoms.

2.2.4.2 Psychotherapy

In addition to medication, psychotherapy, or “talk” therapy, can be an effective treatment for bipolar disorder. It can provide support, education, and guidance to people with bipolar disorder and their families. Some psychotherapy treatments used to treat bipolar disorder include:

Cognitive behavioural therapy (CBT) helps people with bipolar disorder learn to change harmful or negative thought patterns and behaviours.

Family-focused therapy 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.

Interpersonal and social rhythm 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.

Psychoeducation teaches 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. It is usually done in a group. Psychoeducation may also be helpful for family members and caregivers.

2.2.5 Prognosis

For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Quite often, medication is needed to enable this. Persons with bipolar disorder may have periods of normal or near normal functioning

between episodes. Ultimately one's prognosis depends on many factors, several of which are within the control of the individual. Such factors may include: the right medicines, with the right dose of each; comprehensive knowledge of the disease and its effects; a positive relationship with a competent medical doctor and therapist; and good physical health, which includes exercise, nutrition, and a regulated stress level.

A naturalistic study from first admission for mania or mixed episode (representing the hospitalised and therefore most severe cases) found that 50% achieved syndromal recovery (no longer meeting criteria for the diagnosis) within six weeks and 98% within two years. 72% achieved symptomatic recovery (no symptoms at all) and 43% achieved functional recovery (regaining of prior occupational and residential status). However, 40% went on to experience a new episode of mania or depression within 2 years of syndromal recovery, and 19% switched phases without recovery (Tohen et. al., 2003).

2.3 LET US SUM UP

The characteristic feature of bipolar disorders, sometimes referred to as manic-depressive disorders, or bipolar affective disorders, is that the person experiences episodes of both depression and mania or hypomania. Mania is a state of elevated mood flight of ideas, and increased psychomotor activity. A hypomanic episode is referred to a period of manic behaviour that is not extreme enough to greatly impair function. In DSM-IV-TR and ICD-10 bipolar disorder is conceptualised as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists three specific subtypes and one for non-specified:

Bipolar I Disorder

Bipolar I Disorder

Cyclothymia

Bipolar Disorder NOS (Not Otherwise Specified)

Bipolar I Disorder is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. A person with bipolar disorder experiences episodes of mania and, usually, major depressive episodes as well.

Bipolar II Disorder is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes. Hypomanic episodes do not go to the full extremes of mania (*i.e.*, do not usually cause severe social or occupational impairment, and are without psychosis), and this can make Bipolar II more difficult to diagnose. Bipolar II disorder differs from Bipolar I in that – rather than experiencing one or more florid, dramatic manic episodes – the manic behaviour is present to a lesser degree. Cyclothymic disorder is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years.

However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder. Bipolar Disorder Not Otherwise Specified (BP-NOS) is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II.

The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with Bipolar I or II. However, the symptoms are clearly out of the person's normal range of behaviour

Although causes of bipolar disorder likely vary between individuals. But studies suggest that both biological and psychological factors seem to play a role in determining whether a person will develop symptoms of bipolar disorder. Studies conducted on the families of people diagnosed with bipolar disorder show that there is strong tendency for other family members also to have higher than expected risk for a mood disorder of some type including bipolar disorder. Twin studies have indicated a substantial genetic contribution, as well as environmental influence. The concordance rates for these disorders are much higher for identical twins than for fraternal twins. Evidence suggested that psychological factors play a significant role in the development and course of bipolar disorder, and that individual psychosocial variable may interact with genetic dispositions. There is fairly consistent evidence from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes, as they do for onsets and recurrences of unipolar depression.

There are a number of pharmacological and psychotherapeutic techniques used to treat bipolar disorder. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity.

Some of the types of medications generally used to treat bipolar disorder are:

(1) Mood stabilising medications are usually the first choice to treat bipolar disorder. Lithium, valproic acid or divalproex sodium are commonly used as mood stabilisers in bipolar disorder. (2) Atypical antipsychotic medications are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications. (3) Antidepressant medications are also used to treat symptoms of depression in bipolar disorder.

In addition to medication, psychotherapy, or "talk" therapy, can be an effective treatment for bipolar disorder. It can provide support, education, and guidance to people with bipolar disorder and their families.

For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Quite often, medication is needed to enable this.

2.4 UNIT END QUESTIONS

- 1) What do you mean by bipolar disorder? How does it differ from other mood disorders?
- 2) Discuss the symptoms of bipolar disorders in detail.
- 3) What is manic episode? Differentiate between manic and hypomanic episode.
- 4) Discuss the types of bipolar disorder. Differentiate between bipolar I disorder and bipolar II disorder.
- 5) Explain the causes of bipolar disorder.
- 6) Describe the treatment and prognosis of bipolar disorder.
- 7) Differentiate between bipolar disorder and other forms of depressive disorder.

2.5 GLOSSARY

- Antidepressant medication** : General term for a number of drugs used to relieve depression and to elevate mood.
- Antipsychotic medication** : Group of drugs used to treat patients who show severely disturbed behaviour and thought processes.
- Bipolar disorder** : Mood disorder in which a person experiences both manic and depressive episodes.
- Cognitive Behaviour therapy** : Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
- Cyclothymic disorder** : A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
- Depression** : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continues long afterwards.
- Depressive disorder** : Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
- Dizygotic twins** : Twins that develop from two separate eggs.
- Episodic (disorder)** : Term used to describe a disorder that tends to abate and to recur.
- Major depressive disorder** : A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.
- Mania** : Euphoric, hyperactive state in which an individual's judgment is impaired.
- Hypomania** : A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
- Hypomanic episode** : A distinct period of elevated expansive or irritable mood and other manic behaviours that is not severe enough to greatly impair social or occupational functioning and does not require hospitalisation.
- Lithium** : Chemical salt used in the treatment of bipolar disorder.

- Monozygotic twins** : Identical twins developed from one fertilised egg.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Stress** : Effects created within an organism by the application of a stressor.
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

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UNIT 3 OTHER MOOD DISORDERS: MOOD DISORDER DUE TO GENERAL MEDICAL CONDITION

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Mood Disorder Due to General Medical Condition
 - 3.2.1 Parkinson Disease
 - 3.2.2 Multiple Sclerosis
 - 3.2.3 Seizure Disorder
 - 3.2.4 Diabetes
 - 3.2.5 Parathyroid Disorder
 - 3.2.6 Thyroid Disorders
 - 3.2.7 Heart Disease
 - 3.2.8 HIV/AIDS
 - 3.2.9 Cancer
 - 3.2.10 Stroke
- 3.3 Let Us Sum Up
- 3.4 Unit End Questions
- 3.5 Glossary
- 3.6 Suggested Readings

3.0 INTRODUCTION

The depressive disorders are grouped under a category in the DSM-IV-TR called Mood Disorders. Included in this category are major depressive disorder, dysthymic disorder, bipolar disorder, cyclothymic disorder, mood disorder due a general medical condition and substance induced mood disorder. Two subtypes of mood disorders include seasonal affective disorder and postpartum depression, while premenstrual dysphoric disorder has been proposed as a diagnosis for further study. For each of these mood disorders there are specific criteria that a person's symptoms must meet in order to receive a diagnosis. Major depressive disorder, dysthymic disorder, bipolar disorder and cyclothymic disorder have been discussed in previous units. These disorders reflect a disturbance in mood or emotional reaction that is not due to any other physical or mental disorder. In the present unit we will discuss mood disorders that occur due to general medical condition such as cancer, diabetes, or a recent heart attack.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of mood disorder due to general medical condition;
- Describe the diagnostic criteria for mood disorder due to a general medical condition;

- Analyse the differences between mood disorder due to general medical condition and major depressive disorder; and
- Explain the some of the major medical conditions that induce mood disorder.

3.2 MOOD DISORDER DUE TO GENERAL MEDICAL CONDITION

It has been estimated that approximately one of every ten major depressive episodes is caused by medical illness, substance abuse, or medication used to treat another disorder (Clinton, 1993). Almost one of every four hospitalised medical patients has depressive symptoms (Moldin, et. al. 1993). Approximately 27–57% of patients with certain neurologic conditions (e.g., Parkinson’s disease, multiple sclerosis, Huntington’s disease, and epilepsy) develop symptoms of severe depression at some point during their illness. For medical conditions that do not directly affect the brain, prevalence rates appear to be more variable, ranging from less than 8% (for chronic renal disease), to 19% (for coronary artery disease, to 40% (for primary hypothyroidism).

The diagnostic criteria for mood disorder due to a general medical condition are less vigorous than those for the primarily psychiatric mood disorders and require only the presence of depressed mood/diminished enjoyment or elevated, expansive, or irritable mood (manic symptoms). Regarding the medical illness, the required signs, symptoms, and labouratory findings are simply those that, in conjunction with the clinical history, yield the medical diagnosis.

According to Diagnostic of Statistical Manual of Mental Disorders- Fourth Edition-Text Revised the diagnosis of mood disorder due to general medical condition is done when:

- a) the person has significant disturbance in mood that includes either (or both) of depressed mood or significantly reduced level of interest or pleasure in most or all activities, mood that is euphoric, heightened, or irritable,
- b) the person’s symptoms are directly related to the presence of a medical condition,
- c) another disorder does not better explain the mood disturbance,
- d) the mood condition is not present only when a person is delirious
- e) the symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) further specifies that the psychiatric presentation of a medical illness is classified as “the presence of mental symptoms that are judged to be the direct physiological consequences of a general medical condition.”

Therefore, understanding common psychiatric symptoms and the medical diseases that may cause or mimic them is of utmost importance. Failure to identify these underlying causal medical conditions can be potentially dangerous because serious and frequently reversible conditions can be overlooked. Major Depressive, Manic, Mixed, and Hypomanic Episodes in Bipolar I Disorder must be distinguished from episodes of a Mood Disorder Due to a General Medical Condition.

The diagnosis is Mood Disorder Due to a General Medical Condition for episodes that are judged to be the direct physiological consequence of a specific general

medical condition (e.g., multiple sclerosis, stroke, hypothyroidism). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is diagnosed.

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve

- depressed mood
- markedly diminished interest or pleasure
- elevated, expansive, or irritable mood.

Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met.

The predominant symptom type may be indicated by using one of the following subtypes:

- With Depressive Features,
- With Major Depressive–Like Episode,
- With Manic Features, or
- With Mixed Features.

There must be evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition. The mood disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder with Depressed Mood that occurs in response to the psychosocial stress of having the general medical condition).

The diagnosis is also not made if the mood disturbance occurs only during the course of a delirium. The mood disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some cases, the individual may still be able to function, but only with markedly increased effort. In determining whether the mood disturbance is due to a general medical condition, the clinician must first establish the presence of a general medical condition.

Further, the clinician must establish that the mood disturbance is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the mood disturbance and the general medical condition is etiological, several considerations provide some guidance in this area.

One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the mood disturbance.

A second consideration is the presence of features that are atypical of primary Mood Disorders (e.g., atypical age at onset or course or absence of family history).

Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of mood symptoms can provide a useful context in the assessment of a particular situation.

In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Mood Disorder, a Substance-Induced Mood Disorder, or other primary mental disorders (e.g., Adjustment Disorder).

The symptoms of mood disorder due to a general medical condition are the same as during other types of depressions...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 experienced during mood disorder due to a general medical condition 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.

There are a large number of medical conditions which can cause mood disorder due to a general medical condition. Some of the major medical conditions which can cause a mood disorder due to a general medical condition are discussed below:

3.2.1 Parkinson's Disease

Parkinson's disease (PD) is a disorder characterised by movement abnormalities caused by degeneration of the neurons in the substantia nigra. It is estimated that Parkinson disease affects approximately 1% of the population older than 50 years and up to 2.5% of the population older than 70 years (National Institute of Neurological Disorders and Stroke, 2001). The hallmark clinical signs of the motor triad include (1) tremor (2) rigidity, and (3) bradykinesia/akinesia.

The classic motor signs may not be obvious early in the disease, and patients may initially present with only clinical signs of depression. Thus, PD may be misdiagnosed as a primary depressive illness, and concomitant depression may remain undiagnosed in a patient with PD. Similarities in the symptoms common to major depression and PD include impaired memory/concentration, slowed psychomotor activity, restricted affect, and fatigue or decreased energy.

The true prevalence of depression among people with Parkinson's disease is difficult to determine because there are no standardised assessment tools designed to evaluate depressive symptoms in the context of this illness. However, it is estimated to be quite common as many as half of people with Parkinson's may suffer from depression (Working Group Meeting of National Institute of Neurological Disorders and Stroke, National Institute on Aging, and National Institute of Mental Health 2001).

Most treatments are aimed at patients' specific symptoms. PD must be considered in the differential diagnosis of an elderly person presenting with first-time depression/anxiety symptoms, especially when the patient appears depressed but denies experiencing a depressed mood. In addition, treatment of symptoms can be complicated in patients with PD because antiparkinsonian drugs may exacerbate psychiatric symptoms and vice versa. Consultation with both neurologists and psychiatrists can be helpful when treating these patients.

3.2.2 Multiple Sclerosis

Multiple Sclerosis is a disorder characterised by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the central nervous system. Prevalence is estimated to be approximately 50 cases per 100,000 people. It is more common in women than in men and usually manifests in persons aged 20-40 years. This disorder is a highly variable illness, with differences among patients and changes within a patient over time.

Behavioural symptoms in multiple sclerosis include personality changes and feelings of euphoria and/or depression. Approximately 25% of patients experience euphoria that is different from hypomania and is characterised by an unusually cheerful mood. One study showed a 2-fold increase in the lifetime risk of bipolar disease in MS patients. Major depression is very common in individuals with MS; indeed, 25-50% of patients experience major depression after the onset of multiple sclerosis. Suicide attempts are common in patients with multiple sclerosis who are depressed. For treating the depression a combination of psychotherapy and medication is found to be useful.

3.2.3 Seizure Disorder

Epilepsy is one of the most common chronic neurologic diseases, affecting approximately 1% of the US population. Approximately 30-50% of patients with a seizure disorder have psychiatric symptoms sometime during the course of their illness. Psychiatric symptoms can be viewed in the context of their time relationship with the seizures as preictal, ictal, postictal, and interictal. Two major categories of seizures are partial and generalised. Increased psychopathology has been associated with different features (eg, seizure phenomenology, brain pathology, antiepileptic drug use, psychosocial factors). Generalised seizures simultaneously involve both cerebral hemispheres, with classic symptoms of loss of consciousness, tonic-clonic movements or limbs, tongue biting, and incontinence. While the diagnosis is relatively straightforward, the postictal state is characterised by a gradual clearing of delirium lasting a few minutes to many hours. Partial seizures have focal signs and symptoms resulting from electrical discharge in a limited site in one brain hemisphere. Simple partial seizures occur without any impairment of consciousness and usually stem from primary motor, sensory, or visual cortical regions. Complex partial seizures are associated with impairment of consciousness and usually originate from a focus in the temporal lobe. In such seizures, psychiatric signs abound, with memory dysfunction, affective auras, perceptual changes (eg, hallucinations), and depersonalisation.

An estimated average, 10% of patients with complex partial epilepsy have psychotic symptoms such as paranoid ideation, thought disorder, and hallucinations. Mood disorder symptoms occur most often with foci in the temporal lobe. Statistically, 30% of patients with epilepsy have a history of suicide attempts, which attests to the importance of diagnosing depression in these patients. Fear and anxiety are the most common ictal affective states. As far as treatment of depression of patients suffering from seizure disorder is concerned psychotherapy such as cognitive behavioural therapy is generally recommended.

3.2.4 Diabetes

Diabetes is a disorder that impairs the way the body uses digested food for growth and energy. Most of the food we eat is broken down into glucose, a form of sugar that provides the main source of fuel for the body. After digestion, glucose passes into the bloodstream. Insulin helps glucose get into cells and converts glucose to

energy. Without insulin, glucose builds up in the blood, and the body loses its main source of fuel.

In **type 1 diabetes**, the immune system destroys the insulin-producing beta cells of the pancreas. This form of diabetes usually strikes children and young adults, who require daily or more frequent insulin injections or using an insulin pump for the rest of their lives.

Type 2 diabetes, which accounts for about 90 percent of diabetes cases in the United States, is most common in adults over age 40. Affecting about 6 percent of the U.S. population, this form of diabetes is strongly linked with obesity (more than 80 percent of people with type 2 diabetes are overweight), inactivity, and a family history of diabetes. People with type 2 diabetes first develop insulin resistance, a disorder in which muscle, fat, and liver cells do not use insulin properly. At first, the pancreas produces more insulin, but gradually its capacity to secrete insulin falters, and the timing of insulin secretion becomes abnormal. After diabetes develops, insulin production continues to decline.

Studies suggest that individuals with depression may be at greater risk for developing diabetes. Treatment for depression helps people manage symptoms of both diseases, thus improving the quality of their lives. Studies further suggest that diabetes doubles the risk of depression compared to those without the disorder (Anderson, Lustman, & Clouse, 2000). The chances of becoming depressed increase as diabetes complications worsen. Research shows that depression leads to poorer physical and mental functioning, so a person is less likely to follow a required diet or medication plan. Treating depression with psychotherapy, medication, or a combination of these treatments can improve a patient's well-being and ability to manage diabetes.

3.2.5 Parathyroid Disorder

Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia. Hyperparathyroidism is more common in women than in men. Annual incidence is in the 0.1% range and affects up to 0.2% of the population older than 60 years.

Hyperparathyroidism is frequently associated with significant psychiatric symptoms, which are caused by the resultant hypercalcemia and can precede other somatic manifestations of the illness. Patients can experience delirium, sudden dementia, depression, anxiety, psychosis, apathy, stupor, and coma.

Hypomagnesemia also occurs in association with hyperparathyroidism, usually after surgical removal of a parathyroid adenoma.

In hypoparathyroidism, expect to find low serum levels of calcium and magnesium. Patients most commonly experience delirium but may also experience psychosis, depression, or anxiety

3.2.6 Thyroid Disorders

Hyperthyroidism is a common clinical condition caused by excess thyroid hormone. Because this disorder is so common, a high index of clinical awareness for thyroid disease and its complications is needed in any patient who presents with psychiatric symptoms. Always include evaluations of thyroid-stimulating hormone (TSH [thyrotropin]) and free thyroxine (T4) levels in the medical workup of patients presenting with psychiatric symptoms for the first time. Graves disease is the most common

cause in the population. Some evidence indicates that stress can precipitate Graves disease and aggravate treated disease. Toxic nodular goiter is most prevalent in the elderly population.

Similar to patients with hyperthyroidism, those with hypothyroidism often develop symptoms of depression and anxiety. The usual clinical features include apathy, psychomotor retardation, depression, and poor memory. However, when hypothyroidism develops rapidly, the psychiatric features are usually delirium and psychosis, which has also been termed myxedema madness. Subclinical hypothyroidism can have either mild or no symptoms of thyroid hormone deficiency. It is fairly common and affects 5-10% of the population, mainly women, and occurs in 15-20% of women older than 45 years.

3.2.7 Heart Disease

Heart disease includes two conditions called angina pectoris and acute myocardial infarction (“heart attack”). Like any muscle, the heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged and cannot supply enough blood to the heart, the result is coronary heart disease. If not enough oxygen-carrying blood reaches the heart, the heart may respond with pain called angina. When the blood supply is cut off completely, the result is a heart attack. The part of the heart that does not receive oxygen begins to die, and some of the heart muscle may be permanently damaged.

Research over the past two decades has shown that people with heart disease are more likely to suffer from depression than otherwise healthy people, and conversely, that people with depression are at greater risk for developing heart disease. (Nemeroff, Musselman, & Evans, 1998). Furthermore, people with heart disease who are depressed have an increased risk of death after a heart attack compared to those who are not depressed (Frasure-Smith, Lesperance, & Talajic, 1995). Depression may make it harder to take the medications needed and to carry out the treatment for heart disease. Treatment for depression helps people manage both diseases, thus enhancing survival and quality of life.

Depression and anxiety disorders may affect heart rhythms, increase blood pressure, and alter blood clotting. They can also lead to elevated insulin and cholesterol levels. These risk factors, with obesity, form a group of signs and symptoms that often serve as both a predictor of and a response to heart disease. Furthermore, depression or anxiety may result in chronically elevated levels of stress hormones, such as cortisol and adrenaline. As high levels of stress hormones are signaling a “fight or flight” reaction, the body’s metabolism is diverted away from the type of tissue repair needed in heart disease.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. Persons with heart disease, their families and friends, and even their physicians and cardiologists (physicians specialising in heart disease treatment) may misinterpret depression’s warning signs, mistaking them for inevitable accompaniments to heart disease. Symptoms of depression may overlap with those of heart disease and other physical illnesses.

Effective treatment for depression is extremely important, as the combination of depression and heart disease is associated with increased sickness and death. Specific types of psychotherapy can relieve depression. Exercise is another potential pathway to reducing both depression and risk of heart disease.

Treatment for depression in the context of heart disease should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the heart disease treatment. Medications for depression can take several weeks to work and may need to be combined with ongoing psychotherapy.

3.2.8 HIV/AIDS

AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. HIV is spread most commonly by having sex with an infected partner. HIV also is spread through contact with infected blood, which frequently occurs among injection drug users who share needles or syringes contaminated with blood from someone infected with the virus. Women with HIV can transmit the virus to their babies during pregnancy. Many people do not develop any symptoms when they first become infected with HIV. As the immune system deteriorates, a variety of complications start to take over. For many people, their first sign of infection is large lymph nodes or "swollen glands" that may be enlarged for more than three months.

Although as many as one in three persons with HIV may suffer from depression (Bing, Burnam, & Longshore, 2010) the warning signs of depression are often misinterpreted. People with HIV, their families and friends, and even their physicians may assume that depressive symptoms are an inevitable reaction to being diagnosed with HIV. But depression is a separate illness that can and should be treated, even when a person is undergoing treatment for HIV or AIDS. Some of the symptoms of depression could be related to HIV, specific HIV-related disorders, or medication side effects. However, a skilled health professional will recognise the symptoms of depression and inquire about their duration and severity, diagnose the disorder, and suggest appropriate treatment.

3.2.9 Cancer

Development of different varieties of cancer is subject of psychological influences. This has resulted in the development of a new field called psychoncology (Anderson, 1992; Antoni and Goodkin, 1991). Oncology means study of cancer. Cancer can develop in any organ or tissue of the body. Normally, cells grow and divide to produce more cells only when the body needs them. But sometimes cells keep dividing when new cells are not needed. These extra cells may form a mass of tissue, called a tumor. Tumors can be either benign (not cancerous) or malignant (cancerous).

Cells in malignant tumors are abnormal and divide without control or order, resulting in damage to the organs or tissues they invade. Cancer cells can break away from a malignant tumor and enter the bloodstream or the lymphatic system. This is how cancer spreads, or "metastasizes," from the original cancer site to form new tumors in other organs. The original tumor, called the primary cancer or primary tumor, is usually named for the part of the body in which it begins. Research has enabled many men, women, and young people with cancer to survive.

About 9 million Americans of all ages are living with a current or past diagnosis of cancer. People who face a cancer diagnosis will experience many stresses and emotional upheavals. Fear of death, interruption of life plans, changes in body image and self-esteem. Still, not everyone with cancer becomes depressed. Depression can exist before the diagnosis of cancer or may develop after the cancer is identified. While there is no evidence to support a causal role for depression in cancer, depression may impact the course of the disease and a person's ability to participate in treatment.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. While studies generally indicate that about 25 percent of people with cancer have depression, only 2 percent of cancer patients in one study were receiving antidepressant medication (Regier, Narrow, & Rae, (1993).

Treatment for depression can help people feel better and cope better with the cancer treatment process. There is evidence that the lifting of a depressed mood can help enhance survival (McDaniel, Musselman, & Porter, 1995). Treatment for depression in the context of cancer should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the cancer treatment. This is especially important when antidepressant medication is needed or prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specialises in treating individuals with depression and co-occurring physical illnesses such as cancer may be available.

3.2.10 Stroke

A stroke occurs when the blood supply to part of the brain is suddenly interrupted or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding brain cells. Stroke can occur in all age groups and can happen even to fetuses still in the womb; but three-fourths of strokes occur in people 65 years of age and over, making stroke a leading cause of disability in older persons. Of the 600,000 American men and women who experience a first or recurrent stroke each year, an estimated 10 to 27 percent experience major depression. An additional 15 to 40 percent experience some symptoms of depression within two months following a stroke (Depression Guideline Panel, 1993).

The average duration of major depression in people who have suffered a stroke is just under a year. Among the factors that affect the likelihood and severity of depression following a stroke are the location of the brain lesion, previous or family history of depression, and pre-stroke social functioning. Stroke survivors who are also depressed, particularly those with major depressive disorder, may be less compliant with rehabilitation, more irritable, and may experience personality change.

Treatment for depression in stroke survivors should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the post-stroke rehabilitation and treatment. This is especially important when antidepressant medication is prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specialises in treating individuals with depression and co-occurring physical illnesses such as stroke may be available.

3.3 LET US SUM UP

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. This is diagnosed when: the patient is depressed or has lost interest in activities, there is significant impairment in important areas of functioning, the patient's mood is elevated, expansive or irritable, or a combination of these, there is medical evidence to support the diagnosis, the change in mood is not due to stress of the medical condition. the change in mood doesn't occur only in delirium.

Mood disorder due to a general medical condition is characterised by depressions 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...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 experienced during mood disorder due to a general medical condition 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.

Depressive disorder due to a general medical condition affects a lot of people. There are many medical conditions which can cause mood disorder due to a general medical condition. These include:

- 1) Parkinson disease
- 2) Multiple sclerosis
- 3) Seizure disorder
- 4) Diabetes
- 5) Parathyroid disorder
- 6) Thyroid disorders
- 7) Heart disease
- 8) HIV/AIDS
- 9) Cancer
- 10) Stroke

Treatment for mood disorder due to a general medical condition must include treatment of the medical condition causing the depression or manic disorder. Psychiatric and psychological treatment 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.

3.4 UNIT END QUESTIONS

- 1) Explain the nature of mood disorder due to general medical condition.
- 2) Discuss the diagnostic criteria for mood disorder due to a general medical condition.
- 3) Differentiate between mood disorder due to general medical condition and major depressive disorder.
- 4) Explain the etiology of bipolar disorder.
- 5) Discuss any three of the major medical conditions which may cause mood disorder.

3.5 GLOSSARY

- Antidepressant medication** : General term for a number of drugs used to relieve depression and to elevate mood.
- Bipolar disorder** : Mood disorder in which a person experiences both manic and depressive episodes.
- Cognitive Behaviour therapy** : Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
- Cyclothymic disorder** : A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
- Depression** : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
- Depressive disorder** : Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
- Diabetes** : Diabetes is a disorder that impairs the way the body uses digested food, especially glucose (a form of sugar), for growth and energy.
- Dizygotic twins** : Twins that develop from two separate eggs.
- Dysthymia** : A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
- Episodic (disorder)** : Term used to describe a disorder that tends to abate and to recur.
- HIV/AIDS** : AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers.
- Heart Disease** : Heart disease includes two conditions called angina pectoris and acute myocardial infarction ("heart attack"). Heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged and cannot supply enough blood to the heart, the result is coronary heart disease.
- Hypomania** : A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
- Major depressive disorder** : A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of

energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.

- Mania** : Euphoric, hyperactive state in which an individual's judgment is impaired.
- Monozygotic twins** : Identical twins developed from one fertilised egg.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Multiple sclerosis** : Multiple Sclerosis is a disorder characterised by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the central nervous system.
- Parathyroid disorder** : Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia.
- Parkinson disease** : Parkinson disease is a disorder characterised by movement abnormalities caused by degeneration of the neurons in the substantia nigra.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Seizure disorder** : A neurological disorder with symptoms of loss of consciousness, tonic-clonic movements or limbs, tongue biting, and incontinence. While the diagnosis is relatively straightforward, the postictal state is characterised by a gradual clearing of delirium lasting a few minutes to many hours.
- Stress** : Effects created within an organism by the application of a stressor.
- Stroke** : Stroke occurs when the blood supply to part of the brain is suddenly interrupted or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding brain cells.
- Thyroid disorders** : Hyperthyroidism is a clinical condition caused by excess thyroid hormone
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

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UNIT 4 SUBSTANCE INDUCED MOOD DISORDER

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Substance Induced Mood Disorder
 - 4.2.1 Psychoactive Substances and Levels of Involvement
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 - 4.2.5.1.6 Art and Music Therapies
- 4.3 Let Us Sum Up
- 4.4 Unit End Questions
- 4.5 Glossary
- 4.6 Suggested Readings

4.0 INTRODUCTION

When taking a drug or stopping a drug causes days or weeks of mood changes, the problem is called substance-induced mood disorder. Many medicines and illegal drugs can cause you to be depressed. The drugs make you feel sad, uninterested in daily events, and hopeless. You may also get manic symptoms. When you are manic you are overexcited, have too much energy, and have difficulty controlling your actions. If you were depressed or manic before beginning drug use and it worsens with drug use, it is not called substance-induced mood disorder. A Substance-Induced Mood Disorder is distinguished from Major Depressive, Manic, or Mixed Episodes by the fact that a substance (e.g., a drug of abuse, a medication, or

exposure to a toxin) is judged to be etiologically related to the mood disturbance. In the present unit we will discuss the etiology and symptoms substance-induced mood disorder. We will also discuss different types of substances and how these substances induce mood disorders during intoxication (i.e., while the individual is under the influence of the drug) or during withdrawal (i.e., after an individual stops using the drug).

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of substance induced mood disorder;
- Describe the diagnostic criteria of substance induced mood disorder;
- Elucidate the differences between due substance induced mood disorder and mood disorder due to general medical condition;
- Delineate the types of psychoactive drugs that may induce mood disorder; and
- Analyse the differences between substance induced mood disorders from a primary mood disorder.

4.2 SUBSTANCE INDUCED MOOD DISORDER

According to the Diagnostic and Statistical Manual of Mental Disorders- Forth Edition, Text Revised (DSM-IV- TR) substance induced mood disorder is diagnosed when

A: A person has significant disturbance in mood that includes either (or both)

Depressed mood or significantly reduced level of interest or pleasure in most or all activities.

Mood that is euphoric, heightened, or irritable.

B: The person's symptoms develop during (or within four weeks of) intoxication or withdrawal, or are caused by medication use.

C: Another disorder does not better explain the mood disturbance.

D: The mood condition is not present only when a person is delirious.

E: The symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.

Before we start our discussion about the substance induced mood disorder, it is important to explain what we mean by psychoactive substance and also the level of involvement, that is which are substance use, intoxication, abuse and dependence.

4.2.1 Psychoactive Substances and Level of Involvement

Psychoactive substances are chemical compounds that are ingested to alter mood or behaviour. Thus all types of drugs, illegal (e.g. cocaine and heroin) as well as legal and safe drugs (e.g. alcohol, nicotine, and the caffeine in the coffee, soft drinks, and chocolate) are included in this category, as the safe drugs also affect mood and behaviour: they can be addictive, and they account for more health problems than those of illegal drugs (Durand & Barlow, 2000).

Substance use is the ingestion of psychoactive substances in moderate amounts that does not significantly interfere with social, educational, or occupational functioning.

Substance intoxication refers to the physiological reaction to ingested substances—drunkenness, or getting high. Intoxication depends on which drug is taken, how much is ingested, and the person’s individual biological reaction. Intoxication may cause impaired judgment, mood changes, and lowered motor ability.

Substance abuse is defined in terms of how significantly the substances interfere with the user’s life. If substances disrupt user’s education, job, or relationship with others, and put him in physically dangerous conditions, he would be considered a drug abuser.

As far as *substance dependence* is concerned the term substance dependence or “addiction” is generally used to describe people who seem to be enslaved by drugs. Substance dependence is the person is dependent on drug or drugs, requires greater and greater amounts to experience the same effect (tolerance), and will respond physically in a negative way when the substance is no longer ingested (withdrawal) (Kalant, 1989).

Depending on their effect, psychoactive substances are grouped into four categories as depressants, stimulants, opiates, and hallucinogens.

Depressant are those substances which result in behavioural sedation. They include alcohol and the sedative (calming), hypnotic (sleep-inducing), and anxiolytic (anxiety-reducing) drugs in the families of barbiturates (e.g., seconal) and benzodiazepines (e.g., valium and halcion).

Stimulant substances are the substances which cause the person to be more active and alert, and can elevate mood. Amphetamines, cocaine, nicotine, and caffeine are included in this group. Heroin, opium, codeine, and morphine are included in the *opiates* group. Their major effect is to temporarily produce analgesia (reduce pain) and euphoria, while marijuana and LSD are included in *hallucinogens* category. These substances alter sensory perception and can produce delusions, paranoia, and hallucinations.

All psychoactive drugs cause alterations in normal mood. The severity and manner of these alterations are regulated by preexisting mood states, type and amount of drug used, chronicity of drug use, route of drug administration, current psychiatric status, and history of mood disorders. Substance induced mood alterations can result from acute and chronic drug use as well as from drug withdrawal. Moreover, substance induced mood disorders, most notably acute depression lasting from hours to days, can result from sedative-hypnotic intoxication. Similarly, prolonged or sub-acute withdrawal, lasting from weeks to months, can cause episodes of depression, sometimes accompanied by suicidal ideation or attempts.

Also, stimulant withdrawal may provoke episodes of depression lasting from hours to days, especially following high-dose, chronic use. Stimulant-induced episodes of mania may include symptoms of paranoia lasting from hours to days. Overall, the process of addiction per se can result in bio-psychosocial disintegration, leading to chronic dysthymia or depression often lasting from months to years.

Since symptoms of mood disorders that accompany acute withdrawal syndromes are often the result of the withdrawal, adequate time should elapse before a definitive diagnosis of an independent mood disorder is made. Conditions that most frequently cause and mimic mood disorders and symptoms must be differentiated from substance

induced conditions. When symptoms persist or intensify, they may represent substance induced mood disorders.

Transient dysphoria following the cessation of stimulants can mimic a depressive episode. According to the DSM-IV, if symptoms are intense and persist for more than a month after acute withdrawal, a depressive episode can be diagnosed. Symptoms of shorter duration can be diagnosed as a substance-induced mood disorder.

4.2.2 Diagnostic Features of Substance Induced Mood Disorder

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiological effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Alternately, an individual may have a mood disorder coexisting with a substance abuse disorder.

Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. When the symptoms like those seen in a manic, mixed, or hypomanic episode may be part of an intoxication with or withdrawal from a drug of abuse. It is diagnosed as a Substance Induced Mood Disorder (e.g., euphoric mood that occurs only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, with Manic Features, with Onset During Intoxication).

Symptoms like those seen in a manic or mixed episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy, such episodes are also diagnosed as Substance Induced Mood Disorder. The essential feature of Substance Induced Mood Disorder is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a substance.

Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication or withdrawal), the disturbance may involve depressed mood or markedly diminished interest or pleasure or elevated, expansive, or irritable mood.

Although the clinical presentation of the mood disturbance may resemble that of a major depressive, manic, mixed, or hypomanic episode, the full criteria for one of these episodes need not be met. The predominant symptom type may be indicated by using one of the following subtypes: (i) With Depressive Features (ii) With Manic Features (iii) With Mixed Features.

The diagnosis is not made if the mood disturbance occurs only during the course of a delirium. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some cases, the individual may still be able to function, but only with markedly increased effort.

A Substance Induced Mood Disorder is distinguished from a primary Mood Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of dependence, abuse, intoxication, or withdrawal.

Substance-Induced Mood Disorders arise only in association with intoxication or

withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence.

4.2.3 Substances and Accompanying Psychiatric Symptoms

Following is an overview of the most common classes of substances of abuse and the accompanying psychiatric symptoms seen in intoxication, withdrawal, or chronic use.

4.2.3.1 Depressants

Depressants decrease the activities of central nervous system. Their principal effect is to reduce the levels of physiological arousal and help us relax. Some of the most commonly used depressants are discussed below:

4.2.3.1.1 Alcohol

Alcohol is a depressant, but its initial effect is an apparent stimulation. The chronic abuse of alcohol can be associated with significant depression that may, by symptoms alone, be indistinguishable from idiopathic major depression.

However, of patients with depressive disorder from alcohol dependence who are monitored for 2-4 weeks without alcohol, more than 50% have full remission of symptoms without additional intervention for the depressive symptoms. A minority of patients, usually those with more severe symptoms, has a continued depressive syndrome despite sobriety and requires additional treatment (Schuckit, Smith, Danko, 2007).

In most people, moderate to heavy consumption is associated with euphoria, mood lability, decreased impulse control, and increased social confidence (i.e., getting high). Such symptoms might even appear “hypomanic.” However these often are followed with next-day mild fatigue, nausea, and dysphoria (i.e., a hangover). In a person who has many life stresses, losses, and struggles, which is often the case as addiction to alcohol proceeds, the mood lability and lowered impulse control can lead to increased rates of violence toward others and self. Prolonged drinking increases the incidence of dysphoria, anxiety, and such violence potential. Symptoms of alcohol withdrawal include agitation, anxiety, tremor, malaise, hyperreflexia (exaggeration of reflexes), mild tachycardia (rapid heartbeat), increasing blood pressure, sweating, insomnia, nausea or vomiting, and perceptual distortions.

Following acute withdrawal (a few days), some people will experience continued mood instability, fatigue, insomnia, reduced sexual interest, and hostility for weeks, so called “protracted withdrawal.” Differentiating protracted withdrawal from a major depression or anxiety disorder is often difficult. More severe withdrawal is characterised by severe instability in vital signs, agitation, hallucinations, delusions, and often seizures. The best predictor of whether this type of withdrawal may happen again is if it happened before. Alcohol-induced deliriums after high-dose drinking are characterised by fluctuating mental status, confusion, and disorientation and are reversible once both alcohol and its withdrawal symptoms are gone, while by definition, alcohol dementias are associated with brain damage and are not entirely reversible even with sobriety.

4.2.3.1.2 Sedative, Hypnotic, and Anxiolytic Substances

Acute intoxication with sedative, hypnotic, and anxiolytic drugs like barbiturates (which include Amytal, Seconal, and Nembutal) and benzodiazepines (which include

Valium, Xanax, Rohypnol, and Halcion) is similar to what is experienced with alcohol. The DSM-IV criteria for sedative, hypnotic, and anxiolytic drug use disorder do not differ substantially from those alcohol disorders.

Withdrawal symptoms are also similar to alcohol and include mood instability with anxiety and/or depression, sleep disturbance, autonomic hyperactivity, tremor, nausea or vomiting, and, in more severe cases, transient hallucinations or illusions and grand mal seizures. There are reports of a protracted withdrawal syndrome characterised by anxiety, depression, paresthesias, perceptual distortions, muscle pain and twitching, tinnitus, dizziness, headache, derealisation and depersonalisation, and impaired concentration.

Most symptoms resolve within weeks, though some symptoms, such as anxiety, depression, tinnitus (ringing in the ears), and paresthesias (sensations such as prickling, burning, etc.), have been reported to last a year or more after withdrawal in rare cases. No chronic dementia-type syndromes have been characterised with chronic use; however, many people who use sedatives chronically seem to experience difficulty with anxiety symptoms, which respond poorly to other anxiety treatments.

4.2.3.2 Stimulants

Stimulants are the most commonly used psychoactive substances. Included in this group are caffeine (in coffee, chocolate, and many soft drinks), nicotine (in tobacco products) amphetamines, and cocaine. In contrast to depressant substances, stimulants make us more alert and energetic. Several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) and/or anxiety, but which may not meet the symptom severity criteria to qualify as DSM-IV Major Depression. Some of the common stimulant substances are given below:

4.2.3.2.1 Amphetamine

Amphetamines are CNS stimulants and initially cause feelings of increased well-being, energy, and concentration. However, amphetamine abuse can cause development of psychotic symptoms. A low dose of amphetamines can induce feelings of elation and vigor and can reduce fatigue. We literally feel “up”. However, after a period of elation we come back down and “Crash”, Feeling depressed and tired. DSM-IV diagnostic criteria for amphetamine intoxication include significant behavioural symptoms, such as euphoria or affective blunting, changes in sociability, interpersonal sensitivity, anxiety, tension, anger, stereotyped behaviours, impaired judgment, and impaired social or occupational functioning.

Ecstasy (methylenedioxymethamphetamine [MDMA]), a designer drug synthetically derived from amphetamine, is often used in the context of large and energetic parties (raves) and at nightclubs. Initially, it causes mild euphoria, increased energy, and increased libido. Tolerance develops rapidly. Depression, anxiety, and psychosis have also been described with regular use, and some of the symptoms persist for months after cessation of use.

4.2.3.2.2 Caffeine

Caffeine is the most common psychoactive substances. It is used nearly by all people. It is called “gentleman stimulant” because it is thought to be the least harmful of all the addictive drugs. This drug is found in tea, coffee, many cola drinks, and in cocoa products. As with other stimulants, regular use of caffeine can result in

tolerance and dependence on the drug (Strain, Mumford, Silverman, & Griffiths, 1992). When denied the morning tea or coffee the person experiences headaches, drowsiness, and a general unpleasant mood characterised by withdrawal symptoms. When consumed in large quantities, caffeine can cause mild to moderate anxiety, though the amount of caffeine that leads to anxiety varies. Caffeine is also associated with an increase in the number of panic attacks in individuals who are predisposed to them.

4.2.3.2.3 Cocaine

Cocaine is derived from the leaves of coca plant. Cocaine is a powerful stimulant initially causing euphoria and increased alertness and energy. Cocaine can also make the heart beat more rapidly and irregularly, and it can have fatal consequences, depending on the person's physical condition and the amount of drug ingested. As the high wears off, the user may develop symptoms of anxiety and depression, often with drug craving. With continued regular use, symptoms of psychosis develop with hallucinations and frank paranoid delusions. The psychiatric presentation can appear similar to that observed in patients with chronic amphetamine abuse.

4.2.3.2.4 Nicotine

Clients who are dependent on nicotine are more likely to experience depression than people who are not addicted to it; however, it is unclear how much this is cause or effect. In some cases, the client may use nicotine to regulate mood. Whether there is a causal relationship between nicotine use and the symptoms of depression remains to be seen. At present, it can be said that many persons who quit smoking do experience both craving and depressive symptoms to varying degrees, which are relieved by resumption of nicotine use.

Mild to moderate intoxication from cocaine, methamphetamine, or other stimulants is associated with euphoria, and a sense of internal well-being, and perceived increased powers of thought, strength, and accomplishment. In fact, low to moderate doses of amphetamines may actually increase certain test-taking skills temporarily in those with attention deficit disorders and even in people who do not have attention deficit disorders. However, as more substance is used and intoxication increases, attention, ability to concentrate, and function decrease. As dosage of increases cocaine and methamphetamines, the chances of impulsive dangerous behaviours, which may involve violence, promiscuous sexual activity, and others, also increases. Many who become chronic heavy users go on to experience temporary paranoid delusional states.

Even with several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) and/or anxiety, but which may not meet the symptom severity criteria to qualify as DSM-IV Major Depression. These anhedonic states can persist for weeks. As mentioned above, heavy, long-term amphetamine use appears to cause long-term changes in the functional structure of the brain, and this is accompanied by long-term problems with concentration, memory, and, at times, psychotic symptoms. Month-long methamphetamine binges followed by week- or month-long alcohol binges, a not uncommon pattern, might appear to be "bipolar" disorder if the drug use is not discovered.

4.2.3.3 Opioids

The word opiate refers to the natural chemicals in the opium poppy that have a narcotic effect (they relieve pain and induce sleep). The broader term opioids refer

to the family of substances that include natural opiates, synthetic variations, and the comparable substances that occur naturally in brain (Jaffe, Knapp, & Ciraulo, 1997). Morphine, codeine, and heroin are produced from opium poppies. Opiates are analgesics (relieve pain). It also induces euphoria, drowsiness, and slowed breathing. Opioid intoxication is characterised by intense euphoria and well-being. Withdrawal results in agitation, severe body aches, gastrointestinal symptoms, dysphoria, and craving to use more opioids.

Symptoms during withdrawal vary, that is, some will become acutely anxious and agitated, while others will experience depression and anhedonia. Even with abstinence, anxiety, depression, and sleep disturbance can persist for weeks as a protracted withdrawal syndrome. Again, differentiating this from major depression or anxiety is difficult and many clinicians may just treat the ongoing symptom cluster. For many people who become opioid dependent, and then try abstinence, these ongoing withdrawal symptoms are so powerful that relapse occurs even with the best of treatments and client motivation. For these clients, opioid replacement therapy (methadone, suboxone, etc.) becomes necessary and many times life saving. There are reports of an atypical opioid withdrawal syndrome characterised by delirium after abrupt cessation of methadone. Such clients do not appear to have the autonomic symptoms typically seen in opioid withdrawal. Long-term use of opioids is commonly associated with moderate to severe depression.

4.2.3.4 Hallucinogens

Hallucinogens are the substances that can lead to hallucinogen use disorder. Ingestion of these substances change the way the user perceives the world. Sight, sound feelings, taste, and even smell are distorted. They produce visual distortions and frank hallucinations. Some people who use hallucinogens experience a marked distortion of their sense of time and feelings of depersonalisation.

Hallucinogens may also be associated with drug-induced panic, paranoia, and even delusional states in addition to the hallucinations. Hallucinogen hallucinations usually are more visual (e.g., enhanced colors and shapes) as compared to schizophrenic-type hallucinations, which tend to be more auditory (e.g., voices). The hallucinogens can cause a state of intoxication called hallucinosis, which has several features in common with psychotic disorders and a few in common with mood disorders.

4.2.3.4.1 Marijuana

Marijuana is an important drug of hallucinogens category. It is the name given to the dried parts of the Cannabis or hemp plant. Cannabis grows wild throughout the tropical and temperate regions of the world, which accounts for one of its nicknames, “weed.” Marijuana, which has sedative and psychedelic properties, can cause a variety of mood-related effects. In the individual who has not developed tolerance for the drug’s effects, high doses of marijuana can cause acute marijuana intoxication with euphoria or agitation, grandiosity, and “profound thoughts.” Together, these symptoms can mimic mania. Because marijuana is only slowly eliminated from the body, chronic use results in relatively constant marijuana levels. Thus, daily marijuana use can be, in effect, a chronic marijuana intoxication. This state may include symptoms of chronic, low-grade lethargy and depression, perhaps accompanied by anxiety and memory loss. Phencyclidine (PCP) intoxication can include symptoms of euphoria, mania, or depression, in addition to sensory dissociation, hallucinations, delusions, psychotic thinking, altered body image, and disorientation.

Other hallucinogens such as LSD (lysergic acid diethylamide) and drugs such as MDMA (methylenedioxy-methamphetamine, or Ecstasy) and MDA (methylenedioxyamphetamine) may precipitate intense emotional experiences that may be perceived as positive or negative mood states by the drug user. These experiences are affected greatly by personality, preexisting mood state, personal expectations, drug dosage, and environmental surroundings.

While many users will experience sensory and perceptual distortions, some will experience euphoric religious or spiritual experiences that may resemble aspects of a manic or psychotic episode. Others may have a deeply troubling introspective experience, causing symptoms of depression.

4.2.4 Prognosis

Depressive or manic symptoms induced by substance intoxication usually subside once the substance responsible is eliminated. Symptoms persist depending on the half-life of the substances (i.e., how long it takes the before the substance is no longer present in an individual's system). Symptoms, therefore, can persist for hours, days, or weeks after a substance is last used. Mood disorder symptoms induced by substances sometimes do not disappear, even although the substance inducing them has been eliminated. More intensive treatment for the mood disorder symptoms would be necessary and should include a combination of medication and behavioural therapy.

4.2.5 Treatment

A multidisciplinary approach to the treatment of substance induced mood disorder appears to be most effective because the problems are often complex, requiring flexibility and individualisation of treatment procedures (Margolis and Zweben, 1998). Treatment programme objectives usually include detoxification, physical rehabilitation, control over drug-abuse behaviour, and development of an individual's realisation that he /she can cope with the problems of living and lead a much more rewarding life without drugs. Psychotherapy along with some medications is effectively used for treating substance induced mood disorder.

4.2.5.1 Psychotherapy

Substance-induced mood disorder can be successfully treated with either group or individual psychotherapy. Therapy in a group with other people having substance abuse problems is often very helpful. Groups have the benefit of connecting with others having similar problems, thereby overcoming feelings of isolation. Groups provide clients with an opportunity to learn from, and give support to, each other. They can instill hope, encourage information sharing and provide role models. The group allows clients to find new ways to express themselves, or to review old conflicts in a supportive environment. In some cases, medicines for depression or anxiety may help the client to stop substance abuse. Following therapies have been found effective to cure substance induced mood disorder:

4.2.5.1.2 Aversion Therapy

Aversion therapy is based on conditioning model. In aversion therapy substance use is paired with something extremely unpleasant, such as brief electric shock or feelings of nausea. For example, a person might be offered a drink of alcohol, and receive a painful shock when the glass reaches his lips.

4.2.5.1.2 Covert Sensitisation

In covert sensitisation therapy a negative association is to be made by imagining unpleasant scenes. The Client might picture himself to snort cocaine and then becoming violently ill.

4.2.5.1.3 Contingency Management

In contingency management therapy the clinician and client together select the behaviour that the client needs to change and decide on the reinforcers that will reward reaching certain goals. In a study of cocaine abusers, clients received things like lottery tickets for having cocaine-negative urine specimens (Higgins et.al., 1993).

4.2.5.1.4 Biofeedback

Through biofeedback the client learns to control body functions such as muscle tension or brain wave patterns. Biofeedback can help with tension, anxiety, and concentration, and indirectly may help to avoid a return to substance abuse. Biofeedback should be done only in addition to psychotherapy.

4.2.5.1.5 Relaxation Therapies

Learning special relaxation methods can help with mood problems or substance abuse, along with psychotherapy. Yoga and meditation may also be helpful.

4.2.5.1.6 Art and Music Therapies

Some people find art and music therapy, along with psychotherapy, to be helpful.

4.3 LET US SUM UP

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiological effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. When the symptoms like those seen in a manic, mixed, or hypomanic episode may be part of an intoxication with or withdrawal from a drug of abuse, it is diagnosed as a Substance-Induced Mood Disorder.

Psychoactive substances are chemical compounds that are ingested to alter mood or behaviour. Thus all types of drugs, illegal (e.g. cocaine and heroin) as well as legal and safe drugs (e.g. alcohol, nicotine, and the caffeine in the coffee, soft drinks, and chocolate) are included in this category. There are four levels of substance involvement: Substance use, Substance intoxication, substance abuse, and substance dependence or intoxication

Depending on their effect psychoactive substances are grouped into four categories as depressants, stimulants, opiates, and hallucinogens. Depressant are those substances which result in behavioural sedation. They include alcohol and the sedative (calming), hypnotic (sleep-inducing), and anxiolytic (anxiety-reducing) drugs in the families of barbiturates (e.g., seconal) and benzodiazepines (e.g., valium and halcion). Stimulant substances are the substances which cause the person to be more active and alert, and can elevate mood. Amphetamines, cocaine, nicotine, and caffeine are included in this group. Heroin, opium, codeine, and morphine are included in the opiates group. Their major effect is to temporarily produce analgesia (reduce pain) and euphoria, while marijuana and LSD are included in hallucinogens category. These

substances alter sensory perception and can produce delusions, paranoia, and hallucinations.

A Substance-Induced Mood Disorder is distinguished from a primary Mood Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of dependence, abuse, intoxication, or withdrawal. Substance-Induced Mood Disorders arise only in association with intoxication or withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence.

Treatment of substance induced mood disorder usually include detoxification, physical rehabilitation, control over drug-abuse behaviour, and development of an individual's realisation that he /she can cope with the problems of living and lead a much more rewarding life without drugs. Psychotherapy along with some medications is effectively used for treating substance induced mood disorder.

4.4 UNIT END QUESTIONS

- 1) What do you mean by substance-induced mood disorder? Explain in the light of DSM-IV-TR.
- 2) Explain the diagnostic criteria of substance-induced mood disorder.
- 3) Differentiate between mood disorder due substance-induced mood disorder and mood disorder due to general medical condition.
- 4) What do you mean by psychoactive drugs? Discuss the types of psychoactive drugs.
- 5) Distinguish substance induced mood disorder from a primary mood disorder.

4.5 GLOSSARY

Abstinence	: Refraining altogether from the use of an addictive substance.
Addiction	: Pathological need for a substance. It may also involve the abuse of substance or the excessive ingestion of high caloric food, or gambling.
Alcoholism	: Dependence on alcohol that seriously interferes with life adjustment.
Amphetamine	: Drug that produces a psychologically stimulating and energizing effect.
Anhedonia	: Inability to experience pleasure or joy.
Barbiturates	: Synthetic drugs that act as depressants to calm induce sleep.
Biofeedback	: Treatment technique in which a person is taught to control his/her own physiological processes formerly thought to be involuntary.
Bipolar disorder	: Mood disorder in which a person experiences both manic and depressive episodes.

- Caffeine** : Most common psychoactive drug of dependence found in many commonly available drinks and foods.
- Cocaine** : Stimulating and pain reducing psychoactive drug.
- Cyclothymic disorder** : A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
- Delirium** : Condition characterised by a confused mental state, usually resulting from shock or fever, accompanied by alterations in attention and by hallucinations, delusions, and incoherence.
- Depressants** : Psychoactive drugs that decrease the activities of central nervous system.
- Depression** : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
- Depressive disorder** : Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
- Detoxification** : Treatment directed toward ridding the body of alcohol or other drugs.
- Drug Abuse** : Use of a drug to the extent that it interferes with health and/or occupation or adjustment.
- Drug addiction (Dependence)** : Physiological and/or psychological dependence on a drug.
- Dysthymia** : A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
- Episodic (disorder)** : Term used to describe a disorder that tends to abate and to recur.
- Hallucination** : False perception; things seen or heard that are not real or present.
- Hallucinogens** : Drugs which cause to induce hallucinations.
- Heroin** : Psychoactive drug derived from morphine, that relieves pain but more intense and addictive than morphine.
- Hypomania** : A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
- Lability** : Instability, particularly with regard to affect.

- LSD (Lysergic acid diethylamide)** : The most potent of hallucinogens. It is so strong that it can produce intoxication with an amount smaller than that a grain of salt.
- Major depressive disorder** : A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.
- Mania** : Euphoric, hyperactive state in which an individual's judgment is impaired.
- Marijuana** : Mild hallucinogenic substance derived from hemp plant.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Nicotine** : Addictive alkaloid that is the chief active ingredient in tobacco and a drug of dependence.
- Opium** : Narcotic drug that leads to physiological dependence and the development of tolerance, derivatives are morphine, heroin, and codeine.
- Psychoactive drugs** : Drugs that affect mental functioning.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Stimulants** : Drugs that tend to increase feelings of alertness, reduce feelings of fatigue, and enable a person to stay awake over sustained periods of time.
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

4.6 SUGGESTED READINGS

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UNIT 1 SCHIZOPHRENIA: ETIOLOGY, NEUROCOGNITIVE FUNCTIONING AND INTERPERSONAL ASPECTS

Structure

- 1.0 Introduction
- 1.1 Objectives
- 1.2 Concept and Description of Schizophrenia
 - 1.2.1 Incidence of Schizophrenia
 - 1.2.2 Characteristics of Schizophrenia
 - 1.2.3 Onset of Schizophrenia
 - 1.2.4 Neurocognitive Explanation of Schizophrenia
 - 1.2.5 Comorbidity
 - 1.2.6 Tests for Schizophrenia
- 1.3 Etiology of Schizophrenia
 - 1.3.1 Genetics
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 - 1.3.3 Fetal Growth
 - 1.3.4 Hypoxia
 - 1.3.5 Other Factors
 - 1.3.6 Infections
 - 1.3.7 Childhood Antecedents
- 1.4 Substance Use
 - 1.4.1 Cannabis
 - 1.4.2 Amphetamines and other Stimulants
 - 1.4.3 Hallucinogens
 - 1.4.4 Tobacco Use
 - 1.4.5 Social Adversity
 - 1.4.6 Urban City
 - 1.4.7 Close Relationships
 - 1.4.8 Environment
 - 1.4.9 Instinct for Self Respect
 - 1.4.10 Personality Type
- 1.5 Neurocognitive Functioning Aspects in Schizophrenia
- 1.6 Treatment of Schizophrenia
 - 1.6.1 Hospitalisation
 - 1.6.2 Medication
 - 1.6.3 Cognitive Behavioural Therapy
 - 1.6.4 Metacognitive Training
 - 1.6.5 Family Therapy or Education
- 1.7 Unit End Questions
- 1.8 Let Us Sum Up
- 1.9 Suggested Readings

1.0 INTRODUCTION

This unit deals with schizophrenia and focuses on neuropsychological aspects. The unit begins with the concept and description of schizophrenia and provides the incidence and prevalence rate of schizophrenia in India and abroad. It explains the characteristics of schizophrenia and indicates the onset of the disorder to be in the teens and adolescent years to young adulthood. The comorbidity of certain other disorders along with schizophrenia are discussed. Then we present a few important tests to clearly diagnose the schizophrenic disorder. The next section deals with the etiology of schizophrenia in which we discuss the role of genetics, prenatal factors, fetal growth abnormalities, lack of oxygen and some of the important childhood antecedents. The causes then present the role of substance use in schizophrenia and in this we discuss the role of cannabis, amphetamines, hallucinogens, tobacco etc. Social factors, urbanicity, relationships within family and personality types are also considered as causes in the onset of schizophrenia. Then we discuss the neurocognitive functioning of schizophrenia followed by treatment of schizophrenic disorder. The treatment includes hospitalisation, medicines, cognitive behaviour therapy and family therapy.

1.1 OBJECTIVES

On completing this unit, you will be able to :

- Define schizophrenia and describe the characteristic features;
- Explain the etiology of schizophrenia;
- Describe how substance use cause schizophrenic symptoms;
- Explain the neurocognitive functioning aspects of schizophrenia;
- Elucidate the treatment of schizophrenia; and
- Analyse the importance of various psychological therapies.

1.2 CONCEPT AND DESCRIPTION OF SCHIZOPHRENIA

Schizophrenia is a severe, psychotic disorder. People who have it may hear voices, see things that are not there or believe that others are reading or controlling their minds. In men, symptoms usually start in the late teens and early 20s. They include hallucinations, such as visual hallucinations (seeing things which are not there), and auditory hallucinations (hearing things which are not present), and delusions such as false beliefs that others are plotting or conspiring against them while actually there is no such thing.

1.2.1 Incidence of Schizophrenia

The incidence of schizophrenia is estimated to be one percent to one and a half percent of the U.S. population being diagnosed with it over the course of their lives. In India, according to NIMH, it is estimated that 4.3 to 8.7 million people (a rough estimate based on the population) suffer from schizophrenia. According to Barua et al (2006), the prevalence rate of schizophrenia in India is 1%.

1.2.2 Characteristics of Schizophrenia

While there is no known cure for schizophrenia, it is a treatable disorder. Most of those afflicted by schizophrenia respond to drug therapy, and many are able to lead productive

and fulfilling lives. It is characterised by a constellation of distinctive and predictable symptoms. The symptoms that are most commonly associated with the disease are called positive symptoms, that denote the presence of grossly abnormal behaviour. These include thought disorder, delusions, and hallucinations.

Thought disorder is the diminished ability to think clearly and logically. Often it is manifested by disconnected and nonsensical language that renders the person with schizophrenia incapable of participating in conversation, contributing to the person's alienation from his family, friends, and society.

Delusions are common among individuals with schizophrenia. An affected person may believe that he is being conspired against (called "paranoid delusion"). Broadcasting, describes a type of delusion in which the individual with this illness believes that his thoughts can be heard by others.

Hallucinations are perceptual disorder, in which one could suffer from auditory hallucination, visual hallucination and tactile hallucination. Sometime the voices that the schizophrenic hears may describe the person's actions, warn him of danger or tell him what to do. At times the individual may hear several voices carrying on a conversation.

Less obvious than the "positive symptoms" but equally serious are the deficit or negative symptoms that represent the absence of normal behaviour. These include flat or blunted affect (i.e. lack of emotional expression), apathy, and social withdrawal).

Schizophrenia is a mental disorder characterised by a disintegration of thought processes and of emotional responsiveness. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganised speech and thinking, and it is accompanied by significant social or occupational dysfunction.

1.2.3 Onset of Schizophrenia

It can affect anyone at any point in life, it is somewhat more common in those persons who are genetically predisposed to the disorder. The first psychotic episode generally occurs in late adolescence or early adulthood. The probability of developing schizophrenia as the offspring of two parents, neither of whom has the disease, is 1 percent. The probability of developing schizophrenia as the offspring of one parent with the disease is approximately 13 percent. The probability of developing schizophrenia as the offspring of both parents with the disease is approximately 35%. Persons with schizophrenia develop the disease between 16 and 25 years of age.

This disorder has its onset around adolescent years to 20s to early 30s. This disorder makes the person behave in the weirdest manner that persons with this disorder are also stigmatized. As generally thought to be, schizophrenia is not a split personality, it is a rare and very different disorder. Like cancer and diabetes, schizophrenia has a biological basis. It is not caused by bad parenting or personal weaknesses.

Onset is uncommon after age 30, and rare after age 40. In the 16-25 year old age group, schizophrenia affects more men than women. In the 25-30 year old group, the incidence is higher in women than in men.

The onset of symptoms typically occurs in young adulthood, with a global lifetime prevalence of about 0.3–0.7%. Diagnosis is based on observed behaviour and the patient's reported experiences.

1.2.4 Neurocognitive Explanations of Schizophrenia

Increasingly, neuro cognitive paradigms are used to study patients with schizophrenia.

With such paradigms, the cognitive abnormalities in schizophrenia are characterised by means of experimental and clinical tests. These techniques have indicated that some types of cognitive impairment are not only reliably present in schizophrenia, but are also central and enduring features of the disorder. This focuses on certain recent advances in

- i) characterising the precise nature of cognitive impairments in schizophrenia,
- ii) understanding the implications of these for treatment, given the course and relationship to outcome of these variables, and
- iii) on novel applications of neuro cognitive approaches to the genetics of schizophrenia.

1.2.5 Comorbidity

Genetics, early environment, neurobiology, and psychological and social processes appear to be important contributory factors; some recreational and prescription drugs appear to cause or worsen symptoms. Current research is focused on the role of neurobiology, although no single isolated organic cause has been found.

The many possible combinations of symptoms have triggered debate about whether the diagnosis represents a single disorder or a number of discrete syndromes. Despite the etymology of the term from the Greek roots *skhizein* (to split) and *phrēn, phren-* (mind), schizophrenia does not imply a “split mind” and it is not the same as dissociative identity disorder, also known as “multiple personality disorder” or “split personality” a condition with which it is often confused in public perception.

The disorder is thought mainly to affect cognition, but it also usually contributes to chronic problems with behaviour and emotion. People with schizophrenia are likely to have additional (comorbid) conditions, including major depression and anxiety disorders. The lifetime occurrence of substance abuse is almost 50%. Social problems, such as long-term unemployment, poverty and homelessness, are common. The average life expectancy of people with the disorder is 12 to 15 years less than those without, the result of increased physical health problems and a higher suicide rate (about 5%).

It is possible that nearly every cognitive function of a schizophrenic patient is impaired, and to an equivalent degree three functions play a role that is early descriptions of the clinical phenomenology of schizophrenia emphasized impairment of volitional attention. This clinical observation has been amply supported by many years of experimental study with the use of a wide variety of tasks.

1.2.6 Tests for Schizophrenia

Recent models have sharpened the lines between selective attention, shifting attention, and biasing for and encoding relevant target information. We investigate some of these functions by examining three tasks, viz.,

- i) the Continuous Performance Test (CPT),
- ii) the Covert Visual Orienting test, and the
- iii) Stroop Test.

The classic test of selective attention is the Stroop color word task, in which a word (e.g., red) can be printed in incongruent colors (e.g., green). Depending on instructions, the task is either to name the actual word or name the ink color in which the word is written.

The attentional task requires the subject to focus selectively on one dimension of the stimulus and ignore or inhibit contextually inappropriate response tendencies. Normal

subjects are slowed when they have to name a color of ink that is incongruent with the word because they have to inhibit their over learned tendency of reading the word.

Schizophrenic patients may have differential problems on this task in reaction time or accuracy, a finding that has been taken to suggest that they have disproportionate difficulty in inhibiting over learned tendencies (of reading the word), and may be susceptible to failure in conditions of cognitive conflict more generally, because they are unable to use the contextual information appropriately.

Secondly Memory impairment is often the most striking feature of neuro cognitive impairment in schizophrenia. Newer work has sought to determine if patients with schizophrenia have qualitative abnormalities in specific stages of mnemonic processing. Toward this end, Elvevaag and colleagues conducted an encoding study in which subjects had to state whether the letter *a* was present in a word (shallow level) or make a decision as to whether the word represented a living thing or not (deep level).

Much previous work has demonstrated that words are recalled better when they are encoded deeply. Preliminary results indicated that although patients' performance was worse than that of controls, they showed the same benefit of deep encoding. In other words, although impairment in any given cognitive process may exact only a small cost in social and vocational functioning, a constellation of impairments may be disabling and result in the emergence of psychosis. Thus, understanding the genetic architecture of individual processes may well be critical.

Self Assessment Questions

1) Define schizophrenia and bring out its important features.

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2) What is the prevalence and incidence rate of schizophrenia?

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3) Describe the onset of schizophrenia.

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4) Give the neurocognitive explanations of schizophrenia.

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5) What is meant by comorbidity? What are the disorders associated with schizophrenia?

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6) Describe the tests for schizophrenia.

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1.3 ETIOLOGY OF SCHIZOPHRENIA

The causes of schizophrenia have been the subject of much debate, with various factors proposed and discounted or modified. The language of schizophrenia research under the medical model is scientific. Such studies suggest that genetics, prenatal development, early environment, neurobiology and psychological and social processes are important contributory factors.

Current psychiatric research into the development of the disorder is often based on a neurodevelopmental model (proponents of which see schizophrenia as a syndrome. However, schizophrenia is diagnosed on the basis of symptom profiles. Neural correlates do not provide sufficiently useful criteria “Current research into schizophrenia has remained highly fragmented, much like the clinical presentation of the disease itself”

1.3.1 Genetics

Genetic vulnerability and environmental factors can act in combination to result in diagnosis of schizophrenia. Research suggests that genetic vulnerability to schizophrenia is multi factorial, caused by interactions of several genes.

Both individual twin studies and meta analyses of twin studies estimate the heritability of risk for schizophrenia to be approximately 80%. 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. Also the variants in genes are generally within the range of normal human variation and have low risk associated with them each individually. Some interact with each other and with environmental risk factors and that they may not be specific to schizophrenia.

1.3.2 Prenatal

It is well established that obstetric complications or events are associated with an increased chance of the child later developing schizophrenia, although overall they constitute a non specific risk factor with a relatively small effect.

Obstetric complications occur 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. However, the effect is not large. Explanations have included a greater prevalence of viral infections at that time, or a greater likelihood of vitamin D deficiency. A similar effect (increased likelihood of being born in winter and spring) has also been found with other, healthy populations, such as chess players.

1.3.3 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. In addition, the majority of birth cohort studies have failed to find a link between schizophrenia and low birth weight or other signs of growth retardation.

1.3.4 Hypoxia

It has been hypothesized since the 1970s that brain hypoxia (low oxygen levels) before, at or immediately after birth may be a risk factor for the development of schizophrenia.

Hypoxia is now being demonstrated as relevant to schizophrenia in animal models, molecular biology and epidemiology studies. One study in Molecular Psychiatry was able to differentiate 90% of schizophrenics from controls based on hypoxia and metabolism.

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. 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.

Although most studies have interpreted hypoxia as causing some form of neuronal dysfunction or even subtle damage, it has been suggested that the physiological hypoxia that prevails in normal embryonic and fetal development, or pathological hypoxia or ischemia, may exert an effect by regulating or deregulating genes involved in neurodevelopment.

1.3.5 Other Factors

There is an emerging literature on a wide range of prenatal risk factors, such as prenatal stress, intrauterine (in the womb) malnutrition, and prenatal infection. Increased paternal age has been linked to schizophrenia, possibly due to “chromosomal aberrations and mutations of the aging germline.”

Maternal-fetal rhesus or genotype incompatibility has also been linked, via increasing the risk of an adverse prenatal environment. Also, in mothers with schizophrenia, an increased risk has been identified via a complex interaction between maternal genotype,

maternal behaviour, prenatal environment and possibly medication and socio-economic factors.

There may be an association between celiac disease (gluten intolerance) and schizophrenia in a small proportion of patients, though large randomized controlled trials and epidemiological studies will be needed before such an association can be confirmed.

Withdrawal of gluten from the diet is an inexpensive measure which may improve the symptoms in a small ($\leq 3\%$) number of schizophrenic patients.

1.3.6 Infections

Numerous viral infections, in utero or in childhood, have been associated with an increased risk of later developing schizophrenia.

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. This result was corroborated by a later British study of the same pandemic, but not by a 1994 study of the pandemic in Croatia. A Japanese study also found no support for a link between schizophrenia and birth after an influenza epidemic.

Polio, measles, varicella-zoster, rubella, herpes simplex virus type 2, maternal genital infections, Borna disease virus, and more recently *Toxoplasma gondii*, have been correlated with the later development of schizophrenia. Psychiatrists E. Fuller Torrey and R.H. Yolken have hypothesized that the latter, a common parasite in humans, contributes to some, if not many, cases of schizophrenia.

1.3.7 Childhood Antecedents

In general, the antecedents of schizophrenia are subtle and those who will go on to develop schizophrenia do not form a readily identifiable subgroup, which would lead to identification of a specific cause. 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.

1.4 SUBSTANCE USE

The relationship between schizophrenia and drug use is complex, meaning that a clear causal connection between drug use and schizophrenia has not been found. 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.

1.4.1 Cannabis

There is some evidence that cannabis use can contribute to schizophrenia. Some studies suggest that cannabis is neither a sufficient nor necessary factor in developing schizophrenia, but that cannabis may significantly increase the risk of developing schizophrenia and may be, among other things, a significant causal factor. Nevertheless, some previous research in this area has been criticised as it has often not been clear whether cannabis use is a cause or effect of schizophrenia. To address this issue, a recent review of studies from which a causal contribution to schizophrenia can be assessed has suggested that cannabis statistically doubles the risk of developing schizophrenia on the individual level, and may, assuming a causal relationship, be responsible for up to 8% of cases in the population.

1.4.2 Amphetamines and other Stimulants

As amphetamines trigger the release of dopamine and excessive dopamine function is believed to be responsible for many symptoms of schizophrenia (known as the dopamine hypothesis of schizophrenia), amphetamines may worsen schizophrenia symptoms. In addition, amphetamines are known to cause a stimulant psychosis in otherwise healthy individuals that superficially resembles schizophrenia, and may be misdiagnosed as such by some healthcare professionals.

1.4.3 Hallucinogens

Drugs such as ketamine, PCP, and LSD have been used to mimic schizophrenia for research purposes. Using LSD and other psychedelics as a model has now fallen out of favour with the scientific research community, as the differences between the drug induced states and the typical presentation of schizophrenia have become clear. The dissociatives ketamine and PCP, however, are still considered to produce states that are remarkably similar however, and are considered to be even better models than stimulants since they produce both positive and negative symptoms.

1.4.4 Tobacco Use

People with schizophrenia tend to smoke significantly more tobacco than the general population. The rates are exceptionally high amongst institutionalised patients and homeless people. In a UK census from 1993, 74% of people with schizophrenia living in institutions were found to be smokers. A 1999 study that covered all people with schizophrenia in Nithsdale, Scotland found a 58% prevalence rate of cigarette smoking, to compare with 28% in the general population.

Despite the higher prevalence of tobacco smoking, people diagnosed with schizophrenia have a much lower than average chance of developing and dying from lung cancer. While the reason for this is unknown, it may be because of a genetic resistance to the cancer, a side effect of drugs being taken, or a statistical effect of increased likelihood of dying from causes other than lung cancer.

A 2003 study of over 50,000 Swedish conscripts found that there was a small but significant protective effect of smoking cigarettes on the risk of developing schizophrenia later in life. While the authors of the study stressed that the risks of smoking far outweigh these minor benefits, this study provides further evidence for the 'self-medication' theory

of smoking in schizophrenia and may give clues as to how schizophrenia might develop at the molecular level.

1.4.5 Social Adversity

The chance of developing schizophrenia has been found to increase with the number of adverse social factors (e.g. indicators of socio-economic disadvantage or social exclusion) 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. There is some evidence that adversities may lead to cognitive biases and/or altered dopamine neurotransmission, a process that has been termed “sensitisation”.

Specific social experiences have been linked to specific psychological mechanisms and psychotic experiences in schizophrenia. In addition, structural neuroimaging studies of victims of sexual abuse and other traumas have sometimes reported findings similar to those sometimes found in psychotic patients, such as thinning of the corpus callosum, loss of volume in the anterior cingulate cortex, and reduced hippocampal volume.

1.4.6 Urban City

A particularly stable and replicable finding has been 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.^[115] 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 urbanized environments, a significant proportion of which is likely to be described as schizophrenia.

1.4.7 Close Relationships

Evidence is consistent that negative attitudes from others increase the risk of schizophrenia relapse, in particular critical comments, hostility, authoritarian, and intrusive or controlling attitudes (termed ‘high expressed emotion’ by researchers).

1.4.8 Environment

Pollack and Malzberg studied 175 patients of this disease and reached to the conclusion that environment plays a bigger part in creating this disease than does heredity, and so psychologist today refutes the importance of environment in causing of schizophrenia.

1.4.9 Instinct for Self-respect

According to McDougall, when the patient is unable to find proper and desirable expression for his instincts of self-respect, he becomes a prey to schizophrenia.

1.4.10 Personality Type

It is the opinion of some psychologists that only a certain personality type is susceptible to schizophrenic tendencies, primarily the introverted type of individual. But this concept

of the personality type being more prone to schizophrenia has also not found much of the following among the thinkers.

1.5 NEUROCOGNITIVE FUNCTIONING ASPECTS IN SCHIZOPHRENIA

In neuropsychology, that is, inferring regional brain dysfunction based on poor performance on putatively localising neuropsychological tests. On the basis of such an approach, various authors have concluded that schizophrenia is characterised by cognitive test profiles indicative of dysfunction of the frontal lobe, temporal lobe, left or right hemisphere, basal ganglia, etc. This lack of consensus may reflect the heterogeneity of schizophrenia, and may also be a result of the relatively poor localising ability of many standard neuropsychological instruments. A variety of brain regions and associated cognitive functions have thus been implicated in the psychopathology that characterises schizophrenia.

In general, the strongest camps to emerge have been those that claim a disproportionate impairment of memory functioning and relatively selective executive dysfunction. Others have reported more widespread neuropsychological dysfunction. An extreme case is put by Meehl who stated that impaired cognitive test performance in patients with schizophrenia may be an epiphenomenon, for example, reflecting lack of motivation or distraction by hallucinations. In order to convince skeptics that the neuropsychological impairment is important, one would have to demonstrate a clear relationship between cognitive test performance and 'real-life' functional outcome.

An important review of this area was published by Green (1996), who evaluated studies that used cognitive measures as predictors and correlates of functional outcome. The most consistent finding to emerge was that verbal memory functioning was associated with all types of functional outcome. It was observed that verbal memory showed the greatest impairment in the meta-analysis whereas sustained attention or vigilance was found to be related to social problem solving and skill acquisition.

Interestingly, psychotic symptoms were not significantly associated with outcome measures in any of the studies that were reviewed. Green (1996) concluded that deficiencies in verbal memory and vigilance may prevent patients from attaining optimal adaptation and hence may act as rate limiting factors in terms of rehabilitation. It is interesting to observe that where the patients showed symptomatic improvement with clozapine treatment, there was no associated improvement in neuropsychological functioning.

Velligan et al (1997) confirmed a poor correlation between symptomatology and ability to perform daily living tasks. However, cognitive impairment predicted over 40% of the variance in scores on a functional needs assessment rating scale.

Addington & Addington (1999) used a novel video taped measure of interpersonal problem solving skills. In a study of 80 out patients with schizophrenia, they found that better cognitive flexibility and verbal memory were positively associated with interpersonal problem solving ability.

In summary all these studies taken together, strongly support the view that cognitive impairment in schizophrenia is directly related to social deficits and functional outcome for many patients.

Schizophrenia symptoms may more clearly relate to disordered patterns of information processing. Liddle & Morris (1991) conducted a seminal study in this area where they

assessed a group of patients with chronic schizophrenia using a battery of neuropsychological tests allegedly sensitive to frontal lobe dysfunction.

Signs and symptoms were clustered into three syndromes:

- psychomotor poverty,
- disorganisation and
- reality distortion.

Scores for the disorganisation syndrome were associated with impairment on tests that required the subject to inhibit a well established but inappropriate response. Ratings for the psychomotor poverty syndrome were found to be associated with slowness of mental activity.

More recently, Baxter & Liddle (1998) confirmed that the psychomotor poverty syndrome was associated with psychomotor slowing, and disorganisation was associated with impaired performance on the Stroop Attentional Conflict task, but not with other tests of cognitive inhibition.

This led the authors to conclude that the disorganisation syndrome might be associated with a specific difficulty in suppressing irrelevant verbal responses. This approach is appealing, because it tries to integrate neuropsychology with the clinical features of schizophrenia. Pursuing this approach to a more specific level would result in an attempt to explain specific signs or symptoms in terms of aberrant information processing.

As an illustration of this approach, McKenna (1991) proposed that delusions may arise as a consequence of a dysfunctional semantic memory system. Again, this hypothesis has intuitive appeal, as delusions by definition must represent false belief, knowledge. However, efforts to try to provide convincing evidence of a causal relationship between a specific neuropsychological abnormality and a particular sign or symptom have, as yet, been disappointing.

The resulting cognitive data were subjected to cluster analysis and five cognitive clusters emerged:

- selective executive dysfunction;
- normative function;
- executive and motor deficits;
- dementia/multi-focal disturbance; and
- relatively selective motor deficits.

Heinrichs & Awad (1993) proposed that cluster analysis of cognitive test data may thus have promise in reducing and clarifying the heterogeneity of schizophrenia, and concluded that several patterns of neurocognitive dysfunction may underlie schizophrenia, thus contributing to the heterogeneity of the illness and its variable functional outcome.

Frith (1992) has also proposed a fascinating theoretical model, where he relates specific signs and symptoms to particular information processing abnormalities. For example, he proposes that the inability to generate spontaneous (willed) intentions can lead to poverty of action, perseveration and inappropriate action. In contrast, the inability to monitor the beliefs and intentions of others can lead to delusions of reference, paranoid delusions, certain kinds of incoherence and third-person hallucinations.

Self Assessment Questions

1) Discuss the etiology of schizophrenia.

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2) What are the childhood antecedents that cause schizophrenia?

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3) Discuss social adversity and urbanicity as causes of schizophrenia.

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4) Discuss etiology of schizophrenia in terms of substance use.

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5) Describe the neurocognitive functioning aspects of schizophrenia.

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1.6 TREATMENT OF SCHIZOPHRENIA

1.6.1 Hospitalisation

Hospitalisation may occur with severe episodes of schizophrenia. This can be voluntary or (if mental health legislation allows it) involuntary (called civil or involuntary commitment). Long term inpatient stays are now less common due to the policy of deinstitutionalisation, yet we still have large number of patients admitted to institutions for longer period of stay .

Following (or in lieu of) a hospital admission, support services available can include drop in centers, visits from members of a community mental health team or Assertive Community Treatment team, supported employment and patient led support groups.

1.6.2 Medication

The mainstay of psychiatric treatment for schizophrenia is an antipsychotic medication. These can reduce the “positive” symptoms of psychosis. Most antipsychotics take around 7–14 days to have their main effect. Risperidone (trade name Risperdal) is a common atypical antipsychotic medication.

Treatment was revolutionized in the mid 1950s with the development and introduction of the first antipsychotic chlorpromazine. Others such as haloperidol and trifluoperazine soon followed.

Though expensive, the newer atypical antipsychotic drugs are usually preferred for initial treatment over the older typical antipsychotics; they are often better tolerated and associated with lower rates of tardive dyskinesia, although they are more likely to induce weight gain and obesity-related diseases. Of the atypical antipsychotics, olanzapine and clozapine are the most likely to induce weight gain. The effect is more pronounced if high doses of olanzapine are used.^[11] Smaller amounts of weight gain are induced by risperidone and quetiapine. Ziprasidone and aripiprazole are considered to be weight neutral antipsychotics.

It remains unclear whether the newer antipsychotics reduce the chances of developing neuroleptic malignant syndrome, a rare but serious and potentially fatal neurological disorder most often caused by an adverse reaction to neuroleptic or antipsychotic drugs. In combination with drug treatment, Psychosocial and Psychotherapy are also widely recommended and used in the treatment of schizophrenia.

1.6.3 Cognitive Behavioural Therapy (CBT)

CBT is used to target specific symptoms and improve related issues such as the therapy advanced from its initial applications in the mid 1990s, more recent reviews clearly show CBT is an effective treatment for the psychotic symptoms of schizophrenia.

Another approach is cognitive remediation therapy, a technique aimed at remediating the neurocognitive deficits sometimes present in schizophrenia. Based on techniques of neuropsychological rehabilitation, early evidence has shown it to be cognitively effective, resulting in the improvement of previous deficits in psychomotor speed, verbal memory, nonverbal memory, and executive function, such improvements being related to measurable changes in brain activation as measured by fMRI.

A similar approach known as cognitive enhancement therapy, which focuses on social cognition as well as neurocognition, has shown efficacy. CBT, an evidenced based practice, is now offered in community mental health agencies and hospitals.

1.6.4 Metacognitive Training

In view of a many empirical findings suggesting deficits of metacognition (thinking about one’s thinking, reflecting upon one’s cognitive process) in patients with schizophrenia, metacognitive training (MCT) is increasingly adopted as a complementary treatment approach.

MCT aims at sharpening the awareness of patients for a variety of cognitive biases (e.g. jumping to conclusions, attributional biases, over-confidence in errors), which are implicated in the formation and maintenance of schizophrenia positive symptoms (especially delusions), and to ultimately replace these biases with functional cognitive strategies.

1.6.5 Family Therapy or Education

This addresses the whole family system of an individual with a diagnosis of schizophrenia, has been consistently found to be beneficial, at least if the duration of intervention is longer term. Aside from therapy, the impact of schizophrenia on families and the burden on careers has been recognised, with the increasing availability of self help books on the subject.

There is also some evidence for benefits from social skills training, although there have also been significant negative findings. Some studies have explored the possible benefits of music therapy and other creative therapies.

1.7 UNIT END QUESTIONS

- 1) Define the etiology for schizophrenia from genetic, hereditary and biological point of view?
- 2) What are the environmental factors that cause schizophrenia?
- 3) How neurofunctioning deficits affects the life of individual and cause schizophrenia?
- 4) Discuss some of the treatment approaches to schizophrenia.
- 5) Discuss hospitalisation and medication as treatment techniques for schizophrenia.
- 6) Describe family therapy and education as important treatment programme for schizophrenia.

1.8 LET US SUM UP

In the lay imagination, schizophrenic patients experience problems in living because they are divided against themselves, out of touch with reality, and disorganised. The view of scientists, once not altogether different, has changed.

Not only have the symptoms been defined and codified, but the neurobiological underpinnings of the disorder have begun to be described. Emerging also is a view in which cognitive impairments may be a relatively central feature of the disorder.

Cognitive impairments are involved in the genetic etiology of schizophrenia. They seem enduring in that they are present for much of the clinical history and are associated with outcome. Cognitive impairments also may have a relatively well delineated profile in which executive, memory, and attentional deficits are prominent.

As explained, schizophrenia is very disabling. But as research progresses treatment is slowly but surely becoming more and more effective. Fewer patients have to be kept in hospitals and damage to the brain is not as severe.

Scientists discovered the effects of oestrogen, and learned it could be used as a medicine (though long term medications using oestrogen have side effects). They discovered age and gender differences, and learned that there were structural changes even at a cellular level.

In conclusion, though schizophrenia is disabling and sometimes even deadly, modern science has made many medical breakthroughs, and perhaps, if it is even possible, scientists may discover a complete or partial cure.

1.9 SUGGESTED READINGS

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UNIT 2 PARANOID AND DELUSIONAL DISORDER

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 Concept of Paranoia
 - 2.2.1 Definition of Paranoia
 - 2.2.2 Characteristic Features of Paranoia
 - 2.2.3 Symptoms of Paranoia
 - 2.2.4 Kinds of Paranoia
- 2.3 Causes of Paranoia
 - 2.3.1 Homosexual Fixation
 - 2.3.2 Feelings of Inferiority
 - 2.3.3 Emotional Complex
 - 2.3.4 Personality Type
 - 2.3.5 Heredity
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- 2.6 Treatment Approaches to Paranoia and Delusional Disorder
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 - 2.6.5 Combining Pharmacotherapy with Cognitive Therapy
 - 2.6.6 Psychotherapy
 - 2.6.7 Prognosis of Paranoia and Delusional Disorder
- 2.7 Let Us Sum Up
- 2.8 Unit End Questions
- 2.9 Suggested Readings and References

2.0 INTRODUCTION

This unit deals with paranoia and delusional disorder. We start with the concept of paranoia, define paranoia and describe the characteristic features of the same. Then we

delineate the symptoms of paranoia and the kinds of paranoia that are obtained in this disorder. This is followed by Causes of paranoia wherein we deal with various factors including feelings of inferiority, emotional complex, personality type, hereditary factors, biological factors, environmental and psychological factors. We also mention the medical causes, other mental illnesses and substance abuse as a cause. Then we discuss delusional disorder. Delineating the characteristic features of this disorder we deal with the various types of delusional disorders especially the grandiose, erotomaniac etc., and then deal with the motivated or defensive delusions. Since delusions are obtained in various other psychiatric disorders, these aspects are then considered followed by the treatment approach to the paranoia and delusional disorders. We end up with the prognosis of these disorders.

2.1 OBJECTIVES

On completing this unit, you will be able to:

- Define paranoia and delusional disorders;
- Enlist various types of paranoia delusional disorders;
- Elucidate the Symptoms and causes of the disorders;
- Explain the Interventional approaches for the delusional disorders; and
- Analyse the prognosis.

2.2 CONCEPT OF PARANOIA

2.2.1 Definition of Paranoia

Here the patient becomes a prey to premature delusion. According to Kraepelin, in the disease the cause of delusion is internal, and no hallucination is involved.

A paranoid disorder is a medical illness, which happens to affect the brain, and causes changes in thinking and feeling. It's nobody's fault when it develops, and certainly does not mean any personal weakness or failure. It's an illness just as diabetes and asthma are illnesses.

It's not all that uncommon, either Paranoia disorder consists of pervasive, long-standing suspiciousness and generalised mistrust of others. Those with the condition are hypersensitive, are easily slighted, and habitually relate to the world by vigilant scanning of the environment for clues or suggestions to validate their prejudicial ideas or biases.

Paranoid individuals are eager observers. They think they are in danger and look for signs and threats of that danger, disregarding any facts. They tend to be guarded and suspicious and have quite constricted emotional lives. Their incapacity for meaningful emotional involvement and the general pattern of isolated withdrawal often lend a quality of schizoid isolation to their life experience.

Despite the pervasive suspicions they have of others, patients are not delusional (except in rare, brief instances brought on by stress). Most of the time, they are in touch with reality, except for their misinterpretation of others' motives and intentions.

Paranoid Personality Disorder patients are not psychotic but their conviction that others are trying to "get them" or humiliate them in some way often leads to hostility and social isolation.

The word *paranoia* comes from the Greek word *indicating* madness and the term was used to describe a mental illness in which a delusional belief is the sole or most prominent feature. In original attempt at classifying different forms of mental illness, Kraepelin used the term *pure paranoia* to describe a condition where a delusion was present, but without any apparent deterioration in intellectual abilities and without any of the other features of dementia praecox, the condition later renamed “schizophrenia”.

Notably, in his definition, the belief does not have to be persecutory to be classified as paranoid, so any number of delusional beliefs can be classified as paranoia. For example, a person who has the sole delusional belief that he is an important religious figure would be classified by Kraepelin as having pure paranoia.

Even at the present time, a delusion need not be suspicious or fearful to be classified as paranoid. A person might be diagnosed as a paranoid schizophrenic without delusions of persecution, simply because their delusions refer mainly to themselves.

2.2.2 Characteristic Features of Paranoia

People with this disorder do not trust other people. In fact, the central characteristic of people is a high degree of mistrustfulness and suspicion when interacting with others. Even friendly gestures are often interpreted as being manipulative or malevolent.

Whether the patterns of distrust and suspicion begin in childhood or in early adulthood, they quickly come to dominate the lives of those suffering from the said disorder. Such people are unable or afraid to form close relationships with others. 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 do not have 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 this disorder 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. Individual counseling seems to work best but it requires a great deal of patience and skill on the part of the therapist. Phelan, M. Padraig, W. Stern, J (2000) paranoia and paraphrenia are debated entities that were detached from dementia praecox by Kraepelin, who explained paranoia as a continuous systematized delusion arising much later in life with no presence of either hallucinations or a deteriorating course, paraphrenia as an identical syndrome to paranoia but with hallucinations.

2.2.3 Symptoms of Paranoia

The main symptom is permanent delusion. It should be kept in mind that there is delusion in schizophrenia also but in that case it is not permanent or organised. In paranoia the symptoms of delusion appear gradually, and the patient is sentimental, suspicious, irritable,

introverted, depressed, obstinate, jealous, selfish, unsocial and bitter. Hence his social and family adjustment is not desirable, and while he has the highest desirable, the effort that he is prepared to expend is correspondingly little. Here the person does not acknowledge his own failures or faults, and by sometimes accepting certain qualities as belonging to himself, even when imaginary, he develops paranoia.

The “Diagnostic and Statistical Manual of Mental Disorders”, fourth edition (DSM-IV), the US manual of the mental health professional; lists the following symptoms for paranoid personality disorder:

- Preoccupied with unsupported doubts about friends or associates.
- Suspicious; unfounded suspicions; believes others are plotting against him/her.
- Perceives attacks on his/her reputation that are not clear to others, and is quick to counterattack.
- Maintains unfounded suspicions regarding the fidelity of a spouse or significant other.
- Reads negative meanings into innocuous remarks.
- Reluctant to confide in others due to a fear that information may be used against him/her.
- Self-referential thinking: Sensing that other people in the world are always talking about the paranoid individual.
- Thought broadcasting: The sense that other people can read the paranoid individual’s mind.
- Magical thinking: The sense that the paranoid individual can use his or her thoughts to influence other people’s thoughts and actions.
- Thought withdrawal: The sense that people are stealing the paranoid individual’s thoughts.
- Thought insertion: The sense that people are putting thoughts into the paranoid individual’s mind.
- Ideas of reference: The sense that the television and/or radio are specifically addressing the paranoid individual.

2.2.4 Kinds of Paranoia

Persecutory paranoia : This is the most prevalent type of paranoia, and in this patient makes himself believe that all those around him are his enemies, bent on harming him or even taking his life. In this delusion people of an aggressive temperament often turns dangerous killers.

Religious paranoia : Here the patients suffer from a permanent delusion of a primarily religious nature. He for example believes, that he is the messenger of God who has been sent to the world to propagate some religion.

Reformatory paranoia : In this the patient turns to considering himself a great reformer. He accordingly looks upon all those around him. As suffering from dangerous disease, and believes that he is their reformer and curator.

Erotic paranoia : Here the patient often tends to believe that some members of the family of the opposite sex, belonging to an illustrious family, want to marry him. Such people even write love letters and there by, cause much botheration to other people.

Litigious paranoia : In this kind the patient takes to feeling meaningless cases against other people and feels that people are linked together to bother him. Sometimes he, even tries to murder.

Hypochondrical paranoia : In this kind the patients believes that he is suffering from all kind of ridiculous diseases, and also that some other people are to blame for his suffering.

Self Assessment Questions

1) Define Paranoia and bring out the characteristic features of this disorder.

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2) What are the symptoms of paranoia?

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3) What are the different kinds of paranoia?

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2.3 CAUSES OF PARANOIA

2.3.1 Homosexual Fixation

According to Freud, the patient suffering from the disease has repressed his tendency to homosexual love to such an extent that he develops a fixation concerning it. Freud's view has been found correct in many cases, but it does not explain each and every case of the disease.

2.3.2 Feelings of Inferiority

Here the psychologists have found that the main cause of paranoia is a sense of inferiority that may be caused by a variety of condition such as failure, disgust, sense of guilt.

2.3.3 Emotional Complex

Certain psychologist points out emotional complexes, and also believe that they are seen to be present in other mental diseases as also in normal individuals.

2.3.4 Personality Type

Cameron believes a certain type to be more susceptible to this disease, a personality that has sentimentally, jealousy, suspicion, ambition, selfishness and shyness etc. Patients of paranoia do exhibit these peculiarities of personality but on this basis they cannot be said to belong to definite personality.

2.3.5 Heredity

In the opinion of Fisher the main responsibility of paranoia lies fairly and squarely upon heredity, although he does not deny the importance of repression and emotional complexes.

The causes of paranoia are not physical because no patient exhibits any signs of physical deformity and among the causes there are many important” ones, such as defects of personality, sense of inferiority, repression etc.

2.3.6 Biological

Researchers are studying how abnormalities of certain areas of the brain might be involved in the development of delusional disorders. An imbalance of certain chemicals in the brain, called neurotransmitters, also has been linked to the formation of delusional symptoms. Neurotransmitters are substances that help nerve cells in the brain send messages to each other. An imbalance in these chemicals can interfere with the transmission of messages, leading to symptoms.

2.3.7 Environmental/Psychological

Evidence suggests that delusional disorder can be triggered by stress. Alcohol and drug abuse also might contribute to the condition. People who tend to be isolated, such as immigrants or those with poor sight and hearing, appear to be more vulnerable to developing delusional disorder.

2.3.8 Dysfunctional Cognitive Processing

An elaborate term for thinking is “cognitive processing.” Delusions may arise from distorted ways people have of explaining life to themselves. The most prominent cognitive problems involve the manner in which delusion sufferers develop conclusions both about other people, and about causation of unusual perceptions or negative events.

Studies examining how people with delusions develop theories about reality show that the subjects have ideas which which they tend to reach an inference based on less information than most people use.

This “jumping to conclusions” bias can lead to delusional interpretations of ordinary events. For example, developing flu-like symptoms coinciding with the week new neighbours move in might lead to the conclusion, “the new neighbours are poisoning me.”

The conclusion is drawn without considering alternative explanations—catching an illness from a relative with the flu, that a virus seems to be going around at work, or that the tuna salad from lunch at the deli may have been spoiled.

Additional research shows that persons prone to delusions “read” people differently than non-delusional individuals do. Whether they do so more accurately or particularly poorly is a matter of controversy.

Delusional persons develop interpretations about how others view them that are distorted. They tend to view life as a continuing series of threatening events. When these two aspects of thought co-occur, a tendency to develop delusions about others wishing to do them harm is likely.

2.3.9 Medical Causes

Many medical conditions can lead to paranoid thoughts. Alzheimer’s disease, chemical deficiencies, cathinone poisoning and neurological degeneration disorders can harm the nervous system and lead to confusion and unstable emotions. Sufferers of these conditions sometimes forget who they can trust and also lose the ability to differentiate between trustworthy and suspicious behaviour.

2.3.10 Associated Mental Illnesses

Some mental illnesses are associated with paranoia. An inability to think clearly can cause an individual to lose the ability to differentiate between trustworthy and not trustworthy individuals. Schizophrenia causes an individual to have bizarre or disorganised thoughts. Some individuals hallucinate and begin to believe that which they hallucinate rather than their friends and family members. Psychosis involves a detachment from reality that can lead to paranoid thoughts.

2.3.11 Substance Abuse

Many substances lead to paranoia if abused: alcohol, amphetamines, crack, crystal meth, cocaine, ecstasy, marijuana, narcotics, opioids, opium, pain killers, oxycodone, sleeping pills and tranquilizers. Withdrawal from many of these substances can also trigger paranoid thoughts, so withdrawal must be handled carefully with close supervision.

<p>Self Assessment Questions</p> <p>1) What are the causes of paranoia?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>2) Discuss feelings of inferiority and emotional complex as causes of paranoia.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

3) Delineate the hereditary factors and biological factors as causes of paranoia.

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4) What is dysfunctional cognitive processing?

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5) What are the medical causes and associated mental illnesses as causes of paranoia?

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2.4 DELUSIONAL DISORDER

Delusions are irrational beliefs, held with a high level of conviction, that are highly resistant to change even when the delusional person is exposed to forms of proof that contradict the belief.

Non-bizarre delusions are considered to be plausible; that is, there is a possibility that what the person believes to be true could actually occur a small proportion of the time. Conversely, bizarre delusions focus on matters that would be impossible in reality. For example, a non-bizarre delusion might be the belief that one’s activities are constantly under observation by federal law enforcement or intelligence agencies, which actually does occur for a small number of people.

By contrast, a man who believes he is pregnant with German Shepherd puppies holds a belief that could never come to pass in reality. Also, for beliefs to be considered delusional, the content or themes of the beliefs must be uncommon in the person’s culture or religion. Generally, in delusional disorder, these mistaken beliefs are organised into a consistent world-view that is logical other than being based on an improbable foundation.

2.4.1 Characteristic Features

Unlike most other psychotic disorders, the person with delusional disorder typically does not appear obviously odd, strange or peculiar during periods of active illness. Yet the person might make unusual choices in day-to-day life because of the delusional beliefs. Expanding on the previous example, people who believe they are under government observation might seem typical in most ways but could refuse to have a

telephone or use credit cards in order to make it harder for “those Federal agents” to monitor purchases and conversations.

Most mental health professionals would concur that until the person with delusional disorder discusses the areas of life affected by the delusions, it would be difficult to distinguish the sufferer from members of the general public who are not psychiatrically disturbed. Another distinction of delusional disorder compared with other psychotic disorders is that hallucinations are either absent or occur infrequently.

The person with delusional disorder may or may not come to the attention of mental health providers. Typically, while delusional disorder sufferers may be distressed about the delusional “reality,” they may not have the insight to see that anything is wrong with the way they are thinking or functioning. Regarding the earlier example, those suffering delusion might state that the only thing wrong or upsetting in their lives is that the government is spying, and if the surveillance would cease, so would the problems.

Similarly, the people suffering the disorder attribute any obstacles or problems in functioning to the delusional reality, separating it from their internal control. Furthermore, whether unable to get a good job or maintain a romantic relationship, the difficulties would be blamed on “government interference” rather than on their own failures or omissions.

Unless the form of the delusions causes illegal behaviour, somehow affects an ability to work, or otherwise deal with daily activities, the delusional disorder sufferer may adapt well enough to navigate life without coming to clinical attention. When people with delusional disorder decide to seek mental health care, the motivation for getting treatment is usually to decrease the negative emotions of depression, fearfulness, rage, or constant worry caused by living under the cloud of delusional beliefs, not to change the unusual thoughts themselves.

Delusional disorder, previously called paranoid disorder, is a type of serious mental illness called a “psychosis” in which a person cannot tell what is real from what is imagined. The main feature of this disorder is the presence of delusions, which are unshakable beliefs in something untrue.

People with delusional disorder experience non-bizarre delusions, which involve situations that could occur in real life, such as being followed, poisoned, deceived, conspired against, or loved from a distance. These delusions usually involve the misinterpretation of perceptions or experiences. In reality, however, the situations are either not true at all or highly exaggerated.

People with delusional disorder often can continue to socialise and function normally, apart from the subject of their delusion, and generally do not behave in an obviously odd or bizarre manner. This is unlike people with other psychotic disorders, who also might have delusions as a symptom of their disorder. In some cases, however, people with delusional disorder might become so preoccupied with their delusions that their lives are disrupted.

Psychiatrists make a distinction between the milder paranoid personality disorder described above and the more debilitating delusional (paranoid) disorder. The hallmark of this disorder is the presence of a persistent, nonbizarre delusion without symptoms of any other mental disorder.

Delusions are firmly held beliefs that are untrue, not shared by others in the culture, and not easily modifiable. Five delusional themes are frequently seen in delusional disorder. In some individuals, more than one of them is present.

Whether or not persons with delusional disorder are dangerous to others has not been systematically investigated, but clinical experience suggests that such persons are rarely homicidal. Delusional patients are commonly angry people, and thus they are perceived as threatening. In the rare instances when individuals with delusional disorder do become violent, their victims are usually people who unwittingly fit into their delusional scheme. The person in most danger from an individual with delusional disorder is a spouse or lover.

2.4.2 Types of Delusional Disorder

Paranoia is an unfounded or exaggerated distrust of others, sometimes reaching delusional proportions. Paranoid individuals constantly suspect the motives of those around them, and believe that certain individuals, or people in general, are “out to get them.”

Paranoid perceptions and behaviour may appear as features of a number of mental illnesses, including depression and dementia, but are most prominent in three types of psychological disorders: paranoid schizophrenia, delusional disorder (persecutory type), and paranoid personality disorder (PPD).

Individuals with paranoid schizophrenia and persecutory delusional disorder experience what is known as persecutory delusions: an irrational, yet unshakable, belief that someone is plotting against them. Persecutory delusions in paranoid schizophrenia are bizarre, sometimes grandiose, and often accompanied by auditory hallucinations. Individuals with delusional disorder may seem offbeat or quirky rather than mentally ill, and, as such, may never seek treatment.

Persons with paranoid personality disorder (PPD) tend to be self-centered, self-important, defensive, and emotionally distant. Their paranoia manifests itself in constant suspicions rather than full-blown delusions. The disorder often impedes social and personal relationships and career advancement. Some individuals with PPD are described as “litigious,” as they are constantly initiating frivolous law suits. PPD is more common in men than in women, and typically begins in early adulthood.

The exact cause of paranoia is unknown. Potential causal factors may be genetics, neurological abnormalities, changes in brain chemistry, and stress. Paranoia is also a possible side effect of drug use and abuse (for example, alcohol, marijuana, amphetamines, cocaine, PCP). Acute, or short term, paranoia may occur in some individuals overwhelmed by stress.

The diagnosis of patients with paranoid symptoms includes a thorough physical examination and patient history to rule out possible organic causes (such as dementia) or environmental causes (such as extreme stress). If a psychological cause is suspected, a psychologist will conduct an interview with the patient and may administer one of several tests to evaluate mental status.

Paranoia that is symptomatic of paranoid schizophrenia, delusional disorder, or paranoid personality disorder should be treated by a psychologist and/or psychiatrist. **Antipsychotic** medication such as thioridazine (Mellaril), haloperidol (Haldol), chlorpromazine (Thorazine), clozapine (Clozaril), or risperidone (Risperdal) may be prescribed, and cognitive therapy or psychotherapy may be employed to help the patient cope with their paranoia and/or persecutory delusions. It is uncertain whether antipsychotic medication benefit individuals with paranoid personality disorder and may even pose long-term risks.

If an underlying condition, such as depression or drug abuse, is found to be triggering the paranoia, an appropriate course of medication and/or psychosocial therapy is employed to treat the primary disorder.

Because of the inherent mistrust felt by paranoid individuals, they often must be coerced into entering treatment. As unwilling participants, their recovery may be hampered by efforts to sabotage treatment (for example, not taking medication or not being forthcoming with a therapist). They may also exhibit a lack of insight into their condition or the belief that the therapist is plotting against them. Although their lifestyles may be restricted, some patients with PPD or persecutory delusional disorder continue to function in society without treatment.

Distrust is the hallmark of delusional disorder. Someone who suffers from this disorder is very defensive, sometimes to the point of being aggressive, and may constantly question the motives of others. Even if people appear harmless on the surface, the patient believes that they are simply trying to lull the patient into a sense of complacency, and the patient will remain on guard as a result. Other symptoms of delusional disorder can include a sense of social isolation caused in part by the patient's defensive and suspicious behaviour, and a lack of humor.

2.4.3 Delusion of Grandeur

In this patient believes himself to be, a great individual, and according to Bleuler, this delusion of grandeur accompanies a persecutory delusion. A delusion is (common in paranoia) that you are much greater and more powerful and influential than you really are.

One of the toughest psychiatric anomalies both to diagnose and treat is delusion disorder like delusion of grandeur, delusional paranoid, even delusional jealousy. The reason why diagnosis can be tough is the person is often working quite typically in the world. The delusions in this disorder are non bizarre, meaning that they can essentially be plausible even if they are not true. Those suffering from this disorder often will not believe they have a problem, so it is difficult to get them into treatment.

While paranoia is the most typical manifestation, there are more types of delusion disorder including delusion of grandeur, delusional paranoid, even delusional jealousy as well as for example, believing one is the secret love interest of a famous person, being convinced one has striking abilities or is very significant, worrying about physical problems or disfigurements that do not exist, or believing that one's romantic partner is unfaithful. Psychological fitness treatment is sometimes refused because of these convictions, which are immune to any sort of disproof. The patient is certain they are correct.

Therapists who are ready to be used slightly different treatments, instead adopt the more usual drugs or characteristic psychotherapy approaches. They may gain the patient's trust enough to begin exploring any doubts the person expresses about their own ideology. The two of them can work in partnership, gradually discovering real world explanations for those ideology. If the therapist treads conscientiously and uses tactfully, then the patient and therapist together can work through the delusion disorder like delusion of grandeur, delusional paranoid, even delusional jealousy and effect a cure.

2.4.4 Motivated or Defensive Delusions

Some predisposed persons might suffer the onset of an ongoing delusional disorder when coping with life and maintaining high self esteem becomes a significant challenge. In order to preserve a positive view of oneself, a person views others as the cause of personal difficulties that may occur. This can then become an ingrained pattern of thought.

2.5 DELUSIONS AND OTHER DISORDERS

Even though the main characteristic of delusional disorder is a noticeable system of delusional beliefs, delusions may occur in the course of a large number of other psychiatric disorders.

Delusions are often observed in persons with other psychotic disorders such as schizophrenia and schizoaffective disorder. In addition to occurring in the psychotic disorders, delusions also may be evident as part of a response to physical, medical conditions (such as brain injury or brain tumors), or reactions to ingestion of a drug.

Delusions also occur in the dementias, which are syndromes wherein psychiatric symptoms and memory loss result from deterioration of brain tissue. Because delusions can be shown as part of many illnesses, the diagnosis of delusional disorder is partially conducted by process of elimination.

If the delusions are not accompanied by persistent, recurring hallucinations, then schizophrenia and schizoaffective disorder are not appropriate diagnoses. If the delusions are not accompanied by memory loss, then dementia is ruled out.

If there is no physical illness or injury or other active biological cause (such as drug ingestion or drug withdrawal), then the delusions cannot be attributed to a general medical problem or drug-related causes. If delusions are the most obvious and pervasive symptom, without hallucinations, medical causation, drug influences or memory loss, then delusional disorder is the most appropriate categorisation.

Because delusions occur in many different disorders, some clinician researchers have argued that there is little usefulness in focusing on what diagnosis the person has been given.

Those who ascribe to this view believe it is more important to focus on the symptom of delusional thinking, and find ways to have an effect on delusions, whether they occur in delusional disorder or schizophrenia or schizoaffective disorder.

The majority of psychotherapy techniques used in delusional disorder come from symptom-focused (as opposed to diagnosis-focused) researcher-practitioners.

Self Assessment Questions

1) What is Delusional Disorder? Define and bring out its characteristic features.

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2) What are delusions of grandeur?

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3) Describe delusions of persecution and erotomania.

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4) What are motivated defensive delusions?

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5) Discuss delusions as part of other psychiatric disorders.

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2.6 TREATMENT APPROACHES TO PARANOIA AND DELUSIONAL DISORDER

A cure of paranoia is very difficult and it is essential that treatment should be started immediately the disease comes to be known. Once it grows on a person there is no curing to it. The chief method of curing it is the following:

2.6.1 Treatment and Cure

A cure of paranoia is very difficult and it is essential that treatment should be started immediately the disease comes to be known. Once it grows on a person there is no curing to it. The chief method of curing it is the administering Injection of Insulin. Some patients also responds to this treatment but this cannot be said of all.

2.6.2 Psychoanalytic Method

Compared to other mental diseases, this disease does not respond immediately to psychoanalytic treatment because, being suspicious, the patient does not cooperate with the doctor. Even then, with due precaution, certain results can be achieved by employing this method.

2.6.3 Cognitive Behavioural Therapy (CBT)

CBT or other forms of psychotherapy may be helpful for certain people who have paranoia. CBT attempts to make a person more aware of his or her actions and motivations, and tries to help the individual learn to more accurately interpret cues around him or her, in an effort to help the individual change dysfunctional behaviours. Difficulty can enter into a therapeutic relationship with a paranoid individual, due to the level of mistrust and suspicion that is likely to interfere with their ability to participate in this form of treatment.

Support groups can be helpful for some paranoid individuals—particularly helpful in assisting family members and friends who must learn to live with, and care for paranoid individuals.

2.6.4 Drug Therapy

Treatment with appropriate antipsychotic drugs may help the paranoid patient overcome some symptoms. Although the patient's functioning may be improved, the paranoid symptoms often remain intact. Some studies indicate that symptoms improve following drug treatment, but the same results sometimes occur among patients who receive a placebo, a "sugar pill" without active ingredients. This finding suggests that in some cases the paranoia diminishes for psychological reasons rather than because of the drug's action.

Delusional disorder treatment often involves *atypical* (also called *novel* or *newer-generation*) antipsychotic medications, which can be effective in some patients. Risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa) are all examples of atypical or novel antipsychotic medications.

If *agitation* occurs, a number of different antipsychotics can be used to conclude the outbreak of acute agitation. Agitation, a state of frantic activity experienced concurrently with anger or exaggerated fearfulness, increases the risk that the client will endanger self or others.

To decrease anxiety and slow behaviour in emergency situations where agitation is a factor, an injection of haloperidol (Haldol) is often given usually in combination with other medications (often lorazepam, also known as Ativan).

Agitation in delusional disorder is a typical response to severe or harsh confrontation when dealing with the existence of the delusions. It can also be a result of blocking the individual from performing inappropriate actions the client views as urgent in light of the delusional reality.

A novel antipsychotic is generally given orally on a daily basis for ongoing treatment meant for long-term effect on the symptoms.

Response to antipsychotics in delusional disorder seems to follow the "rule of thirds," in which about one-third of patients respond somewhat positively, one-third show little change, and one-third worsen or are unable to comply.

Cognitive therapy has shown promise as an emerging treatment for delusions. The cognitive therapist tries to capitalise on any doubt the individual has about the delusions; then attempts to develop a joint effort with the sufferer to generate alternative explanations, assisting the client in checking the evidence. This examination proceeds in favour of the various explanations.

Much of the work is done by use of empathy, asking hypothetical questions in a form of therapeutic Socratic dialogue—a process that follows a basic question and answer format, figuring out what is known and unknown before reaching a logical conclusion.

2.6.5 Combining Pharmacotherapy with Cognitive Therapy

The integration of both the treatment may bring out the possible underlying biological problems and the symptoms can be reduced with psychotherapy.

2.6.6 Psychotherapy

This is the primary treatment for delusional disorder, including psychosocial treatment which can help with the behavioural and psychological problems associated with delusional disorder. Through therapy, patients also can learn to control their symptoms,

identify early warning signs of relapse, and develop a relapse prevention plan. Psychosocial therapies include the following:

Individual psychotherapy: Can help the person recognise and correct the underlying thinking that has become distorted.

Cognitive behavioural therapy (CBT): Can help the person learn to recognise and change thought patterns and behaviours that lead to troublesome feelings.

Family therapy: Can help families deal more effectively with a loved one who has delusional disorder, enabling them to contribute to a better outcome for the person.

2.6.7 Prognosis of Paranoia and Delusional Disorder

Predicting the prognosis of an individual suffering from Paranoia is quite difficult. Paranoia generally becomes a whole life or lifelong condition if there exists any underlying mental disorder, such as schizophrenia or paranoid personality disorder. It certainly and sometimes get better with some treatments or remission or with slight changes in medication. People who have symptoms of paranoia as part of another medical condition may also have a waxing and waning mental course.

Sometimes it is the case that paranoia is caused by the use of a particular drug or medication. In this case, it is possible that discontinuing that substance may completely reverse the symptoms of paranoia.

Paranoia can also occur as a symptom of other neurological diseases. Individuals suffering from the aftereffects of strokes, brain injuries, various types of **dementia** (including Alzheimer's disease), Huntington's disease, and Parkinson's disease may manifest paranoia as part of their symptom complex. The paranoia may decrease in intensity when the underlying disease is effectively treated, although since many of these diseases are progressive, the paranoia may worsen over time along with the progression of the disease's other symptoms.

2.7 LET US SUM UP

We defined paranoia as a medical illness, which happens to affect the brain, and causes changes in thinking and feeling. Those with the condition are hypersensitive, are easily slighted, and habitually relate to the world by vigilant scanning of the environment for clues or suggestions to validate their prejudicial ideas or biases.

Paranoid individuals are eager observers. They think they are in danger and look for signs and threats of that danger, disregarding any facts. They tend to be guarded and suspicious and have quite constricted emotional lives. Their incapacity for meaningful emotional involvement and the general pattern of isolated withdrawal often lend a quality of schizoid isolation to their life experience.

Even at the present time, a delusion need not be suspicious or fearful to be classified as paranoid. A person might be diagnosed as a paranoid schizophrenic without delusions of persecution, simply because their delusions refer mainly to themselves.

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. The main symptom of paranoia is permanent delusion. It should be kept in mind that there is delusion in schizophrenia also but in that case it is not permanent or organised. In paranoia the symptoms of delusion appear gradually, and the patient is sentimental, suspicious, irritable, introverted, depressed,

obstinate, jealous, selfish, unsocial and bitter. Hence his social and family adjustment is not desirable, and while he has the highest desirable, the effort that he is prepared to expend is correspondingly little.

The “Diagnostic and Statistical Manual of Mental Disorders”, fourth edition (DSM-IV), has listed the symptoms of paranoid personality disorder:

Then we deal with different kinds of paranoia such as the persecutory, religious, reformatory, erotic, litigious etc. Then the causes of paranoia were delineated.

Delusions are often observed in persons with other psychotic disorders such as schizophrenia and schizoaffective disorder. In addition to occurring in the psychotic disorders, delusions also may be evident as part of a response to physical, medical conditions (such as brain injury or brain tumors), or reactions to ingestion of a drug.

Delusions also occur in the dementias, which are syndromes wherein psychiatric symptoms and memory loss result from deterioration of brain tissue. Because delusions can be shown as part of many illnesses, the diagnosis of delusional disorder is partially conducted by process of elimination.

The majority of psychotherapy techniques used in delusional disorder come from symptom-focused (as opposed to diagnosis-focused) researcher-practitioners. A cure of paranoia is very difficult and it is essential that treatment should be started immediately the disease comes to be known. Once it grows on a person there is no curing to it. The chief method of curing it is the following:

Compared to other mental diseases, this disease does not respond immediately to psychoanalytic treatment because, being suspicious, the patient does not cooperate with the doctor. Even then, with due precaution, certain results can be achieved by employing this method.

CBT or other forms of psychotherapy may be helpful for certain people who have paranoia. CBT attempts to make a person more aware of his or her actions and motivations, and tries to help the individual learn to more accurately interpret cues around him or her, in an effort to help the individual change dysfunctional behaviours. Difficulty can enter into a therapeutic relationship with a paranoid individual, due to the level of mistrust and suspicion that is likely to interfere with their ability to participate in this form of treatment.

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Predicting the prognosis of an individual suffering from Paranoia is quite difficult. Paranoia generally becomes a whole life or lifelong condition if there exists any underlying mental disorder, such as schizophrenia or paranoid personality disorder. It certainly and sometimes get better with some treatments or remission or with slight changes in medication. People who have symptoms of paranoia as part of another medical condition may also have a waxing and waning mental course.

2.8 UNIT END QUESTIONS

- 1) Define paranoia and delineate its characteristic features.
- 2) What are the symptoms of paranoi and what are its causes?
- 3) What are delusional disorders?
- 4) Describe in detail the delusional disorder of grandeur and persecution

- 5) What are motivated delusions?
- 6) What are the various treatment methods available for paranoia and delusional disorders? How effective they are?

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UNIT 3 PSYCHOTIC DISORDER DUE TO GENERAL MEDICAL CONDITION

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Medical Conditions that may Cause Psychosis
 - 3.2.1 Neurologic Disorders that may Produce Psychiatric Symptoms
- 3.3 Symptoms of Psychotic Disorders
 - 3.3.1 Types of Psychotic Disorders
 - 3.3.2 Causes of Psychotic Disorders
- 3.4 Symptoms of Psychotic Disorders due to Medical Conditions
 - 3.4.1 Symptoms
 - 3.4.2 Types of Delusions
 - 3.4.3 Hallucinations
- 3.5 Causes of Psychotic Disorders due to Medical Conditions
 - 3.5.1 Functional Causes
 - 3.5.2 General Medical Conditions
 - 3.5.3 Psychoactive Drugs
 - 3.5.4 A Stress Response
 - 3.5.5 Postpartum Psychosis
- 3.6 Defense Mechanisms in Personality Disorders
 - 3.6.1 Culturally Defined Disorder
- 3.7 Treatment
 - 3.7.1 Early Intervention
 - 3.7.2 Hospitalisation
 - 3.7.3 Medications
 - 3.7.4 Psychosocial Therapy
- 3.8 Let Us Sum Up
- 3.9 Unit End Questions
- 3.10 Suggested Readings and References

3.0 INTRODUCTION

This unit deals with psychotic disorders caused by medical conditions. We start with explaining how these disorders caused by medical condition. Then we deal with the psychotic disorders associated with neurological disorders. Then we present the various features of psychotic disorders followed by symptoms of psychotic disorder. The symptoms include delusions and hallucinations which are explained in detail. Then we deal with the causes of psychological disorders due to medical conditions. Then we deal with defense mechanisms and treatment approaches to the psychotic disorders due to medical conditions.

3.1 OBJECTIVES

On completing this unit, you will be able to:

- Describe the medical conditions that cause psychotic disorder;
- Elucidate the Neurologic disorder that may cause psychotic symptoms;
- Explain the symptoms of psychotic disorders;
- Delineate the Causes of psychotic disorders due to medical conditions;
- Explain stress syndrome and postpartum psychosis;
- Describe the Defense mechanisms in psychotic disorders;
- Analyse the psychotic disorder in terms of Culturally defined disorder; and
- Enlist the various Treatment approaches to medically induced psychotic disorder.

3.2 MEDICAL CONDITIONS THAT MAY CAUSE PSYCHOSIS

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, the psychiatric presentation of a medical illness is classified as “the presence of mental symptoms that are judged to be the direct physiological consequences of a general medical condition.” Therefore, understanding common psychiatric symptoms and the medical diseases that may cause or mimic them is of utmost importance. Failure to identify these underlying causal medical conditions can be potentially dangerous because serious and frequently reversible conditions can be overlooked. Proper diagnosis of a psychiatric illness necessitates investigation of all appropriate medical causes of the symptoms.

The following features suggest a medical origin to psychiatric symptoms:

- Late onset of initial presentation
- Known underlying medical condition
- A typical presentation of a specific psychiatric diagnosis
- Absence of personal and family history of psychiatric illnesses
- Illicit substance use
- Medication use
- Treatment resistance or unusual response to treatment
- Sudden onset of mental symptoms
- Abnormal vital signs
- Waxing and waning mental status.

Because multiple secondary causes of mental disorders exist, the major medical disorders that can induce psychiatric symptoms are listed in the Table below

Table: Medical Disorders that can Induce Psychiatric Symptoms*

**Psychotic Disorder Due to
General Medical
Condition**

Medical and Toxic Effects	CNS	Infectious	Metabolic/Endocrine	Cardiopulmonary	Other
<ul style="list-style-type: none"> • Alcohol • Cocaine • Marijuana • Phencyclidine (PCP) • Lysergic acid diethylamide (LSD) • Heroin • Amphetamines • Jimson weed • Gamma-hydroxybutyrate (GHB) • Benzodiazepines • Prescription drugs 	<ul style="list-style-type: none"> • Subdural hematoma • Tumor • Aneurysm • Severe hypertension • Meningitis • Encephalitis • Normal pressure hydrocephalus • Seizure disorder • Multiple sclerosis 	<ul style="list-style-type: none"> • Pneumonia • Urinary tract infection • Sepsis • Malaria • Legionnaire disease • Syphilis • Typhoid • Diphtheria • HIV • Rheumatic fever • Herpes 	<ul style="list-style-type: none"> • Thyroid disorder • Adrenal disorder • Renal disorder • Hepatic disorder • Wilson disease • Hyperglycemia • Hypoglycemia • Vitamin deficiency • Electrolyte imbalances • Porphyria 	<ul style="list-style-type: none"> • Myocardial infarction • Congestive heart failure • Hypoxia • Hypercarbia 	<ul style="list-style-type: none"> • Systemic lupus erythematosus • Anemia • Vasculitis

*(Adapted from Williams E, Shepherd S. Medical clearance of psychiatric patients. *Emerg Med Clin North Am.* May 2000; 18:2; 193.)

3.2.1 Neurologic Disorders that may Produce Ssychiatrtic Symptoms

Seizure disorder

Epilepsy is one of the most common chronic neurologic diseases, affecting approximately 1% of the US population. In India the prevalence is estimated to be 5.33 per 1000 population. Approximately 30-50% of patients with a seizure disorder have psychiatric symptoms sometime during the course of their illness. Increased psychopathology has been associated with different features (eg, seizure phenomenology, brain pathology, antiepileptic drug use, psychosocial factors).

In partial seizures, psychiatric signs abound, with memory dysfunction, affective auras, perceptual changes (e.g., hallucinations), and depersonalisation.

In temporal lobe epilepsy, the most common psychiatric abnormality is personality change. Development of psychosis is also described in temporal lobe epilepsy.

Parkinson disease

Parkinson disease (PD) is a disorder characterised by movement abnormalities caused by degeneration of the neurons in the substantia nigra. The prevalence of major depression in patients with PD is estimated to be 40%, with prevalence rates of 4-70%. The anxiety syndromes in PD are apparently related to an underlying brain disease, with evidence implicating noradrenergic dysfunction. In several studies, anxiety syndromes developed before or after the onset of motor symptoms.

Brain tumors

Brain tumors and cerebrovascular disease are important causes of psychiatric symptoms and patients with these diseases can present with virtually any symptom. A complete clinical history and neurologic examination are essential in diagnosing either condition. Given the nature of the onset and presentation of a cerebrovascular event, it is rarely misdiagnosed as a mental disorder. However, up to 50% of patients with brain tumors reportedly have manifestations of a psychiatric nature.

Frontal lobe tumors, which are responsible for approximately 88% of the patients with psychiatric symptoms, can elicit presenting signs such as cognitive impairment, personality change, or motor and language dysfunction.

Limbic and hypothalamic tumors can cause affective symptoms such as rage, mania, emotional lability, and altered sexual behaviour. They can also produce delusions involving complicated plots.

Hallucinations, which are often considered the hallmarks of psychiatric illness, can be caused by focal neurologic pathology.

Multiple sclerosis

Multiple sclerosis (MS) is a demyelinating disorder characterised by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the CNS.

Symptoms can be categorised as cognitive and psychiatric. Abstract reasoning, planning, and organisational skills are some of the functions also affected by MS. Dementia may eventually ensue.

Meningitis

Acute bacterial, fungal, and viral meningitis can be associated with a psychiatric presentation with or without abnormal vital signs.

Patients usually present with acute confusion, headaches, memory impairments, and fever with possible neck stiffness.

Parathyroid disorder

Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia. Hyperparathyroidism is frequently associated with significant psychiatric symptoms, which are caused by the resultant hypercalcemia and can precede other somatic manifestations of the illness. Patients can experience delirium, sudden dementia, depression, anxiety, psychosis, apathy, stupor, and coma.

Thyroid disorders

Patients with hyperthyroidism can present in various ways but commonly present with symptoms of anxiety, confusion, and agitated depression. Patients can also present with hypomania and frank psychosis. In most patients who present with depression or anxiety associated with hyperthyroidism without other psychiatric history, psychiatric symptoms usually resolve with treatment of the hyperthyroidism.

Similar to patients with hyperthyroidism, those with hypothyroidism often present with depression and anxiety.

Adrenal disorders

Adrenal disorders cause changes in the normal secretion of hormones from the adrenal cortex and may produce significant psychiatric symptoms. Patients with this condition can exhibit symptoms such as apathy, fatigue, depression, and irritability. Psychosis and confusion can also develop.

The existence of moderate-to-severe depression in up to 50% of patients with Cushing syndrome is well documented, with symptoms sometimes severe enough to lead to suicide. Decreased concentration and memory deficits may also be present.

Neuropsychiatric manifestations of patients with lupus have a prevalence of up to 75-90%. Major psychiatric symptoms include depression, emotional lability, delirium, and psychosis. The presence of severe depression or psychosis is associated with anti-P antibodies in the serum, which suggests an autoimmune mechanism for inducing mental symptoms.

Sodium imbalance

This causes irritability, Confusion, Anxiety, Delusions and hallucinations, etc. Without proper treatment, seizures, stupor, and coma ultimately ensue. Treatment consists of correcting the serum sodium level at a slow but adequate rate.

The clinical manifestations of stages of hepatic encephalopathy are listed below

Stage I

- Apathy
- Restlessness
- Impaired cognition
- Impaired handwriting
- Reversal of sleep rhythm

Stage II

- Lethargy
- Drowsiness
- Disorientation
- Asterixis
- Beginning of mood swings
- Beginning of behavioural disinhibition

Stage III

- Arousable stupor
- Hyperactive reflexes
- Short episodes of psychiatric symptoms

Stage IV - Coma (responsive only to pain)

Patients may also experience short episodes of depression, hypomania, anxiety, and obsessive-compulsive symptoms.

Dialysis dementia is a specific syndrome characterised by encephalopathy, dysarthria, dysphasia, poor memory, depression, paranoia, myoclonic jerking, and seizures.

Vitamin B-1 deficiency

Much more commonly today, thiamine deficiency manifests as Wernicke encephalopathy, often, but not exclusively, in individuals with heavy and prolonged alcohol use.

Vitamin B-12 deficiency

Deficiency of vitamin B-12 (cobalamin) is the cause of pernicious anemia. Psychiatric symptoms include depression, fatigue, psychosis, and progressive cognitive impairment can accompany neurologic symptoms.

Alcohol

Although volumes have been written concerning the pathologic changes in patients who use alcohol for short and long periods, a brief review is appropriate because patients in alcohol withdrawal can present with numerous psychiatric symptoms that can be fatal if not identified and treated quickly.

Withdrawal symptoms can emerge, particularly in the absence of a measurable blood alcohol level. Florid delirium tremens (DT) is the most serious and potentially fatal alcohol withdrawal syndrome. The clinical picture includes hallucinations (most commonly auditory and/or visual), gross confusion and disorientation, and autonomic hyperactivity (e.g. tachycardia, fever, sweating, hypertension). These patients are often agitated and paranoid and may not readily allow physical examination. The temptation to view an agitated, paranoid, overtly hallucinating patient as in need of nothing further than admission to a psychiatric unit may be a grave mistake because untreated DT is potentially fatal.

Patients may also present with hallucinations in a clear sensorium (differentiating it from DT), usually in the setting of recent cessation of or significant decrease in the amount of alcohol used. Known as alcoholic hallucinosis, the hallucinations (most frequently auditory) may be relatively brief, usually resolving within approximately 30 days, but they may persist. Recurrences are likely with continued alcohol use.

Cocaine and amphetamines

Cocaine is a powerful stimulant initially causing euphoria and increased alertness and energy. As the high wears off, the user may develop symptoms of anxiety and depression, often with drug craving. With continued regular use, symptoms of psychosis develop with hallucinations and frank paranoid delusions. The psychiatric presentation can appear similar to that observed in patients with chronic amphetamine abuse.

Hallucinogens

A brief mention must be made of lysergic acid diethylamide (LSD), a potent hallucinogen that causes intense and vivid hallucinations in a clear sensorium. LSD-elicited hallucinations are usually of relatively short duration, but flashbacks of varying intensity may occur in a small number of users.

Ecstasy

Depression, anxiety, and psychosis have also been described with regular use, and some of the symptoms persist for months after cessation of use.

Solvents

Long-term and heavy use can lead to hallucinations, cognitive impairment, personality change, and neurologic impairment, particularly cerebellar findings.

Heavy metals

Lead, mercury, manganese, arsenic, organophosphorus compounds, and others can cause psychiatric symptoms. Exposure is usually industrial or environmental and should be considered in the appropriate settings.

Self Assessment Questions

1) Describe seizure disorder in terms of producing psychotic symptoms.

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2) What role brain tumors play in producing psychotic symptoms?

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3) How does multiple sclerosis affect the medical condition and produce psychotic symptoms?

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4) Discuss thyroid disorder and the production of psychotic symptoms.

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5) How does sodium imbalance contribute to psychiatric disorders. Describe the stages?

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6) Which are the vitamin deficiencies cause psychiatric disorders? Explain.

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7) How do amphetamines, solvents and hallucinogens produce psychotic symptoms?

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3.3 SYMPTOMS OF PSYCHOTIC DISORDERS

In a psychotic disorder, perception and understanding of reality is severely impaired. Symptoms may include fixed but untrue beliefs (delusions), seeing visions or hearing voices (hallucinations), confusion, disorganised speech, exaggerated or diminished emotions, or bizarre behaviour. Level of functioning may be severely impaired with social withdrawal and inability to attend to work, relationships, or even basic personal care. Individuals generally have little awareness of the mental abnormalities associated with their illness. It may be impossible to identify a specific psychotic disorder due to insufficient information or contradictory findings. Psychotic symptoms are described as positive or negative.

1) *Positive symptoms*

Positive symptoms are delusions, hallucinations, bizarre behaviours, and thought broadcasting where the individual believes others can supernaturally influence his or her thoughts or vice versa.

2) *Negative symptoms*

Negative symptoms refer to a reduction or loss of normal functions such as restriction and flattening of emotions, severely reduced speech or thought, and lack of interest in goal-directed activities. A delusion is a firm belief that others cannot verify.

The delusional individual clings to the belief despite evidence to the contrary. A common type of delusion involves thoughts of persecution such as being spied upon or conspired against. There may also be delusions of grandeur where individuals believe they have extraordinary powers, are on a special mission, or think they are someone important such as Jesus Christ. The delusion is termed bizarre if it is not based on ordinary life experiences. An example is of aliens controlling an individual's body and / or thoughts.

Hallucinations are sensory perceptions that no one else can detect and can involve the sense of sight, touch, hearing, smell, or taste. Hearing voices is the most frequent hallucination in psychosis. The hallucinations occur when the individual is awake. Disorganised thoughts (loosening of associations) are characterised by jumping from one topic to another. Grossly disorganised behaviour can result in neglect of personal appearance and hygiene, proper nutrition, and other tasks of living.

The individual may dress inappropriately and act unpredictably such as shouting or swearing in public. Usually these disorders involve hallucinations or delusions that are very prominent. Psychosis is a symptom or feature of mental illness typically characterised by radical changes in personality, impaired functioning, and a distorted or non-existent sense of objective reality. Patients suffering from psychosis have impaired reality testing; that is, they are unable to distinguish personal, subjective experience from the reality of the external world. They experience hallucinations and/or delusions that they believe are real, and may behave and communicate in an inappropriate and incoherent fashion.

Psychosis may appear as a symptom of a number of mental disorders, including mood and personality disorders. It is also the defining feature of schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, and the psychotic disorders (i.e., brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, and substance induced psychotic disorder). Psychosis may be caused by the interaction of biological and psychosocial factors depending on the disorder it presents. Psychosis can also be caused by purely social factors, with no biological component.

3.3.1 Types of Psychotic Disorders

According to the Diagnostic and Statistical Manual of Mental Disorders (2000), text revision (DSM IV TR), there is not an universal acceptance of the term *psychotic*, however the DSM IV TR definition refers to the existence of specific symptoms such as delusions, prominent hallucinations, disorganised speech, disorganised or catatonic behaviour. In layman's terms a psychotic individual could be described as someone who is "insane."

DSM IV TR is a manual that classifies and describes in great detail all mental disorders and is highly used in clinical, educational, and research settings. The manual further describes all of the psychotic disorders in greater detail. Those disorders are: Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition, Substance-Induced Psychotic Disorder, and Psychotic Disorder Not Otherwise Specified.

1) *Schizophrenia*

Schizophrenia is probably the one that most people are familiar with because it is seen most commonly in society and in the clinical setting. Schizophrenia is characterised as being a psychotic disorder that has to last for at least 6 months and include two or more of active phase symptoms (i.e. hallucinations or delusions) for at least 1 month.

2) *Schizophreniform disorder*

Schizophreniform Disorder is very similar to Schizophrenia except that it lasts from 1 to 6 months and also there 't have to be a decline in functioning.

3) *Schizoaffective disorder*

Schizoaffective Disorder is characterised by an individual having a mood episode and the active phase symptoms of Schizophrenia at the same time. Also there must have been at least 2 weeks of delusions or hallucinations (without mood symptoms) before or after the occurrence of them together.

4) *Delusional disorder*

An individual with Delusional Disorder must have had at least 1 month of non-bizarre symptoms without any other active phase symptoms. Brief Psychotic Disorder must last more than 1 day and goes away by 1 month. An individual with Shared Psychotic Disorder has delusions that have been influenced by someone else who has similar delusions.

A Psychotic Disorder Due to a General Medical Condition is due to direct relation from a physiological condition (i.e. psychosis due to lime disease from a tick bite).

A Substance-Induced Psychotic Disorder are due to a direct physiological condition from medication, drug abuse, or toxin exposure.

Psychotic Disorder Not Otherwise Specified is included in this section to describe all Psychotic Disorders that do not fit into any of the above criteria or when there is not enough information or contradictory information provided. Brief psychotic disorder is a short-term, time-limited disorder. An individual with brief psychotic disorder has experienced at least one of the major symptoms of **psychosis** for less than one month. **Hallucinations, delusions**, strange bodily movements or lack of movements (catatonic behaviour), peculiar speech and bizarre or markedly inappropriate behaviour are all classic psychotic symptoms that may occur in brief psychotic disorder.

3.3.2 Causes of Psychotic Disorder

The cause of the symptoms helps to determine whether or not the sufferer is described as having brief psychotic disorder. If the psychotic symptoms appear as a result of a physical disease, a reaction to medication, or intoxication with drugs or alcohol, then the unusual behaviours are not classified as brief psychotic disorder.

If hallucinations, delusions, or other psychotic symptoms occur at the same time that an individual is experiencing major clinical depression or bipolar (manic-depressive) disorder, then the brief psychotic disorder diagnosis is not given. The decision rules that allow the clinician to identify this cluster of symptoms as brief psychotic disorder are outlined in the Diagnostic and Statistical Manual of the Fourth Edition Text Revision, produced by the American Psychiatric Association. This manual is referred to by most mental health professionals as *DSM-IV-TR*.

Psychosis (from the Greek “psyche”, for mind/soul, and “-osis”, for abnormal condition) means abnormal condition of the mind, and is a generic psychiatric term for a mental state often described as involving a “loss of contact with reality”. People suffering from psychosis are described as *psychotic*. Psychosis is given to the more severe forms of psychiatric disorder, during which hallucinations and delusions and impaired insight may occur. Some professionals say that the term psychosis is not sufficient as some illnesses grouped under the term “psychosis” have nothing in common (Gelder, Mayou & Geddes 2005).

People experiencing psychosis may report hallucinations or delusional beliefs, and may exhibit personality changes and thought disorder. Depending on its severity, this may be accompanied by unusual or bizarre behaviour, as well as difficulty with social interaction and impairment in carrying out the daily life activities. A wide variety of central nervous system diseases, from both external poisons and internal physiologic illness, can produce symptoms of psychosis. Trauma and stress can cause a short-term psychosis (less than a month’s duration) known as brief psychotic disorder. Major life-changing events such as the death of a family member or a natural disaster have been known to stimulate brief psychotic disorder in patients with no prior history of mental illness.

Psychosis may also be triggered by an organic cause, termed a psychotic disorder due to a general medical condition. Organic sources of psychosis include neurological conditions (for example, epilepsy and cerebrovascular disease), metabolic conditions (for example, porphyria), endocrine conditions (for example, hyper- or hypothyroidism), renal failure, electrolyte imbalance, or autoimmune disorders. Common such underlying medical conditions are: thyroid disease with too much or too little thyroid hormone production; brain tumor; stroke; infection of central nervous system; epilepsy; liver or kidney disease; systemic lupus erythematosus with central nervous system involvement; severe fluid and electrolyte disturbances; metabolic conditions affecting blood sugar or oxygen content of the blood. There are more, but these illustrate the point. For instance, in temporal lobe epilepsy it is common to have the occasional patient develop religious delusions.

Other hallucinations associated with temporal lobe epilepsy are olfactory hallucinations such as smelling burning rubber or other unpleasant smells. In some patients the medical diagnosis is known and the hallucinations develop subsequently. In other patients the hallucinations are the first clue that there may be an underlying medical condition. If the psychotic condition starts at an age atypical for a psychotic disorder and visual or olfactory hallucinations are present, the clinician must think about a medical condition (or hidden drug abuse) that may cause these symptoms.

Self Assessment Questions

1) What are the positive and negative symptoms of psychotic disorders?

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2) Describe hallucinations and delusions.

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3) What are the various types of psychotic disorders?

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4) What are the causes of psychotic disorders? Explain.

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3.4 SYMPTOMS OF PSYCHOTIC DISORDERS DUE TO MEDICAL CONDITION

Psychosis is characterised by the following symptoms:

1) *Delusions*

An unshakable and irrational belief in something untrue. Delusions defy normal reasoning, and remain firm even when overwhelming proof is presented to disprove them.

2) *Hallucinations*

Psychosis causes false or distorted sensory experience that appear to be real. Psychotic patients often see, hear, smell, taste, or feel things that aren't there.

3) *Disorganised speech*

Psychotic patients often speak incoherently, using noises instead of words and “talking” in unintelligible speech patterns.

4) *Disorganised or catatonic behaviour*

Behavior that is completely inappropriate to the situation or environment. Catatonic patients have either a complete lack of or inappropriate excess of motor activity. They can be completely rigid and unable to move (vegetative), or in constant motion. Disorganised behaviour is unpredictable and inappropriate for a situation (e.g., screaming obscenities in the middle of class).

3.4.1 Symptoms

The main symptoms of this disorder are delusions and hallucinations. There has to be medical evidence that the symptoms are a direct physiological consequence of a medical condition. All other mental disorders have to be ruled out before this diagnosis is given. There are many medical conditions that can cause psychotic symptoms. These medical conditions include; epilepsy, multiple sclerosis, central nervous system infections and migraines. There are two subtypes of this disorder. The two subtypes are:

Delusions: The person has delusions. A delusion is a fixed belief that is either false, fanciful, or derived from deception. In psychiatry, it is defined to be a belief that is pathological (the result of an illness or illness process) and is held despite evidence to the contrary. As a pathology, it is distinct from a belief based on false or incomplete information, dogma, stupidity, poor memory, illusion, or other effects of perception.

Delusions typically occur in the context of neurological or mental illness, although they are not tied to any particular disease and have been found to occur in the context of many pathological states (both physical and mental). However, they are of particular diagnostic importance in psychotic disorders.

3.4.2 Types of Delusions

Delusions are categorised into different groups:

- 1) *Bizarre delusion:* A delusion that is very strange and completely implausible; an example of a bizarre delusion would be that aliens have removed the affected person's brain.
- 2) *Non-bizarre delusion:* A delusion that, though false, is at least possible, e.g., the affected person mistakenly believes that he is under constant police surveillance.
- 3) *Mood-congruent delusion:* Any delusion with content consistent with either a depressive or manic state, e.g., a depressed person believes that news anchors on television highly disapprove of him, or a person in a manic state might believe he is a powerful deity.
- 4) *Mood-neutral delusion:* A delusion that does not relate to the sufferer's emotional state; for example, a belief that an extra limb is growing out of the back of one's head is neutral to either depression or mania.
- 5) *Delusion of control:* This is a false belief that another person, group of people, or external force controls one's thoughts, feelings, impulses, or behaviour.
- 6) *Nihilistic delusion:* A person with this type of delusion may have the false belief that the world is ending.
- 7) *Delusional jealousy (or delusion of infidelity):* A person with this delusion falsely believes a spouse or lover is having an affair.
- 8) *Delusion of guilt or sin (or delusion of self-accusation):* This is a false feeling of remorse or guilt of delusional intensity.

- 9) *Delusion of mind being read*: The false belief that other people can know one's thoughts.
- 10) *Delusion of reference*: The person falsely believes that insignificant remarks, events, or objects in one's environment have personal meaning or significance.
- 11) *Erotomania*: A delusion where someone believes another person is in love with them.
- 12) *Grandiose delusion*: An individual is convinced he has special powers, talents, or abilities. Sometimes, the individual may actually believe he or she is a famous person or character (for example, a rock star).
- 13) *Persecutory delusion*: These are the most common type of delusions and involve the theme of being followed, harassed, cheated, poisoned or drugged, conspired against, spied on, attacked, or obstructed in the pursuit of goals.
- 14) *Religious delusion*: Any delusion with a religious or spiritual content. These may be combined with other delusions, such as grandiose delusions (the belief that the affected person is a god, or chosen to act as a god, for example).
- 15) *Somatic delusion*: A delusion whose content pertains to bodily functioning, bodily sensations, or physical appearance. Usually the false belief is that the body is somehow diseased, abnormal, or changed—for example, infested with parasites.
- 16) *Delusions of parasitosis (DOP) or delusional parasitosis*: a delusion in which one feels infested with an insect, bacteria, mite, spiders, lice, fleas, worms, or other organisms. Affected individuals may also report being repeatedly bitten. In some cases, entomologists are asked to investigate cases of mysterious bites. Sometimes physical manifestations may occur including skin lesions.
- 17) *Delusions of poverty*: The person strongly believes that he is financially incapacitated. Although this type of delusion is less common now, it is however interesting to note that it was particularly widespread in the days before state support

3.4.3 Hallucinations

The person has Hallucinations. Hallucinations can occur in any sensory modality (i.e., visual, olfactory, gustatory, tactile, or auditory), but certain etiological factors are likely to evoke specific hallucinatory phenomena. Olfactory hallucinations, especially those involving the smell of burning rubber or other unpleasant smells, are highly suggestive of temporal lobe epilepsy. Hallucinations may vary from simple and unformed to highly complex and organised, depending on etiological factors, environmental surroundings, nature and focus of the insult rendered to the central nervous system, and the reactive response to impairment. The latter definition distinguishes hallucinations from the related phenomena of dreaming, which does not involve wakefulness; illusion, which involves distorted or misinterpreted real perception; imagery, which does not mimic real perception and is under voluntary control; and pseudohallucination, which does not mimic real perception, but is not under voluntary control.^[1] Hallucinations also differ from “delusional perceptions”, in which a correctly sensed and interpreted genuine perception is given some additional (and typically bizarre) significance.

Hallucinations can occur in any sensory modality — visual, auditory, olfactory, gustatory, tactile, proprioceptive, equilibrioceptive, nociceptive, thermoceptive and chronoceptive.

Self Assessment Questions

1) What are the various symptoms of psychotic disorders due to medical conditions?

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2) Describe the symptoms of this disorder.

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3) What are the various types of delusions?

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4) Define hallucinations.

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5) What are the various types of hallucinations?

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3.5 CAUSES PSYCHOTIC DISORDERS DUE TO MEDICAL CONDITIONS

Psychosis may be caused by a number of biological and social factors, depending on the disorder underlying the symptom. Trauma and stress can induce a short-term psychosis known as brief psychotic disorder. This psychotic episode, which lasts a month or less, can be brought on by the stress of major life-changing events (e.g., death of a close friend or family member, natural disaster, traumatic event), and can occur in patients with no prior history of mental illness.

Psychosis can also occur as a result of an organic medical condition (known as psychotic disorder due to a general medical condition). Neurological conditions (e.g., epilepsy, migraines, Parkinson's disease, cerebrovascular disease, dementia), metabolic imbalances (hypoglycemia), endocrine disorders (hyper- and hypothyroidism), renal disease, electrolyte imbalance, and autoimmune disorders may all trigger psychotic episodes.

Hallucinogenics, PCP, amphetamines, cocaine, marijuana, and alcohol may cause a psychotic reaction during use, abuse, or withdrawal. Certain prescription medications such as anesthetics, anticonvulsants, chemotherapeutic agents, and antiparkinsonian medications may also induce psychotic symptoms as a side-effect. In addition, toxic substances like carbon dioxide and carbon monoxide, which may be deliberately or accidentally ingested, have been reported to cause substance-induced psychotic disorder.

3.5.1 Functional Causes

Functional causes of psychosis include the following:

- brain tumors
- drug abuse amphetamines, cocaine, marijuana, alcohol among others
- brain damage
- schizophrenia, schizophreniform disorder, schizoaffective disorder, brief psychotic disorder
- bipolar disorder (manic depression)
- severe clinical depression
- severe psychosocial stress
- sleep deprivation
- some focal epileptic disorders especially if the temporal lobe is affected
- exposure to some traumatic event (violent death, etc.)
- abrupt or over-rapid withdrawal from certain recreational or prescribed drugs.

A psychotic episode can be significantly affected by mood. For example, people experiencing a psychotic episode in the context of depression may experience persecutory or self-blaming delusions or hallucinations, while people experiencing a psychotic episode in the context of mania may form grandiose delusions.

Stress is known to contribute to and trigger psychotic states. A history of psychologically traumatic events, and the recent experience of a stressful event, can both contribute to the development of psychosis. Short-lived psychosis triggered by stress is known as brief reactive psychosis, and patients may spontaneously recover normal functioning within two weeks.

In some rare cases, individuals may remain in a state of full-blown psychosis for many years, or perhaps have attenuated psychotic symptoms (such as low intensity hallucinations) present at most times.

3.5.2 General Medical Conditions

Psychosis arising from “organic” (non-psychological) conditions is sometimes known as secondary psychosis. It can be associated with the following pathologies:

- neurological disorders, including:
- brain tumour
- dementia with Lewy bodies
- multiple sclerosis
- sarcoidosis
- Lyme Disease
- syphilis
- Alzheimer’s Disease
- Parkinson’s Disease.

3.5.3 Psychoactive Drugs

Various psychoactive substances (both legal and illegal) have been implicated in causing, exacerbating, and/or precipitating psychotic states and/or disorders in users. On the other hand, cannabis use has increased dramatically over the past few decades but declined in the last decade, whereas the rate of psychosis has not increased.

An early phase of schizophrenia.

Because of the similarities between brief psychotic disorder, **schizophreniform disorder** and **schizophrenia**, many clinicians have come to think of brief psychotic disorder as being the precursor to a lengthier psychotic disorder. Although this can only be identified retrospectively, brief psychotic disorder is often the diagnosis that was originally used when an individual (who later develops schizophrenia) experiences a first “psychotic break” from more typical functioning.

3.5.4 A Stress Response

At times, under severe **stress**, temporary psychotic reactions may appear. The source of stress can be from typical events encountered by many people in the course of a lifetime, such as being widowed or divorced. The severe stress may be more unusual, such as being in combat, enduring a natural disaster, or being taken hostage. The person generally returns to a normal method of functioning when the stress decreases or more support is available, or better coping skills are learned.

3.5.5 Postpartum Psychosis

In some susceptible women, dramatic hormonal changes in childbirth and shortly afterward can result in a form of brief psychotic disorder often referred to as *postpartum psychosis*. Unfortunately, postpartum conditions are often misidentified and improperly treated. In many cases of a mother killing her infant or committing **suicide**, postpartum psychosis is involved.

<p>Self Assessment Questions</p> <p>1) What are the causes of psychosis in general medical conditions?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

2) What are psychoactive drugs? How are they involved in producing psychotic symptoms?

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3) Describe a stress response in the context psychotic symptoms.

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3.6 DEFENSE MECHANISM IN PERSONALITY DISORDER

Persons with **personality disorders** appear to be more susceptible to developing brief psychotic reactions in response to stress. Individuals with personality disorders have not developed effective adult mechanisms for coping with life. When life becomes more demanding and difficult than can be tolerated, the person may lapse into a brief psychotic state.

3.6.1 Culturally Defined Disorder

Culture is a very important factor in understanding mental health and psychological disturbance, and brief psychotic disorder is an excellent example. The types of behaviour that occur during brief psychotic disorder are very much shaped by the expectations and traditions of the individual's culture. Many cultures have some form of mental disorder that would meet criteria for brief psychotic disorder the features of which are unique to that culture, wherein most sufferers have similar behaviours that are attributed to causes that are localised to that community. The *DSMIV-TR* calls disorders unique to certain societies or groups "culture-bound."

An example of a culture-bound syndrome is *koro*, a syndrome observed in Japan and some other areas of Asia but not elsewhere. Koro is an **obsession** to the point of delusion with the possibility that the genitals will retract or shrink into the body and cause death.

Conversely, while culture shapes the form a psychotic reaction may take, culture also determines what is *not* to be considered psychotic. Behaviours that in one culture would be thought of as bizarre or psychotic, may be acceptable in another. For example, some cultural groups and religions view "speaking in tongues" as a valuable expression of the gifts of God, whereas viewed out of context, the unrecognisable speech patterns might be viewed as psychotic. If the behaviours shown are culturally acceptable in the person's society or religion, and happen in an approved setting such as a religious service, then brief psychotic disorder would not be diagnosed.

3.7 TREATMENT

The treatment of psychosis depends on the cause or diagnosis or diagnoses (such as schizophrenia, bipolar disorder and/ or substance intoxication). The first line treatment for many psychotic disorders is antipsychotic medication (oral or intramuscular injection), and sometimes hospitalisation is needed. There is growing evidence that cognitive behaviour therapy and family therapy can be effective in managing psychotic symptoms.

3.7.1 Early Intervention

Early intervention in psychosis is a relatively new concept based on the observation that identifying and treating someone in the early stages of a psychosis can significantly improve their longer term outcome. This approach advocates the use of an intensive multi-disciplinary approach during what is known as the critical period, where intervention is the most effective, and prevents the long term morbidity associated with chronic psychotic illness.

Newer research into the effectiveness of cognitive behavioural therapy during the early pre-cursory stages of psychosis (also known as the “prodrome” or “at risk mental state”) suggests that such input can prevent or delay the onset of psychosis.

3.7.2 Hospitalisation

Hospitalisation is preferred when dealing with patients who exhibit severe symptoms of Schizophrenia. The aim of hospitalisation is to prevent them from hurting or injuring themselves and gain stability as they take medication.

Psychiatric hospitalisation may be needed to observe individuals and protect them from their own loss of reality, judgment, and impulse control. Antipsychotic medication may be given along with any appropriate psychotherapy. In certain situations, group therapy may be effective. Electroconvulsive therapy (ECT) is not as effective. Fifty to sixty percent of cases get better with ECT if the patient has a psychotic disorder (Ghaziuddin 119). With continued observation, it may be possible to reach a more specific diagnosis and initiate appropriate treatment. Psychosis caused by schizophrenia or another mental illness should be treated by a psychiatrist and/or psychologist. Other medical and mental health professionals may be part of the treatment team, depending on the severity of the psychosis and the needs of the patient. Medication and/or psychosocial therapy is typically employed to treat the underlying disorder.

3.7.3 Medications

Antipsychotic medications commonly prescribed to treat psychosis include risperidone (Risperdal), thioridazine (Mellaril), halperidol (Haldol), chlorpromazine (Thorazine), clozapine (Clozaril), loxapine (Loxitane), molindone hydrochloride (Moban), thiothixene (Navane), and olanzapine (Zyprexa). Possible common side-effects of antipsychotics include dry mouth, drowsiness, muscle stiffness, and hypotension. More serious side effects include tardive dyskinesia (involuntary movements of the body) and neuroleptic malignant syndrome (NMS), a potentially fatal condition characterised by muscle rigidity, altered mental status, and irregular pulse and blood pressure.

Once an acute psychotic episode has subsided, psychosocial therapy and living and vocational skills training may be recommended. Drug maintenance treatment is usually prescribed to prevent further episodes.

Antipsychotics are the primary medications for treating schizophrenia. This medicine

reduces disturbing symptoms like hallucinations and delusion. Some of the common medicines include Prolixin, Navane, Trilafon, Clozaril, Geodon and Zyprexa.

3.7.4 Psychosocial Therapy

Psychosocial therapy is considered the most effective in dealing with social, psychological and behavioural problems resulting from schizophrenia. Therapy includes rehabilitation which helps an individual to focus on skills and training to help an individual to be independent. Family therapy enables a person to interact and effectively deal with the family members.

3.8 LET US SUM UP

Thus it can be said that psychosis caused by a medical condition may be a single isolated incident or may be recurrent, cycling with the status of the underlying medical condition. Although treating the medical condition often results in the remission of the psychosis. The symptoms of psychosis sometimes persists long after the medical conditions and caused psychosis. Prominent hallucinations and delusions are the main cause for such psychotic development. Individuals with brief psychotic disorder experience delusions, hallucinations, and/or disorganised speech and behaviour that lasts for at least one day. However, these symptoms remit within one month, and their behaviour returns to normal. If the observed psychotic symptoms can be reasonably thought to have been due to a pre-existing mental illness diagnosis .

About 1% of the world's population has psychotic disorders. Symptoms for most psychotic disorders often first appear when an individual is in their late teens to 30's. Psychotic disorders affect men and women equally. Men more commonly develop symptoms of schizophrenia between 18 to 25 years old, while women tend to develop symptoms of schizophrenia between 25 years old to the mid 30's. Late onset (after 40 years old) is more common in women than in men. In psychosis persons with some preexisting vulnerability experience some stress and symptoms emerge as a result. Psychotic symptoms disrupt the lives and this need to be handle with the interventions like therapy, medications and early identification of the disorder.

3.9 UNIT END QUESTIONS

- 1) What are the symptoms of psychotic disorders due to general medical conditions?
- 2) What are the causes of psychotic disorders due to medical conditions?
- 3) What is meant by defense mechanisms in psychotic disorders?
- 4) What do we understand by culturally defined disorders?
- 5) Describe the early intervention as part of treatment of these disorders.
- 6) When are these patients hospitalised and what are the main reasons for the same?
- 7) Discuss the psychosocial therapy for psychotic disorders due to general medical condition.

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UNIT 4 SUBSTANCE INDUCED PSYCHOTIC DISORDER

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Substance Induced Psychotic Disorders
 - 4.2.1 Causes of Substance Induced Psychotic Disorders
 - 4.2.2 Diagnosis of Substance Induced Psychotic Disorder
 - 4.2.3 Essential Features of Substance Induced Psychotic Disorders
 - 4.2.4 Difference Between Substance Induced Psychotic Disorders and Other Psychotic Disorders
- 4.3 Subtypes and Specifiers
- 4.4 Diagnosis
 - 4.4.1 Differential Diagnosis of Substance Induced Psychotic Disorder and Medicine Induced Psychotic Disorders
- 4.5 Treatments
 - 4.5.1 Hospitalisation
 - 4.5.2 Medical Care
 - 4.5.3 Counselling
 - 4.5.4 Detoxification
 - 4.5.5 Surgical Care
 - 4.5.6 Medications
 - 4.5.7 Prognosis
 - 4.5.8 Prevention
- 4.6 Let Us Sum Up
- 4.7 Unit End Questions
- 4.8 Suggested Readings

4.0 INTRODUCTION

In this unit we will be dealing with substance induced psychotic disorders. We begin with substance induced psychotic disorders in terms of what are psychotic disorders and what types of such disorders exist. This is followed by the type of substances that could induce these disorders. The various causes that lead to psychoactive substances and their effects resulting in psychotic reactions are discussed. This is followed by diagnostic criteria to decide the substance induced psychotic disorder. We then present the essential features of substance induced psychotic disorders and bring out the differences between these disorders and the medically induced psychotic disorders. This is followed by the subtypes of these disorders and the specifiers. We then use different criteria to diagnose these disorders and make a differential diagnosis of these disorder vis a vis other psychotic disorders. Then we take up the treatments of these

disorders which includes hospitalisation onwards to medical care, counseling and surgical care. The prognosis and prevention are discussed briefly.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define substance induced psychotic disorder;
- Enlist various types of such psychotic disorders;
- Delineate the Symptoms and causes of the disorders;
- Explain the differential diagnosis of substance induced psychotic disorders vis a vis other psychotic disorders; and
- Analyse the different treatment approaches to these disorders.

4.2 SUBSTANCE INDUCED PSYCHOTIC DISORDER

Let us start with psychotic disorders.

Psychotic disorders are a group of serious illnesses that affect the mind. These illnesses alter a person's ability to think clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately. When symptoms are severe, people with psychotic disorders have difficulty staying in touch with reality and often are unable to meet the ordinary demands of daily life. However, even the most severe psychotic disorders usually are treatable.

There are different types of psychotic disorders, including:

Schizophrenia: People with this illness have changes in behaviour and other symptoms — such as delusions and hallucinations — that last longer than six months, usually with a decline in work, school and social functioning.

Schizoaffective disorder: People with this illness have symptoms of both schizophrenia and a mood disorder, such as depression or bipolar disorder.

Schizophreniform disorder: People with this illness have symptoms of schizophrenia, but the symptoms last more than one month but less than six months.

Brief psychotic disorder: People with this illness have sudden, short periods of psychotic behaviour, often in response to a very stressful event, such as a death in the family. Recovery is often quick — usually less than a month.

Delusional disorder: People with this illness have delusions involving real-life situations that could be true, such as being followed, being conspired against or having a disease. These delusions persist for at least one month.

Shared psychotic disorder: This illness occurs when a person develops delusions in the context of a relationship with another person who already has his or her own delusion(s).

Substance-induced psychotic disorder: This condition is caused by the use of or withdrawal from some substances, such as alcohol and crack cocaine, that may cause hallucinations, delusions or confused speech.

Psychotic disorder due to a medical condition: Hallucinations, delusions or other

symptoms may be the result of another illness that affects brain function, such as a head injury or brain tumor.

Paraphrenia: This is a type of schizophrenia that starts late in life and occurs in the elderly population.

4.2.1 Causes of Substance Induced Psychotic Disorders

A large number of toxic or psychoactive substances can cause psychotic reactions. Such substance induced psychosis can occur in multiple ways.

These include the following:

- 1) People may inadvertently ingest toxic substances by accident, either because they do not know any better or by mistake.
- 2) People may take too much of a legitimately prescribed medicine, medicines may interact in unforeseen ways. Doctors may miscalculate the effects of medicines they prescribe.
- 3) People may overdose on recreational drugs they commonly use (such as cocaine), or become dependent on drugs or alcohol and experience psychotic symptoms while in withdrawal from those substances.
- 4) While the substance induced psychosis is triggered and then sustained by intoxication or withdrawal, its effects can continue long after intoxication or withdrawal has ended.
- 5) Drugs of abuse that can cause psychosis include alcohol, amphetamines, marijuana, cocaine, hallucinogens, inhalants, opioids, and sedative-hypnotics, including medicines that are sometimes used to treat anxiety.
- 6) Common over the counter and doctor prescribed medications that can cause psychosis include anesthetics, analgesics, anticholinergic agents, anticonvulsants, antihistamines, cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents, corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti inflammatory medications like ibuprophen, and anti-depressants.
- 7) Environmental toxins reported to induce psychotic symptoms include anticholinesterase, organophosphate insecticides, nerve gases, carbon monoxide (car exhaust), carbon dioxide, and volatile substances such as fuel or paint.

4.2.2 Diagnosis of Substance Induced Psychotic Disorders

The following diagnostic criteria must be met before a diagnosis of Substance Induced Psychotic Disorder is warranted. According to the DSM IV TR the symptoms must be

- a) Prominent hallucinations or delusions
- b) Evidence from the history, physical examination, or laboratory findings of either (1) or (2) given below.
 - 1) The symptoms in Criterion A developed during, or within a month of, substance intoxication or withdrawal
 - 2) Medication use is etiologically related to the disturbance
- c) The disturbance is not better accounted for by a Psychotic Disorder that is not substance induced.

If it is other psychotic disorder, the symptoms would include the following:

- i) the symptoms would precede the onset of the substance use (or medication use);
 - ii) the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication, or
 - iii) are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or
 - iv) there is other evidence that suggests the existence of an independent non substance induced Psychotic Disorder, as for example, a history of recurrent non substance related episodes.
- d) The disturbance does not occur exclusively during the course of a delirium.

4.2.3 Essential Features of Substance Induced Psychotic Disorders

The essential features of Substance-Induced Psychotic Disorder are prominent hallucinations or delusions (Criterion A) that are judged to be due to the direct physiological effects of a substance.

Hallucinations that the individual realises are substance induced are not included here and instead would be diagnosed as Substance Intoxication or Substance Withdrawal with the accompanying specifier with Perceptual Disturbances.

The disturbance must not be better accounted for by a Psychotic Disorder that is not substance induced (Criterion C).

The diagnosis is not made if the psychotic symptoms occur only during the course of a delirium (Criterion D).

This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the psychotic symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

4.2.4 Difference between Substance Induced Psychotic Disorders and Other Psychotic Disorders

Table below presents the differences between substance induce and other psychotic disorders.

Substance induced psychotic disorders	Other psychotic disorders
Onset: Following ingesting the substance of abuse	Onset Insidious onset or over a period of time. Has nothing to do with any substance abuse
Course of this disorder is associated with the drug intake. The moment the drug is withdrawn, after the period of withdrawal syndrome, the psychotic episodes also disappear	Course of this disorder continues on and the symptoms reduce or disappear with intake of medications
There must be evidence from the history, physical examination, or laboratory findings of Dependence, Abuse, intoxication, or withdrawal	Physical examination etc do not show any ingestion of drugs. There is no history of substance abuse.

Schizophrenia and Other Psychotic Disorders

Substance Induced Psychotic Disorders arise only in association with intoxication or withdrawal states	Other Psychotic disorders do not have any association with drug or intoxication or withdrawal.
May persist for weeks	These precede the onset of substance use or may occur during times of sustained abstinence.
Once initiated the psychotic symptoms may continue as long as the substance use continues	There is no relationship between psychotic features and use of substances
Age of onset has no importance here	Age of onset is very important as for instance the age of onset for schizophrenia is adolescent years to young adulthood
No specific role of history of psychotic disorder	There is history of psychotic disorder at an earlier age level or in the family
Generally there is non auditory hallucinations	In this there is generally auditory hallucinations
The psychotic symptoms persist so long as the substance abuse continues	Psychotic symptoms persist for a substantially long period of time
Persistence of psychotic symptoms for a substantial period of time (i.e., a month or more) after the end of Substance Intoxication or acute Substance Withdrawal.	There is no connection between substance use or withdrawal symptoms and the psychotic features.
Symptoms of psychotic disorder are limited to the use of substance.	The development of symptoms that are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use.

Other causes of psychotic symptoms must be considered even in a person with Intoxication or Withdrawal, because substance use problems are not uncommon among persons with non substance induced Psychotic Disorders.

Self Assessment Questions

1) Describe in detail the various psychotic disorders.

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2) Define substance induced psychotic disorders.

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3) What are the criteria to diagnose substance induced psychotic disorders?

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4) Describe the essential features of substance induced psychotic disorders.

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5) Differentiate between substance induced psychotic disorder and other psychotic disorders.

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4.3 SUBTYPES AND SPECIFIERS

One of the following subtypes may be used to indicate the predominant symptom presentation. If both delusions and hallucinations are present, indicate whichever is predominant:

With Delusions: This subtype is used if delusions are the predominant symptom.

With Hallucinations: This subtype is used if hallucinations are the predominant symptom.

The context of the development of the psychotic symptoms may be indicated by using one of the specifiers listed below:

With Onset During Intoxication: This specifier should be used if criteria for intoxication with the substance are met and the symptoms develop during the intoxication syndrome.

With Onset During Withdrawal: This specifier should be used if criteria for withdrawal from the substance are met and the symptoms develop during, or shortly after, a withdrawal syndrome.

A substance induced psychotic disorder that begins during substance use can last as long as the drug is used. A substance induced psychotic disorder that begins during withdrawal may first manifest up to four weeks after an individual stops using the substance.

The speed of onset of psychotic symptoms varies depending on the type of substance. For example, using a lot of cocaine can produce psychotic symptoms within minutes.

On the other hand, psychotic symptoms may result from alcohol use only after days or weeks of intensive use.

The type of psychotic symptoms also tends to vary according to the type of substance.

For instance, auditory hallucinations (specifically, hearing voices), visual hallucinations,

and tactile hallucinations are most common in an alcohol-induced psychotic disorder, whereas persecutory delusions and tactile hallucinations (especially formication) are commonly seen in a cocaine – or amphetamine-induced psychotic disorder.

4.4 DIAGNOSIS

Diagnosis of a substance-induced psychotic disorder must be differentiated from a psychotic disorder due to a general medical condition.

Some medical conditions (such as temporal lobe epilepsy or Huntington’s chorea) can produce psychotic symptoms, and, since individuals are likely to be taking medications for these conditions, it can be difficult to determine the cause of the psychotic symptoms.

If the symptoms are determined to be due to the medical condition, then a diagnosis of a psychotic disorder due to a general medical condition is warranted.

Substance-induced psychotic disorder also needs to be distinguished from delirium, dementia, primary psychotic disorders, and substance intoxication and withdrawal. While there are no absolute means of determining substance use as a cause, a good patient history that includes careful assessment of onset and course of symptoms, along with that of substance use, is imperative.

Often, the patient’s testimony is unreliable, necessitating the gathering of information from family, friends, coworkers, employment records, medical records, and the like. Differentiating between substance-induced disorder and a psychiatric disorder may be aided by the following:

Time of onset: If symptoms began prior to substance use, it is most likely a psychiatric disorder.

Substance use patterns: If symptoms persist for three months or longer after substance is discontinued, a psychiatric disorder is probable.

Consistency of symptoms: Symptoms more exaggerated than one would expect with a particular substance type and dose most likely amounts to a psychiatric disorder.

Family history: A family history of mental illness may indicate a psychiatric disorder.

Response to substance abuse treatment: Clients with both psychiatric and substance use disorders often have serious difficulty with traditional substance abuse treatment programs and relapse during or shortly after treatment cessation.

Client’s stated reason for substance use: Those with a primary psychiatric diagnosis and secondary substance use disorder will often indicate they “medicate symptoms,” for example, drink to dispel auditory hallucinations, use stimulants to combat depression, use depressants to reduce anxiety or soothe a manic phase.

While such substance use most often exacerbates the psychotic condition, it does not necessarily mean it is a substance-induced psychotic disorder.

Unfortunately, psychological tests are not always helpful in determining if a psychotic disorder is caused by substance use or is being exacerbated by it. However, evaluations, such as the MMPI-2 and MAC-R scale or the Wechsler Memory Scale—Revised, can be useful in making a differential diagnosis. Also *Neuropsychological assessment* or Neuropsychological testing is also an important tool for examining the effects of toxic substances on brain functioning. Some physicians may use neuropsychological assessments to reveal patients’ cognitive and physical impairment after cocaine use.

Neuropsychological testing assesses brain functioning through structured and systematic behavioural observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, and language. An example of a task that a physician might ask the patient to complete as part of a neuropsychological examination is to name as many words beginning with a particular letter as the patient can in one minute. Patients who abuse cocaine often have difficulty completing tasks, such as the one described, that require concentration and memory.

4.4.1 Differential Diagnosis of Substance Induced Psychotic Disorder and Medicine Induced Psychotic Disorders

A diagnosis of Substance-Induced Psychotic Disorder should be made instead of a diagnosis of **Substance Intoxication** or **Substance Withdrawal** only when

- 1) The psychotic symptoms are judged to be in excess of those usually associated with the intoxication or withdrawal syndrome.
- 2) When the symptoms are sufficiently severe to warrant independent clinical attention.
- 3) Individuals intoxicated with stimulants, cannabis, the opioid meperidine, or phencyclidine, or those withdrawing from alcohol or sedatives, may experience altered perceptions (scintillating lights, sounds, visual illusions) that they recognise as drug effects.
- 4) If reality testing for these experiences remains intact (i.e., the person recognises that the perception is substance induced and neither believes in nor acts on it), then the diagnosis is not Substance-Induced Psychotic Disorder.
- 5) Instead, **Substance Intoxication or Withdrawal, With Perceptual Disturbances**, is diagnosed (e.g., Cocaine Intoxication, With Perceptual Disturbances).
- 6) “Flashback” hallucinations that can occur long after the use of hallucinogens has stopped are diagnosed as **Hallucinogen Persisting Perception Disorder**.
- 7) Moreover, if substance-induced psychotic symptoms occur exclusively during the course of a delirium, as in some severe forms of Alcohol Withdrawal, the psychotic symptoms are considered to be an associated feature of the delirium and are not diagnosed separately.
- 8) A Substance-Induced Psychotic Disorder is distinguished from a **primary Psychotic Disorder** by the fact that a substance is judged to be etiologically related to the symptoms.
- 9) A Substance-Induced Psychotic Disorder due to a prescribed treatment for a mental or general medical condition must have its onset while the person is receiving the medication (or during withdrawal, if there is a withdrawal syndrome associated with the medication).
- 10) Once the treatment is discontinued, the psychotic symptoms will usually remit within days to several weeks (depending on the half-life of the substance and the presence of a withdrawal syndrome). If symptoms persist beyond 4 weeks, other causes for the psychotic symptoms should be considered.
- 11) Because individuals with general medical conditions often take medications for

those conditions, the clinician must consider the possibility that the psychotic symptoms are caused by the physiological consequences of the general medical condition rather than the medication, in which case Psychotic Disorder Due to a General Medical Condition is diagnosed.

- 12) The history often provides the primary basis for such a judgment. At times, a change in the treatment for the general medical condition (e.g., medication substitution or discontinuation) may be needed to determine empirically for that person whether the medication is the causative agent.
- 13) If the clinician has ascertained that the disturbance is due to both a general medical condition and substance use, both diagnoses (i.e., Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder) may be given.
- 14) When there is insufficient evidence to determine whether the psychotic symptoms are due to a substance (including a medication) or to a general medical condition or are primary (i.e., not due to either a substance or a general medical condition), Psychotic Disorder Not Otherwise Specified would be indicated.

Specify if:

With Onset During Intoxication: if criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome

With Onset During Withdrawal: if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

Self Assessment Questions

1) What are the subtypes and specifiers? Discuss.

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2) What are the methods used in diagnosing the substance induced psychotic disorders?

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3) Differentiate between substance induced and medicine induced psychotic disorders.

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4.5 TREATMENTS

Treatment is determined by the underlying cause and severity of psychotic symptoms. However, treatment of a substance-induced psychotic disorder is often similar to treatment for a primary psychotic disorder such as schizophrenia. Appropriate treatments may include psychiatric hospitalisation and antipsychotic medication.

Treatment is determined by the underlying cause and severity of psychotic symptoms. However, treatment of a substance-induced psychotic disorder is often similar to treatment for a primary psychotic disorder such as schizophrenia. Appropriate treatments may include psychiatric hospitalisation and antipsychotic medication.

4.5.1 Hospitalisation

Hospitalisation or inpatient care is the most restrictive form of treatment for a psychiatric disorder, addictive disorder, or for someone with more than one diagnosis. Whether it is voluntary or involuntary, the patient relinquishes the freedom to move about and, once admitted, becomes subject to the rules and schedule of a treatment environment.

Patients who are likely to require hospitalisation include especially if the patient is delirious, suicidal, homicidal, or gravely disabled. As inpatients, they may require the administration of medications (e.g. haloperidol, risperidone, carbamazepine) to relieve any psychosis related to the chemicals inhaled.

Hospitalisation is necessary in cases where an individual is in imminent danger of harming himself or others or has made a suicide attempt. Crisis stabilization, behaviour modification, supervised substance abuse detoxification, and medication management are compelling reasons to consider hospitalisation. Ideally, hospitalisation is at one end of a comprehensive continuum of services for people needing treatment for behavioural problems. It is generally viewed as a last resort after other less restrictive forms of treatment have failed.

Treatment may vary depending on the drug involved. Hallucinogen and phencyclidine psychosis may not respond well to antipsychotics. A supportive approach is preferred, with reassuring, structured, and protective surroundings. Agitation may be best treated with short-acting benzodiazepines.

4.5.2 Medical Care

The medical care of patients with inhalant-related psychiatric disorders encompasses many areas.

A team of medical professionals must work in unison to ensure that every aspect of the treatment plan is fulfilled.

4.5.3 Counselling

The goals of substance abuse counseling are:

- 1) Achieving and maintaining abstinence from alcohol or other drugs of abuse or, for patients unable or unwilling to work toward total abstinence, reducing the amount and frequency of use and concomitant biopsychosocial sequelae associated with drug use disorders.
- 2) Stabilizing acute psychiatric symptoms.
- 3) Resolving or reducing problems and improving physical, emotional, social, family, interpersonal, occupational, academic, spiritual, financial, and legal functioning.

- 4) Working toward positive lifestyle change.
- 5) Early intervention in the process of relapse to either the addiction or the psychiatric disorder.

Counseling (supportive therapy) should be initiated, along with patient education to explain the dangers of huffing. Evaluate patients for psychiatric comorbidity.

Interventions include the following:

- 1) Motivating patients to seek detoxification or inpatient treatment if symptoms warrant, and sometimes facilitating an involuntary commitment for psychiatric care.
- 2) Educating patients about psychiatric illness, addictive illness, treatment, and the recovery process.
- 3) Supporting patients' efforts at recovery and providing a sense of hope regarding positive change.
- 4) Referring patients for other needed services (case management, medical, social, vocational, economic needs).
- 5) Helping patients increase self-awareness so that information regarding dual disorders can be personalised.
- 6) Helping patients identify problems and areas of change.
- 7) Helping patients develop and improve problem solving ability and develop recovery coping skills.
- 8) Facilitating pharmacotherapy evaluation and compliance. (This requires close collaboration with the team psychiatrist.)

Change in the addictive behaviour may occur as a result of the patient counselor relationship and the team relationship (i.e., counselor, psychiatrist, psychologist, nurse, or other professionals such as case manager or family therapist). A positive therapeutic alliance is seen as critical in helping patients become involved and stay involved in the recovery process. Community support systems, professional treatment groups, and self-help programs also serve as possible agents of positive change. For the more chronically and persistently mentally ill patients, a case manager may also function as an important agent in the change process.

Although patients have to work on a number of intrapersonal and interpersonal issues as part of long term recovery, medications can facilitate this process by attenuating acute symptoms, improving mood, or improving cognitive abilities or impulse control. Thus, medications may eliminate or reduce symptoms as well as help patients become more able to address problems during counseling sessions. A severely depressed patient may be unable to focus on learning cognitive or behavioural interventions until he or she experiences a certain degree of remission from symptoms of depression. A floridly psychotic patient will not be able to focus on abstinence from drugs until the psychotic symptoms are under control.

No controlled studies have been performed to guide the treatment of patients who abuse inhalants and who have inhalant dependence. Additionally, no specific medications indicated by the pharmaceutical industry are available for detoxification from inhalants.

Programs are available that specifically treat inhalant abuse; however, they are rare and difficult to find. Therefore, treatment planning most often is tailored much like that of the

treatment of patients with chemical dependence, in which the first step is to detoxify the patient.

Patients who are addicted to inhalants experience withdrawal symptoms similar to those of any other patient addicted to drugs, including tremors, chills, sweats, cramps, nausea, and hallucinations.

Next, a peer system is established.

Once these 2 tasks are accomplished, assess the patient for physical, cognitive, and neurologic problems. If any problems are noted in these areas, they must be treated immediately. Identify any strengths the patient has and build on these strengths to increase them and to create new additional strengths for the patient. Address any other problems they may have. The goals are to return the patient to the community with a drug-free peer network and to continue or enhance self-support.

Treat any conduct problems noted.

Once the patient is detoxified, evaluate for other psychiatric illnesses using the *DSM-IV-TR*.

The patient should participate in group therapy sessions, 12-step programs/chemical dependency groups, rational-emotive therapy, cognitive behaviour therapy, and family therapy.

Discuss safe sex with the patient, including partner precautions and birth control. In addition, the family should receive education about the disorder, secure substances that could be huffed, and become familiar with local mental health laws regarding commitment policies.

No medications should be used unless a treatable *DSM-IV-TR* diagnosis has been identified.

If the patient has depression independent of the inhalant abuse, treat with the antidepressant of choice.

If the patient abuses alcohol in addition to inhalants, disulfiram (Antabuse) or naltrexone can be used in appropriate settings.

If the patient meets *DSM-IV-TR* criteria for attention-deficit/hyperactivity disorder, a psychostimulant such as pemoline (Cylert) can be used for treatment. The United States Food and Drug Administration (FDA) concluded that the overall risk of liver toxicity from pemoline outweighs the benefits. In May 2005, Abbott chose to stop sales and marketing of their brand of pemoline (Cylert) in the United States. In October 2005, all companies that produced generic versions of pemoline also agreed to stop sales and marketing of pemoline.

If the patient is psychotic as a result of the inhalant abuse (inhalant-induced psychosis), the physician may use an appropriate antipsychotic such as haloperidol (Haldol) or risperidone (Risperdal), with or without a benzodiazepine. This is the physician's choice.

If the patient has an inhalant-induced mood disorder, detoxification is recommended, without the use of any medications unless the depression persists for longer than 2-4 weeks after withdrawal.

4.5.4 Detoxification

Detoxification is also recommended for patients who are experiencing inhalant-induced

anxiety; however, the use of sedatives or antianxiety medications is contraindicated because inhalant intoxication can worsen if the patient uses again.

If the patient cannot maintain sobriety, the physician should consider residential treatment options, which can last anywhere from 3-12 months.

Most persons who abuse inhalants receive most of their medical care in local emergency departments after they have either passed out or become psychotic from chemical inhalation. In the emergency department, they receive supportive care, social interventions, and appropriate medical care.

4.5.5 Surgical Care

Patients may need liver or kidney transplantation.

Consultations

Chemical dependence counselor

Attorney, if legal problems develop

Social worker

Family therapist

Peer-group therapist

Dietitian (possibly)

Diet

Consultation with a dietitian may be helpful if patients have poor nutrition (eg, liver problems, low protein).

If no additional medical problems are present, patients can eat a regular diet.

Activity

Maintain sobriety.

Patients who are not a danger to themselves or others, are not gravely disabled, and are medically stable can maintain routine activities.

4.5.6 Medications

If psychosis or delirium is present, use an antipsychotic such as risperidone or haloperidol and/or an anticonvulsant such as carbamazepine. Avoid benzodiazepines because they may worsen respiratory depression.

Antipsychotics

Reduce psychosis and aggressive behaviour. All antipsychotics may be equally efficacious, but their adverse effect profiles are different. The atypical antipsychotics such as risperidone, olanzapine, quetiapine, and ziprasidone have an advantage in the adverse effect profile, especially with their lower risk to cause adverse extrapyramidal effects and tardive dyskinesia.

4.5.7 Prognosis

Psychotic symptoms induced by substance intoxication usually subside once the substance is eliminated. Symptoms persist depending on the half-life of the substances

(i.e., how long it takes the before the substance is no longer present in an individual’s system). Symptoms, therefore, can persist for hours, days, or weeks after a substance is last used.

4.5.8 Prevention

There is very little documented regarding prevention of substance-induced psychotic disorder. However, abstaining from drugs and alcohol or using these substances only in moderation would clearly reduce the risk of developing this disorder. In addition, taking medication under the supervision of an appropriately trained physician should reduce the likelihood of a medication induced psychotic disorder. Finally, reducing one’s exposure to toxins would reduce the risk of toxin-induced psychotic disorder.

Self Assessment Questions

1) Discuss the various treatment approaches to substance induced psychotic disorder.

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2) Discuss hospitalisation and medical care as important methods of treatment of this disorder.

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3) What is the prognosis of this disorder?

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4) How do we prevent this substance induced psychotic disorder from manifesting?

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4.6 LET US SUM UP

Substance-Induced Psychotic Disorders may at times not resolve promptly when the offending agent is removed. Agents such as amphetamines, phencyclidine, and cocaine have been reported to evoke temporary psychotic states that can sometimes persist for weeks or longer despite removal of the agent and treatment with neuroleptic medication.

These may be initially difficult to distinguish from non-substance-induced Psychotic Disorders.

The essential features of Substance-Induced Psychotic Disorder are prominent hallucinations or delusions that are judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure). Hallucinations that the individual realises are substance induced are not included here and instead would be diagnosed as Substance Intoxication or Substance Withdrawal with the accompanying specifier.

With Perceptual Disturbances. The disturbance must not be better accounted for by a Psychotic Disorder that is not substance induced. The diagnosis is not made if the psychotic symptoms occur only during the course of a delirium. This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the psychotic symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

A Substance-Induced Psychotic Disorder is distinguished from a primary Psychotic Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of Dependence, Abuse, intoxication, or withdrawal.

Substance Induced Psychotic Disorders arise only in association with intoxication or withdrawal states but can persist for weeks, whereas primary Psychotic Disorders may precede the onset of substance use or may occur during times of sustained abstinence. Once initiated, the psychotic symptoms may continue as long as the substance use continues.

Another consideration is the presence of features that are atypical of a primary Psychotic Disorder (e.g., atypical age at onset or course). For example, the appearance of delusions de novo in a person over age 35 years without a known history of a primary Psychotic Disorder should alert the clinician to the possibility of a Substance-Induced Psychotic Disorder. Even a prior history of a primary Psychotic Disorder does not rule out the possibility of a Substance-Induced Psychotic Disorder.

It has been suggested that 9 out of 10 nonauditory hallucinations are the product of a Substance-Induced Psychotic Disorder or a Psychotic Disorder Due to a General Medical Condition. In contrast, factors that suggest that the psychotic symptoms are better accounted for by a primary Psychotic Disorder include persistence of psychotic symptoms for a substantial period of time (i.e., a month or more) after the end of Substance Intoxication or acute Substance Withdrawal; the development of symptoms that are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or a history of prior recurrent primary Psychotic Disorders.

Other causes of psychotic symptoms must be considered even in a person with Intoxication or Withdrawal, because substance use problems are not uncommon among persons with (presumably) non-substance induced Psychotic Disorders. Psychotic symptoms induced by substance intoxication usually subside once the substance is eliminated. Symptoms persist depending on the half-life of the substances (i.e., how long it takes the before the substance is no longer present in an individual's system). Symptoms, therefore, can persist for hours, days, or weeks after a substance is last used. There is very little documented regarding prevention of substance-induced psychotic disorder. However, abstaining from drugs and alcohol or using these substances

only in moderation would clearly reduce the risk of developing this disorder. In addition, taking medication under the supervision of an appropriately trained physician should reduce the likelihood of a medication-induced psychotic disorder. Finally, reducing one's exposure to toxins would reduce the risk of toxin-induced psychotic disorder.

4.7 UNIT END QUESTIONS

- 1) Define and describe substance induced psychotic disorders.
- 2) Discuss how substance induced disorder can be caused?
- 3) Define subtypes of substance induced psychotic disorder?
- 4) What are the causes of these disorders?
- 5) Discuss critically the various treatments available for this disorder.

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UNIT 1 BORDERLINE PERSONALITY DISORDER

Structure

- 1.0 Introduction
- 1.1 Objectives
- 1.2 Personality Disorders
 - 1.2.1 Cluster A (odd or eccentric disorders)
 - 1.2.2 Cluster B (dramatic, emotional or erratic disorders)
 - 1.2.3 Cluster C (anxious or fearful disorders)
 - 1.2.4 Appendix B: Criteria Sets and Axes Provided for Further Study
 - 1.2.5 Symptoms of Personality Disorder
 - 1.2.6 Causes of Personality Disorder
 - 1.2.7 Treatment of Personality Disorder
- 1.3 Borderline Personality Disorder
 - 1.3.1 Clinical Features of Borderline Personality Disorder
 - 1.3.2 Causes of Borderline Personality Disorder
 - 1.3.3 Treatment of Borderline Personality Disorder
 - 1.3.4 Prognosis
- 1.4 Let Us Sum Up
- 1.5 Unit End Questions
- 1.6 Glossary
- 1.7 Suggested Readings

1.0 INTRODUCTION

In our lives, we come across different types of people. Some persons might be over suspicious, distrustful to others while others might be much orderly and systematic even in trivial matters. We also see people who give too much importance to self and have little time for others. These people may suffer some sort of personality disorder. The individual's characteristic ways of responding are often referred to his or her personality. Most people's personality styles do not affect their behaviour similarly in all situations. Personality styles can be maladaptive if an individual is unable to modify his or her behaviour when the environment undergoes significant changes. If personality characteristics are not flexible enough to allow an individual to respond adaptively to at least an ordinary variety of situations, a disorder may be present. Personality disorders are longstanding and inflexible styles of relating to the environment. They cause problems in interpersonal relationships, on the job or result into personal distress. In this unit we will first try to understand major personality disorders and their characteristics, and then we will discuss border line personality in detail.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define the nature and types of personality disorder;

- Describe the diagnostic criteria of personality disorder;
- Describe the causes and treatment of personality disorder;
- Explain the clinical features of borderline personality disorder;
- Elucidate the causes of borderline personality disorder; and
- Discuss the treatment and prognosis of borderline personality disorder.

1.2 PERSONALITY DISORDERS

Personality disorders, which were formerly referred to as *character disorders*, are a class of personality types and behaviours that the American Psychiatric Association (APA) defines as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the culture of the individual who exhibits it. Personality disorders are noted on *Axis II the Diagnostic of Statistical and Manual-IV- Text Revised or DSM-IV-TR* of the American Psychological Association.

According to DSM- IV- TR (2000) Personality disorder is enduring subjective experiences and behaviour that deviates from cultural standards, are rigidly pervasive, have an onset in adolescence or early adulthood, are stable through time, and lead to unhappiness and impairment. So 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.

Moreover, personality disorders typically do not stem from debilitating reactions to stress, as in post-traumatic stress disorder or in many cases of major depression. Rather, personality disorders stem largely from the gradual development inflexible and distorted personality and behavioural patterns, which result in persistently maladaptive ways of perceiving, thinking about, and relating to the world. These maladaptive approaches usually significantly impair at least some aspects of functioning and in some cases cause a good deal of subjective distress. For example, people with avoidant personality disorder are so shy and hypersensitive to rejection that they actively avoid most social interaction.

The DSM- IV lists ten personality disorders, grouped into three clusters in Axis II. The DSM - IV also contains a category for behavioural patterns that do not match these ten disorders, but nevertheless exhibit characteristics of a personality disorder. This category is labeled Personality Disorder not Otherwise Specified.

1.2.1 Cluster A (odd or eccentric disorders)

- 1) **Paranoid personality disorder (DSM- IV code 301.0):** Paranoid personality disorder is characterised by irrational suspicions and mistrust of others. Personality characteristics may be ‘active’, resulting in hostility, quarrels, litigation, and even violence or destructive behaviour on occasions, or ‘passive’, with the individual facing the world from a position of submission and humiliation. Person suffering from paranoid personality disorder believes that others dislike him and will do him down but is not able to do much about it.
- 2) **Schizoid personality disorder (DSM-IV code 301.20):** This disorder is characterised by lack of interest in social relationships, seeing no point in sharing time with others, anhedonia, introspection. Schizoid personalities are introverted, withdrawn, solitary, emotionally cold, and distant. Often absorbed with their

own thoughts and feelings, they fear closeness and intimacy with others. People suffering from schizoid personality disorder tend to be more daydreamers than practical action takers, often living “in a world of their own.”

- 3) **Schizotypal personality disorder (DSM-IV code 301.22):** This is characterised by odd behaviour or thinking. Schizotypal personalities tend to have odd or eccentric manners of speaking or dressing. They often have strange, outlandish, or paranoid beliefs and thoughts. People with Schizotypal personality disorders have difficulties bonding with others and experience extreme anxiety in social situations. They tend to react inappropriately or not react at all during a conversation, or they may talk to themselves. They also have delusions characterised by “magical thinking,” for example, by saying that they can foretell the future or read other people’s minds.

1.2.2 Cluster B (dramatic, emotional or erratic disorders)

- 1) **Antisocial personality disorder (DSM-IV code 301.7):** Antisocial personality disorder is characterised by a pervasive disregard for the law and the rights of others. Antisocial personalities typically ignore the normal rules of social behaviour. These individuals are impulsive, irresponsible, and callous. They often have a history of violent and irresponsible behaviour, aggressive and even violent relationships. Antisocial personalities are at high risk for substance abuse, since it helps them to relieve tension, irritability and boredom.
- 2) **Borderline personality disorder (DSM-IV code 301.83):** Borderline personalities are characterised by unstable interpersonal relationships, behaviour, mood, and self-image. They are prone to sudden and extreme mood changes, stormy relationships, unpredictable and often self-destructive behaviour. These personalities have great difficulty with their own sense of identity and often experience the world in extremes, viewing experiences and others as either “black” or “white.” They often form intense personal attachments only to quickly dissolve them over a perceived offense.
- 3) **Histrionic personality disorder (DSM-IV code 301.50):** Histrionic personality disorder, previously known as hysterical personality disorder, is a pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions. Theatrical behaviour, craving for attention and excitement, excessive reaction to minor events, and outbursts of mood characterises histrionic personality. There is a shallowness of feelings and relationships, seen by others as lack in genuineness, and producing difficulty in long-term partnership.
- 4) **Narcissistic personality disorder (DSM-IV code 301.81):** Narcissistic personality disorder is characterised by a pervasive pattern of grandiosity, need for admiration, and a lack of empathy. . Narcissistic personalities tend to have an exaggerated sense of self-importance, and are absorbed by fantasies of unlimited success. They also seek constant attention, and are oversensitive to failure, often complaining about multiple physical disorders. They also tend to be prone to extreme mood swings between self-admiration and insecurity, and tend to exploit interpersonal relationships.

1.2.3 Cluster C (anxious or fearful disorders)

- 1) **Avoidance personality disorder (DSM-IV code 301.82):** Social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance

of social interaction are the characteristic features of avoidance personality disorder. People suffering from Avoidant personality disorder are often fearful of rejection and unwilling to become involved with others. They are characterised by excessive social discomfort, shyness, fear of criticism, and avoidance of social activities that involve interpersonal contact.

- 2) **Dependent personality disorder (DSM-IV code 301.6):** It is characterised by pervasive psychological dependence on other people. People suffering from dependent personality disorders exhibit a pattern of dependent and submissive behaviour, relying on others to make decisions for them. They fear rejection, need constant reassurance and advice, and are oversensitive to criticism or disapproval. They feel uncomfortable and helpless if they are alone and can be devastated when a close relationship ends. Typically lacking in self-confidence, the dependent personality rarely initiates projects or does things independently.
- 3) **Obsessive-compulsive personality disorder (DSM-IV code 301.4):** Obsessive-compulsive disorder is characterised by rigid conformity to rules, moral codes and excessive orderliness. People suffering from this disorder are conscientious, reliable, dependable, orderly and methodical, but with an inflexibility that often makes them incapable of adapting to changing circumstances. They have such high standards of achievement that they constantly strive for perfection. Never satisfied with their performance or with that of others, they take on more and more responsibilities.

Self Assessment Questions

1) Discuss cluster A personality disorders.

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2) What are the characteristic features of cluster B personality disorders?

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3) Elucidate all the personality disorders under cluster C and highlight their characteristics.

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1.2.4 Appendix B: Criteria Sets and Axes Provided for Further Study

Appendix B contains the following disorders:

- 1) **Depressive personality disorder:** Depressive personality disorder is a pervasive pattern of depressive cognitions and behaviours beginning by early adulthood.
- 2) **Passive-aggressive personality disorder (negativistic personality disorder):** Passive-aggressive personality disorder is characterised by a pattern of negative attitudes and passive resistance in interpersonal situations.

1.2.5 Symptoms of Personality Disorder

Symptoms vary widely depending on the specific type of personality disorder, but according to the American Psychiatric Association, individuals with personality disorders have most of the following symptoms in common:

- Self-centeredness that manifests itself through a “me-first,” self-preoccupied attitude.
- Lack of individual accountability that result in a “victim mentality” and blaming others for their problems.
- Lack of empathy and caring.
- Manipulative and exploitative behaviour.
- Unhappiness, suffering from depression, and other mood and anxiety disorders.
- Vulnerability to other mental disorders.
- Distorted or superficial understanding of self and others’ perceptions that results in being unable to see how objectionable, unacceptable, and disagreeable their behaviour is.
- Self-destructive behaviour.
- Socially maladaptive changing the “rules of the game,” or otherwise influencing the external world to conform to their own needs.

1.2.6 Causes of Personality Disorder

The exact cause of personality disorders is unknown. However, evidence points to genetic and environmental factors such as a history of personality disorders in the family. Some experts believe that traumatic events occurring in early childhood exert a crucial influence upon behaviour later in life. Others propose that people are genetically predisposed to personality disorders or that they have an underlying biological disturbance (anatomical, electrical, or neurochemical).

1.2.7 Treatment of Personality Disorder

For treatment of personality disorder, personality type entirely dictates the nature of treatment and differs for each type. Thus, for obsessive-compulsive personality disorder, for example, pharmacological treatment may be used for the component of anxiety associated with doubts, indecisiveness, and scruples.

Psychological treatment, especially cognitive behavioural treatment, concentrates upon

perfectionism, rigidity, scrupulousness, and intolerance of failure. Psychodynamic psychotherapy was formerly extensively used. For dissocial personality disorder, drugs have been used to control impulsivity and aggression. In-patient small self-help groups and the larger group therapeutic community have proved beneficial to a limited extent. Personality is regarded as relatively fixed during adult life and the aim of treatment is to enable patients to live more comfortably and safely with themselves.

Frequently personality disorder overlaps with other psychiatric disorder and this makes the other condition more difficult to treat and exacerbates the prognosis. Comorbidity is especially frequent with substance misuse but also quite often occurs with schizophrenia, depressive illness, and neurotic disorders such as anxiety, dissociative, and obsessive-compulsive disorders.

Self Assessment Questions

1) Explain major personality disorders and their main characteristics.

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2) What are the main symptoms of personality disorder?

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3) Discuss the causes and treatment of personality disorder.

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1.3 BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder, one of ten personality disorders recognised by the DSM IV, is one of the most common personality disorders. In psychiatric settings, it accounts for about 15% of the population and about 50% of the patients with personality disorders (Widiger & Weissman, 1991). The name borderline was coined by Adolph Stern in 1938. It was officially recognised as a diagnosis in 1980. Since that time the borderline category has been used so widely that 20% of psychiatric patients are given this diagnosis and it is estimated to occur in 3 to 5% of the general population (Frances & Widiger, 1986). About two thirds of those with borderline personality disorder are female.

The name borderline personality disorder was used for patients who were on a 'borderline' between neurosis and psychosis. However, the symptoms of borderline personality disorder are not as simple as this description might make them sound: the

diagnosis of borderline personality disorder is based upon signs of emotional instability, feelings of depression and emptiness, and identity and behavioural issues, rather than signs of neurosis and psychosis. However, the 'borderline' label has remained, even though the definition has changed.

People with borderline personality disorder are often very intense, going from anger to deep depression in a short time. They are characterised by impulsivity. The mood disorders are also common with borderline personality disorder, with 24% to 74% having major depression, and 4% to 20% having bipolar disorder (Widiger & Rogers, 1989). Up to 67% of the people with personality disorder are also diagnosed with at least one induced disorder (Dulit et.al., 1993).

1.3.1 Clinical Features of Borderline Personality Disorder

According to the DSM IV (Diagnostic and Statistical Manual of Mental Disorders, fourth edition), "A person who suffers from borderline personality disorder has labile interpersonal relationships characterised by instability". This pattern of interacting with others will have persisted for years, and is usually closely related to the individual's self-image and early social interactions. The pattern is present in a variety of settings (i.e. not just at work or home), and is often accompanied by a similar lability (fluctuation back and forth, often in a quick manner) in a person's affect (mood) or feelings. Relationships and the person's affect may often be characterised as shallow. A person with this disorder may also exhibit impulsive behaviours and exhibit a majority of the following symptoms:

- 1) Frantic efforts to avoid real or imagined abandonment.
- 2) A pattern of unstable and intense interpersonal relationships characterised by alternation between extremes of idealisation and devaluation.
- 3) Identity disturbance - markedly and persistently unstable self-image or sense of self.
- 4) Impulsivity in at least two areas that are potentially self-damaging, e.g. spending, sex, substance abuse, reckless driving or binge-eating.
- 5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
- 6) Affective instability due to a marked reactivity of mood, e.g. intense episodic dysphoria, irritability or anxiety, which usually lasts for between a few hours and several days.
- 7) Chronic feelings of emptiness
- 8) Inappropriate, intense anger, or difficulty controlling anger, e.g. frequent displays of temper, constant anger or recurrent physical fights.
- 9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

Anyone with six or more of the above traits and symptoms may be diagnosed with borderline personality disorder. However, the traits must be long standing (pervasive), and there must be no better explanation for them, e.g. physical illness, a different mental illness or substance misuse.

Although a heterogeneous group of individuals receive this diagnosis, yet they share a number of characteristics, including fears of abandonment, unstable personal relationships, impulsivity, threats of self-destructive behaviour, and chronic range of

cognitive distortions. Many people with borderline personality disorder are prone to impulsive behaviour. This impulsiveness can manifest itself in negative ways. For example, self-harm is common among individuals with borderline personality disorder and, in many instances, this is an impulsive act.

Sufferers of borderline personality disorder can also be prone to angry outbursts and even criminal offences as a result of impulsive urges (mainly male sufferers). Another common feature of borderline personality disorder is affective lability; sufferers have trouble stabilizing moods – as a result, mood changes can become erratic. Other characteristics of this condition include the distortion of reality, a tendency to see things in ‘black and white’ terms, excessive behaviour such as gambling or sexual promiscuity, and proneness to depression. A person with this disorder can often be bright and intelligent, and appear warm, friendly and competent.

They sometimes can maintain this appearance for a number of years until their defense structure crumbles, usually around a stressful situation like the breakup of a romantic relationship or the death of a parent. Relationships with others are intense but stormy and unstable with marked shifts of feelings and difficulties in maintaining intimate, close connections. The person may manipulate others and often has difficulty with trusting others.

There is also emotional instability with marked and frequent shifts to an empty lonely depression or to irritability and anxiety. The person may show inappropriate and intense anger or rage with temper tantrums, constant brooding and resentment, feelings of deprivation, and a loss of control or fear of loss of control over angry feelings. There are also identity disturbances with confusion and uncertainty about self-identity, sexuality, life goals and values, career choices, friendships. Under extreme stress or in severe cases there can be brief psychotic episodes with loss of contact with reality or bizarre behaviour or symptoms. Even in less severe instances, there is often significant disruption of relationships and work performance. The depression which accompanies this disorder can cause much suffering and can lead to serious suicide attempts.

1.3.2 Causes of Borderline Personality Disorder

Although there is no specific cause for borderline personality disorder, like most other mental disorders, it is understood to be the result of a combination of biological vulnerabilities, ways of thinking, and social stressors. An overview of the existing literature suggested that traits related to borderline personality disorder are influenced by genes (Torgersen, 2000). A major twin study found that if one identical twin met criteria for borderline personality disorder, the other also met criteria in 35% of cases. People that have borderline personality disorder influenced by genes usually have a close relative with the disorder (Torgersen, Lygren, Oien, 2000).

One psychosocial influence that has received great deal of attention is the possible contribution of childhood trauma, especially sexual and physical abuse. Numerous studies have shown a strong correlation between child abuse, especially child sexual abuse and development of borderline personality disorder (Kluft, 1990; Zanarini et.al., 1989; Herman, 1992; Quadrio, 2005). Many individuals with borderline personality disorder report to have had a history of abuse and neglect as young children (Zanarini & Frankenburg, 1997).

Patients with borderline personality disorder have been found to be significantly more likely to report having been verbally, emotionally, physically or sexually abused by their caregivers of either gender. There has also been a high incidence of incest and

loss of caregivers in early childhood for people with borderline personality disorder. They were also much more likely to report having caregivers (of both genders) deny the validity of their thoughts and feelings.

They were also reported to have failed to provide needed protection, and neglected their child's physical care. Parents (of both sexes) were typically reported to have withdrawn from the child emotionally, and to have treated the child inconsistently. Besides the child abuse other factors including family environment have also been found to contribute to the development of the disorder (Bradley, Jenei, & Westen, 2005).

For example Bradley et al. (2005) found that both child sexual abuse and childhood physical abuse and borderline personality disorder symptoms were significantly related, and both child sexual abuse and childhood physical abuse were significantly related to family environment. When family environment and childhood physical abuse were entered simultaneously into a regression equation, family environment was related to borderline personality disorder symptoms and childhood physical abuse was related to borderline personality disorder symptoms, although the relationship between borderline personality disorder symptoms and childhood physical abuse was reduced.

Therefore, child sexual abuse and childhood physical abuse both directly influence the development of borderline personality disorder symptoms directly and are mediated by family environment.

Borderline personality disorder has been found among people who have gone through rapid socio-cultural changes. The problem of identity, emptiness, fears of abandonment, and low anxiety threshold have been found in child and adult immigrants (Laxenaire, Ganne-Vevonec, & Streiff, 1982; Skhiri, Annabi, Bi, & Allani, 1982).

These observations further support the possibility that early trauma may, in some individuals, lead to borderline personality disorder.

1.3.3 Treatment of Borderline Personality Disorder

The American Psychiatric Association reports that recent advancements have led to treatments reaching an 86% remission rate 10 years after treatment. Treatments for borderline personality disorder have improved in recent years. Group and individual psychotherapy are at least partially effective for many patients.

Within the past 15 years, a new psychosocial treatment termed dialectical behaviour therapy (DBT) was developed specifically to treat borderline personality disorder, and this technique has looked promising in treatment studies (Koerner, & Linehan, 2000).

Dialectical behaviour therapy is an approach to psychotherapy in which the therapist specifically addresses four areas that tend to be particularly problematic for individuals with borderline personality disorder: self-image, impulsive behaviours, mood instability, and problems in relating to others.

To address those areas, treatment with dialectical behaviour therapy tries to build four major behavioural skill areas: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness.

Talk therapy that focuses on helping the person understand how their thoughts and behaviours affect each other (cognitive behavioural therapy or CBT) has also been found to be effective treatment for borderline personality disorder.

Other psychotherapy approaches that have been used to address borderline personality disorder include interpersonal psychotherapy (IPT) and psychoanalytic therapy. Interpersonal psychotherapy is an approach that focuses on how the person's symptoms are related to the problems that person has in relating to others.

Psychoanalytic therapy, which seeks to help the individual understand and better manage his or her ways of defending against negative emotions, has been found to be effective in addressing borderline personality disorder, especially when the therapist is more active or vocal than in traditional psychoanalytic treatment and when this approach is used in the context of current rather than past relationships.

Pharmacological treatments are often prescribed based on specific target symptoms shown by the individual patient. Antidepressant drugs and mood stabilizers may be helpful for depressed and/or labile mood. Antipsychotic drugs may also be used when there are distortions in thinking.

1.3.4 Prognosis

As with any illness, an appropriate question about borderline personality disorder is if it is curable. While improvement in any personality disorder is not synonymous with being cured, the symptoms of borderline personality disorder do tend to diminish with time.

How well or poorly people with borderline personality disorder progress over time seems to be influenced by how severe the disorder is at the time that treatment starts, the state of the individual's current personal relationships, whether or not the sufferer has a history of being abused as a child, as well as whether or not the person receives appropriate treatment.

Simultaneously suffering from depression, other emotional problems, or a low level of conscientiousness have been found to be associated with a greater likelihood of symptoms of borderline personality disorder returning (relapse).

Self Assessment Questions

1) Explain the characteristic features of borderline personality disorder.

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2) What are the causes of borderline personality disorder?

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3) Discuss the treatment and prognosis of borderline personality disorder.

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1.4 LET US SUM UP

Personality disorder is enduring subjective experiences and behaviour that deviates from cultural standards, are rigidly pervasive, have an onset in adolescence or early adulthood, are stable through time, and lead to unhappiness and impairment. The DSM- IV lists ten personality disorders, grouped into three clusters in Axis II. These ten personality disorders are: 1-Paranoid personality disorder, 2-Schizoid personality disorder, 3-Schizotypal personality disorder, 4- Antisocial personality disorder, 5- Borderline personality disorder, 6-Histrionic personality disorder, 7- Narcissistic personality disorder, 8- Avoidance personality disorder, 9- Dependent personality disorder, and 10- Obsessive-compulsive personality disorder.

The exact cause of personality disorders is unknown. However, evidence points to genetic and environmental factors such as a history of personality disorders in the family. Some experts believe that traumatic events occurring in early childhood exert a crucial influence upon behaviour later in life. Others propose that people are genetically predisposed to personality disorders or that they have an underlying biological disturbance (anatomical, electrical, or neurochemical).

For treatment of personality disorder, personality type entirely dictates the nature of treatment and differs for each type. Psychological treatment, especially cognitive-behavioural treatment, concentrates upon perfectionism, rigidity, scrupulousness, and intolerance of failure. Psychodynamic psychotherapy was formerly extensively used. For dissocial personality disorder, drugs have been used to control impulsivity and aggression.

Borderline Personality Disorder, one of ten personality disorders recognised by the DSM IV, is one of the most common personality disorders. In psychiatric settings, it accounts for about 15% of the population and about 50% of the patients with personality disorders. Borderline personality disorder is a personality disorder characterised by consistently problematic ways of thinking, feeling, and interacting. In order to be diagnosed with borderline personality disorder, the sufferer must experience at least five of the following symptoms: unstable self-image, relationships or emotions, severe impulsivity, repeated suicidal behaviours or threats, chronic feelings of emptiness, inappropriate anger, trouble managing anger, or transient paranoia or dissociation. Psychotherapy approaches that have been helpful in treating borderline personality disorder include dialectical behaviour therapy, cognitive behavioural therapy, interpersonal therapy, and psychoanalytic psychotherapy.

The use of psychiatric medications like antidepressants, mood stabilizers, and antipsychotics may be useful in addressing some of the symptoms of borderline personality disorder but do not manage the illness in its entirety. While the symptoms of borderline personality disorder tends to diminish over years for many people, how well or poorly people with borderline personality disorder progress over time seems to be influenced by the severity of the symptoms, the individual's current personal relationships, whether or not the sufferer has a history of being abused as a child, as well as whether or not the individual receives appropriate treatment.

1.5 UNIT END QUESTIONS

- 1) What do you mean by personality disorder? Discuss the major personality disorders.
- 2) Explain the diagnostic features of personality disorder.

- 3) Discuss the symptoms and treatment of personality disorder.
- 4) Prepare a clinical picture of borderline personality disorder.
- 5) What are the causes of borderline personality disorder?
- 6) Discuss the treatment and prognosis of borderline personality disorder.

1.6 GLOSSARY

- Anhedonia** : Inability to experience pleasure, associated with some mood and schizophrenic disorders.
- Antisocial personality disorder**: Personality disorder involving a pervasive disregard for the law and the rights of others.
- Avoidant personality disorder** : Personality disorder characterised by social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction.
- Borderline personality disorder** : Personality disorder involving extreme “black and white” thinking, instability in relationships, self-image, identity and behaviour. Borderline personality disorder occurs in 3 times as many females than males.
- Cognitive-behavioural therapy** : Group of treatment procedures aimed at identifying and modifying faulty thought processes, attitudes and attributions, and problem behaviours.
- Dependent personality disorder** : Personality disorder characterised by pervasive psychological dependence on other people.
- Depressive personality disorder**: Personality disorder involving is a pervasive pattern of depressive cognitions and behaviours beginning by early adulthood.
- Dialectical behaviour therapy** : It is an approach to psychotherapy in which the therapist specifically addresses four areas that tend to be particularly problematic for individuals with borderline personality disorder: self-image, impulsive behaviours, mood instability, and problems in relating to others.
- Histrionic personality disorder** : Personality disorder characterised by pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions.
- Interpersonal psychotherapy** : Newer brief treatment approach that emphasises resolution of interpersonal problems and stressors such as role disputes in marital conflict, or forming relationships in marriage or new job. It has demonstrated effectiveness for such problems as depression.

- Interpersonal therapy** : Brief, structured treatment that focuses on teaching a person skills to improve existing relationships or develop new ones.
- Narcissistic personality disorder**: Personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.
- Obsessive-compulsive personality disorder** : Personality disorder characterised by rigid conformity to rules, moral codes and excessive orderliness.
- Paranoid personality disorder** : Personality disorder characterised by irrational suspicions and mistrust of others.
- Passive aggressive personality disorder** Personality disorder characterised by a pattern of negative attitudes and passive resistance in interpersonal situations.
- Personality disorders** : Enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.
- Schizoid personality disorder** : Personality disorder involving lack of interest in social relationships, seeing no point in sharing time with others.
- Schizotypal personality disorder** : Personality disorder characterised by odd behaviour or thinking.

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UNIT 2 NARCISSISTIC PERSONALITY DISORDER

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 Narcissistic Personality Disorder
 - 2.2.1 Diagnostic Features of Narcissistic Personality Disorder
 - 2.2.2 Subtypes of Narcissistic Personality Disorder
 - 2.2.3 Causes of Narcissistic Personality Disorder
 - 2.2.4 Treatment of Narcissistic Personality Disorder
 - 2.2.5 Prognosis
- 2.3 Let Us Sum Up
- 2.4 Unit End Questions
- 2.5 Glossary
- 2.6 Suggested Readings

2.0 INTRODUCTION

In our social interactions we sometimes come across to such persons who are in love with the self and give too much importance to it. They have great expectations of social favours and constant attentions for others. They feel that they are very special in brilliance, power and, beauty and take advantage of others. They consider themselves somehow different from others and deserving special treatment. They exhibit extreme self-importance, inability to empathize with others and heightened sensitivity to criticism. Self-involvement and lack of empathy characterise this personality disorder. In narcissistic personality disorder this tendency is taken to its extreme. Narcissistic personality disorder is a pervasive disorder characterised by self-centeredness, lack of empathy, and an exaggerated sense of self-importance. In the present unit we will discuss the nature, diagnostic features, causes, and treatment of narcissistic personality disorder.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the meaning of narcissistic personality disorder;
- Understand the diagnostic features of narcissistic personality disorder;
- Describe the causes of narcissistic personality disorder; and
- Explain the treatment and prognosis of narcissistic personality disorder.

2.2 NARCISSISTIC PERSONALITY DISORDER

Sigmund Freud (1856-1939) is credited with the promulgation and presentation of a first coherent theory of narcissism. He described transitions from subject directed libido (*The psychic and emotional energy associated with instinctual biological*

drives. According to Freud, all behaviour is motivated by the desire to feel pleasure. That motivation is organised and directed by two instincts: sexuality (Eros), and aggression (Thanatos). Freud conceptualised both these instincts as being powered by a form of internal psychic energy that he called the Libido. Libido is the pleasure principle, or basic psychic energy.) to object directed libido through the intermediation and agency of the parents. To be healthy and functional, the transitions must be smooth and unperturbed. Neuroses are the results of such perturbations.

Freud conceived of each stage of development linked to the next stage of development. Thus, if a child reaches out to his objects of desire and fails to attract their love and attention, the child will regress to the previous phase, to the narcissistic phase. The first occurrence of narcissism is adaptive.

It “trains” the child to love an object. It ensures gratification through availability, predictability and permanence. But regressing to “secondary narcissism” is maladaptive. It is an indication of failure to direct the libido to the “right” targets (to objects, such as the child’s parents).

Secondary narcissism corresponds to the return of the libido to the ego, that is withdrawn from objects. Freud described this for the first time in relation to a state he called “paraphrenia,” which corresponded to the schizophrenia identified by Bleuler. Withdrawal of the libidinal investment in objects, followed by a reinvestment in the ego, was considered responsible for two characteristic manifestations, that is,

- i) lack of interest in the external world and
- ii) delusions of grandeur.

If this pattern of regression persists and prevails, a “narcissistic neurosis” is formed. The narcissist prefers fantasyland to reality, grandiose self conception to realistic appraisal, masturbation and sexual fantasies to mature adult sex, and daydreaming to real life achievements.

Carl Gustav Jung (1875-1961) had a mental picture of the psyche as a giant warehouse of archetypes (the conscious representations of adaptive behaviours). Fantasies to him were just a way of accessing these archetypes and releasing them. Any reversion to earlier phases of mental life, to earlier coping strategies, to earlier choices is interpreted as simply the psyche’s way of using yet another, hitherto untapped, adaptation strategy.

Actually, there is little difference between Freud and Jung. When libido investment in objects (esp. the Primary Object) fails to produce gratification, maladaptation results that is a default option is activated which is secondary narcissism. This default enhances adaptation, it is functional and adaptive and triggers adaptive behaviours. As a by product, it secures gratification.

We are at such peace when we exert reasonable control over our environment, i.e., when our behaviours are adaptive. The compensatory process has two results (i) enhanced adaptation and (ii) inevitable gratification. Perhaps the more serious division between them is with regard to introversion. Freud regards introversion as an instrument in the service of a pathology

As opposed to Freud, Jung regards introversion as a useful tool in the service of the endless psychic quest for adaptation strategies (narcissism being one such strategy). The Jungian adaptation repertoire does not discriminate against narcissism. To Jung

it is as legitimate a choice as any. But even Jung acknowledged that the very need to look for a new adaptation strategy means that adaptation has failed. In other words, the search itself is indicative of a pathological state of affairs. It does seem that introversion per se is not pathological (because no psychological mechanism is pathological per se). Only the use made of it can be pathological.

Jung distinguished introverts (those who habitually concentrate on their selves rather than on outside objects) from extroverts. Not only was introversion a totally normal and natural function in childhood, it remains normal and natural even if it predominates the mental life.

Pathological narcissism is exclusive and all pervasive. Other forms of narcissism are not. Hence though there is no healthy state of habitual, predominant introversion, it remains a question of form and degree of introversion. Often a healthy, adaptive mechanism goes awry. When it does, as Jung himself recognised, neuroses form.

Freud regards Narcissism as a point, while Jung regards it as a continuum (from health to sickness).

In a way, Heinz Kohut took Jung a step further. He said that pathological narcissism is not the result of excessive narcissism, libido or aggression. It is the result of defective, deformed or incomplete narcissistic (self) structures. Kohut postulated the existence of core constructs which he named: the Grandiose Exhibitionistic Self and the Idealized Parent Image.

Children entertain notions of greatness (primitive or naive grandiosity) mingled with magical thinking, feelings of omnipotence and omniscience and a belief in their immunity to the consequences of their actions. These elements and the child's feelings regarding its parents combine and form these constructs. The child's feelings towards its parents are reactions to their responses (affirmation, buffering, modulation or disapproval, punishment, even abuse). These responses help maintain the self structures. Without the appropriate responses, grandiosity, for instance, cannot be transformed into adult ambitions and ideals. To Kohut, grandiosity and idealisation were positive childhood development mechanisms. Even their reappearance in transference should not be considered a pathological narcissistic regression.

Kohut agreed with Freud that neuroses are conglomerates of defence mechanisms, formations, symptoms, and unconscious conflicts. He even accepted the unresolved Oedipal conflicts (ungratified unconscious wishes and their objects) as the root of neuroses. But he identified a whole new class of disorders: the self-disorders. These were the result of the perturbed development of narcissism.

It was not a superficial distinction. Self disorders were the results of childhood traumas quite different from Freud's Oedipal, castration and other conflicts and fears. These are the traumas of the child either not being seen (an existence, not affirmed by the Primary Objects, that is the parents) or being regarded as an object for gratification or abuse. Such children develop to become adults who are not sure that they do exist (lack a sense of self continuity) or that they are worth anything (lack of self worth, or self esteem). They suffer depressions, as neurotics do. But the source of these depressions is existential (a gnawing sensation of emptiness) as opposed to the "guilty-conscious" depressions of neurotics.

They are individuals whose disorders can be understood and treated only by taking into consideration the formative experiences in childhood of the total body mind self and its self object environment as for instance, the experiences of joy of the total self

feeling confirmed, which leads to pride, self esteem, zest, and initiative; or the experiences of shame, loss of vitality, deadness, and depression of the self who does not have the feeling of being included, welcomed, and enjoyed.”

This is not to say that they do not change - rather, that they are capable only of slow change. Kohut and his Self-psychology disciples believed that the only viable constructs are comprised of self-selfobject experiences and that these structures are lifelong ones. Melanie Klein believed more in archaic drives, splitting defenses and archaic internal objects and part objects. Winnicott (and Balint and other, mainly British researchers) as well as other ego-psychologists thought that only infantile drive wishes and hallucinated oneness with archaic objects qualify as structures.

Narcissism. Karen Horney’s Contributions

Horney is one of the precursors of the “Object Relations” school of psychodynamics. She said that personality was shaped mostly by environmental issues, social or cultural. She believed that relationships with other humans in one’s childhood determine both the shape and functioning of one’s personality. She expanded the psychoanalytic repertoire. She added needs to drives. Where Freud believed in the exclusivity of the sex drive as an agent of transformation, Horney believed that people (children) needed to feel secure, to be loved, protected, emotionally nourished and so on. She believed that the satisfaction of these needs or their frustration early in childhood were as important a determinant as any drive. Society was introduced through the parental door. Biology converged with social injunction to yield human values such as the nurturance of children.

Horney’s great contribution was the concept of anxiety. Freudian anxiety was a rather primitive mechanism, a reaction to imaginary threats arising from early childhood sexual conflicts. Horney argued convincingly that anxiety is a primary reaction to the very dependence of the child on adults for its survival. Children are uncertain (of love, protection, nourishment, nurturance) and so they become anxious.

Defenses are developed to compensate for the intolerable and gradual realization that adults are human. They are capricious, arbitrary, unpredictable and non dependable. Defenses provide both satisfaction and a sense of security. The problem still exists, even as the anxiety does, but they are “one stage removed”. When the defenses are attacked or perceived to be attacked (such as in therapy) anxiety is reawakened.

The capacity to be alone develops out of the baby’s ability to hold onto the internalisation of his mother, even during her absences. It is not just an image of mother that he retains but also her loving devotion to him. Thus, when alone, he can feel confident and secure as he continues to infuse himself with her love. The addict has had so few loving attachments in his life that when alone he is returned to his detached, alienated self.

This feeling state can be compared to a young child’s fear of monsters without a powerful other to help him, the monsters continue to live somewhere within the child or his environment. It is not uncommon for patients to be found on either side of an attachment pendulum. It is invariably easier to handle patients for whom the transference erupts in the idealising attachment phase than those who view the therapist as a powerful and distrusted intruder.

So, the child learns to sacrifice a part of his autonomy, in order to feel secure. Horney identified three neurotic strategies: submission, aggression and detachment. The choice of strategy determines the type of personality, or rather of neurotic

personality. The submissive (or compliant) type is fake. He hides aggression beneath the facade of friendliness. The aggressive type is fake as well: at heart he is submissive. The detached neurotic withdraws from people. This cannot be considered an adaptive strategy.

Horney's is an optimistic outlook. Because she believes biology is only one of the forces shaping our adulthood, and culture and society being the predominant ones, she believes in reversibility and in the power of insight to heal. She believes that if an adult were to understand his problem (his anxiety) he would be able to eliminate it altogether. Other theoreticians are much more pessimistic and deterministic.

They think that childhood trauma and abuse are rather impossible to reprogramme, let alone erase. Modern brain research tends both to support this view and offer some solution. The brain seems to be plastic. It is physically impressed with abuse and trauma. But no one knows when this "window of plasticity" shuts. It is conceivable that this plasticity continues well into adulthood and that later "reprogramming" (by loving, caring, compassionate and empathic experiences) can remold the brain permanently. Yet others believe that the patient has to accept his disorder as a given and work AROUND it rather than attack it directly.

Our disorders were adaptive and helped us to function. Their removal may not always be wise or necessary to attain a full and satisfactory life. Additionally, we should not all conform to a mold and experience life the same. Idiosyncracies are a good thing, both on the individual level and on the level of the species. The word "narcissism" comes from a Greek mythology in which a handsome young man named Narcissus sees his reflection in a pool of water and falls in love with it. Psychoanalysts, including Sigmund Freud, used the term narcissistic to describe people who show an exaggerated sense of self-importance and are preoccupied with receiving attention (Cooper & Ronningstam, 1992). Narcissistic personality disorder is one of a group of conditions called dramatic personality disorder. 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. However, these attitudes and behaviours do not reflect true self-confidence. Instead, the attitudes conceal a deep sense of insecurity and a fragile self-esteem. Some of the common traits of a narcissistic type person are:

- An inability to listen to others, and
- A lack of awareness of another person's deadlines, time frames, or interests.
- An inability to admit wrongdoing, even sometimes when presented with evidence of their 'wrong' behaviour.
- Coldness or overly practical responses to interpersonal relationships,
- A sense of distance or matter of factness emotionally.
- Can be prone to severe bouts of anger.
- Has the ability to write friends off forever, over one perceived or actual transgression.
- Pride in the accomplishments of children if they have them, often combined with an overly developed desire for control over their directions and activities.
- An above average interest in social class and importance may be seen.

It should be noted that narcissistic personality disorder exists as a diagnostic category only in *DSM-IV-TR*, which is an American diagnostic manual. The *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)*, the European equivalent of *DSM* lists only eight personality disorders. What *DSM-IV-TR* defines as narcissistic personality disorder, *ICD-10* lumps together with “eccentric, impulsive-type, immature, passive-aggressive, and psychoneurotic personality disorders.”

Narcissistic personality disorder was introduced as a new diagnostic category in *DSM-III*, which was published in 1980. Prior to *DSM-II*, narcissism was a recognised phenomenon but not an official diagnosis.

At that time, narcissistic personality disorder was considered virtually untreatable because people who suffer from it rarely enter or remain in treatment. Typically, they regard themselves as superior to their therapist, and they see their problems as caused by other people’s “stupidity” or “lack of appreciation.”

More recently, however, some psychiatrists have proposed dividing narcissistic patients into two subcategories based roughly on age:

- i) those who suffer from the stable form of narcissistic personality disorder described by *DSM-IV-TR*, and
- ii) younger adults whose narcissism is often corrected by life experiences.

This age group distinction represents an ongoing controversy about the nature of narcissistic personality disorder whether it is fundamentally a character disorder, or whether it is a matter of learned behaviour that can be unlearned. Therapists who incline toward the first viewpoint usually pessimistic about the results of treatment for patients with narcissistic personality disorder.

2.2.1 Diagnostic Features of Narcissistic Personality Disorder

DSM-IV-TR specifies nine diagnostic criteria for narcissistic personality disorder. For the clinician to make the diagnosis, an individual must fit five or more of the following descriptions:

- He or she has a grandiose sense of self-importance (exaggerates accomplishments and demands to be considered superior without real evidence of achievement).
- He or she lives in a dream world of exceptional success, power, beauty, genius, or “perfect” love.
- He or she thinks of him or herself as “special” or privileged,
- He or she can only be understood by other special or high status people.
- He or she demands excessive amounts of praise or admiration from others.
- He or she feels entitled to automatic deference, compliance, or favourable treatment from others.
- He or she is exploitative towards others and takes advantage of them.
- He or she lacks empathy and does not recognise or identify with others’ feelings.
- He or she is frequently envious of others or thinks that they are envious of him or her.

- He or she “has an attitude” or frequently acts in haughty or arrogant ways.

In addition to these criteria, *DSM-IV-TR* groups narcissistic personality disorder together with three other personality disorders in Cluster B. These four disorders are grouped together on the basis of symptom similarities, insofar as patients with these disorders appear to others as overly emotional, unstable, or self-dramatising.

The other three disorders in Cluster B are antisocial, borderline, and histrionic personality disorders.

The *DSM-IV-TR* clustering system does not mean that all patients can be fitted neatly into one of the three clusters. It is possible for patients to have symptoms of more than one personality disorder or to have symptoms from different clusters. In addition, patients diagnosed with any personality disorder may also meet the criteria for mood, substance abuse, or other disorders.

People with narcissistic personality disorder have an unreasonable sense of self-importance and are so preoccupied with themselves that they lack sensitivity and compassion for other people (Gunderson, Ronningstam, & Smith, 1995). They are not comfortable unless someone is admiring them. Their exaggerated feelings and their fantasies of greatness, called “grandiosity” create a number of negative attributes. They require and expect a great deal of special attention. They also tend to use or exploit others for their own interests and show little empathy. When confronted with other successful people, they can be extremely envious and arrogant. Thus narcissistic personality disorder involves a pattern of self-centered or egotistical behaviour that shows up in thinking and behaviour in a lot of different situations and activities. People with narcissistic personality disorder would not (or can not) change their behaviour even when it causes problems at work or when other people complain about the way they act, or when their behaviour causes a lot of emotional distress to others (or themselves). This pattern of self-centered or egotistical behaviour is not caused by current drug or alcohol use, head injury, acute psychotic episodes, or any other illness, but has been going on steadily at least since adolescence or early adulthood.

2.2.2 Subtypes of Narcissistic Personality Disorder

Millon (1996) identified five subtypes of narcissist. Any individual narcissist may exhibit none or one of the following:

- i) **Unprincipled narcissist including antisocial features:** Such an Unprincipled narcissist will be fraudulent, exploitative, deceptive and unscrupulous individual.
- ii) **Amorous narcissist including histrionic features:** Such an Amorous narcissist will be an erotic, exhibitionist.
- iii) **Compensatory narcissist:** This includes negativistic (passive-aggressive), avoidant features.
- iv) **Elitist narcissist:** This is a variant of pure pattern. Corresponds to “phallic narcissistic” personality type.
- v) **Fanatic type including paranoid features:** A severely narcissistic individual, usually with major paranoid tendencies and who holds onto an illusion of omnipotence.

Some have suggested the following subcategories of narcissistic personalities:

- i) **Craving narcissists:** These are people who feel emotionally needy and undernourished, and may well appear clingy or demanding to those around them.
- ii) **Paranoid narcissists:** This type of narcissist feels intense contempt for him- or herself, but projects it outward onto others. Paranoid narcissists frequently drive other people away from them by hypercritical and jealous comments and behaviours.
- iii) **Manipulative narcissists:** These people enjoy “putting something over” on others, obtaining their feelings of superiority by lying to and manipulating them.
- iv) **Phallic narcissists:** Almost all narcissists in this subgroup are male. They tend to be aggressive, athletic, and exhibitionistic; they enjoy showing off their bodies, clothes, and overall “manliness.”

DSM-IV-TR states that 2% to 16% of the clinical population and slightly less than 1% of the general population of the United States suffers from narcissistic personality disorder. Between 50% and 75% of those diagnosed with narcissistic personality disorder are males. Little is known about the prevalence of narcissistic personality disorder across racial and ethnic groups. Like most personality disorders, narcissistic personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

Narcissistic personality disorder is more prevalent in males than females. The high preponderance of male patients in studies of narcissism has prompted researchers to explore the effects of gender roles on this particular personality disorder. Some have speculated that the gender imbalance in narcissistic personality disorder results from society’s disapproval of self centered and exploitative behaviour in women, who are typically socialised to nurture, please, and generally focus their attention on others.

Some are of the view that the imbalance is more apparent than real, and that it reflects a basically sexist definition of narcissism. Like most personality disorders, narcissistic personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

2.2.3 Causes of Narcissistic Personality Disorder

While the exact cause of narcissistic personality disorder is unknown, researchers have identified some factors that may contribute to the disorder. Childhood experiences such as parental overindulgence, excessive praise, unreliable parenting, and a lack of realistic responses are thought to contribute to narcissistic personality disorder.

Although researchers today do not know what exactly causes narcissistic personality disorder, there are many theories, however, about the possible causes of narcissistic personality disorder.

For example, Kohut (1977) and Kernberg (1984) attempted to trace the roots of narcissistic personality disorder to disturbances in the patient’s family of origin specifically, to problems in the parent child relationship before the child turned three.

Where they disagree is in their accounts of the nature of these problems. According to Kohut (1977), the 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.

In contrast, Kernberg (1985) views narcissistic personality disorder as rooted 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 hyper-inflated 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. In both accounts, the child emerges into adult life with a history of unsatisfactory relationships with others.

The adult narcissist possesses a grandiose view of the self but has a conflict-ridden psychological dependence on others. At present, however, psychiatrists do not agree in their description of the central defect in narcissistic personality disorder; some think that the problem is primarily emotional while others regard it as the result of distorted cognition, or knowing.

Other theorists maintain that the person with narcissistic personality disorder has an “empty” or hungry sense of self while others argue that the narcissist has a “disorganised” self. Still others regard the core problem as the narcissist’s inability to test reality and construct an accurate view of him- or herself.

According to sociologist Lasch (1978) narcissistic personality disorder is increasing in prevalence, primarily as a consequence of large scale social changes, including greater emphasis on short-term hedonism, individualism, competitiveness, and success. He further stated that the “me-generation” has produced more than its share of individuals with narcissistic personality disorder. Indeed reports confirm that narcissistic personality disorder is increasing in prevalence (Cooper & Ronningstam, 1992).

Some other theorists believe that narcissistic personality disorder results from extremes in child rearing. For example, the disorder might develop as the result of excessive pampering, or when a child’s parents have a need for their children to be talented or special in order to maintain their own self-esteem. On the other end of the spectrum, narcissistic personality disorder might develop as the result of neglect or abuse and trauma inflicted by parents or other authority figures during childhood. The disorder usually is evident by early adulthood.

Some other theorists subscribe a bio psychosocial model of causation that is, the causes which are biological and genetic in nature, the social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual’s personality and temperament, shaped by their environment and learned coping skills to deal with stress).

This suggests that no single factor is responsible rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be “passed down” to their children.

2.2.4 Treatment of Narcissistic Personality Disorder

It is important to note that people with this disorder rarely seek out treatment. Individuals often begin therapy at the urging of family members or to treat symptoms that result from the disorder. So the therapy for the persons suffering from narcissistic personality disorder can be especially difficult because they are often unwilling to acknowledge the disorder. In addition, the tendency of these patients to criticize and devalue their therapists (as well as other authority figures) makes it difficult for therapists to work with them.

Narcissistic personality disorder treatment is centered around psychotherapy. There are no medications specifically used to treat narcissistic personality disorder. However, if the person has symptoms of depression, anxiety or other conditions, medications such as antidepressants or anti-anxiety medications may be helpful.

Psychotherapy helps the person learn to relate to others in a more positive and rewarding way. Psychotherapy tries to provide the person with greater insight into his or her problems and attitudes in the hope that this will change behaviour.

The goal of therapy is to help the person develop a better self-esteem and more realistic expectations of others. Medication might be used to treat the distressing symptoms, such as behavioural problems, that might occur with this disorder.

Several different approaches to individual therapy have been tried with narcissistic personality disorder patients, ranging from classical psychoanalysis and Adlerian therapy to rational emotive approaches and Gestalt therapy. The consensus that has emerged is that therapists should set modest goals for treatment with narcissistic personality disorder patients. Most of them cannot form a sufficiently deep bond with a therapist to allow healing of early childhood injuries. Other forms of psychotherapy that may be helpful for narcissistic personality disorder include:

- i) **Cognitive behavioural therapy:** Cognitive behavioural techniques are often effective to help individuals change destructive thinking and behaviour patterns. The goal of treatment is to alter distorted thoughts and create a more realistic self-image. In general, cognitive behavioural therapy helps to identify unhealthy, negative beliefs and behaviours and replace them with healthy, positive ones.
- ii) **Family therapy:** It is a type of group therapy in which the members of the family of the patient all participate in group treatment sessions. The basic idea is that the family, not just the individual patient has to alter behaviour to solve the problem. By bringing the whole family together in therapy sessions, joint efforts by all family members are made to explore conflicts. Communication among family members and problem solving help cope with relationship problems.
- iii) **Group therapy:** Group therapy, in which client meets with a group of people with similar conditions, may be helpful by teaching him to relate better with others. This may be good for the client to learn about truly listening to others, learning about their feelings and offering support.

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.

The first step toward developing a working alliance is empathy with the surprise and hurt that the patient experiences as a result of confrontations within the group. The external structuring that the group therapy provides can control destructive behaviour in spite of ego weakness.

In groups,

- a) the therapist is less authoritative (and less threatening to the patient's grandiosity);
- b) intensity of emotional experience is lessened and
- c) regression is more controlled,
- d) create a better setting for confrontation and clarification.

Because personality traits can be difficult to change, therapy may take several years. The short-term goal of psychotherapy for narcissistic personality disorder is to address such issues as substance abuse, depression, low self-esteem or shame. The long-term goal is to reshape the personality, at least to some degree, so that the person can change patterns of thinking that distort his self-image and create a realistic self-image.

Psychotherapy can also help the person to learn to relate better with others so that his relationships are more intimate, enjoyable and rewarding. It can help the person to understand the causes of his emotions and what drives him to compete, to distrust others and perhaps to despise himself and others.

Narcissistic patients generally enjoy the attention they receive through involvement in the treatment. Long-term outpatient involvement is critical to maintain a narcissistic patient's pro-social behaviour and sobriety. Therapists who strive to build narcissistic patients' strengths and who pay close attention to them in therapy will find them active participants in the recovery process.

2.2.5 Prognosis

The prognosis for younger persons with narcissistic disorders is hopeful to the extent that the disturbances reflect a simple lack of life experience. The outlook for long standing narcissistic personality disorder, however, is largely negative.

Some narcissists are able, particularly as they approach their midlife years, to accept their own limitations and those of others, to resolve their problems with envy, and to accept their own mortality.

Most patients with narcissistic personality disorder, on the other hand, become increasingly depressed as they grow older within a youth-oriented culture and lose their looks and overall vitality.

The retirement years are especially painful for patients with narcissistic personality disorder because they must yield their positions in the working world to the next generation.

In addition, they do not have the network of intimate family ties and friendships that sustain older people

2.3 LET US SUM UP

The word "narcissism" comes from a Greek mythology in which a handsome young man named Narcissus sees his reflection in a pool of water and falls in love with it. The term narcissistic is used to describe people who show an exaggerated sense of self-importance and are preoccupied with receiving attention.

Narcissistic personality disorder is characterised by an abnormal love of self, an exaggerated sense of superiority and importance, and a preoccupation with success and power.

Narcissistic personality disorder exists as a diagnostic category only in DSM-IV-TR. DSM-IV-TR specifies nine diagnostic criteria for narcissistic personality disorder. For the clinician to make the diagnosis, an individual must fit five or more of the following descriptions:

A grandiose sense of self-importance (exaggerates accomplishments and demands to be considered superior without real evidence of achievement).

He or she lives in a dream world of exceptional success, power, beauty, genius, or “perfect” love.

He or she thinks of him- or herself as “special” or privileged.

He or she demands excessive amounts of praise or admiration from others.

He or she feels entitled to automatic deference, compliance, or favourable treatment from others.

He or she is exploitative towards others and takes advantage of them.

He or she lacks empathy and does not recognise or identify with others’ feelings.

He or she is frequently envious of others or thinks that they are envious of him or her.

He or she “has an attitude” or frequently acts in haughty or arrogant ways.

The exact cause of narcissistic personality disorder is unknown.

Researchers have identified some factors that may contribute to this disorder.

Childhood experiences such as parental overindulgence, excessive praise, unreliable parenting, and a lack of realistic responses are thought to contribute to narcissistic personality disorder.

Although researchers today do not know what exactly causes narcissistic personality disorder, there are many theories, however, about the possible causes of narcissistic personality disorder.

For example, Kohut (1977) and Kernberg (1984) attempted to trace the roots of narcissistic personality disorder to disturbances in the patient’s family of origin. Specifically, to problems in the parent-child relationship before the child turned three.

At present, however, psychiatrists do not agree in their description of the central defect in narcissistic personality disorder.

Some think that the problem is primarily emotional while others regard it as the result of distorted cognition, or knowing.

Some maintain that the person with narcissistic personality disorder has an “empty” or hungry sense of self while others argue that the narcissist has a “disorganised” self. Still others regard the core problem as the narcissist’s inability to test reality and construct an accurate view of him- or herself.

Some other theorists believe that narcissistic personality disorder results from extremes in child rearing.

Some other theorists subscribe a bio-psychosocial model of causation - that is, the causes of are likely due to biological and genetic factors, social factors (such as how

a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress.

People with this disorder rarely seek out treatment. Individuals often begin therapy at the urging of family members or to treat symptoms that result from the disorder. So the therapy for the persons suffering from narcissistic personality disorder can be especially difficult because they are often unwilling to acknowledge the disorder. In addition, the tendency of these patients to criticize and devalue their therapists (as well as other authority figures) makes it difficult for therapists to work with them. Narcissistic personality disorder treatment is centered around psychotherapy. There are no medications specifically used to treat narcissistic personality disorder. Several different approaches to individual therapy have been tried with narcissistic personality disorder patients, ranging from classical psychoanalysis and Adlerian therapy to Rational-Emotive approaches and Gestalt therapy. Other forms of psychotherapy that may be helpful for narcissistic personality disorder include cognitive behavioural therapy, family therapy, and group therapy.

Goal of Therapy in Narcissistic Personality Disorder

Because personality traits can be difficult to change, therapy may take several years. The short-term goal of psychotherapy for narcissistic personality disorder is to address such issues as substance abuse, depression, low self-esteem or shame.

The long-term goal is to reshape your personality, at least to some degree, so that you can change patterns of thinking that distort your self-image and create a realistic self-image.

The prognosis for younger persons with narcissistic disorders is hopeful to the extent that the disturbances reflect a simple lack of life experience.

The outlook for long standing narcissistic personality disorder, however, is largely negative.

Some narcissists are able, particularly as they approach their midlife years, to accept their own limitations and those of others, to resolve their problems with envy, and to accept their own mortality.

2.4 UNIT END QUESTIONS

- 1) Prepare a clinical picture of narcissistic personality disorder.
- 2) How does narcissistic personality disorder differ from borderline personality disorder?
- 3) Discuss the diagnostic features of narcissistic personality disorder.
- 4) Discuss the causes of narcissistic personality disorder.
- 5) Explain the treatment and prognosis of narcissistic personality disorder.

2.5 GLOSSARY

Cognitive-behavioural therapy : Group of treatment procedures aimed at identifying and modifying faulty thought processes, attitudes and attributions, and problem behaviours.

- Craving narcissists** : These are people who feel emotionally needy and undernourished, and may well appear clingy or demanding to those around them.
- Empathy** : Ability to understand and to some extent share the feelings and emotions of another person.
- Gestalt therapy** : Type of therapy emphasising wholeness of the person and integration of thought, feeling, and action.
- Manipulative narcissists** : These people enjoy “putting something over” on others, obtaining their feelings of superiority by lying to and manipulating them.
- Narcissistic personality disorder** : Personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.
- Paranoid narcissists** : This type of narcissist feels intense contempt for him or herself, but projects it outward onto others. Paranoid narcissists frequently drive other people away from them by hypercritical and jealous comments and behaviours.
- Passive aggressive personality disorder** : Personality disorder characterised by a pattern of negative attitudes and passive resistance in interpersonal situations.
- Personality disorders** : Characterised by enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.
- Psychoanalysis** : Method used by Freud to study and treat patients.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Phallic narcissists** : Phallic narcissists tend to be aggressive, athletic, and exhibitionistic; they enjoy showing off their bodies, clothes, and overall “manliness.”
- Rational-Emotive therapy** : A cognitive-behavioural approach that seeks to identify and eliminate irrational beliefs that may cause maladaptive behaviours.

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UNIT 3 DEPENDENT AND HISTRIONIC PERSONALITY DISORDER

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Dependent Personality Disorder
 - 3.2.1 Diagnostic Features
 - 3.2.2 Causes
 - 3.2.3 Treatment
- 3.3 Histrionic Personality Disorder
 - 3.3.1 Diagnostic Features of Histrionic Personality Disorder
 - 3.3.2 Causes of Histrionic Personality Disorder
 - 3.3.3 Treatment of Histrionic Personality Disorder
 - 3.3.3.1 Cognitive Behaviour Therapy
 - 3.3.3.2 Group Therapy
 - 3.3.3.3 Family Therapy
 - 3.3.4 Prognosis
- 3.4 Let Us Sum Up
- 3.5 Unit End Questions
- 3.6 Glossary
- 3.7 Suggested Readings

3.0 INTRODUCTION

In your social interactions you might come across such persons who are extremely dependent on other persons. They behave in extremely submissive way. They show acute discomfort at the possibility of separation or sometimes of simply having to be alone. They build their lives around other people and subordinate their own needs or views for the sake of other persons, even when their needs are justified and their views are right. The persons having these characteristics are labeled as suffering from dependent personality disorder. On the other hand, you might come across to such persons are typically concerned about their looks. They are inclined to express their emotions in an exaggerated fashion; for example hugging someone they have just met or crying uncontrollably during a sad movie. Their self-esteem depends on the approval of others and does not arise from a true feeling of self-worth. These are the characteristic features of histrionic personality disorder. In the present unit we will discuss the nature and symptoms of dependent and histrionic personality disorders. We will also attempt to understand the causes and treatment of dependent and histrionic personality disorders.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the meaning of dependent personality disorder;

- Describe the diagnostic features of dependent personality disorder;
- Distinguish dependent personality disorder from other forms of personality disorders;
- Elucidate the causes of dependent personality disorder;
- Explain the treatment of dependent personality disorder;
- Define histrionic personality disorder and explain its symptoms;
- Delineate the diagnostic features of histrionic personality disorder;
- Distinguish histrionic personality disorder from borderline and dependent personality disorders;
- Analyse the causes of histrionic personality disorder; and
- Describe the psychotherapies used for the treatment of histrionic personality disorder.

3.2 DEPENDENT PERSONALITY DISORDER

Dependent personality disorder, formerly known as asthenic personality disorder is a personality disorder that is characterised by a pervasive psychological dependence on other people. Persons affected by dependent personality disorder have a disproportionately low level of confidence in their own intelligence and abilities and have difficulty in making decisions and undertaking projects on their own. They rely on others to make ordinary decisions as well as important ones. Their pervasive reliance on others, even for minor tasks or decisions, makes them exaggeratedly cooperative out of fear of alienating those who help their needs. Individuals with dependent personality disorder sometimes agree to other people when their own opinion differs, so as not to be rejected (Hirschfeld, Shea, & Weise, 1995). They are reluctant to express disagreement with others and are often willing to go to abnormal lengths to win the approval of those on whom they rely. Their desire to obtain and maintain supportive and nurturant relationships may lead to their other behavioural characteristics (Bornstein, 1997), including submissiveness, timidity, and passivity. Another common feature of the disorder is an exaggerated fear of being left to fend for oneself. Adolescents with dependent personality disorder rely on their parents to make even minor decisions for them, such as what they should wear or how they should spend their free time, as well as major ones, such as what college they should attend or which career they should choose.

In the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revision (DSM-IV-TR)*, the American Psychiatric Association states that five of the following criteria should be present for a diagnosis of dependent personality disorder.

Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others;

Require others to take responsibility for major decisions and responsibilities beyond what would be age-appropriate (e.g., letting a parent choose a college without offering any input on the decision);

Has difficulty expressing disagreement with others because of fear of loss of support or approval;

Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy);

Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant;

Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself;

Urgently seeks another relationship as a source of care and support when a close relationship ends;

Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Dependent personality disorder is more common in those who have suffered from chronic illness in childhood.

A child may also exhibit dependent behaviour in response to a specific stressful life event (such as the death of a caregiver or divorce). However, it should not be considered a potential symptom of dependent personality disorder unless the behaviour becomes chronic and significantly interferes with day-to-day functioning and/or causes the child significant distress.

The ICD- 10 of World Health Organisation lists dependent personality disorder as F 60.7.

Dependent personality disorder is characterised by at least 3 of the following:

- encouraging or allowing others to make most of one's important life decisions;
- subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes;
- unwillingness to make even reasonable demands on the people one depends on;
- feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself;
- preoccupation with fears of being abandoned by a person with whom one has a close relationship, and of being left to care for oneself;
- limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others.

3.2.1 Diagnostic Features

The essential feature of Dependent Personality Disorder is a pervasive and excessive need to be taken care of. Individuals with Dependent Personality Disorder have great difficulty making everyday decisions (e.g., what color shirt to wear to work or whether to carry an umbrella) without an excessive amount of advice and reassurance from others (Criterion 1).

These individuals tend to be passive and to allow other people to take the initiative and assume responsibility for most major areas of their lives (Criterion 2).

Adults with this disorder typically depend on a parent or spouse to decide where they should live, what kind of job they should have, and which neighbours to befriend.

Adolescents with this disorder may allow their parent(s) to decide what they should

wear, with whom they should associate, how they should spend their free time, and what school or college they should attend.

This need for others to assume responsibility goes beyond age appropriate and situation appropriate. Because they fear losing support or approval, individuals with dependent personality disorder often have difficulty expressing disagreement with other people, especially those on whom they are dependent (Criterion 3).

These individuals feel so unable to function alone that they will agree with things that they feel are wrong rather than risk losing the help of those to whom they look for guidance.

They do not get appropriately angry at others whose support and nurturance they need for fear of alienating them. Individuals with this disorder have difficulty initiating projects or doing things independently (Criterion 4).

They lack self-confidence and believe that they need help to begin and carry through tasks. They will wait for others to start things because they believe that as a rule others can do them better.

These individuals are convinced that they are incapable of functioning independently and present themselves as inept and requiring constant assistance.

They are, however, likely to function adequately if given the assurance that someone else is supervising and approving.

There may be a fear of becoming or appearing to be more competent, because they may believe that this will lead to abandonment.

Because they rely on others to handle their problems, they often do not learn the skills of independent living, thus perpetuating dependency.

Individuals with Dependent Personality Disorder may go to excessive lengths to obtain nurturance and support from others, even to the point of volunteering for unpleasant tasks if such behaviour will bring the care they need (Criterion 5).

They are willing to submit to what others want, even if the demands are unreasonable.

Their need to maintain an important bond will often result in imbalanced or distorted relationships.

They may make extraordinary self-sacrifices or tolerate verbal, physical, or sexual abuse.

Individuals with this disorder feel uncomfortable or helpless when alone, because of their exaggerated fears of being unable to care for themselves (Criterion 6).

They will “tag along” with important others just to avoid being alone, even if they are not interested or involved in what is happening.

When a close relationship ends (e.g., a breakup with a lover; the death of a caregiver), individuals with dependent personality disorder may urgently seek another relationship to provide the care and support they need (Criterion 7).

Their belief that they are unable to function in the absence of a close relationship motivates these individuals to become quickly and indiscriminately attached to another person. Individuals with this disorder are often preoccupied with fears of being left to care for themselves (Criterion 8).

They see themselves as so totally dependent on the advice and help of an important other person that they worry about being abandoned by that person when there are no grounds to justify such fears. To be considered as evidence of this criterion, the fears must be excessive and unrealistic.

Dependent Personality Disorder must be distinguished from other personality disorders, especially from borderline personality disorder, histrionic personality disorder, and avoidant personality disorder, because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features.

Similarities and differences

Both dependent personality disorder and borderline personality disorder are characterised by fear of abandonment.

However, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands.

The individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support.

Borderline personality disorder patients show a typical pattern of unstable and intense relationships.

Individuals with histrionic personality disorder, like those with dependent personality disorder, have a strong need for reassurance and approval and may appear childlike and clinging.

However, unlike dependent personality disorder, which is characterised by self-effacing and docile behaviour, histrionic personality disorder is characterised by gregarious flamboyance with active demands for attention.

Both dependent personality disorder and avoidant personality disorder are characterised by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance.

However, individuals with avoidant personality disorder have such a strong fear of humiliation and rejection that they withdraw until they are certain they will be accepted.

In contrast, individuals with dependent personality disorder have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships.

3.2.2 Causes

Although the exact cause of dependent personality disorder is not known, it most likely involves both biological and developmental factors.

Some researchers believe an authoritarian or over-protective parenting style can lead to the development of dependent personality traits in people who are susceptible to the disorder.

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.

Caretakers may foster dependence in the child to meet their own dependency needs, and may reward extreme loyalty but reject attempts the child makes towards independence.

Families of those with dependent personality disorder often do not express their emotions and are controlling.

They demonstrate poorly defined relational roles within the family unit.

Some other researchers suggest that dependent children are insecurely attached to their mothers or other caregivers and may not have had close and trusting relationships with others during childhood.

Individuals with dependent personality disorder often have been socially humiliated by others in their developmental years. Hence they may carry significant doubts about their abilities to perform tasks, take on new responsibilities, and generally fear to function independently of others. This reinforces their suspicions that they are incapable of living autonomously.

In response to these feelings, they portray a helplessness that elicits care giving behaviour from some people in their lives.

3.2.3 Treatment

The primary treatment for dependent personality disorder is psychotherapy with an emphasis on learning to cope with anxiety, developing assertiveness, and improving decision-making skills. The most effective psychotherapeutic approach is one which focuses on solutions to specific life problems the patient is presently experiencing.

Long term therapy, while ideal for many personality disorders, is contra indicated in this instance since it reinforces a dependent relationship upon the therapist. While some form of dependency will exist, no matter of the length of therapy, the shorter the better in this case. Examining the client's faulty cognitions and related emotions (of lack of self-confidence, autonomy versus dependency, etc.) can be an important component of therapy.

Assertiveness training and other behavioural approaches have been shown to be most effective in helping treat individuals with this disorder.

Group therapy can also be helpful, although care should be utilised to ensure that the patient doesn't use groups to enhance existing or new dependent relationships. Challenging dependent relationships the client has with others that may be unhealthy for the client should generally be avoided at the onset of therapy.

As therapy progresses, these challenges can occur but must be done carefully; restraint must be used if the individual is not ready to give up these unhealthy relationships.

Termination issues will likely be of extreme importance and will virtually be a litmus test of how effective the therapy has been.

If the individual cannot end therapy successfully and move on to become more self-reliant, it should not be seen as a therapeutic failure. Rather, the individual was not likely seeking life-changing therapy in the first instance but instead solution-focused therapy.

Self Assessment Questions

1) What do you mean by dependent personality disorder?

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2) Discuss the diagnostic features of dependent personality disorder.

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3) How does dependent personality disorder differ from other personality disorder?

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4) Explain the causes of dependent personality disorder.

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5) How can dependent personality disorder be treated? Discuss the methods of treatment.

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3.3 HISTRIONIC PERSONALITY DISORDER

Histrionic personality disorder 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 histrionic personality disorder are highly emotional, charming, energetic, manipulative, seductive, impulsive, erratic, and demanding. Individuals with histrionic personality disorder tend to be so overly dramatic that they often seem almost to be acting which is why, the term *histrionic*, which means theatrical in manner, is used.

The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition- Text Revised (the *DSM-IV- TR*) classifies histrionic personality disorder as a personality disorder. More specifically, histrionic personality disorder is classified by DSM-IV-TR as a Cluster B (dramatic, emotional, or erratic) personality disorder. The personality disorders which comprise Cluster B include histrionic, antisocial, borderline, and narcissistic. Histrionic personality disorder is defined as a personality disorder characterised by a pattern of excessive emotionality and attention seeking including an excessive need for approval and inappropriate seductiveness usually beginning in early adulthood. These individuals are lively, dramatic, enthusiastic, and flirtatious.

DSM-IV-TR lists eight symptoms that form the diagnostic criteria for histrionic personality disorder. An individual having at least five of the below characteristics might be considered to have a histrionic personality disorder:

- Center of attention: Patients with histrionic personality disorder experience discomfort when they are not the center of attention.
- Sexually seductive: Patients with histrionic personality disorder displays inappropriate sexually seductive or provocative behaviours towards others.
- Shifting emotions: The expression of emotions of patients with histrionic personality disorder tends to be shallow and to shift rapidly.
- Physical appearance: Individuals with histrionic personality disorder consistently employ physical appearance to gain attention for themselves.
- Speech style: The speech style of patients with histrionic personality disorder lacks detail. Individuals with histrionic personality disorder tend to generalise, and when these individuals speak, they aim to please and impress.
- Dramatic behaviours: Patients with histrionic personality disorder display self-dramatisation and exaggerate their emotions.
- Suggestibility: Other individuals or circumstances can easily influence patients with histrionic personality disorder.
- Overestimation of intimacy: Patients with histrionic personality disorder overestimate the level of intimacy in a relationship.

The ICD-10 of World Health Organisation lists histrionic personality disorder as (*F60.4*) Histrionic personality disorder is characterised by at least 3 of the following:

- self-dramatisation, theatricality, exaggerated expression of emotions;
- suggestibility, easily influenced by others or by circumstances;
- shallow and labile affectivity;
- continual seeking for excitement and activities in which the patient is the center of attention;
- inappropriate seductiveness in appearance or behaviour; and
- over-concern with physical attractiveness.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

3.3.1 Diagnostic Features of Histrionic Personality Disorder

Excessive attention-seeking behaviour and emotionality is the essential feature of histrionic personality disorder. Individuals with histrionic personality disorder tend to feel unappreciated if not the center of attention, and their lively, dramatic, and excessively extraverted styles often ensure that they can charm others into attending to them.

In seeking attention, their appearance and behaviour are often quite theatrical and emotional, as well as sexually provocative and seductive. They are inclined to express their emotions in exaggerated fashion; for example hugging someone they have just met are crying uncontrollably during a sad movie (Pfohl, 1995).

They are often seductive in appearance and behaviour, and typically concerned about their looks; for example they may spend a great deal of money on unusual jewelry. Their style of speech may also be dramatic but is quite impressionistic but often vague, lacking in detail, and characterised by hyperbole.

The cognitive style associated with histrionic personality disorder is impressionistic (Shapiro, 1965) characterised by a tendency to view situations in very global, black-and-white terms. Individuals with this disorder are usually able to function at a high level and can be successful socially and professionally.

People with histrionic personality disorder usually have good social skills but they tend to use these skills to manipulate other people and become the center of attention.

Furthermore, histrionic personality disorder may affect a person's social or romantic relationships or their ability to cope with losses or failures.

Their sexual adjustment is usually poor (Apt and Hurlbert, 1994) and their interpersonal relationships are stormy because they may attempt to control their partner through seductive behaviour and emotional manipulation, but they also show a good deal of dependence.

Usually they are considered to be self-centered, vain, and over-concerned about the approval of others. People with these disorders have also distorted self-images.

For people with histrionic personality disorder, their self-esteem depends on the approval of others and does not arise from a true feeling of self-worth.

They have an overwhelming desire to be noticed, and often behave dramatically or inappropriately to get attention.

Prevalence rate

The prevalence of histrionic personality disorder in the general population is estimated to be approximately 2%-3% (and 10%-15% of psychiatric outpatients). Individuals who have experienced pervasive trauma during childhood have been shown to be at a greater risk for developing histrionic personality disorder as well as for developing other personality disorders.

Clinicians tend to diagnose histrionic personality disorder more frequently in females; however, when structured assessments are used to diagnose histrionic personality disorder, clinicians report approximately equal prevalence rates for males and females. In considering the prevalence of histrionic personality disorder it is important to recognise that gender role stereotypes may influence the behavioural display of histrionic

personality disorder and that woman and men may display histrionic personality disorder symptoms differently.

Similarities and differences

Histrionic Personality Disorder must be distinguished from other personality disorders, especially from dependent and borderline personality disorders because they have certain features in common.

It is, therefore, important to distinguish among these disorders based on differences in their characteristic features.

Both histrionic personality disorder and borderline personality disorder are characterised by manipulative, projection sensitive, and attention seeking behaviours.

However histrionic personality disorder and borderline personality disorder have different emphasis.

Borderline personality disorder is characterised by intense clinging dependency, whereas for the persons with histrionic personality disorder getting the attention of others is a high priority.

Histrionic personality disorder can further be distinguished from dependent personality disorder.

Patients with histrionic personality disorder and dependent personality disorder share high dependency needs, but only dependent personality disorder is linked to high levels of self-attributed dependency needs.

Moreover, persons with histrionic personality disorder tend to be more active and seductive as compared to those persons with dependent personality disorder.

3.3.2 Causes of Histrionic Personality Disorder

The exact cause of histrionic personality disorder is not known, but many mental health professionals believe that both learned and inherited factors play a role in its development. For example, the tendency for histrionic personality disorder to run in families suggests that a genetic susceptibility for the disorder might be inherited.

However, the child of a parent with this disorder might simply be repeating learned behaviour.

Other environmental factors that might be involved include a lack of criticism or punishment as a child, positive reinforcement that is given only when a child completes certain approved behaviours, and unpredictable attention given to a child by his or her parent(s), all leading to confusion about what types of behaviour earn parental approval.

Psychosexual stages of development through which each individual passes determine an individual's later psychological development as an adult.

Early psychoanalysts proposed that the genital phase is a determinant of histrionic personality disorder. Later psychoanalysts considered the oral phase, Freud's first stage of psychosexual development, to be a more important determinant of histrionic personality disorder.

Most psychoanalysts agree that a traumatic childhood contributes towards the development of histrionic personality disorder.

Some theorists suggest that the more severe forms of histrionic personality disorder derive from disapproval in the early mother-child relationship.

Anthony Storr, a psychoanalyst, (1980) has interpreted histrionic behaviour as a pattern that is often adopted by individuals who do not feel able to compete with others on equal terms and believe that no one is paying attention to them.

According to Storr such people may have been disregarded by their parents as children. Although the child repeatedly tried to get the parents to think of him or her as an individual, those attempts failed.

The child then becomes demanding and resorted to all kinds of dramatic behaviour in order to be noticed. The less attention the parents paid to the child, the more the child has to shout or dramatise to get their attention.

Another component of Freud's theory is the defense mechanism. Defense mechanisms are sets of systematic, unconscious methods that people develop to cope with conflict and to reduce anxiety. According to Freud's theory, all people use defense mechanisms, but different people use different types of defense mechanisms. Individuals with histrionic personality disorder differ in the severity of the maladaptive defense mechanisms they use. Patients with more severe cases of histrionic personality disorder may utilise the defense mechanisms of repression, denial, and dissociation.

3.3.3 Treatment of Histrionic Personality Disorder

Histrionic personality disorder, 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 histrionic personality 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 histrionic personality disorder and to assist patients in decreasing their emotional reactivity. Cognitive behaviour therapy, group therapy, and family therapy have been used for treating histrionic personality disorder.

3.3.3.1 Cognitive Behavioural Therapy

Cognitive therapy is a treatment directed at reducing the dysfunctional thoughts of individuals with histrionic personality disorder. Such thoughts include themes about not being able to take care of oneself. Cognitive therapy for histrionic personality disorder focuses on a shift from global, suggestible thinking to a more methodical, systematic, and structured focus on problems. Cognitive behavioural training in relaxation for an individual with histrionic personality disorder emphasises challenging automatic thoughts about inferiority and not being able to handle one's life. Cognitive behavioural therapy teaches individuals with histrionic personality disorder to identify automatic thoughts, to work on impulsive behaviour, and to develop better problem-solving skills.

3.3.3.2 Group Therapy

Group therapy is suggested to assist individuals with histrionic personality disorder to work on interpersonal relationships. Psychodrama techniques or group role play can assist individuals with histrionic personality disorder to practice problems at work and to learn to decrease the display of excessively dramatic behaviours. Using role-playing, individuals with histrionic personality disorder can explore interpersonal relationships and outcomes to understand better the process associated with different

scenarios. Group therapists need to monitor the group because individuals with histrionic personality disorder tend to take over and dominate others.

3.3.3.3 Family Therapy

To teach assertion rather than avoidance of conflict, family therapists need to direct individuals with histrionic personality disorder to speak directly to other family members. Family therapy can support family members to meet their own needs without supporting the histrionic behaviour of the individual with histrionic personality disorder who uses dramatic crises to keep the family closely connected. Family therapists employ behavioural contracts to support assertive behaviours rather than temper tantrums.

3.3.4 Prognosis

The personality characteristics of individuals with histrionic personality disorder are long-lasting. Individuals with histrionic personality disorder utilise medical services frequently, but they usually do not stay in psychotherapeutic treatment long enough to make changes. They tend to set vague goals and to move toward something more exciting. Treatment for histrionic personality disorder can take a minimum of one to three years and tends to take longer than treatment for disorders that are not personality disorders, such as anxiety disorders or mood disorders.

Research indicates that a relationship exists between poor treatment outcomes and premature termination from treatment for individuals with Cluster B personality disorders.

Self Assessment Questions

1) Define histrionic personality disorder and describe its symptoms.

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2) Discuss the diagnostic features of histrionic personality disorder.

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3) Distinguish histrionic personality disorder from dependent personality disorder.

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4) Explain the causes of histrionic personality disorder.

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5) Discuss the psychotherapies used for the treatment of histrionic personality disorder.

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3.4 LET US SUM UP

Dependent personality disorder is characterised by a pervasive psychological dependence on other people. Persons affected by dependent personality disorder have a disproportionately low level of confidence in their own intelligence and abilities and have difficulty in making decisions and undertaking projects on their own. They rely on other to make ordinary decisions as well as important ones. The essential feature of Dependent Personality Disorder is a pervasive and excessive need to be taken care of.

The cause of dependent personality disorder is not known, it most likely involves both biological and developmental factors. It is believed that an authoritarian or over-protective parenting style can lead to the development of dependent personality traits in people who are susceptible to the disorder. 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 other caregivers or did not have close and trusting relationships with others during childhood.

The primary treatment for dependent personality disorder is psychotherapy with an emphasis on learning to cope with anxiety, developing assertiveness, and improving decision-making skills. The most effective psychotherapeutic approach is one which focuses on solutions to specific life problems the patient is presently experiencing. Long-term therapy, while ideal for many personality disorders, is contra-indicated in this instance since it reinforces a dependent relationship upon the therapist.

Histrionic personality disorder is classified by DSM-IV-TR as a Cluster B (dramatic, emotional, or erratic) personality disorder. Histrionic personality disorder 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.

Excessive attention seeking behaviour and emotionality is the essential feature of Histrionic Personality Disorder. Individuals with histrionic personality disorder tend to feel unappreciated if not the center of attention, and their lively, dramatic, and excessively extraverted styles often ensure that they can charm others into attending to them. In seeking attention, their appearance and behaviour are often quite theatrical and emotional, as well as sexually provocative and seductive. The prevalence of

histrionic personality disorder in the general population is estimated to be approximately 2%-3% (and 10%-15% of psychiatric outpatients)

The exact cause of histrionic personality disorder is not known, but many mental health professionals believe that both learned and inherited factors play a role in its development. Early psychoanalysts viewed the genital stage of psychosexual development as a determinant of histrionic personality disorder. Later psychoanalysts considered the oral phase to be a more important determinant of histrionic personality disorder. Most psychoanalysts agree that a traumatic childhood contributes towards the development of histrionic personality disorder.

Some theorists suggest that the more severe forms of histrionic personality disorder derive from disapproval in the early mother-child relationship.

Psychoanalytic therapy is a treatment of choice for histrionic personality 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 histrionic personality disorder and to assist patients in decreasing their emotional reactivity. Cognitive behaviour therapy, group therapy, and family therapy have been used for treating histrionic personality disorder.

3.5 UNIT END QUESTIONS

- 1) Define dependent personality disorder and explain its symptoms.
- 2) Discuss the diagnostic features of dependent personality disorder.
- 3) In what respect does dependent personality disorder differ from other forms of personality disorder?
- 4) Explain the causes of dependent personality disorder.
- 5) How can dependent personality disorder be treated? Discuss the methods of treatment.
- 6) Explain the nature and symptoms of histrionic personality disorder.
- 7) Explain the diagnostic features of histrionic personality disorder.
- 8) In what respect is histrionic personality disorder different from dependent personality disorder?
- 9) Discuss the causes of histrionic personality disorder.
- 10) Discuss psychotherapies used for treating the individuals with histrionic personality disorder.

3.6 GLOSSARY

Borderline personality disorder : Personality disorder involving extreme “black and white” thinking, instability in relationships, self-image, identity and behaviour. Borderline personality disorder occurs in 3 times as many females than males.

Cognitive-behavioural therapy : Group of treatment procedures aimed at identifying and modifying faulty thought

processes, attitudes and attributions, and problem behaviours.

Dependent personality disorder : Personality disorder characterised by pervasive psychological dependence on other people.

Histrionic personality disorder : Personality disorder characterised by pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions.

Family therapy : Specialised type of group therapy in which the members of the family of the client all participate in group-treatment session.

Group therapy : Psychotherapy of several persons at the same time in small groups.

Narcissistic personality disorder : personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.

Oral stage : First stage of psychosexual development, during which pleasure is derived from lip and mouth contact from need-fulfilling objects.

Personality disorders : Characterised by enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.

Phallic stage : Stage of psychosexual development during which a child begins to perceive his or her own body as a source of gratification. Feelings of narcissism are heightened during this period.

Psychoanalysis : Method used by Freud to study and treat patients.

Psychotherapy : Treatment of mental disorders by psychological methods.

3.7 SUGGESTED READINGS

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UNIT 4 SCHIZOID AND PARANOID PERSONALITY DISORDER

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Schizoid Personality Disorder
 - 4.2.1 Diagnostic Criteria
 - 4.2.2 Causes
 - 4.2.3 Treatment
 - 4.2.4 Prognosis
- 4.3 Paranoid Personality Disorder
 - 4.3.1 Diagnostic Criteria
 - 4.3.2 Causes
 - 4.3.3 Treatment
 - 4.3.4 Prognosis
- 4.4 Let Us Sum Up
- 4.5 Unit End Questions
- 4.6 Glossary
- 4.7 Suggested Readings

4.0 INTRODUCTION

In our social interaction we sometimes come across to such persons who are alone, reserved, socially withdrawn, and seclusive. They choose a solitary walk over an invitation to a party. Such people rarely express their feelings directly. Since they show an inability to form social relationship, they typically do not have good friends. The persons having these characteristics are labeled as suffering from schizoid personality disorder. On the other hand we sometimes come across to such persons who are very mistrustful and suspicious of others. Being too distrustful they can interfere with making friends, working with other. The persons having these characteristics are labeled as suffering from paranoid personality disorder. In the present unit we will discuss the meaning, diagnostic criteria of schizoid and paranoid personality disorders. We will also try to understand the causes and treatment of schizoid personality disorder and paranoid personality disorder.

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the meaning of schizoid personality disorder;
- Discuss the diagnostic criteria of schizoid personality disorder;
- Distinguish schizoid personality disorder from other mental disorders;
- Understand the causes of schizoid personality disorder;
- Explain the treatment of schizoid personality disorder;

- Define paranoid personality disorder and explain its symptoms;
- Understand the diagnostic criteria of paranoid personality disorder;
- Explain the differential diagnosis of paranoid personality disorder;
- Explain the causes of paranoid personality disorder; and
- Understand the treatment of paranoid personality disorder.

4.2 SCHIZOID PERSONALITY DISORDER

The term schizoid is relatively old, having been used by Bleuler (1924) to designate a natural human tendency to direct attention toward one's inner life and away from the external world, a concept akin to introversion in that it was not viewed in terms of psychopathology. Bleuler also labeled the exaggeration of this tendency the "schizoid personality". Schizoid Personality Disorder is characterised by a long-standing pattern of detachment from social relationships. A person with schizoid personality disorder often has difficulty in expressing emotions and does so typically in very restricted range, especially when communicating with others. A person with this disorder may appear to lack a desire for intimacy, and will avoid close relationships with others. They may often prefer to spend time with themselves rather than socialise or be in a group of people. In lay people terms, a person with schizoid personality disorder might be thought of as the typical "loner." Individuals with Schizoid Personality Disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion. Their lives sometimes seem directionless, and they may appear to "drift" in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Employment or work functioning may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation.

4.2.1 Diagnostic Criteria

The *DSM-IV-TR* defines schizoid personality disorder (in Axis II, Cluster A) as:

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

- neither desires nor enjoys close relationships, including being part of a family;
- almost always chooses solitary activities;
- has little, if any, interest in having sexual experiences with another person;
- takes pleasure in few, if any, activities;
- lacks close friends or confidants other than first-degree relatives;
- appears indifferent to the praise or criticism of others;
- shows emotional coldness, detachment, or flattened affectivity.
- it is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

The ICD-10 of World Health Organisation lists schizoid personality disorder as (*F 60.1*). It is characterised by at least four of the following criteria:

- Emotional coldness, detachment or reduced affection.
- Limited capacity to express either positive or negative emotions towards others.
- Consistent preference for solitary activities.
- Very few, if any, close friends or relationships and a lack of desire for such.
- Indifference to either praise or criticism.
- Taking pleasure in few, if any, activities.
- Indifference to social norms and conventions.
- Preoccupation with fantasy and introspection.
- Lack of desire for sexual experiences with another person.

People with schizoid personality disorder show no interest or enjoyment in developing interpersonal relationships; this may also include family members. They perceive themselves as social misfits and believe they can function best when not dependent on anyone except themselves. They rarely date, often do not marry, and have few, if any, friends (criterion-1). They prefer and choose activities that they can do by themselves without dependence upon or involvement by others. Examples of activities they might choose include mechanical or abstract tasks such as computer or mathematical games (criterion-2). There is typically little or no interest in having a sexual experience with another person. This would include a spouse if the affected person is married (criterion-3). Lacks pleasure: There is an absence of pleasure in most activities. A person with schizoid personality disorder seems unable to experience the full range of emotion accessible to most people (criterion-4). People affected with this disorder typically do not have the social skills necessary to develop meaningful interpersonal relationships. This results in few ongoing social relationships outside of immediate family members (criterion-5). Indifferent to praise or criticism: Neither positive nor negative comments made by others elicit an emotionally expressive reaction. They don't appear concerned about what others might think of them (criterion-6). Their emotional style is aloof and perceived by others as distant or "cold." They seem unable or uninterested in expressing empathy and concern for others. Emotions are significantly restricted and most social contacts would describe their personality as very bland, dull or humorless. The person with schizoid personality disorder rarely picks up on or reciprocates normal communicational cues such as facial expressions, head nods, or smiles (criterion-7).

It is difficult to accurately assess the prevalence of this disorder because people with schizoid personality disorder rarely seek treatment. Schizoid personality disorder affects men more often than women and is more common in people who have close relatives with schizophrenia. Schizoid personality disorder usually begins in early adulthood. Schizoid personality disorder is uncommon in clinical settings. Schizoid personality disorder is rare compared with other personality disorders. Its prevalence is estimated at less than 1% of the general population (Weismann, 1993).

Although schizoid personality disorder shares several aspects with other psychological disorders, there are some important differentiating features. While people who have schizoid personality disorder can also suffer from clinical depression, this is certainly

not always the case. Unlike depressed people, persons with schizoid personality disorder generally do not consider themselves inferior to others, although they will probably recognise that they are different. The social deficiencies of people with schizoid personality disorder are also similar to those of people with paranoid personality disorder, although they are more extreme. As Beck and Freeman (1990) put it, they “consider themselves to be observers rather than participants in the world around them”. They do not seem to have the very unusual thought processes that characterise the other disorders in Cluster A (Kalus et.al., 1993). Unlike avoidant personality disorder, those affected with schizoid personality disorder do not avoid social interactions due to anxiety or feelings of incompetence, but because they are genuinely indifferent to social relationships.

4.2.2 Cause

The exact causes of schizoid personality disorder are unknown, although a combination of genetic and environmental factors, particularly in early childhood, are thought to contribute to development of all personality disorders. 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. Many individuals with schizoid personality disorder feel misunderstood by others.

A person with schizoid personality disorder may have had a parent who was cold or unresponsive to emotional needs, or might have grown up in a foster home where there was no love. Or, because people with schizoid personality disorder are often described as being hypersensitive or thin-skinned in early adolescence, a person with schizoid personality disorder may have had needs that others treated with exasperation or scorn. A family history such as having a parent who has any of the disorders on the schizophrenic spectrum also increases the chances of developing the disorder.

Some other theorists subscribe to a bio-psychosocial model of causation- that is, the causes of are likely due to biological and genetic factors, social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual’s personality and temperament, shaped by their environment and learned coping skills to deal with stress). This suggests that no single factor is responsible — rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be “passed down” to their children

4.2.3 Treatment

As with all personality disorders, the treatment of choice for schizoid personality disorder is psychotherapy. However, people with this disorder are unlikely to seek treatment unless they are under increased stress or pressure in their life. Treatment will usually be short-term in nature to help the individual solve the immediate crisis

or problem. The patient will then likely terminate therapy. Goals of treatment most often are solution-focused using brief therapy approaches. Long-term psychotherapy should be avoided because of its poor treatment outcomes and the financial hardships inherent in length therapy. Instead, psychotherapy should focus on simple treatment goals to alleviate current pressing concerns or stressors within the individual's life. Cognitive behavioural therapy, group therapy, family therapy and marital therapy have been widely used for treating people with schizoid personality disorder.

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. Another helpful method can be teaching social skills through role-playing. This might enable individuals to become more conscious of communication cues given by others and sensitise them to others' needs. 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. Since the patient usually avoids social contact, timing of group therapy is of particular importance. It is best to develop first a therapeutic relationship between therapist and patient before starting a group therapy treatment. It is unlikely that a person with schizoid personality disorder will seek family therapy or marital therapy. If pursued, it is usually on the initiative of the spouse or other family member. Many people with this disorder do not marry and end up living with and are dependent upon first-degree family members. In this case, therapy may be recommended for family members to educate them on aspects of change or ways to facilitate communication. Marital therapy may focus on helping the couple to become more involved in each other's lives or improve communication patterns.

4.2.4 Prognosis

Since a person with schizoid personality disorder seeks to be isolated from others, which includes those who might provide treatment, there is only a slight chance that most patients will seek help on their own initiative. Those who do may stop treatment prematurely because of their difficulty maintaining a relationship with the professional or their lack of motivation for change. If the degree of social impairment is mild, treatment might succeed if its focus is on maintenance of relationships related to the patient's employment. The patient's need to support him- or herself financially can act as a higher incentive for pursuit of treatment outcomes.

Self Assessment Questions

1) Discuss the meaning of schizoid personality disorder.

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2) Explain the diagnostic criteria of dependent personality disorder.

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3) How does dependent personality disorder differ from other mental disorders?

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4) Explain the causes of schizoid personality disorder.

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5) How can schizoid personality disorder be treated? Discuss the methods of treatment.

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4.3 PARANOID PERSONALITY DISORDER

Paranoid personality disorder is one of a group of conditions called eccentric personality disorders in which people with these disorders often appear odd or peculiar. People with paranoid personality disorder also suffer from paranoia, an unrelenting mistrust and suspicion of others, even when there is no reason to be suspicious. Paranoid personality disorder is characterised by an extreme level of distrust and suspicion 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 then serve to confirm and reinforce their original pessimistic expectations. People with paranoid personality disorder 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, Kantor 2004). They are often preoccupied with doubts about the loyalty of the friends, leading to a reluctance to confide in others. They also may be hypersensitive, as indicated by a tendency to read threatening meanings into benign remarks. They also commonly bear grudges, are unwilling to forgive perceived insults and slights, and are quick to react with anger (Bernstein, Useda, & Siever, 1995; Widiger & Frances, 1994). This disorder usually begins by early adulthood and appears to be more common in men than in women. The prevalence of Paranoid Personality Disorder has been estimated to be as high as 4.5% of the general population.

4.3.1 Diagnostic Criteria

Paranoid personality disorder is a condition characterised by excessive distrust and suspiciousness of others. This disorder is only diagnosed when these behaviours

become persistent and very disabling or distressing. This disorder should not be diagnosed if the distrust and suspiciousness occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association, 1994) describes paranoid personality disorder as a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts. Paranoid personality disorder is considered a Cluster A personality disorder along with schizoid and Schizotypal and characterised by odd or eccentric behaviour. A diagnosis of paranoid personality disorder should be considered when these paranoid behaviours become persistent and disabling.

According to the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders), a patient must fit at least four of the following criteria in order to be diagnosed with paranoid personality disorder:

The unfounded suspicion that people want to deceive, exploit or harm the patient.

The pervasive belief that others are not worthy of trust or that they are not inclined to or capable of offering loyalty.

A fear that others will use information against the patient with the intention of harming him or her. This fear is demonstrated by a reluctance to share even harmless personal information with others.

The interpretation of others' innocent remarks as insulting or demeaning; or the interpretation of neutral events as presenting or conveying a threat.

A strong tendency not to forgive real or imagined slights and insults. People with paranoid personality disorder nurture grudges for a long time.

An angry and aggressive response in reply to imagined attacks by others. The counterattack for a perceived insult is often rapid.

Suspiciousness, in the absence of any real evidence, that a spouse or sexual partner is not sexually faithful, resulting in such repeated questions as "Where have you been?" "Whom did you see?" etc., and other types of jealous behaviour.

The ICD – 10 of World Health Organisation lists paranoid personality disorder as (*F 60.0*)

It is characterised by at least 3 of the following:

- excessive sensitivity to setbacks and rebuffs;
- tendency to bear grudges persistently, i.e. refusal to forgive insults and injuries or slights;
- suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous;
- a combative and tenacious sense of personal rights out of keeping with the actual situation;
- recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner;

- tendency to experience excessive self-importance, manifest in a persistent self-referential attitude;
- preoccupation with unsubstantiated “conspiratorial” explanations of events both immediate to the patient and in the world at large.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Paranoid personality disorder is confused with other mental disorders or behaviours that have some symptoms in common with the paranoid personality. For example, it is important to make sure that the patient is not a long-term user of amphetamine or cocaine. Chronic abuse of these stimulants can produce paranoid behaviour. Also, some prescription medications might produce paranoia as a side effect; so it is important to find out what drugs, if any, the patient is taking. There are other conditions that, if present, would mean a patient with paranoid traits does not have paranoid personality disorder. For example, if the patient has symptoms of schizophrenia, hallucinations or a formal thought disorder, a diagnosis of paranoid personality disorder can't be made. The same is true of delusions, which are not a feature of paranoid personality disorder.

There are a number of disorders or other mental health conditions listed in the *DSM-IV-TR* that could be confused with paranoid personality disorder because they share similar or identical symptoms with paranoid personality disorder. It is important, therefore, to eliminate the following entities before settling on a diagnosis of paranoid personality disorder: paranoid schizophrenia; Schizotypal personality disorder; schizoid personality disorder; persecutory delusional disorder; mood disorder with psychotic features; symptoms and/or personality changes produced by disease, medical conditions, medication or drugs of abuse; paranoia linked to the development of physical handicaps; and borderline, histrionic, avoidant, antisocial or narcissistic personality disorders.

4.3.2 Causes

The specific cause of paranoid personality disorder is unknown, but the incidence appears increased in families with a schizophrenic member. There seem to be more cases of in families that have one or more members who suffer from such psychotic disorders as schizophrenia or delusional disorder (Bernstein et. al., 1993). Although evidence for biological contribution to paranoid personality disorder is limited, some studies of identical and fraternal 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, including paranoid personality disorder (Bernstein et. al., 1995; Kendler et.al 2006).

Psychological and social factors have also been considered for the development in paranoid personality disorder. Some psychologists point directly to the thoughts of people with paranoid personality disorder as a way of explaining their behaviour. One view is that people with this disorder make the following basic mistaken assumptions about others: “People are malevolent and deceptive,” “They will attack you if they get the chance” and “You can OK only if you stay on your toes” (.Freeman, Pretzer, Fleming, & Simon, 1990). This maladaptive way to view the world results in the development paranoid personality disorder. Paranoid personality disorder can also result from negative childhood experiences fostered by a threatening domestic atmosphere. It is prompted by extreme and unfounded parental rage and/or condescending parental influence that cultivate profound child insecurities.

4.3.3 Treatment

As it has been stated that people with paranoid disorder are mistrustful of everyone, they are unlikely to seek professional help when they need it and also have difficulty developing the trusting relationships necessary for successful therapy. Therapists try to provide an atmosphere that is conducive to developing a sense of trust (Freeman et. al., 1990). Cognitive therapy is widely used to counter the person’s mistaken assumptions about others (Tukat & Maisto, 1985), focusing on changing the person’s belief that everyone is malevolent and that most people cannot be trusted. Group and family therapy, not surprisingly, is not of much use in the treatment of paranoid personality disorder due to the mistrust people with paranoid personality disorder feel towards others.

As personality is a relatively stable, deeply rooted aspect of self, the long-term projection for those with paranoid personality disorder is often bleak. Most patients experience the symptoms of their disorder for their entire life and, in order to manage their symptoms of paranoia, require consistent therapy (Dobbert 2007, Kantor 2004).

Medication generally is not used to treat paranoid personality disorder. However, medications, such as anti-anxiety, antidepressant or anti-psychotic drugs, might be prescribed if the person’s symptoms are extreme, or if he or she also suffers from an associated psychological problem, such as anxiety or depression.

4.3.4 Prognosis

Personality disorder is a chronic disorder, which means it tends to last throughout a person’s life. Although some people can function fairly well with paranoid personality disorder and are able to marry and hold jobs, others are complete disabled by the disorder. Because people with paranoid personality disorder tend to resist treatment, the outcome often is poor. Since paranoid personality disorder is often a chronic, lifelong condition; the long-term prognosis is usually not encouraging. Feelings of paranoia, however, can be controlled to a degree with successful therapy.

Self Assessment Questions

1) Discuss the nature of paranoid personality disorder.

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2) Explain the diagnostic criteria of paranoid personality disorder.

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3) How does paranoid personality disorder differ from other mental disorders?

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4) Explain the causes of paranoid personality disorder.

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5) Can paranoid personality disorder be treated? Discuss the methods of treatment.

4.4 LET US SUM UP

Schizoid Personality Disorder is characterised by a long-standing pattern of detachment from social relationships. A person with schizoid personality disorder often has difficulty in expressing emotions and does so typically in very restricted range, especially when communicating with others. A person with this disorder may appear to lack a desire for intimacy, and will avoid close relationships with others. The *DSM- IV-TR* defines schizoid personality disorder as a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood (age eighteen or older) and present in a variety of contexts.

The exact causes of schizoid personality disorder are unknown, although a combination of genetic and environmental factors, particularly in early childhood, are thought to contribute to development of all personality disorders. The schizoid personality disorder has its roots in the family of the affected person.

Psychotherapy is the treatment of choice for schizoid personality disorder. Goals of treatment most often are solution-focused using brief therapy approaches. Long-term psychotherapy should be avoided because of its poor treatment outcomes and the financial hardships. Instead, psychotherapy should focus on simple treatment goals to alleviate current pressing concerns or stressors within the individual's life. Cognitive behavioural therapy, group therapy, family therapy and marital therapy have been widely used for treating people with schizoid personality disorder.

Paranoid Personality Disorder is characterised by an extreme level of distrust and suspicion of others. Paranoid personalities are generally difficult to get along with, and their combative and distrustful nature often elicits hostility in others. People with paranoid personality disorder 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 grudge.

The exact cause of paranoid personality disorder is not known, but it likely involves a combination of biological and psychological factors. The fact that paranoid personality

disorder is more common in people who have close relatives with schizophrenia suggests a genetic link between the two disorders. Early childhood experiences, including physical or emotional trauma, are also suspected to play a role in the development of paranoid personality disorder.

Since people with paranoid disorder are mistrustful of everyone, they are unlikely to seek professional help when they need it and also have difficulty developing the trusting relationships necessary for successful therapy. Cognitive therapy is widely used to counter the person's mistaken assumptions about others focusing on changing the person's belief that everyone is malevolent and that most people cannot be trusted

4.5 UNIT END QUESTIONS

- 1) Define schizoid personality disorder and explain its symptoms.
- 2) Discuss the diagnostic features of schizoid personality disorder.
- 3) In what respect does schizoid personality disorder differ from other forms of personality disorder?
- 4) Explain the causes of schizoid personality disorder.
- 5) How can schizoid personality disorder be treated? Discuss the methods of treatment.
- 6) Explain the nature and symptoms of paranoid personality disorder.
- 7) Explain the diagnostic features of paranoid personality disorder.
- 8) In what respect histrionic personality disorder is different from paranoid personality disorder?
- 9) Discuss the causes of paranoid personality disorder.
- 10) Discuss psychotherapies used for treating the individuals with paranoid personality disorder.

4.6 GLOSSARY

Antisocial personality disorder: A personality disorder featuring a pervasive pattern of disregard for and violation of rights of others.

Avoidant personality disorder : A personality disorder featuring a pervasive pattern of social inhibition, feeling of inadequacy, and hypersensitivity to criticism.

Borderline personality disorder: Personality disorder involving extreme “black and white” thinking, instability in relationships, self-image, identity and behaviour. Borderline personality disorder occurs in 3 times as many females than males.

Cognitive-behavioural therapy : Group of treatment procedures aimed at identifying and modifying faulty thought processes, attitudes and attributions, and problem behaviours.

- Delusion** : False belief about reality but maintained in spite of strong evidence to the contrary.
- Dependent personality disorder:** Personality disorder characterised by pervasive psychological dependence on other people.
- Depression** : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
- Empathy** : Ability to understand and to some extent share the feelings and emotions of another person.
- Family therapy** : Specialised type of group therapy in which the members of the family of the client all participate in group-treatment session.
- Group therapy** : Psychotherapy of several persons at the same time in small groups.
- Hallucination** : False perception; things seen or heard that are not real or present.
- Histrionic personality disorder:** Personality disorder characterised by pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions.
- Introversion** : Tendency to be shy and withdrawn.
- Narcissistic personality disorder:** personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.
- Paranoia** : Person's irrational beliefs he or she is especially important or that other people are seeking to do him or her harm.
- Paranoid personality disorder** : Cluster A (odd or eccentric) personality disorder involving pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent.
- Personality disorders** : Characterised by enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Schizoid personality disorder** : Cluster A (odd or eccentric) personality disorder featuring a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions.
- Schizophrenia** : Psychoses characterised by the breakdown of integrated personality functioning, withdrawal from reality, emotional blunting and distortion, and disturbances in thought and behaviour.

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